HALTON
BOROUGH COUNCIL

Adults & Community Directorate

Fair Access to Care Services Policy

Eligibility for Adult Care Services

Revised March 2010

INFORMATION SHEET

Service area	**Adult Services**
Date effective from	**April 2010**
Responsible officer(s)	**Divisional Managers – Assessment Services** **People & Communities Manager**
Date of review(s)	**June 2006** **March 2010**
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	**Mandatory**
Target audience	**All Adult Services Staff**
Date of committee/SMT decision	**March 31, 2010**
Related document(s)	**Care Management and Assessment – Policy, June 2005** **Adult Carer Assessment - Policy and Procedures, June 2005** **Mental Capacity Act, Overall Policy, Feb 2010**
Superseded document(s)	**FACS Policy April 2003,**
File reference	**FACS/APR/2010**

Fair Access to Care Services Policy
(Halton's Eligibility Criteria for Adult Care Services)

Contents

Appendices:

1. National Context - Fair Access to Care Services

In 2003 the Department of Health introduced its 'Fair Access to Care Service' framework (FACS). Its purpose was to eliminate inconsistencies nationwide in order to create a fairer and more transparent system for the allocation of social care services. Under FACS local authorities are required to provide or commission services to meet needs, subject to their resources, so that people with similar eligible needs receive services that deliver equivalent outcomes no matter where they live. There is also parallel guidance for councils on how to apply eligibility criteria for carers (Carers and people with responsibility for disabled children: practice guidance (2001). This closely models the criteria for people in need of social care services and local authorities need to ensure there is effective interaction between both sets of guidance.

Due to the fact that public funding for social care will always be limited, many local authorities have opted to tighten their rules for eligibility. This runs the risk that some individuals who ought to be receiving support are being ruled as ineligible. In addition there is evidence to suggest that limiting access in this way had had only a modest and short-term effect on expenditure (CSCI and Audit Commission, 'The effect of Fair Access to Care Services Bands on Expenditure and Service Provision,' (2008). Clearly, a programme for transforming social care services was required and the cross-sector agreement 'Putting People First': a shared vision and commitment to the transformation of social care. (2007), became the blueprint promoting personalised care coupled with the ability to exercise choice, against a background of supportive local communities. This wider context of personalisation beyond those with highest need, places a strong emphasis on prevention, early intervention and support for carers. In practice, it enables councils to make adjustments to ensure a seamless approach between their personalisation programmes and how they determine eligibility for social care.

Further, the concepts of prevention and early intervention can be extended beyond adult social services to include: adapted housing smart technology and equipment, improved health care and joint working, greater benefits take-up and community support that can help delay or avoid the need for care completely. The 2008 document, 'Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own,' views carers as fundamental to strong families and stable communities. The aim of support is two-fold: enabling carers to balance their caring responsibilities with their life outside caring while at the same time enabling the person they are supporting to have full and equal citizenship. Carers…2008 also says that children and young people should be protected from inappropriate caring and have the support they require to learn, develop, and thrive, while achieving all 5 outcomes of the 'Every Child Matters' (2003). This requires the support of adult and children's services.

These themes from 'Putting People First' and the 'Carers Strategy' also run through the 'Care and Support' Green Paper (Shaping the future of care together, 2009). This sets out long-term proposals to tackle the challenges of rising demand and expectation facing the present system. Its aim is to ensure that: care is high quality and cost effective, people have choice and control over the care and support they receive, the funding system is sustainable and affordable for individuals and the state. To achieve these goals effectively

councils need to have a strong focus on the overall wellbeing of their communities and recognise that people should be helped in a way that can prevent, reduce or delay their need for social care support. There is a growing body of evidence that interventions can prevent or delay people entering the social care system and therefore produce better outcomes for individuals at a lower overall cost.

The CSCI 'State of Social Care' report (2006-7) highlighted the trend for councils to raise their eligibility thresholds and the potential implications for people seeking support. As a consequence, CSCI were asked by the Minister for Care Services to review the application of eligibility criteria and their impact these were having on people. Their resulting review, 'Cutting the Cake Fairly…' (2008) makes several recommendations for making eligibility criteria more equitable and effective. Based on these the DoH has issued separate guidance on eligibility – Prioritising need in the context of 'Putting People First': A whole system approach to eligibility for social care (2010). This guidance replaces Fair access to care services – guidance on eligibility criteria for adult social care (2003) and aims to support fairer, more transparent and consistent implementation of the criteria. Further practice guidance to support its implementation will be published separately by the Social Care Institute for Excellence. Outcome priorities include greater choice and control, better access to public services and information, empowerment of people and their carers using services at local level and the definition of 'User Satisfaction' as the measure of success (Cabinet Office Strategy Unit, Excellence and Fairness: achieving world class public services, 2008).

This guidance reflects the current responsibility held by local authorities for identifying local priorities and allocating their own resources accordingly. In doing so, they need to ensure that those individuals who do not meet the eligibility threshold are adequately signposted to alternative sources of support such as: luncheon clubs, befriending, volunteering…(Prioritising need in the context of putting people first, Place-shaping and promotion of well-being through universal services, p 13-14, 2010). Such universal services improve outcomes for the wider population and could help some individuals avoid or delay having to rely on health or social care services for support. If councils base their approach to needs on achieving outcomes rather than providing specific services, then people with similar needs within the same local authority area should expect to receive a similar quality of outcome.

The eligibility framework is based on:

- "The impact of needs on factors that are key to maintaining an individual's independence over time." (FACS Guidance, DoH, p. 3)

- That level of impact will be critical, substantial, moderate or low

The approach requires councils to prioritise their support to individuals in a hierarchical way. Those whose needs have immediate and longer term critical consequences for their independence and safety should be supported ahead of those with needs that have substantial consequences and so on.

Fair Access to Care Services requires that there should **not** be Eligibility Criteria for different services.

The FACS guidance confirms that resources can be taken into account in assessing a person's needs for services and in deciding whether it is necessary to make arrangements for those services.

2. Legal Context

Community care *".is about assisting people with social care needs, and enabling them to remain living at home, as independently as possible for as long as is possible, in the belief that this is what most people want."* (ref. Michael Mandelstam: Community Care Practice and the Law - 2nd edition 1999.) Community care assessment is the process by which information is gathered about a person to see if they have a need for community care services.

Community care assessment is a statutory duty on the local authority and a service in its own right that is separate from the later decision about the provision of services. It is provided under the National Health Service and Community Care Act 1990 Section 47(1) (a), which states:

"...where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority – shall carry out an assessment of his needs for those services.."

This means that an assessment is triggered when:

- The individual **appears** to be a person for whom the council may provide a community care assessment, for example they are disabled, elderly or unwell

and

- The individual's circumstances **may** need the provision of community care services

Carers also have a right to an assessment under the Carers and Disabled Children Act 2000 (Carer Practice Guidance, DoH).

Community care services may be provided to individual adults with needs arising from physical, sensory, learning or cognitive disabilities and impairments or from mental health difficulties. In general, the council's responsibilities to provide such services are set out in the legislation specified in Appendix 1.

The Mental Capacity Act (2005) applies to all individuals in England and Wales who are aged 16 and above and who lack capacity to make decisions. Hence everyone directly involved in the care of such individuals or employed in health and social care will be subject to the Act. The Act provides levels of protection and transparency for those whose capacity is under question and for those who may have to make decisions on their behalf. It refers to the ability of individuals to make decisions that have consequences for their finances, health care and

quality of life. The Act provides a statutory framework and sets out who can act for and take decisions on behalf of a person who lacks capacity, under which circumstances and how they should go about this. According to the Act a person lacks capacity if they fail at least one of the following four tests:

- Understand information relevant to the decision
- Are able to retain and later recall that information
- Can use or analyse that information as part of the decision process
- Can communicate the decision by any means (talking, blinking, signing grunting, hand squeezing…etc)

Further:

- An individual is assumed to have capacity unless there is evidence otherwise
- Individual capacity can fluctuate and if lost may be regained at a later date. Hence an assessment postponement may be appropriate
- Ascertain as far as possible from the person, their family, friends, any previous writing…etc, what the individual's wishes are likely to be
- When making a decision on behalf of a person always do so in their best interests
- Provide information in a way that is easy to understand
- A person with capacity also has the right to make a wrong or unwise decision.

You should not:

- Assume a person lacks capacity until you have tried your best to help them pass each of the four tests above.
- Regard a person as incapable of making a decision just because their decision seems unwise.
- Make judgements on a person's capacity by their appearance, race, age, condition or behaviour.

The Mental Capacity Act impacts on many aspects of social care. Halton has well-established training for staff likely to encounter individuals who lack capacity and a current policy document and guidance (Guidance Notes for Assessing Mental Capacity, HBC Feb 2010). It is also important to consider where the use of Independent Mental Capacity Advocates (IMCAs) and other advocates specialising in learning and disability.

3. Concerning FACS 2010 – Changes & Enhancements

This section summarises the main aspects of FACS that are the same, those that have changed and those that are either new or enhanced as a result of policy wider developments such as the following:

- Putting People First: A shared vision and commitment to the transformation of adult social care (DH, 2007a)
- Shaping the future of care together (DH, 2009b)
- Cutting the cake fairly: CSCI review of eligibility criteria for social care (CSCI, 2008b)
- Mental Capacity Act 2005
- National Carers Strategy (DH, 2008)
- Independent Living Strategy (ODI, 2008)
- Valuing People Now (DH, 2009e)
- National Dementia Strategy (DH, 2009e)

What has changed?

Features of FACS 2003 that are Changed in FACS 2010	
FACS 2003	FACS 2010
Needs-based assessments and reviews	Outcomes-based assessments and reviews
Preventative approaches	Preventative strategies
Care planning	Personalisation and support planning

What's new or enhanced?

The following changes in the context of the wider policy stem from recent legislation such as 'Putting People First,' personalisation, service transformation, and public service reform:

- Prevention, early intervention and enablement are to become the norm and are seen as an investment in wellbeing and delaying or preventing needs escalating.
- There is an enhanced focus on:
  - Rights, discrimination and equality as well as social inclusion
  - Self-assessment with support if necessary prior to any formal assessment as a way of putting the person seeking support at the heart of the process
  - Early information on resource, to assist self-directed support, personal budgets and the right to take managed risks
  - First contact as a critical aspect of assessment and referral recognising that the first response can determine the quality of future contact saving time and costs on assessment later
  - Promoting community wellbeing and preventive approaches
  - Transitions to ensure that young people with social care needs have every opportunity to lead as independent a life as possible and are not disadvantaged by the move from children's to adult services
  - Improving information sharing between organisations

- The five statutory principles of the Mental Capacity Act (MCA Code of Practice (DH, 2007))
- The development and evaluation of the Common Assessment Framework for adults through local authority-led demonstrator sites that run to 2012 and are working to inform improved information sharing between IT systems and across organisational boundaries
- The rights and needs of young carers as children and young people (Carers Act 1995 [Recognition and Services], Carers and Disabled Children Act 2000).
- Reforms introduced in April 2009 to establish a common approach to handling complaints in the NHS and adult social care (DH 2008c).

4. Local Policy

This policy sets out how decisions will be made in Halton about 'what sorts of people with what kinds of needs qualify for what types of services'.

Principles and Standards

Halton's Eligibility Criteria will:

- Be non-discriminatory.
- Be applied equally across **all** adult service user groups including adult carers.
- Lead to equitable, transparent and consistent decision making within available resources.
- Be based on the needs of, and risks to, individuals with particular reference to the seriousness of any consequences to independence.
- Be clear about the level of risk to independence that will trigger a service and the level that will trigger redirection and / or information and advice.
- Enable the authority to balance demand for services with available budget.
- Be written in a way that is easily understood by staff, service users and carers and available in different formats.

The Eligibility Criteria sets out where Halton will draw the 'threshold for services' line (Appendices 2, 3). This has been set at Moderate and the same 'Eligibility Criteria' will be used for all adult service users, to ensure services are offered on a fair and consistent basis.

Individuals' views will always be heard and respected. However, in the interests of equity and best use of resources, the council retains responsibility to apply its Eligibility Criteria.

This policy and procedural guidance has been developed with the involvement of managers, staff and users and carers and will provide employees with clarity and the assurance that they are working within the framework adopted by the Borough Council. Students will be made aware of Halton's FACS policy and encouraged to apply it in work they undertake as part of their placement.

The Eligibility Criteria threshold is set, and can only be changed by members of the council and must be reviewed at least annually.

This policy only applies to those needs that the Social Services are responsible for meeting. Assessments may identify needs that other agencies are responsible for meeting. These agencies have their own policies for determining how services will be allocated to people. These include:

- NHS responsibilities for meeting continuing health care needs.
- Nursing care as set out in Section 49 of the Health and Social Care Act 2001.
- Intermediate care.
- Supporting People.
- Disabled Facilities Grants

5. Procedural Guidance

Principles of Assessment

Decision-making about eligibility for services is underpinned by the assessment and review process. The principles of, and standards for, assessments are set out in the following national documents:

- National Service Frameworks for mental health and older people
- The White Paper Valuing People
- General Principles for Assessment within the FACS Guidance
- Single Assessment Process guidance
- Carers and Disabled Children Act 2000 - Practice Guidance

Within Halton the guidance concerning the different types of assessment, together with the practice principles underpinning assessment, is set out in the following documents:

- Assessment and Care Management Policy (June 2005)
- Assessment Procedures (June 2005)
- Support planning Procedures (June 2005)
- Review Procedures (June 2005)
- Adult Carer Assessments – Policy and Guidance (October 2008)

The fundamental principle underpinning these policies is that people are experts about their own situation. Therefore assessments should ensure the needs, wishes and views of the individual and that of their carer are taken into account throughout the decision making process.

Prevention

Prevention, promotion of independence and recovery are key themes in national documents for **all** adult service user and carer groups, including: The National Service Framework (NSF) for Mental Health (1999), the NSF for Older People (2001), the White Paper Valuing People (2001), the Carers and Disabled Children Act (2000), 'Making a strategic shift to prevention and early intervention

– a guide' DoH (2008), 'Our health, our care, our say (2006), 'Putting People First' (2007), 'Transforming Social Care' (2008) and 'High Quality Care For All' ('the Darzi report', 2008). HBC and NHS Halton and St Helens have drawn up a joint Prevention and Early Intervention Strategy (2010-2015) to establish a clear framework and rationale to support an increased shift to improving preventive and early intervention services in the borough.

Halton's preventive strategy defines the three distinct areas of prevention as:

- Primary Prevention / Promoting Wellbeing
  This is aimed at people who have no particular social or health care needs. The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting healthy and active lifestyles, delivering practical services…etc.

- Secondary Prevention / Early Intervention
  This is aimed at identifying people at risk and to halt or slow down any deterioration and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes or falls) or those that have existing low level social care needs.

- Tertiary Prevention
  This is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus is on maximising people's functioning and independence through interventions such as rehabilitation/ enablement services and joint case-management of people with complex needs.

By clearly defining prevention in this way, Halton as a local authority, can begin to consider how addressing people's low-level needs and wants, enables it to shift service provision from high- cost complex care, to more cost-effective low level support.

Needs and Eligible Needs

This guidance defines the term 'need' in its every day sense. This term is referred to as 'presenting needs'. Needs may be intermittent or continuous in nature.

The term 'eligible need' has a specific meaning and is defined as:

"..needs that the council will meet as they are assessed as falling inside the Council's eligibility criteria that are set according to the council's resources."
(ref. Fair Access to Care: Guidance on Eligibility Criteria for Adult Social Care - Department of Health)

If a person's assessed needs fall within the council's Eligibility Criteria, it becomes an 'eligible need' that the council should meet.

The distinction between need / presenting needs on the one hand and eligible needs on the other should be taken into account when assessment information is being evaluated and summarised and support plans drawn up.

Transition

Young people who are moving from provision of service within Children's Services to provision within Adult Service, must have an assessment undertaken in accordance with 'Fair Access to Care Services' framework and they and their carers must be advised regarding their eligibility for services when they are in Year 12 at school. A Review will take place in Year 13. This is prior to the transfer of care management responsibilities to Adult Services on the young person's 18th birthday. This is to ensure continuity and consistency of services.

6. Practice Guidance

Publishing Information

Information to assist individuals to make arrangements to meet their own needs can be given at any stage, regardless of whether the person has needs above or below the threshold line for services. Wherever possible, people should be empowered to make arrangements to meet their own needs through the provision of wide ranging information and advice, including that about welfare benefits. In its local authority circular 'Transforming Adult Social Care' the Department of Health stressed that:

> *By 2011, all local authorities must provide "Universal joined-up information and advice available for all individuals and carers, including those who self-assess and fund*. (DH)(2009)1

To achieve this it has set-out a timetable of requirements:

- By April 2010 every council will have a strategy in place to create universal information and advice services
- By October 2010 the council will have put in place arrangements for universal access to information and advice
- By April 2011 the public are informed about where they can go to get the best information and advice about their care and support needs.

Information is seen as an important core component of personal choice, empowering citizens to make informed decisions. Personalisation in particular requires quality information in order to fully realise the goal of person-centred care. As an authority, Halton is committed to delivering information at a place and in a format that is convenient to the citizen. However, the task of delivering a universal information service raises important issues such as:

- Who is collecting and updating information about services?
- Who is responsible for the ongoing quality assurance of information?
- How are partners likely to be supported in their Information, Advice and Advocacy (IAA) role?

- How can referrals be reduced so that a one-stop shop can be delivered as the first point of contact?

Halton is well advanced in dealing with these issues and will shortly (April 2010) be introducing its strategy for universal information and advice. As part of this, practitioners should either give the information and advice requested, or with the person's permission, contact another agency for this. Information and advice is an appropriate response at the initial point of contact where:

- A person does not meet the legal criteria for community care assessment
- Where the person is clear about what is required and why, their needs are clearly defined and require no further checking and the presenting situation is stable
- Where another agency is better placed to respond to the presenting needs

Important points to highlight are:

- Has delivery of the service been co-designed to ensure that it actually meets local need?
- Is the information accessible in a wide variety if ways?
- Does the information equally support service users and self-funders?
- Is peer-to-peer recommendation made easier?

Determining Eligibility for Assessment

Before beginning a community care assessment customer services staff and/or practitioners first have to determine whether the level of need is actually (or likely to be) significant and whether the person requires community services. For example, are they disabled or do they have an illness (National Health Service and Community Care Act 1990 Section 47(1), a).

Access to carers assessments is defined by the Carers and Disabled Children Act 2000, where:

- The carer provides or intends to provide a substantial amount of care on a regular basis to another person aged 18 or over
- The carer does not provide or intend to provide the care under a contract or as a volunteer for a voluntary organisation
- The council is satisfied that the person cared for is someone for whom it may provide or arrange for the provision of community care services
- The carer asks the local authority for an assessment

An assessment should only follow where these criteria are met. Therefore, it follows that not every contact will require an assessment, in particular requests for information about services (see above).

Halton's Eligibility Criteria for Assessment are to be found at Appendices 2,3. It is important to stress that case priority is based on information acquired at the initial point of contact. It does **not** indicate a person's eligibility for services.

The level and type of assessment / review carried out should be determined by presenting needs and difficulties and will require practitioners to exercise judgement about how best to respond.

Applying Eligibility Fairly and Consistently

It is important that those applying eligibility criteria are aware that risks to independence and well-being relate to all areas of life and that in general there is not a hierarchy of needs (two exceptions to this are: life threatening circumstances and serious safeguarding concerns). For example needs relating to social inclusion and participation are just as important as needs relating to personal care issues. For example a disabled individual facing significant obstacles taking up education and training to support their independence and well-being should be given equal weight to an older person who is unable to perform vital personal care tasks. Hence overall, decisions are made within the context of human rights where people's needs are considered not just in terms of physical functionality, but also in terms of their basic right to dignity and respect.

Further, there is no implicit assumption that low-level needs will always be equated with low-level services or that critical needs will always require complex costly services as a response. A person with relatively low needs may still need more complex intervention in the short-term to counter any immediate risks to their independence and/ or well-being. Sometimes a simple one-off intervention, such as provision of the right piece of equipment will provide the support needed. Also, in 'Cutting The Cake Fairly,' CSCI identified that carers are often willing to provide substantial personal care, but can find it difficult to manage household tasks at the same time. It is therefore important not to be too restrictive about the kind of support that is made available, if such support can sustain the caring role and maintain independence and well-being in the longer term.

A person's needs must be considered over a period of time, rather than as the consequence of a single snapshot. In this way the needs of those who have fluctuating or long-term conditions can be properly taken into account. Also, before any final decisions are taken about longer-term needs for support and whether such needs are eligible for local authority support, consideration should always be given to whether a period of re-ablement or intermediate care should be made available. This can help maximise what people can do for themselves, before any further assessment of needs is undertaken.

There are others with disabilities in danger of being overlooked in the assessment of eligible need. These would include people with specific communication needs, or blind and partially sighted individuals who could be disadvantaged by assessors who are unaware of the impact that loss of vision has. In order to maximise what individuals with newly acquired disabilities can do for themselves, consideration should be given to making available rehabilitation services, before assessing for longer-term need. Groups with "hidden" needs often include people with autism. For example, in the case of Asperger's syndrome individuals have occasionally been refused assessment or access to support by some local authorities. The argument being because their IQ scores are too high they cannot have a learning disability! This is clearly unacceptable.

The government is to publish a new national strategy for Autism by the end of March 2010 to support best practice and higher quality services for their particular requirements.

As a means of ensuring that eligibility criteria are applied fairly and consistently it is important to consider whether the individual's needs are likely to prevent the following outcomes from being achieved:

- Exercising choice and control
- Health and well-being, including mental and emotional as well as physical health and well-being
- Personal dignity and respect
- Quality of life
- Freedom from discrimination
- Making a positive contribution
- Economic well-being
- Freedom from harm, abuse and neglect
- Taking wider issues of housing and community safety into account

Assessing Need

The purpose of the assessment is to gather information about a person's needs, situation, strengths, abilities and difficulties. This information can then be used to identify the impact those needs are likely to have on the individual's safety and / or independence. The assessment process should be person centred throughout and also consider the wider family and community context. Professionals should fully involve the person seeking support. This involves listening to their views, and encouraging a partnership approach, based upon the person's aspirations and the outcomes they wish to achieve such as: how they want to live their lives and how they can make a valued contribution to their community.

The evaluation of a person's needs must take into account how needs and risks could change over time and the possible outcome if help were not provided. This should also include consideration of the impact upon the person of changes in the circumstances of the carer(s). In this way assessment will be most effective if conducted as an ongoing process rather than a singular event.

People with all levels of need, regardless of whether or not they have eligible needs, or fund their own care need to be taken into consideration. With the right kind of intervention, such individuals may be able to reduce or even eliminate their dependency on social support. Support plans should be constructed with such individuals in mind. These plans would focus on what individuals can achieve with the right help, rather than simply putting arrangements in place to prevent their situation getting worse.

Assessment forms are simply a tool for gathering the required information in a structured format. The forms do not in any way replace the need for practitioners to interpret and analyse the information collected in relation to each individual's unique circumstances. Alternatives to the need for social care assistance arranged by social services, should always be explored and recorded at the assessment stage. This should include contributions from the individual, family,

wider community, voluntary sector and other agencies, such as Supporting People.

Agencies should work together to ensure that information from assessment and related activities is shared among professionals, with due regard for data protection. In coordinating assessment, agencies should maintain an emphasis on outcomes rather than functions or services. The result should be as assessment process that individuals experience as consistent, seamless and timely. The DoH has recently consulted on proposals for the development of a Common Assessment Framework (CAF) for adults with the aim of promoting more person-centred assessments. This is likely to replace SAP and is currently art the development stage in certain local authority 'Demonstrator Sites,' with the hope that it can facilitate more efficient, timely and secure sharing of information around assessments. Full evaluation is expected in 2012, but learning from the Demonstrator sites is being shared throughout the programme. Halton, although not a Demonstrator Site will need to keep abreast of these shared developments.

The assessment process should not marginalise specific groups of people. Instead, people should be helped to prepare for the assessment process and to find the best way for individuals to state their views. The use of interpreters, translators, advocates or supporters can be critical in this regard.

Assessments will also identify needs that other agencies are responsible for meeting. These agencies have their own policies for determining how services will be allocated. Social Services should not provide social care as an alternative to other agencies meeting their responsibilities. It is also important to stress that:

> *The act of completing an assessment is not a commitment by Social Services to provide or arrange social care services.*

Evaluation and Analysis of Needs and Risks

Risk assessment is an integral part of the assessment and review processes and a critical part of determining an individual's eligibility for services. As well as identifying the individual's strengths and abilities, the individual and practitioner should clarify potential difficulties and possible risks that could lead to increased dependency, harm or danger including risks to carers or other close relationships if needs are not addressed.

Using the assessment information, practitioners will need to predict how likely the risk is to occur and how quickly it will impact on an individual's independence if it is not addressed. In exploring the interaction between a person's needs and risks the individual and practitioner should consider:

- Instability / unpredictability of needs
- Intensity of needs and level of distress
- Number of different needs, how they interact and how the individual reacts to the difficulties facing them
- Impact of external and environmental factors.
- Sustainability of assistance from self, family, wider community and other agencies.

Risk assessments should explore what is an acceptable level of risk, the individual's attitude and wishes concerning risk taking and whether the risks are a normal part of independent living or a cause for serious concern.

There are four levels of risk assessment – Low, Moderate, Substantial and Critical. These are defined along with examples, desired outcomes and services that might be appropriately provided under Halton's 'Eligibility Criteria' (Appendix 3).

Applying the Eligibility Criteria for Services

A person is eligible for social care support where:

- They have needs above the threshold line for services (Appendix 5).

Halton Borough Council has set its threshold at moderate. However, there may be occasions where a wider view, incorporating low-level services, may be agreed as a preventative approach to reduce the risk of loss of independence. The assessment will have identified the interaction between **all** of a person's assessed needs and risks, the individual's views and attitudes towards the risks and the predictability and time frames within which they are likely to occur. This information will inform decision-making about the level of seriousness of the risks in terms of harm or danger and the level of impact to an individual's independence. Hence, the undertaking of a rigorous risk assessment of needs that may initially appear to be below the threshold could in fact result in a critical or substantial need being identified.

For example, the impact of risks to an individual's independence will be influenced by factors such as their housing circumstances and the level of support they receive from others such as carers, family, wider community, other agencies and voluntary organisations, and so on.

Each individual's situation is unique and the interaction of needs and risks will vary accordingly. Practitioners must use their skills to interpret and analyse the assessment / review information to inform their judgements concerning eligibility. The assessment format will indicate whether a person is unable to do many/ most/ some important tasks or have difficulty with one or two activities.

In determining eligibility for services, staff must take account of the reasonable standards that a multi-cultural society would expect, including any eligible needs arising from ethnic, religious or gender requirements, balanced against resource constraints, thus enabling the council to discharge its legal duty

The Statement of Eligible Needs (Appendix 7) should be completed and presented to Resource Panel together with other required documentation.

Note: It does not follow that once a person has some eligible needs for services, that all presenting needs become eligible. Also, needs and risks may vary over time leading to a variety of outcomes at the review stage.

Implementing the Support Plan

The eligible needs detailed on the Statement of Eligible Needs will form the basis of the 'Support Plan' which will set out the goals agreed by the service user and practitioner and the support and intervention that can best meet the eligible needs. 'Putting People First' clearly stresses that all individuals in receipt of social care support and their carers should be in control of their own lives, using personal budgets to direct funding in a way that best meets their needs.

'Fair Access to Care Services' requires that there are no service led Eligibility Criteria. Wherever applicable, the use of Direct Payments must be considered. In deciding on levels and types of support practitioners should:

- Give people information so that they can solve their own problem where appropriate
- Take account and encourage the strengths of the individual to problem solve, thereby minimising our intervention
- Consider the contributions of family, friends and other agencies
- Provide short-term intervention to enable people to become independent without support from Social Services
- Provide intervention to assist people to live independently over the longer term
- Ensure people are not discriminated against on the grounds of their age, gender, ethnic group, religion, disabilities, personal relationships or living and caring arrangements

In order to be successful, self-directed support initiatives depend upon effective support planning. This needs to be person-centred, focusing upon what is important to the person and how best they can achieve their aims through use of a personalised budget. For those in receipt of directly managed services, choice and control should also be available as a means of identifying individual solutions matched to outcomes. Hence, support planning always incorporates decisions made by the individual, supported by anyone they have chosen to assist them in this planning.

A written record of an individual's support plan should include the following:

- A note of any eligible needs that have been identified during assessment
- Any agreed outcomes and in what way support will be organised to meet these
- A risk assessment including any actions to be taken to manage identified risks
- Contingency plans to manage emergency changes
- Any financial contributions the individual has been assessed to pay
- Any support which carers and others are willing and able to provide
- Support to be provided to address needs identified through the carer's assessment
- A review date

Monitoring The Support Plan For Service User Need

Monitoring underpins the delivery of the support plan on a continuing basis. It's about supporting the achievement of set objectives over time and adapting the support plan to the changing needs of the service user. The type and level of monitoring will relate to the scale of intervention and the complexity of the needs that are being addressed

Where, for whatever reason, delays occur providing or arranging services, this should be discussed with the service user and carer. People will be prioritised according to the risks to their independence with critical needs first, then people with substantial needs and so on.
Where the service user and / or carer refuse help and services for whatever reason the following applies:

- **If** the person has capacity to make an informed decision then that person's refusal of services determines the situation. Agencies do not have the power to compel a person to receive services.
- **If** the person is a 'Vulnerable Adult' agencies must discuss their concerns at a strategy meeting or case conference convened under the inter-agency Adult Protection policy. A letter should be sent to the person concerned setting out what services were offered and why and the fact of the person's refusal to accept them. The letter should make it clear that the person can contact social services at any time if they change their mind. In cases of high risk, consideration should be given to arrangements for monitoring the case to ensure that circumstances do not deteriorate to an unacceptable degree. Where a service user has declined an assessment or service(s), a carer is still eligible for an assessment under the Carers and Disabled Children Act 2000. Carers may also receive services as a carer where they have an eligible need (Carers and Disabled Children Act policy and practice guidance).

Reviewing /Reassessment

The review will gather information about a person's situation, needs, strengths, abilities, difficulties and risks and identify the impact of those needs on the individual's safety and / or independence. The review will also establish how far the support provided has achieved the outcomes set out in the support plan. Review forms enable the information to be captured in a structured way. The forms do not replace the need for practitioners to interpret and analyse the information collected in relation to each individual's unique circumstances.

Alternatives to the need for social care assistance arranged by social services should always be explored and recorded at the assessment and review stages. This should include contributions from the individual, family, wider community, voluntary sector and other agencies, such as Supporting People. Assessments / reviews will identify needs that other agencies are responsible for meeting. These agencies have their own policies for determining how services will be allocated. Social Services should not provide social care as an alternative to other agencies meeting their responsibilities.

Reviews should follow the process for assessments and evaluation and analysis described above. No assumptions should be made about an individual's needs. An initial review should take place within six weeks of the service being provided or major changes in service provision being effected. Reviews should then take place at least annually, more often if necessary.

Some Important Points to Remember:

- Eligibility Criteria are used to determine if an individual is eligible for social care services arranged by social services.
- Eligibility is about allocating resources based on risks to independence, harm or danger if social care needs are not addressed.
- Eligibility Criteria should assist practitioner decision-making, not replace it.
- Social Services should not provide social care as an alternative to other agencies meeting their responsibilities.

Managers and practitioners are responsible for adhering to this policy and guidance

7. Additional FACS Related Issues

Roles and Accountabilities

Practitioners are accountable for:

- ♦ Adhering to the policy and practice guidance so that individuals are treated fairly and consistently.
- ♦ Ensuring that the level of resource request is appropriate to the level of need and risks.
- ♦ Provision of advice/support and signposting to other services.
- ♦ Completion of the Statement of Eligible Needs where required and ensuring the statement reflects the information gathered during the assessment / review.
- ♦ Ensuring a copy of the Checklist is placed on the service user's file (Appendix 7).
- ♦ Highlighting individual learning needs and participating in and contributing to identified learning opportunities.

Principal and Practice Managers are accountable for:

- ♦ Agreeing that the Practitioner has applied the appropriate resource request to the level of need and risk.

- Ensuring consistency of application of the policy and practice guidance.
- Ensuring that resources are used effectively so that individuals are treated fairly and consistently.
- Ensuring that all staff, including new staff, are familiar with the 'Eligibility Criteria' so that they act lawfully and within the policy of the council.
- Develop a culture of learning on the job through coaching, team learning opportunities and individual supervision.
- Setting up appropriate monitoring systems.

In all circumstances variations to these criteria must be discussed with the line manager, thus:

- Ensuring consistency in the application of the policy and practice guidance.
- Ensuring eligibility levels and resource allocation is appropriate to the level of need and risk
- Acting in a monitoring role in terms of ensuring the equitable implementation of FACS and use of available resources.
- Monitoring assessments to identify unmet needs and service deficits that will then inform the commissioning process.
- Identifying problem areas in micro commissioning which will inform macro commissioning, linking with the Contracts section and budget monitoring.

Staff Learning Needs

The effective application of Eligibility Criteria is, to a large extent, determined by the skill and sensitivity of staff in assessing people's needs. Managers must ensure a culture of learning on the job through coaching and team learning opportunities with outcomes being evidenced on supervision files.

The national policy requires councils to put the following in place:

- Training and development activities to encourage an organisational culture that promotes independence, person-centred care and anti-discriminatory practice.
- Risk assessment skills development for longer term planning.
- Consequences to a person's independence are understood and identified.
- Involvement of staff from other agencies in staff training.

Currently Halton offers a comprehensive learning and development programme throughout the year, to enable staff to acquire and develop their knowledge and skills. Some examples are:

Social Care Risk assessment	(1 Day)
Risk Assessment for Managers	(half Day)
Dementia Awareness	(1 Day)
Dementia Advanced	(1 Day)
Mental Capacity Act Assessment Basic Awareness	(1 Day)
Safeguarding Vulnerable Adults	(2 Day)
Mental Health	(1 Day)

The line manager must ensure new staff are familiar with the Eligibility Criteria to ensure employees act lawfully and within the policy of the Council.

Information Sharing

Halton Borough Council is required under Caldicott guidance to safeguard the Personal, confidential information it holds on all its service users and carers and not to share that information with other agencies without an information sharing agreement being in place. Before any information is shared about a service user or carer and providing their consent has been given, staff must ensure that an information sharing agreement. The Caldicott Guardian and Caldicott Officer will provide assistance with any queries including arranging introduction of new information sharing agreements.

Complaints

In all cases, service users and carers should be encouraged to first approach the assessing worker to discuss their concerns and then the local manager. Following this where disagreements persist concerning the decision making about eligible needs the service user and / or carer has the right to access Halton's complaints procedure, which may include a second opinion.

It is important that all decisions are well-documented and evidenced, as set out in this policy.

Monitoring and Review of the FACS Process

The purpose of Eligibility Criteria is to support the most effective and efficient use of available resources and to ensure consistency and fairness across the county and across service user groups. It is therefore important that the application of the Eligibility Criteria is carefully monitored and reviewed on a regular basis.

The national policy requires councils to audit and monitor their performance in respect of fair access to care services in the following ways:

- Monitor the extent to which different groups are referred, which groups receive an assessment and, following assessment, which groups go on to receive services

- Monitor the quality of the assessment and eligibility decisions of their staff
- Monitor which presenting needs are evaluated as eligible needs and which are not
- Audit service effectiveness with reference to support plans and reviews
- Monitor the speed of assessment and subsequent service delivery in accordance with the local Better Care Higher Standards Charter
- Monitor the timing and frequency of reviews
- Monitor the extent to which residents of different geographical areas with the council's boundary receive an assessment and which go on to receive services

Further the guidance states that once information has been collected and analysed, results from all the above analyses should be shared with a range of interested parties including service user, elected members, and other local agencies. Appendix 4 specifies the quantitative measures and indicators that will support this monitoring process.

This will be achieved in Halton through FACS monitoring exercises. These are carried out annually and Performance Management and Quality Systems, which include:

- 'Fair Access' and 'Quality of Services for Users and Carers' performance information within New Local Performance Framework (Appendix 4, for details of relevant indicators and targets)
- File Audit and other internal audit and inspection processes. File Audits will examine the following to monitor FACS is being implemented in accordance with the policy and practice guidance:
  - Assessment documentation
  - Support plans
  - Risk assessments
  - Panel applications
  - Statement of eligible needs
  - Review documentation
- Customer satisfaction and feedback surveys
- Analysis and evaluation of Complaints and Compliments
- Staff Supervision and Appraisal system
- Information from external inspections and audits such as, Social Services Inspectorate, District Audit and the Best Value Inspectorate
- Monitoring financial performance against the FACS categories and service targets

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Appendix 1

Relevant Legislation

Part III of the National Assistance Act 1948

Section 21 concerns the provision of residential accommodation to certain groups of people who are in need of care and attention that would otherwise be unavailable to them.

Section 29 concerns the promotion of the welfare of certain groups of people. To qualify for community care services under this section a person must be:

" aged 18 or over who are blind, deaf or dumb, or who suffer from mental disorder of any description, and other persons 18 or over who are substantially and permanently handicapped by illness, injury, congenital deformity or other such disabilities as may be prescribed by the Minister."

LAC (93)10 Appendix 4 asks councils to give a wide interpretation to the term substantial to take full account of individual circumstances and a flexible interpretation to the term permanent in cases where they are uncertain of the duration of the condition.

The definition of **disabled person** must be interpreted in this context to mean people over 18 years who have a permanent and substantial disability such as a learning disability, physical disability, sensory impairment, mental health difficulty, chronic illness or a combination of these.

- **Section 2, Chronically Sick and Disabled Persons Act 1970**
  Concerns services for disabled people, both adults and children.
- **Section 45, Health Services and Public Health Act 1968**
  Concerns the making of arrangements for promoting the welfare of old people.
- **Section 21 and Schedule 8, National Health Service Act 1977**
  Concerns the prevention of illness, care and aftercare of people.
- **Section 117, Mental Health Act 1983, 2007**
  Concerns the provision of aftercare services for people who were previously detained under certain sections of the Mental Health Act 1983.

Additional important legislation:

Disabled Persons (Services, Consultation and Representation) Act 1986
Mental Capacity Act, 2005
Mental Health Act, 2003, Amended 2007
Deprivation of Liberty Safeguards (Part of the 2007 Mental Health Act and an amendment to the Mental Capacity Act 2005)

Appendix 2

Eligibility Criteria for Assessment

When a referral is received, the following indicators should be used to determine whether or not a person should be assessed for community care services:

(a) The person should be:

- Aged 18 or over and Ordinarily Resident in Halton (subject to the relevant guidance – LAC 97/3)

and

- Have a learning disability, or
- Have a physical (including sensory) disability, illness, or injury, or
- Have a mental health problem, or
- Misuse drugs / alcohol or
- Are an older person and experiencing physical or mental frailty

and

- Appear, due to the problems and issues they face, to be eligible for the provision of Community Care Services (i.e. they appear to come within needs category 1 to 3.

(b) Or

- The person is a carer who provides regular and substantial care for a person who may be eligible for a Community Care Assessment

(c) Or

- The person may have a right to an assessment under the Disabled Persons (Services, Consultation and Representation) Act 1986.

Assessments should be prioritised in line with the priorities set out below. For people in the community, an initial assessment should be completed within three weeks of allocation. The exception to this is for people in a short stay acute hospital, where all assessments should be started within two working days of receipt of the referral and the initial assessment completed within 3 days of the hospital identifying the service user being fit for discharge. The time scales for allocation are for guidance only, and are the maximum time that should elapse. Judgement must be exercised as to the priority for allocation, particularly in Priority Group 2, where timely allocation could prevent a situation from deteriorating.

Priority 1 - Critical/ substantial: (assessment begun as soon as possible, but within 24 hours of receipt of the referral) e.g. the person appears:

- To be at, or pose, a risk of serious harm.

- There has been an allegation, disclosure or concern about adult abuse.
- To be neglecting their own care, so putting themselves at significant risk of harm.
- To require urgent intervention to prevent the imminent breakdown of their care arrangements that would put them at serious risk
- To have deteriorated from a previously stable state that puts them at significant risk of harm.
- Assessment under the Mental Health Act 1983
- Provision of an appropriate adult under the Police and Criminal Evidence Act.

Priority 2 - Moderate: (Begin initial assessment within 48 hours of receipt of the referral (refer to allocations policy)): e.g. the person appears:

- To have care needs which have significantly increased
- To be self-funding in a care home/ care home (nursing) who has fallen below the financial threshold. People must not be excluded from an assessment just because they are self-funding. They are still entitled to an assessment and signposting to available services.
- To have significant unmet care and support needs in relation to maintaining their independence
- To need assistance in the near future due to deteriorating circumstances or possible carer breakdown

Priority 3 - Low (Begin initial assessment within 48 hours of receipt of the referral (refer to allocations policy))*:* e.g. the person appears:

- To need to plan their long term care needs due to the frailty of their current carer
- To need intermittent support for themselves or their carer
- To be socially isolated

Not eligible for assessment: e.g. the person appears:

- To be able to access preventative services to overcome the issues and problems they face
- To be in a stable situation
- People who fall into this category should be offered appropriate information and support to enable the person to obtain preventative services
- It is important to stress that screening people out does not happen

Appendix 3

Eligibility Criteria

Eligibility Levels Agreed by Halton Borough Council for provision of services are critical and substantial					
Service Eligibility Level	**Threshold criteria, including risk factors**	**Relevant Legislation**	**Example situations**	**Desired outcomes of services**	**Examples of services Which might appropriately be provided at this level**
Critical – when	1. life is, or will be, threatened; and/or 2. significant health problems have developed or will develop; and/or 3. there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or 4. serious abuse or neglect has occurred or will occur; and/or 5. there is, or will be, an inability to carry out vital personal care or domestic routines; and/or 6. vital involvement in work, education or learning cannot or will not be sustained; and/or 7. vital social support systems and relationships cannot or will not be sustained; and/or 8. vital family and other social roles and responsibilities cannot or will not be undertaken.	Disability Discrimination Act 1996 NHS and Community Care Act 1990 Chronically Sick and Disabled Person's Act 1970 National Assistance Act 1948 Housing Act 1985/96 Carers and Disabled Children Act 2000 Community Care Direct Payments Act 1996 Carers (Recognition and Services Act 1995) Disabled Person Act 1944 Disabled Person Act 1986 National Health Service Act 1997 Mental Health Act 1983	The person requires 24 hour care and supervision The person's actions put him/her at risk of causing physical damage to others or the person is threatening or committing physical damage to another person. The person's actions put him/herself at risk, e.g. a severe eating disorder or history of self-harm The person may be at risk of significant self-neglect if not supported, e.g. the person is unable to feed themselves or drink and there is a danger of malnutrition/dehydration The person's existing care arrangements have broken down The person is homeless The person would cease to be able to function in the community without continuing social work involvement The person or their carer is at risk of being abused	Be safeguarded against abuse, neglect, self-harm Manage the essential task of daily living Live in a safe home environment Maintain a satisfactory level of personal care Prevent family breakdown or breakdown of social networks Communicate effectively Be able to summon help	Residential Nursing Home Care Complex Assessment work Therapeutic intervention Multi-disciplinary/joint work with specialist therapeutic provider teams Specialised day Community support service Respite care Carer's assessment Supervision of medication Domiciliary care Personal care Shopping and pension Collection Provision of meals Sitting service Access to education Help into employment Referral for specialist Benefits advice Supported accommodation Guardian Social supervisor Advocacy Multi-agency support Hospitalisation

Service Eligibility Level	**Threshold criteria, including risk factors**	**Relevant Legislation**	**Example situations**	**Desired outcomes of services**	**Examples of services Which might appropriately be provided at this level**
Substantial - when	1. there is, or will be, only partial choice and control over the immediate environment; and/or 2. abuse or neglect has occurred or will occur; and/or 3. there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or 4. involvement in many aspects of work, education or learning cannot or will not be sustained; and/or 5. the majority of social support systems and relationships cannot or will not be sustained; and/or 6. the majority of family and other social roles and responsibilities cannot or will not be undertaken.	Disability Discrimination Act 1966 NHS and Community Care Act 1990 Chronically Sick and Disabled Person's Act 1970 National Assistance Act 1983 National Assistance Act 1948 Housing Act 1985 Housing Act 1996 Carers and Disabled Children Act 2000 Community Care Direct Payments Act 1996 Carers (Recognition and Services Act 1995) Disabled Person Act 1944 Disabled Persons Act 1986 National Health Service Act 1977 Mental Health Act 1977, 1983 Mental Capacity Act, 2005	The level of dependency is high and the person's carer finds the physical and emotional strain of caring excessive, but wishes to be involved in the caring process The person is socially isolated and requests daytime activities to alleviate loneliness The person has a pattern of self-neglect, which will lead to gradual deterioration of his/her living conditions over time The person is an adult returning from residential college or school, or is moving from Children's to Adult's Services The person is or has resettled from a long stay institution The person is an adult subject to Guardianship under the Mental Health Act	Be safeguarded against abuse, neglect, self-harm Manage the essential tasks of daily living Live in a safe home Environment Maintain a satisfactory level of personal care Prevent family breakdown or breakdown of social networks Communicate effectively Be able to summon help	Nursing residential or home care Complex Assessment work Therapeutic intervention Multi-disciplinary/Joint work With specialist therapeutic provider teams Specialised day care Respite care Carer's assessment Personal care Provision of meals Sitting service Access to education Help into employment Referral for specialist Benefits advice Supported Accommodation Advocacy A need for an Appropriate Adult Support to maintain existing care arrangements Focussed short-term piece of work eg counselling, teaching, advising or crisis intervention Interim or long term support planning Multi-agency support package Hospitalisation Rolling respite care

THRESHOLD FOR SERVICES					
Service Eligibility Level	**Threshold criteria, including risk factors**	**Relevant Legislation**	**Example situations**	**Desired outcomes of services**	**Examples of services Which might appropriately be provided at this level**
Moderate	1. there is, or will be, an inability to carry out several personal care or domestic routines; and/or 2. involvement in several aspects of work, education or learning cannot or will not be sustained; and/or 3. several social support systems and relationships cannot or will not be sustained; and/or 4. several family and other social roles and responsibilities cannot or will not be undertaken.	Disability Discrimination Act 1996 NHS and Community Care Act 1990 Chronically Sick and Disabled Person's Act 1970 National Assistance Act 1948 Housing Act 1985 Housing Act 1996 Carers and Disabled Children Act 2000 Community Care Direct Payments Act 1996 Carers (Recognition and Services Act 1995) Disabled Person Act 1944 Disabled Person Act 1986 National Health Service Act 1997 Mental Health Act 1983	The person is experiencing some distress and would benefit from input or services to relieve strain or improve the quality of life, but there is no imminent risk of breakdown Help would prevent the person's current difficulties getting worse The person is functioning reasonably well, but may want specific low key input, eg, help with access to or information about drop-in centres, benefits, local resources, etc	Be safeguarded against abuse, neglect, self-harm Manage the essential tasks of daily living Live in a safe home environment Maintain a satisfactory level of personal care Prevent family breakdown or breakdown of social networks Communicate effectively Be able to summon help	Day Care Personal care Provisional of meals Carer's assessment Access to education Help into employment Referral for specialist Benefits advice Advocacy Re-direction to the voluntary sector Provision of written information

Service Eligibility Level	**Threshold criteria, including risk factors**	**Relevant Legislation**	**Example situations**	**Desired outcomes of services**	**Examples of services Which might appropriately be provided at this level**
Low - when	1. There is, or will be, an inability to carry out one or two personal care or domestic routines and/or 2. Involvement in one or two aspects of work, education or learning cannot or will not be sustained and/or 3. One or two social support systems and relationships cannot or will not be sustained and/or 4. One or two family and other social roles and responsibilities cannot or will not be undertaken.	Disability Discrimination Act 1996 NHS and Community Care Act 1990 Chronically Sick and Disabled Person's Act 1970 National Assistance Act 1948 Housing Act 1995/6 Children Act 2000 Community Care Direct Payments Act 1966 Carers (Recognition and Services Act 1995) Disabled Person Act 1944 Disabled Person Act 1986 National Health Service Act 1977 Mental Health Act 1983	Assistance with access to any other services that may be appropriate to meet needs Information on how people can institute the Complaints Procedure to appeal against decisions made	Be safeguarded against abuse, neglect, self-harm Manage the essential tasks of daily living Live in a safe home Environment Maintain a satisfactory level of personal care Prevent family breakdown or breakdown of social networks Communicate effectively Be able to summon help	Assistance with access to any other services that may be appropriate to meet needs Information on how people can institute the Complaints Procedure to appeal against decisions made

Appendix 4

National Indicator Set and the New Local Performance Framework

Adult Health & Well-being, Tackling Exclusion and Promoting Equality
(A Selection From NI 119-150)

The new performance framework for local government (Strong and Prosperous Communities, Govt. White Paper, October 2006) focuses on improving both quality of life and public services. It combines national standards and priorities set by Government and local priorities developed by local authorities and their partners. This single set of indicators replaces all previous Central Government sets (PAF) and has been developed as part of the Comprehensive Spending Review (CSR). Their purpose is to measure success in local delivery through Public Service Agreements (PSAs), Service Transformation Agreements (STRs) and Departmental Strategic objectives (DSOs). The table below shows how the indicators relate to PSAs and DSOs. (Dept. for Transport (DfT).

PSAs, STA and DSOs	National Indicator Number (NI)
PSA 15. Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief.	13, 140
PSA 16. Increase the proportion of socially excluded adults in settled accommodation and employment, education or training.	143, 144, 145, 146, 147, 148, 149, 150.
PSA 17. Tackle poverty and promote greater independence and well-being in later life.	137, 138, 139.
PSA 18. Promote better health and well-being for all.	120, 123, 136
PSA 19. Ensure better care for all.	126, 127
PSA 21. Build more cohesive, empowered and active communities.	1, 2, 4.
PSA 23. Make communities safer.	15, 16, 17, 18, 19, 21, 2628, 29, 32, 34,
PSA 28. Secure a healthy natural environment for today and the future.	194
Communities and local government DSO. support local government that empowers individuals and communities and delivers high-quality services efficiently.	3, 4, 179
Communities and local government DSO. Improve the supply, environmental performance and quality of housing that is more responsive to the needs of individuals, communities and the economy.	141, 142, 154, 155, 156, 158, 160.
CO DSO. Encourage more widespread enjoyment of culture and sport.	8, 9, 10, 11.

CO DSO. Drive delivery of the Prime Minister's cross-cutting priorities to improve outcomes for the most excluded people in society and enable a thriving voluntary sector.	6, 7.
DfT DSO. To enhance access to jobs, services and social networks including the most disadvantaged.	175, 176
DfT DSO. To strengthen the safety and security of transport.	47, 48
DfT DSO. Ensure better health and well-being for all.	119, 121, 122, 125
DfT DSO. Ensure better care for all.	124, 128, 129, 131, 132, 133, 135
DfT DSO. Better value for all.	134
HO DSO. Help people feel secure in their homes and local communities.	17, 21, 24, 27, 40, 41
DWP DSO. Pay our customers the right benefits at the right time	43, 44, 45, 46

Quality of Services for Users and Carers:

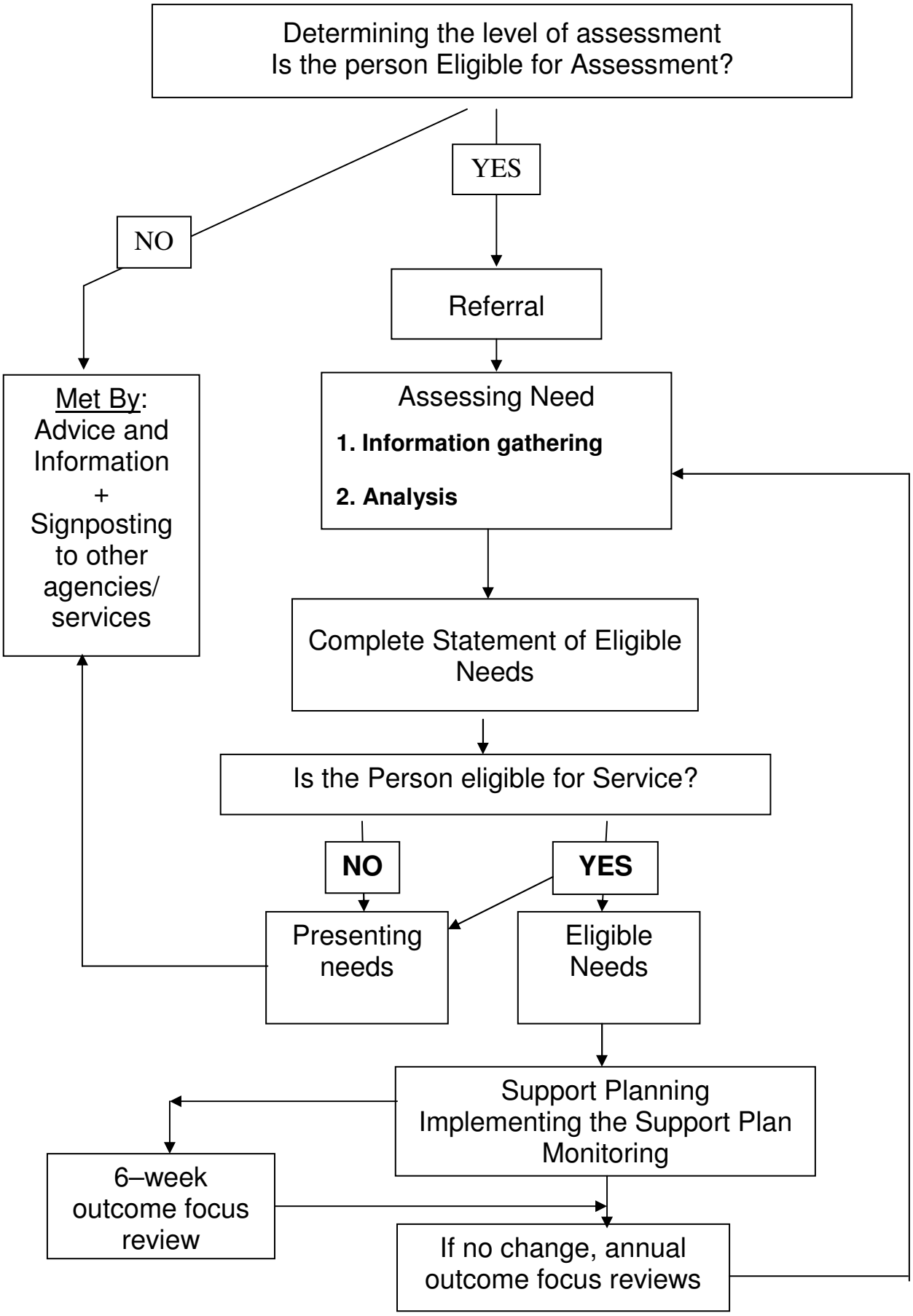
NI 119 Self-reported measure of people's overall health and wellbeing
NI 124 People with a long-term condition supported to be independent and in control of their condition
NI 125 Achieving independence for older people through rehabilitation/ intermediate care
NI 127 Self-reported experience of social care users
NI 129 End of life care – access to appropriate care enabling people to be able to choose to die at home
NI 130 Social care clients receiving self-directed support per 100,000 of the population
NI 132 Timeliness of social care assessment (all adults)
NI 133 Timeliness of social care packages following assessment
NI 135 Carers receiving needs assessment or review and a specific carer's service or advice and information
NI 136 People supported to live independently through social services (all adults)
NI 137 Healthy life expectancy at age 65
NI 138 Satisfaction of people over 65 with both home and neighbourhood
NI 139 The extent to which older people receive the support they need to live independently at home

Fair Access:

NI 140 Fair treatment by local services

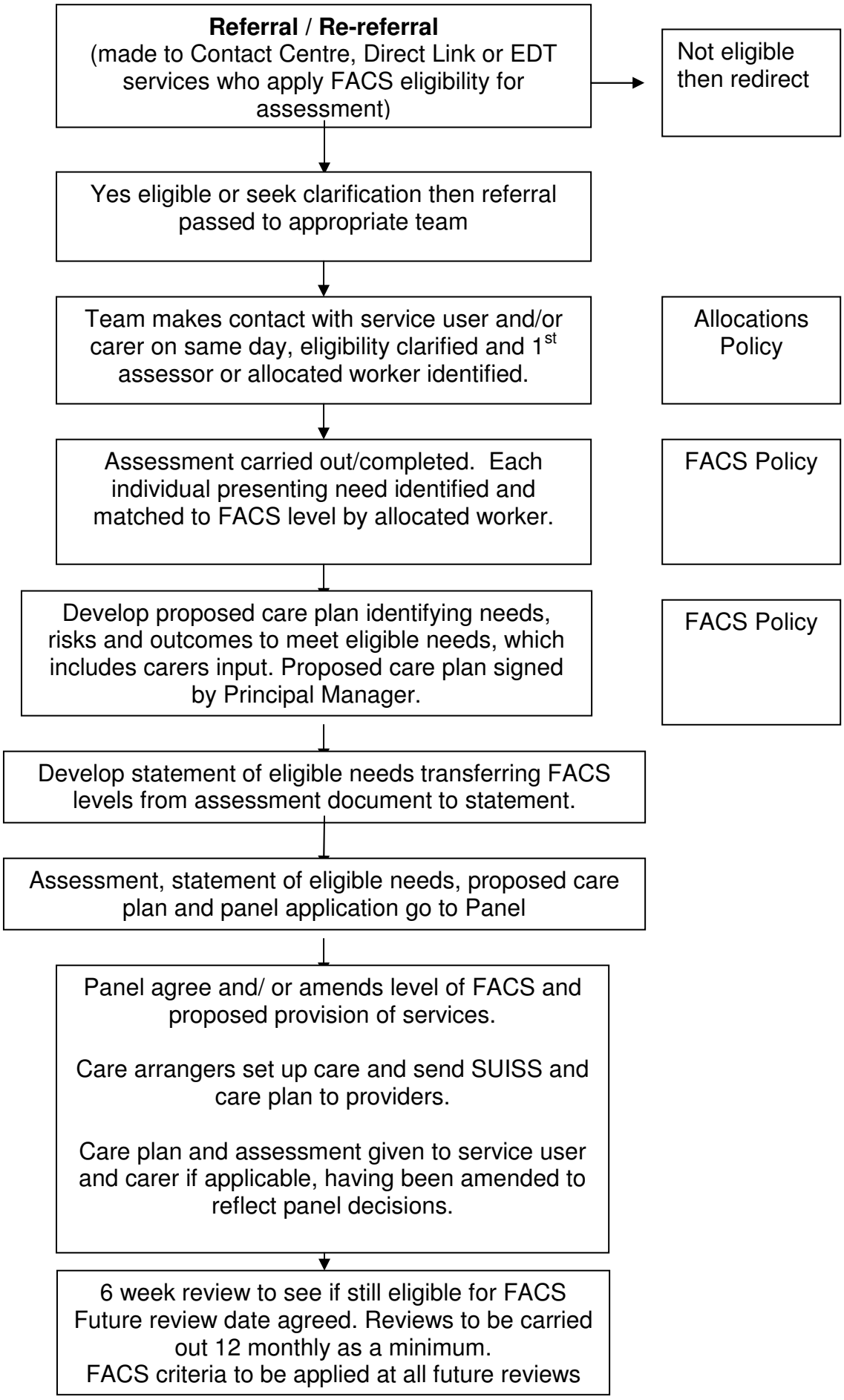
Appendix 5

Applying the Eligibility Criteria



Appendix 6

FACS /Allocations Process Flowchart



Appendix 7

HALTON BOROUGH COUNCIL
RUNCORN • WIDNES

- Adult Services

Statement of Eligible Needs

SEN\01Jun 05

Service User:_____ **Carefirst No:** _____

Critical and Substantial Needs		
No	**Presenting Need & Associated Risks to Independence**	**Eligibility Band***
Moderate and Low Needs		
No	**Presenting Need & Associated Risks to Independence**	**Eligibility Band***

*** C = Critical S = Substantial M = Moderate L = Low**

Assessor: _____ Date: _____

Principal/
Practice Manager: _____Date: _____