City of
BRADFORD
METROPOLITAN DISTRICT COUNCIL

RAISING EXPECTATIONS

Practice Guide

Assessment & Support Planning

Contacts and further information:

For more information visit www.bradford.gov.uk and search for Adult Social Care

Telephone: 01274 435400
Textphone: 07582 101115

Alternatively you can write to: Department of Adult Social Care,
5th Floor, Britannia House, Bradford, BD1 1HX

The wording in this publication can be made available in other formats such as large print and Braille. Please call 01274 435400.

Table of Contents

Assessment & Support Planning

1. Back to What You Know:

An assessment is the means by which we begin to work with people to help them think about how they can get on with their lives and maintain or take up an active part in their local community in the way that suits them. If a person needs care and support to help them with this, an assessment will start this conversation.

The assessment process is based on our practice model. Professional practice and accountability are core to our work, so we are:

- open and personalised in our approach.
- timely and defensible through being legally literate.
- clear and transparent, building on the person's strengths and amplifying their voice.
- enabling of risk recognising it can be a positive force to support development and growth.
- critically reflective ensuring that the person's human rights are at the centre of our approach.

The process is underpinned by strengths, legal literacy, human rights, risk enablement and community assets. What does the person, their family, their friends and neighbours and local community have that can help? We understand and respect that people are all experts about their own lives and our Practice Model supports them through ensuring that their wishes, feelings and beliefs remain central to all decisions.

The Care Act statutory guidance (chapter 6.3) reminds us that... 'an "assessment" must always be appropriate and proportionate. It may come in different formats and can be carried out in various ways...'. All our interventions, our assessments and support plans should be proportionate and should only be as intrusive as necessary. We need to understand from the start why we're involved but should also explore and try to understand d any underlying needs. There are eight fundamental principles woven through the Care Act, which should be reflected in social care practice you are completing your assessment, those are:

- Strengths-based approach
- Transparency
- Whole family / holistic approach
- Maximise the person's involvement
- Recognise fluctuating needs
- Promote individual choice and control
- Appropriateness
- Proportionality

Adhering to these principles will ensure that your practice is person-centred and that you are working towards the key legal duty of promoting individual wellbeing. Assessment should also ensure that the persons wishes are central and are included in any such assessment or subsequent planning to meet eligible needs:

Assessment & Support Planning

""The central elements of the framework are (1) the "well-being" principle (2) the assessment of needs (3) making the arrangements to meet those needs and (4) in certain cases, identifying the adult's personal budget. There is a clear statutory theme placing the individual at the heart and centre of the process so that he or she is fully involved in decision making. This is emphasised by the duty to have regard to the wishes and preferences of the individual." (para. 32) "

JF, R (on the application of) v The London Borough of Merton (Rev 1) [2017] EWHC 1519 (Admin) (30 June 2017)

We want our assessments to be timely – taking into account urgent needs but being aware that things can change. This means short term solutions are appropriate for crisis situations, but it is usually quite inappropriate to arrange long term solutions in a crisis. We should let people and carers know what our timescales might be – and keep them informed throughout.
We want you to trust your professionalism and skills to understand the person, what needs to happen and why. Doing our assessments this way will make them person- centred, solution-driven, strengths-based and outcome-focused.

2. Before the assessment

Having a clear idea (a good referral) of what the situation is will help focus the assessment – even if during the process other issues arise.
The first contact with someone in need of care and support, or their representative, is at the beginning of an assessment conversation and there are many routes for this to happen. With increasing need and complexity, this guide offers support in setting out a range of assessment methods, and how best to utilise them.
Before we begin the process, we should make contact with them to check that they know and understand that a referral has been made about them and checking they have given valid consent for this. Ideally, we should ring the person to let them know the types of questions we may be asking or advise the person to consider areas of their life they would like to discuss. If people are prepared and know what to expect this can reduce the intrusion and save time.
Some things to think about might include:

Communication needs:
- what means of communication are suitable for the person- verbal, written, sign?
- is an interpreter needed?
- do we need to make adjustments in how we communicate?
- is information required in different ways?
- do they need someone to speak up for them?

Capacity and level of understanding:
- is an independent advocate needed?
- should a Mental Capacity Act assessment take place?
- is there anybody with Deputyship, Power of Attorney and so on?

How to carry out the assessment:
- can it be done by phone?
- should it be face-to-face?
- if so, where would be best for the person?
- who should be involved?
- is a specialist assessment required – carer, sensory, mobility?

Assessment & Support Planning

3. Facts, analysis, judgement and outcomes

During the assessment we gather the facts (information or evidence), work out what those facts are telling us (analysis) and this leads us to what we think (our judgement). A good conversation should enable people to articulate what they want to achieve (their outcomes) and what should happen because of all that (any care or support planning that might be needed).

- Facts:This is a conversation about the person and their carer to find out about them and their current situation. Do ask about what life was like before and what life could be like next.
- Analysis: Analysis is the art of fully understanding something in order to explain it. This is where the assessment comes to life: this is you making sense of the situation and using your skills and experience to understand what's happening and to start to think what we can do about it. What are all the facts telling you?
- Judgement: Having analysed the facts, you begin to form your professional judgement. This is the situation: these are the strengths, these are the needs, this is what we need to do. We're now beginning to move towards what outcomes we need to be achieving.
- Outcomes: This is what the person wants to achieve e.g. 'P wants to get back to work', 'P wants to help out with his grandchildren', 'P wants to be able to get herself to the loo'.

4. Proportionality - Being Person Centred

Personalised assessments will capture the essence of the person, their lived life, their aspirations and their culture. The person will recognise themselves in the assessment, which is about them as an individual and their character, and goes beyond the initial purpose of the assessment. To act proportionately is to provide the right level of response to suit the needs of the person, the situation or the level of risk. This includes the right profession and skill mix to work with people in need of care and avoid duplication.Conversation based assessment, during which we exchange information with the person to ensure they remain informed and in as much control as possible of the outcomes from the process, can help individuals explain a problem themselves and decide how big an issue it is. This will also help us to appear less intrusive, as we can also avoid areas that they don't see as a problem (unless, of course, professionally we disagree and need to explore it).

Talking with people, spending time with them, getting to know them means you can together, better understand them, their strengths, their culture and identity, their needs and how to meet them. During their assessment the person should feel listened to, their views clearly recorded and shared with the person for their views and validation. They are the expert of their lives, on what outcome they want from the assessment and how they want it be achieved. During the conversation, you use your observation, questioning and listening skills to find out the relevant information to best understand a person's current situation.

It is an individualised or person-centred response and not a decision based on the needs of an organisation for efficiency benefits. Your skills, diplomacy, warmth and empathy will help you to find out what you need to know. Your experience and knowledge will suggest things to consider as part of any assessment.

Assessment & Support Planning

We need to ensure that the person only has to tell their story once, and that we share information with colleagues where appropriate.
Assessments are likely to think about the person in terms of:

- do they need support doing the assessment (communication or sensory needs?)
- their situation as they (and you) see it.
- what's important to them.
- their skills, ambitions and priorities.
- who and what is available to provide care and support.
- what others have to say?
- physical health.
- mental health.
- medicines and treatments.
- where they live and getting around inside and out.
- managing money.
- making decisions and associated risks.
- staying safe from harm.
- managing behaviour and any risks to others.
- looking after themselves.
- getting enough to eat and drink
- keeping themselves clean and comfortable.
- what can prevent increased dependency and enable increased independence.
- eligibility and consent.
- their culture and identity.

5. Choosing the Method of Assessment

Factors to consider in deciding the right method of assessment or intervention, at the right time include:

- what the purpose of the assessment is, as this will impact the different ways it can be undertaken, and what the person agrees to
- what is right for the person, considering levels of autonomy and control, communication needs and ability to use technology
- whether the person has an appropriate person to represent or support them who can remain suitably independent
- the complexity, concern or urgency of the situation and the local authority intervention required
- the level of engagement with the local authority by the person and/or their family or friend carers

6. Mental Capacity and Deprivation of Liberty

Mental capacity assessments should normally be completed in person, but it may be appropriate to carry out the assessment remotely if, for example, it is not possible to visit the person. If this is a possibility, then you should speak to the Mental Capacity Act team for advice. The principles of the Mental Capacity Act 2005 must underpin assessments of capacity. Most deprivation of liberty safeguards assessments should be face to face in order to, for example, meet any communication needs of the person.

Assessment & Support Planning

Mental capacity assessments should normally be completed in person, but it may be appropriate to carry out the assessment remotely if, for example, it is not possible to visit the person. If this is a possibility, then you should speak to the Mental Capacity Act team for advice. The principles of the Mental Capacity Act 2005 must underpin assessments of capacity. Most deprivation of liberty safeguards assessments should be face to face in order to, for example, meet any communication needs of the person.

An important principle of the Mental Capacity Act 2005 is that it must be assumed that the person has capacity unless it is established that they lack capacity. Assuming capacity, however, should not be used as a reason for not assessing capacity in relation to a decision. There should always be an assessment where there is a proper reason to doubt a person's capacity to make a decision. You will need to make a professional decision as to whether there is proper reason, being mindful of Article 8 ECHR right to a private life. However, where a concerned third party such as a family member, or an allied professional colleague is concerned and able to provide demonstrable evidence of why they are concerned, we would encourage you in consultation with the person to record a capacity assessment and outcome.

Advocacy

Where the person and/or their carer has a substantial difficulty in understanding the purpose of assessment, or where a third party is concerned about the expressed views of the person during the assessment process, you should consider a referral for Care Act Advocacy to ensure that their voice is heard and that they have independent support. An advocacy referral can be made when the following three conditions apply:

- A process is taking place: social care needs assessment, carers assessment, support planning, review or a Section 42 safeguarding inquiry;
- Without support, the person would have substantial difficulty in being involved; and
- There are no appropriate, able and willing family or friends to support the person's active involvement.

Where a person is supported by a provider, sometimes the provider staff will offer to support them during this process. Politely and respectfully thank them, however, they are not an independent third party and in this instance an advocacy referral should always be made. 'Substantial difficulty' in this context means that the person will find it very hard to do one or more of the following:

- Understand relevant information
- Retain that information
- Use or weigh up that information
- Communicate their wishes or views

Power of Attorney and Deputyship

Where a person aged 18 or over lacks the mental capacity to make decisions, they may already have made a Lasting Power of Attorney (LPA) registered with the Office of the Public Guardian when they had the mental capacity to do so. These are made in respect of Property & Financial Affairs and Personal Welfare. They are two separate documents and attorneys acting on behalf of the person are bound by the Mental Capacity Act 2005. Note that if the person has a registered Personal Welfare LPA yet still has the mental capacity to make a decision about their health and social care, they cannot delegate that decision making to their attorney. However, a capacitous person can ask their attorney to make financial decisions while they still have the mental capacity to do so, if they included that when they made the Property & Financial Affairs LPA.

Assessment & Support Planning

Attorneys are created jointly and/or severally, that is, there may be more than one attorney and the LPA will stipulate whether they can make decisions independently of each other, or whether decisions must be made jointly between them.

In the event the person has lost the mental capacity to decide who should make certain decisions in their best interests and where there is no LPA, the Court of Protection can appoint a deputy who will have the power to make decisions specified by the Court.

Social workers and Occupational Therapists are encouraged to check the status these (LPAs and deputy orders) by contacting the Office of the Public Guardian and completing an OPG100 form. opg100-find-out-if-registered-attorney-or-deputy.pdf. The OPG will advise what orders and LPAs exist, names of attorneys or deputies, what the scope of decision making is etc.

In either case, whether working with an attorney or a deputy, that person is lawfully the decision maker in terms of the specific decisions with regards to the person and as specified in the LPA or the deputyship order. You should work with the attorney or deputy in this context. However, you still have responsibility to consider during your assessment what is a proportionate support plan and what is necessary to meet eligible needs and to provide attorneys and deputies with information they might not know, just as the relevant person might not know, for example, what options are available. Where your assessment may indicate a different plan would be proportionate to the one the attorney or deputy is proposing, you should take advice from the Mental Capacity Service which may be to make a referral to ASC Legal.

7. Professional Analysis

This is where you can make sense of the situation and understand what has happened/is happening and what are the implications. Your professional knowledge and understanding as well as all that you have come to know about the person will inform your view and analysis. Here, you think creatively about what might be helpful and apply social work theories and knowledge. Consider, for example, Saleeby's 7 strengths-discovery questions and frame your analysis around these:

1. Survival questions: How have you managed to overcome/survive the challenges that you have faced? "What have you learned about yourself and your world during those struggles?" (Saleebey, 2006, p. 87)
2. Support questions: Who are the people that you can rely on? Who has made you feel understood, supported, or encouraged?
3. Exception questions: "When things were going well in life, what was different?" (Saleebey, 2006, p.87)
4. Possibility questions: What do you want to accomplish in your life? What are your hopes for your future, or the future of your family?
5. Esteem questions: What makes you proud about yourself? What positive things do people say about you?
6. Perspective questions: "What are your ideas about your current situation?" (Saleebey, 2006, p.87)
7. Change questions: What do you think is necessary for things to change? What could you do to make that happen?

Saleebey, D. (Ed.). (2006). The Strengths Perspective in social work practice (4th ed.). Boston: Allyn & Bacon

Assessment & Support Planning

8. Agreeing Outcomes

service we use to help them. A desired outcome is the way the person wants things to turn out, the impact on their quality of life. Outcomes must be specific and personal rather than vague and generic.

A desired outcome might be:

- Patricia would like to get back home and for life to be as much as it was before her fall as possible.
- Ranjit would like to go out when they choose.
- Aiysha would like to exercise her faith and be supported to do so.

9. Care and Support Planning

We then need to work out how best to achieve these outcomes – and where support is needed, who will provide this. Sometimes this can be straightforward; sometimes we need to be more creative.

An example of a care and support plan to meet Patricia's desired outcome might be:

> Patricia's son will call in or phone her once a day to check how Patricia is feeling and managing.
> Homecare 1x daily for next two weeks to help with ……. while Patricia regains her strength and gets used to being back at home.

10. Early Help and Prevention

This is the first contact following a referral or review where the person's needs have changed. This isn't a tick box exercise or an assessment for formal care services. It's a person-centred, solution-focused conversation to find out what the person wants to achieve (the outcomes). We will explore a person's strengths and those of their family, friends and neighbours and the local community to see what they can all offer to enable people to achieve outcomes and prevent deterioration.

This might mean offering information and advice or signposting a person elsewhere. There are plenty of resources to tap into e.g.:

https://bradford.connecttosupport.org/
https://www.bradford.gov.uk/adult-social-care/adult-social-care/
https://mylivingwell.co.uk/
https://www.bradford.gov.uk/benefits/general-benefits-information/help-with-cost-of-living/
https://tec-bradford.co.uk/

Assessment & Support Planning

11. Enablement and Short-Term Support

Where information and advice alone is not sufficient to help people meet their outcomes and to delay and prevent the need for long term support, they may also need time-limited professional input (social work or occupational therapy), minor resources, one-off payments or purchases to do so. Short term support is aimed at reducing or removing the need for more permanent or costly care and support.

Enabling people may mean people gain confidence to learn and/or regain some of the skills and independence they may have lost because of poor health, disability or after a spell in hospital. It maybe we can support people to develop new skills that they have never had the opportunity to do so before, due to their care environment or perceptions about their disability. Independence will be different for everyone – it isn't just independence from care and support but could be independence to access services that live better lives and respect their rights. Traditional enablement outcomes such as the ability to use the home safely and get out and about are important, but the quality-of-life outcomes that make life worth living are just as important – having a purpose to be able to use these skills and independence.

In order to achieve these outcomes we might look at:

- a number of visits by an occupational therapist to enable confidence in completing tasks required in and around the home.
- Connection to personalised home support or a personal assistant to enable agreed outcomes to be achieved over set time period.
- a one-off direct payment.

- equipment or minor adaptations to the home.
- a short break for a carer to help them continue to care.
- emergency responses where a short term escalation has occurred in the level of care and support needed.

12. Long-Term Support

Although our emphasis is to set and achieve outcomes as set out above, some people will need more long-term or intensive support. They will meet the Care Act eligibility criteria for a Personal Budget.
Care Act eligibility must be established:

- if the person has a condition as a result of either physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.
- as a result of the person's needs, they are unable to achieve two or more of the outcomes set out in the regulations without assistance.
- as a consequence there is, or there is likely to be, a significant impact on their wellbeing.
- you will need to evidence this in your recording of your assessment on SystmOne, drawing on all of the information that has been shared.

Agreeing the support plan

You can add further relevant information if more depth is needed for good support planning and for understanding the outcomes to be achieved. Once you and the person involved feel

Assessment & Support Planning

you have all the information needed to clarify the outcomes you are aiming to meet then you can start to pull together the support plan.

Outcomes

Outcomes are key. What does the person want to achieve and how will the support plan help them to do this? The focus must be on supporting the person to achieve their outcomes rather than just directing care. We know the wrong care for people can be just as disabling as no care at all.

Needs can still be met by the person's own strengths, community resources, their family, or information and advice. Outcomes agreed with the person are often about living their best life. They are not usually about a particular service.The default should be that people's ability to plan how their outcomes are met is respected and that they are supported to remain in control of this. If a Personal Budget is needed to help meet agreed outcomes, the first discussion with the person should therefore be about them using their Personal Budget through a Direct Payment to ensure that they remain in control of their Support Plan and how their outcomes are being met.

Charging

Long term support services, following on from enablement and short term support, commissioned through adult social care are not free. At this stage therefore, you must inform individuals that a financial assessment will determine whether they pay towards their care and support, but this must have no bearing on the assessment process itself. The person does have the right to decline an assessment at any stage including once they understand the costs of their care and support.

Continuing Healthcare

You should also always give consideration as to whether the person is eligible for Continuing Healthcare (CHC). NHS health care remains free at the point of access.The NHS Decision Support Tool (DST) supports practitioners in the application of the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. As such you should capture the required information at this point in the assessment process to enable relevant CHC processes. There is further guidance on the procedures share point site and social workers are supported to bring any person's assessment to a weekly CHC clinic for senior support.

Other Resources

- Care Act 2014
- Assessment of needs under the Care Act 2014 - Social Care Institute for Excellence
- Care and support statutory guidance
- Good Assessment Practitioners' Handbook 2022 - Research in Practice
- Care Act: Legal duties and impact on individuals - Social Care Institute for Excellence

Carer's Assessments

Caring for a friend or relative can be a fulfilling and rewarding experience. We naturally want to help those closest to us when they need support. However, many carers face difficult choices and sacrifices to continue in their caring role. Their caring journey may have caused them to experience isolation, financial hardship or challenges with their own physical or mental health. It's quite common for carers to feel anxious about the future. For some, caring responsibilities might have gradually increased over years. Others may have experienced an unforeseen change in circumstances that led them to care for another person. Some don't recognise themselves as carers at all and are unaware that help might be available to them.

A carer is anyone who provides unpaid care for a family member, partner or friend who needs help because of their illness, frailty, disability, mental health problem or addiction. The care they give may vary from a few hours a week to round the clock care. A carer might be a child or an adult.

"Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment" Care Act 6.16.

In co-production with our partners and carer networks, we have agreed the following 8 key areas of support. We wish to support carers to:

- Carry on caring if they want to
- Get good quality information and advice when they need it
- Be recognised, feel respected and heard as carers and partners in care and experts in the needs of the person they care for
- Have a life outside of their caring role, including working or volunteering if they want to and being able to fully access their local community and local services
- Stay mentally fit and physically fit and healthy
- Be safe
- Access full benefit entitlements and financial advice
- Receive consistent joined up services.

Time for carers

Carers could have many demands on their time. From the person they care for and the potential multitude of professionals connected to their health and care needs, to being able to do all the things which could be considered a part of everyday life. Every contact we make should be meaningful. The time we spend with carers should help us build a picture of their life, their aspirations and the impact of their caring role.

Carer’s Assessments

Carer’s Rights

Carers of adults over the age of 18 have rights to assessments and support under the following Acts:

- The Carers (Recognition of Services) Act 1995 – this gives carers a right to a carer’s assessment.
- The Carers and Disabled Children Act 2000 – this extends the rights of carers to include rights to support services and to receive support through direct payments and vouchers.
- The Carers (Equal Opportunities) Act 2004 - this Act introduced a legal duty on local authorities to inform carers of their rights and requires carers assessments to consider whether the carer works or wishes to work and / or is undertaking or wishes to undertake, educate, training or any leisure activity.

The Care Act 2014 Section 10 of the Care Act 2014 introduced key changes to the existing rights of carers for young people over 18 to assessments:

- Carers do not have to request an assessment to obtain one and they must be completed by the local authority on appearance of need.
- The carer does not have to establish that they are providing substantial care on a regular basis to qualify. Instead, the only requirement is that the carer ‘may have needs for support – whether currently or in the future’.

The assessment must consider:

- whether the carer is able / willing to provide and continue to provide the care; • the impact on the carers ‘well-being’ of their caring role;
- the outcomes the carer wishes in day-to-day life;
- whether the carer works or wishes to work (and / or) to participate in education, training or recreation.

Local authorities must also consider whether the carer would benefit from preventative services, information and advice. There is a national eligibility threshold to determine following the assessment whether the carer has eligible needs. Where a carer is assessed as having an eligible need, the local authority has a legal duty to meet those needs

Prior to the assessment, re-assessment or review

A Carer’s Assessment isn’t just a time for a carer to discuss their caring role, it’s an opportunity to think about how this affects their whole life. For some this might be a difficult conversation so setting the right scene can make all the difference. Before arranging an assessment with a carer, please do the following:

- Ensure you provide your full name, job title and team
- Check which assessment format they prefer (e.g. face-to-face, by telephone) and be clear when an assessment has started (additionally when it has finished too)
- Any information or communication must be provided in an accessible format in the person’s self-identified needs (e.g. verbal, written, sign, easy read). Consider the use of Interpreting Services

Carer's Assessments

- Familiarise yourself with all available information on the carer and cared for
- Offer the conversation away from the person(s) they care for
- Offer a time that doesn't impact upon their caring role(s) – be flexible
- Suggest the carer might find it helpful to be supported by family or a friend during their assessment
- If they want support but no-one is available, offer access to an advocate (paid or unpaid)
- Where the cared-for cannot be left or carer feels unable to leave them especially if the carer prefers to meet away from home, help arrange for alternative care
- Check their understanding of what a carer's assessment is. Carers sometimes have the mistaken view that it's an assessment of their ability to care so do be clear this is a conversation about them

The conversation

Conversations with carers should be strengths based and risk positive and should be just that; a conversation. The most important thing we can do is listen as this may be one of the first times a carer has spoken about themselves. Our conversations should support carers to consider:

- Anything they can do or are doing to help themselves
- Anything their friends, family or community might reasonably be asked to do to help whether currently or in the future (Do not assume that because someone has a large family around them, they get a lot of support)
- What is working well for them and why.

The Carer's Assessment should allow a carer to discuss their wishes, feelings, aspirations and the support they may need to realise their goals. This includes understanding the impact of caring on a carer's ability to work or take part in education, training, recreational activities and whether the carer has any time for themselves. This impact should be considered in both a short-term immediate sense but crucially the culminative effect over the longer term.It may be that the person they care for requires an assessment of their needs in their own right.

During our conversations, carers may be clear about potential service solutions they'd find helpful. It's good practice to acknowledge these requests or suggestions and to note them within the assessment, but to not let this limit your exploration across the nine wellbeing domains. The aim of a carer's assessment is to think creatively about what might be helpful; not to stick to the confines of traditional services.

Staying Safe

We must always consider the aspect of carer's safety and their right to be protected from intentional or unintentional abuse. Carers have the right to remain safe in their caring role but not all may be aware when they experience abuse as they might mistakenly write off an experience as
'normal' or 'to be expected'. We should be vigilant towards carer's anxieties about raising issues for fear of creating negative perceptions of the people they care for or their ability to care. It's

Carer's Assessments

helpful to ask carers how they feel their health or wellbeing might be affected by their caring responsibilities. Such a stance may put carers more at ease when discussing potentially sensitive issues.

Where we have concerns for a carer's safety the usual safeguarding practice applies. However even if they do not appear to meet the referral threshold, the assessor's own judgement for not referring must be recorded. These notes will act as a benchmark should the situation change. Engaging carers as expert partners, and often as advocates for the person they care for can be helpful in scoping and managing risks in a proportionate, enabling and sustainable way. Where carers are not involved or treated as partners the chance of unrecognised or unreported risks of abuse and neglect may increase.

Throughout our ongoing conversations with carers we should advocate the importance of them recognising their own safety from other people and from both the physical and mental demands of their caring role.

Young carers

Where a person under the age of 18 is also providing unpaid care and support, they would be classed as a Young Carer. Their role might not be obvious; they may for example be providing sibling support. They may not even live in the same household. It's important to explore with adult carers everyone who is supporting them in their caring role, however small that role might be.

Where we discover a young person is providing care, and may have needs for support, you should consider whether the young carer has needs in relation to care and if so, whether they can be met by the Bradford Children's Trust under section 17 of the Children and Families Act. The assessment may identify the young carer as a child in need.

Parent carers and preparing for adulthood

Parent carers are defined as a person aged 18 or over who provides or intends to provide care for a disabled child or young person. When a young person with Special Educational Needs (SEND) approaches adulthood both they and the person(s) who care for them will inevitably face big changes and this may cause anxiety and uncertainty for everyone involved.

Preparing for adulthood is not just for the young person involved but for those who provide their care. Part of our role with carers is to have early conversations, possibly over a period of time to support them to develop their understanding of what this may mean for them and their young person. This will include but not be limited to helping them to address changes they'll be experiencing due to differing assessment practices and legislative frameworks, services such as health and social care, resources, claiming benefits in their own right and gaining more financial control, having greater independence or moving away from home. One of the most significant changes will be that education, at some point will cease.

Carer’s Assessments

Supporting change

Change is something that happens to all of us over the course of our lives. It can be both positive or negative and it can occur suddenly or over a prolonged period. An example might be when a person has to move away from their family or home to a residential setting. Or the change in dynamics of a carer’s and cared for’s relationship over time. We all deal with change differently and need to be aware of its potential impact when considering longer-term support planning, especially where any changes may pose challenges for a carer or the person they support.

Early Help and Prevention

The interventions available to prevent, reduce or delay the need for carer support may be universally available but a carer may need help to identify what’s helpful. Workers should explore a person’s resiliencies and strengths as well as those of their family, friends and community and what they can all offer to enable the carer to achieve outcomes and prevent losing control of their lives. This might mean offering information and advice or signposting a person to support. We’re asking our professional workforce to tap into local resources and think of innovative solutions for prevention strategies. Additionally, a carer’s outcomes may also best be achieved through the support that’s provided for the cared for where the situation permits.

Enablement and Short-Term Support

This stage is aimed at enabling carers to maintain or build upon their independence, reducing or removing the need for more permanent support. Enabling carers may mean they gain confidence to learn and/or regain some of the skills and independence they may have lost or it maybe we can support carers to develop new skills that might not have been possible previously due to their caring role.

Quality of life outcomes are just as important as traditional enablement outcomes as this is what makes life worth living. To help carers achieve their outcomes we may need to offer time-limited professional input either through ourselves or another professional, or with an agreed personal budget. Spending time with a practitioner completing specific work may be more powerful than any care plan that can be commissioned.

You have access to a small budget for short-term enabling interventions, held by your Head of Service, which may support carers to retain and/or regain control over their lives. You also have access to Bradford Carer Wellbeing Grants which are managed on the Council’s behalf by Carer’s Resource Centre.

Long-Term Support

Where certain outcomes have not or cannot be achieved through support as set about above, consideration could be made for longer term services such as a regular Direct Payment for short breaks or access to other respite services. However this would nor usually be following on from your first contact to support the person caring. Care Act eligibility is established at this stage and is evidenced in the recording, drawing on all of the information that has been shared up to this point.

There may be occasions where the person who is cared for is either not eligible for support

Carer's Assessments

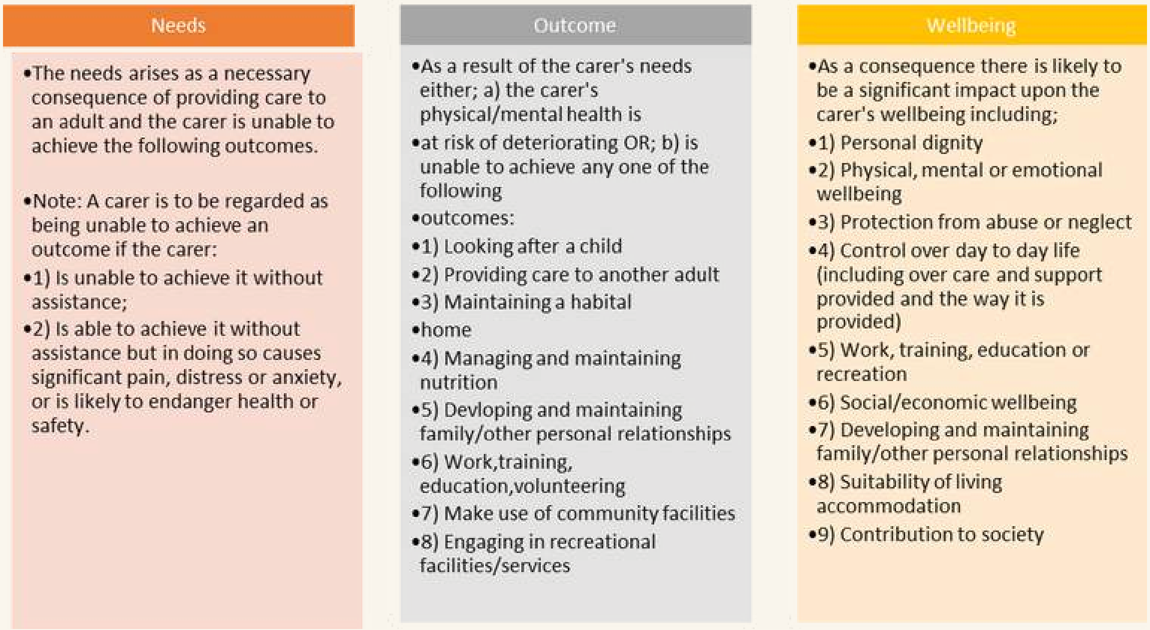
under the Care Act or makes a capacatous decision to decline support for themselves. We might then need to consider peripheral solutions that support the carer in delivering the care directly.

Finalising the Carer's Assessment

- Provide a pre-finalised copy of the assessment to the carer so they can check that all information is correct, and that they are happy with the information recorded.
- Note any areas of disagreement and what steps have been taken to resolve them
- If the carer is happy send two copies with your signature, one for them to sign and keep and one to sign and return
- You may wish to agree an initial check back date first before setting up a planned review.

Eligibility criteria for carers

The Care Act sets out three conditions that must be met to determine eligibility for services to promote wellbeing and independence and reduce dependency. These national thresholds for carers are set out below.

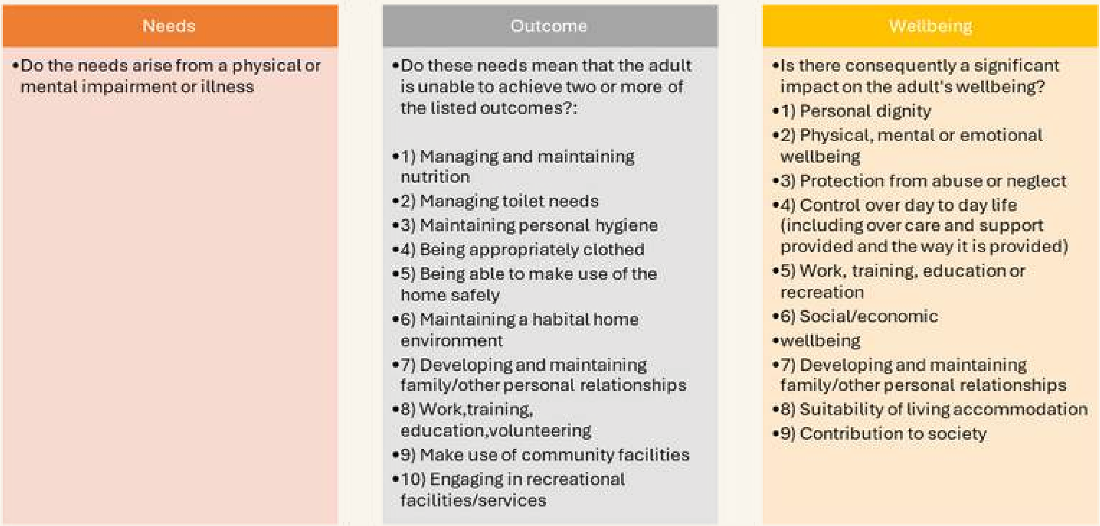


Needs	Outcome	Wellbeing
•The needs arises as a necessary consequence of providing care to an adult and the carer is unable to achieve the following outcomes. •Note: A carer is to be regarded as being unable to achieve an outcome if the carer: •1) Is unable to achieve it without assistance; •2) Is able to achieve it without assistance but in doing so causes significant pain, distress or anxiety, or is likely to endanger health or safety.	•As a result of the carer's needs either; a) the carer's physical/mental health is •at risk of deteriorating OR; b) is unable to achieve any one of the following •outcomes: •1) Looking after a child •2) Providing care to another adult •3) Maintaining a habital •home •4) Managing and maintaining nutrition •5) Devloping and maintaining family/other personal relationships •6) Work,training, education,volunteering •7) Make use of community facilities •8) Engaging in recreational facilities/services	•As a consequence there is likely to be a significant impact upon the carer's wellbeing including; •1) Personal dignity •2) Physical, mental or emotional wellbeing •3) Protection from abuse or neglect •4) Control over day to day life (including over care and support provided and the way it is provided) •5) Work, training, education or recreation •6) Social/economic wellbeing •7) Developing and maintaining family/other personal relationships •8) Suitability of living accommodation •9) Contribution to society

Eligibility criteria for carers with care and support needs

We may discover through the course of the Carer's Assessment a carer has care and support needs in their own right. Where these situations arise Care Act eligibility must be determined. These national thresholds are set out below.

Carer’s Assessments



Needs	Outcome	Wellbeing
•Do the needs arise from a physical or mental impairment or illness	•Do these needs mean that the adult is unable to achieve two or more of the listed outcomes?: •1) Managing and maintaining nutrition •2) Managing toilet needs •3) Maintaining personal hygiene •4) Being appropriately clothed •5) Being able to make use of the home safely •6) Maintaining a habital home environment •7) Developing and maintaining family/other personal relationships •8) Work,training, education,volunteering •9) Make use of community facilities •10) Engaging in recreational facilities/services	•Is there consequently a significant impact on the adult's wellbeing? •1) Personal dignity •2) Physical, mental or emotional wellbeing •3) Protection from abuse or neglect •4) Control over day to day life (including over care and support provided and the way it is provided) •5) Work, training, education or recreation •6) Social/economic •wellbeing •7) Developing and maintaining family/other personal relationships •8) Suitability of living accommodation •9) Contribution to society

How to determine eligibility

There are a number of key elements to consider when making a determination which must recorded in the professional analysis:

- Use the knowledge and information gathered
- Apply the national eligibility criteria
- Consider principles of risk in relation to wellbeing
- Enable effective decision making
- Be transparent and collaborative
- Ensure decisions are evidenced appropriately


RISK ENABLING
STRENGTHS BASED
VALUES BASED
LEGAL LITERACY
RIGHTS BASED
PURPOSE
DIVERSITY & EQUALITY
VALUES & ETHICS
RIGHTS, JUSTICE & ECONOMIC WELLBEING
IMPACT
PROFESSIONALISM
PROFESSIONAL LEADERSHIP
ASYE level
Newly Qualified