Integrated Assessment, Planning and Review Arrangements for Older People

Guidance for Professionals in supporting the Health, Care and Well-being of Older People

Date: 2 December 2013

Copies in large print/braille are available on request.
socialservicesNSM@wales.gsi.gov.uk

1. INTRODUCTION

The Welsh Government aims to transform health and social care outcomes for the citizens of Wales by ensuring that people themselves are at the centre of decisions about their health, care and well-being, and they remain in control and enabled at all times to maintain this well-being.

This means building on the strengths people have, and their networks and community contacts, in order to promote independence. It means the relationship between professionals and people who use public services must shift in order to secure the very best outcomes for people. It means recognising that many people can only communicate their care needs effectively through the medium of Welsh. For many Welsh speakers, being able to use one's own language has to be seen as a core component of care, not an optional extra.

The Welsh Government's vision is for primary, community and well-being services that are reliable and accessible, and help people to improve their lives- to help them when they are vulnerable and to support them to maintain their independence and to remain safely in their home wherever possible.

The vision requires bold changes in services to better promote people's well-being and reduce inappropriate admissions to hospital, nursing and care homes. This can be achieved through an integrated system of community support, early intervention, re-ablement and intermediate care. A common understanding and application of the assessment of need, and the ability to identify and assess the impact of those factors which promote independence for individuals, is essential at a local level.

These changes must help citizens to build confidence in their ability to manage their own care through improved information, knowledge, and support, and ensure that real choice and control over their services is available to those who do need help.

The Welsh Government has set out its requirements for integrated health and social care in *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs*[1] and this guidance, which sets out a process for delivering integrated assessment processes, is a key part of implementing the overall framework. This guidance replaces the Unified Assessment Process (UAP) in its application to people aged 65 years and over

Partners across the sector recognise the need to place high quality primary and community care and well-being at the heart of support for citizens and rebalance care between acute hospital and community settings. This requires a whole system change. The Social Services and Well-being (Wales) Bill will take this forward by placing greater emphasis on the role of local authorities and Local Health Boards (LHBs) in supporting the well-being of their populations. The Bill strengthens the duties on these bodies to

[1] http://wales.gov.uk/consultations/healthsocialcare/integration/?lang=en – subject to public consultation 22 July – 31 October 2013.

work together in the planning, design and delivery of services, and developing integrated primary, community and well-being services that are focussed on the holistic needs of people.

Underpinning these changes is the need for more effective integrated assessment, care and support planning and review arrangements that are used and understood by all professionals in their work with individuals. Improving these arrangements locally, and getting greater consistency of practice across Wales now will help drive better co-ordinated practice across primary, secondary, acute and community care to provide the right care, at the right time, in the right place.

This guidance requires health and local government in Wales, working with their communities and third sector partners, to ensure they have integrated well-being, assessment, care and support planning and review arrangements **specifically to support older people**, which will support the wider agenda and be the catalyst to support the broader integration of care.

The approach is one that focuses on people's needs and capacities, and the outcomes they seek to enable them to maximise their independence and well-being.

We expect the implementation of these arrangements will have a positive impact on the key indicators and data available on carers that the Welsh Government will monitor in respect of the *Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs.*

By implementing this guidance it is intended that local partners will:

- Work in partnership with individuals, service users, patients and their carers to secure the best and most cost-effective way to meet their needs
- Offer seamless care and support which meets people's needs
- Speed up the pace at which professionals can respond to people's needs
- Simplify the assessment and care management process

2. PURPOSE OF THIS GUIDANCE

2.1 This guidance sets out the responsibilities of health and social care professionals in supporting people who are aged 65 years and over to improve their health care and well-being. It builds on and compliments the *Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* published for consultation by the Welsh Government in July 2013. This guidance replaces the Unified Assessment Process in its application to people aged 65 years and over

2.2 This guidance is about working in partnership with people and their carers to build on their strengths and understand their needs in order to enable them to maintain their independence and well-being.

2.3 This guidance supports people's right to have respectful conversations about their well-being, and to exercise a strong voice and control in decisions about their care.

2.4 This guidance aims to simplify and minimise administrative burdens so people get better services and better outcomes. Professionals will be able to spend more time working directly with people to better understand their needs and act earlier in helping them.

2.5 This guidance supports professionals to exercise their professional judgement working in partnership with people to agree solutions that are in the best interest of the individual.

2.6 This guidance will drive integrated practice and will shape relationships between professionals, and between professionals and the individuals they support. It will lead to improved outcomes for individuals; a motivated workforce and raise public confidence in their dealing with health and social care professionals.

2.7 This guidance is a critical element in the successful implementation of *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs.*

3. SCOPE OF THIS GUIDANCE

3.1 This guidance covers the duties and functions on local authorities and Local Health Boards (LHBs) to promote the well-being, assessment, care and support planning and review arrangements for services for people aged 65 and over. This is irrespective of presenting need, disability or condition and supports access to care and support in the community. This guidance is to apply in any situation where an older person needs help from the NHS or a local authority to:

- Maintain or promote their well-being;
- Regain or maintain their independence;
- Be discharged from hospital;
- Return or continue to live in their own home;
- Secure appropriate residential or nursing care;
- Help protect them from abuse and neglect; and
- Help them manage continuing health conditions.

3.2 This guidance applies specifically to promoting well-being, assessment, care and support planning and review for older people who need support from any health or care professional, and for the following range of services provided by local authorities, the NHS and the independent sector:

- Services to help people avoid the need for hospital care or to help recover in the community, commonly called re-ablement services;
- Other health services such as hospital care, continuing health care support, equipment, secondary mental health support, nursing care;
- Social care services such as domiciliary care, equipment, telecare and telehealth, day care, residential care;
- Community health services such as General Practice, district nursing, continence, optometry, dental, and physiotherapy; and
- Services in the community to support older people's well-being such as transport, leisure and housing support.

3.3 For completeness throughout this guidance the term ***care and support*** has been adopted and is taken to include; health care and support, social care and support or both health and social care and/or support.

3.4 References in this guidance to LHBs should be read as applying to all Local Health Boards in Wales and Velindre NHS Trust.

3.5 This guidance is issued under sections 7 (1) of the Local Authority Social Services Act 1970 and sections 1 & 2 of the National Health Service (Wales) Act 2006. Local authorities are required to act under this guidance in exercising their social services functions.

3.6 LHBs and local authorities are reminded of their duties under section 82 of the NHS (Wales) Act 2006 to co-operate with one another in order to secure and advance the health and welfare of the people of Wales.

3.7 LHBs and local authorities are also reminded of their powers under section 33 of the NHS (Wales) Act 2006 to enter into partnership arrangements which enable them to delegate functions to each other as part of the integrated assessment arrangements.

3.8 Annexes A-J in this guidance offer resources on which professionals can draw, and these provide evidence-based sources which give a steer on good practice. Local authorities and LHBs will be able to use these resources and add to these to provide locally specific materials. Annex B is an example leaflet explaining the arrangements to citizens. Local authorities and LHBs should use Annex B as a template to create versions specific to the needs of their local population.

3.9 For people under 65 years of age the Unified Assessment Process (UAP) continues to apply. However local partners may wish to draw on the principles of this guidance in their application of the process of the assessment of care needs for all adults, in particular with respect to the broader application of promoting well-being.

3.10 This guidance replaces **(only in its application to people who are aged 65 and over)** *Creating a Unified and Fair System of Accessing and Managing Care*[2] (FACS) or the 'Unified Assessment Process (UAP)'. The eligibility criteria decision guide that was set out in Chapter 5 of that document has been incorporated into this guidance and is detailed at Annex G. This has not changed from that given in FACS and must be used by local authorities and LHBs where appropriate. Similarly the Continuing NHS Health Care Decision Tool[3] remains applicable. The requirement to provide 'monitoring/PI information' remains for both local authorities and LHBs.

3.11 This guidance must be considered along with key statutory provisions and guidance including:

- *Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010*[4]
- *Wales Interim Policy and Procedure for the Protection of Vulnerable Adults from Abuse* (January 2013)[5]
- *Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) 2011*[6]

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[2] http://wales.gov.uk/about/foi/publications-catalogue/circular/circulars2002/NAFWC09a2002?lang=en

[3] Welsh Government, Circular: 015/2010, ***Continuing NHS Healthcare, The National Framework for Implementation in Wales***, May 2010 http://wales.gov.uk/docs/dhss/publications/100614chcframeworken.pdf
Continuing NHS Healthcare (CHC) Framework, which includes the Decision Support Tool, will be revised in 2014.

[4] http://www.assemblywales.org/bus-home/bus-business-fourth-assembly-laid-docs.htm?act=dis&id=232786&ds=4/2012

[5] http://www.ssiacymru.org.uk/home.php?page_id=8297

- Mental Capacity Act 2005 – Code of Practice 2007[7]
- Fundamentals of Care – Guidance for Health and Social Care staff (2003)[8]

3.12 This guidance specifies the requirements on local authorities and LHBs in facilitating the individual to move through this pathway, and comprises statements about the statutory requirements on local authorities and LHBs in:

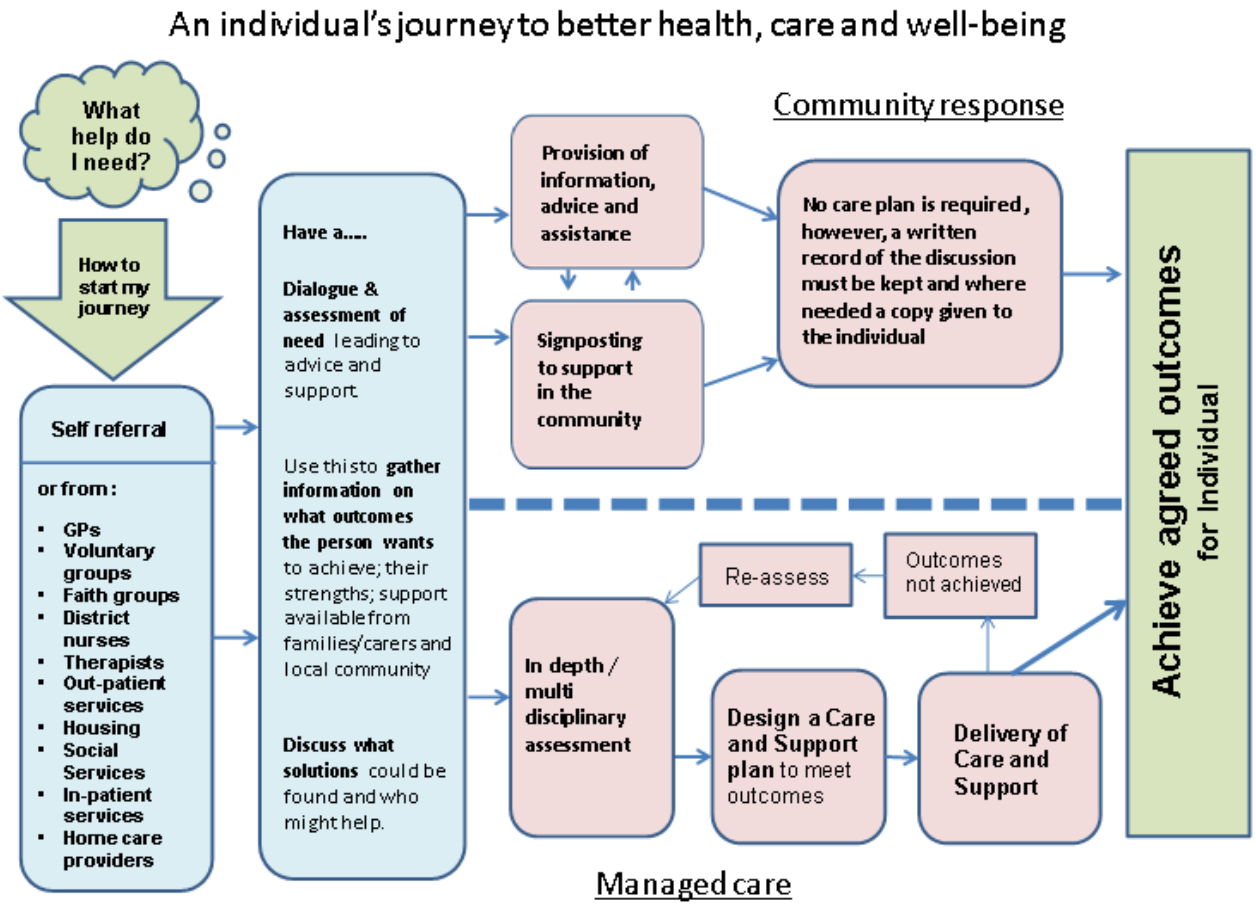
- Promoting well-being;
- Care and support assessment;
- Care and support planning; and
- Care and support review.

3.13 Professionals must apply this guidance in supporting an individual's journey through the well-being, care and support pathway, ensuring that older people, their families and carers are enabled to:

- Communicate with an appropriate person to get help, advice and support to maintain or promote their well-being;
- Get a care and support assessment from the right NHS or local authority professional;
- Take part in an assessment which will consider the individual's needs, capacity and resources, desired outcomes and eligibility for services, and help them to complete a care and support plan to address those needs (where appropriate);
- Access help to arrange or secure services/community support agreed in the care and support plan (where appropriate); and
- Take part in a timely review of their care and support plan (where appropriate).

Diagram 1 illustrates an individual's journey through the well-being, care and support pathway which is at the heart of this guidance.

[6] http://wales.gov.uk/topics/health/publications/socialcare/guidance1/directpayments/?lang=en
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf
[8] http://www.wales.nhs.uk/documents/booklet-e.pdf



3.14 Annexes A-J set out further information, sources of evidence and examples of good practice. Local authorities and LHBs may wish to draw on these resources to help them develop their own local arrangements.

4. GUIDING STATEMENTS

4.1 The statements below are ones which health and social care professionals should apply when exercising their functions under this guidance to promote an individual's well-being.

- **Citizen centred**
  A person's views and wishes should shape the assessment and care and support planning process. The person themselves must be enabled and supported to have a strong voice and control in the whole process.

- **Promote well-being**
  The process must build on people's strengths and abilities and enable them to maintain an appropriate level of independence with the appropriate level of care and support.

- **Outcome based**
  The assessment and care and support planning process must be based on an analysis of key factors: strengths and abilities; needs; desired outcomes; and the capacity and resources an individual has available to them.

- **Involving carers**
  Assessment and care and support planning arrangements must require professionals to recognise the contribution of the carer and to assess for appropriate support to them when required.

- **Proportionate**
  The depth and detail of the assessment and care and support planning process should be proportionate to the individual's needs.

- **Language and communication are matters of need**
  The person must be able to fully participate in their assessment and care and support planning process by being able to express their needs and outcomes through their preferred language and means of communication.

- **Clear**
  The assessment and care and support planning process should be simple, safe for both the person and professional and based on the issues that the person wishes to discuss.

- **Safeguards**
  Professionals should always be alert to any risk or harm to the person (to themselves or others). The assessment and care and support planning process should explore the possible responses to those risks and agree approaches to risk management and/or mitigation.

- **Integrated**
  Assessment and care and support planning arrangements need to be consistent and common across health and social care services, and jointly owned and operated by health and social care professionals, in order to ensure that older people receive timely and effective access to safe care and support.

- **Distinct**
  Assessment and care and support planning arrangements should ensure that the completion of an assessment is not dependent on resource allocation or an individual's financial circumstances.

- **Informed**
  Arrangements should ensure that information about a person is shared between relevant agencies wherever possible and agreed by the individual, and be of a depth and detail proportionate to the person's needs.

- **Shared and Specialist**
  Assessment and care and support planning arrangements must ensure that specialist assessment tools and processes are used where appropriate, whilst retaining the principles detailed above.

- **Accessible**
  Assessment and care and support planning arrangements must ensure that a person's records use common and consistent language and be jargon free. They must record people's language need and preference.

- **Equality**
  Arrangements must ensure that assessments and care and support planning provide equality of opportunity for all older people to achieve an optimal level of well-being, and respect diversity of need and resources.

5. PROMOTING WELL-BEING

5.1 Promoting people's well-being is a key aspect of the change needed in the model of care in Wales. This includes the shift from dependency to partnership and from acute and substitute care to early intervention and support. To achieve this there is a collective responsibility on all public agencies to deliver effective joined-up well-being services, and to help individuals connect to their natural communities. A goal of promoting well-being is to make better use of support in the community so fewer people need to become reliant on more intensive support. The vital contribution of broader, evidence-based 'well-being services' is central to effective support for all individuals. There is also an expectation on people that, wherever possible, they exercise their responsibilities for promoting their own well-being and independence, and for choosing and controlling the support they need.

5.2 A key element of this agenda is that citizens should have direct and easy access to informed, respectful conversations at key points when they need advice, information and assistance.

Requirements

5.3 Local authorities and LHBs are expected to work together to develop and introduce common arrangements to enable an older person in the community, residential care or hospital to get advice and information from professionals to help them promote their well-being. This help should not be limited to the specific area of expertise of the professional. The arrangements must ensure that:

- Individuals, and those who care for them, have a strong voice in deciding how they can be supported. In general, an individual is best placed to make judgements about their own well-being, and the role of the professional is to advise and inform them.

- Social and health care services provided for older people promote maximum independence and support community integration. A common understanding of needs assessment, and the ability to identify and assess the impact of those factors which promote independence for individuals, is essential. Critical to this is the extent to which the older person is able to exercise control over their day to day life. This understanding should inform any decisions about the advice, help or services that are to be provided.

- Any professional in the local community is able to have an informed, respectful conversation with an individual about how they can get appropriate well-being support, and in doing so they should consider the following areas of enquiry (see Annex A & F for further information):

    - Physical and mental health, and emotional well-being;
    - Protection from abuse and neglect;

- Education, training and recreation;
- Domestic, family and personal relationships;
- Contribution made to society;
- Securing rights and entitlements; and
- Social and economic well-being.

- A professional's response is proportionate to the request for help and the urgency of the person's need. It helps the individual to consider what outcomes are important to them, what they need to change, and what plan is needed to achieve their desired outcomes.

- Having an informed respectful conversation and informing an individual about how to promote their well-being does not inevitably require the completion of a formal assessment form, but the local authority or LHB must keep a record of the conversation/enquiry including a record of the advice given or the outcome of the contact. Contact records will be of particular value where an older person's engagement with local authorities and LHBs, although not necessarily complex, may take place over a sustained period of time. Box 1 in Annex A provides advice on recording well-being advice or information.

- Through advice and information professionals promote access to preventative services available in the community without necessarily having to rely on complex assessment and formal care packages.

- A professional who advises and informs an individual is alert to risks to the individual or others, and helps the individual and their family and community to manage those risks.

- Systems, forms, recording procedures and practices are consistent between the local authorities and the LHB in the local area.

- The local authorities and their LHB jointly specify those assigned or delegated professionals in the local area who are able to advise and inform individuals.

- Local authorities and their LHB are expected to work together to develop common guidance to assigned or delegated professionals about good practice in responding to the well-being needs of individuals (see Annexes A, B and C).

- *'More than Just Words' The Strategic Framework for Welsh Language Services in Health, Social Services and Social Care*[9] should underpin these arrangements.

[9] http://wales.gov.uk/topics/health/publications/health/guidance/words/?lang=en

6. CARE AND SUPPORT ASSESSMENT

6.1 Where an individual may need help from health or social care services, they are entitled to an assessment for care and support. The purpose of a care and support assessment is to work with a citizen to understand their needs, capacity and resources and the outcomes they wish to achieve, and then to identify how they can best be supported to achieve them. At the core of this is a conversation about how to enable and support independence by maximising people's control over their day to day lives.

6.2 Effective assessments are valuable experiences in themselves as well as being the catalyst for helping someone get the care and support they need. They should help an individual gain a better understanding of what they could do, identify the most appropriate approach to addressing their particular circumstance, and reach an agreed shared plan for how they will achieve their outcomes.

6.3 Good assessments should also ensure that information relevant to the individual is correct, consistent and shared, and that the process as a whole is well co-ordinated and proportionate to the individual's need (see Chapter 7 and Annex D)

6.4 The assessment should be jointly owned by the individual and the professional, and the experience should encourage the individual to exercise choice, control and to maintain their independence.

6.5 It is important that statutory agencies recognise the role played by unpaid carers in supporting the independence of older people and promoting their well-being. It is vitally important that these unpaid carers are themselves supported and are not disadvantaged as a result of caring. Practitioners must always tell carers who are identified during a cared for person's assessment, or at a later stage, that they have the right to request a carer's assessment.[10]

6.6 In undertaking an assessment local authorities and LHBs will need to consider whether or not the person whose needs are being assessed would benefit from the presence of a carer, friend or advocate. Carers and cared for older people may wish for their needs to be assessed together. However both should be offered an opportunity to talk separately and it may be that some of the assessment of their needs may have to be done separately.

Requirements for all assessments

[10] The Carers (Equal Opportunities) Act 2004 places a duty on local authorities to inform carers of their right to an assessment. Practitioners should also refer to the Carers and Disabled Children Act 2000, and the Practitioners Guide to Carers' Assessment (National Assembly for Wales, 2001).

6.7 Local authorities and LHBs are expected to work together to develop and introduce arrangements for appropriate health and social care professionals (who have authority to undertake assessments assigned or delegated to them under local agreement) to work with an older person, and those who care for them, to complete an assessment of their needs, resources and desired outcomes. This applies to older people in the community, residential care or hospital. This includes those who may have a need for hospital discharge, re-ablement support or wider health or social care support.

6.8 The local arrangements will include agreed templates for assessment which can be completed by a social worker, nurse, therapist or anyone else assigned or delegated to undertake an assessment by the local authority or LHB. This assessment will capture the outcomes identified as being important to the individual together with their assessed needs and resources.

6.9 This assessment document together with the referral form should also capture the core data set requirements referred to later. It will be up to the LHB and its partner local authorities to design the assessment which will follow or facilitate the conversation between the professional and the individual. This integrated assessment tool may need to include a professional or specialist assessment - such as occupational therapy, speech and language, or an assessment of mental health needs, (see Diagram 2)

6.10 The arrangements must ensure that:

- An individual and those who care for them are able to fully participate by being able to express themselves through their preferred language and means of communication: e.g. British Sign Language (BSL), Makaton etc. The contribution of a specialist who can communicate directly with the older person is important to completing effective assessments. However, where professionals cannot communicate directly in with the older person, interpreters should be used and professionals will need to consider the most appropriate source for this assistance.

- An assessment is proportionate to the request for help. It is timely and appropriate to the urgency of the individual's needs;

- An assessment involves a balanced analysis of the individual's needs, their resources and capacities and the outcomes they want to achieve, and should consider the following areas of enquiry (see Annexes A and F):
    - Physical and mental health and emotional well-being;
    - Protection from abuse and neglect;
    - Education, training and recreation;
    - Domestic, family and personal relationships;
    - Contribution made to society;
    - Securing rights and entitlements; and

- Social and economic well-being.

It is for the professional with the individual to judge which areas of enquiry are relevant in any specific situation.

- An assessment promotes access to preventative services available in the community without inevitably having to rely on complex assessment and formal care packages;

- A professional who assesses the needs of an individual ensures that the individual is protected from abuse and harm. They consider any risks to the individual or to others, and help the individual, and their family and community, to manage those risks;

- An assessment takes account of an individual's mental capacity and makes the necessary arrangements to ensure that where this is impaired, their needs and wishes are understood and taken into account. The underlying philosophy of the Mental Capacity Act 2005 (Annex H) is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decisions made, or action taken on their behalf is made in their best interests;

- The completed assessment is owned by both the individual (and their representative) and the agencies involved in completing it. A copy of the assessment is given to the individual or their representative;

- The individual must be asked to consent to information collected for the purposes of the assessment being shared between the local authority and the LHB. It must be clearly explained to the individual who will have access to their details, and what will happen as a result of that.

- The assessment data should only be shared with those with a need to know, and with those organisations that the individual would expect to receive the information in order to identify the well-being care and support needs of an individual.

- Where no specialist service is needed or a person's issue is resolved during the assessment period (for example as a result of a period of re-ablement or rehabilitation) the individual is entitled to written confirmation of the discussion and actions agreed. The arrangements for the method of transmission of this record should be determined locally, with a focus on meeting the individual's requirements.

Data requirements for all assessments

6.11 A national minimum core data set is needed to ensure that individuals can rely on their local agencies to undertake assessments in a consistent way and to provide uniformity and coherence across documents. This will mean that individuals do not have to repeat the same details many times, and that professionals in local areas are able to share a common data set as the basis for well co-ordinated services. The information collected needs to be jointly owned by the citizen and by the agencies involved.

6.12 Local authorities, LHBs and Velindre NHS Trust are expected to work together to ensure that, by April 2014, a common local template which meets the national minimum core data set (Box A, see next page) is used by all partners in the local area. The format for collecting the national minimum core data set must be consistent across all agencies providing care and support services working within the LHB footprint. An example template covering the national minimum core data set requirements is provided at Annex E.

6.13 Agencies should aim to complete the assessment process without undue delay and should not allow difficulties in collecting information for the core data set to delay getting the right help to the older person. For example, where there is urgent need, professionals may collect basic details, undertake an assessment to address the presenting need, and then return to complete the core data set.

Box A - National Minimum Core Data Set

Citizen's NHS Number
Citizen's Title
Citizen's Surname
Citizen's Forename(s)
Preferred Name
Current Address and Postcode
Permanent Address and Postcode
Date of Birth
Home Telephone Number (landline)
Mobile Telephone Number
Email Address

Sex
Marital Status
Religion
Ethnic Group
Occupation
First Language
Preferred Language
Interpreter Required
Method of Communication

GP Surgery Name
GP Surgery Address
GP Telephone number
GP Fax Number

Significant Health Conditions

Any Known Allergies?
Allergy to What?
Type of Reaction
Action Needed

Name of Next of Kin/First Contact
Relationship to Citizen
Contact details for Next of Kin/First Contact

Name of Main Carer
Relationship to Citizen
Contact Details for Main Carer
Does citizen's carer have other caring responsibilities?
Is citizen's carer a child?

Does the citizen live alone?
Does the citizen have dependents?
Is the citizen a parent/carer with responsibilities for children/others?
Does the citizen's condition directly affect the care of other?

Type of Accommodation
Accommodation Facilities

Are there any environment/lone worker risks?

Does citizen have a Care Co-Ordinator?
Contact details of Care Co-Ordinator

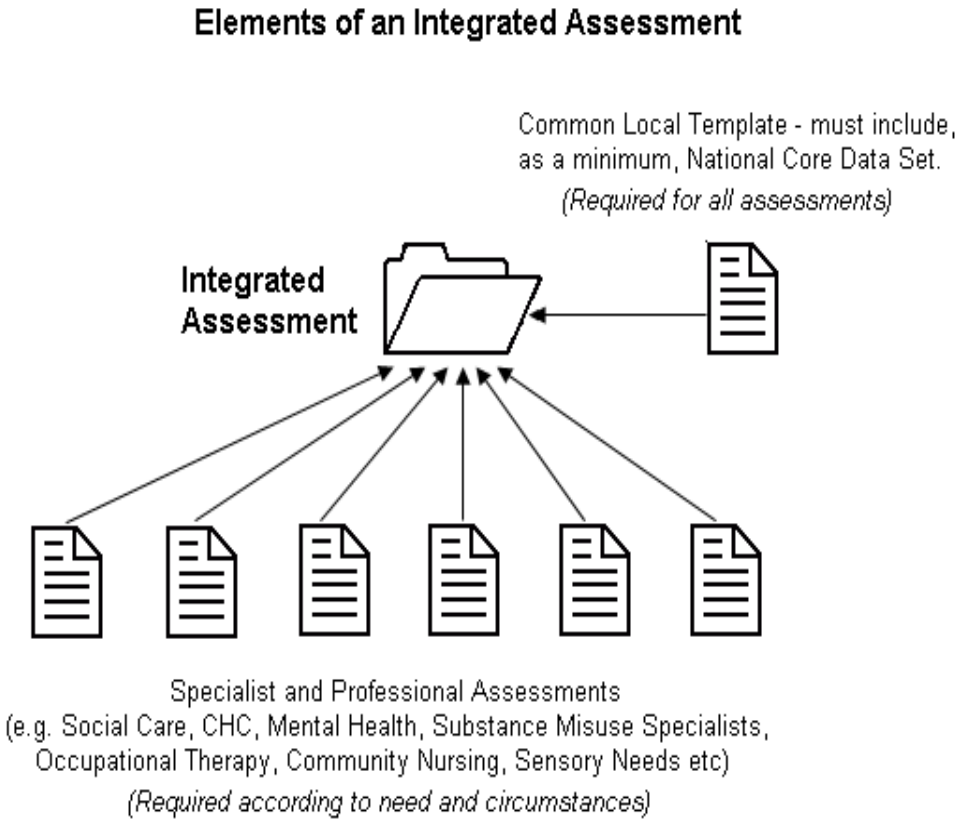
Information taken by (name)
Designation
Organisation
Date Time

6.14 The local template containing the information from the national minimum core data set will be used by all partners for all assessments and a copy will be given to the individual whose needs are being assessed.

- A simple assessment may **only** require use of the common local template.

- Where a more complex assessment is required then, supporting that core assessment data, an assessment of care and support needs may comprise a compendium of one or more professional assessments each from within a particular professional discipline and designed to suit the specific assessment task of that professional discipline. These elements together (core data and specialist assessment) will form the integrated assessment of need.

Diagram 2 illustrates this:



6.15 This guidance requires that:

- The national minimum core data set applies to all health and social care assessments of needs including Continuing NHS Health Care, hospital discharge, support for long-term conditions and mental health assessments.

The information requirements are consistent with other national guidance in these areas.[11]

- The national minimum core data set is used as the basis to start all other professional and service assessments undertaken with the individual.

- Protocols and systems in place will ensure that the national minimum core data set for an individual is shared, kept up to date and that the most up to date version of the information is maintained as the record (See Annex D).

- The core data relating to an individual is stored in such a way as to be able to be portable should the person move to another LHB or local authority area.

- The information in the core data set is not static and will change over time. Local arrangements for version control must ensure the information in the core data set remains accurate and accessible to all agencies providing care and support services, including information and advice services, across the LHB footprint.

6.16 Referrals for support from GPs

- For many people GPs are the first point of contact with health and well-being services and have a key role in referring people to social services or to other health professionals.

- Local authorities and LHBs must ensure that GPs are informed about well-being, care and support services in their community and have access to local information relevant to patients in their community to ensure that referrals are appropriate.

- GPs have established patient referral arrangements under the Welsh Clinical Communications Gateway (WCCG). This guidance requires that GPs expand the WCCG form as described in Box B (below) and use that expanded form[12] when referring a patient for assessment by: social services; primary care and others agencies / professions within the LHB and local authority areas.

[11] Welsh Government, Free to Lead, Free to Care - Core Nursing Adult Documentation Data Set Standard Version 5, December 2012

[12] If the WCCG form is disabled or not available, the standard reference proforma used for secondary care referrals should be used (which should include the same requirements as the WCCG form)

Box B – Welsh Clinical Communications Gateway referral

- GP referrals for care and support assessments must comply with the Welsh Clinical Gateway standards.

- Within the WCCG form, GPs are also required to set out:
  - reason for referral
  - patient history (any carers)
  - indication of the outcome the patient would like to see

Additional requirements for complex care and support assessments

6.17 Early identification of complex needs using approved tools and techniques such as *Passing the Baton*[13] supports more effective care planning, reduces the risk of delays and dependency and maximises independence. This is particularly important in improving patient flow on discharge planning from hospital as is the early decision about a person's eligibility of continuing health care or other support from local authority funded care under FACS eligibility criteria (see Annex G) the eligibility decision criteria set out in Annex G. The Continuing NHS Health Care eligibility process (at Annex I)[14] sets out steps that professionals must follow in determining if the citizen is entitled to continuing health care. It is anticipated that the information gathered through the Integrated Assessment, will read across to the domains of the Decision Support Tool. Where additional evidence is required under a Decision Support Tool domain, further specialist assessment may be sought as illustrated above.

6.18 Local authorities and LHBs are expected to work together to ensure that for assessments with people with complex needs there is an on-going care and support plan or a multi-agency response. This will include that:

- A named lead professional is appointed to co-ordinate the assessment process.

- This lead professional manages the assessment process, and draws in additional specialists as required; to act as a focus for communication for different professionals and the individual to make sure that information is recorded correctly and that the national minimum core data set is made

[13] http://www.wales.nhs.uk/sitesplus/829/page/36467

[14] The Discharge Process Map is an illustration of the expectations regarding assessment for longer-term care. It was developed by task groups looking at both the flow through secondary (hospital) care and the process for determining eligibility for Continuing NHS Healthcare. Further detailed work is being progressed to address the practicalities of implementation.

available to the individual; and to ensure that any problems or difficulties in the co-ordination or completion of an assessment are resolved.

- Professional and service specific /specialist assessments are used as appropriate in addition to the national core data to complete an assessment.

- In cases where the care and support plan identifies health or social care services which may require a financial contribution from the individual, arrangements must be made to ensure that the individual is clear about this. Local Authorities must apply the eligibility criteria set out in Annex G, and where appropriate undertake a financial assessment of the individual using statutory guidance on charging for residential care[15] or non-residential services as required[16]. The Continuing NHS Health Care eligibility process must also be applied where appropriate.

- Where the individual might be most appropriately supported through the provision of a direct payment, the system, entitlements and options are made clear and the individual is able to make an informed choice.

- Where the individual might best be supported through a continuing NHS health care arrangement, then the system, their entitlements and options are made clear, and the individual is able to make an informed choice.

- Local authorities and LHBs seek to reach agreement on any circumstances where a commitment is required to complete assessments within a given timescale and publish that commitment.

- The completion of an assessment does not inevitably need to lead to a care and support plan. It must depend on the result of the assessment, the application of relevant eligibility criteria and whether it is agreed that services cannot be delivered without a care plan or where the service can be delivered without a care plan but the individual needs on-going support to access these services.

[15] *Charging for Residential Accommodation Guide (CRAG) April 2012*
http://wales.gov.uk/topics/health/publications/socialcare/guidance1/accomodation12/?lang=en
[16] *Introducing More Consistency in Local Authorities' Charging for Non-Residential Social Services (April 2011)*
http://wales.gov.uk/topics/health/publications/socialcare/guidance1/consistency/?lang=en

7. CARE AND SUPPORT PLANNING

7.1 Many people's needs can be met without a care and support plan. However, where it is agreed that services cannot be delivered without a plan, or the individual needs on-going support to access these services, care and support plans should be created.

7.2 Care and support plans are about bringing together the individual, their carers and professionals to agree how their assessed needs can best met, the actions needed and who will be responsible for them.

7.3 Care and support planning is a dynamic process. An effective care and support plan will identify the individual's intended outcomes and work out the best way to help achieve them.

7.4 The analysis, judgement and decisions made by the individual, with support from professionals, their family and carers will form the basis of a care and support plan. The complexity or severity of the individual's need will determine the scope and detail of the care and support plan and the range of interventions, including the type of support; charges for the support; and the frequency of reviews.

7.5 A good care and support plan is outcome based, not exclusively task orientated, and supports both a person-centred and outcome based approach. A good care and support plan describes strategies and/or responses to eliminate, prevent or minimise risks to safety and to independence. The plan must be jointly owned by the individual and the agencies involved in supporting them.

Requirements

7.6 Local authorities and LHBs are expected to work together to develop and introduce arrangements for assigning or delegating health and social care professionals to work with an older person in the community, residential care or hospital, whose needs require a care and support plan, to create and implement one.

7.7 The arrangements must ensure that:

- A care and support plan is created when the assessment identifies that services cannot be delivered without a care plan or where the service can be delivered without a care plan but the individual needs on-going support to access these services.

- It is the responsibility of the professional who has developed the plan with the individual to ensure there is a clear and concise confirmation of the conversations, agreed actions, and who will undertake them within the plan.

- The format of the care and support plan must be agreed by the local authorities and their LHB and be consistent across the local area. As a minimum, plans should cover the areas outlined in Box C. However local authorities and LHBs must have regard to the prescribed content of the care and treatment plan for people who are eligible to secondary mental health services[17].

Box C – describes what must be contained within a care and support plan:

Plans and actions to be undertaken to help achieve the desired outcomes;

The roles and responsibilities of the individual, carers and family members, and practitioners (including for example GP, nurse), and the frequency of contact with those;

The resources (including financial resources) required from each party; and

The review and contingency arrangements and how progress will be measured.

- The plan must make clear who is the lead professional (care and support co-ordinator) with specific responsibility for completing and monitoring the care and support plan, where it is agreed that this is required.

- In cases where there are overlapping duties to prepare care plans that are prescribed; (for example: Part 2 and 3 of the Mental Health Measure (Wales) 2010), professionals must have regard to the requirement of the regulations and Code of Practice but must combine the care arrangements into a single integrated care plan. The format of the care plan must be consistent across all agencies providing care and support services working within the regional LHB footprint.

- In cases where the care and support plan identifies health or social care services which may require a financial contribution from the individual, arrangements must be made to ensure the individual is clear about this, that FACS eligibility criteria (Annex G) or CHC criteria (Annex I) are applied, where appropriate, and that a financial assessment is undertaken.

[17] Section 18 of the Mental Health (Wales) Measure 2010 and associated regulations refer

8. CARE AND SUPPORT PLAN REVIEW AND RE-ASSESSMENT

8.1 The purpose of a review and/or a re-assessment is to systematically revisit the care and support plan and consider how it has helped the individual to achieve their outcomes, re-assess their needs, capacity and resources and desired outcomes, and determine what support is needed in future.

8.2 A review is a key part of effective health and social care, and good arrangements can ensure that services remain appropriate, well targeted and relevant to the individual, and encourage the individual to continue to maintain control over their support.

Requirements

8.3 Local authorities and LHBs are expected to work together to develop and introduce arrangements for assigned or delegated health and social care professionals to work with an older person in the community, residential care or hospital who has a care and support plan. The plan must be reviewed regularly to understand whether the provision of that care and support is meeting the identified needs of the individual, consider if their needs have changed, and if a re-assessment is required. The arrangements must ensure that:

- Care and support plans are regularly reviewed to monitor progress and changes, re-assess needs, resources and capacity, desired outcomes and eligibility, and confirm, amend or end the services involved;

  The individual or their carer or representative (where appropriate) is an active participant in the review;

- At a minimum, there is an initial review within three months of long term services being provided. Thereafter reviews are scheduled at least annually or more often if the individual's circumstances appear to warrant it. Where a person who has been admitted to residential care, the plan is best reviewed after 6-8 weeks of the person moving in;

- The recording of the review follows the format of the assessment and care and support plans;

- For people with complex needs who need the support of secondary mental health services the process of monitoring the implementation of the care and treatment plan includes:

  (i) On-going assessment of the relevant patient's mental health related needs taking into account the nature and degree of need /risk they are currently presenting;

(ii) Ensuring the delivery of the care and treatment specified in the plan; and,

(iii) Checking the outcomes specified within the care and treatment plan continue to be suitable and minimise the risks posed.

8.4 Where it is agreed that services will no longer be provided, the review includes a closure statement covering:

(i) Reasons for closure;

(ii) An evaluation and record of the extent to which the outcomes were achieved; and

(iii) Confirmation that the individual has appropriate information, advice or assistance and/or access to community based preventative services to meet their needs.

9. INFORMATION SHARING

9.1 The willingness and ability to share the Core Data Set for an individual (and any other appropriate and relevant information) between professionals and service providers is inherent to the delivery of effective integrated health and social care services for older people.

9.2 This guidance requires local authorities and LHBs to have protocols and systems in place to ensure that the core data set for an individual is shared between partners. The approach must be to share information and to share it appropriately.

9.3 Organisations should ensure that the arrangements they put in place to share personal information are compliant with the Data Protection Act 1998[18](DPA) and their staff are supported and trained appropriately in both information sharing and compliance with the DPA. Staff accessing or using the data must be trained in good data handling and be aware of security issues.

9.4 Guidance on the principles that organisations should adhere to when sharing personal information are set out in documents such as the Information Commissioner's Office Data Sharing Code of Practice[19] and the Wales Accord on the Sharing of Personal Information (WASPI)[20].

9.5 Below is an extract of the key message from Caldicott 2[21]

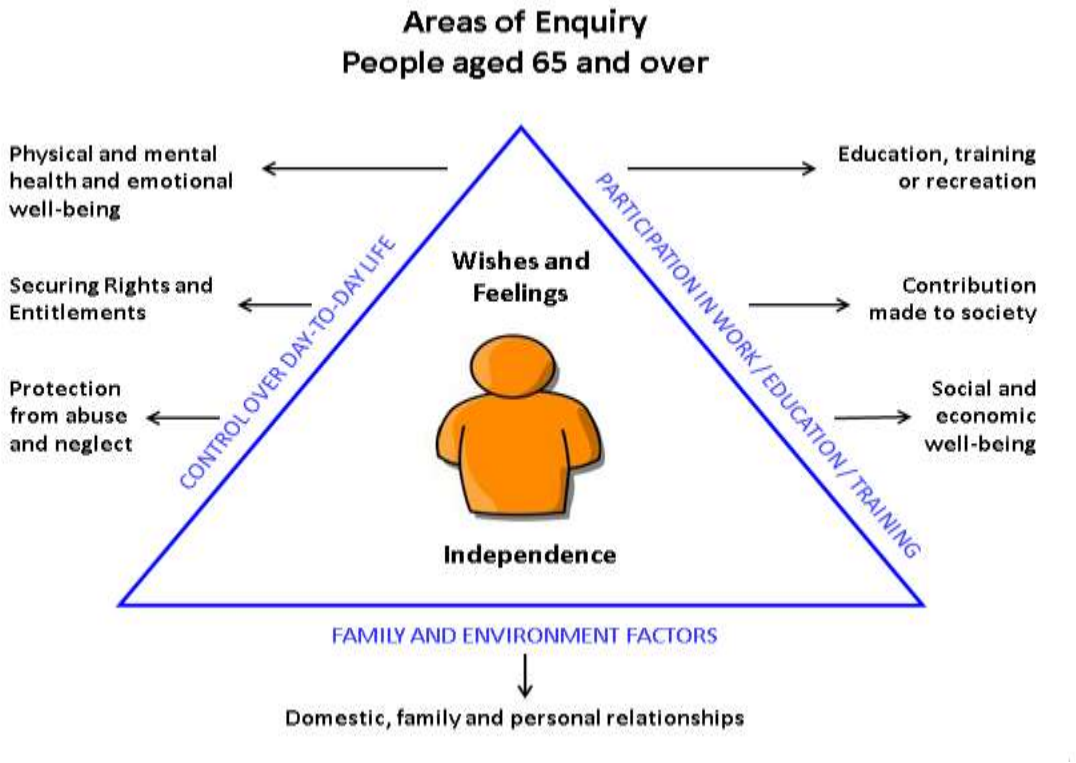
"The constant message from caring and committed staff is that there should be a presumption in favour of sharing for an individual's direct care and that the exceptions should be thoroughly explained, not vice versa. The motto for better care services should be: 'To care appropriately, you must share appropriately'."

9.6 ICT-based solutions to sharing information should make it quicker, easier and safer to share and exchange information. Local authorities and LHBs should identify consistent solutions to help staff share effectively. This may range from shared common systems to controlled use of email and document sharing portals.

[18] http://www.legislation.gov.uk/ukpga/1998/29/contents
[19] http://www.ico.org.uk/for_organisations/data_protection/topic_guides/data_sharing
[20] http://www.waspi.org/
[21] http://www.wales.nhs.uk/sites3/page.cfm?orgid=950&pid=68298

ANNEX A: PROMOTING WELL-BEING

The following description is an example of the way in which well-being might be assessed:



Well-being can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole.

A person-centred assessment starts from the individual's perspective of his/her situation. The assessment should be based on an appreciation of their particular needs and the impact of those needs on their independence.
Central to an individual's independence is his/her:

- Autonomy and freedom to make choices;
- Health
- Freedom from abuse or neglect, and the extent to which any risk of abuse or neglect is mitigated (including taking wider issues of housing and community safety into account)
- Ability to manage personal and other daily routines; and
- Involvement in family and wider community life, including leisure, hobbies, unpaid work, learning and volunteering.

The assessment should begin by exploring the wishes and feelings of the individual to identify what matters to them and what outcomes they want to achieve. The outcomes will be specific to the individual seeking help but may be viewed as relating to one of the seven ‘high-level’ outcomes positioned outside the triangle.

The assessment process should identify the strengths of the individual and of their social and community network, together with the identification of any barriers to achieving those outcomes. These may be identified by consideration of the factors that form the triangle. This information will contribute to identifying areas of enquiry to be pursued in more detail.

The assessment must focus on identifying what capacity the person has, and what support they need, to achieve their desired outcomes by maintaining or developing elements of each of the three factors that affect overall well-being.

It is good practice to enable people to have a period of reflection after an assessment interview. This allows people who may have found it difficult to express their views or wishes to the professional interviewing them, to take time to consider their responses and re-visit the assessment should they wish to do so.

When undertaking an assessment of need, local authorities and LHBs should consider the most suitable environment for the person in which to conduct the assessment and make every reasonable effort to offer the assessment process in that environment.

Local authorities and LHBs should also recognise that the person whose needs are being assessed may want support from a friend or advocate during the assessment, and enable the older person to be supported by them.

There is no national template for how to provide or record well-being advice or information but local arrangements might wish to consider the following example of good practice in **Box 1** below:

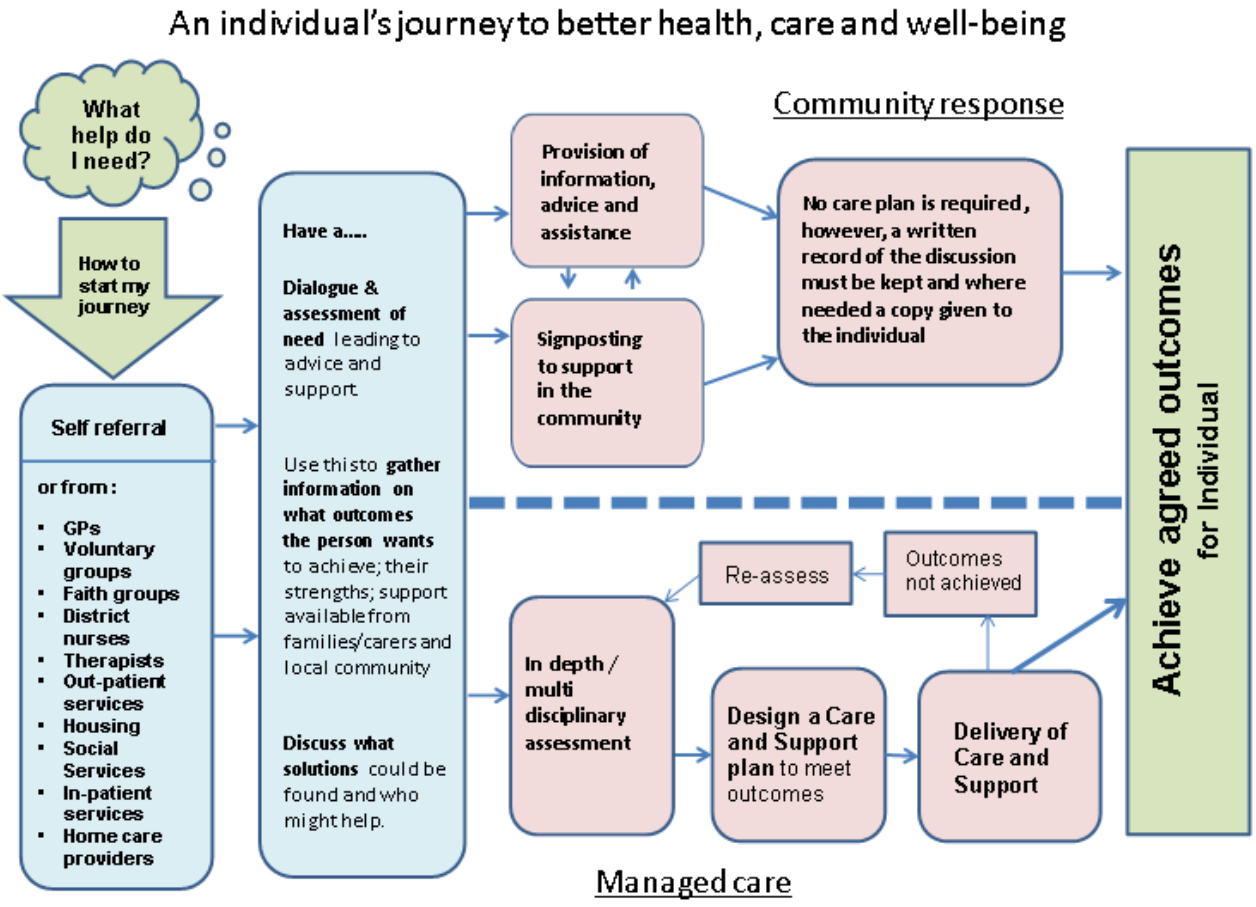
- What matters to you, what are you trying to achieve?
- Is there anything that gets in the way of you achieving that outcome/ what matters to you?
- Can you/we do anything to change that?
- Are there other people/agencies that are currently providing help?
- What (further) support might help? – Where could you/we get this help from?
- Are there other people who would have information that will help us? - What other sources of information could/should be approached?
- What are the care and support agencies with who you have significant contact – what are the contact names, contact details at those agencies?
- As a result of this assessment have any risks been identified (personal, environmental, safeguarding)? Are there further risks/matters of safety not addressed?
- Should a separate carer's assessment be arranged?
- What action have we agreed is needed to achieve your outcomes/meet your needs; who will take these actions; when and how?
- What do you need to do if your situation changes?

ANNEX B: EXEMPLAR CITIZEN'S LEAFLET: *IMPROVING YOUR WELL-BEING*

(Please note this is a standalone document available on the same webpage as this guidance document)

ANNEX C: AN INDIVIDUAL'S JOURNEY TO BETTER HEATH, CARE AND WELL-BEING

The Diagram below is an illustration of the way in which well-being support, assessment and care planning arrangements can be summarised:



An individual who needs help with care and support either for themselves or for someone else (such as a family member) can approach any agency to discuss their difficulties and seek advice, information or assistance. The agency will offer the opportunity for a discussion with an appropriate professional that is proportionate to the individual's needs.

From here the professional may direct the individual towards community based services and preventative services such as the provision of community equipment to help people stay safe and independent in their own homes.

Some individual's needs will warrant a more specific health, social care or multi-disciplinary assessment (often in addition to the provision of information advice and assistance), and in these cases professionals will provide an assessment process proportionate to the extent of the care and support needs being presented.

This may involve a range of professionals from different agencies – often including health working with staff from social services, in which case a care and support co-ordinator will be identified as the central link for professionals with the individual or their family, and to drive forward the completion of the assessment.

The assessment will identify what matters to, and the needs of the individual, their resources and capacity and the outcomes that they wish to achieve. It will then look at what care and support services could contribute to the achievement of those outcomes.

There will be circumstances where the appropriate care and support will need to be arranged and managed through a care and support plan. The needs, outcomes and strengths identified in the assessment should be recorded in the care and support plan alongside the actions or solutions co-produced by the individual, the carer and professional.

The needs of the individual and carer will continue to be monitored and the achievement of the outcomes will be subject to regular review.

ANNEX D: SHARING INFORMATION

Definitions of Consent from Caldicott 2 Report

Definitions of consent

Consent is the approval or agreement for something to happen after consideration. For consent to be legally valid, the individual must be informed, must have the capacity to make the decision in question and must give consent voluntarily. This means individuals should know and understand how their information is to be used and shared (there should be 'no surprises') and they should understand the implications of their decision, particularly where refusing to allow information to be shared is likely to affect the care they receive. This applies to both explicit and implied consent.

Explicit consent

Explicit consent is unmistakeable. It can be given in writing or verbally, or conveyed through another form of communication such as signing. A patient may have capacity to give consent, but may not be able to write or speak. Explicit consent is required when sharing information with staff who are not part of the team caring for the individual[i]. It may also be required for a use other than that for which the information was originally collected, or when sharing is not related to an individual's direct health and social care.

Implied consent

Implied consent is applicable only within the context of direct care of individuals. It refers to instances where the consent of the individual patient can be implied without having to make any positive action, such as giving their verbal agreement for a specific aspect of sharing information to proceed. Examples of the use of implied consent include doctors and nurses sharing personal confidential data during handovers without asking for the patient's consent. Alternatively, a physiotherapist may access the record of a patient who has already accepted a referral before a face-to-face consultation on the basis of implied consent.

ANNEX E: EXAMPLE CORE DATA SET TEMPLATE

The following is an example of a template to capture the core data requires of an individual which might be used and shared by local partners – this complies with the national minimum core data set requirements shown in Box A.

Citizen's Surname:	**Citizen's Forename/s:**	
Preferred Name:		
	Title:	**Date of Birth:**
NHS Number:		
Current address: Postcode:	Home Telephone: Mobile: Email:	
Permanent address (If different): Postcode:	Indicate preferred contact number - *	
Religion:	Ethnic Group:	

Sex: Male ☐ Female ☐ Other ☐ Bungalow ☐ Flat ☐ Residential Home ☐
Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Bath ☐ Bed: Upstairs

Occupation:	
First Language: Preferred Language: Speech/Sign/Other	Interpreter required Yes ☐ No ☐ Method of communication:
GP Surgery Name: Telephone: Fax:	GP Surgery Address:
Significant Health Conditions:	

Any Known Allergies?: Yes ☐ None Known ☐		
Allergy to What?:	Type of Reaction:	Action Needed:
Citizen's Next of Kin/Significant Other		
Name:		Relationship:
Contact details:		

Citizen's Main Carer:	
Name:	Relationship: Age: Gender:
Contact details: *(if different from patient)*	
Does citizen's carer have other caring responsibilities? Yes ☐ No ☐ Specify:	Is citizen's carer a child? Yes ☐ No ☐
Citizen Lives With: Spouse ☐ Alone ☐ Relative ☐ Other ☐ (please specify) Dependents: No ☐ Yes ☐ Specify:	
Is the citizen a Parent/Carer with responsibilities for children/others? Yes ☐ No ☐ Specify:	
Does the citizen's condition directly affect the care of children/relatives/others? Yes ☐ No ☐ Specify:	
Accommodation Type: Rented ☐ Home owner ☐ Tenure: _____ House ☐ Bungalow ☐ Flat ☐ Residential Home ☐ Nursing Home ☐ Sheltered Accommodation ☐ Other ☐ _____	
Accommodation Facilities: Stairs / lift ☐ Number of floors: _____ Bathroom/toilet: Upstairs ☐ Downstairs ☐ Shower ☐ Bath ☐ Bed: Upstairs ☐ Downstairs ☐ Heating: Coal ☐ Oil ☐ Gas ☐ Other ☐ _____ Aids to independent living: e.g. rails Yes ☐ If yes, Specify: _____ No ☐	
Are there any environmental or lone work risks which health or social care workers need to be aware of? Yes ☐ No ☐ If yes, specify:	
Does citizen have a Care Co-ordinator? Yes ☐ No ☐ If yes, state contact details	
Information Taken by (print name):	Date & Time:
Signature:	
Designation:	
Organisation:	

ANNEX F: AIDE MEMOIRE – AREAS OF ENQUIRY

An Individual's Well-being	Well-being Factors	Previous UAP Domains
Promotion of well-being **Must have regard to the individual's views, wishes, and feelings** **Voice and Control**	**Physical and Mental Health and Emotional Well-being**	**Mental Health** • Cognition and dementia including orientation and memory • Mental health including confusion or paranoid states, depression and reactions to loss and other emotional difficulties **Clinical background** • History of medical conditions and diagnosis • History of falls • Medication use and ability to self medicate • Recent hospitalisation • Breathing difficulties **Disease prevention** • History of blood pressure monitoring • Nutrition / current diet, swallowing ability. Fluids • Vaccination history • Drinking and Smoking history • History of screening **Personal care and physical well-being** • Pain • Oral health • Foot care • Skin care Inc. prevention of pressure areas • Mobility in and out of home • Climbing stairs • Continence and other aspects of elimination • Sleeping patterns **Activities of Daily Living** • Washing • Bathing • Showering • Grooming inc hair care and shaving • Dressing • Accessing and using the toilet • Transfer in / out of chair/ bed • Eating and drinking • Ability to make choices and have control over environment

<table>
<tr><th>An Individual's Well-being</th><th>Well-being Factors</th><th>Previous UAP Domains</th></tr>
<tr><td rowspan="7"></td><td></td><td><u>Senses</u>
Sight
Hearing
Smell
Taste
Speech/ communication first / preferred language and understanding
<u>Instrumental activities daily living</u>
Meal and snack preparation
Make a hot drink
Heavy housework (cleaning)
Keeping warm
Shopping
Managing affairs (finances, paperwork)</td></tr>
<tr><td>Safety and Protection from abuse and Neglect</td><td><u>Safety</u>
Abuse and neglect (risk assessment)
Other aspects of personal safety (risk assessment)
Public safety (risk assessment)
Manual handling assessment (risk assessment)</td></tr>
<tr><td>Domestic family and personal relationships</td><td><u>Relationships</u>
Social support and networks e.g. personal relationships and involvement in leisure, hobbies and religious groups
Carer support and strength of carer arrangements
Ability to care for others where necessary e.g. partner
Intimacy/ relationships</td></tr>
<tr><td>Education, training or recreation</td><td><u>Immediate Environment and Resources</u>
Work, education, learning and participating in community activities</td></tr>
<tr><td colspan="2">Contribution made to society</td></tr>
<tr><td colspan="2">Securing Rights and Entitlements</td></tr>
<tr><td>Social and economic well-being</td><td><u>Immediate environment and resources</u>
Accommodation
Level and management of finances and need for benefit advice (risk assessment).
Access to local facilities and services
Transport needs</td></tr>
</table>

ANNEX G: ELIGIBILITY: FAIR ACCESS TO CARE SERVICES

This section sets out how local authorities will make and review decisions on individual eligibility.

This guidance is also relevant to health bodies as

a) Local Authorities at a minimum will need to consult with health partners and ensure the development of the social care eligibility criteria is compatible with the current continuing NHS care criteria.

b) It ensures that health bodies are fully aware of eligibility for social care services.

Local authorities should use this guidance to review and revise their eligibility criteria and related arrangements in consultation with health partners. This guidance may also be used as a starting point for developing integrated eligibility criteria for packages of continuing health and social care.

Eligibility decisions should be made with reference to assessed needs and their impact on independence.

Assessing an individual's problems, circumstances and related risk, is the basis for determining an individual's eligibility. Whilst many people have difficult problems and circumstances, it is only when these have an impact on independence which falls within the banding that the local authority has deemed eligible will it result in the person receiving help.

For some individuals some factors may be more crucial than others and it will be through assessment that the importance of these factors for the individual is identified.

A person-centred assessment starts from the individual's perspective of his/her situation. The assessment should be based on an appreciation of their particular needs and the impact of those needs on their independence.

Central to an individual's independence is his/her:

- Autonomy and freedom to make choices;
- Health
- Freedom from abuse or neglect, and the extent to which any risk of abuse or neglect is mitigated (including taking wider issues of housing and community safety into account)
- Ability to manage personal and other daily routines; and
- Involvement in family and wider community life, including leisure, hobbies, unpaid and paid work, learning, and volunteering.

Eligibility decisions should be made with reference to assessed needs and their impact on independence in both the short and longer-term, were help not to be provided. Local authorities should take a longer term, preventative view of individuals' needs, issues and circumstances.

Combining the extent of risk to the key factors of independence provides the framework of eligibility criteria. The framework has four bands each describing the extent of risk to independence if needs and issues are not addressed. The four bands range from critical and substantial, to moderate and low. It will be for individual local authorities to draw the line of eligibility within the framework according to their local circumstances

Framework for setting the Eligibility Criteria

Local authorities should use the following framework for determining their eligibility criteria. These should be developed in conjunction with statutory health bodies and the framework should assist in the development of unified eligibility criteria over time.

The eligibility framework is constructed by identifying the impact of needs and issues on factors that are judged to be key to maintaining an individual's independence.

Critical – when:

- Life is, or could be, threatened; and/or
- Major physical or mental health problems have developed or are likely to develop; and/or
- There is, or could be, an extensive loss of choice and control over vital aspects of the immediate environment; and/or
- Abuse or neglect (self or other) have occurred or are likely to occur; and/or
- There is, or could be, an inability (physical or mental) to carry out vital personal care, domestic or other routines; and/or
- Vital involvement in work, education or learning is, or could be, at great risk of not being sustained; and/or
- Vital social support systems and relationships cannot or will not be sustained; and/or
- Vital family and social roles and responsibilities cannot or will not be undertaken.

Substantial – when:

- Significant physical or mental health problems have developed or are likely to develop; and/or
- There is, or could be, some significant loss of choice and control over the immediate environment; and/or

• There is, or could be, an inability (physical or mental) to carry out the majority of personal care, domestic or other routines; and/or • Involvement in many aspects of work, education or learning is, or could be, at risk of not being sustained; and/or • The majority of social support systems and relationships are, or could be, at risk; and/or • Individuals cannot undertake, or will be unlikely to be able to undertake, some significant family and social roles and responsibilities that are important to them and others.
Moderate – when: • There is, or could be, some inability (physical or mental) to carry out several domestic or other routines; and/or • Several aspects of work, education or learning are, or could be, at risk of not being sustained; and/or • Several social support systems and relationships are, or could be, at risk; and/or • Individuals cannot undertake, or will be unlikely to be able to undertake, several family and social roles and responsibilities.
Low – when: • There is, or could be, some inability (physical or mental) to carry out one or two domestic or other routines; and/or • Involvement in one or two aspects of work, education or learning cannot or will not be sustained and/or • One or two social support systems and relationships are, or could be, at risk of not being sustained; and/or • Individuals cannot undertake, or will be unlikely to be able to undertake, one or two family and social roles and responsibilities.

ANNEX H - MENTAL CAPACITY ACT 2005

The underlying philosophy of the Mental Capacity Act is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible, and that any decisions made, or actions taken, on their behalf are made in their best interests.

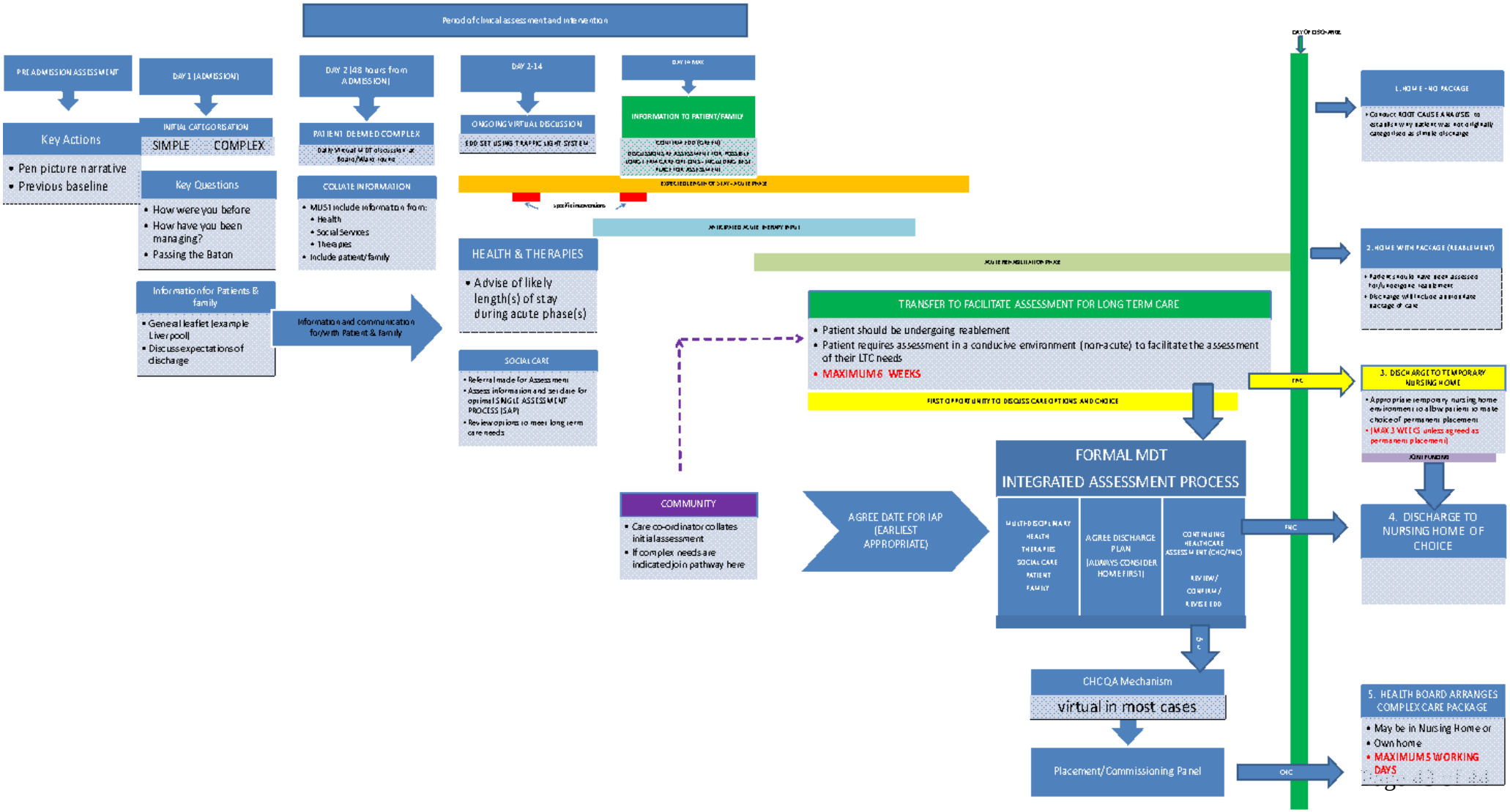
The five key principles in the Act are:

- Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
- A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms

ANNEX I – DISCHARGE PROCESS MAP- Extract from the Continuing NHS Health Care Eligibility Process

This process map supports this guidance and complements the Individual's Journey through the Health, Care and Well-being

DISCHARGE PROCESS MAP



ANNEX J – IMPLEMENTATION CHECKLIST

Local authorities and LHBs will need to embed the implementation of this guidance into the overall implementation of *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs.*

That document provides the overall context and framework for successful integration.

Specifically in relation to the arrangements required in this guidance, LHBs and their partner local authorities will need to consider the following:

- Ensure that the implications of this guidance are fully understood at a strategic and operational level across partners.
- Ensure people aged 65 and over and their carers fully understand these new arrangements; in particular, their right to information and advice about their well-being and care and support; an integrated assessment; ownership of their core data set (referred to in Box A); right to have a copy of the core information and where relevant assessment and a care plan.
- Local systems for monitoring compliance with this guidance
- Local measurement of improved outcomes for people aged 65 and over through the new integrated arrangements to underpin the indicators that the Welsh Government will be monitoring.
- Engage with professions about the best approach to undertaking more creative well-being assessments with individuals.
- Review existing information systems and information sharing protocols and identify improvements needed.
- Develop and implement a common communications strategy to ensure that professionals and citizens understand the arrangements and their roles and rights.
- Undertake a cost-benefit analysis of the plan and review budgets accordingly.
- Ensure new arrangements are accommodated with any national performance or statistical return required by the Welsh Government.
- Ensure this guidance is integral to the local workforce development programme and partnership training plans.
- Involve partners from the third and independent sectors especially with respect to their contribution to the delivery of community based, early intervention, and preventative services.