1. Back to basics

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

The Connected Lives assessment process is based on our practice principles. Professional practice and accountability are core to our work so we are:

- open and personalised in our approach;
- efficient and defensible;
- clear and transparent;
- risk positive;
- reflective;
- consistent; and
- in-line with practice governance.

The process is underpinned by strengths, enablement and independence. What does the person, their family, their friends and neighbours and local community have that can help? We understand and respect that people are all the experts about their own lives and Connected Lives encourages you to allow people to express their own wishes and preferences.

We want to make assessments appropriate and proportionate – so are only as intrusive as necessary. We need to understand from the start why we’re involved, but should also explore and try to understand any underlying needs.

We want our assessments to be timely – taking into account urgent needs but being aware that things can change. This means short term solutions are appropriate for crisis situations but it is usually quite inappropriate to arrange long term solutions in a crisis. We should let people and carers know what our timescales might be – and keep them informed throughout.

We want you to trust your professionalism and skills to understand the person, what needs to happen and why. Doing our assessments this way will make them person-centred, solution-driven, strengths-based and outcome-focused.
2. Before the assessment

Having a clear idea (a good referral) of what the situation is will help focus the assessment – even if during the process other issues arise.

Depending upon the complexity of the case, we can decide how, where and how long an assessment might take. We can send out the pre-assessment booklet and potentially ring the person to let them know the types of questions we may be asking. If people are prepared and know what to expect this can reduce the intrusion and save time.

Some things to think about might include:

**Communication needs:**
- what means of communication are suitable for the person?
- is an interpreter needed?
- is information required in different ways?
- do they need someone to speak up for them?

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

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

3. Facts, analysis and judgement and outcomes

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

**Facts**
This is conversation is about the person and their to carer to find out about them and their current situation. Do ask about what life was like before and what life could be like next.

**Analysis**
Analysis is the art of fully understanding something in order to explain it. This is where the assessment comes to life: this is you making sense of the situation and
using your skills and experience to understand what’s happening and to start to think what we can do about it. What are all the facts telling you?

**Judgement**
Having analysed the facts, you begin to form your professional judgement. This is the situation: these are the strengths, these are the needs, this is what we need to do. We’re now beginning to move towards what outcomes we need to be achieving.

**Outcomes**
This is what the person wants to achieve eg. ‘P wants to get back to work’, ‘P wants to help out with his grandchildren’, ‘P wants to be able to get herself to the loo’

**4. The conversation**

Talking with people, spending time with them, getting to know them means you can together, better understand them, their strengths, their needs and how to meet them.

The conversation can help individuals explain a problem themselves and decide how big a problem it is. This will also help us to appear less intrusive, as we can also avoid areas that service users don’t see as a problem (unless, of course, professionally we disagree and need to explore it).

You as the assessor are the expert on change. The person or carer is the expert on what to change and how best to change it. Our role is to focus on what’s possible and changeable.

During the conversation, you use your observation, questioning and listening skills to find out the relevant information to best understand a person’s current situation.

Your skills, diplomacy, warmth and empathy will help you to find out what you need to know. Your experience and knowledge will suggest things to consider as part of any assessment.

**Assessments are likely to think about the person in terms of:**

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

5. Professional analysis

This is where you can make sense of the situation and understand what has happened/is happening and what are the implications. Your professional knowledge and understanding as well as all that you have come to know about the person will inform your view and analysis. Here, you think creatively about what might be helpful.

The person has strongly influenced the content in “the current situation and where I want to be” section; this is where you have your say. With your professional judgement comes accountability – everything must be underpinned by the practice principles and your professional ethics.

6. Agreeing outcomes

This is the impact or result for the person or the difference it will make for the person. It’s not the service we use to help them. A desired outcome is the way the person wants things to turn out; the impact on their quality of life. Outcomes must be specific and personal rather than vague and generic.

A desired outcome might be

Mrs P would like to get back home and for life to be as much as it was before her fall as possible

7. Care and Support Planning

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

An example of a care and support plan to meet Mrs P’s desired outcome might be

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

8. The three stages of the Connected Lives Assessment

There are three stages to our assessment framework:

• Connect and Prevent
• Connect and Enable
• Connect and Support
The focus is enablement, independence and the use of community opportunities. Wherever possible we want to prevent or reduce the need to provide more long-term services.

9. Connect and Prevent

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

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

- HertsHelp
- Hertfordshire Directory
- local libraries
- the person's, your and your team's local knowledge
- our website and factsheets
- there's always Google!

Once you have agreed what to do – you can record your conversation and plan on ACSIS. You can approve your own assessment (there's no manager authorisation required). You should set a check-back date within four weeks, to see how things are working out but you can stay in touch as much as you need to during this time.

If, following the check-back, the outcomes have been achieved, the case can be closed. Sometimes if the outcomes have not been met this may be ok. If the person has managed or found alternate ways to remain in control you can still close the case. If not, or the needs change before final check-back, you could extend your Prevent period and explore further Prevent options. There are no resources committed at this stage of the assessment. If you need to look at more focused support that may require care or professional intervention, you should move on to Connect and Enable stage.
9. **Connect and Enable**

The information recorded at the Connect and Prevent stage is now pulled through to this stage (so no need for repetition). Connect and Enable is also geared towards helping people meet their outcomes but recognises they may need time-limited professional input (social work or occupational therapy), minor resources, one-off payments or purchases to do so. This stage is aimed at reducing or removing the need for more permanent or costly care.

Enabling people may mean people gain confidence to learn and/or regain some of the skills and independence they may have lost because of poor health, disability or after a spell in hospital. It may be we can support people to develop new skills that they have never had the opportunity to do so before; due to their care environment or perceptions about their disability. This may be particularly relevant to people with learning disabilities who might not have had such opportunity before.

Independence will be different for everyone – it isn’t just independence from care and support, but could be independence to access services that give people better lives. Traditional enablement outcomes such as the ability to use the home safely and get out and about are important, but the quality of life outcomes that make life worth living are just as important – having a purpose to be able to use these skills and independence.

**In order to achieve these outcomes we might look at:**

- up to four weeks’ professional support, for example a number of visits by an occupational therapist to enable confidence in completing tasks required in and around the home
- commissioned services to enable agreed outcomes to achieved over set time period
- a one off direct payment
- equipment or
- crisis response

Provided the one-off or short-term cost is under £500, you can approve your own assessment. There’s no eligibility test at this stage although as part of your assessment you will be considering how you are enabling someone to not need to further eligible services or minimising the amount that may be needed. You can set a final check-back date dependent on the involvement, to see if everything has gone well; but you should stay in touch as much as you need to during this time.

If, following the final check-back, the outcomes have been achieved, the case can be closed. Sometimes if the outcomes have not been met this may be ok. If the person has managed or found alternate ways to remain in control you can still close the case. If not, or the needs change before final check-back, you could explore further enable options. If this is not possible, you should move on to **Connect and Support** stage.

You can find further guidance in our Connect and Enable Guide.
10. Connect and support

Although our emphasis is to set and achieve outcomes in Connect and Prevent or Connect and Enable, some people will need more long-term or intensive support. They will meet the eligibility criteria and require a personal budget. The information recorded at the Connect and Prevent and Connect and Enable stages are pulled through to this stage (so no need for repetition).

**Care Act eligibility must be established:**

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

**Agreeing the plan**

You can add further relevant information if more depth is needed for good support planning and for understanding the outcomes to be achieved. Once you and the person involved feel you have all the information needed to clarify the outcomes you are aiming to meet then you can start to pull together the support plan.

**Outcomes**

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

Needs can still be met by the person’s own strengths, community resources, their family, information and advice.

The focus of any support provided is likely to enable people to achieve the relevant Care Act wellbeing principles.

**Charging**

At this stage you’ll inform individuals that a financial assessment will determine whether or not they pay towards their care and support, but this must have no bearing on the assessment process itself.

**Continuing Healthcare**

You may also need to consider if the person is eligible for Continuing Healthcare. The NHS Decision Support Tool (DST) supports practitioners in the application of the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. As such you should capture the required information at this point in the assessment process to enable relevant CHC processes. There is further guidance in our Connected Lives CHC guide.