Assessing needs

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

Feedback about access to Care Act 2014 assessments was mostly positive; people said they received timely assessments and had their needs met through effective care planning. Staff and people described how the front door team provided a single point of access to assessment, and provided early interventions such as signposting, information, and advice.

The approach to assessment focused on people's strengths and what was important to them. Staff and leaders talked about taking a personalised approach to assessments and this was reflected in feedback from people. There was a strengths-based approach to assessments which focused on people's abilities and their existing support. The approach reflected people's right to choose, built on their strengths, reflected what they wanted to achieve, and how they wished to live their lives. The assessments were then used to develop personalised care plans.

Examples seen showed people's human rights were respected and protected, they were involved in decisions, and their protected characteristics under the Equality Act 2010, such as in relation to their religious or cultural needs were understood and incorporated into care planning. However, there were sometimes barriers to accessing advocacy services which had the potential for decisions being made without peoples' voices being heard.

National data showed people's experiences were positive in this area. In the Adult Social Care Survey (ASCS) 87.5% of people said they felt they had control over their daily lives, which is significantly higher than the national average in England of 77.21% and was consistent with feedback we received. Staff articulated good social work practice to us and shared examples which demonstrated a commitment to personalised assessments and care planning, with a focus on people's strengths and their human rights. We heard examples of people being supported to achieve outcomes in different areas of their lives, such as maintaining important family relationships, being more active in their community, or gaining employment.

Leaders told us strengths-based practice was an area they wanted to enhance and build upon. Plans were underway to adopt a new model of strengths-based practice known as the ‘Patchwork’ model. This is a model where people’s strengths and assets are assessed as a variety of small complete sections, which come together to represent a holistic picture of people’s lives. Staff and leaders talked about how they were building upon their current approach so simplify the tools available to staff, so it would enable them to gain a better understanding of a person’s family and support networks, to ensure care plans were proportionate and promoted people’s strengths and independence.

There was a clear pathway people followed from assessment through to review. We heard how the front door team would carry out assessments and put care packages or equipment in place where necessary, before carrying out a six-week review and transferring cases to the community teams.

Assessments and care planning considered people’s health needs, including how and when they administered their medicines. Assessments we saw were strengths-based and looked at people’s ability to self-administer medicines and the level of support they required where they were not able to self-administer. Care plans recorded this clearly so commissioned services had clear information about what people needed. The local authority also told us about work they did through commissioning to ensure providers had robust medicines training in place for their staff, as well as how the local authority worked with the Integrated Care Board medicines optimisation team to share any themes and learning.

Where necessary, staff worked jointly with health colleagues to identify and meet people’s needs. The front door team worked with the local access point (LAP) which was a jointly commissioned function where health partners and local authority staff worked together to support people in a way which prevented needs from developing and avoided or delayed hospital admissions. We heard positive feedback about the work of this team, with staff describing how they took a multidisciplinary approach by discussing cases and carrying out home visits or assessments jointly.

People usually received an assessment from specialist teams where they had complex needs, but we heard some referral criteria could cause barriers to these teams. The community teams received cases from the front door team after care and support had been put in place and reviewed after six weeks; the community teams then oversaw ongoing reviews and responded to changes in need. Where people had needs because of a learning disability there was a community team for people with a learning disability (CTPLD) and for people with needs related to mental health conditions or autism there was an integrated community mental health team (CMHT) where local authority staff worked alongside staff from Berkshire Healthcare NHS Foundation Trust.

We heard how the CTPLD and the CMHT teams provided a specialist assessment from staff who had a good understanding of their specialisms in learning disability, autism, and mental health. Feedback about the training on offer for staff to understand their specialisms was positive. However, there had been instances where people did not have a formal diagnosis, which meant they did not fit the referral criteria for the CTPLD. This had led to uncertainty about how a person's needs could be met in situations where there was no formal diagnosis but a presenting need consistent with a learning disability or autism. There were very few examples where this had happened and when it did, staff worked together to find the right team for the person. This ability of staff to problem solve reduced the risk that people could fall through gaps or receive assessments from staff without the right skills and expertise.

The local authority ensured staff training was up to date, and staff gave positive feedback about the support they received to develop their skills. We heard examples of learning being focused on particular areas staff had raised, such as recent training in how to support people with no recourse to public funds, in response to increases in assessments of people who could be undocumented or from a refugee community.

Timeliness of assessments, care planning and reviews

People did not often have to wait for an assessment, but where they did the local authority took steps to meet urgent needs. Assessments and care planning for social care were timely but there were waits for assessments for occupational therapy (OT). There were no significant waiting lists for social care across the front door team and the community teams, and leaders had a good understanding of their waiting lists and the risk-reduction processes. Staff and leaders frequently reviewed waiting lists and we heard how initial interventions, such as smaller-scale equipment provision, signposting to alternative services, or interim packages of care, were used to mitigate risks to people whilst they waited for a full OT assessment.

The local authority employed OTs across its community teams and at hospital discharge. The local authority used occupational therapy assistants and trusted assessors which enabled some equipment to be installed more quickly to reduce need and risk. Whilst this reduced the potential impact assessment delays would have on people, it still meant people could wait up to 6 months for a full assessment of their OT needs so there could be a risk of some needs not being identified and met promptly. This heightened the risk that people's needs could increase in that time and opportunities to build their independence could be missed. Local authority data showed 180 people were on the waiting list for OT assessment with an average wait of 39.8 days. However, 2.2% of people had waited over six months.

People did not always receive a timely annual review of their care and support needs. The local authority took a risk-based approach to reviews and staff and leaders acknowledged planned reviews did not always take place promptly. Planned reviews are where there has not been a change in need, but it would be considered good practice to carry out an initial review after 6 weeks followed by an annual review, to check the support the person is receiving is continuing to meet their needs. The local authority had data on reviews but this data combined planned 6 week reviews and annual reviews. We heard from staff and leaders that it was annual reviews where people could wait longer if there had not been any changes in need or risks, we heard that 6-week reviews usually took place in a timely way.

Local authority data showed that 156 older people or people with a physical disability had a planned review which was overdue and for people with a learning disability there were 26 planned reviews outstanding. In mental health there were 11 planned reviews overdue across both working age and older adults and there were no planned reviews outstanding for people with sensory needs and autistic people.

Leaders regularly risk assessed waiting lists to identify and respond to urgent need. Staff and leaders had a good understanding of which cases were awaiting reviews and we heard how reviews were prioritised where there was increased risk or changing need. However, teams and leaders acknowledged this meant people with no change in need, such as those in settled residential care placements, did not receive a timely annual review. Staff told us they would usually carry out a review sooner for people placed out of county. Local authority data showed that for people placed outside of the county, there was an average wait of 75 days for a review, compared to 84 days for people placed within the county. These average wait times for planned reviews included both annual and 6-week reviews.

National data on Short and Long-Term Support (SALT) showed 70% of people receiving long-term support had been reviewed (includes both planned and unplanned reviews) and this was higher than the England average of 55%. This showed that the local authority was performing better in relation to other local authorities.

Leaders had identified delays to reviews as a risk and had commissioned an external company to support them with these reviews. Whilst this would address the issue in the short term, there would be more work to do to ensure reviews always took place in a timely way in the future.

Assessment and care planning for unpaid carers, child’s carers and child carers

Unpaid carers received a separate assessment to the person with care needs and staff understood how the needs of unpaid carers were distinct from the person they cared for. Data showed waiting lists for carers assessments for adult unpaid carers were very low and carers did not have to wait for an assessment, which was consistent with the feedback we received from people and unpaid carers.

The feedback about carers assessment and reviews for unpaid carers was mixed. We heard carers were routinely assessed, and support was built around their needs. However, we also heard information and advice was not always easy to find prior to assessment, which in turn would impact on the local authority's ability to identify unpaid carers in a proactive way. There had been recent work to develop and publish directories which would provide clear information on what was available to unpaid carers, but this feedback showed this was not yet having the anticipated impact. The local authority had identified a need to do more strategic planning around services for unpaid carers. Plans were in place to use joint funding with health partners to introduce a new role, to map the resources available to unpaid carers at an early stage, and to identify and address any gaps in provision. The Survey of Adult Carers in England (SACE) data showed 32.26% unpaid carers in Royal Borough of Windsor & Maidenhead said they were able to spend time doing things they enjoyed, which was higher than the national average in England of 15.97%.

Care was planned holistically around unpaid carers' lives and support plans included replacement care for their loved ones. We heard examples of how care planning was used to enable unpaid carers to pursue leisure activities, practice their faith, and sustain important family roles. We heard positive feedback about the support put in place for unpaid carers, but we did hear feedback planned reviews were not always holistic. There were extended waiting times for planned reviews which the local authority were aware of. Staff and leaders described processes for identifying and assessing unpaid carers in a strength-based way, with assessments considering the needs of the whole family. SACE data showed 48.48% of unpaid carers said they were satisfied with social services, which was above the national average in England of 36.83%.

We received feedback that young carers were not always identified proactively and it could sometimes be difficult to access a young carers assessment. The local authority commissioned an organisation, to carry out young carers assessments. Staff and leaders described processes for identifying young carers and offering support, but feedback from voluntary groups showed this could be more proactive. The local authority recognised a need to do more in this area, particularly around raising awareness of young carers. Data showed the average waiting time for assessment for young carers was 12 weeks after referral. Managers monitored waiting lists, and we heard how staff would put interim support in place, such as replacement care or direct payments, to reduce risk and alleviate the impact the caring role was having on the young person. We also saw that the local authority risk rated young carers cases to prioritise cases where the young carer was primary carer for the person. However, there was a difference in experience of wait times for assessment for young carers compared to adult unpaid carers when it came to accessing assessments.

Help for people to meet their non-eligible care and support needs

People were able to access information and advice, as well as early support to meet non-eligible care needs. The local authority and partners had recently carried out a series of 'World Café' events. These engagement events took place across the Borough and were used to hear the views of residents to understand what was important to them; the events identified loneliness and isolation as a priority. The local authority identified a need to improve the information and advice provided by the front door team, which had been implemented. We also saw multiple examples of joint health and social care funding being used to set up clubs and activity groups for people of different ages, needs, cultures, or faiths, to provide people with opportunities to reduce isolation and loneliness.

The front door team frequently received referrals from people without eligible care needs. Staff described how they often carried out a home visit even where the person was not likely to have eligible needs because it provided an opportunity to signpost and identify early input which could prevent or delay needs developing. Staff also described how they often worked remotely across the Borough, such as from health centres or GP practices, to be on hand to provide information and advice to people about how to access an assessment, or to signpost to voluntary and community resources where people did not have eligible needs.

There were community health and wellbeing events held in local libraries and community centres, such as a recent ‘Men Matter’ session which provided support and advice to men about mental health and wellbeing. There was a jointly funded social prescribing team and a community connections service supporting people with mental health issues as well as support in areas such as loneliness or drug and alcohol misuse. Local authority data showed the social prescribing service had over 2,000 referrals in the first three quarters of 2023/2024 with 98% of new referrals contacted and a person-centred plan started within 7 days. There were satisfaction survey measures available of over 95%. We also heard positive feedback about community groups as well as services provided, such as leisure support for unpaid carers without eligible needs.

These proactive approaches mitigated some feedback we heard that information and advice for people without eligible care needs was not always easy to find. We saw a lot of recent work had taken place in this area, and the local authority told us it was aware this was an area to develop further as part of their transformation.

Eligibility decisions for care and support

The local authority had a policy in place outlining how to accept and process appeals about eligibility decisions. There had been no appeals against an eligibility decision in the last 12 months. The local authority website had guidance for people on how to complain, but it did not detail people's rights to appeal eligibility decisions after a Care Act assessment. The Local Government and Social Care Ombudsman (LGSCO) website did not show any eligibility appeals were referred to the LGSCO in the previous 12 months.

Financial assessment and charging policy for care and support

The local authority had a financial assessment and charging policy which was accessible to people, but they recognised a need to improve how quickly people were invoiced for charges. Local authority data showed 80% of new referrals were completed within the target of 20 working days. However, the local authority told us their target to invoice people within 30 days was not always met, which could impact on people's ability to plan their finances around care charges. Despite the local authority highlighting this to us, we did not receive any negative feedback about financial assessment and charging.

The local authority told us appeals against charging decisions were often submitted as complaints; this meant they did not have accurate data about the number of appeals made following financial assessments. However, senior leaders had used complaints to identify and address themes from complaints. For example, where there had been issues with the information and advice provided by staff the local authority had implemented training to address this. Teams told us training in this area was useful and assisted them in providing the right information to people about financial assessments and charging.

Provision of independent advocacy

Access to advocacy was sometimes limited. An advocate can help a person express their needs and wishes, weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations.

Safeguarding Adults Collection data showed 58.33% of people who lacked mental capacity were supported by advocates, family, or friends. This was significantly lower than the national average in England of 83.12% and shows that people who lacked mental capacity to make particular decisions faced a risk of not having their voices heard in decision-making that affected their lives.

Staff feedback on use of advocacy was mixed. We heard where people faced increased risks because of their care needs or circumstances, then staff could usually access advocates. However, staff and leaders said the budget for advocacy was limited which could create barriers to accessing an advocate in cases where the levels of risk were not as high. Local authority data showed there was a waiting list of 17 people for non-urgent referrals and no waiting list for urgent referrals. However, the local authority's use of advocates was significantly lower than national averages which could indicate more work was required to ensure staff were always making referrals where necessary. Reduced use of advocacy meant people could be subject to decisions in which their voice was not heard, and their rights not upheld. The local authority was aware of this and commenced a new contract for advocacy in July 2024. Leaders told us about recent plans to improve understanding of advocacy amongst staff and they had implemented training in the Mental Capacity Act 2005 and the use of independent mental capacity advocates because they had identified a training need in this area. It will take time for the impact of these changes to demonstrate improved access to advocacy for people who lacked the mental capacity to make particular decisions.
