Care & Support Planning
Preparing for Adulthood
Nov 2023

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WELCOME!

- Introduction and housekeeping
- On this session we will –
  - Look at what the Care and Support Plan is
  - Put it in the context of the Care Act
  - Give some tips on how to make the most of a Care and Support Plan

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"The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life."

Care and Support Statutory Guidance

Line 1.1

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The Care Act Pathway

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Throughout the process

Does the person have capacity?

Do they need support for involvement, including independent advocacy?

What is the impact on the whole family?
Should there be a carer's assessment?

Is there a safeguarding concern?

Today we will talk about this stage

If, after review, the care and support plan changes – or if … r circumstances change
then a proportionate assess…

First contact: assessment begins

Assessment process

Eligibility determination

Care and support planning

Review

Needs can be met by supporting the person's own strengths, by universal, community or voluntary services, by information and advice, or by a carer

After assessment, the person and anybody else must be given a record of the assessment.
The person must also receive a written record of the eligibility determination.

For more information on safeguarding and independent advocacy, see chapters 14 and 7

There are accessible summaries of different parts of this pathway on [MyLife here]

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The Care Act Guidance section 10 ‘Person Centred Care and Support Planning’ says the purpose of the Plan is to -

“agree how a person’s [assessed and eligible] needs should be met, and therefore how the local authority will discharge its duty, or its power, to do so.”

Note the Local Authorities duty is to meet need, as opposed to just provide services.

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"Ultimately, the guiding principle in the development of the plan is that this process should be **person-centred** and person-led, in order to **meet the needs** and achieve the **outcomes** of the person in ways that work best for them as an individual or as part of a family."

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Person Centred

"Person centred planning is a process of continual listening and learning, focussing on what is important to someone now and in the future, and acting upon this in alliance with their family and friends." - HSA

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Person Centred

The Care and Support Plan belongs to the person and is 'Co-Produced'* with the council.

People can make their own Care and Support Plan, with the council's role to 'Assure and Sign Off', but in practice they are mostly done in partnership.

* In this context the Care Act says "Co-production is when you as an individual influence the support and services you receive"

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Person Centred

Plans can be combined, including needs and outcomes for carers and cared for.

Where there was a combined assessment, there should be a combined Care and Support Plan.

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Person Centred

Understanding what is important to someone is key to being Person Centred. This can include –

- Dream and ambitions
- Culture
- Hobbies, interests and passions
- Social networks
- Anything that motivates the person and contributes to their overall wellbeing

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Meeting Needs

The Local Authority's duty is to ensure a person's assessed and eligible needs are met.

A Person-Centred Care and Support plan should encourage flexible, creative and innovative ways of meeting needs, informed by what is important to them.

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Meeting Needs

The Care and Support Plan must say –

- How needs are met informally
- How the Personal Budget will be used to meet needs

For example

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Meeting Needs

Building on peoples own strength gifts and abilities

Support from existing networks – Family, friends, community connections

Making a contribution - Working / volunteering / start a business

Being part of a community – Faith groups, hobbies and interests

Using community resources – leisure centres / cinemas, café's – these usually reasonable adjustments in place already

Equipment – IT / crafts / hobbies

Creating community capacity – what barriers are preventing these networks playing a role

Once all of these have been explored, if there are still unmet needs, consider a funded service

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Meeting Needs

The Care and Support Plan must take into account fluctuating needs.

This could be because;

- The person’s needs can change with their health
- There can be seasonal changes
- Some needs (for example ‘Respite’) may be met once or twice a year

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Outcomes / Goals

A person's Outcomes are the things they want to achieve in their lives.

Crafting Person Centred outcomes is key to good Care and Support Planning

n.b. – the Enfield Care and Support Plan uses the word 'goals'

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Outcomes

Outcomes should look at peoples ‘Whole Life’

It can be helpful to look at long term ambitions and break them down into smaller more achievable steps.

Outcomes need to be evidencable – they will be checked at review.

Evidence could be ‘Hard’, for example, managing my own money.

Evidence could be ‘Soft’, for example, feeling more confident.

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Outcomes

For example, it may be important to a young person to have their own flat, to eat their favourite food and wear their favourite clothes. However, they may need support around cooking and laundry. Outcomes could be –

- To get my own flat one day
  - To prepare for this, I will learn to cook a meal for my family once a week
  - I will also learn to do my own laundry

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Contingency Planning

A contingency plan sets out support needed in an emergency (to prevent an emergency turning into a crisis!)

Emergency support could be needed is a carer;

- Becomes ill or has an accident;
- Needs to go into hospital as an emergency or a planned admission;
- Has to be elsewhere for some other reason, for example to care for another family member or friend.

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Contingency Planning

Things to consider -

- Does the Person and/or Carer have a plan for emergency support? If so include it in the Care and Support Plan
- Is there anyone who would care for the service user in an emergency if their primary carer giver is not able to?
- Is there a support worker/PA who may be able to help in an emergency

Emergency Card Scheme – Enfield Carers Centre

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Information should be meaningful to the person

The plan belongs to the person, it should be written in a language they feel comfortable will –

- Use 1st person perspective, unless it cannot be done authentically (this should not happen often)
- Avoid Jargon and Abbreviations
- Use Diagnostic labels carefully – if at all
- The person should be given a copy of their plan in a form they can meaningfully understand.

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Personal Budgets & Direct Payments

The Personal Budget is money allocated by the council to meet a persons assessed and eligible needs

An indicative budget is a ‘best guess’, based on information from the assessment and how other peoples needs have been met previously

You will be told the Indicative Budget at the start of the Care and Support Planning process

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Personal Budgets & Direct Payments

- The Care and Support Plan process is how the final Personal Budget is agreed.
- It can be below or (rarely) above the indicative budget. If it is above is must be clear why this is the only way to meet need.

Personal Budgets & Direct Payments

- Direct Payments are the most common way people get their Personal Budget's, via the Enfield 'ecard'.
- This is a pre-pay card that can be used like other bank cards (but without overdraft facilities)
- This is designed to increase flexibility and creativity in meeting people's needs

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Personal Budgets & Direct Payments

- The Care and Support Plan must state how the person’s Direct Payment is being administered and spent.
- This information will be used by the Finance Team when monitoring ecard spending
- If a person does not have capacity to manage their Direct Payment and there is no one to do it for them, they can have a managed account
- Where a Direct Payment is not appropriate, the council can still directly commission services with all or part of the budget

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Paying for Care and Support

- Adult Social Care services are chargeable.
- Before the Direct Payment is set up (or service commissioned, etc…), the young person will have a financial assessment.
- There is some Easy Read information on MyLife here.

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Mental Capacity

There was a session on the 27th September

To summarise for anyone who missed it –

- It provides a framework to determine if someone has the capacity to make a specific decision at a specific time
- Where someone does not have capacity, it provides a process to make decisions in that persons 'Best Interest'
- Mencap have a very useful guide here

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Risk

Any Conversations about risk should be done in the context of the Mental Capacity Act

- People have the right to make ‘Unwise Decisions’, if they have the capacity to do so.
- They should still continue to have good information and advice.
- Outcome setting can be a good framework for ‘Adult’ conversations

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Risk

Where people lack capacity, Best Interest Decisions should take a 'least restrictive' approach.

Where the risk involved a behaviour of concern, we will take a Positive Behaviour Support approach

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Any Questions?

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References

- Care and Support Statutory Guidance
- Think Local Act Personal Personalised Care and Support Planning Tool
- Mencap – Care and Support Planning
- Helen Sanderson – Care and Support Planning
- MyLife Enfield – Care and Support

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