Northumbria Healthcare NHS
NHS Foundation Trust

Needs Assessment Handbook

Operational Guidance for needs assessors

In partnership with
Northumberland
Northumberland County Council

Version Control

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Target Audience	All Needs Assessors

Statement of Changes

Version	Date	Description
3.0	11/8/2017	Substantial rewrite, to reflect version 3 of the CSP1, launch of the CSP4 and Urgent Needs Plan form, and general review of the guidance.
2.0	2/3/2015	Substantial rewrite, to reflect version 2 of the CSP1 and lessons from the first year.
1.3	22/06/2015	Additional information added.
1.2	22/05/2015	Young Carers section added.
1.1	02/04/2015	Additional information added.

Contents

__NB__: all page numbers are clickable in the electronic version of the handbook. The red arrows on each page pointing upwards (🡅) will return you to the contents pages.

ABOUT THE NEEDS ASSESSMENT HANDBOOK

1. This handbook provides guidance to staff about needs assessment under the Care Act 2014. It sets out the organisation's general expectations about needs assessments and gives detailed advice about completing Northumberland's standard needs assessment form (the CSP1), no-change review form (the CSP4), standalone carer assessment form (the CSP2) and Urgent Needs Plan form.

2. Needs assessors should also be familiar with other guidance (most of which can be found in the Guidance and Procedures folder on your tablet, where it will automatically be updated to the latest version when you check out forms).

- The Statutory Guidance about needs assessment under the Care Act (available online here)
- Technical guidance on needs assessment recording on Swift and on tablets.
- Case File Recording Standards guidance
- The information sheets for service users and carers

3. You will see tips (💡), warnings (!) and notes (**NB.**) boxes for extra guidance on completing the relevant detail within the forms.

4. If you are accessing this handbook electronically while connected to the Northumbria network you will be able to click on links to information available on the NCC Health and Social Care website, forms and guidance held in a shared area on the network. The most up to date versions of guidance documents which you regularly need to refer to are now available on your tablet, and are automatically updated when you check forms out if they have changed..

5. We would welcome feedback on issues with this guidance or the assessment process itself which we need to address, or improvements which we could make. Please email all comments to careactqueries@northumbria.nhs.uk – but note that this is not a helpdesk for urgent technical problems with the forms; these should be raised with the Systems Help Line, Systemshelpline@northumbria.nhs.uk or 01670 622450. ↑

GENERAL GUIDANCE ON ASSESSMENT

What the law requires

6. The Care Act makes it a statutory duty to do a number of things during an assessment which were previously regarded as good practice but not required. All needs assessors should be aware of the duties in the Act which affect needs assessments (on the CSP1) and carer assessments (in the CSP1 or on the CSP2). They should also be aware of the contents of the Care Act statutory guidance, particularly the chapters on assessment and eligibility, care and support planning, personal budgets, direct payments, and reviews. ↑

Needs assessments (people with care and support needs)

7. We must **carry out an assessment** if someone has care and support needs, regardless of whether we think those needs are eligible for support, and regardless of the person's means (S9(1)) (unless they don't want one – see next point). The Act does not define what "care and support needs" are, and the courts may ultimately clarify that, but our current view is that **a person has care and support needs if there is *anything* that they need help from other people to do which people can normally do themselves, or if they need help from other people to keep themselves safe from *any* risk which people can normally protect themselves from**.

8. People **can refuse** an assessment (S11). If it becomes clear during a visit that the person will not benefit from one, you should discuss with them whether they would prefer to get information and advice without a full assessment. If they do choose not to have an assessment, you should document this using the Options Guidance form OG1, which is available through Swift (It is linked to a contact note of type "Options Guidance". Staff in early intervention services (such as STSS and OTs) use this regularly, and can give advice on it.) But the Act says that we **must** assess anyone who is at risk of abuse or neglect (S11(2)). If someone in that situation who has the capacity to do so refuses an assessment, we will need advice about the legal position – team managers should pass requests for legal advice to senior managers.

9. If someone doesn't have the mental capacity to make an informed decision to refuse an assessment, we **must** consider (and document) whether an assessment is in their best interests (S11(2)). For instance if we become aware of someone with severe dementia who is being supported by their spouse and family, then even if they don't want an assessment we need to make our own decision about whether it would be in the person's best interests to have one – for example because their support arrangements don't seem to be robust.

10. We **must**, wherever practicable, give the person information about the assessment process, in a form which they can understand, before the assessment takes place (regs). This will usually mean making sure they have copies of the information sheets which we standardly include in the information folder. If the person is unlikely to understand these, you should if possible identify someone who will be able to explain the process to them. ↑

11. We **must** assess all of the person's care and support needs, whether or not they are eligible for social care funding and whether or not a family or friend carer will be meeting them (S9(3)).

12. We **must** ensure assessors have **appropriate skills and knowledge** and that they consult people with relevant expertise where relevant (regs). The statutory guidance specifically lists a number of conditions which require an assessor to have appropriate skills and knowledge themselves, or to consult an expert who does – autism, learning disabilities, mental health needs and dementia. There is a further specific requirement that all assessments of people who are deafblind must be carried out by someone with a level 3 qualification.

13. We **must** consider the impact of care and support needs on the person's **wellbeing** and on the **outcomes** which they wish to achieve in day to day life S9(4). (In practice, this means that we must also document that we have considered these issues – in the CSP1, this goes under the "What you want to achieve" heading.)

14. We **must** consider what **preventative services** or **information** or **resources in the community** the person might benefit from, and what else could help the person to achieve the outcomes they want (S9(6)). This means that an assessment **can't** just be about what costed services the person may be eligible for. If costed services aren't a solution we must consider what else might help. (In the CSP1, this is recorded under "your strengths and opportunities".)

15. We **must** involve in an assessment any **carers** that the person has (S9(5)) – i.e. anyone who is providing or plans to provide the person with care, other than paid workers or people doing voluntary work. This means that you must talk to each carer about their view of the person's needs and about the help they are providing or intend to provide, whether or not the person asks you to – though it does *not* mean that you should give carers confidential information about the person without their consent. As well as being a statutory duty, identifying and talking to carers is an essential part of assessing needs and designing support arrangements – we need to listen to their advice about what works for the person, and understand the limits of the care they are able and willing to provide.

16. We **must** offer a "**supported self-assessment**" (regs). This means that we must offer people the opportunity to participate in the process of writing the assessment. We intend ultimately to make an online version of the form available; in the meantime, if people want to give us their own description of their needs, we should encourage them to do so, though in the end we are responsible for deciding whether the information is correct, and whether needs are eligible for support.

17. We **must** give the person a **copy in writing** of their assessment and their care and support plan (S12). The Act does not give us discretion about this – which means we **can't** decide not to send out an assessment because we think it would distress or confuse the person. This requires a major change from the way many forms used to be filled in. Assessment documents can't now be written in a language intended for professionals or bureaucrats; they should be understandable by the people they are about (or the family members or friends who are speaking for them). . ↑

18. If the person can't fully participate in the assessment, we **must** identify someone to speak for them (S67). This won't usually be a paid **advocate** – more often it will be an "**appropriate person**", such as a family member or friend or a peer advocate. The appropriate person or advocate should always be given a copy of the form.

19. We **must** consider whether the person's condition **fluctuates** (regs). If it does, we need to be able to demonstrate that we have considered how their care and support needs may vary. ↑

20. We **must** consider the impact of the person's condition on carers and others (regs) – including children's welfare, education and development and whether children are carrying out inappropriate tasks.

21. We **must** give people a written record of what we have decided about the **eligibility** of their needs – **including needs which carers are intending to meet** (S13 and eligibility regs) – the CSP1 is designed to fulfil this duty.

22. We **must** give people a **written record** of their care and support plan (S25) – also included in the CSP1. A care and support plan **must** include: details of the services to be provided; a "personal budget" (how much the services will cost, and how much of that the person will pay); and details of direct payments. These are in the CSP1, except that direct payments information is currently in an annexe to the CSP1 sent out by the Direct Payments Team.

23. Strictly speaking, the Care Act assessment duty does not apply to people receiving aftercare under **Section 117** of the Mental Health Act 1983. The Code of Practice under the Act says that Section 117 assessments and care plans should be joint health/social care assessments developed within the framework of the Care Programme Approach. If we can't produce these assessments and care plans in a single joint document, there should be close liaison when completing or updating the CSP1 and the NTW CPA documentation, so that taken together they constitute a single coherent assessment and plan.↑

People moving between local authority areas

24. We are responsible for meeting the needs of anyone who is "ordinarily resident" in Northumberland. This includes anyone who lives in Northumberland unless they are deemed to be the responsibility of another local authority. Unfortunately the Care Act rules about when people are "deemed" to be the responsibility of another authority are not entirely clear – but basically regulations say that if an authority places someone outside its boundary in a care home, a supported living scheme, or a shared lives scheme, it remains responsible for them. In some cases, it may not be clear whether this applies, for instance the definition of "supported living accommodation" in the regulations is not easy to interpret, and a previous local authority *may* be responsible even if it has not made the arrangements for the person's new supported accommodation.

25. The duty to assess a person's needs applies whether or not we believe that the person is ordinarily resident in Northumberland. The main reason for this is to avoid a situation where no local authority carries out an assessment because there is a dispute about which authority is responsible. If another local authority accepts responsibility for the person, there would in practice be no point in carrying out an assessment. ↑

26. If there is uncertainty about ordinary residence, or if the local authority which appears to be responsible disputes that, you should seek advice. In the meantime, we should make sure that we understand the needs of anyone living in Northumberland where responsibility is disputed, and should inform the other local authority about all significant events. If the person lives in Northumberland, then even if we think that responsibility clearly rests with another local authority we should do what we reasonably can to help sort their situation out.

27. When people with care and support needs move between areas into any kind of accommodation *other* than a care home, supported living scheme or shared lives scheme, the local authority whose area they move to becomes responsible. (For instance we are responsible for anyone who moves to Northumberland to live with family members, or who buys a house or takes up an ordinary tenancy in Northumberland.) The local authority for the person's old address has a duty to send the new local authority on request the needs assessment, care and support plan and any relevant carer assessment (S37). If someone moves here, we have a duty to continue to meet the needs identified in their old authority's assessment until we have completed our own assessment, and if we reach a different view about the person's eligible needs we have a duty to explain this in writing to the person (we should do this in the CSP1).

28. We are responsible for assessing the needs of **carers** who support anyone ordinarily resident in Northumberland, wherever they live. ↑

Meeting urgent needs

29. We **may** provide urgent services without carrying out a needs assessment which meets the full requirement of the Care Act (S19(3)). The specific example given in the Act of a situation where this would be appropriate is terminal illness, but our view is that it would be reasonable to follow a simpler process in any circumstances where the urgent need to find immediate solutions and/or the instability of the person's current situation mean that it would be inappropriate to try to have the kind of considered discussion about the person's plans for their life which a Care Act needs assessment requires.

30. We **may** charge for services provided to meet urgent needs (the charging power in (S14)) is not linked to a needs assessment). However our view is that it would not be acceptable to charge for services without explaining that this will happen, and documenting that this discussion has taken place.

31. There is no specific statutory provision about how we should assess a person's urgent needs. The Urgent Needs Plan form is designed to ensure that the basic necessary information is recorded. There is no statutory requirement to provide the person with a written copy of their urgent needs plan, but our view is that this should happen, in line with the spirit of the Care Act and to avoid any suggestion that we are using the urgent needs process to evade our Care Act duty to co-produce assessments with the people they are about.

32. Technically, the national eligibility criteria do not apply when meeting urgent needs. S13 says that eligibility must be considered *after* a needs assessment, which makes sense, because a formal eligibility decision ought to take account of all of the information gathered during a full assessment. However we would expect decisions about meeting urgent needs to be based on broadly the same assumptions as those in the eligibility criteria about what needs must be met, though some longer-term eligible outcomes, such as participation in work, volunteering or education, will often not be relevant to short-term plans for meeting urgent needs. ↑

Carer assessments

33. We **must** assess any carer who appears to have current or future needs for support (S10), unless they tell us they don't want us to.

34. Carers like the people they care for can **refuse** assessments (S11). Information Sheet C4 is intended to explain to carers when a carer assessment is and is not likely to be of benefit to them. In general, our advice is that if the cared-for person is going to have a care and support plan, it is likely to be beneficial for any carers providing significant levels of support to have a carer assessment, either as part of the CSP1 or on the separate CSP2, to help us shape the care and support plan in a way that will support them best. If the cared-for person is not having a care and support plan, we'd usually advise carers first to talk to Carers Northumberland, who can give them advice and support, and then discuss with them whether they still could benefit from a formal carer assessment by us (which would always be on a separate CSP2). However all carers with support needs do have a right to ask for an assessment immediately if they wish. If a carer decides not to have an assessment, or doesn't appear to need support, you should record in a contact note on Swift the reason why no carer assessment has taken place (contact note type "Carers Assessment Declined").

35. Carers must be given a **written record** of their assessment and plan (either in the CSP1 or as a CSP2) (S12(4))

36. Carers have a **right to support** if they meet eligibility criteria(S13 & S20). Often, however, their eligible needs will be best met by arranging care and support for the person they look after. ↑

Assessments and assessment forms

37. An assessment is a discussion with someone about issues they have in their life which you may be able to help them to resolve. It is **not** the completion of a form, and it is **not** a procedure for deciding whether someone is eligible for publicly-funded services. We do need to do those things, but most of all we need to have an open-ended discussion with people about all of the issues they face and all of the possible solutions to them – including for instance solutions which call on the resources of their family and community, housing solutions, and social security benefits that they may be entitled to.

38. This guidance is structured around the assessment forms, but your first priority should be to understand people's situations, and how those interact with the lives of the other people around them. You should not start to fill in forms until you have talked about those wider issues. ↑

Using the CSP forms in people's homes

39. The CSP forms have been designed to be used on tablet computers in the homes of disabled people and carers. However this does **not** mean that people should experience assessment visits as being about filling in a form, or recording their data on a computer. The purpose of an assessment visit is to explore with the person what issues they have as a result of disability, or of being a carer; how they want things to change; and how that might be achieved. The way the discussion takes place should be determined by what makes sense to the person, not by the way the form is arranged. The form should never get in the way of talking about the issues which matter to the person in the way that they want to talk about them.

40. There is no one right way to use the forms and the tablet in a person's home. Sometimes it may work well to share and discuss in detail with the person everything that is written on the form, so that they are confident that we have understood their situation, and that we have recorded it correctly. In other situations, it may be more natural to use the form as a checklist of the issues that need to be covered, but to make only simple notes while in the person's home, to be written up more fully afterwards.

41. There should always be a general discussion before you start to fill in information on the form about what the person sees as the main issues which they want to talk about/have help with. When you are carrying out a needs assessment (CSP1), you should summarise the result of that discussion in Part A, in the box headed **What you want to achieve**. It may often be best for this to be the first part of the form you fill in. Whatever approach you take to the rest of the form, you should always aim to complete this box while you are with the person, and you should make sure that they are happy with the way you have described the outcomes they want.

> The “document map” which appears at the left of forms is there to make it easier to complete them in whatever order works best for each assessment. For instance you may need to go back to earlier questions if you find out new information, or the person changes their mind.

42. Because the tablet may have forms for other people on it as well as those for the person you are visiting, you need to be careful not to mix them up and disclose confidential information about someone else. To make sure of this, you should open the correct service user’s folder on the tablet before you meet the person. ↑

The design of the assessment forms

43. The forms are designed to cover the Care Act requirements while minimising the need for assessors to repeat the same text on the forms for most of the people they see, or in several places in the same form. **If you find yourself regularly copying and pasting text between forms or within forms, something is going wrong** – either there is a problem with the design of the forms that you should tell us about, or you should be thinking about better ways of organising the information.

44. The intention is that any questions on the forms that don’t need to be answered are hidden. You should answer all questions that are visible. The CSP1 cannot be finalised until you have done this. If this creates a problem in some unusual situation, or because of a technical glitch, please phone the Systems Helpline.

45. In some places, choosing from a drop-down list changes the standard text in the form, as well as hiding or showing further questions. Unless you are very familiar with the way this works, you should make sure you read the standard text to check that what it says is right, particularly if you are in any doubt about whether you have picked the right option from the drop-down. (This is particularly important for some of the questions about mental capacity in the CSP1.)

46. There is technical advice about use of the forms available separately, in the Swift Guidance for Needs Assessment Recording, which is one of the policy and procedure documents available on your tablet. ↑

Style when writing the forms

47. The text in the forms should be written so as to make sense to the person the assessment is about – or the family member or friend who is acting on the person’s behalf. It should not use jargon or abbreviations, and should not assume that the reader understands how social care or health services work. It should usually be written in complete sentences rather than in note form, and you should spellcheck any text which you are not certain that you have typed correctly.

48. You should aim to produce a document which people will find easy to read, rather than just answering each question in isolation. If you find yourself repeating the same text in several places, you should think about how to avoid that – and you should never find yourself copying and pasting the same text into several different places in the form. For instance if you have set out the details of the person's weekly schedule of services in the diary sheet at the end, you shouldn't find yourself repeating all of that anywhere else. ↑

49. The form should be consistent in how it refers to the person whose assessment it is. The text you write, like the standard text, should address that person as "**you**". When you are referring to decisions made by our organisation, you should use "**we**" ("we have decided"; "we think that"…). When you are referring specifically to things that you have done or will do yourself, use "**I**" – but make sure that you are also the person identified in Part D as having carried out the assessment, so it is clear who is writing this.

50. If you are quoting word for word what the person said, or of the person wrote the answer to a question themselves, put it in quotes – it is fine for the form to say this:

> You have told us that "I am anxious about what other people think"
>
> *But not this:*
>
> You have told us that I am anxious about what other people think.
> *(Which reads as if the service user is saying that you, the assessor, are anxious)*

51. If the person has someone else speaking for them because they don't have the capacity to participate fully in the assessment themselves (an "**appropriate person**" such as a family member or a friend, or a formal **advocate**), statements beginning "you told us…" will mean "the person speaking for you told us on your behalf…". When you answer the questions about mental capacity at the start of the CSP1, text will be inserted explaining who "you" refers to in the rest of the form.

52. Sometimes a person may have someone speaking for them because they have *substantial difficulty* participating in the assessment, though they *do* have the mental capacity to do so. In this case, "you" should still refer to the person themselves, and you should satisfy yourself that what you are recording *is* the person's own view, even if they needed help from their appropriate person/advocate to articulate it. (Choosing this in the mental capacity section as the reason for having an appropriate person/advocate will insert text explaining this.) If there is room for doubt, you **must** make sure that it is clear whose comments you are reporting on the form. ↑

Carers

53. Throughout the form, **"carer"** should be used to refer to family members or friends of the person who help them without being paid. People who are being paid to provide care and support should be referred to as **care workers**.

54. When the form asks about whether meeting a need requires help from "a carer or a care worker", this includes *anyone* who is looking after the person. It is *never* right to say that someone does not need help from "a carer or a care worker" because their wife, or husband, or neighbour will help instead. Anyone who helps the person with things that they need help with because of illness or disability is a carer, whether or not they think of themselves in that way, unless they are being paid to do so, or are working as a volunteer in an organised arrangement. ↑

55. One of the biggest changes required by the Care Act to the way we carry out assessments is that we are required to assess what eligible needs *carers* are going to be meeting. In the past, we probably focused on needs which carers *wouldn't* be meeting, and things carers were doing which there were concerns about – for instance because the carer was risking their own health, or didn't feel they could carry on. Now we have a duty to record all the person's needs, whether or not a carer is meeting them, and to say whether we would accept needs as eligible if the carer stopped doing so.

56. Carers must always be involved in assessments of the needs of the person they are looking after. If caring appears to be having a significant impact on their own lives, or if it looks as if they may need support, we should also always ask them about their own needs, offering the choice of having these recorded on the CSP1 or having a separate assessment on a CSP2. Whichever option the carer chooses, a discussion of the carer's own needs is a **carer assessment**. You should not say anything to a carer which gives them the impression that having a carer assessment is an optional extra for carers with particular problems – discussing what issues carer(s) are having should be seen as a normal part of any assessment. Carers do have a right to refuse to have that discussion, but if you introduce it properly, it should be very rare that that happens.

> It will never be right to finish the discussion about everything else on the CSP1 and then at the end say "Now what about you [the carer]? If you want, you have a right to have an assessment of your needs as well." Normally, the best approach will be to have at least a short private conversation with the carer(s) about how things are going for them right at the *start* of the needs assessment, as soon as you have established that they will be providing some care and support, so that you are aware early on of any issues which might affect the care and support plan. It is particularly important to have a private conversation if there are any signs of disagreements between the person and their carer.

57. Carers should always be given the information sheet for carers (Sheet C4), and encouraged to make contact with Carers Northumberland, and with any local support groups for people caring for others with similar conditions.

58. We have special duties towards **young carers** – defined in law as carers aged under eighteen, though we shouldn't ignore young adults over that age who may be missing out on education or training opportunities, or prevented from moving on into independent adulthood, because of their caring responsibilities. There is more advice about this in the section of the handbook about the CSP2. But the recommended approach is to consider the **whole family** around the person, thinking about how their disability or illness is affecting everyone around them, both positively and negatively, and how the solutions which you suggest can achieve the greatest benefit for all of the people who they will affect. ↑

Checklist before finalising a form

59. Assessment forms should make sense on their own as an explanation of the decisions we have made about the person's needs and the care/support required to meet them. As well as giving answers to each of the specific questions on the form, you should step back and ask yourself whether the form as a whole does give a full explanation.

60. In particular, you should ask yourself:

- If there is a change to the level or nature of the support the person will be getting, does the form clearly spell out what the change is and why it is happening?
- If more than one possible solution was discussed, is it clear from the form why the others were rejected?
- If there were disagreements, is it clear what they were, and how you have tried to resolve them? ↑

Management of the forms

61. Detailed technical guidance on the process of checking forms in and out from Swift is available separately. Key points to note about the management of the forms are as follows:

- Forms should be checked back into Swift as soon as reasonably possible after you have done substantial work on them, to minimise the risk of information being lost or becoming hard to access if you are absent from work. (If you need to do further work on the form, you can then check it out again, having made sure that a copy is held on the system.) Forms should **never** be checked out continuously for more than five working days.
- Forms should not remain in draft for more than 28 days. If there is a particular reason why an assessment cannot be finalised within that period, you should discuss it with your manager as soon as you realise that there may be a problem.
- There is no requirement that paper copies of the forms must be kept on the manual file.
- Forms should standardly be checked out onto the tablet and taken with you when you carry out an assessment or review. It is up to your judgement how you use the tablet during your discussions, but the normal expectation is that the assessment should be “co–produced” with the person, and that the person should have as much opportunity as they wish to see and comment on what you are saying.
- If you are carrying out a review or reassessment, you should always talk through with the person the information carried through from the previous form, to make sure that it remains current. However for new assessments, or changes to existing assessments, it may sometimes work best to add new information only in note form, and turn it into continuous prose afterwards.
- Copies of other relevant assessments (e.g. OT assessments and STSS assessments) will be transferred to the tablet along with the CSP forms, so that you can consult them if necessary. ↑
- Carer assessments will now usually be recorded on the CSP1 – however if you know in advance that there is a carer who wishes to have a separate assessment, you should check out a CSP2 along with the CSP1. If you discover while visiting that a carer wishes to have a separate assessment, a CSP2 can be created using the template which is copied into the client folder on the tablet when you check out the CSP1. If you have completed a manual

CSP2 form you must email this to your admin support who will transfer the information into a Swift CSP2 form.

- If there is some information which should not be shared with service providers for any reason, you should include this information in a contact note, with a note at the relevant point in the CSP1 to indicate that there is additional information held in a contact note, including the date and time of the note so that it is easy to locate, and using the note type “CSP1 – information not to be sent to providers” – you may find it helpful to use the Word contact note template which is made available on your tablet when you check out a CSP1 bundle from Swift (but you will need to cut and paste the text from there into Swift when next connected). You should send a copy of the contact note to the person the assessment is about at the same time that you send the CSP1. In the next update of the CSP1, we intend to add a box for this kind of information in Part B, which will be removed automatically in the provider copy.
- In very exceptional circumstances, you may judge that some assessment information should not be shared with the subject of the assessment. This would be very unusual, since we have a clear statutory duty to share assessments. If you believe that this is necessary, you must get approval from a senior manager, documenting clearly your reasons. The senior manager will need to take legal advice. If a decision is confirmed not to share some information with the person, the information which is not on the CSP1 should be recorded in a contact note – please contact the Systems Helpline for advice. You will also need a written record of the senior manager’s decision, the reasons for it, and what advice has been taken. ↑

Updating details for transfer to Swift

62. If you obtain new or updated information when completing a CSP form which requires an update to Swift, you will need to inform your admin support. This could be a change to demographic information, details of professionals involved with the person or of their family members, or an email address for correspondence.

NB. Information about required NFRS visits will automatically be transferred to the Fire Service when you next check in the form. But no other information is currently automatically picked up. We hope in future to develop automatic notifications to admin that updates are required to Swift, but this is not in place at present, so you need to do this yourself. ↑

Requesting Brokerage Involvement

63. When you have drawn up a care and support plan which you expect to be approved, and which will need to start soon, you should ring the brokerage service and let them know the details of the proposed services. The broker will complete their enquiry form and wait for approval to be sent to them by the budget approver before finalising arrangements. Brokers will input services that they have arranged into Swift’s Costed Packages of Care module. Guidance about the brokerage process is available in the “General Brokerage Process” which should be available on your tablet. ↑

Budget Approval

64. When a draft CSP1 is ready for approval, you should email the budget approver. If they are happy with the proposed care and support plan, the budget approver should email the Brokerage/AC inbox for input into CPC.

65. You should make sure that the CSP1 is organised in a way which makes it easy for the budget holder to find the key information. In particular:

- The **summary of the care and support plan** in Part C should give a clear short overview of the plan, and in particular what changes to any existing arrangements are proposed (though it does *not* need to give full details).
- The **indicative plan** should be presented in a way which makes it as clear as possible how much support you are assessing as eligible, including support provided by carers which we would be responsible for replacing if the carers became unable to, or chose not to do so.
- **The reasons why you need care and support** in Part A should give an up to date summary of the person's ongoing disabilities, health conditions and other circumstances which affect their need for support – and should *not* include any out of date information, or irrelevant material such as detailed notes of specific meetings.
- The second box in Part D should give a short account of any specific recent events which have led to the review or reassessment.
- Budget holders are recommended to use these sections of the form to get an overview, looking at other information in more detail as necessary. The "document map" on the left hand side of the screen provides a quick means of doing this. Budget holders should also ensure that assessments which they approve are written appropriately for sending to the people they are about and their carers, and that they explain clearly why decisions have been made. ↑

Input of costed services/sending providers the form

66. Brokers will input costed services they have arranged into CPC. Where a Broker hasn't been involved in arranging service, admin will enter service details on Swift.

67. Admin/Brokers will send the provider a "Provider Copy" of assessments and reviews. This is different from the "Client copy", because it omits information about charges. ↑

Sending forms to the person they are about

68. We must always send CSP1s, CSP4s and urgent needs plan forms to the person they are about, though this can be by way of an "appropriate person" or advocate who is speaking for them. If the person/appropriate person/advocate uses email, you should encourage them to agree to communicate electronically, though choice should always be offered.

69. Since the CSP1 is now usually where the assessment of the carer's needs is recorded, the carer must also have access to a copy. Where the carer and the person live together, it will usually be enough to send a single copy to both of them, but if there is any doubt about this you should check. You should check before deciding where to record the carer assessment that both the carer and the person are happy for their information to be shared.

70. If sent by post, the forms are designed to be sent to the person in a window envelope; if they are being sent to an appropriate person or advocate, the address will need to be put on the envelope manually, preferably as “[Person’s name] c/o [AP/advocate’s name]”, to emphasise that the addressee is still the person themselves, who the person speaking for them should aim to convey as much as possible of the information to.

71. A “client copy” of the CSP1 can be generated for sending to the person at any point during the Needs Assessment process. Usually this will be at the end of the process, or at the end of the assessment stage after the indicative budget has been agreed, if the person wants to consider a direct payment or wants to discuss options for the care and support plan in more detail once the nature and level of support has been agreed. However if the person wants to see draft copies throughout the process of a complex assessment, you should aim to meet this wish – if possible using email rather than printing multiple draft copies. Sending CSP1s to the person is the responsibility of the needs assessor, who is accountable for ensuring that the versions sent are correct and complete. ↑

> ! **Before you send a copy of the CSP1 to the person you should ensure that any updated Swift demographic information or involved family/ friends/ professionals have been entered in Swift by your admin support. If you are sending a final version with a care and support plan, the costed services and if necessary a current financial assessment also need to have been entered on Swift. You should check that all automatically-inserted information on a final form is correct.**

72. If the service user agrees to correspond with us by email, please ensure that you record this email address on the form and inform your admin support. Admin will send a test email to this address before any personal and confidential information is sent. The test email will not include any sensitive information, but will ask the person to confirm information that someone else would not know if they got the email by mistake. ↑

Dates

73. As part of the letterhead on the CSP1, there is a date, which should update automatically each time you update the form – in the final version which you send to the person this will therefore show the date when you finalised the form. Note that this is not the same as the date of the assessment recorded on Swift (and in the file name for the form). This is because the Swift assessment date is the start date of the assessment, which may not be a meaningful date to the person if the process has taken a few weeks to complete.

74. When you finalise and send the form, you should enter on Swift a contact note of type “CSP1 sent to service user”. The date of this contact note should match the date in the letterhead.

75. If there has been a gap between when you visited the person and when you send the care and support plan, so that they might be confused about what discussions the document is based on, it would be good practice to include the dates of key discussions with the person, carers etc. in the box at the start of Part D for describing how the assessment/review was carried out.

If there is a problem

76. If there is a technical or other problem which prevents you from completing a CSP1/CSP2 on the tablet with the person/carer, the contingency is to refer to a paper copy of the main headings on the form (for a new assessment, or if you discover you do not have the existing assessment with you) or a paper copy of the existing form (for a review or reassessment where there is a problem getting an electronic copy onto the tablet). You should always carry with you a paper copy of the Contingency CSP1 and Contingency CSP2.

77. The contingency forms provide a structure for the assessment/review, however due to the structure of the forms you will not be able to view the list answers to the questions. Written notes should be taken and the CSP1/CSP2 Swift forms updated when back at the office. It may be necessary to revisit the service user/carer in order to complete the assessment/review. ↑

THE CSP1 – NEEDS ASSESSMENT

How the form is organised

78. The **preliminary section** describes the current status of the form and whether the person has been able to participate fully in the assessment. If they have needed support to do so, or if a family member or other advocate has spoken for them because they lack the capacity to speak for themselves this must be recorded here.

79. Part A covers the **background information** for an assessment: what the person's health conditions or disabilities are; how and where they live; and who else should be involved in the assessment. One of the most important questions in this part asks what outcomes the person wants from the assessment. There should always be agreement with the person about the answer to this question at the start of an assessment (though this may sometimes be revised later). ↑

80. Part B is about the person's and where relevant carers' needs. The person's needs may include both **regular tasks** which the person needs help with and **unpredictable risks** which the person needs help to stay safe from. You should make sure you discuss all of the tasks and risks on the checklists in this handbook which may be relevant to the person. You should also cover any other kinds of need which the person identifies, such as financial or housing problems, though these will not usually require social care or CHC services.

81. If the person's carer(s) are happy to have their needs recorded alongside those of the person, this part of the form can also be used for this. However you should always offer the alternative of a separate carer's assessment.

82. Part C is about the plan for meeting the care and support needs (and where relevant carers' needs) identified in Part B. First it asks for an **Indicative Plan**, summarising how much support from other people the person needs, and illustrating one cost-effective way in which that could be organised) as a basis for setting an indicative budget. The person may choose to develop their own detailed plan using this as a starting point, and to organise this using a direct payment. If not, this part should set out details of the actual **care and support plan**, including information pulled through from Swift about the service providers and the costs. Where relevant, it should also set out the plan for the carer. ↑

83. Part D is for information specifically about the current assessment or review, including the reasons why it took place, any referrals being made as a result of it, and any changes to be made to services. This part of the form is blanked out each time there is a new reassessment or review; the rest of the form stays the same unless something has changed. ↑

Stages of the form

84. In many cases, you will only send the form to the person or providers once, as a finished care and support plan. But sometimes there may be a series of discussions, and the form may go through several versions – or the form may be completed without leading to a finished care and support plan. The first drop-down on the form says what stage the document has currently reached.

> Which option you pick here determines which sections of the form are visible. In particular, the care and support plan details (though not the indicative plan and indicative personal budget) are all hidden if you choose an "assessment" option. This is particularly useful if you are reviewing an existing plan which you expect to make major changes to, and want to start by agreeing an updated or revised account of the person's needs, before moving on to a discussion of options for the services.
>
> If you want all sections of the form to be visible from the start, choose "your draft care and support plan" if you are carrying out a new assessment, or "a draft review of your assessment and plan" if you are doing a reassessment or review. Then when the plan has been authorised and you are ready to finalise the form, change them to "your initial care and support plan" (for a new assessment) or "your updated care and support plan" (for a review or reassessment).

85. The full list of options is as follows:

- "**the information we have so far about your needs**". You should select this option if you are sending out the form with the assessment information only partly completed. An example would be if you are carrying out an assessment over two or more visits, and after the first visit the person wants a copy of what you have written down so far. Another example might be if you (or someone else) have partly completed the form before visiting, on the basis of a phone conversation.
- "**a draft assessment of your needs**". In law, assessing the person's needs is separate from agreeing a plan to meet them. Sometimes it may be best for the first version of the form that you send the person to be *just* an assessment of their needs, without a plan – for instance when there are likely to be disagreements about the best solutions, but you want to start by agreeing what the needs are which the solutions will have to meet. If you pick this option, the indicative plan section of Part C will be visible, but not the sections for the actual plan.
- "**an assessment of your needs**". As described above, it may sometimes be best to complete the assessment before moving on to discuss the plan. Picking this option will usually mean that the *assessment* (including the indicative plan) has been signed off by the budget holder, though the actual plan is still to be agreed. It could also sometimes mean that you have completed the assessment, but decided that the person has no eligible needs

– or this could be the final version of the document for someone who wanted an assessment to help them think about their needs, but who now wants to make their own arrangements without our involvement. ↑

- "**a partly-updated assessment of your needs**". This option could be used if you are carrying out a review or reassessment over more than one visit, and the person wants to see what you have written down so far, though parts of the form are still based on what was agreed previously and haven't yet been discussed again. If sending the form in a partly-updated state, you may need to think about how to make it clear what has been updated and what is still the old text from before – perhaps in a covering email or note.
- "**your draft care and support plan**". This option means that the whole of the form has been completed, but either it hasn't yet been signed off by the budget holder, or the budget holder has agreed it but there are unresolved issues that need to be discussed further with the person or their advocate.
- "**a draft review of your assessment and plan**" is like the previous option, but for a review or reassessment.
- "**your initial care and support plan**" or "**your updated care and support plan**". These are for final plans, agreed by the budget holder, which have either agreed with the person or reached the point where there is no further prospect of reaching agreement. An "initial" plan is one prepared after an initial assessment; an "updated" plan is one prepared after a review or reassessment.
- "**an assessment/plan which was not completed**". This should be the final status selected if an assessment or review is abandoned without being finished. For instance this might be because the person has decided that they don't want to carry on with an assessment, or because they have been admitted to hospital following a further serious health crisis, making the assessment irrelevant.

86. The next dropdown asks whether the form is **the final result** of the assessment. If you say that it *is* final, the form will then be saved as a finalised version, and cannot be changed. If you finalise the form and then discover an error, you will need to contact the Systems Helpline to restore the form to an editable state. If you finalise the form and then there is a *change*, you should usually record a review or reassessment, or an update, so that both versions of the form are kept on the record.

87. When you choose the option “the final result”, the form will be **validated** to check whether you have answered all the questions (unless you have said that it is “an assessment/plan which was not completed”). Because questions which aren’t relevant are hidden, the validation is based on the assumption that all visible questions should have been answered. It doesn’t currently check the boxes for additional text, though you should aim to write something in every visible box, even if only “Not applicable”.

88. You can also validate the form using the red “**Check if complete**” link at the top right. For instance this may be useful if you are sending a draft care and support plan to the budget holder, and want to be sure you’ve not missed anything out.

> ! **The CSP1 should not be finalised until the service details and a financial assessment have been entered on Swift. This is because the Care Act requires us to tell people their final “personal budget”, which is calculated from the Swift information. If the CSP1 is sent too early, it may include misleading figures based on former rather than new services.** ↑

Mental Capacity/Substantial Difficulty/Advocacy

89. The second preliminary question in the form is about how the person is participating in the assessment and planning process. **If you are not able to discuss all aspects of the assessment and the plan fully and directly with the person they are about**, you **must** describe in this part of the form how you have established what their views are, or how you have made decisions if they can’t express an informed view.

90. We should aim to decide as early as possible how we are going to provide any support that the person needs to participate in the assessment – ideally before we plan how to carry out the assessment. If you discover when you visit that the person will have difficulty in participating fully, the first thing you need to do is to establish how they will be supported or who will be speaking on their behalf.

91. There are three possible situations in which a person may need help:

- The person may understand the issues and be able to express their own views, but may want someone who knows them well to be present to help them put their views across – for instance because they find the situation intimidating and get flustered, or because they are hard of hearing or can’t speak very clearly, or need an interpreter. In this kind of case, you should pick the option “We have **agreed that you need some support**”, and describe in the box that appears below what kind of support is involved – this would include any special arrangements you are making when carrying out the assessment, to make it easier for the person to participate. You must **not** use this option if the person isn’t able to participate fully once they do have support.
- The person may not be capable of participating fully, or may have substantial difficulty doing so, which we can’t overcome by adjusting the way we carry out the assessment, and may because of this need a family member or a friend to

speak on their behalf. The Care Act calls this an **appropriate person**. We have to be satisfied that anyone who we agree can speak on the person's behalf *is* an appropriate person to do so, and can be relied on to be guided by the person's best interests. In some cases, a peer advocate or citizen advocate could be an appropriate person. But the appropriate person **can't** be anyone who is paid to provide the person with care or treatment (either hands on or as a manager) or who has any other kind of professional role in supporting the person.

- If the person needs someone to speak for them and there is nobody suitable to speak for them as an appropriate person, then we must involve a **formal advocate**. ↑

92. A person is not capable of participating fully in the assessment if they are unable to understand, retain or make use of relevant information, or unable to communicate their views, and an appropriate person or advocate should be arranged if they would have substantial difficulty doing any of those things. But you should always consider first whether there is a way to overcome the difficulty and enable the person to speak for themselves. For instance you should consider whether they might be able to think more clearly at a different time of day, or when they are less unwell, or whether they could communicate more easily in a different way, or if they were given more time. You should never rely on someone else speaking for the person if, given time and patience, they might be able to speak for themselves.

93. In all cases where the person isn't going to be able to participate fully themselves, you need to pick the option "We have **agreed that someone else will speak for you**", which will make visible the questions you need to answer to explain how you have decided who that will be – usually an "appropriate person" such as a family member.

94. The only situation where we do not have a strict legal obligation to ensure that someone has either an "appropriate person" or a formal advocate is when we are carrying out a limited review, whose sole purpose is to *check whether there is a need* to reconsider the person's current assessment or care and support plan (which will generally be recorded on a CSP4 rather than a CSP1). For instance it is not legally a requirement to involve an appropriate person or an advocate in a review of arrangements for someone living in a care home, whose needs are believed to have remained stable. However if it turns out that there is a need to reassess the person's needs, or to consider changes to their care and support plan, an appropriate person or advocate must be identified. It is of course always good practice to involve family members in any review.

95. If for some reason you need to use the CSP1 rather than the CSP4 to carry out a limited review of someone who can't fully participate, and there is no appropriate person available to speak on their behalf, you should discuss the situation with your manager. If it is agreed that there is no need for formal advocacy, the current version of the form does not provide a neat way of recording this – so you should choose the option "We have **agreed that you need some support**", and explain in the box that appears below that the person would need an appropriate person or advocate if their needs were reassessed or their plan was changed, but that this has not been necessary on this occasion because the review has concluded that changes aren't required, and the existing assessment remains current.

96. In all other cases, you need to answer more detailed questions. The first of these is whether the person needs someone to speak for them because they would otherwise have "substantial difficulty" participating fully, or because they don't have the mental capacity to participate. Which of these options you choose affects how you should complete the rest of the form:

- If you decide that the person would have **substantial difficulty** without someone speaking for them, but does have mental capacity, then what you write on the rest of the form as “your” [the person’s] views should be what they themselves have told you, or have asked the person speaking for them to tell you. If there are any exceptions to that, you should clearly indicate them where they occur.
- If you decide that the person **doesn’t have mental capacity** and that the person speaking for them is therefore trying to present what they believe the person *would* have said if they were able to do so, then wherever you write on the rest of the form that “you [the person] told us” something, it means the appropriate person or advocate told us that. In this case, if there are some questions which the person themselves was able to answer coherently, you should make it clear that these answers, unlike most others, are the person’s own. ↑

97. A paragraph explaining what “you” means in the form will appear when you pick an option from the dropdown.

98. The next block of questions is about who will be speaking for the person and how you have decided on that:

- The first question is whether there is someone who has legal authority to make decisions on the person’s behalf, with a Lasting Power of Attorney, an Enduring Power of Attorney, or deputyship authorised by the Court of Protection. In any of these cases, you should ask to see the documentation, and should check exactly what their authority covers. For instance someone with an LPA covering financial affairs and property is *not* authorised by that to make decisions about the person’s care arrangements. Even an LPA for health and welfare may have restrictions on what decisions it includes.
- If someone has legal authority to make decisions about the issues that your assessment will cover, they will almost always be the appropriate person to speak for the person. The main exception would be if you have reason to think that they may be set on achieving a particular outcome for their own reasons, which may not be in the person’s best interests. If this becomes an issue, you should immediately discuss it with your manager, who may need to ask a senior manager to seek legal advice.
- Even if the person’s legal powers don’t include making decisions on care arrangements, they may be the best person to speak for the person. But in this case, or if there isn’t anyone with legal powers, you need to consider carefully who is best placed to act as the appropriate person. You should not make automatic assumptions about that. For instance the person’s next of kin will *not* automatically be the best person to take on this role, and even if they are, the fact that they are the next of kin should not be the only reason that you give for choosing them. Usually if the person has a spouse, they will be the first person you should consider, but not if the spouse themselves has difficulty understanding. If there are disputes within the family, you will need to ask your manager about getting legal advice.
- Whatever you decide, you should explain clearly how you made the decision, so that there is a clear record if there is ever a dispute about this. Often the

explanation will simply be that the family member or friend you have chosen is the person's main or only carer, and that you are satisfied that it would be in the person's best interests for them to speak for the person. But you should consider whether the carer has views of their own which may prevent them from putting forward what the person themselves would want, and document that you have considered this if it is a possible issue.↑

- If there is no appropriate person, you will need to arrange a formal advocate. You should discuss this with your manager before making a final decision. Arranging a formal advocate unnecessarily could make the assessment process longer and more confusing than it should be, since time will need to be added for the advocate to get to know all of the people involved, and the extra meetings may also become a burden for carers and family members. If you have decided that a formal advocate is needed, you cannot start the rest of the assessment until the advocate is in place. This does not prevent you from making urgent short-term arrangements (best recorded on the Urgent Needs Plan form), but it does mean that you should not make any decisions that involve long-term commitments. If you have decided that there is no appropriate person, you need to document why you have made that decision. This should include explaining what steps you have taken to try to find family members or friends who could have played this role.

99. Even if you have arranged for an appropriate person or advocate to speak for the person, they can't make decisions on the person's behalf, unless they have a legal power of advocacy or deputyship which gives them the right to do that. So in the end you as the needs assessor will have to decide what is in the person's best interests, after taking all relevant advice and listening to what everyone has to say.

100. There are two separate decisions we need to take about the care and support plan:

- A "**public law**" decision about what level of publicly-funded support we can offer to meet the person's needs. This is the same kind of decision that we would have to take if the person did have capacity. Usually, having decided on the level of care and support which is necessary to meet eligible needs, there will be some options about *how* the care and support is provided.
- A "**private law**" decision taken on behalf of the person about which of the available options to choose. This is the decision which the person would have made themselves if they had the capacity to do so.

101. What you are recording in the mental capacity section of the form is the *private law* decision about what the person would choose if they were able to. This should come after you have carried out the rest of the assessment to decide what level of care and support services the person is eligible for.

102. If the issues to be considered are complicated, it may be better to record the best interests decision separately on form MC2, but if it is clear what the person would choose if they had capacity, the CSP1 provides the means to record how you arrived at that conclusion.

103. Sometimes there may not be any best interests decisions that we need to take – either because all necessary decisions fall within the scope of the legal powers of an attorney or deputy, or because the assessment concludes that no care and support services are needed, or that the care and support needed is so straightforward that there are no significant choices to be made.

104. The best interests decision questions on the CSP1 are a simpler version of the questions on the MC2. First you need to describe briefly what decision about best interests needs to be taken. This shouldn't be a detailed description of the whole care plan – just a summary of the key decisions. For instance these might be questions like "Is it a good idea for the person to stay living at home, given the risks involved and the level of support which can realistically be offered?", or "Is it in the person's best interests for them to have some intimate tasks carried out by care workers, when we know that this will distress them, but will reduce the risks to their safety?"

105. If the question needing to be decided is whether the person should move permanently into a care home, it will be necessary to consider whether a Deprivation of Liberty Safeguards (DoLS) assessment is required, since many people with severe cognitive impairments living in a care home now fall within the scope of the DoLS legislation, as interpreted by the courts. You should discuss with your manager whether a DoLS assessment is needed. This should take place *before* the person moves into a care home (though in exceptional circumstances a *short-term* placement in a care home before a DoLS assessment is possible might be the only way to meet urgent needs).

106. Deprivation of liberty can also be an issue in any other care setting where someone with limited mental capacity is under continuous supervision and control by staff. The DoLS safeguards only apply in care homes, so an application to the Court of Protection would be needed to authorise this kind of arrangement. You should discuss as early as possible with your manager any situation where this might apply.

107. The remaining questions cover the key requirements for a best interests decision:

- First, you need to explain in more detail how you have decided that the person does not have the capacity to make the decision themselves. You should refer explicitly to the criteria in the Mental Capacity Act – understanding of information, ability to retain and use it, and ability to communicate. You should **not** simply refer to the person's medical diagnosis, and you should explain what steps you have taken to try to overcome the person's difficulties so that they can take part. If the person's condition fluctuates, you should explain why you have decided not to delay a decision. ↑

- The next boxes ask for explanations of how you have tried to involve the person to the greatest extent possible, including finding out about their past views so as to understand what they would have wanted if they still had capacity; and what discussions you have had with people who know the person, to find out what they think the person would have decided (and who you have tried to speak to but not been able to).

- If the plan will put restrictions on what the person can do – for instance by making it harder for them to go out on their own for a walk -- you need to describe these restrictions and why you have decided there isn't a better alternative. Restrictions on the person don't necessarily mean that they are being "deprived of their liberty", unless they will be being supervised by care workers 24 hours a day and are not free to leave – but if you are in doubt about whether the restrictions may be so severe as to amount to "deprivation of liberty", you should discuss this with your manager. If a DoLS assessment (or in some circumstances a Court of Protection application) is needed, the form allows you to record this fact, though the assessment itself will be on separate forms.

- Finally, you must record any disagreements about best interests. (Note that these are different from disagreements about what level of support the person is eligible for, though sometimes there may be disagreements about both.) If there are major disagreements, you should usually carry out a fuller best interests assessment on form MC2. ↑

Part A: Background information

! **Before you start answering questions on the form, you should have a general conversation with the person about why the assessment or review is taking place – why they asked for it, or why someone referred them to us – and what they hope to achieve as a result of it. You should then answer the questions in Part A in whatever order makes sense after that conversation. Often it may be best to begin with their answer to the question "What you want to achieve", and then talk about the details of the person's health condition.**

108. The person's basic details are inserted into the form from Swift. If any of these are incorrect, or have changed, make a note of this in the box underneath them, and **make sure you ask admin to update Swift**. Once that has been done, you should delete the contents of the box, to avoid confusion. ↑

Reasons why you need care and support

109. In the first box summarise the person's ongoing health conditions and disabilities. This box is for information which is likely to remain relevant for the foreseeable future. If there have been specific recent events at the time of the assessment or review which explain why it took place when it did, but which will no longer be relevant at the time of the next review, describe those in Part D, not here. You should aim to describe the person's situation in a way which will remain understandable if the text is left unchanged at later reviews because the person's disabilities and health conditions haven't changed. So don't write "You broke your leg in a fall a month ago", but "You broke your leg in a fall in August 2017", and don't use this box for a note of a specific recent meeting or conversation.

110. While you do need to list the person's relevant health conditions, you need also to explain why those give rise to care and support needs. The detailed explanation of the person's needs belongs in Part B, but you should describe here in what ways the person's health conditions disable or limit them.

! **Don't put a lot of information in this box just because it is the first free text box in the form – this isn't the place to record the current care plan, or the recommendations you are making about future services.**

111. The dropdowns below this box record whether the person has one or more of a list of conditions which are specially listed in the statutory guidance on the Care Act. The guidance says that if so, the needs assessor must have specific relevant experience or training, or get advice from someone who has. We aim to make sure that assessors always have relevant experience or training, but we specifically need to document this when the person being assessed has one or more of the conditions listed in the guidance -- a learning disability, autism, mental health issues, dementia or deafblindness. **Record all of the relevant conditions** if more than one applies.

If none of them does, just select “needs assessment under the Care Act” on the first dropdown, and leave the rest blank.

112. If you are not sure whether you do have appropriate expertise about the person’s conditions or know where to get advice about it, whether or not it is on the list, you should discuss this with your manager. If the person is deafblind, regulations say that the assessor **must** have had appropriate training. This refers to people where the *combined* effect of impaired sight and hearing causes particular difficulties with communication, access to information and mobility. If you think the person may be deafblind, and you do not have the appropriate qualification, you **must** ask your manager about this.

113. The next question, about whether the person’s condition **fluctuates**, so that they need different levels of support at different times, also reflects a statutory requirement. If someone’s condition does fluctuate, you must make sure you have enough information to be able to assess what support they need when their condition is at its worst, as well as what they need at the time you see them, and you must take account of this in the rest of the assessment, explaining how the care and support plan will cope with this.

114. If there is any possibility that the person may at some time (not necessarily recently) have been **compulsorily treated in hospital** under mental health legislation, you need to establish details of this, since anyone in this position *may* be entitled to free social care, though this will depend on the detail of their history. To make sure that we don’t miss this possibility, you should routinely ask everyone you assess whether they have ever used mental health services (this includes mental health services for people with dementia), and if so whether they have ever been in hospital for mental health treatment. If they have, you need to find out enough about the details to establish whether the aftercare provisions of the Mental Health Act (section 117) may apply to them. If they have never been treated in hospital, or if they have definitely only been treated as voluntary patients, then these provisions will not apply. If you are not sure from what they tell you, you must make further enquiries when you get back to the office. ↑

115. If you record that someone *is* receiving aftercare, this will change the text on charges in Part D as well as showing a box for information about when and why they were compulsorily treated in hospital. If you are not sure whether this is held on Swift, you must check, or ask admin to check and update Swift if necessary. ↑

> The paragraph about mental health treatment will now be deleted automatically in the client and provider copies if the answer is that the person has *not* been detained for treatment. This is because the inclusion of this paragraph was causing distress to some people who had not had any mental health issues.

116. The questions about people’s **medication and treatment** are intended purely as a probe to help us be sure we understand the range of health issues that the person has. You don’t need to give detailed information about doses of medication – as the form explains, this information must not be used as a basis for actually administering medication. However if the person is receiving ongoing treatment or therapy of any kind (whether from the NHS or from others such as alternative therapists) you should consider whether to ask the person for permission to talk to the people providing the treatment (and add them to the list of professionals and services that the person is in contact with). ↑

Your life

117. Usually it should be the person being assessed who decides how much detail about their **life history** they want included in the form (though in some relatively unusual circumstances you may have to say that recording specific information here is essential even though they would rather not mention it – for instance about past involvement with the criminal justice system). The two main reasons for including some information about the person's life history in the assessment are:

- to help you understand the wider context of the person's current issues
- to document any information about the person's past use of services which is relevant to understanding their current situation
- if the person will need support from care workers, to give them some background about who the person is. This is particularly important if the person has communication or memory problems, and may not find it easy to tell care workers about what matters to them themselves.

118. The purpose of the box for describing a person's activities in a typical week is to provide context for the discussion of their needs and the options they may have for meeting them – for instance by making sure you understand what arrangements they currently have to get out of the house and maintain social contacts. You *don't* need to summarise their current care plan here – the focus should be on *other* aspects of their day-to-day life (including how the person spends their time when they are *not* getting care services). ↑

What you want to achieve

119. This is an important question. One of the key requirements in the Care Act is that assessments should consider the outcomes which the person themselves wants to achieve. You **must** record here what the person is hoping to achieve as a result of the assessment (or if this is a review, you must make sure that what is said here still reflects what the person sees as the key outcomes which the person wants our involvement to achieve for them). Possible examples could be "to be able to stay at home" or "to be less of a burden on my daughter". At the end of the process, when you describe the care and support plan in Part C, you must return to these outcomes and say whether/to what extent they are expected to be achieved. ↑

120. You should make sure that the person is happy that what you write here properly captures what they see as the point of the assessment. Sometimes this may be very different from what professionals or services think the assessment is for – but this box is about the person's own views (or the views of the appropriate person or advocate, if the person is not mentally capable of putting forward their own views). If you think the outcomes the person wants are unrealistic, you should discuss that with them, but it is for them to decide what they want recorded here. However if the outcomes which the person wants to achieve are clearly unrealistic, you may find it best to avoid misunderstanding by adding at the end of the box, a short summary of what you have said to the person about this, and what more modest versions of the outcomes you have advised them to aim for.↑

Avoid using standard phrases in this box, such as "to maintain independence" or "to have my personal care needs met". This box should reflect the person's individual view about what matters to them, expressed in language that the person will recognise as their own.

Other professionals or services that you are in contact with

121. A list of professionals currently recorded on the Swift Involvements screen is automatically inserted here each time you open a new or draft form within Swift, along with information from SystmOne about district nursing involvement.

122. When you discover that additional professionals are involved, or if you discover an error in the details of an existing involvement, you can record the new information by clicking the red text “click to add another professional…”.

123. If you are made aware of another professional or service involved with the person, you should seek the person’s consent for that professional or service sharing relevant information with you, and record that in the details of the professional. Some professionals or services may not accept this as sufficient evidence of consent, and may require the person to confirm consent in an additional way. If this becomes a problem, please ask your manager to raise this so that we can consider alternative solutions.

124. Our longer-term aim is to provide an automated way for admin to be notified that there is new information about involvements which needs transferring to Swift. At present, you need to let admin know about this yourself.

125. Information which you enter here about whether the person has consented to the involved professional or service sharing information with us is now recorded by admin along with the basic details, and will then be pulled through from Swift into the list of involvements under the heading. The description of what each professional or service is doing to support the person will also now be entered on Swift and pulled through into the list – this should be a brief explanation of their involvement; if detailed information needs to be recorded that should be elsewhere on the form.

126. When you are confident that all the additional information you have added here has been transferred to Swift, you should delete your entry by clicking on the red “Delete” underneath it, so that the form doesn’t include the same information twice.

127. Below the list of services and professionals, there is a box to record any general issues the person has about us sharing their information with other professionals or services involved in the assessment or the care and support plan. If there is information which the person is not happy to share, you need to discuss with them any consequences this might have for how well we can assess their needs, or what care arrangements we can make. ↑

128. If the outcome of the discussion is that some information will not be shared with some of the people who would usually receive a copy of the CSP1, such as home care providers, you will need to consider how to record this information. For now, we recommend recording this separately in a contact note of type “CSP1 – information not to be sent to providers” – which you should send the person themselves a copy of, since it is part of their assessment. You should also state at the appropriate point in the CSP1 that there is additional information in a contact note, and give the date of this contact note, so that anyone reviewing the assessment in future is able to access it easily. In a future version of the CSP1, we expect to add a box to the form for information not to be shared with providers, which will be removed from the provider copy. ↑

Your family members and friends

129. As with involvements, a list of all the family members/friends currently recorded on the Swift Relationships screen is automatically inserted in a new form and when a draft form is opened in Swift. To add further family members/friends click on the red text "click to add person …". You can also use this to add further information, or correct existing information, about a person. If you are using it to do this, you *don't* need to complete all the boxes – just enough to make it clear which person you are adding details for, plus the new details.

130. If there are **children** in the household, you **must** discuss with the person how their care and support needs affect the children, and you should normally record details of the children unless it is clear that they are not providing the person with support, do not depend on the person, and are not significantly affected in other ways by the person's condition (for instance because they find it distressing).

131. You must aim talk to anyone who is an unpaid carer for the person. The Care Act says that you must do this whether or not the person consents, though you should always discuss this with the person. However you *can't* give carers confidential information about the person without their consent, unless this is necessary to protect them from significant risks. You should ask the person whether they would like copies of the completed form to be sent to their carers, or anyone else – but if the form is going to be sent on paper, you should check whether there is really a need to send multiple copies to people who live in the same household, or who visit frequently.

132. As with involvements, we hope eventually to have an automatic mechanism to notify admin of new information about family members and friends which needs to be entered on Swift, but for now you need to tell admin when you have added or changed information.

133. Information which you enter here about whether the person has consented to assessment-related information being shared with a carer or family member is now recorded on Swift by admin along with the basic details, and will be pulled through automatically into the list of involvements under the heading.

134. When you are confident that all the additional information you have added here has been transferred to Swift, you should delete your entry, so that the form doesn't include the same information twice. ↑

The accommodation which you are living in

135. The specific questions in this section of the form focus on the kind of accommodation which the person is living in, rather than who they live with – so, for instance, they don't ask whether the person lives with their family or on their own. But information like that can be added in the last box in the section for "any other information".

136. If the person has a key safe, selecting the option "**There is some special information** about getting into your home" will reveal the field for recording the details of this, as well as any other information that it would be useful for people visiting the person to know.

137. If the service user has a key safe number recorded on a different Swift form, this will automatically be pulled through into key safe field in the CSP1. You should check that the information is still current. ↑

Communicating with you

138. Obviously not all service users can make use of documents sent by **email**, but we should encourage this option where we can, to reduce postage and printing costs and speed up communication. Points to note are:

- The email address we send the assessment to does not have to be the person's own – if the person is happy for their carer to be sent the form, it may be possible to use the carer's email address as the main method of sending forms to the person. (But obviously you need to be sure that forms sent in this way will reliably get to the person.)
- Before asking anyone to agree to receive information by email, they must be given a copy of Information Sheet C10 - Communicating with us by email. We recommend carrying a supply of this information sheet with you. There should be a current copy of it automatically kept up to date in the Guidance and Procedures folder on your tablet, or it can be found at www.northumberland.gov.uk/careandsupport.
- Where the client has agreed to correspond with us by email, please check carefully that you have recorded the correct email address on the CSP1 and inform your admin support. Admin will send a test email to this address before any personal and confidential information is sent. The test email will not include any sensitive information, but will ask the recipient to confirm information that someone else would not know if they got the email by mistake. ↑

139. If the person has asked someone else to manage their **financial arrangements**, or if someone else has authority to manage their money under a power of attorney or deputyship, you should record this here.

140. Finally this section asks about any special issues there may be about communicating with the person. There are specific questions about whether they are comfortable communicating by phone, and about whether they need documents in large print. There are boxes for describing any other issues about the format for documents, and any other general issues about communication. Points to note are:

- If you indicate that someone needs large print, the CSP1 itself will be printed in the font size you have selected ("large" or "giant" print). The Weekly Diary of Services will not appear in larger font, but it can be blown up by printing it on A3 if this is necessary. ↑
- We should always aim to provide both the client copy of the CSP1 itself and supporting material such as information sheets in a format which the person can use. If someone asks for information in an alternative format (such as Braille or audio), you should email CareActQueries@Northumbria.nhs.uk for advice about this. Please think first about exactly what information will be useful to the person – we may ask you to justify your request if we are not sure that it has been properly thought through. For some people, an alternative solution might be using software to read an emailed electronic version of the form.
- The same arrangements will usually apply if someone cannot read information in English and needs it in a different **language**. In this case it is even more important to be clear exactly what information will be useful, because in most cases a translation, even of a standard information sheet, is likely to be used only once, so it would be wasteful to arrange this if it will in fact be irrelevant to the person it is sent to. You should also consider whether the person might actually find it more helpful for a family member to have a copy of the information – particularly the CSP1 itself – in English, so that they can explain it to the person. Translation by a third party who doesn't know the person's situation could sometimes be a source of confusion. If personal information is

to be translated by a third party, you must get the person's consent to this. You could record it in the box at the end of the "Other professionals and services" section.

- Similarly, if someone can't readily make use of any written material, the best solution may sometimes be for someone to explain it to them face to face, rather than to produce in every case an "easy read" version which might still not be an effective way to explain the important details. But you should always aim to write the CSP1 in a way which is as close as possible to the way you would explain it to the person if you were speaking to them. ↑

Part B: Your Needs

141. Part B is the core of the assessment: identifying **the person's needs** -- how they can be met and whether they are eligible for publicly-funded support. It consists of a series of boxes for free text. How much text is needed each of these boxes will depend on the complexity of the person's situation. In some cases, a brief account of a few straightforward needs will be adequate; in other cases some or all of the boxes might require several pages of detailed analysis.

142. Part B will usually also be where **carers' needs** are recorded. But carers have a right to ask for a separate needs assessment if they are not happy about the person seeing what they have said. ↑

What goes in which box

143. The Care Act lists the issues about needs which assessments must cover, and the boxes in this part of the form are based on that list. They form a logical sequence – starting with a longlist of *all* needs that matter to the person and then filtering them down over the next three boxes to leave only those which we will meet.

- First you should document under **"Your Needs"** all the care and support needs the person has, on the broadest of definitions – listing *all* needs that matter to the person, whether or not they are likely to be eligible for public funding, and whether or not social care (or CHC) services would be an appropriate way to meet them.
- Next, you should consider under **"Your strengths and opportunities"** what **other than care and support** might help the person to achieve the outcomes they want to achieve and meet their needs, including preventative services such as equipment and reablement, information and advice, and other resources available in the community.
- Then you should say which of the remaining needs are **"Needs which meet our eligibility criteria"**. This *includes* needs that will be met by carers, as well as needs which we expect to meet through services.
- As the last stage in the filtering process, you should say **"How your carer(s) expect to support you"**, including the extent to which eligible needs will be met by carers. We have a duty to meet all *other* eligible needs – but also a potential future duty to meet any eligible needs initially met by carers, if the carers cannot continue, or choose not to.
- Finally, you should document "**Your carer(s) own needs**", including whether the carer(s) have eligible needs of their own, which will have to be met either

through the way that services are provided to the person or (more rarely) through services or a direct payment provided to the carer themselves. ↑

"Your needs"

144. The text in this first box should describe *all* of:

- the **tasks** which matter to the person that they cannot carry out without assistance from another person because of their disability or illness (including consequences of alcohol/substance misuse);
- the **risks** which the person runs because of their disability or illness;
- **anything else** which the person regards as a need that is related to their disability or illness (though it would be unusual for us to provide ongoing services for reasons other than supporting people with eligible tasks or protecting them from significant risks). ↑

145. You should include tasks and risks which are not eligible for support from us, and tasks and risks for which carers are likely to be providing support – in this box, you should simply describe anything which matters to the person and which at the time of the assessment they needed help from other people to do, without commenting on eligibility or possible solutions. If someone intends to pay privately for some elements of their care and support, you should ask them whether they want those needs to be covered in the assessment. If they do, you should describe them; if not, you should mention on the form that they have said they preferred to limit the assessment to needs which they weren't sorting out privately.

146. There are no fixed rules about how this information should be arranged, but you should observe the following principles:

- **If there is any information which might be critical for the person's safety or the safety of others (for instance about particularly serious risks), it should be made as prominent as possible – for instance by putting it near the top of the text and using a bold font;**
- You should include anything that the person says they need help with, but you should pay particular attention to tasks which the person appears to be unable to carry out without someone else helping them (whether that's a care worker or a carer), and risks which might require someone else to be on hand to keep the person safe – since these are the needs that are most likely to require ongoing care and support.
- For tasks, unless it's obvious, you should explain specifically what elements of a routine the person can't carry out and why, what another person would have to do, and when they would have to be there.
- For risks, you should discuss how often and in what circumstances the risks have actually arisen. (For instance, if you mention a risk of falls, you should usually record how often the person has actually fallen, or nearly fallen, in the recent past, and whether there have been patterns in the circumstances of this – types of activity, times of day, etc.)
- If there is a risk which the person chooses to take rather than limit what they do, or so as not to become dependent on others, you should document this, including any warnings that you judge it is necessary to give the person (or you may decide it fits better to put this warnings into the care and support plan in Part C).

- This box should describe the person’s needs, *not* potential service solutions to them – for instance it would be appropriate to say here that the person cannot safely get out of bed without help, and that they need two people to bear their weight, but *not* to say that the person requires a daily visit first thing in the morning by two home care staff from a named provider. You should bear in mind that the person might later decide to arrange support through a direct payment (or might choose to change from a direct payment to agency support), and write your assessment in a way which would remain appropriate either way.
- Aim for a clear and logical structure, using subheadings if there is a lot of information, to make it easy to locate specific points (but you don’t need to provide separate lists of tasks and risks if it is clearer to explain these together) ↑
- If you have a different view from the person about what they can be expected to do without help, the text should reflect your considered view after discussion with the person
- If there are areas of life that the person did not want to talk about, you should say clearly what those were (and make sure that this is their free choice, and isn’t, for instance, because they don’t want to talk about them in front of someone else in the room).

147. **Don’t** copy into this box (or any other box on the form) the whole of a specialist assessment carried out by someone else. Pick out the relevant points, and explain those in the same style as the rest of the form. (You can attach the specialist assessment when you send the form, if that would be useful to the person, after checking whether there is any reason not to, such as third party information.)

148. See Checklist 1 for a list of tasks which people often need support with and Checklist 2 for a list of risks which frequently need to be considered. You should make sure that you have asked about all items on these lists which might be relevant, as well as discussing any other relevant needs. You may find it helpful to show people copies of these checklists. ↑

> Versions of these checklists also appear in Information Sheet C2. It may be helpful to ask the person to look at the sheet and tell you which of them they want to talk about.

149. Some important kinds of risk do not appear in the checklist because in many assessments it would be inappropriate to raise them. For instance it may be important when assessing someone with severe mental health issues to discuss whether they have thoughts of suicide, but people for whom that isn’t a relevant issue might find that question offensive or distressing.

150. Asking about some of the risks on the checklist could be offensive if not sensitively managed. You should aim to raise issues like alcohol use, or problems controlling behaviour, in ways that are appropriate to the person you are talking to. It is unlikely to be a good approach simply to read the checklist out (even if you do that in a way which implies that you’re just going through a standard form and you know that they’re not going to be relevant – indeed doing that might make it harder for someone to tell you that, actually, they do frequently cheer themselves up by drinking more than they feel they should, or that they sometimes become so frustrated by their disabilities that they behave in ways that frighten their spouse).

Checklist 1: tasks people often need help with

The tasks below should always be discussed if they may be relevant, because they are the most likely kinds of task to meet the eligibility criteria, if the person is unable to carry them out. Other tasks which matter to the person and which they are unable to carry out, should also be discussed and recorded, whether or not they are likely to meet the eligibility criteria.

Tasks marked with a star should always be accepted as eligible needs if the person is unable to carry them out. Other tasks on the list will often be eligible needs, but this may depend on whether there is a significant impact on the person's wellbeing (see Checklist 3 for the eligibility criteria and Checklist 4 for how to assess impacts on wellbeing).

★Getting out of bed in the morning and getting dressed and ready for the day.

★Getting ready for bed in the evening.

★Using the toilet.

Having a bath or a shower. *(If the person can already safely do one of these things, it would not normally be an eligible need to be able to do the other as well, unless there are special reasons why their health would suffer if they could not.)*

Preparing nourishing food that you can eat.

★Eating food safely, without choking or other risks.

★Getting enough to drink.

★Taking medicines that you have been prescribed.

Moving around your home.

Getting in and out of your home.

Keeping your home, your clothes and your bedclothes clean enough to avoid significant health risks.

Looking after your home so that you are safe living in it.

Being able to study, or train, or work or volunteer.

Staying in touch with your family, or other people who are important to you.

Developing new social networks, if disability or illness has isolated you.

Looking after children who you are responsible for.

Getting to places you need to in the local community. ↑

Checklist 2: unpredictable risks

The risks below should always be discussed if there is a possibility that they may be relevant. In some cases, there may also be a need to ask about other significant risks relevant to the person's condition or circumstances. Any other risks which the person is concerned about themselves should also be documented in the assessment, whether or not they are likely to be eligible for support.

Risk of falling.

Risk when you lift or carry things

Risk from fire.

Risk letting people into your home.

Risk because of pets or animals.

Risk because of other problems with your home.

Risk of infection.

Risk because of allergies.

Risk of skin damage (e.g. pressure sores).

Risk of confusion.

Risk from other people.

Risk of not being able to control your behaviour.

Risk because of alcohol or drugs. ↑

“Your strengths and opportunities”

151. This box should be used to record a discussion with the person about what helps them to manage their situation and what else might help them in future. There is an explicit duty in the Care Act to provide these kinds of advice when carrying out an assessment. The Act and the guidance issued under it are clear that **an assessment is not just about determining eligibility for services**, and you should invite an open-ended discussion about anything which might help the person, and undertake to find out about anything which you can't immediately advise them about.

152. If solutions other than care and support can meet some (or all) of the person’s needs, or make them easier to meet, these should be described here. This might include equipment, adaptations, reablement, use of resources available in the community, or changes in the way the person carries out some tasks. It might also include private purchase of some services, such as cleaners or shopping delivery services, where this is a reasonable way for the person to meet their own needs – but you need to consider whether the person is in fact reasonably able to meet their needs in these ways (for instance whether there are affordable services available where the person lives). You should consider whether the person might be eligible for benefits which would help them to arrange solutions for themselves.

153. Some solutions which you suggest here may be longer-term ones which will not remove the immediate need for care and support – for instance moving to more manageable or accessible housing, or to a location where it won’t be as much of a problem for them that they can’t any longer drive a car.

154. Acceptable alternatives to care and support may include applying for help from another public sector body. For instance if someone has difficulty in working because of their disability, they may be entitled to support under the Access to Work scheme; in other cases, people may have entitlements to education or training, or rights under housing legislation. It might be reasonable to expect someone to follow the rules of a different statutory scheme even if they would prefer to get support under the Care Act, for instance because they will have to pay less.

155. In the specific case where someone has an assessed need for adaptations to their home, someone might not be entitled to Disabled Facilities Grant because of the DFG means test, though they would otherwise meet the DFG criteria. In this case, it will usually be reasonable to assume that they are able to pay for adaptations themselves, and do not need our help. Note that we have agreed to fund minor adaptations costing up to £1000 from the social care budget without a charge if this is required in order to meet eligible needs. We also need to look individually at difficult cases where someone is not eligible for DFG, but says they can’t afford the adaptation.

156. We must always consider the person’s individual situation, rather than applying a standard rule to everyone. For instance you may need to consider whether the person can’t reasonably afford to use a commercial service, even if many non-disabled people do so; or the person may have special dietary requirements which mean that they can’t easily use microwaveable meals; or there might be reasons why the person couldn’t handle the social events available in their neighbourhood. ↑

Solutions which you describe in this box should be **preventative** solutions rather than **care and support** provided by other people to help the person with tasks or keep them safe. So equipment and adaptations belong in this box, but care and support provided by friends or family members doesn't.

157. If the person will need help to make arrangements, the form should explain what specific steps we will take to assist them – usually the best place to do this will be the box in Part D about who we will put them in contact with. ↑

"Needs which meet our eligibility criteria"

158. The Care Act requires us to give people a written statement of which of their needs meet eligibility criteria, and the reasons for this. In practice, it may not be essential to spell out the reasons why a need *is* eligible if it is obvious that it is, but if you have decided that a need which matters to the person is *not* eligible, this should be explained.

159. You don't need to repeat in this box the detailed information about the person's needs which you have already recorded under "Your needs".

160. In simple situations, the text in this box does not need to be complicated. For instance it might be enough for it to say something like these examples:

> **"**All of the needs described above meet our eligibility criteria, except for the upkeep of your garden. This is not eligible for support from us because it is not necessary in order to achieve any of the outcomes which national regulations require us to meet.**"**
>
> **"**As explained above, you will no longer need help to get into the bath now that a grab rail has been installed to make sure you can keep your balance. All of the other needs described above meet our eligibility criteria.**"**

161. You **must** record whether needs which carers are intending to help with meet our eligibility criteria, and would therefore be eligible for support if carers were not available. You don't have to distinguish in this box between the needs which carers will meet and the needs which we expect to require costed services, though sometimes that will be a good idea to reduce the risk of misunderstanding. ↑

! **If we assess that needs met by a carer are eligible, we will have a duty to meet them if the carer becomes unavailable. So you need to be just as rigorous about eligibility as you would be if you were considering costed services. If you are not able to assess whether a need met by a carer is eligible (for instance because the carer is always with the person, so that you can't judge how well the person would cope if they were left alone), explain this, and make sure that the care and support plan is clear about what we would do if the carer suddenly became unable to support the person.**

162. Northumberland's eligibility criteria are in principle slightly more generous than the new national minimum eligibility criteria. So while you should read the statutory guidance on assessment and eligibility (www.tinyurl.com/AssElGuidance), you should use the advice in this handbook as the basis for explaining your decisions about eligibility. Checklist 3 summarises our local eligibility criteria. ↑

Summary: explaining why someone doesn't need care and support

163. There are a number of possible reasons why someone might not need care and support to help them with a task, and you should consider them in sequence. **Don't** assume that the reason for not providing care and support is always the eligibility criteria – often the real reason is more straightforward. ↑

164. The first possible reason is that the person **does *not* in reality need** help to carry out a task, even if they or their family – or other professionals – believe that they do. For instance this may be because of a mistaken perception of the level of risk. You should record reasons of this kind in the "**Your needs**" box, explaining clearly how you have reached your conclusion.

165. The second possibility is that there is an **acceptable alternative**, so that there is no need for another person to provide help with the task, whether that's a care worker or a carer. (NB: you should never record help from a spouse, family member or friend as an *alternative* to care and support, because what they are doing *is* care and support.) This should be explained in the "**Your strengths and opportunities**" box.

166. Only if neither of those reasons applies will eligibility be the reason for not providing a care and support service. If eligibility *is* the issue, you should first consider whether the outcome that the person wants to achieve is on the list of eligible outcomes (see Checklist 3). Only if it is on the list do you need to consider whether not achieving the outcome would have a "significant impact" on their wellbeing (see Checklist 4). Because "significant impact" is very much a matter of judgement, you should avoid basing your decision on that except where none of the other reasons applies.

167. If the person could avoid a significant risk by changing the way they arrange their daily life, or by giving up some activity which matters to them, you will need to consider whether making this change would have a "significant impact" on their wellbeing. This isn't just a matter of how strongly they object to making the change, or how upset they would be about it in the short term (though you need to listen to their views and document them) – you need to consider the person's life as a whole, and make a decision based on whether, overall, the change would have a significant impact on their wellbeing.

168. The regulations on eligibility say that, even if there wouldn't be a significant impact on the person's wellbeing as a result of any one need not being met, taken on its own, there may be a significant impact when several of these needs are considered together. If that may be relevant, you need to document that you have considered it. ↑

An example: help with housework

169. One recurrent issue is eligibility for help with housework, including cleaning, laundry and other tasks. You should **not** tell people that we "don't do housework" – which would be unlawful, as well as being an inflexible response to people's individual needs – but in practice this will only be an eligible need in unusual circumstances.

170. If the person has difficulty doing housework, and the results of this matter to them, you should record this in the "**Your needs**" box. If they could reasonably be expected to make private arrangements, you should record that under "**Your strengths and opportunities**".

171. Housework would only be likely to be required under the eligibility criteria if the person needs help with it to “maintain personal hygiene”, “maintain a habitable home environment”, or avoid significant preventable risks to their health. These are high thresholds – if the issue is ability to maintain personal standards/social expectations, rather than health risks, there would *not* be an eligible need.

172. If the house is shared with other people, it *may* also be acceptable to take account of what housework those other people could reasonably be expected to do. Unlike personal care tasks, the fact that someone is doing housework in the house where they themselves live does not necessarily mean that they are acting as a carer – but if the person who would be doing the housework *is* also a carer for the person, you need to consider whether it would cause problems for them if they were trying to do everything. If the carer tells you it would, you need to reflect that in the “Your carer(s)’ own needs” box, or in a separate carer assessment (CSP2), and say whether the carer has an eligible need which calls for support with the housework.↑

Checklist 3: eligible care and support needs

There are three elements to the eligibility criteria for care and support. All three of the statements in bold below must be true for a care and support need to be eligible.

- **the need arises from or is related to a physical or mental impairment or illness**

  The Care Act guidance says this includes physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse and brain injury

- **as a result of the need the adult is unable to achieve one or more of the outcomes listed below**

  Being "unable" to do something includes being unable to do it without significant pain, distress or anxiety; or without endangering the health and safety of the person or other people; or without taking significantly longer than would normally be expected.

- **as a consequence there is, or is likely to be, a significant impact on the adult's well-being**

  Checklist 4 summarises what should be taken into account when considering impacts on someone's wellbeing.

The outcomes listed in the national eligibility criteria are:

- **managing and maintaining nutrition;**
- **maintaining personal hygiene;**
- **managing toilet needs;**
- **being appropriately clothed;**
- **being able to make use of your home safely;**
- **maintaining a habitable home environment;**
- **developing and maintaining family or other personal relationships;**
- **accessing and engaging in work, training, education or volunteering;**
- **making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and**
- **carrying out any caring responsibilities you have for a child.**

To ensure that we continue to meet the same needs as before April 2015, you should also treat as eligible the further outcome of:

- **being protected from significant preventable risks to yourself or others**

… but you should consider whether there is a way in which the person could reasonably avoid the risk without requiring care and support ↑

Checklist 4: impacts on wellbeing

When deciding on the eligibility of the needs of either people with care and support needs or carers, we have to consider whether not achieving an outcome would have a significant impact on the person's wellbeing.

The Care Act defines wellbeing as including:

- **personal dignity (which includes you being treated with respect)**
- **physical and mental health and emotional well-being**
- **protection from abuse and neglect**
- **control over day-to-day life (including control over care/support provided to you and the way in which it is provided)**
- **participation in work, education, training or recreation**
- **social and economic well-being**
- **domestic, family and personal relationships**
- **the suitability of your living accommodation**
- **your contribution to society**

In deciding what is a "significant impact", we should give words their everyday meaning. Guidance says we have to "consider whether the adult's needs and their consequent inability to achieve the relevant outcomes will have an important, consequential effect on their daily lives, their independence and their wellbeing". This is a matter of judgement, and it is in the end our responsibility to make that judgement.

However the Care Act tells us that it is important to begin with the assumption that people are best-placed to make judgements about their own well-being. This doesn't mean that we must always agree with people, but it does mean that the assessment should start from what the person says is the impact on their wellbeing, and explain the reasons if we have come to a different view.

If someone is unable because of their impairment/illness/carer role to achieve an outcome which is not on the list of eligible outcomes in Checklist 3 (or Checklist 5 for carers), we do not have any obligation to provide services to support them, even if the impact on their wellbeing is significant. But we do have a duty to consider what other advice and assistance we can offer, e.g. by putting them in touch with other agencies.🡅

"How your carer(s) expect to support you"

173. This part of the CSP1 needs to be completed even if the carer(s) have asked for a separate assessment, because it is part of the person's needs assessment.

174. What you write in this section **must** however be based on a discussion with the carer(s), which should normally be at least partly in private, to ensure that the carer(s) are able to tell you things which they would be uncomfortable saying in front of the person, or to warn you about differences of opinion between the person and themselves.

175. If there is more than one significant carer, you should make sure that it is clear who is expecting to do how much (and you should normally talk to each carer separately).

176. You don't need to repeat in this box all the detail set out under "Your needs" about the needs which a carer will be meeting. You just need to write enough for it to be clear to anyone reading through Part B which needs carers are intending to meet. So for instance it might be enough to write in this box:

> **"**Your husband is intending to meet all of the needs described above, except that he cannot safely get you up in the morning, since he cannot bear your weight without risking injury to himself.**"**
>
> **"**Your daughter will meet all of your needs at weekends, but not during the working week.**"** ↑

"Your carer(s)' own needs"

177. The text in this box also **must** be based on individual discussion with the carer(s), normally in private. During that discussion, the carer(s) should be asked whether they are happy for the information about their needs to be shared with the user. If they are not, the carer assessment must be carried out separately, using a CSP2.

178. If there is a carer who is aged under 18, you **must** consider the separate guidance about young carers.

179. In your discussions with carers, you should talk through each of the potential areas of need set out in the national eligibility criteria for carers – see Checklist 5. If a carer has a need which falls within the national criteria, we **must** meet that need. In most cases the best way to do this will be to make sure that the care and support arrangements for the cared-for person take account of the carer's needs, and to help them to make contact with Carers Northumberland and any relevant condition-specific support groups for carers, for instance the local branch of the Alzheimer's Society.

180. In some cases, particularly if a carer is intending to provide a very high level of care and support, meeting their needs may include arranging services for the carer themselves – for instance somebody providing constant care to a seriously ill spouse might need help with basic housework. Note that carer services arranged as a result of a formal assessment are charged for in Northumberland, so if the carer can easily afford to arrange help such as a cleaner they are unlikely to benefit from being offered this as a carer's service – but the position may be different if a carer is less financially comfortable.

181. If a carer tells you about some tasks which don't meet the carer eligibility criteria but which because of caring they can't now do without help, you should document these on the form, and do what you can to assist with them. However you should explain that these needs are not eligible – which means that we will do what we can, but will not be able to provide services specifically to help with this.

182. Note that carers have a right to tell us that they will not be providing some specific kinds of care, or that they will not be available to provide care at particular times or on particular dates. We **cannot** tell a carer that they are not eligible to spend time away from caring whenever they choose to do so. However when a carer is not available, for whatever reason, we can only guarantee to meet the cared-for person's eligible needs, which may be less than the carer would have done. ↑

Checklist 5: eligible needs of carers

There are three elements to the national eligibility criteria for carers. All three of the statements in bold below must be true for a need to be eligible.

- **The need arises as a consequence of providing necessary care for an adult**

  "Necessary care" would not include care provided to meet needs which the person could meet themselves (or could meet in other ways, such as by using universally-available services). The Care Act guidance says you ***should not*** *base your decision about whether care is "necessary" on whether the needs of the cared-for person would be eligible for social care support. If you are not clear whether care is "necessary", you may need to ask for advice.*

- **As a result of the need, either the carer's physical or mental health is, or is at risk of, deteriorating or they are unable to achieve one or more of the outcomes listed below**

- **As a consequence there is, or is likely to be, a significant impact on the carer's well-being**

  Checklist 4 summarises what should be taken into account when considering impacts on someone's wellbeing.

Usually the best way to meet a carer's needs is to take them into account in designing the care arrangements for the cared-for person, though sometimes it may be necessary to provide support directly to the carer, for instance because the carer chooses to provide a level of care and support which means that other key aspects of their life will fall apart without support.

The outcomes listed in the national carer eligibility criteria are:

- **carrying out any caring responsibilities the carer has for a child;**
- **providing care to other persons for whom the carer provides care;**
- **maintaining a habitable home environment in the carer's home (whether or not this is also the home of the adult needing care);**
- **managing and maintaining nutrition;**
- **developing and maintaining family or other personal relationships;**
- **engaging in work, training, education or volunteering;**
- **making use of necessary facilities or services in the local community, including recreational facilities or services; and**
- **engaging in recreational activities.** ↑

Part C: Your personal budget and your care and support plan

183. There should be a clear separation between the **needs assessment** and the **care and support plan** setting out how needs will be met. People have a right to propose their own care and support plan to meet their assessed needs, and you should make this clear to them.

184. The **needs assessment** concludes with the identification of which of the person's eligible needs will require publicly-funded services, and the calculation of an **indicative personal budget**, which provides a starting point for care and support planning, whether that is carried out by you, in discussion with the person, or by the person themselves.

185. The **care and support plan** is a plan for meeting all of the person's eligible needs, and any non-eligible needs which can be met by means other than social care funding. It is not just a schedule of services to be provided, whether arranged by us or by the person themselves through a direct payment. The care and support plan includes a **final personal budget**, which sets out either the gross value of the direct payment or the cost of the services to be provided, together with the contribution which the person will have to make.

186. Even if the person seems very clear that they want us to arrange services for them, you should always have a discussion with them about the option of using available funding in a different way. You should explain that the indicative plan is just an *example* of how their needs could be met, and that if they can see an alternative that would suit them better at the same or a lower cost, we will help them to set that up, either through a direct payment or by arranging the services for them (though if they ask us to make arrangements, we may not be able to be quite as flexible as they could be if they were managing a direct payment themselves.) ↑

Your indicative plan and your indicative personal budget

187. The form first asks where the person's needs will best be met. If they will be met **in a care home**, no indicative plan or indicative personal budget is required. National policy on indicative personal budgets is primarily about care and support outside care homes.

188. In all other cases, you need to set out an indicative care and support plan. This is not necessarily the same as the actual plan you are expecting to arrange – it is an illustrative plan used solely for the purpose of calculating an indicative budget.

189. The form provides three different formats for describing elements of the support that the person will need. These are labelled "**support with tasks**", "**support with risks**", and "**replacement care**" – but you should choose whichever combination of formats produces the clearest description of the support required, without worrying too much about the labels, which will not be visible on the final form. Clicking on any of the three options in red will insert a row in the indicative plan.

- **Add support with tasks** adds a row in a format designed for describing support with predictable regular tasks. In the commonest case, each row will correspond to a potential visit by home care workers, or an illustrative assumption about when carers might provide eligible support with tasks. This format assumes that while the carer/care worker is providing support to the person, they will be wholly occupied in doing that – this is not the right format for describing support from someone who could be supporting other people or doing other things at the same time. However there are options for saying that more than one person is needed, for instance if the task involves manual lifting.

- **Add support with risks** adds a row in a format designed for describing periods of time when the person needs someone else available, for instance to keep them safe from unpredictable risks. It will often make sense to have a row for each of the different situations in which the person needs support on hand – for instance one row might be for the support needed at night, one for support during the day at home, and one for support when the person goes out. You need to say in each row whether the support needed is **undivided** 1:1 attention, "**nearby**" support from someone who might be doing something else near the person, but could be available quickly when needed, or "**on call**" support from someone who could be based somewhere else, so long as they were available to come round to help the person when required. You also need to say whether the support will be provided by carers or care workers – if it will be a mixture, you need a separate row for each form of support, setting out your assumptions about how much time will come from carers and how much from paid workers. ↑
- **Add replacement care** will add a row for a periods when carers have other commitments or need breaks, and therefore cannot provide the support that they would be providing in a normal week.

! **If you discuss the number of hours or indicative personal budget during an assessment visit, always make it clear that what you are writing down is not a final decision. For instance you might say: "I'll need to talk to my manager, who may have further suggestions about alternatives I should discuss with you, so this isn't a definite figure yet – but it will give you some idea of what we might be talking about." It is important to be upfront about this – but you should never say "this is what I think you need, but I may not get budget approval for it". If as an organisation we agree that a person requires care and support to meet an eligible need, we must provide it – we can't decide not to on financial grounds – but the ultimate decision about whether there is adequate evidence that care and support is needed rests with team managers (or sometimes more senior managers).**

190. Particular care is needed when describing the kind of support that someone needs to protect them from risks:

- **Intensive support** (1:1 or more) would only be required in a minority of cases for example in some forensic cases, or for people with particularly complex needs because of head injuries or mental health conditions. You should record the level of support that the person *needs*, rather than what you think the plan for meeting the need may have to be. For instance if a service user needs there to be someone available to help them quickly at night, it is unlikely that they *need* to have 1:1 support throughout the night – they probably could in principle get this support through a shared arrangement also supporting other people, such as a shared supported living scheme or a care home, though that may not turn out to be practicable in a specific case. See §191 for advice about recording this need when support is mostly provided by carers.

- **"Nearby"** support is support for someone who is at risk in ways which are too urgent or frequent for it to be good enough for someone to be available to come to their help as a call out, but who doesn't require 1:1 attention. Most people in shared supported living schemes or care homes are there because they require nearby support – but there are also many people living in their own homes whose nearby support needs are met most of the time by partners or other family members, with paid care workers filling the gaps when that isn't available. See §191 for advice about recording this need when support is mostly provided by carers. ↑
- **"On call"** support is support provided by someone not in the same place as the person who can come round fairly quickly (perhaps within half an hour). Usually on-call support is provided by family members or friends, and we do not in all parts of the county have commissioned services able to provide this, though we will continue to explore options for making it more widely available. You should **not** record someone as needing on-call support simply because they have a community alarm system as an "insurance" against an accident. On-call support is only likely to be appropriate if there has been a *pattern* of crises requiring help (or if the person's medical condition means that they are *expected* to have crises). If a fall or other crisis is *possible* but not *expected*, the fall-back if family members or friends are not available is likely to be the ambulance service rather than on-call support arranged by us. In that case, you should not record a need for on-call support.

191. Some specific points to note about the indicative plan are:

- You should include support with tasks or risks which family or friend **carers** will be providing to meet eligible needs, as well as support from paid care workers. However you should only include the part of the support they provide which you have assessed as being required in order to meet eligible needs. For instance if a spouse is with the person almost full time, but your assessment is that the only thing they do which meets eligible needs is to carry out some specific tasks, it is only the time required for those tasks which should be shown here. (You should do this by including illustrative timings for those tasks, basing these on how long a visit you'd expect to be needed if a home care worker was carrying out the tasks, though a spouse may in practice carry them out in a different way.) If your assessment is that the carer *does* need to be there all the time to keep the person safe from significant risks, you should consider carefully whether what is needed is "nearby support" or "intensive support", noting the comments above about how rare it is for someone to need constant undivided attention from another person. **The support from a carer entered in the indicative plan should correspond to the minimum level of paid-for support that we would provide if the carer was taken ill** (assuming that no other family member took over from them). What you enter here will not currently affect the indicative personal budget, though it may in future be used to calculate the indicative budget for replacement care. ↑
- If meeting a need requires two care workers, the dropdowns let you show this. If you need to show a visit during which a second worker would be required only for *part* of the time (for instance to get the person out of bed, but not to help them with their breakfast), enter one row for the full time slot of support from one worker, and a second row for part of the time slot of support from "an additional care worker". ↑

- If the plan is based on care workers supporting the person all the time (or all the time while they are awake, or all the time they are out of the house), the reason will be that the person would not be safe if left unattended, and it should be entered using “**Add support with risks**”. If there are also specific regular tasks which these care workers will be helping the person with, you don’t necessarily need to list them in the indicative plan – but if that would make it clearer, use the text field at the end to do this – for instance “to keep you safe and give you any specific help you need while *you are at home, including helping you with all of the tasks which this assessment says you need help with.*” In some cases, it might be useful to summarise the tasks to be carried out during a particular block of time – but try to avoid making the plan harder to understand than it needs to be. If the person needs someone with them throughout the day, you should usually show that in a single “support with risks” row for the whole day, rather than breaking it up unnecessarily into a series of separate rows just to show which tasks would be carried out when. ↑

Enabling and day services

192. One common situation is that a person needs someone with them to keep them safe when they are out of the house – this will often be the reason why we arrange an enabler, or a day service. In the needs assessment, you should describe the underlying reasons why the person will need support – nobody has a need for a day centre or an enabler as such; usually the person has a need to get out of the house or to maintain social contact, or the carer has a need for a few hours’ break -- and during that time the person needs someone with them to keep them safe. Enablers and day care services are common ways of meeting that need, but are not in themselves what the person needs (and should not be described as needs in Part B).

193. The indicative plan should also not describe a specific solution to the need, but should explain how much support from other people is actually needed. Usually, the best way to do this in the indicative plan will be to enter a row for the time that the person needs to spend out of the house, using the “**support with risks**” option, saying how many hours the person needs to be out of the house, and what level of support they need when they are out. In most cases the level of support needed will be for there to be “a paid care worker available nearby”, unless the person has a specific assessed need for 1:1 support. ↑

194. You should make sure that there is an explanation in Part B of how much time the person needs to be out of the house. For instance:

- If the reason is to give the carer a break, the need for this should be explained under “Your carer(s)’ own needs” in Part B, or on a CSP2, and the row in the indicative plan might describe a need for nearby support for N hours a week “to keep you safe and give you any specific help you need while *you are out of the house to give your wife a break*”

- If the reason is that the person needs to have opportunities to get out and meet other people, this should be explained in Part B under “Your needs”. There might also be a discussion under “Your strengths and opportunities” about whether there are alternative ways of meeting this need without care and support (such as local volunteer-run activities), and there might be a brief explanation under “needs which meet our eligibility criteria” of why not meeting this need would have a significant impact on the person’s wellbeing, and why the person doesn’t need *more* time out of the house. ↑

The indicative personal budget

195. Once you have completed or revised the indicative plan, the **indicative budget** can be calculated or recalculated by clicking the = sign in the paragraph below the plan. If you have omitted some crucial information, or if there are inconsistencies in the form which may affect the indicative personal budget, a dialogue box will appear telling you what needs to be added or corrected. The software checks only for some obvious kinds of error or omission; you are responsible for making sure that overall the information which you have provided is reasonable, and that the indicative budget is sensible. ↑

196. Some points to note about the calculation of the indicative budget are:

- The sum of money is based on what we would normally expect it to cost to employ personal assistants for the number of hours identified in the indicative plan. If someone intends to use a direct payment to fund agency home care, this will normally be more expensive, and we will uplift the amount to fund this at the rate we would pay a preferred provider for the location where the person lives (or the actual agency rate, if that is lower).
- Currently, the effect of adding a night of replacement care is to add a notional additional four hours of support time. In a later version, we may use the information in the indicative plan about the level of support being provided by carers to do a more personalised calculation of what will be required as a replacement – but in all cases the indicative budget is only an indication, and actual costs may be higher or lower. ↑

Your care and support plan

197. From this point in the form, the CSP1 sets out the care and support plan rather than the needs assessment. (The indicative personal budget is effectively the outcome of the needs assessment rather than part of the plan, its purpose is to set the starting point for planning.) If the drop-down at the start of the form says that this is an assessment rather than a draft or final plan, this part of the form will be hidden.

198. There are separate boxes for summaries of the plan for the person and the plan for the carer(s). There is no need to duplicate information between these – usually the summary of the plan for the person should include a description of the support that the carer(s) will be providing, and the plan for the carer should explain what steps are being taken to provide services for the person at times and in ways which will make things easier for the carer.

199. The care plan summary for the person should not simply be a list of services, but should give a broad account of how the needs which have been identified will be met, including for instance any informal arrangements that have been put in place and any other public services that the person will be using. There is no need to include all the practical details of the services in this box if they are already in other parts of the form such as the service diary, but you should ensure that anyone reading this box (including a budget holder) can get a clear picture of what overall level of service you are proposing.

200. If this is a reassessment, and there will be a change in the level or nature of services provided, the overall change should be described and at least briefly explained here. **This is particularly important if the level of services provided is going to be reduced**. Illustrative examples of this would be:

- "With effect from 1 September 2017, the lunchtime visits which you were previously getting will not continue, and your evening visit will be shorter, because you no longer need help with preparing meals."
- "The number of enabling hours in your plan has been reduced from 30 to 15 with effect from 2 October 2018, because you are now able to do more things independently." ↑
- "From 3 November 2019, you will be getting three visits a day from home care workers. This is an increase from the two visits you have been getting previously, because your arthritis has become worse and further limits what you can do for yourself."

201. At the following review/reassessment, the description and explanation of the change **should be removed**, since it will no longer be relevant. (But as illustrated above, you should include dates for changes in services, so that they will not become misleading if the form is reviewed on a CSP4 and the CSP1 is not changed.)

202. Examples of other issues which it would be appropriate to cover in this box are:

- How arrangements are expected to change over time – for instance whether we expect that the amount of support the person needs will reduce or increase, or whether the initial arrangement is provisional, and will be reviewed in a month or two to see what would is needed in the longer term
- How care and support will relate to other services the person gets or other activities that the person engages in – for instance how it will fit with their college course, or the church and community activities that the person expects to continue
- How short breaks are expected to be organised, if they are not set out in detail in the CSP1 (e.g. whether this will be done through the care manager or using the voucher scheme)
- Any monitoring arrangements that will be put in place – for instance regular visits from someone in a social care team or arrangements for a community nurse who is already visiting to notify us if there is a problem ↑

If you are a social worker in a complex needs team handing over a case to a care manager in a social care support team, this is where you should set out your "prescription" for what monitoring and other support are needed. This should be written in a way which will make sense to the person (and their family or friends) – for example you might include something like this at the bottom of the care and support plan summary:

Monitoring and review

Claire Manager from our social care support team will be monitoring your arrangements. She will visit to review your plan every six months. Your sister will be visiting you daily to make sure that you are OK, and can contact Claire if she has any concerns. ↑

Further details of your care and support services

203. The details of costed services which appear under this heading are inserted automatically from Swift. Over time, we hope to make this information increasingly detailed and useful. Because of the range of possible variations in how services are recorded on Swift, it is possible that information may be confusing – you should let the Systems Helpline know if you find any text that needs to be adjusted.

204. Immediately above this section is the dropdown for choosing whether a service diary is included in the form. ↑

If nobody answers the door

205. This section will be hidden if the accommodation section in Part A records that the person is living in a care home. If the person is in some other setting where no special steps would need to be taken if there was no response, you should pick the option "leave a note but take no special action" – this might for instance be appropriate if the person is in supported living or shared lives accommodation. ↑

Your final personal budget

206. Once costed services have been recorded in the Costed Packages of Care module of Swift and a financial assessment has been carried out, this section will reflect the service user's "personal budget" as defined by the Care Act.

207. The personal budget has three elements: the total weekly cost of the social care services recorded on Swift; the person's weekly contribution and the net weekly sum paid by the local authority. NHS funding is shown as well – though technically this is not part of the "personal budget" as defined by the Care Act, which is only about social care.

208. The personal budget will often be higher than the indicative personal budget (and may also sometimes be lower). The explanation is that the indicative personal budget is based on what would usually be the most cost-effective option, which is for the person to take a direct payment and employ personal assistants. If the person decides subsequently that they would like to change to a direct payment, you should explain that this will be based on costing a revised care and support plan, and that this will not necessarily be the same amount of money as the previous personal budget, even if their needs are the same.

209. Short break care charges are currently shown separately, and short breaks are not included in the weekly cost figure

! **This information is automatically inserted from Swift, and should be checked for anomalies. If the figures don't look right, and you don't think this is because of a mistake in the way services have been entered on Swift which can be corrected by admin, please contact the Systems Helpline.** ↑

What this plan is expected to achieve

210. This should be a comparison of what the approved care and support plan will achieve against the outcomes sought by the person, as recorded under the heading "What you want to achieve" in Part A.

211. If the plan will not fully achieve the person's desired outcomes, you should explain in the boxes that appear below how and why it will fall short of that. There is no need to repeat in detail explanations about eligibility which you have already provided in Part B – you should just give a summary of what outcomes won't be achieved, and a brief explanation which might be no more than "We weren't able to find a safe way of achieving this", or "We decided that some of the help you wanted wasn't eligible for funding from us", or "We decided that supporting you in the way you wanted wasn't a good use of our limited resources". ↑

Your view of this plan - disagreements

212. We have a duty under the Care Act to take all reasonable steps to reach agreement with the person we are preparing a plan for. This means that, if there are disagreements which can't be resolved, we **must** record these, and explain how we have tried to reach agreement.

213. The box for "Your reasons for disagreeing…" should as far as possible be in the person's own words. If the person has written a letter or email setting out what they disagree with, you should usually copy the statement of their disagreements word-for-word from what they have written. If you need to edit their written version to make it clear, or if you are summarising an oral discussion, you should aim to agree the wording with the person. Don't omit any points that the person sees as important, whether or not we think that their view is reasonable, or that they have understood the facts of the situation right. (If necessary you can write "You told us that you believe Dr N said you need XXX", to avoid the risk that the person reads the form as confirmation that Dr N did say that, when you are confident that they didn't.)

214. If you have already explained disagreements about specific issues in Part B, you don't need to repeat in full what you have said there, but you should refer to it, so that this section is a full summary of the areas of disagreement.

215. In the box below this ("steps we have taken"), you should aim to respond point by point to the issues which the person has raised – this will be easiest if you have helped the person to express their reasons for disagreeing in a clear and structured way. ↑

216. You should explain as fully as possible what we have done to try to resolve disagreements, and you should discuss with your manager whether there are other steps which ought to be taken before the response is finalised. Try to avoid sounding defensive or bureaucratic – you should aim to demonstrate that you understand why the person is unhappy, that you have done as much as you could to arrive at an agreed plan. It may be a good idea to give a commitment that we will monitor how any care and support arrangements that the person isn't happy about work in practice and will review them if there do turn out to be problems. If there are issues that your manager feels it would be useful to get further advice about, you can discuss your draft response with the Complaints Team at County Hall – this doesn't mean that we will treat the issue as a complaint (unless the person has said that they want to complain). ↑

Part D: About this needs assessment/care and support plan/review

217. This part of the form is about what happened during this specific assessment/reassessment/review. The information recorded here will *not* be carried forward to the next version of the form when the assessment and plan are reviewed.

218. The first box is for a description of *how* the assessment or review was carried out. It should at a minimum name all the people who you talked to. If some discussions were not detailed, it may be best to acknowledge that. ("I also spoke briefly with Dr N, who did not feel she had any relevant information to add.") ↑

219. If the form is recording a **review or reassessment**, Part D will be headed "About this review", and a paragraph should be displayed asking whether this is a planned or earlier-than-planned review. (If this heading and paragraph are not shown, this is likely to be because you have not picked one of the review options on the first dropdown at the very top of the form. For a review/reassessment, the form should be marked as “a partly updated assessment of your needs”, “your updated care and support plan”, “a draft review of your assessment and plan”, or “a review of your assessment and your plan”.)

220. The information then required depends on what you say about the reason for the review:

- For “**a special early review**”, you will be asked to pick from a list “one major reason” for this. (This is required for a Department of Health statistical return – if more than one of the options apply, pick any one of the main reasons.) There is a box in which you should describe more fully why the early review has taken place, and any specific recent events which are relevant to understanding the assessment. Note that any *lasting* changes to the person’s disability or health condition should be recorded in Part A of the form rather than here, so that they will be carried forward into the version of the form used as a starting point for the next review.
- For “**a regular review**”, you will just be asked whether there had been significant recent events or changes to the person’s life at the time we worked on the review. If you say that there have been, a box will appear for recording details of these; if you say not, the box will disappear. ↑

221. The next question asks who else we considered putting the person in contact with. This is the place to record any **referrals to other agencies** which have been made as a result of the assessment/review, and any community groups or voluntary organisations that you have put the person in contact with (or discussed with the person). If the person will not be seeing a FABO (for instance because they do not have to pay charges), you should discuss **disability benefits** such as Attendance Allowance or PIP. If you think they might be eligible for some benefits which they are not currently receiving, you should offer to put the person in contact with the Citizens’ Advice Bureau or another source of support with claiming.

222. The next section deals with **CHC eligibility and charges**. If you have said in Part A that the person is receiving after-care under Section 117 of the the Mental Health Act, the text will be changed to reflect that. Whether or not the person is eligible for CHC, you should discuss charges with them – if they are eligible, you should discuss the possibility that they might cease to be eligible in future, and have to pay charges then. (The same applies to people receiving Section 117 aftercare.) The form will prompt you if you need to make sure the person has a copy of the information sheet about Continuing Health Care.

> **!** **You <u>must</u> record in detail what you have said to the person about charging. This will avoid misunderstandings or unpleasant surprises. Also, if the person later complains that they didn’t understand that they would have to pay, or didn’t realise that their charges would increase, and there is no documentation to confirm that we explained this, we may have to waive or refund their charges, reducing the funding available to pay for services.**

223. If the person does not have a current charging assessment, is not eligible for CHC or Section 117 and may be receiving costed services, you should make a referral as early as possible to the Lead Financial Assessment and Benefits Officer using the Swift contact note “Message to FABO Action Required (Workflow job created)”. The form should not be finalised until the person has had a financial assessment. If you are not sure whether the financial assessment has taken place, you can look at the “Your final personal budget” section in Part C, which is updated each time the form is opened from Swift or checked out. ↑

224. The next question asks about **fire safety advice**. If the person says that they would like a visit from NFRS, this information will be automatically used to generate a referral the next time you check the form into Swift, or save the form as a draft when you are running it from Swift (to avoid delays, this does not depend on the form being finalised). If the person says they do *not* want a visit, you should ask them whether they would want us to pass on their details and tell NFRS not to visit them even if they are making general visits to all households in their area, or whether they simply want us not to ask for a special visit. If we have previously made a referral, the date of this will be pulled through into the form, so that you can remind the person of that.

NB: If there is an urgent issue about fire risks, you should make a telephone referral to NFRS, and record on the form that you have done so.

Expected date of the next review

225. The final paragraph before the service change details gives the expected date of the next review. This is *not* automatically populated from Swift, because you may wish to enter a date during your discussions with the person – but if you enter a date different from what has been put on Swift, you will need to make sure that Swift is updated. The name of the current key worker will also be automatically inserted in this paragraph as the person to contact with any queries before the next review. If the case has been transferred from a complex team to a care manager team, you should ensure that Swift is updated so that the correct person is identified here. ↑

New or changed care and support services

226. This is where you should record the information needed by admin to put new or changed services on Swift. Relevant sections for details will appear depending on which (if any) new/changed services you say the person will be getting. **Only** new, ended or changed services should be included in this part of the form.

227. In the **community services** section, clicking on “**Add a row**“ will enable you to add a further service, and “**Clear old info**” will reset the table. If you have completed the service diary, you do not need to repeat information which will be obvious from that, but you must make it clear what the overall change to the level of each service is, so that brokers/admin can check that the changes are right (e.g. “an extra 30 minutes each day”).

228. The **short breaks** section also includes a clickable option to “**Add a row**“, and an option to “**clear**“ any old information.

229. In the **care home** section, note that you need to record whether the placement is permanent or temporary. Is someone changes from a temporary to a permanent placement, you **must** complete the care home section and explain in Part C why the plan is no longer temporary, even if there are no other changes to the person’s care arrangements.

230. Currently the details of **direct payment** arrangements are sent out separately as a supplementary part of the care and support plan. We may eventually incorporate them in the CSP1. ↑

Weekly diary of your services

231. You don’t have to use the diary sheet, but it will often be the best way to make it clear to the service user and the brokers/admin what the overall pattern of services is (and you **must** make sure that, between this and the information about new/changed services in Part D, it is clear exactly what should be recorded on Swift).

232. Points to note are:

- The diary will only display if you have selected a option at the top of the form which shows the care and support plan rather than just the assessment, and have picked the “below and in the diary sheet at the end” option in Part C. ↑
- You can use the copy button (⎘) to copy text across all days of the week for the specific time of day. (It can then be edited, for instance if there are additional tasks on some specific days.) If you want the same text on *every* day, you should enter it on Monday – if you enter text against a later day, it will be copied only to *later* days of the week. This is most likely to be useful for services which are provided on both days of the weekend.
- If you need to remove all of the information from a row, use the delete button (✖). ↑

Reviewing or reassessing a CSP1

233. If you are reviewing or reassessing an existing CSP1, you should edit the text of the form so that it is up to date throughout – **you should <u>not</u> simply add new text at the end of each box recording changes from the previous version**.

234. If the previous assessment included in Part B some needs which it said could be addressed without requiring ongoing care and support services, you should normally rewrite “Your needs” and “Your strengths and opportunities” to make it clear whether the person still has these needs. For instance if the person had difficulty carrying out a task at the time of the previous assessment, but equipment or adaptations were arranged to resolve that, the updated CSP1 might say under “Your needs” something like “Since your level access shower was installed, you have had no difficulty showering”, and delete any other text about how adaptations were going to be arranged.

235. If the person's situation has changed considerably, it may be best to delete the previous text entirely and rewrite the relevant parts of the form from scratch. It may sometimes also be sensible to do this simply because the way that the previous assessment was written up doesn't read well as a reflection of the discussions that you had with the person, even if the overall conclusions are similar. All previous finalised forms are retained, and can be accessed through the catalogue in Swift, so no historical information about past assessments will be lost if you replace the previous text.

236. If there is information from a previous assessment carried out by a different needs assessor which you are not certain is still up-to-date, and cannot check out with the person themselves during the assessment (for instance a summary of a specialist assessment by another professional), you should either check this with the original source or remove it. The updated CSP1 should include only information which you are confident you can rely on in assessing the person's current needs. ↑

CSP2 – CARERS NEEDS ASSESSMENT

237. ***The CSP2 has not yet been revised from the initial version. We are now beginning to think about what changes to make in Version 2 – which will include changing the dropdowns to work in the same way as the CSP1. The guidance in this section will be updated when Version 2 is issued.***

238. When you are carrying out a needs assessment of an adult, you should always discuss with at least the main carer(s) how the care and support which they are providing is affecting their own lives. Many carers are likely to be happy to have this recorded on the CSP1, but you should always explain that they have the option of a separate assessment, which should be recorded on a CSP2

239. The purpose of a carer's assessment is to establish not only the carer's need for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. It must also give consideration of the carer's potential future need for support.

240. In most cases the carer assessment will be carried out at the same time as a needs assessment in a coordinated way, with the agreement of both the person and the carer, so that interrelated needs are properly captured and the process is as efficient as possible. Where assessments are combined, it is important that each individual, including any children, has a chance to have a private conversation with the assessor in case there are areas they wish to identify and explore separately.

241. The **CSP2** may also be used for a separate carer assessment if:

- either party refuses a combined assessment
- the individual cared for refuses a needs assessment.

242. The CSP2 is a simpler form than the CSP1, and it is not expected that it will pass through as many separate stages. It therefore does not have a field for recording the stage of the assessment. In the unusual situation where a carer decides before the assessment is complete that they do not wish to complete it, record the relevant detail in bold in the text box underneath "The support you provide" section and finalise the CSP2.

Eligibility

243. Checklist 5 summarises the eligibility criteria for carers, and the CSP2 is designed to follow the structure of the list of eligible needs.

244. In most cases, it will be possible to meet eligible needs by adjusting the care and support plan for the cared-for person, or by arranging replacement care for the person while the carer gets a break, rather than by providing separate services to the carer. However you should consider each of these options.

NB If you know that there is a carer assessment but you are unable to view it from the Client Needs Assessment bundle in Swift, you must check or ask admin to check whether the carer has been correctly recorded as a carer on Swift.

General information

245. In situations where a person lives with or is significantly dependent on their carer for support, registration with the Carers Emergency Card scheme, administered by Carers Northumberland, is encouraged. The scheme offers peace of mind that, should something happen to prevent the carer being with the person cared for, temporary support can be put in place using British Red Cross volunteers. The temporary sitting service may remain until the carer deals with the urgent situation or, if necessary, until replacement care arrangements can be made. The service is free www.carersnorthumberland.org.uk ↑

Young Carers

246. A young carer is anyone under the age of 18, whose life is in some way restricted because of the need to take responsibility for the care of someone, usually in their family. Many young carers assume significant levels of responsibility normally associated with an adult. It should not be assumed that all children whose parents are ill or disabled are automatically young carers; however an increasing number of disabled and ill adults are forced to rely on their children for their survival and wellbeing, resulting in their children becoming young carers. (Definition from the Northumberland Joint Carers Strategy 2013-2016)

247. If the CSP1 (guidance above) says that there are children in the household, you **must** discuss with the person how their care and support needs affect the children, and you should normally record details of the children unless it is clear that they are not providing the person with support, do not depend on the person, and are not significantly affected in other ways by the person, for instance because they are distressed by some of the consequences of their condition.

248. The CSP1 will consider the needs of the person, including their parenting needs, and identify any needs that are being addressed by young carers. Consideration should be given to whether any of the caring responsibilities the young carer is undertaking are inappropriate or excessive. Inappropriate caring tasks may indicate an increase in the services the service user gets. ↑

249. Inappropriate caring responsibilities should be considered as anything which is likely to have an impact on the child’s health, wellbeing or education, or which can be considered unsuitable in light of the child’s circumstances and may include:

- Personal care such as bathing and toileting;
- Carrying out strenuous physical tasks such as lifting;
- Administering medication;
- Maintaining the family budget;
- Emotional support to the adult;
- Support through the night.

250. If there is an **adult carer** in the home their CSP2 will consider their responsibility for others, including children and they may be eligible for support as a result e.g. to support the parents time with the children or to manage other parenting tasks (again the response may be an increase in the users plan or may involve services directly to the carer.)

251. In many situations, even if someone under the age of 18 is providing care, their parents will be making sure that they get the support which they need to avoid any harmful impact on their wellbeing, welfare, education and development. If a young carer appears to need support which they are not getting, and if this cannot be resolved by providing additional support to the cared-for person, you should make a referral to the **First Contact Service** in Children's Services on **01670 536 000**, who can arrange a young carer's assessment or any other appropriate response.

252. Documents and guidance about locality hubs and early help assessments in Children's services can be found at www.tinyurl.com/NCCFamilies. If you need general advice about arrangements in children's services, contact Mary.Connor@northumberland.gov.uk. Other useful resources are:

- The Northumberland young carers directory at www.tinyurl.com/ycvoices
- The Young Carers Website at www.northumberlandyoungcarers.org ↑

Sharing information

253. Carers must be given a copy of the CSP2. ↑

254. If the carer is happy to receive information by email you must give them a copy of Information Sheet C10 - Communicating with us by email (available at www.northumberland.gov.uk/careandsupport).

255. Where the carer agrees to correspond with us by email, please ensure that you record their email address on the CSP2 and inform your admin support. Admin will send a test email to this address before any personal and confidential information is sent. The test email will not include any sensitive information, but will ask that they confirm information that someone else would not know if they got the email by mistake. ↑

The support that you provide

256. This information will be a brief summary of the support provided if a needs assessment has also been completed which includes full details.

257. If the person cared for refuses a needs assessment then more detail will need to be provided in the CSP2. A carer may be eligible for statutory support if the needs arise as a consequence of providing necessary care for an adult, even if the adult themselves declines care and support. Information may need to be gathered from other sources, e.g. GP, District Nurse etc. to verify whether the care provided is necessary before eligibility is confirmed. ↑

Needs that you have as a carer

258. You must consider and document ways to prevent any difficulty from becoming a significant problem or to minimise risk, now or in the future with regard to whether:

- the carer's physical or mental health is at risk of deteriorating or
- the carer is unable to achieve any of the list of other outcomes listed
- other issues important to the carer, (these may not come under the eligibility criteria but management may help sustain the caring relationship)

259. The plan to prevent this being a problem should record:

- things the carer, family or friends can change to make caring easier
- access to universal or voluntary sector services, provision of information etc.
- costed care as a result of the carer's assessment is most likely to involve an increase in the care plan for the person cared for, if they have an assessment,

for example providing increased support to allow the carer to take a break. Carers cannot be charged for these services but the service user can). ↑

- where significant risk is indicated and the best solution involves the provision of services directly to the carer then the carer may be offered a direct payment. The carer may be charged for these services. ↑

Information you have told us in confidence

260. Record here information the carer does not wish to be shared with the person cared for (or others). ↑

Support from us

261. This section summarises costed services and adjustments to how care and support is provided to the person you care for.

262. Summarise the recommendation for change to the service user's care plan as a result of the carer's assessment and areas of the user's plan that already support the carer without increase e.g. day care.

263. Carers can be charged for services that support them directly but cannot be charged for services received by the person cared for. Discretion may be applied e.g. if there is a cost to essential training that a carer needs to access so that they can provide care safely. ↑

Disagreements

264. We have a duty under the Care Act to take all reasonable steps to reach agreement. If that turns out not to be possible, you must record clearly the areas of disagreement and the steps you have taken to try to resolve them

265. Both the carer's view and the view of the organisation about any disputed assessment and eligibility decisions should be recorded here. ↑

THE CSP4 – NO CHANGE REVIEWS

266. The CSP4 provides a short and simple means of recording reviews when:

- There is no significant change to the person's ongoing needs or circumstances
- **and** there is no significant change to their carer's ongoing needs or circumstances
- **and** there are no changes required to the current care and support plan, apart from *temporary* responses to urgent problems (if you need to arrange urgent short-term services to meet changed *ongoing* needs pending a reassessment, this should be documented using the Urgent Needs Plan form)

267. In all other circumstances, the CSP1 should be updated. A CSP4 is a record of a limited **review**, which is simply a check that everything is going as planned, *not* of a **reassessment**, which is what is required if someone's needs have changed or if the care and support plan isn't working as expected.

Below are *examples* of situations where the CSP1 would need updating, even if there are no changes to the services required:

- If the *carer* is now having to do significantly more than previously
- If the arrangements for support from carers have changed substantially (e.g. because the person’s spouse has died, and it is now a daughter and son who are providing the care)
- If there are significant errors or omissions in the information in the CSP1
- If the CSP1 includes information which will cause confusion if it is used to check the person’s circumstances – e.g. because it does not follow the advice in this handbook about giving the *dates* when significant events took place rather than saying “last year” or “in July this year”.

268. If you expect only to need to carry out a review, but discover when you visit that there have been significant changes, you will need to switch to carrying out a reassessment and completing a CSP1 (and if relevant a CSP2). If you are not the appropriate person to carry out the reassessment – for instance if you are a care manager and it requires a social worker or a nurse – you may need to complete an urgent needs plan form to ensure that the person’s immediate needs are met, while referring to the appropriate team for a full reassessment. ↑

Completing the CSP4

269. The CSP4 is a record of how you have checked that the current assessment and plan are still appropriate. You should always read through the current CSP1 before carrying out a review. **If you find that the CSP1 is obviously out of date, you should update it, and not use the CSP4, even if there are no changes required to services (see the box above)**. The CSP1 should always be the right place to look to find the current assessment and care plan. ↑

“Checking our information about you”

270. Basic information from Swift is automatically inserted into the CSP4, but no other information is copied forward from previous CSP4s or from the CSP1. This is because the CSP4 is intended only as a record of how you have checked that there is no need to change the CSP1.

271. The first part of the form is a check on the basic information that we hold about the person, the professionals involved with them and their family members. Updates and additions should be entered in the same way as on the CSP1 – and the form must be passed to admin to ensure that these are entered on Swift. Note that they will only be carried forward into future CSP1s or CSP4s if they have been entered on Swift. (Similarly, if additional involvements or relatives have been entered on the most recent CSP1 but not transferred to Swift, those will not show up in the CSP4. If possible, you should check the CSP1 to make sure that there is no information on it which has not been pulled through into the CSP4.)

272. The only information entered on a CSP1 which will currently transfer directly between that and the CSP4 is the keysafe code. ↑

“The outcome of your review”

273. Please make sure that you select an answer from the first drop-down in the first paragraph in this section (“a regular or early review”). If the review is earlier than planned, please also select an answer from the second drop-down (“choose one major reason”). Sometimes there will be more than one reason – if one of them is obviously the most important, choose that one; otherwise it doesn't matter which you choose. These questions are needed for national statistics.

274. The most important box in this section will often be the first one, “Your needs”. You should summarise all of the issues covered during your discussion with the person, and any actions that you have agreed on, such as making a referral to another professional or agency, taking an issue up with a care provider, or seeking advice about something which the person is concerned about. If you have checked through the CSP1 in detail with the person, you may not need to write more than “We went through your existing assessment, and agreed that your needs hadn’t changed” – but if there was a more substantial discussion about some specific points, you should record this.

275. You should also include in the “Your needs” box a summary of who other than the person and their carers you talked to, and anything significant that they told you.

276. The CSP4 does not include the NFRS referral question, on the assumption that if the person’s needs have not changed there will usually not be a reason to reconsider fire safety. However if you do have fire safety concerns you should offer to make a direct referral to NFRS.

277. You should write something in each of the other three boxes in this section, even if the answers are just “You do not have carers”, “No urgent changes are needed” and “No reassessment is required”.

278. If the person does have a carer, you should always speak to them, and check whether anything has changed in their own situation, as well as whether they are happy about the services being provided to the cared-for person. The main points of this discussion should appear under “Your carer(s)’ needs”.

279. As with an assessment, you should normally speak in private separately to the carer and to the cared for person, to make sure that there is nothing that either of them wants to tell you which they are not happy to say in front of the other. During the private conversation with the carer, you should check whether they are happy for the record of your discussion with them to be shared with the user. If not, you will need either to complete/update a CSP2 or to send the carer a separate letter/email recording what they said to you (and copy this into a Swift contact note). If there is already a CSP2 for the carer, you should read this before you visit. ↑

280. The box for “Urgent changes to your care and support arrangements” should only be used for temporary arrangements to deal with an urgent short-term issue. Any longer-term changes should be recorded on a CSP1. The CSP4:

- should only be used for service changes which will last for a fortnight or less – for instance additional home care while a carer is having some hospital treatment
- should not be used for a short break in a care home, unless this is an additional short break for someone who already has short breaks in their care and support plan. This is particularly important if the person does not have the mental capacity to agree to a short break, or is not happy about the idea, or if you think that the short break might turn out to be the beginning of a permanent stay.

281. Budget holders will need to agree to any urgent services, and you will need to include in this box all the information that brokers or local admin will require to enter them on Swift.

282. In the “Conclusion” section, you should confirm whether there have been any changes which will require a reassessment. If a reassessment is needed, you should explain how that will happen (for instance that a social worker will be coming to do it, that you will be making a further visit, or that you have already carried out this assessment and will be sending a copy shortly).

283. Please add an approximate review date at the end of the form after discussing this with the person. ↑

After the CSP4 has been completed

284. If there are any changes to the person’s details or the details of involvements or relatives in the “Checking our information about you” section, you must pass the completed form to admin for entry on Swift.

285. The review date that you have entered on the form must be entered on Swift – either by you or by your admin.

286. If there are any urgent temporary services, you must get budget holder approval, and then copy the form to the brokers (or if relevant your local admin).

287. The person whose needs you have reviewed should always be sent a copy of the form. If it is being sent to the person directly, it is formatted so that it can be used with a window envelope; if it is being sent via someone else, the letter addressed to the service user should still be used, but in a manually-addressed envelope (or by email). If there is a carer, you should check during your visit whether it will be OK to send one copy for both the carer and the cared-for person. If not you should send a separate copy to the carer, unless the person has said they do not wish their information to be shared with the carer (note also the advice in §279 above about how to handle information which the carer doesn’t wish to share).

288. At the same time as sending the letter, you should complete a contact note on Swift to confirm that you have done so, using the note type “CSP4 sent to service user”. ↑

THE URGENT NEEDS PLAN FORM

289. The Urgent Needs form is a simpler alternative to the CSP1, for use **only** in circumstances where services are needed urgently, and it would not be possible or appropriate to carry out a full Care Act needs assessment. ↑

When to use the Urgent Needs Plan form

290. There are three kinds of situation where an Urgent Needs Plan may be called for:

- For someone **newly referred**, who needs care and support urgently because of a crisis, where it isn’t immediately possible to have the kind of considered discussion of the person’s needs and aspirations expected during a full needs assessment. This might be because there isn’t time to talk about longer-term issues with the person and everyone else who should be involved; it might be because the person’s condition or situation is currently too unstable for their longer-term needs and options to be clear; or it might be because the person is not currently in a state where they are ready to talk about the future.
- For an **existing service user** whose needs or circumstances have suddenly changed, where there is an immediate need to change the care and support

arrangements, but it isn’t immediately possible or sensible to carry out a full reassessment. If the changes to the arrangements are only temporary – for instance arising because of a carer’s short-term absence, or because the person has flu – the CSP4 review form can be used to arrange services; however the Urgent Needs Plan form should be used when the person’s ongoing needs have changed, but it is too early to carry out a full reassessment.

- For someone who is **terminally ill**, where the kind of discussion of the person’s longer-term life plans which is expected during a full Care Act needs assessment would be inappropriate and possibly insensitive. The Urgent Needs Plan form will usually be the best way for community matrons to record the service arrangements they are making when they are the case managers for fast track CHC plans (with support from locality team clerks). It may also in many situations be an appropriate alternative to a CSP1 for Macmillan social workers.

291. The Urgent Needs Plan form should only be used to make time-limited arrangements. The text of the form is intended to make it clear that the services involved are not long-term arrangements, and you should explain this clearly to the person and their carers/family.

292. The Urgent Needs Plan form **must not** be used to make a long-term placement in a care home, or any other long-term change to the person’s living arrangements. (This also means that it would not be acceptable to use the form to arrange a placement described as a “short break” in a care home in a situation where there is an expectation that this will subsequently be converted into a permanent placement.)
↑

293. The Urgent Needs Plan form is an “episode” form like the safeguarding episode form, and it is possible to revise the plan as the situation changes, including extending its duration – but this should only happen when the reasons for not immediately carrying out a full needs assessment still apply. Urgent needs services should never become long-term arrangements because they have been allowed to drift.

294. A social work/nursing team **must not** transfer a case to an unqualified care manager team while the assessment is set out only in an Urgent Needs Plan. Cases can only be handed over with an up to date full needs assessment on a CSP1. (However Hospital to Home/Early Response handovers may sometimes be direct to an unqualified care manager.) ↑

Completing the form

The background to this plan

295. The explanation of the **reasons for care and support** does not need to be as full as if this was a CSP1. Unlike the “reasons why you need care and support” heading in the CSP1, this box is not intended to be a description of the person’s ongoing needs and circumstances, but should focus on the specific short-term issues at the time when the Plan is prepared.

296. The second box covers **mental capacity** issues. Because this form is not intended to record plans with long-lasting consequences, it will usually not be necessary to cover these issues in as much detail as on a CSP1 – but you should at least make it clear whether the person was able to speak for themselves, or whether someone else had to speak for them, and document how if the person didn't speak for themselves you have taken reasonable steps to ensure that this was because they couldn't, rather than because a family member was easier to communicate with.

297. The third box asks for a brief summary of **who you talked to**. How specific this needs to be, and whether you record any detail about what specific professionals or family members told you, may depend on whether it seems possible that there will subsequently be any disagreements about what happened. ↑

The basic information which we have about you

298. This is the same basic information that is recorded on the CSP1 and CSP4. If you have added any information in this section, you should let admin know, and ask them to update Swift. ↑

How we plan to meet your needs

299. The **existing care and support arrangements** box is an opportunity to explain whether any existing services will continue alongside the new services in the plan, or be replaced by them. This might include privately-funded services as well as any services arranged by us.

300. The **what you need support with now** box is for a (usually brief) summary of the *new* support that the person needs during the period of this plan.

301. The **what family members or friends will be able to help with** box is about carer support. You should make it clear to everyone that you are asking *only* about what support family members or friends will be providing during the period of the Urgent Needs Plan, and that there will be a separate discussion about future arrangements if the person needs long-term care and support. Because this is only about the short term, it will not usually be necessary to record a separate assessment of carer needs, though you do need to make sure you have checked out whether carers are happy with the assumptions that the person (or others) may be making about what they are willing and able to do. Usually this will involve at least a brief private conversation with each carer. ↑

Services which we will arrange to meet your urgent needs

302. The list of new/changed **services** and the **service diary** are in the same format as in the CSP1, except that there is no option to enter a long-term care home placement. It is also unlikely to be appropriate for an Urgent Needs Plan to include a *new* direct payment for someone not already receiving one, though the form can be used to add a temporary enhancement to an ongoing direct payment to support additional support for the next few days or weeks. For people not already receiving a direct payment, it may, depending on the situation, be a good idea to have an initial discussion about the longer-term option of a direct payment, so that the person and their carer(s) can start thinking about that.

> Services entered on the urgent needs form need budget approval and the involvement of brokers/admin in the same way as services on the CSP1.

303. You should always discuss **charges**, and document on the form that this has happened. Even if the person is already paying charges for existing services, you should tell them whether they can expect to pay more because of the extra services in the Urgent Needs Plan.

304. You must give an indication of **how long** the plan is expected to continue. This can be revised later, if the situation changes. ↑

Sending the form

305. The Urgent Needs form should be sent to the person, to anyone else who the person has asked us to send it to, and (usually) to service providers. Usually, further copies should be sent each time it is updated, particularly if there are changes to the level or timings of services. You should enter a contact note of type "Urgent needs form sent to service user" on Swift. ↑

Updating and closing the form

306. The Urgent Needs Plan form is an "episode" form, like the safeguarding episode form. This means that it can be updated as the person's care arrangements change. The text on the form will reflect which stage it is at, based on the assessment type that you choose in Swift:

- When you first begin an urgent needs plan, record it against the assessment type "Urgent Needs Plan (Start)", finalising it when it is ready to send
- If the plan is then updated, use "Urgent Needs Plan (Revision)"
- To close the plan, either because the services are stopping or because support will now be provided through a longer-term plan described in a CSP1, use "Urgent Needs Plan (End)".

307. Each time the Urgent Needs Plan is updated, you should check that all elements of the plan are up to date, including the entry for the date by which we expect the plan to end. You should use the first box on the form to indicate briefly what has changed.

There is no need to repeat in the box about what has been changed the detail of the service changes entered further down the form. You should just give a very brief explanation of how the new plan differs from the previous one: Examples of things you might write in this box would be:

- "Alterations to the times of visits, as discussed with you on the phone"
- "Changes to the plan now that your daughter is going back to work"
- "Reduced support now that you are more mobile"

308. When you close the Urgent Needs episode, you should use the "what has been changed" box to summarise why the plan has been closed – e.g. "Long-term plan now in place", or "Private arrangements in place". There will usually be no need to send the person a copy of the final version of the form which closes the episode, but they should get written confirmation of what has happened, in one of two ways:

- If they will be getting ongoing support arranged by us, the CSP1 should clarify in Part D whether any of the services arranged as part of the urgent needs plan are continuing or whether they have all ended
- If they have ongoing care and support needs which will be met in other ways, the Options Guidance form should be completed, and the Options Guidance letter should be sent

- If they won't need any further care and support, because they have recovered, it will often be a good idea to send a brief letter or email confirming that, in case there are any differences of perception. ↑

> This is an example of a letter confirming the end of services with no ongoing care and support needs:
>
> Dear Mrs Example,
>
> This is just to confirm that, as discussed, the home care services which we arranged to support you after your fall are ending after the visit on 1 July. This is because you have now recovered enough not to need any further care and support, though you should carry on doing the exercises recommended by the physio to help you complete your recovery. If you have any further problems, please feel free to contact us on **01670 536 400**.
>
> I hope everything goes well, and that you are soon completely back to normal.
>
> Clare Manager

309. Once the Urgent Needs Plan episode is closed any new Urgent Needs Plan forms generated will start from fresh and will not display any information recorded in previous Urgent Needs episodes. ↑

Moving on to a full assessment

310. Usually, an Urgent Needs plan will be followed by a full Care Act needs assessment on a CSP1. The only exceptions to this other than the person making a full recovery should be end of life care, the person's death or departure from Northumberland, or situations where the person does not wish to have an assessment of their longer term needs, for instance because they are planning to make private arrangements and do not want our ongoing help. In any case where the person tells us they don't want a full needs assessment, the Options Guidance documentation should be completed, and the person should be sent the Options Guidance letter, so that we have written evidence that we have explained to the person their options and entitlements.

311. Otherwise, a full assessment/reassessment on a CSP1 should begin as soon as the person is ready for that – indeed it may be sensible to start a CSP1 in draft at the same time as completing an Urgent Needs Plan form, or soon afterwards, so that there is an appropriate place to document longer-term issues as they become apparent. (For the purposes of monitoring the 28-day target for finalising CSP1s, there will be an adjustment to take account of forms started early during urgent needs services.)

312. Assessment information does *not* transfer automatically from the Urgent Needs form to the CSP1 (except for basic information about the person, their relationships and other involved professionals, which should be passed to admin to enter on Swift, and will then be pulled through onto the CSP1 in the usual way). This is intentional – the expectation is that the Urgent Needs form will be written in a way which focuses on what the person needs over the next few days or weeks, rather than as the longer-term description of the person's needs expected on the CSP1. ↑

WHICH FORM TO USE – A FLOWCHART