Putting the Care Act 2014 into practice in Croydon when assessing care and support needs

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Contents

1: Making sense of the Care Act 2014 in Croydon

In this document, we provide some ideas for making sense of some terms that are included in the Care Act 2014, or in the Care and Support statutory guidance, but which may not have clear, or any, definitions in those documents. We also seek to describe best practice in relation to preventative work and partnership work with local Voluntary and Community Sector (VCS) organisations.

The intention here is to give a helpful starting point for making sense of these terms in practice. These are not definitions to be rigidly followed. If we did that, we would be at risk of breaching the public law principle that we cannot “fetter our discretion”. We cannot make a blanket rule to say we would never use a discretionary power. We must make decisions case-by-case, on the merits of the particular circumstances in that case.

We also need to be clear in our own mind about when we have a legal power that allows us to choose whether we do something or not, and when we are under a legal duty which means there is a non-negotiable obligation to do something. Sometimes one piece of the Care Act interacts with another to turn what is usually a discretionary power into a non-negotiable duty. This document is intended to help you think through what powers and duties might arise when doing work under the Care Act 2014.

2: Prevent. Reduce. Delay. Meet: Strengths-based Approaches, Community-Led Support (CLS) and the Care Act

A key focus of the Care Act 2014 is on the prevention, reduction and delaying of crises. Essentially, this is done through conversations that enable people to recognise and utilise their own strengths and that identify the 'natural support' from the important people around them. It is also achieved by informing people of community-led opportunities that can keep them safe and maintain positive physical and mental health. The connection to these groups, organisations and activities gives purpose and effectively tackles social isolation and loneliness

This can be seen, for example, in what paragraph 6.2 of the Care and Support statutory guidance has to say on the purpose of assessment:

"The assessment process starts from when local authorities begin to collect information about the person, and will be an integral part of the person's journey through the care and support system as their needs change. It should not just be seen as a gateway to care and support, but should be a critical intervention in its own right, which can help people to understand their situation and the needs they have, to reduce or delay the onset of greater needs, and to access support when they require it. It can also help people to understand their strengths and capabilities, and the support available to them in the community and through other networks and services."

(Care and Support statutory guidance, paragraph 6.2)

Using the Community Led Support (CLS) 'Resource Wheel' to structure a strength-based conversation

The Community Led Support Resource Wheel

In the past, ‘medical model’ and deficit-based practice would commonly have only asked the question: “How can *WE* help *YOU?”* This would then lead to a focus on just what was wrong or missing and how the Council could ‘fix’ the problem by putting a statutory service-based package of care in place. In the CLS Resource Wheel above, the assessment would jump straight from the ‘Start’ across to the ‘Public and Paid’ stage.

Under the Care Act and as part of Croydon’s commitment to strengths-based approaches and community-led support, however, conversations are now expected to cover the ‘Personal’, ‘People’ and ‘Places and Spaces’ (Community) stages of the process, before the need for ‘Public and Paid’ (Statutory Service) support is explored. These are two completely different ways of working. The strengths-based conversation that uses the CLS Resource Wheel is described in more detail below:

1. Firstly, warmly greet the person, make them feel as comfortable as possible and then ask how they are and invite them to tell you how things are. Then listen…and keep listening…allow some of the worry and agitation to settle as the person has the opportunity to speak, hear their own words and be listened to… Acknowledge and reflect back what you have heard.
2. Then, starting at ‘Personal’ on the CLS Wheel, ask questions to find out what’s important to the person – the things they like doing, the places they like going to and the things they like to have around them, as well as their gifts and talents…what are they good at?
3. Then, gently ask questions about the important people in the person’s life - family, friends, neighbours etc. Try to find out why they are important? What support do they give the person? Could this support be increased or re-established if it has stopped for some reason
4. Next, ask questions about places in their local community that are important to the person. Again, try to find out why these places are important? Start to use your knowledge of community-based groups, organisations and activities that the person could be connected to, based on what they enjoy doing.
5. Only after these 3 stages, consider any statutory/paid support that may be required.
6. Use what has been learned to agree outcomes that the person would like to achieve and to draw up an Action Plan for each outcome. Make this as detailed and ‘SMART’ as possible
7. Agree a date to review progress and where and by what means this will be done.
8. Send the resident a copy of the Outcomes and the Action Plan.
9. Celebrate success and write and share ‘Change Stories’

How the CLS Wheel relates to the s9 Care Act assessment Good Conversation Record

Highlighted below are some examples of where the prompts in the s9 Care Act assessment Good Conversation Record relate to the Community-led support wheel

What have you found out about the person and their circumstances?

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Prompts: *(You do not need to ask the check box questions for every conversation, but might want to use them as prompts around the kind of things you may wish to discuss)*

- ☐ *What does the person like doing? Things they enjoy at home?*
- ☐ *Local places the person enjoys going to and what does the person like doing there?*
- ☐ *What can the person do for themselves? Mobility? Washing & dressing? Cooking? Other things?*
- ☐ *Who are the important people in the person's life? Family, friends and neighbours? How do they help*
- ☐ *Community support and groups that the person gets help from and/or enjoys going to? Faith groups?*
- ☐ *What does a good day look like?*
- ☐ *How is the person's physical and mental health? What do they do to stay healthy and safe?*
- ☐ *What equipment or support services does the person currently have in place?*
- ☐ *Has there been a recent change in the person's health? Does the person feel safe? Is the person having problems with equipment they use to help themselves?*
- ☐ *How does the person manage their day-to-day finances?*
- ☐ *How was the person managing before? What has the person already tried to make things better?*
- ☐ *What things would they like to be able to do or achieve?*
- ☐ *Signposting to community groups? Aids/adaptions? Assistive technology? Preventative/Enabling support?*
- ☐ *Is there something else we should know about your life or circumstances which has been impacting your day-day life or wellbeing?*
- ☐ *What help is the person hoping to get from Social Care today?*

Finding out more about community-led support and strengths-based conversations

At the time of writing, there are series of workshops available on community-led support and strengths-based conversations. Further information is available on learningpool.

3: The meaning of “care and support needs”

What the Care Act and the Care and Support statutory guidance say

The Care Act says we have duties toward adults with care and support needs but does not define what it means by care and support needs.

The Glossary in the Care and Support statutory guidance takes us a bit further. It says care and support is

> *“The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people’s needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.”*

However, there are some difficulties with this:

- It says care and support can include assessment, but an assessment is how we establish if someone has the need for care and support, which takes us in a circle;
- It is focused on a person’s need for social care services, which seems more in line with the arrangements pre-Care Act than being in the spirit of the Care Act.
    - Section 22 of the Care Act is clear that some care and support needs must be met by the NHS. That is not reflected in this definition.
    - Section 23 of the Care Act is clear that that some care and support needs must be met by the housing department of a local authority. Again, that is not reflected in this definition.

SCIE guidance

The “Adult Safeguarding Practice Questions” guidance from the Social Care Institute of Excellence (SCIE) can help take us further in understanding what care and support needs means. SCIE wrote that:

“an adult with care and support needs may be:

- an older person
- a person with a physical disability, a learning difficulty or a sensory impairment
- someone with mental health needs, including dementia or a personality disorder
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.

This is not an exhaustive list … There may be times when a person has care and support needs and is unable to protect themselves for a short, temporary period – for example, when they are in hospital under anaesthetic."

The inclusion here of "an older person" is problematic. It should not be taken to mean that age alone means a person has care and support needs, but as a recognition that the risk of some conditions that can lead to care and support needs developing may increase with age.

Care and Support eligibility regulations

The Care and Support (Eligibility Criteria) Regulations 2014 can help us get a better understanding of the meaning of 'care and support needs' by looking at the issues of cause, degree and impact.

Regarding the cause and the degree of care and support needs, the regulations say that an eligible care and support need is one that

1. Arises from or is related to a physical or mental impairment or illness;
2. Results in the adult being unable to achieve two or more of the outcomes specified in the regulations; and
3. Which has, or is likely to have, a significant impact on the adult's well-being

Items (2) and (3) relate to the degree of the need, which is not relevant to determining whether a care and support need exists. Item (1) relates to the nature of the need, which does take us forward in understanding what a care and support need is.

A care and support need is something arising from, or related to, a physical or mental impairment or illness.

The regulations go on to say that care and support needs have an impact on the following outcomes:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the 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
- Carrying out any caring responsibilities the adult has for a child

In deciding if an issue is a care and support need, then any impact on one or more of these outcomes may be relevant. As we are just considering whether a need exists,

not whether it is an eligible need, there is no threshold of that being a significant impact.

Bringing these together

Unless and until the statutory guidance or case law say otherwise, our position is that a starting point for understanding care and support needs in the context of the Care Act 2014 is that

- Care and support needs arise from, or are related to, a physical or mental impairment or illness. These may include, but are not limited to, being
    - an older person experiencing an age-related condition
    - a person with a physical disability, a learning difficulty or a sensory impairment
    - someone with mental health needs, including dementia or a personality disorder
    - a person with a long-term health condition
    - someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.
- Those needs have an impact on one or more of these outcomes
    - Managing and maintaining nutrition
    - Maintaining personal hygiene
    - Managing toilet needs
    - Being appropriately clothed
    - Being able to make use of the 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
    - Carrying out any caring responsibilities the adult has for a child

4: The steps of assessment of care and support needs and care & support planning

The Care Act sets out a sequence of steps that are required when assessing needs and planning how they will be met. Some of these are very familiar but others are perhaps less familiar or are at risk of being glossed over. Each of the steps has some potential pitfalls.

These steps have a fixed sequence. Though the process can end without all the steps being completed, until that is done each step should be done in order and should not be skipped over.

The steps are

- Recognising an appearance of care and support needs
- Offer of an assessment
- Assessment of care and support needs
- Eligibility determination
- Decision on whether the local authority is required to meet the needs

5: Recognising an appearance of care and support needs

This step is in s9(1) Care Act 2014.

That section says

> *"Where it appears to a local authority that an adult may have needs for care and support, the authority must assess*
>
> *(a) whether the adult does have needs for care and support, and*
>
> *(b) if the adult does, what those needs are."*

This step is usually a straightforward one. Typically, we will receive a referral asking if we can consider offering somebody some type of support. If it appears that the person has care and support needs, then we will have a duty to assess those needs. Using the definition of "care and support needs" in section 2 helps us ensure that we are being consistent in making the decision whether s9 Care Act applies in the case of any particular person.

Common pitfalls during this step

- **Using the Care Act eligibility criteria to gatekeep assessment**
  The duty to carry out an assessment is triggered by the appearance of care and support needs, not eligible care and support needs (see step 4 on eligibility determination). We cannot make a decision not to carry out a s9 Care Act assessment on the basis that we do not think the person has eligible care and support needs.
- **Not recognising some needs**
  Some care and support needs are more obvious than others. It tends to be that those needs that impact on the earlier items in the list of outcomes in the eligibility regulations (see above) can be easier to spot than those lower down. If it appears that a person has a care and support need that means they are unable to manage their toileting needs, it will be obvious that we will have a duty to assess their needs. However, it may not be so obvious at the point of considering a referral whether the person has needs impacting on outcomes such as developing and maintaining family or other personal relationships or accessing and engaging in work, training, education or volunteering. But the Care Act does not have a hierarchy of needs, and care and support needs impacting on those outcomes can as readily trigger a duty to assess as more obvious needs.

On both these issues, it can be useful to have in mind what s9(3) Care Act says

> *"The duty to carry out a needs assessment applied regardless of the local authority's view of*
>
> - *The level of the adult's need for care and support, or*
> - *The level of the adult's financial resources"*

Can the process end at this step?

Yes. We might get a referral asking us to consider what support we may be able to offer a person but on reviewing the information there may be no appearance of needs for care and support. If, after taking any reasonably required action to establish if that is the case, we find there is nothing to suggest that there is an appearance of care and support needs, we would end at this stage.

If we were ending at this stage, we would want to consider whether the person might benefit from any advice and information under s4 Care Act, or if there is anything that might be available to them to help prevent them developing care and support needs in the future, under s2 Care Act.

There is guidance on tri.x about preventing or delaying needs for care and support, and on providing information and advice about care and support and about support for carers. A useful resource for information and advice is Simply Connect Croydon.

6: Offer of assessment

If it appears to us that a person may have care and support needs, we must offer them the option of us assessing those care and support needs. But we would always do that in the context of having a strengths-based conversation with them that helps them to reflect on their own skills, talents and capabilities, the support of important people in their life and explore what community-led support may be available to them. Some people will decide that they want to explore those other options before they would want to go ahead with an assessment under the Care Act.

We might also explore with them, prior to assessment, their financial circumstances as there may be people who would prefer to make their own arrangements for care when they understand the issues around the charges local authorities may make for services.

However, the final decision will be one for the person with the appearance of care and support needs. If they decide they wish to be assessed, then we will need to do so.

Common pitfalls during this step

- Not having a good enough strengths-based conversation with the person about their other options, which leads to them having an assessment which they then find was unnecessary
- Not offering a person an assessment when we should
- Not carrying out an assessment when the person wants one and we should be carrying one out
- Accepting the refusal of the offer of an assessment in circumstances when we should be going ahead with that assessment (see below)
- Not assessing the needs of someone who is at risk of self-neglect (see below)

Can the process end at this step?

Yes. It may appear to us that a person may have care and support needs but, when we offer them an assessment of their care and support needs, they refuse that offer. Section 11(1) Care Act 2014 says “Where an adult refuses a needs assessment, the local authority concerned is not required to carry out the assessment”, and our s9 Care Act duty to assess no longer applies.

Where a person is refusing an assessment, we should

- Ensure we have explained the benefits of an assessment to the person, taking account of any communication needs they may have
- Satisfy ourselves that the person has made an informed decision
- Ensure that they know how to contact us later if they change their mind
- Consider whether there is a need to assess mental capacity

- Record what we have done to try to engage the person
- Consider discussing the situation in supervision

However, there are two categories of people that the Care Act says cannot refuse an assessment. If it appears to us that a person may have care and support needs, and they are in either of these categories, then the assessment must go ahead even if they have refused the offer an assessment.

These categories are

- S11(2)(a) Care Act: A person who lacks the mental capacity to decide whether to have a needs assessment, and we think it is in their best interest to do so. We will need to establish that through a mental capacity assessment and best interest decision that meet the requirements of the Mental Capacity Act 2005.
- S11(2)(b) Care Act: A person who has the mental capacity to decide to refuse the offer of an assessment, but we believe that they are experiencing, or are at risk of, abuse or neglect.

Circumstances that meet s9 and s11(2)(b) Care Act are likely to also meet the criteria in s42(1) Care Act, so there may be dual duties about assessment and adult safeguarding enquiry. But

- Those duties can fall to different local authorities if the person is ordinarily resident in one area, and the abuse or neglect occurs elsewhere;
- Where the matter relates to self-neglect, the local authority has a discretion not to carry out an adult safeguarding enquiry, unlike all other forms of abuse or neglect. But that discretion only applies to s42 Care Act. Local authorities do not have discretion not to carry out an assessment of a person's care and support needs where a concern about self-neglect means s11(2)(b) Care Act applies.

It can be challenging carrying out an assessment where the person has refused the offer of an assessment but we have to continue as s11(2)(b) applies. In these circumstances it can be useful to consider

- What the assessment requires: Paragraph 6.20 of the Care and Support statutory guidance says "Where the adult who is or is at risk of abuse or neglect has capacity and is still refusing an assessment, local authorities must undertake an assessment **so far as possible** and document this." (emphasis added). We should consider what "so far as possible" means in each case. This may be an issue that it is useful to discuss with your manager or supervisor.
- Though the person may not cooperate with our assessment, it may be possible to gather collateral information from others. We can demonstrate to others that we may have a "need to know" because of our statutory duties under s9 and s11(2)(b) Care Act 2014. That does not guarantee that they will share information with us, but it does create a gateway for them to do so if they should choose to.

- Using a strengths-based approach and applying the skills that good strengths-based practice requires can be useful in these circumstances.
- It can be useful to consider what we can do to help promote change in the person's life, even if they may not yet be ready for that right now. Applying a model of change, such as Prochaska and Di Clemente's Transtheoretical Model of Change might be useful.
- We should keep the door open. We should let the person know that they can come back to us if they change their mind. Paragraph 6.21 of the Care and Support statutory guidance says "In instances where an individual has refused a needs or carer's assessment but at a later time requests that an assessment is carried out, the local authority must do so. Additionally, where an individual previously refused an assessment and the local authority establishes that the adult or carer's needs or circumstances have changed, the local authority must consider whether it is required to offer an assessment, unless the person continues to refuse."

7: Assessment of care and support needs

Having established that the person may have care and support needs; and either

- They want to be assessed
  or
- They have refused the offer of assessment, but under either s11(2)(a) or (b) Care Act we have to carry out the assessment despite their refusal

then we carry out the s9 Care Act assessment.

When carrying out an assessment under section 9 Care Act, we are required to

- **S9(4) Care Act**: Include an assessment of
  - The impact of the needs for care and support on their wellbeing
  - The outcomes they wish to achieve in day-to-day life
  - How the provision of care and support could contribute to achieving those outcomes
- **S9(5) Care Act:** Involve
  - The adult
  - Any carer that the adult has, and
  - Any person that the adult asks us to involve, if they have the mental capacity to make that decision
  - Any person who appears to be interested in the adult's welfare, if the adult lacks the mental capacity to make the decision who should be involved
- **S9(6) Care Act**: Consider
  - whether, and if so to what extent, matters other than the provision of care and support could contribute to the achievement of the outcomes that the adult wishes to achieve in day-to-day life, and
  - whether the adult would benefit from the provision of anything under section 2 or 4 or of anything which might be available in the community.

Also, if the person has substantial difficultly in contributing to their assessment, and the do not have family or friends to represent them, you should consider whether there is a need for you to arrange for a s67 Care Act advocate.

Common pitfalls during this step

- **Identifying needs but not the impact on their wellbeing**:
  "The purpose of an assessment is to identify the person's needs and how these impact on their wellbeing, and the outcomes that the person wishes to achieve in their day-to-day life." (Care and Support guidance, paragraph 6.9)
  We need to do more than, say, list the diagnosed health conditions a person has. We need to identify in our assessments what the specific impact of those conditions are for that person.

- **Service-led assessment**: The Care Act 2014, and the NHS and Community Care Act 1990 that preceded it, both had the ambition of moving from "service led assessment" to "needs led assessment". For example, the Care and Support statutory guidance says
  "The assessment process also provides the opportunity for local authorities to take a holistic view of the person's needs in the context of their wider support network" (Care and Support guidance, paragraph 6.10)
  The House of Lord's Adult Social Care Committee produced a report in 2022, "A gloriously ordinary life" which highlighted that how the Care Act 2014 had been implemented fell short of the ambition for it, and this included the tendency for assessments often to not take the holistic approach the Care and Support guidance envisaged. A way to tackle this in practice when carrying out an assessment, is to consider each of the outcomes in the care and support eligibility regulations and ask "have I understood whether there is an impact for the person regarding this outcome?". This can be particularly useful for the outcomes that may be less obvious at first glance, such as 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; and carrying out any caring responsibilities the adult has for a child.
- **Taking account of needs being met by a carer**: During the assessment, we must consider all of the adult's care and support needs, regardless of any support being provided by a carer. The assessment should show all the care and support needs that the person has, whether a carer is meeting those needs or not. Where the adult has a carer, information on the care that they are providing can be captured during assessment, but it must not influence our determination of what needs the person has, or the eligibility determination. When carrying out an assessment or a review, we should check that the carer is still able and willing to continue delivering support. Consideration should be given to whether to carry out a carer's assessment. There is guidance about this on tri.x. We should ensure that the carer has information about what to do if the persons needs or if other circumstances change.

Can the process end at this step?

No. We must give a copy of the assessment in writing to the person, and to anyone else that they want us to. If the person has no care and support needs, we will stop at this step.

However, if we have identified any care and support needs, we must go on to determine whether any needs identified are eligible to be met by the local authority

8: Eligibility determination

If we identify that the person has care and support needs, then we must make a determination against the national eligibility criteria to establish whether we are required to meet those care and support needs, if they are not being met in any other way.

An eligible need is one that meets the three conditions of

- Arising from or are related to a physical or mental impairment or illness
- as a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes of
    - Managing and maintaining nutrition
    - Maintaining personal hygiene
    - Managing toilet needs
    - Being appropriately clothed
    - Being able to make use of the 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
    - Carrying out any caring responsibilities the adult has for a child
- as a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing

If we establish that a person has eligible care and support needs which we propose to meet, we must also

- establish if the person is ordinarily resident in our area; and
- if we think that if we were to meet their needs for care and support that we would charge them, then we must carry out a financial assessment

Common pitfalls during this step

- **Not giving an equal weighting to all eligibility outcomes**: There is no hierarchy among the specified outcomes. Needs are eligible if the person is unable to achieve any two of those outcomes. A learning from Safeguarding Adults Reviews has been that there is a risk that the outcomes lower down the list may sometimes be given less weight than those higher up the list. If a person is unable to feed themselves and unable to wash themselves, it can be obvious that they have care and support needs. However, if a person is unable to develop and maintain family or other personal relationships and is unable to carry out caring responsibilities for a child, as a result of a physical or mental impairment or illness, they too will have eligible care and support needs.

- **A carer meeting a need does not affect whether that need is eligible**: If the person with care and support needs has someone, such as a family member or a friend, who is meeting that need, it does not mean that the need is not eligible. If the need is an eligible need, that remains the case however that need is being met. The assessment should show that they have that need, the eligibility determination should be done in the usual way, and the care and support plan should show how that need is being met by their carer.
- **If the person does not want the need met, it does not go away**: People might not want us to meet an eligible need. If that is the case, s13(3)(b) Care Act says we do not have to meet that need. But that does not mean the need does not exist, nor that it has become an ineligible need. Our assessment should still reflect that they have this need. Our care and support plan should say that we are not meeting this need because the person does not want us to. We should never say that a person's need is not eligible solely on the basis that they do not want us to meet that need. Where a person is choosing not to have an eligible need met, we should
    - Ensure we have explained the benefits of having their needs met, taking account of any communication needs they may have
    - Satisfy ourselves that the person has made an informed decision
    - Ensure that they know how to contact us later if they change their mind
    - Consider whether there is a need to assess mental capacity
    - Record what we have done to try to engage the person
    - Consider discussing the situation in supervision

Can the process end at this step?

Yes. If the person does not want us to meet any of their eligible care and support needs then we would stop at this point.

9: Decision on whether the local authority is required to meet the needs

If a person has eligible care and support needs, is ordinarily resident in our area, and they want us to meet those needs, then are under a duty to do so, unless we establish that we are not required to meet those needs. There are only a few circumstances where this will be the case. These include

- **S21 Care Act: Someone subject to immigration control:** Where the care and support needs arise only because of deprivation due to someone being subject to immigration control, then we are not required to meet those needs.
- **S22 Care Act: Needs to be met by the NHS**: Where the NHS should meet a care and support need, a local authority cannot meet that need. There is an exception to his where meeting the need is incidental to something else that we are doing to meet the person's needs, and the nature of the service is something that a local authority could expect to provide. Having home care workers prompt someone to take medication, during a visit they were making anyway, would be an example.
- **S23 Care Act**: **Needs to be met by a housing authority**: Where a need is to be met under the Housing Act 1996, then it should be met by the housing department of the relevant local authority.

There is guidance available on tri.x.

Common pitfalls during this step

- **Not meeting the care and support needs of someone subject to immigration control where those needs are not due to destitution**. The Home Office has guidance on asylum seekers with care and support needs. There is a growing body of case law on these issues. We may need to consider seeking legal advice where the matter is complex.
- **Health needs can be care and support needs**: The logic of s22 Care Act is that the same need can simultaneously be a care and support need and a health need. We should avoid applying rigid, binary categories to needs, saying that they can only be one or the other. If our assessments are to live up to the vision of being holistic, then they must reflect the health of the person, and take into account how any health care needs they have are to be met, even if that is only to say that this is being done by an NHS body.

  Recommendations from NICE about assessing and reviewing a person's medicines support needs can be found in Appendix A.

- **Making casual observations about mental capacity to apply for housing**: This is a complicated area of the law. However, one principle that has been well established in case law is that a local authority's housing department cannot accept a homeless application made by a person who lacks mental

capacity. We could unwittingly find ourselves causing a person to be blocked from making a housing application by making a passing reference in an assessment to their mental capacity in relation to housing matters. We should avoid making comment on such matters unless it is clear that we are the decision-maker for the issue, and that we have carried out any mental capacity assessment in line with the requirements of the Mental Capacity Act 2005. If a person with care and support needs is unable to make a homelessness application, it can sometimes fall to the local authority with Care Act responsibility for them to make arrangements for their accommodation.

- **Assuming someone else will meet the needs**: Paragraph 10.25 of the Care and Support statutory guidance says “The duty to meet eligible needs is not discharged just because a person has another entitlement to a different service which could meet those needs, but of which they are not availing themselves. The needs remain ‘unmet’ (and so the local authority remains under a duty to meet them) until those needs are actually met by the relevant service bring provided or arranged. Local authorities should therefore consider how to inform and advise people on accessing any such entitlements at the earliest stage possible, as well as working collaboratively with other local services to share information.”

Can the process end at this step?

Yes. If we have established, and demonstrated on care and support plan, that the local authority is not required to meet any care and support needs that the person has, even though they are needs that meet the eligibility criteria, then that may be as far as we need to take the matter.

Appendix A: Assessing and reviewing a person's medicines support needs

The information below is taken from section 1.2 of the NICE Guideline (NG67) "Managing medicines for adults receiving social care in the community"

Many people want to actively participate in their own care. Enabling and supporting people to manage their medicines is an essential part of this, with help from family members or carers if needed. The term 'medicines support' is defined as any support that enables a person to manage their medicines. This varies for different people depending on their specific needs.

Assess a person's medicines support needs as part of the overall assessment of their needs and preferences for care and treatment.

- Do not take responsibility for managing a person's medicines unless the overall assessment indicates the need to do so, and this has been agreed as part of local governance arrangements.
- Ensure that people assessing a person's medicines support needs (for example, social workers) have the necessary knowledge, skills and experience.
- Engage with the person (and their family members or carers if this has been agreed with the person) when assessing a person's medicines support needs.
- Focus on how the person can be supported to manage their own medicines, taking into account:
    - the person's needs and preferences, including their social, cultural, emotional, religious and spiritual needs
    - the person's expectations for confidentiality and advance care planning
    - the person's understanding of why they are taking their medicines
    - what they are able to do and what support is needed, for example, reading medicine labels, using inhalers or applying creams
    - how they currently manage their medicines, for example, how they order, store and take their medicines
    - whether they have any problems taking their medicines, particularly if they are taking multiple medicines
    - whether they have nutritional and hydration needs, including the need for nutritional supplements or parenteral nutrition
    - who to contact about their medicines (ideally the person themselves, if they choose to and are able to, or a family member, carer or care coordinator)
    - the time and resources likely to be needed.

Record the discussions and decisions about the person's medicines support needs. If the person needs medicines support include the following information in the provider's care plan:

- the person's needs and preferences
- the person's expectations for confidentiality and advance care planning
- how consent for decisions about medicines will be sought
- details of who to contact about their medicines (the person or a named contact)
- what support is needed for each medicine
- how the medicines support will be given
- who will be responsible for providing medicines support, particularly when it is agreed that more than one care provider is involved
- when the medicines support will be reviewed, for example, after 6 weeks.

Review a person's medicines support to check whether it is meeting their needs and preferences. This should be carried out at the time specified in the provider's care plan or sooner if there are changes in the person's circumstances, such as:

changes to their medicines regimen

- a concern is raised
- a hospital admission
- a life event, such as a bereavement.

Appendix B: Working with people who choose not to engage with services

Adults who are reluctant or do not engage with services can have complex and diverse needs that often fall between different agencies.

Assessment, and after the assessment

Adult Social Care and Health may have different legal obligations to people who choose not to engage with us at the point of assessing their care and support needs and after that assessment. If the person falls within s11(2)(a) or (b).

If the person

a) lacks the mental capacity to make the decision whether to accept the offer of a s9 Care Act assessment, and we believe it is in their best interest to be assessed, then we must carry out that assessment. Establishing the lack of mental capacity and what is in their best interest must be done in line with the requirements of the Mental Capacity Act 2005.
b) Has the mental capacity to decide to refuse the assessment and has done so, and is at risk of abuse or neglect, then we must carry out the s9 Care Act assessment despite them refusing it.

Unless we can point to powers or duties arising from elsewhere, such as the Mental Capacity Act 2005, the Mental Health Act 1983, or a court order, following a s9 Care Act assessment we usually cannot impose care and support services on a person who has refused them. Section 13(3)(b) Care Act requires us to take account of whether the adult wants to have their eligible needs met.

Good practice when working with someone who chooses not to engage with an assessment or with having their eligible needs met depends not only on understanding our legal duties and powers and applying those correctly but also, and often more so, depends on skilled work with people in often challenging situations.

Set out below is some brief guidance on good practice is such circumstances.

Who are 'difficult to engage' adults?

The individuals' presenting problems can be wide ranging.

For example:

- The person 'hoards' excessively and this impacts on the living environment causing health and safety concerns.
- There are signs of serious self-neglect regularly reported by the public or other agencies but no change in circumstances occur. The public /agencies become frustrated

- Personal or domestic hygiene that exacerbates a medical condition and could lead to a serious health problem.
- The property they live in becomes filthy and verminous causing a health risk or possible eviction.
- No heating or water and the person refuses to move to alternative accommodation.
- Structural problems with the property and the person cannot afford repairs or refuses to consider alternative accommodation.
- Health and safety issues around gas or electricity and the individual refuses or cannot afford the get appliances repaired.
- Anti-social behaviour that intimidates neighbours and causes social isolation.
- The conditions in the property cause a potential risk to people providing support or services.
- People who live 'chaotic' lifestyles
- There could be other wide-ranging situations not listed above, or a situation could include a combination of the above

The historical risk of a lack of engagement from vulnerable people has been social isolation, homelessness, higher risk of 'grooming' and or bullying and a risk to health and wellbeing.

Some people are often difficult to engage because of presenting behaviours associated with diagnosed or undiagnosed mental health problems, cognitive impairments or other anti-social behaviours. Unfortunately, when there is no clear diagnosis or people refuse treatment/support they often fall outside of the eligibility criteria for specific service areas.

Where a person is reluctant to engage with use, the use of a strengths-based approach and looking at community-led support, as set out in section 2 above, can led to creative and collaborative work which finds a way forward that can work for the person.

When working in such a situation consider:

- Seeking support from your line manager / supervisor
- Whether there is a self-neglect, or other abuse or neglect issue, here that would require a response under s42 Care Act 2014. Consulting with the S42 Care Act Adult Safeguarding Enquiry team may be useful when considering this.
- Whether or make use of other processes such as convening a s1 Care Act meeting to look at the what can be done to promote the person's wellbeing, or a referral to the Risk and Vulnerability Management Panel (RVMP). The RVMP is a meeting where information is shared on complex/high risk cases between various stakeholders. The purpose of the meeting is to work together to take appropriate action to prevent people with vulnerabilities being a victim and or perpetrator of crime and or ASB.