think local act personal

Delivering Care and Support Planning

Supporting implementation of the Care Act 2014

Acknowledgements

Contents

SUMMARY OF KEY MESSAGES

This guide is designed to help councils develop their local arrangements and approach to care and support planning for both adults with care and support needs and carers. The guide reflects the wellbeing principle of the Care Act (2014) and has a particular focus on lean systems and processes that help achieve better outcomes for people.[1]

THE GUIDE IS ORGANISED AROUND FIVE IMPORTANT ELEMENTS FOR EFFECTIVE CARE AND SUPPORT PLANNING:

1) Moving from assessment to care and support planning
2) Who supports the planning process and how this takes place
3) What's in the plan, including how to record it
4) Agreeing the plan (including sign off and panel arrangements)
5) Review

In addition, the guide reflects ten principles and 'I Statements' of what really good care and support planning looks like in practice, developed in co-production with people with care and support needs, carers and family members.

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1 *See the 3rd National Personal Budget Survey (NPBS) published by Think Local Act Personal (TLAP) in Autumn 2014.*

WHAT GOOD LOOKS LIKE
What People Want in Care and Support Planning

1) The process from assessment through to review is transparent and clear; I know what to expect and when to expect it, and people do what they say they will do.

2) If I need help to plan, I can choose who supports me to plan and put the plan into practice.

3) People who support me to plan have a flexible, open, honest, positive, solution-focussed attitude.

4) I am trusted to write my own care and support plan with whatever help I need.

5) I can involve friends and family if I choose.

6) I have all the information I need to plan; when I need it, in an accessible way, including signposting to what is available locally.

7) I am supported to take risks, and know it is OK to make mistakes and change my mind.

8) My care and support plan is about the whole of my life, not just about assessed needs or money.

9) I am encouraged and supported to think creatively about ways to achieve my outcomes.

10) My review is person-centred, focused on me and my life, my outcomes and what is working and not working, not just the money. Through my review I can also contribute my views to improving the system.

Councils vary widely in the approaches they have adopted for delivering care and support planning for both adults with care and support needs and carers, and in their readiness for implementation of the Care Act. There are four main ways in which councils are designing and delivering care and support planning:

1) In-house provision with care and support planning undertaken by social work teams.

2) In-house provision with care and support planning undertaken by a discrete function or team.

3) The whole process of assessment, care and support planning and money management is outsourced, typically to a third sector organisation or consortium of third sector organisations.

4) Care and support planning is outsourced as a discrete function/ service, again typically to a third sector organisation.

Information about costs, cost effectiveness and outcomes achieved through care and support planning is patchy and incomplete in most places. It is therefore not possible to offer firm conclusions about which of the four approaches is more cost effective in delivering care and support planning/ plans. However, some evidence[2] indicates that outsourced arrangements, particularly those involving user led organisations can be more cost effective in delivering good outcomes for people by encouraging creativity in planning and drawing more fully on informal supports and community

resources. Councils should consider how they might better understand what elements of care and support planning/ plans need to be costed, and how outcomes can be consistently measured to ensure that such measures are meaningful and robust, for example, by using the Personal Outcomes Evaluation Tool (POET) from In Control.

Councils who work with local partners to deliver care and support planning according to the 10 principles identified in this guide will not only deliver what local people want but they will also be Care Act compliant. Some councils are already doing this. However, while there is much positive practice, it is also true that there is inequity of access to and experience of care and support planning in some areas, which remains a cause for concern.

It is important for councils to understand, and to stress in local implementation plans, both the inter-relationship between and requirements of other legal frameworks in helping them to become Care Act compliant (the Equality Act, the Mental Health Act and the Mental Capacity Act in particular).

A number of councils are co-designing their systems and processes for care and support planning; a small number facilitate choice and control over who is involved in developing their plan but fewer areas enable full choice and control over all aspects of care and support planning. A greater emphasis on individual as well as collective co-production is required to

ensure that people really are in control of their own lives in terms of the support options they may need to live a good life.

THE STRUCTURE OF THE GUIDE

This guide is written for decision makers within councils and their partners (e.g. voluntary and community sector organisations involved in care and support planning) to help them better understand the requirements of the Care Act in relation to Care and Support Planning for adults and carers. It describes what good looks like based on what people want, what is Care Act compliant and lean and therefore good at delivering positive outcomes for people who use services.

In addition to clear steers drawn from the Act and accompanying statutory guidance on care and support planning, this guide also shares ideas, lessons and practical examples for designing and delivering care and support planning and plans that work well for local people. This shows how to get "beyond the Care Act" to deliver the spirit as well as the letter of the law. In some places where we refer to what the Care Act or Guidance states we have summarised or paraphrased sections and have also included detailed paragraphs and direct links so that you can read the exact wording.

Section 1 provides background information including a summary of the main principles of the Care Act and what it says about care and support planning.

Section 2 shares information, lessons and examples from 12 councils who assisted in the development of this guide. These are arranged under each of the five main elements (presented on page 2) that councils and their partners will need to address to deliver effective care and support planning.

For each of these issues the guide sets out what good looks like, followed by a summary of what the Care Act says must happen and how to be compliant with the duties outlined in the Act. Hyperlinks to the guidance are provided here for ease of reference. This section also summarises "what works" and identifies elements of practice that are not effective or not compliant.

Section 3, draws together the most important lessons and a number of recommendations for how councils should prepare for and implement the Act from April 2015.

In addition to these recommendations, six priority actions are identified for councils and those supporting them to deliver person-centred and person-led care and support planning arrangements:

1) Creating enabling and empowering organisational cultures

2) Designing supportive infrastructures and systems.

3) Ensuring equity of access, opportunity and outcome.

4) Understanding panels, safeguarding and risk.

5) Examining costs and cost effectiveness.

6) Developing partnerships for personalisation.

PART 1 INTRODUCTION AND BACKGROUND

This guidance is designed to help councils develop their local arrangements and approach to care and support planning for both adults with care and support needs and carers, reflecting the wellbeing principle of the Care Act (2014), with a particular focus on minimal systems and processes to achieve better outcomes for people.

The statutory guidance is clear that *"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 outcomes of the person intended in ways that work best for them as an individual or family."* It also states that, *"both the process and the outcome should be built holistically around people's wishes and feelings, their needs, values and aspirations."*

Personal care and support planning is not new, but there are significant differences in both practice and local delivery models from one area to the next.

Successfully implementing the Act will require local areas to have a better understanding of current best practice, the different models that can be used and their respective benefits, including costs.

This guidance is informed by work with people with care and support needs, carers and family members from two national co-production groups, the National Co-production Advisory Group from TLAP and from the Co-production Group of the Coalition for Collaborative Care. Together they developed a set of 10 statements that reflect what good looks like in relation to care and support planning across health and social care from their perspective (please see the diagram on page 3).

The guidance is also informed by work with 12 councils, which explored what they were already trying and learning around care and support planning, and how they were getting ready to implement the Care Act. Lessons from these areas are drawn upon throughout this report.

While efforts were made to collect data about the varying costs associated with these different models of care and support planning, limited conclusions can be drawn since the information available was at best partial. This reflects similar difficulties in other research that has attempted to measure the costs of different elements of social work practice (Campbell et al, 2011; Manthorpe et al, 2014). Appendix 1 summarises the data collected for this guide alongside evidence from other sources also drawn upon.

Although this guide provides an insight into the potential and varying costs of care and support planning, there is not enough evidence available currently to draw firm conclusions about the cost effectiveness of different models.

Understanding the context for Care and Support Planning

The requirements of the Care Act (2014) cannot be considered in isolation from other policy and legal frameworks, such as the Equality Act (2010), the Mental Capacity Act (2005) and the Mental Health Act (1983/2007). It is not about introducing new concepts or approaches; even if some of the language is new (e.g. Care and Support Planning rather than person-centred support planning). It embeds the principles and practices of the personalisation agenda in health, social care and housing services that have been at the forefront of service planning and delivery since the publication of Putting People First in 2008. It places the transformation of services for individuals and families within a clear, legal framework and as such is the next step in ensuring that everyone who needs support is assured of and entitled to timely, responsive and fair assessment, planning and support (where needs are assessed as eligible).

The implementation of the Act will also be influenced by competing priorities and pressures on councils and their partners, not least the current financial climate and the tightening public purse which in many places has resulted in restructure, re-design and a re-focusing of resources. The examples shared by the 12 councils and the 10 statements of what people want should help decision-makers to keep on track with their transformation plans in the face of these pressures and competing demands.

The guide also shares approaches designed to engage people in their own Care and Support Planning arrangements at as early a stage as possible (from and even during their assessment of needs), with illustrations from councils who say that doing this has reduced demand for more intensive support from local statutory services.

What the Care Act and Statutory Guidance says about Care and Support Planning

The general principle of promoting wellbeing underpins the whole of the Care Act (referred to as "the wellbeing principle", see the Care Act section 1 (1)). A core part of this principle is the concept of "independent living" (see Guidance 1.18 & 1.19) – people having choice and control over any support they need to live their everyday life.

Other key principles which underpin the Act that councils must have regard to are:

- The importance of beginning with the assumption that the individual is best-placed to judge their own wellbeing.

- The individual's views, wishes, feelings and beliefs.

- The importance of preventing or delaying the development of needs for care, or needs for support, and the importance of reducing needs of either kind that already exist.

- The need to ensure that decisions about the individual are made having regard to all the individual's circumstances. It is important that these decisions are not based only on the individual's age, or appearance or any condition of the individual's or aspect of the individual's behaviour which might lead others to make unjustified assumptions about the individual's wellbeing.

- The importance of the individual participating as fully as possible in decisions relating to the exercise of the function concerned, and being provided with the information and support necessary to enable the individual to participate.

- The importance of achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual.

- The need to protect people from abuse and neglect.

- The need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of a function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

The Care Act section 1 (3)

In addition to these fundamental principles, a number of important definitions are set out in the Act and supporting Guidance, including:

Care and support plan – a document prepared by a local authority which specifies the needs of an individual, which needs meet the eligibility criteria, what needs the local authority will meet and how, the personal budget, and advice and information about reducing and preventing needs (the Care Act section 25 (1)).

Care and support planning – part of the process for putting people in control of their care with the support that they need to enhance their wellbeing and improve

their connections to family, friends and community (Guidance 10.1).

Review – ensures that people with a care and support plan have the opportunity to reflect on what's working, what's not working and what needs to change; and that plans are kept up to date and relevant to the person's needs and aspirations. The plan must be kept under review generally (Guidance 13.1).

Wellbeing – a broad concept, described as relating to the following areas:

• Personal dignity (including treatment of the individual with respect).

• Physical and mental health and emotional wellbeing.

• Protection from abuse and neglect.

• Control by the individual over day-to-day life (including over what care and support is provided and the way it is provided).

• Participation in work, education, training or recreation.

• Social and economic wellbeing.

• Domestic, family and personal relationships.

• Suitability of living accommodation

• The individual's contribution to society.

(The Care Act section 1 (2)

The Care Act stresses the need for fair and equitable approaches to the design, commissioning and delivery of care and support services.

This emphasis on fairness and equity reflects the duties of all public bodies including councils set out in the Equality Act (2010), specifically the Public Sector Equality Duty[3] that came into force in April 2011.

This requires public bodies to:

• Eliminate discrimination.

• Advance equality of opportunity between people who share a relevant protected characteristic and those who do not share it.

• Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The Care Act also works alongside the Mental Capacity Act (2005), supporting its principles in maintaining the rights of individuals who may lack capacity. A good working understanding of the Mental Capacity Act and its implementation is essential for anyone involved in supporting people with their Care and Support Plans. The Guidance clearly outlines how people who may lack capacity for certain decisions relating to planning their care and support, must be involved in the decision-making in ways that suit them.

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3 *www.legislation.gov.uk/ukpga/2010/section/149*

PART 2 CARE AND SUPPORT PLANNING – MAKING IT HAPPEN

This section shares ideas, approaches and lessons from 12 councils about how to make Care and Support Planning work well for people with care and support needs and carers – to achieve their aims, aspirations and outcomes whilst also delivering Care Act requirements.

FIVE KEY ELEMENTS FOR EFFECTIVE CARE AND SUPPORT PLANNING, DEVELOPED WITH EVERYONE INVOLVED IN PRODUCING THIS GUIDE:

1) Moving from assessment to care and support planning

2) Who supports the planning process and how this takes place

3) What's in the plan, including how to record it

4) Agreeing the plan (including sign off and panel arrangements)

5) Review

This section describes what good looks like in relation to each of these elements (see diagram on page 3); what the Care Act requires of councils and their partners in each case and what councils shared about what works and what doesn't work in practice (including practical examples and illustrations).

Each step concludes with summary of issues and recommendations designed to help councils be both Care Act compliant and able to deliver care and support planning in the ways people find most effective.

1) Moving from assessment to care and support planning

WHAT GOOD LOOKS LIKE

The process from assessment through to review is transparent and clear; and I know what to expect and when to expect it, and people do what they say they will do.

WHAT THE CARE ACT & STATUTORY GUIDANCE SAYS

Following a needs assessment and determination of eligibility, a care and support plan must be provided for people for whom the local authority is required to meet needs of or decides to meet the needs of. (see the Care Act section 24 (1)).

The care and support plan should be person-centred and person-led. (see Guidance 10.5).

The plan must detail the needs to be met and how the needs will be met, and will link back to the outcomes that the adult wishes to achieve in day-to-day life as identified in the assessment process, and to the wellbeing principle in the Act. This should reflect the individual's wishes, their needs and aspirations, and what is important to and for them, where this is reasonable. This process is central to the provision of person-centred care and support that provides people with choice and control over how to meet their needs. (see Guidance 10.31).

This first step determines how well care and support planning happens and ultimately the outcomes identified in someone's plan. It is therefore an essential step in creating the right approach for ensuring a person-centred and inclusive planning process that results in an outcome-based plan.

There is considerable variation in how councils approach this interlinked series of tasks: moving from an assessment of need to developing a care and support plan composed of a clear statement of outcomes that need to be achieved. Then, how and when they need to be achieved, plus, the amount and type of personal budget allocated to enable this to happen.

WHAT WORKS WELL?

Some councils do a mix of assessment and care and support planning and others separate out these functions e.g. through councils contracting with third sector agencies or having separate in-house teams. Councils told us that the most creative and person-centred planning processes and plans occur when care and support planning is one step removed from the assessment of need, whilst ensuring a seamless and invisible transition from one step to the next.

In Greenwich, the assessment of need is completed by in-house teams. The completed assessment of need and indicative budget is provided to the individual and their independent care and support planner (who is employed by a voluntary sector organisation, part of a consortium of third sector agencies who can undertake this role) to identify creative care and support solutions that meet their needs and agreed outcomes. The care and support plan makes it clear which needs/outcomes can be met through natural supports (e.g. in the local community) and which needs/outcomes will be met using their personal budget.

Councils that have a clear focus on developing care and support plans with clear outcome statements and indicative budgets have designed their assessment processes to facilitate this happening. They have also re-designed or built their IT systems to enable this approach, rather than thinking about how good care and support planning can happen in the context of existing IT systems.

In Doncaster, the questions explored as part of the assessment are the same as those in a really good Care and Support Plan. For example: What's a typical week? Who are the important people and relationships in your life? In other words, conversations about what people want and what they want to achieve are started within the assessment process, which means that care and support planning and plans build on this initial discussion in a natural and meaningful way.

Some councils provide a facility for assessments to be completed online, including one council which has designed this system to lead onto care and support planning.

In Doncaster, the process starts after the initial assessment and after all those who would benefit from information advice and support have been signposted to those services. The council considers this makes the process smooth for the people in contact with their services and avoids unnecessary delays in the system.

Nottinghamshire County Council has an internal brokerage team who carry out person-centred support planning which is started by completed assessments being sent through to them by the initial assessment team.

Shropshire County Council outsourced the whole of their support planning and delivery functions to an independent social work practice.[4] Strong links have been established between council teams and staff and volunteers who undertake support planning and brokerage functions within People2People, who trained and support the council's first point of contact team to undertake person-centred assessments using a shared form called a Personal Profile. This combines the assessment summary and conclusions ("a mini support plan"). Once the assessment has been done (section 1 of the personal profile), this is shared with the support planning team in People2People. At the time of assessment, people are able to make a booked appointment to meet with a member of the support planning team in a community venue close to where they live (in Let's Talk Local Hubs). At this session, the information from the personal profile is taken forward into the process of care and support planning that has effectively already begun.

An indicative budget enables people to see transparently what they are entitled to receive in terms of council funded care and support. It is indicative and therefore needs to be treated as the financial parameters for social care funding available to deliver care and support to meet someone's eligible needs. It should not, however, dominate the planning conversations. This should focus on what's important to and for that person from their perspective, including their broader life outcomes within which specific needs and support should be considered. Resources are available to help people have these conversations and to plan for outcomes.[5]

In moving from the assessment to care and support planning it is important that the social worker talks to the person about whether they feel confident to be able to develop their care and support plan themselves or if they need help. If they want help, then looking at whether family or friends could support them, or whether they want assistance from someone else (depending on the local arrangements), is important.

4 *People2People www.people2peoplecic.org.uk*

5 *www.supportplanning.org/ ; www.nationalvoices. org.uk/what-care-and-support-planning; www. helensandersonassociates.co.uk/reading-room/ how/personal-budgets/support-planning.aspx; www.local.gov.uk/care-support-reform)*

WHAT DOESN'T WORK WELL?

Where councils prioritise internal processes and systems rather than the principles and ethos of good care and support planning described in this guide and in statutory Guidance, people are more likely to experience delays and "hand offs" to other professionals. People are also less likely to experience assessment and planning as person-centred or to develop plans that make full and creative use of all the resources available.

Councils and teams whose practice is restricted by the requirements of their IT systems (e.g. the completion of standardised fields) will find they are not compliant with either the spirit or the requirements of the Act, since these IT systems are likely to have been built to support a previous and now outdated process. For example, some assessment processes and aligned IT systems prompt

questions about which services people might need at the assessment stage, before a full assessment of need and eligibility has been determined, and before care and support planning has begun. One IT system generates possible service based solutions (e.g. care home) at the assessment stage. Clearly this does not allow the person to design their own support and may impede their ability to access universal services since it pre supposes certain service solutions.

Some councils clearly feel under pressure from mounting demand and crisis management (e.g. facilitating early hospital discharge for large numbers of people) which can inadvertently influence how and when assessments are carried out – and therefore also how care and support planning is done and what follows.

One local authority described the pressures of "crisis care and support planning"

for those needing to leave hospital, as generating lower quality outcomes and plans for individuals, in comparison with people who were supported to plan over a longer timeframe. This was in part due to the speed at which support needs to be put into place for some people, but also in respect to the time for quality conversations to take place with the individual and family members. Shorter term or immediate outcomes, rather than aspirations, can become the focus for planning in pressured circumstances. This needs to be recognised with thought given to how plans that are necessarily developed at speed can be adapted to be more person-centred and/or creative over time.

A number of councils shared their concerns about the wide variation in expectation, aspiration and implementation of good, person-centred assessments and care and support planning between different population and client groups. This was most often described as *we do this well for people with a learning disability and mental health problems but not for older people*.

This variation is also seen in differing, inequitable resource allocation, access to/ take up of personal budgets (particularly as a direct payment), and access to independent advocacy and brokerage services in enabling plans to be implemented

Some councils have addressed this by developing a market of support brokerage providers external to the council who support all client groups, ensuring that this is available to everyone and not just those who have had good access to support planning historically (i.e. people with a learning disability or those with physical disabilities).

SUMMARY OF ISSUES AND RECOMMENDATIONS

- A priority concern for Councils in preparing for the Care Act should be to develop care and support planning processes and plans that are outcomes focused rather than systems driven.

- Councils need to think about the continuity between assessment of need, the identification of outcomes and resource allocation. Assessments must not be 'service prescriptions', but instead, they must lead to outcome statements and resources should be allocated on the basis of these outcomes. Then, care and support planning can take place with individual's outcomes to be achieved and the financial context as its focus.

- Councils who have separated the two core functions of assessment and care and support planning, find that the quality and creativity of care and support plans increases, but acknowledge that there is a challenge in ensuring a streamlined interface between them.

- Different parts of the system (whether done in-house or externally) need to work closely together. The key to making this happen is having trained staff/teams working to a common goal with one supportive and enabling IT system and associated paperwork.

- Good care and support planning conversations focus on outcomes to be achieved – both in relation to the person's assessed need and what the person wants to change (their wellbeing), and they always have an indicative resource allocation to work with.

- Equitable processes and plans are fundamental to the Act and other supporting frameworks (including the Equality Act, the Mental Capacity Act and the Mental Health Act).

- Where care and support planning needs to take place in a crisis or time-pressured situation focusing on immediate outcomes (such as in hospital or at the point of discharge from hospital), planning for longer term outcomes and support solutions should follow, either as part of the initial review, or when the immediate issues have been addressed.

- Councils who are constrained by the limitations of current IT systems should approach their suppliers to look at how their solutions can better support a change in practice.

2) Who supports the planning process and how this takes place

WHAT GOOD LOOKS LIKE

If I need help to plan, I can choose who supports me to plan and put the plan into practice.

People who support me to plan have a flexible, open, honest, positive, solution-focussed attitude.

I am trusted to write my own care and support plan – with whatever help I need.

I can involve friends and family if I choose.

I have all the information I need to plan – when I need it, in an accessible way, including signposting to what is available locally.

WHAT THE CARE ACT & STATUTORY GUIDANCE SAYS

In preparing a care and support plan, the local authority must involve:

- The person the plan is intended for

- The carer (if there is one)

- Any other person the adult requests to be involved, or, where the person lacks capacity to ask the authority to do that, any person who appears to the authority to be interested in the welfare of the person.

• An independent advocate must be provided in certain circumstances. (see the Care Act sections 25 (3) & 67 (1-4)).

The local authority may authorise a person (including the person for whom the plan is to be prepared) to prepare the care and support plan jointly with the local authority. The authority may provide information, resources or access to facilities in order to facilitate this (The Care Act sections 25 (7-8).

The approach should be flexible, holistic and encourage innovative forms of care and support (Guidance 10.37, 10.38 & 10.48). It should avoid lengthy processes, restrictive lists of what can be purchased, placing undue pressure on the person and excessive quality control (Guidance 10.37, 10.48 & 10.81).

Care and support plans should be completed in a timely fashion, proportionate to the needs to be met, ensuring that sufficient time is taken to ensure the plan is appropriate to meet the needs in question (Guidance 10.84).

WHAT WORKS WELL?

Three core elements determine a good experience of and outcomes from care and support planning, from who "owns" and does the planning and produces the plan, to who is involved and how they work together to achieve a clear summary of outcomes and actions that form the basis of the plan.

i) Being clear about who owns the process and the plan, and therefore who is involved in doing and leading it

"It's our plan and we determine what happens to it."

Where the principle of choice and control is applied and embedded within planning processes and approaches, including who plans and how that happens, both the process and plan are more likely to be rooted in people's lives, personal outcomes and ambitions, rather than merely reflecting their needs and reliance on services.

While many councils emphasise the importance of choosing who to involve in the planning process with the person, fewer councils are actively working to facilitate this choice.

Lancashire Council has outsourced care and support planning and brokerage functions, and in doing so has embraced the concept of choice and control. People can choose who helps them to plan via the council's online information and advice/portal. Once selected, this person can help the individual download their outcomes from the completed assessment as the basis for care and support planning, and if wanted, the same person can 'stick around' to help put that plan into action and review progress.

Hertfordshire Council uses a variety of ways to engage and support people in the planning process – including high quality, accessible web pages, a wide array of facilities and venues that provide information (e.g. libraries, community centres, leisure centres), a call centre/first point of contact, a focus for every team on giving out information, modern leaflets, trained staff and an e-market place for support that doesn't need to be commissioned.

Where the plan is supported by someone familiar with or close to the community where the person lives, and/or is from a non-professional background, there appears to be greater creativity and use of natural supports. There is some evidence that this reduces demand for expensive services or additional support from council teams. This seems to be the case whether the model is outsourced or in-house.

People2People CIC and Shropshire County Council have worked together to design a system that provides support to plan and implement plans in neighbourhoods across the county. People2People employs social workers, social care staff and local people as volunteers who meet with people in "Let's Talk Local Hubs" where conversations during support planning focus on opportunities to access natural resources and supports rather than service based solutions.

They aim to support people to plan for their own support and/or have help to develop their care and support plan in a quick and timely fashion – in line with the emphasis in the Act on early intervention and prevention which also helps to manage or reduce demand for more intensive and expensive support.

Derby City and Derbyshire County Councils have developed Local Area Coordination (LAC) in some of their neighbourhoods. The principles of this asset based approach are felt to be embedded in their arrangements for care and support planning, where the closer those tasked with the responsibility of helping people to plan (and then realise that plan) are to local communities, the better the information, quality of signposting and access to sources of advice and support.

Two councils who have outsourced their care and support planning arrangements (including help to deliver the plan) have started to co-produce their systems and services.

In Greenwich, the delivery of care and support planning is provided by a consortium of local voluntary organisations. A "challenge" system has been built into the commissioning process between the local authority and local providers, in order to ensure creativity and drive up the quality of planning and support solutions in the area.

In Lancashire, a third sector organisation (Salvere, *www.salvere.co.uk*) delivers the care and support planning, brokerage and support services for people with a direct payment. They have developed robust arrangements for checking the quality and creativity of support plans including a "support plan of the month" to highlight and share great practice and experience with others.

Some councils and third sector teams have developed internal mentoring roles that enable trained social workers to be advisors and trouble shooters in the planning process, focusing their time and caseloads on complex situations and needs. The Care Act suggests the need for different social work roles to both deliver support in different ways and make use of increasingly limited capacity whilst moving care and support planning closer to the person and into the community. Where this change engages everyone involved, the experiences of that change are positive. Conversely, poorly managed change can lead to a perceived loss of specialism and professional value.

In Doncaster, staff and local people worked together to develop a clear specification to ensure the quality of the overall approach to assessment, care and support planning and brokerage, including new roles and key relationships. This specification is used to inform contracting decisions and management arrangements with support planning and brokerage providers.

ii) A focus on planning, not plans

Personal care and support planning is a fundamentally different way of identifying what needs to happen to support people well; it is not the same as care planning. To do this well requires cultural change, investment in staff development and training and often wider organisational, system and structural change.

Greenwich Council uses person-centred conversations to drive care and support planning and plans. The voluntary sector based support planners all underwent training in person-centred approaches and practices to ensure a facilitative, outcome focused approach to planning support with individuals and families.

A number of councils are considering how to empower and enable people to do as much of the planning that they are able to themselves. Some councils have called this "DIY Planning/Plans" and have piloted or set up systems to enable people to do this. This reflects the 'Empower and Enable' approach set out in previous TLAP guidance,[6] or a 'Just Enough Support' approach to enabling people to develop their care and support plan.

Lancashire Council and Salvere actively promote what they call "DIY support planning" for as many people as possible to produce their own plans with varying levels of support to achieve this. They always offer people a one page profile to help them to start thinking about what's important to them and what support they might need, so that if needs develop or it's identified through full assessment that they do need more intensive support, "they're already well on the way". If someone is assessed as eligible for support, Salvere helps them to complete a care and support plan.

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6 *www.youtube.com/ watch?v=axCYWdbuzw8&sns=em*

Some councils have made real progress in developing the local market of support including care and support planning, brokerage and access to a wide range of different options for support.

Hertfordshire Council has developed a mix of community based, integrated statutory teams who lead on assessment and some elements of care and support planning, and third sector providers offering paid independent brokerage. In councils, such as this one, where there are a lot of self funders they see this is something that will take off as an area of innovation within the third sector.

iii) A focus on broader life outcomes (and how you are going to achieve them)

The aim for care and support planning is for the process to be person-centred and person-led to meet the needs and outcomes of the person intended in ways that work best for them as an individual or family.

This is more likely to happen when care and support planning builds on the information in an assessment but takes place independently from the assessment and the person who completed it. We have also learned that where assessments begin by asking about people's lives, then the information they contain is more likely to lead to support plans that focus on the things that really matter to people and what they want to achieve.

Some councils feel there is potential for more creative use of resources and budgets than is happening currently; for example by working with and helping people to think about pooling budgets to share common resources or address a shared goal or need. They also highlight the need for enabling financial as well as IT systems to facilitate this happening.

Appendix 2 has a graphic that illustrates the difference between traditional and really creative approaches that promote flexibility and openness about what people are allowed to spend their money on. This is necessary if a whole life approach focused on promoting independence and wellbeing is to be achieved.

WHAT DOESN'T WORK WELL?

Whilst many councils promote choice over who can be involved *with* the person, very few actively facilitate choice over *who does* the plan, or encourage wider involvement beyond immediate family members and/or an advocate (e.g. friends and family). There is a common perception that the process of meaningful involvement with people important to the person is lengthy and complex; which is not borne out by the experiences of those who build this into their care and support planning ethos, process and design. Some councils shared their concerns about local practice that excludes existing providers from being properly involved or informed.

A small number of councils are starting from the basis of all provision being in-house, resulting in quite a traditional approach to care and support planning and actual provision of support; in some of these areas, nothing is provided or available to local people outside of council teams (in terms of assessment and care and support planning). We have found that these are also the places where less focus is given to exploring the use of natural supports and community assets, and less attention seems to be paid to promoting access to advocacy services.

However, even in these situations, councils are starting to think about where and who may become trusted assessors in the future. For example, one such council deploys its qualified professional staff to lead on care and support planning for people with complex needs (which are assumed to be more expensive to meet), whilst all new cases of support are referred to their in-house brokerage service.

These issues and challenges are influenced by a number of factors, including:

- The state of local markets for support planning and brokerage services.
- Local market development in terms of what's available to help people implement their plan.
- The nature of the partnership between councils and third sector partners contracted to deliver support planning and brokerage.

Some local authorities have suggested that care and support planning is more successful, creative and innovative, when there is a range of community-based care and support plan facilitators. This shifts the balance of power away from one statutory agency to a network of local organisations who together are arguably better placed to understand people's individual needs and preferences and have a greater awareness of what is available or possible in the locality.

There is a common concern over the quality and accessibility of information and advice, and awareness and understanding about care and support planning, including who is available to help you plan and what is available to help you "live" your plan. People therefore are less likely to have clear expectations and/or aspirations for themselves in this respect (e.g. in relation to 'DIY planning'). Few places are proactively engaging local communities and increasing their awareness and understanding alongside targeted information and advice for people who need support.

Some councils have moved all of their information and advice online, which is accessed through one main portal. However, this doesn't mean that it is easy for people to get the information they need, or engage in the process of care and support planning; if people do not have access to or are not confident with IT they will struggle to engage as such systems have no alternative provision for explaining what to expect and what is available.

This "corporatisation" of the information and advice function is relatively common place and can harm the relationship and engagement with local people. For example, taking away all noticeboards, front desks and receptions so there is nothing to help people to navigate their surroundings unless they are online.

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SUMMARY OF ISSUES AND RECOMMENDATIONS

- Councils and their partners need to work together to facilitate personal choice and control within all areas of care and support planning, and carefully consider how best to achieve this within the local model/approach adopted. They should pay particular attention where different teams and organisations are involved in different steps of the overall process. Consideration should be given to how people are enabled to have the opportunity to choose who supports them to plan if they want help.

- Councils need to invest in staff training and development that focuses on staff enabling people to do as much of their care and support planning as they can – using an Empower and Enable approach.[7]

- Councils and their partners will need to recognise that achieving the above is likely to require radical changes to roles, responsibilities, relationships and skills as well as supporting infrastructure and systems.

- Councils and their partners will need to manage role changes proactively, co-producing workforce planning and restructuring decisions and new arrangements for existing and new staff.

- Councils have a duty to provide good quality information, advice and signposting services for their local populations, including sources of help with care and support planning and support to achieve identified outcomes in care and support plans. In doing so, they should avoid overdependence on online sources of information and advice which some people find difficult to engage with and/or navigate, particularly at times of crisis or uncertainty.

- Councils and their partners need to invest in public engagement, information and education to inform and shape local arrangements for care and support planning, to ensure that local people are equipped to be well informed "intelligent consumers" if they should need to access care and support or are involved in supporting someone else.

7 *www.groundswellpartnership.co.uk/ EmpowerandEnable; and www.thinklocalactpersonal.org. uk/_library/Resources/Personalisation/ TLAPPaper4MinimumProcessFramework.pdf*

3) What's in the plan and how to record it

WHAT GOOD LOOKS LIKE

My care and support plan is about the whole of my life, not just about assessed needs or money. I am encouraged and supported to think creatively about ways to achieve my outcomes.

WHAT THE CARE ACT & STATUTORY GUIDANCE SAYS

The following must always be incorporated in the final plan:

- The needs identified by the assessment.

- Whether, and to what extent, the needs meet the eligibility criteria.

- The needs that the authority is going to meet, and how it intends to do so.

- The individual's desired outcomes requiring care and support.

- The personal budget.

- Information and advice on what can be done to reduce the needs in question, and to prevent or delay the development of needs in the future.

- Where needs are being met via a direct payment, the needs to be met via the direct payment and the amount and frequency of the payments.

(The Care Act sections 25 (1-2))

The care and support plan should also include:

- Any needs currently being met by a carer (Guidance 10.26).

- Contingencies for fluctuating needs, sudden change or emergency. (Guidance 10.44).

- An anticipated review date if the person would find that helpful.

As outlined earlier, the plan must detail the needs, how they are to be met, and how they link to the individual's desired outcomes and to the wellbeing principle in the Act. Outcomes should reflect the individual's wishes, aspirations and what is important to them, where this is reasonable (Guidance 10.31).

The care and support plan may include any additional elements where relevant (Guidance 10.42) and be presented in a format that makes sense to the person (Guidance 10.45).

Upon completion of the plan, the local authority must give a copy of the final plan in a format that is accessible to the person and any carer, advocate or other person requested by the individual (the Care Act 25 (9)).

WHAT WORKS WELL?

Councils whose approach to care and support planning for both adults with care and support needs and carers covers the whole of people's lives – taking account of personal circumstances, aspirations and broad life outcomes as well as specific needs – have designed processes and plans that summarise and record key information such as: outcomes to be achieved, how, by whom, the budget for achieving this and how it will be allocated. In other words, focusing on outcomes helps people focus on the most important information to be captured in a care and support plan.

This highlights the need for assessments to produce a summary of needs, outcomes that are important to the individual and an estimated resource (i.e. the indicative budget) so that these then enable care and support planning to be based on knowledge of all relevant factors. In this approach, there is a difference between the Care and Support Plan required by the Care Act (a summary of how needs relate to outcomes and how these will be achieved) and notes and reflections that may be captured as part of the care and support planning process that remain with the person, and can be as detailed or brief as they choose.

The following councils have each adopted an approach which illustrates a common focus on ensuring person-centred and person-led processes. These lead to short, clear care and support plans that highlight outcomes to be achieved, by when, how and with what resource(s).

Doncaster Council has moved away from standard care plan templates to a personalised care and support planning process and care and support plan summary. This summary is recorded using a form (attached in Appendix 3) that outlines agreed actions to achieve identified outcomes, and has been designed to be proportionate, in line with Care Act requirements. There is a simple sign off process based on the summary record. Those involved in this process emphasise that it's the quality of conversation, skills and judgement of those involved that really matters in this approach rather than having to record and defend lots of detail that is not relevant to the person.

Shropshire County Council and People2People have developed a form that records a series of person-centred conversations starting with the assessment and encompassing the final care and support plan and review. This "Personal Profile" focuses on actions for the individual and resolution of any problems and need for support at the earliest possible stage. This form has evolved from a good quality template with prescribed headings to a more open ended form based on the skills and judgement of those facilitating and recording the process and decision made.

Derby City Council uses a standard template care and support plan that is used for everyone, in every team in all agencies. It also provides a dedicated support plan service. These help ensure a focus on person-centred care and support planning through the use of clear "I" statements that form the basis of the template Care and Support Plan. There is a shared focus on plans belonging to the person and people doing as much of the support planning themselves as possible, with the support of Local Area Coordinators to link them into local resources, natural supports and networks. Professionals only lead the planning process in exceptional cases. For example, people who have complex needs can access qualified social work support, and in-house brokers are available for people if their circle of support or the person indicates that they need help.

Barnsley Council has adopted a creative, fun way of capturing what's in a care and support plan using a comic strip to highlight what's important to and for the person and the outcomes as well as needs that will be met.

WHAT DOESN'T WORK WELL?

An overriding focus on assessed needs and access to services rather than achieving outcomes for the person goes against the spirit and requirements of the Care Act (and wider personalisation agenda). However, there is need to ensure a common and consistent experience and approach. Councils where there is a focus on matching assessed needs to pre-determined services tend to be using a care and support planning template comprised of standard headings, sometimes with extra categories to meet new requirements of the Care Act. Other councils have developed or co-designed a more open-ended or semi-structured form that prompts the person leading or facilitating the planning process to capture person-centred information that can inform actions for achieving outcomes.

One council expressed concern that their standard plan feels tokenistic and 'process-y'; they estimated that currently only 15 per cent of people have really good support planning experiences and
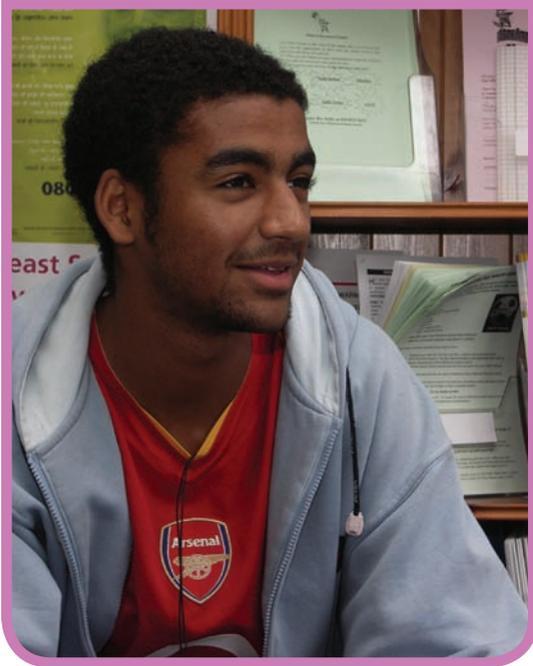
plans. They plan to move towards being Care Act compliant and have invested heavily in training all staff during the first few months of 2015 in preparation for the Act coming into force.

Councils using standardised templates often referred to the need to be IT compliant rather than Care Act compliant, alongside a need to satisfy financial approval and sign off arrangements including panel requirements. IT driven processes and plans focus on identifying indicative budgets and conversations about what the person will spend their budget on. In other words the care and support plan is about how/where I spend my money, not what actions I/others will take to achieve my outcomes and the resources required to do this.

One local authority who has used a variety of approaches to care and support planning felt that "templates [for planning] limit creativity". They stressed the importance of conversations rather than set questions in determining outcomes and support to meet them.

A common concern across local authorities is the variation in quality and approach to care and support planning, resource allocation and the content of care and support plans depending on which client group it is for. They report that fewer plans currently exist and good quality, person-centred planning is less likely to happen for and with older people than for other groups. Councils shared their concerns about the challenges associated with moving from doing care and support plans for small numbers of people (e.g. people who previously had a direct payment or who have been in contact with services for a long time) to this becoming ordinary business for the whole council, i.e. doing this at scale (for example, including those who fund their own care).

SUMMARY OF ISSUES AND RECOMMENDATIONS

• Councils should seek to ensure a focus on outcomes to be achieved, and distilling care and support planning conversations into a summary of these outcomes, agreed actions for achieving them and the budget and other resources that will be used.

- Councils should consider the shape and content of care and support planning forms that enable this process and the record of decisions made to be as individualised as possible whilst meeting the requirements of the Act (e.g. through a semi structured form that is easily adapted to suit the person and their circumstances rather than a standardised template).

- Councils will need to ensure that everyone involved in leading, facilitating, writing and reviewing care and support plans is trained and supported to deliver these elements in consistently person-centred, person-led ways, through person-centred practices.

- Councils will need to consider how information gathered through the planning process can be easily transferred or uploaded onto electronic systems covering assessment, care and support planning and review processes and decisions.

- Due consideration should be given to how personal care and support planning can be experienced equitably across different groups of people drawing on evidence available for what works. For example, where there is local area coordination, this appears to help maintain many older people in mainstream and prevention services and avoid the need for secondary specialist support.

4) Agreeing the plan (including sign off, approval and panel arrangements)

WHAT GOOD LOOKS LIKE

I am supported to take risks, and know it is OK to make mistakes and change my mind.

WHAT THE CARE ACT & STATUTORY GUIDANCE SAYS

The care and support plan should be signed off when the person, any third party and authority have agreed on the factors within the plan, the personal budget amount and how the needs in question will be met (Guidance 10.83).

The agreement should be recorded and a copy placed within the plan (Guidance 10.83).

Responsibility for sign-off should take place at the most appropriate level. (Guidance 10.85).

Due regard should be taken to the use of approval panels, and local authorities should refrain from creating or using panels that seek to amend planning decisions, micro-manage the planning

process or are in place purely for financial reasons. In some cases panels may be appropriate to sign-off large or unique personal budget allocations and/or plans. (Guidance 10.85).

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WHAT WORKS WELL?

Councils highlighted that care and support plans should be agreed on the basis of whether people's outcomes and assessed needs will be met by their allocated budget.

A small number of councils have taken the step of dismantling panels and complicated mechanisms for approving plans and differing levels of allocated budgets or expenditure. Instead, they have clear thresholds for different levels of approval by different grades or levels of staff without the need to seek approval from a panel of council managers.

Shropshire County Council has delegated powers of authority for all expenditure under £1,000/week to People2People. For costs over £1,000 or very complex situations, a weekly conference call is held to resolve any issues and ensure every option has been explored. There is no panel.

In Doncaster, if the person wants a direct payment the social worker phones the direct payments team to arrange implementation as soon as possible. The support plan is only signed off once the person has received their first payment and got started. This means approval is based on how well the arrangement is working for the person.

Some places only use panels to approve unusual financial allocations, for example, significantly higher or lower requests than the indicative budget or where there is a certain level of perceived risk around an individual's support arrangements.

WHAT DOESN'T WORK WELL?

Using funding panels for the primary purpose of controlling demand and costs runs counter to the principles of the Care Act, and to person-centred, person-led care and support planning in particular.

In some councils every care and support plan goes to panel. Even if the package is reduced after review, this decision also needs to go back to panel for approval. This is overly bureaucratic and complex and can lead to considerable anxiety for the individual. Other councils operate panels only for expensive and complex cases or for plans or packages that are jointly funded and delivered with the NHS.

In areas where all care and support plans or personal budgets go through a panel, financial control and formal sign off, it can dominate conversations, decisions and ways of working This makes a person-centred approach more difficult. In the worst cases, this can mean processes that effectively serve to short circuit support planning, discouraging staff from doing the thorough work of person-centred care and support planning that is needed. Where this happens, staff can feel enoucraged to go straight to panel with a short-term crisis plan in order to get a support package signed off rather than having to go through a longer term but more thorough process of care and support planning.

In some areas, the direct payment policy influences how creative people are and can be in care and support planning activities. For example, one council described conversations that focus on how much people "have to spend" per week, every week if they have a direct payment. Such practice limits creativity as much as financial thresholds and expectations are set too low. Conversely, a more effective and personalised approach would outline an indicative, annual budget that can be used flexibly over time to meet someone's needs.

SUMMARY OF ISSUES AND RECOMMENDATIONS

- There is a need for much greater clarity about local sign off and approval arrangements, with a focus on the Care Act principles being implemented with minimal processes and systems.

- Care and support plans should be agreed according to whether the way that people want to spend their budget is likely to meet their outcomes and assessed needs.

- Councils and their partners need to also be clear about the costs of these arrangements. For example, what it costs for panels to meet (including lengthy preparation time) and the time it takes for the whole process to be completed. This includes the knock on effect in terms of delayed decisions, reviews and other competing commitments and obligations for staff involved.

- As part of these considerations, councils can ask themselves if going through a panel is an exception or the norm. The aim should be for exceptions, if used at all.

- Where panels continue to operate, councils also need to think about how people are involved and/or represented at panel meetings. This means how the commitment to enhance choice and control and shift power to the person is maintained.

5) Review

WHAT GOOD LOOKS LIKE

My review is person-centred, focused on me and my life, my outcomes and what is working and not working, not just the money. Through my review I can contribute my views to improving the system as well.

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WHAT THE CARE ACT & STATUTORY GUIDANCE SAYS

Purpose of a review:

- A review helps to identify if the person's needs have changed and whether the plan is enabling the person to meet their needs and aspirations (Guidance 13.4 &13.12).

- Reviews must not be used to arbitrarily reduce a care and support package (Guidance 13.4).

Type of review and who to involve:

There should be a range of review options available which may include self-review, peer led review, reviews conducted remotely, or face-to-face reviews with a social worker (Guidance 13.16).

The review process must involve:

- The person the plan is intended for
- The carer where feasible

- An independent advocate in the circumstances specified in the Act. (Guidance 13.2).

The review may be carried out by a paid professional e.g social worker, or where relevant another party including the individual, a provider, carer or advocate. In such cases, the Local Authority may adopt an assurance and sign off role. (Guidance 13.3).

When reviews should take place:

- A planned review (the date for which is set with the individual during care and support planning, or through general monitoring).

- An unplanned review due to a change in needs or circumstance.

- A requested review, where the person with the care and support plan, their family, carer advocate or other makes a request that a review is conducted. This may also be as the result of a change in needs or circumstances (Guidance 13.13).

- Small or temporary changes to a care and support plan may require only a light touch review (Guidance 13.6 & 13.7).

Frequency of reviews:

The first planned review should be an initial 'light- touch' review of the planning arrangements 6-8 weeks after sign-off of the personal budget and plan.

This light-touch review should also be considered after revision of an existing plan (Guidance 13.15 & 13.32).

It is the expectation that authorities should conduct a review of the plan no later than every 12 months, or more frequently where risks are higher or the person's needs change progressively (Guidance 13.32 & 13.18).

Where an individual has chosen to take a direct payment, this should be reviewed within six months of the payment starting (for new, not existing direct payments). This may be incorporated into the initial 6-8 week review of the care and support plan (Guidance 12.61 & 12.62).

Where a local authority is satisfied that circumstances have changed in a way that affects a care and support plan, the authority must, to the extent it thinks appropriate, carry out a needs assessment, a financial assessment and make an eligibility determination and revise the care and support plan or support plan accordingly (the Care Act section 27 (4). It should not be possible to decide whether to revise a plan without a thorough review to ascertain if a revision is necessary, and in the best interests of the person (Guidance 13.5).

WHAT WORKS WELL?

A person-centred, person-led approach to reviews is central to ensuring that a care and support plan can be actioned as a dynamic tool that flexes in the same way that people's lives change and evolve. It follows that reviews should be at a time, place and pace that suits the individual rather than when an internal process dictates.

Doncaster Council has based their review system and practice on person-centred thinking and practice. A review asks "what's working/not working" from different perspectives; and what is most important for the future taking account of the person's life and identified outcomes. It asks "have you done the actions you committed to?" The person invites who they want to invite and their care and support plan is updated on the basis of this conversation. People's outcomes may not change but how they will achieve them probably will, e.g. what will you or others do over the next six months to achieve your outcomes?

Reviews should be proportionate and include the chance to reflect on how the person's life is going and how care and support is working for them as well as how funding is meeting their needs. This should not mean just a review of purchasing decisions, and therefore

cannot be done by an audit team. Rather, it should be a review of whether the person is achieving the outcomes identified through planning and what is working and not working, including what has been purchased with their personal budget.

Ensuring this happens for everyone who has a care and support plan does have implications for the council and their partners that need to be thought through. For example, who does the review, when and how? What training and skills development do they need to do this? The person facilitating the review must have the skills and values to enable the person and other supporters to reflect and consider how support is working now and what might be needed to ensure outcomes are met in the coming months.

Isle of Wight Council has developed a team whose primary function is to review individuals' care and support plans with them.

In Calderdale, the person who facilitates the review with individuals is, wherever possible, the person who has helped them develop their care and support plan. There is positive feedback from individuals and families where this is offered; an ongoing relationship with the person is key to their feelings of trust and confidence.

Many councils are working out how to differentiate between, and best use, the 'initial review'. This is often undertaken within 6-8 weeks of the care and support plan being implemented, although this varies widely. Councils are also reviewing the standard 'routine review' more typically undertaken at 12 months (six months where a new direct payment is in place). The key challenge for a person-centred system is to ensure that the timing and timeliness of a review is tailored to suit the person's situation and needs.

In Lancashire, staff from Salvere undertake an initial 'welfare check' within the first 2-3 months of a care and support plan being put in place. However, the exact timing is determined by each person's situation, plan and needs. The system flags when each person's review is due and the same person who facilitated the plan facilitates the review with them.

In another area, all social work teams have been trained in person-centred reviews, and information from reviews is used to inform wider service planning and market development through the use of the Working Together For Change.[8]

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8 *www.thinklocalactpersonal.org.uk/library/WTFC_Final.pdf*

Derby City Council offers a standard of a review within three months of the care and support plan being implemented; and they are keen to develop this further. They wish to explore the following questions as part of the review: is the plan promoting and increasing independence? What does the personal budget achieve? How does safeguarding interact with increased independence? Derby also want to better understand how to achieve good value for money for the person as well as the council; for example, through offering leisure passes as a way to promote health and wellbeing. The council is also scrutinising how the market is developing to support people well, taking account of information obtained through people's person-centred reviews. They see reviews as an enabler and facilitator of the market rather than a means for controlling demand.

WHAT DOESN'T WORK WELL?

Where reviews are entirely standardised and "one-size fits-all", councils are more likely to experience long delays in their entire process which is inefficient and ineffective. A more proportionate approach can recognise where a full review is not needed or justified.

Likewise, those areas who treat reviews as a complete reassessment of needs, ie they start the whole process again, will experience similar bottlenecks and delays. Such arrangements are neither proportionate nor adequately personalised.

When reviews are focused purely on the review of the direct payment or other financial arrangement, rather than on the outcomes identified by the individual and broader aspects of what is working and not working for them with their current care and support, important information can be missed and potential problems with delivery of, or access to, support can escalate unnecessarily.

SUMMARY OF ISSUES AND RECOMMENDATIONS

- Councils should aim for person-centred, person-led reviews to be the norm with a shared commitment to ensuring choice and control of the person including over who leads or facilitates the review, who else is involved and where/how this happens.

- Councils need to ensure there is adequate flexibility of timing and frequency, for example by designing a flagging system for scheduling reviews on a personalised basis whilst factoring

in statutory requirements set out in the Act, e.g. initial light touch review within two months, routine review at least annually, and a six monthly review of direct payments (which can be built into the initial check).

- Councils should ensure that reviews focus on progress towards outcomes identified in the care and support plan and what's working and not working from the perspective of the person and others involved in achieving their plan (a 'person-centred review'); it is not a reassessment of needs and should rarely necessitate a repeat of the whole care and support planning process.

- Councils should consider how to ensure that training and support for staff and others associated with preparing for the Care Act includes the review process and approach adopted locally.

- Councils should think about the wider value of information collected at review and how this might be used to drive changes in commissioning and the development of new services, Working Together For Change is one approach to this.

PART3 SUMMARY OF RECOMMENDATIONS

This section pulls together the challenges and opportunities for councils in implementing the requirements of the Care Act relating to care and support planning for both adults with care and support needs and carers. It summarises our recommendations for councils in implementing the five key elements of successful care and support planning and sets out priority actions for councils to act on those recommendations.

1) MOVING FROM ASSESSMENT TO CARE AND SUPPORT PLANNING

- All assessment and planning must start with the person and their informal support in the centre. The best plans are written by people themselves, with any support that they need.

- Good care and support planning conversations start with outcomes, and they always have an indicative resource allocation to work with.

- Ensure paperwork, processes and systems support and enable this approach (not the other way around). Aim for one process and form that can be used by all teams and organisations involved in assessment, resource allocation, care and support planning, brokerage and reviews. Do not run dual or double systems and paperwork.

- Ensure a seamless transition from assessment to support planning, whilst ensuring that people supporting individuals to plan are independent from/external to the assessment function, particularly if this continues to be completed from within council teams.

- Equitable processes and plans are fundamental to the Act and other supporting frameworks (including the Equality Act, the Mental Capacity Act and the Mental Health Act). Council's need to start using person-centred care and support planning for everyone and across the whole council. Gaps and concerns about inequity need to be addressed as a matter of urgency (in line with the Public Sector Equality Duty).

- Where care and support planning needs to take place in a crisis or time-pressured situation focusing on immediate outcomes (such as in hospital or at the point of discharge from hospital), planning for longer term outcomes and support solutions should follow, either as part of the initial review, or when the immediate issues have been addressed.

- Where there are constraints resulting from the limitations of current IT systems, councils should approach their suppliers to look at how their solutions can better support a change in practice.

2) WHO SUPPORTS PLANNING AND HOW THIS TAKES PLACE

- Facilitate personal choice and control within and across all five elements of care and support planning (see page 2), and carefully consider how best to achieve this within the local model/approach adopted. Pay particular attention where different teams and organisations are involved in different steps of the overall process.

- Recognise that achieving the above is likely to necessitate radical changes to roles, responsibilities, relationships and skills as well as supporting infrastructure and systems. Focusing on what good looks like in respect of care and support planning will provide a common, clear steer for local developments.

- Manage role changes proactively, co-producing workforce planning and restructuring decisions and new arrangements for existing as well as new staff/roles. Staff need to be supported to be creative rather than seeing care and support planning as 'yet another process'. Without creativity we tend to arrive at traditional block purchased service solutions rather than flexible approaches that deliver better outcomes for people.

- Consider the provision of and access to good quality, personalised information, advice about personal care and support planning.[9]

- Avoid an overdependence on online information and advice, creating virtual care and support systems that many people find difficult to engage with and/or navigate, particularly at times of crisis or uncertainty.

- Invest in public engagement, information and education to inform and shape local arrangements for care and support planning, to ensure that local people are equipped to be well informed "intelligent consumers" if they should need to access care and support or are involved in supporting someone else.

9 *www.thinklocalactpersonal.org.uk/Browse/ Informationandadvice/*

3) WHAT'S IN THE PLAN AND HOW TO RECORD IT

- Focus on outcomes to be achieved, and distilling care and support planning conversations into a summary of these outcomes with agreed actions for achieving them and the budget/other resources that will be used.

- Think about how to design a care and support plan form that enables this process and the record of decisions made to be as individualised as possible whilst meeting the requirements of the Act (e.g. through a semi structured form that is easily adapted to suit the person and their circumstances rather than a standardised template).

- Ensure everyone involved in leading, facilitating, writing and reviewing care and support plans is trained and supported to deliver these elements in consistently person-centred, person-led ways.

- Think about how this information can easily be transferred or uploaded onto electronic systems covering assessment, care and support planning and review processes and decisions.

- Give due consideration to how personal care and support planning can be experienced equitably across different groups of people drawing on available evidence for what works.

- Consider how to make more use of and facilitate better access to universal services. Better work could be done with Public Health teams based within councils to assist this.

4) AGREEING THE PLAN (INCLUDING SIGN OFF, APPROVALS AND PANELS)

- There is a need for much greater clarity about local sign off and approval arrangements, with a focus on the Care Act principles being implemented with minimal processes and systems.

- Care and support plans should be agreed according to whether the way that people want to spend their budget is likely to meet their outcomes and assessed needs.

- Be clear about the costs of these sign off arrangements; for example what it costs for Panels to meet (including lengthy preparation time), and the time it takes for the whole process to be completed including the knock on effect in terms of delayed decisions, reviews and other competing commitments and obligations for staff involved.

- As part of these considerations, councils can ask themselves if going through a panel is an exception or the norm? The aim should be for exceptions.

- Where panels continue to be run, the council also needs to think about how people are involved and/or represented at panel meetings, i.e. how the commitment to enhance choice and control and shift power to the person is maintained.

5) REVIEWS

- Aim for person-centred reviews to be the norm across the board, with a shared commitment to ensuring choice and control for the person including over who leads or facilitates the review, who else is involved and where/how this happens.

- Ensure that this is not primarily a review of purchasing decisions, and therefore is not done by an audit team. It should be a review of how well the person is achieving the outcomes identified in their plan and what is working and not working, including what has been purchased with their personal budget.

- Ensure that flexibility of timing and frequency is also assured, for example by designing a flagging system for scheduling reviews on a personalised basis whilst factoring in statutory requirements set out in the Act, e.g.

initial light touch review within two months, routine review at least annually, and a six monthly review of direct payments (which can be built into the initial check).

- Make sure that reviews focus on progress towards outcomes identified in the care and support plan and what's working/not working from the perspective of the person and others involved in achieving their plan; it is not a reassessment of needs and outcomes and should rarely necessitate a repeat of the whole care and support planning process.

- Ensure that training and support for staff and others associated with preparing for the Care Act includes the review process and approach adopted locally.

- Consider using approaches like 'Working Together For Change' and intelligence gained from people's person-centred reviews to continually develop the market. This is a way for issues raised by people and social workers to controbute directly to the development of commissioning plans.

Considering these recommendations, we feel there are six priority areas for action by councils and those supporting them to deliver personalised care and support services.

Six priority areas for action:

1) Creating enabling and empowering organisational cultures

2) Designing supportive infrastructures and systems

3) Ensuring equity of access, opportunity and outcome

4) Understanding panels, safeguarding and risk

5) Examining costs and cost effectiveness

6) Developing partnerships for personalisation

These actions cover all five areas of the care and support planning function, and are drawn from concerns shared by councils and work considering the cost effectiveness of different approaches to care and support planning. They do not therefore constitute additional recommendations to those outlined above; they serve to provide a clear set of priorities that need significant attention from councils and their partners.

1) CREATING ENABLING AND EMPOWERING ORGANISATIONAL CULTURES

This set of actions is informed by a range of connected issues concerned with how councils can get beyond focusing on the bare minimum of Care Act requirements in order to realise the transformational potential of the Act's underlying principles (wellbeing, innovative approaches to achieving personal outcomes, proportionality, person-centred and person-led practices within personalised systems of care and support).

This will require a keen **focus on outcomes** (rather than needs and services) and creative ways of achieving those outcomes. This is a significant shift from current ways of thinking and working. It will only happen if the person themselves is enabled to design their own care and support plan with help and guidance where and when needed, based on what's important to them in their life and where they want to be in terms of personal goals and aspirations. There is considerable confusion in many places about what an outcome is, and this must be addressed. This approach is what should drive the whole process, inform care and support plans, guide reviews and form the basis of what gets measured.

Building and embedding an **asset based approach** to local care and support services and systems is an essential foundation for making this happen and work well. This is about both personal assets and wealth, and broader thinking about local communities and natural supports and resources as an asset. Both of these elements are needed if the vision of the Care Act is to be achieved. Local Area Coordination is being used in a number of areas as a mechanism for supporting individuals to have greater voice, choice and control (realising their own assets) over their support by being better connected to their local communities and natural networks.[10]

Continuing to focus on **greater voice, choice and control** is at the heart of the Act and the wellbeing principle in particular. This means ensuring people are at the heart of discussions, decisions and delivery relating to all five areas of care and support planning and beyond in wider local developments. Many of the examples shared in this report emphasise the powerful changes brought about through co-production with local people including those who need support and staff working in a range of teams and organisations.

Developing the workforce within and across all teams, agencies, sectors and roles is crucial if councils are to successfully implement the Act. Skills for Care have produced helpful materials to support this.[11] Where councils have outsourced care and support planning they have invested in the skills and qualities of their local workforce, taking a rigorous and creative approach to supporting their learning and development. This means doing more than offering and requiring attendance at Care Act training sessions. Some councils have offered lots of training to lots of staff and are now wondering if this has led to a focus on process rather than the personalisation of support that the Act requires. At the same time, other councils are concerned there is still much to do to prepare staff for implementation of the Act; many councils have not invested in staff training since the advent of Putting People First in 2007. In determining what training and development staff involved in care and support planning need, the learning from this project has highlighted the importance of being really clear about what good looks like – i.e. focusing on the 10 statements that have informed this work as a guide for teams and partners.

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10 Examples of asset-based approaches in social care are forthcoming in TLAP's Minimum Process Framework and on asset-based community development on TLAP's web site: *www. thinklocalactpersonal.org.uk/SiteSearch/?page=doSearch&keywords=asset&x=0&y=0*

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11 *www.skillsforcare.org.uk/Standards/Care-Act/ Care-Act.aspx*

Doncaster Council brought together a group of social workers from across the organisation on a regular basis, reducing their workloads so that they could come together one day a week with a facilitator to think about implications of the Care Act on their roles and what needed to happen or change. They then held workshops in every locality for this group to share their learning and present ideas and agreed actions to their peers. A training programme was coproduced to address issues that emerged from this process.

Barnsley Council followed a similar process with their personal assistant (PA) market, meeting with this network on a regular basis in a pub over a meal to consult them on the local market for PA support. A virtual, online version of this forum now exists, including a facility for people who are looking for support to find and book a session with a PA.

Camden Council has taken the view that the Care Act both requires and embodies great practice. Rather than creating mandatory training courses on the legal requirements, they adopted a matrix developed by Skills for Care to plan what learning resources are needed on the Care Act, and at what level these should be aimed.[12]

Manchester Council brought people and social workers together to co-produce their own standards around what good looks like. Then they developed this with social workers and social work managers into a 'Progress for Providers' document. This communicates a clear, **shared view of what good practice is**, and a way to assess progress against this. It can be used:

- By individual practitioners to reflect on their practice.
- With a practitioner and manager to reflect on progress and set goals together for practice development.
- Within teams to share examples of good practice and explore challenges and difficulties.

Effective training and support needs to be seen in the wider context of **organisational and system change** to achieve the requirements of the Act. Co-designing the local approach to care and support planning with colleagues and local people based on the 10 statements e.g. to identify the model, key roles and relationships and supporting systems and paperwork that will deliver what good looks like. The Skills for Care matrix can then be used to identify what individual staff members need and want in order to meet the requirements of their roles and key relationships (see footnote 12).

12 This tool can be used by any Council to aid their internal planning, and is available at *www. skillsforcare.org.uk/Document-library/Standards/ Care-Bill-consultation/WCP-resources/The-Care-Bill---learning-and-development-needs-matrix.pdf*

2) DESIGNING SUPPORTIVE INFRASTRUCTURES AND SYSTEMS

Person-centred and person-led practices can only be sustained in supportive environments where **enabling systems and infrastructures** exist to make this happen. Too many councils have described the opposite experience, where people's plans and support are constrained by what their system allows them to purchase or deliver within increasingly tight financial parameters. Creative care and support planning does not have to be more expensive or time consuming if done in a prompt and timely way by people who are in charge of their own planning and plans with the support of experienced, skilled facilitators where needed.

Where this is the case, and systems have been designed with this in mind, it is possible to create **light touch, simple summaries of agreed care and support plans** that can be uploaded onto an electronic system that shares relevant information with those who have a need to know the information this summary contains. The Act makes it clear that the person themselves owns their care and support plan and that it is the summary information that is agreed with the council and drives release of payments for support.

Finally, people value the **opportunity to come together**, reflect and learn with each other about what good looks like and what they are doing to deliver this. Such opportunities are necessary to assist with successful implementation of new duties and to deliver what people say they want from care and support planning.

This does have **major implications for IT systems** that need to move away from cumbersome and unwieldy information requirements and access rights, lengthy processes and template based information that is financially driven. The route to making this change is through agreement of a **minimum data set based on outcomes** and actions to achieve them including confirmed budget arrangements.

There are two key components to the information technology and information sharing needs of councils:

- Public facing information and systems for communities about communities as well as the local care and support system

- Business-to-business information and systems for councils and their partners including contracted providers delivering some or all elements of planning and support.

Some councils are fortunate that they have a comprehensive IT system across the whole council and their partners which they can develop and amend to accommodate the Care Act requirements. Other councils have developed online markets of care and support and are moving towards local rating scales for providers and brokers. However, councils described problems and challenges with their systems in enabling both of these components to work well and deliver the requirements of the Act. It is imperative that these issues are resolved.

3) ENSURING EQUITY OF ACCESS, OPPORTUNITY AND OUTCOME

The inequity of access to and variability of experience of care and support planning must be addressed. All of the councils involved in developing this guide were particularly concerned that older people and people with mental health support needs often miss out on creative approaches and options for support, and that many people working in these areas are still not familiar with person-centred approaches. This **discrepancy between "client groups"** works against the Care Act, the public sector equality duty and requirements of other supporting frameworks (the Mental Capacity Act and the Mental Health Act).

A key concern of councils, which may partly explain this discrepancy, is their anxiety about the anticipated volume of older people requiring care and support and the thought of doing good care and support planning at scale. This includes both those assessed as eligible for care and support and those who are not eligible for state funding. The most creative councils are thinking about what they will offer to everyone, including those people who are not yet (but may become) eligible for state funding. An important aspect of this approach is understanding the meaning behind the new language in the Act (with effect from 2016) relating to a **'continuum of contribution'**. In other words, the concept of universality which means that the same fundamental offer of information, advice and access to support is available to

all; it is just that those who are assessed as eligible for state funded care and support go onto have a care and support plan with an indicative or allocated budget.

Adopting the examples of "what works" shared in this report will help to address these concerns and increase access to excellent practice in care and support planning. A good starting point is for councils, their partners and local communities to work together to agree where inequity exists, in line with the requirements of the Equality Act (2010), using existing evidence based tools (such as the Achieving Age Equality in Health and Social Care toolkit[13]).

4) PANELS, SAFEGUARDING AND RISK

This report has highlighted a number of concerns about the plethora of arrangements that exist within and between councils for the sign off and approval of care and support plans and allocated budgets. Many councils have instigated strict controls as a result of financial concerns associated with reducing resources and efficiency measures, without recognising the costs of complex approval arrangements and panel requirements. Some of these councils think that additional layers of approval will help control risk and manage safeguarding concerns, despite the lack of evidence to suggest that such practice improves outcomes or increases independence and wellbeing.

A **streamlined approach** to signing off, approving and "actioning" care and support plans is more likely to be cost effective and enable proactive risk management where concerns are identified through care and support planning. **Delegated powers of authority**, as close to the person as possible, for agreed levels and limits of budgetary allocations is proving to be not only cost effective, but an enabler for developing creative care and support plans with a focus on natural supports and access to community resources.

5) COSTS AND COST EFFECTIVENESS

The summary of cost information provided by the 12 councils involved in this work (Appendix 1) illustrates the difficulties encountered in comparing the costs associated with the different models of delivering care and support plans. The data that we have been able to collect shows that even for the one model where there is a reasonable amount of cost data (care and support planning outsourced as a discrete function), the **range of the cost of delivering a care and support plan is considerable**.

It has been suggested that there are **potential efficiencies and cost saving through external care and support planning** (Carr, 2010; Jones and Netten, 2010) and one of the recommendations of an Audit Commission report on reducing the cost of assessments and reviews was to involve user-led organisations, and third

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13 See *age-equality.southwest.nhs.uk*

and private sector organisations (Audit Commission, 2012). However, the combination of the broad range of costs where the data does exist and the very limited data available for other models means that there is not enough evidence available to reach firm conclusions about one particular model being more cost-efficient than the others. Furthermore, the outcomes of the care and support plans need to be considered for any cost-effectiveness or cost-benefit analysis to be undertaken, for example, by using The Personal Budgets Outcome and Evaluation Tool (POET).

Further work is needed to **identify different costs and benefits associated with different models and approaches for delivering care and support planning** (and wider elements of the assessment process and delivery of support to achieve outcomes agreed in care and support plans). Councils need to disaggregate costs where these steps and functions are all provided in-house; and examine these in the light of outcomes achieved rather than as a means to further reduce costs or achieve efficiencies in the absence of this information.

6) PARTNERSHIPS FOR PERSONALISATION

This report shares examples of successful and productive partnerships between a number of councils with third sector organisations, and internal relationships between different teams working within the same council. Where good partnerships also exist between local third sector organisations, it is clear that different kinds of markets and plans for support emerge.

What is less clear is the effectiveness of partnerships between councils and their health and housing partners, who also have duties under the Care Act (even though the focus is on Local Authorities to make these new arrangements happen). This is a key area for action and local development in order to develop holistic care and support planning and joined up budgets, for example for integrated services/trusts, in the delivery of personal health budgets and streamlined arrangements for continuing health care funding. It is particularly important in ensuring good care and support planning can happen at scale and across all population and client groups. Where councils plan and deliver services jointly with their health, housing and third sector partners, they find that it is easier to think together about how to do this well.

FINANCIAL COST OF DELIVERING CARE AND SUPPORT PLANNING

As part of the case studies from the councils involved in this work, we sought to collect information about the varying costs associated with different models of care and support planning.

We attempted to collect data on the costs of care and support planning delivered in the following four ways:

1) In-house by social work team.

2) In-house by discrete function or team.

3) Whole process of assessment, care and support planning and money management outsourced.

4) Care and support planning outsourced as discrete function.

Overall, local authorities were able to provide very limited detail about the cost of the care and support planning process. Due to the limited cost data that the local authorities were able to provide, we have supplemented the data available from the case studies with other evidence available from other studies, reports and information available on the internet. The evidence available for each model is provided, followed by a table summarising the data for all models.

1) IN-HOUSE BY SOCIAL WORK TEAM

Local authorities reported particular difficulties in estimating the costs of care and support plans produced in-house by social work teams. They reported that as care and support planning often overlaps and merges with assessments and implementation of the care and support, it is difficult to identify the time spent on the discrete functions of planning and reviews. Attempts to measure the costs of elements of social work practice or support planning in other research studies have experienced similar difficulties in terms of a lack of available information from local authorities (Campbell et al, 2011; Manthorpe et al, 2014).

An evaluation of the Social Work Practice with Adults pilots which aimed to investigate the cost or benefits of contracting out functions of social work such as assessment, care planning and review in comparison to standard services was unable to do so in part due to difficulties in estimating the costs (Manthorpe et al, 2014). A report on a project which transferred support, advocacy and brokerage from traditional, local authority care-management systems to user-led support planning and brokerage, found that direct cost comparisons between user-led organisations and local authorities were not possible, largely because of the difficulty in identifying local authority staff time spent on support planning (Campbell et al, 2011).

An estimate from one local authority suggested that carrying out support planning in house by the social work team could cost between £101 to £328 for a support plan, and £20 and £328 for a review, depending on the complexity of need and whether it is done by a social worker or community care worker. This is based on an estimated cost per hour of between £10.12 and £16.38.

In an article about Sheffield Council's externalisation of support planning, Sheffield Council reported costs of £27.11 an hour for an internal planner and £28-30 an hour for the external counterpart (Community Care, 2012).

2) IN-HOUSE BY DISCRETE FUNCTION/TEAM

One local authority was able to provide figures for the costs of support plans and reviews carried out in-house by a discrete team. In this local authority support plans are costed at £120 for a standard plan and £260 for a complex plan, and reviews are costed at £50.

3) WHOLE PROCESS OF ASSESSMENT, CARE AND SUPPORT PLANNING AND MONEY MANAGEMENT ELEMENTS OUTSOURCED

One local authority was able to provide an estimate for the cost of a support plan when the whole process of assessment, care and support planning and money management is outsourced. A support plan costs £116 on average – this includes support plans completed in group planning workshops as well as individual one-to-one sessions.

4) CARE AND SUPPORT PLANNING OUTSOURCED AS A DISCRETE FUNCTION

There was much more evidence available on the cost of care and support planning that is outsourced as a discrete function – four local authorities were able to provide us with some cost information. Some organisations charge per hour and some have an agreed set price for a support plan or review. Hourly costs range between £10 and £18 per hour and the number of hours for a support plan ranges between three and 10 hours, and set costs for a care and support plan range between and £75 and £450 (although the plan costed at £450 also includes help to implement the plan).

Other evidence shows there is a huge range in the cost of outsourced care and support planning. On the website *www.shop4support.com* support planning is advertised by over 20 organisations between £10.50 to £33 per hour and packages between £200 and £250 (shop4support, 2014). On another website over 20 organisations and individuals advertise support planning between £15 to £32.50 per hour, and packages between £150 and £360 (Help Yourself, 2014).

Type/model of support planning	Local Authority (LA)	Number of hours of staff time	Cost per hour	Estimated cost per care and support plan
In house by social work team	LA A	10-20 hours for support plan, 2-20 hours for review	Estimates based on average salaries: social workers £16.38[i], community care workers £10.12[ii]	Estimates: social workers – between £163.80-£327.60 for support plan and between £32.76-£327.60 for review, community care workers – between £101.20-£202.40 for support plan and between £20.24-£202.40 for review
	Other local authorities	General response from other local authorities is this is not known and difficult to estimate as the time taken to do care and support plan is not separated from assessment etc.		
In house by discrete function/ team	LA B	Info not available	Info not available	
	LA C	Standard planning and information – 6 hours, complex planning and information – 13 hours, review 2.5 hours	Grade 6 staff member £20 per hour (includes on costs)	£120 for standard plan, £260 for complex plan, £50 for review

i Based on average social worker salary of £26,242 *(www.payscale.com/research/UK/Job=Social_Worker/Salary)* x20% (NI and pension)=£31,490/52/37= £16.38

ii Based on average support worker salary of £16,222 *(www.totaljobs.com/salary-checker/average-support-worker-salary)* x20% (NI and pension)=£19,466/52/37=£10.12

Type/model of support planning	Local Authority (LA)	Number of hours of staff time	Cost per hour	Estimated cost per care and support plan
Whole process of assessment, care and support planning and money management outsourced	LA D			£116 average cost per support plan (includes some done in group planning workshops as well as individual 1:1 sessions)
Care and support planning outsourced as discrete function	LA E	3 to 4 hours for basic level of support, up to 6 to 7 hours for more complex support	£18 per hour	Between £54 and £126 (excludes separate service level agreement for management, admin, support plan allocation etc.)
	LA F			£450 for care and support plan (includes help to implement it), £200 for review (includes help to implement it)
	LA G	Use three organisations, average hours not provided (though one capped at 10 hours)	Two out of the three organisations have hourly charge of £10 per hour	One organisation provides free support planning if no support plan previously been produced and decision not made re which support/ service/activity wanted, one charges £100 for support planning
	LA F	Takes average 3 to 6 hours but not paid by hour, paid based on set tariff for support plan	Support planners paid £11.80 per hour (excludes on costs and travel)	£75-£100 per plan – agreed set tariff

A report on a project which transferred support, advocacy and brokerage from traditional, local authority care-management systems to user-led support planning and brokerage detailed the cost of support planning in three user-led organisations.

In one organisation the average time to complete a support plan was just under eleven hours and the estimated the average unit cost to deliver one support plan was just over £550. In the second user-led organisation the mean amount of time taken for support planning was around 12 and a half hours and the average cost for delivering the support plan was £740. In the third organisation the average amount of time taken to complete support plans was just under five hours and the estimated average cost including brokerage, was £880 (Campbell t al, 2011).

This summary highlights the difficulties in comparing the cost of the different models of delivering care and support plans. The data that we have been able to collect shows that even within the one model that we have a reasonable amount of cost data for, the range of the cost of delivering a care and support plan is vast. It should be emphasised for the models where we have cost data for just one local authority this cannot be taken to be representative of the cost of delivering care and support planning in this way.

It has been suggested that there are potential efficiencies and cost saving through external support planning (Carr, 2010; Jones and Netten, 2010) and one of the recommendations of an Audit Commission report on reducing the cost of assessments and reviews was to involve user-led organisations, and third and private sector organisations (Audit Commission, 2012). However, the combination of the broad range of costs where the data does exist and the very limited data available for other models means that there is not enough evidence available to confidently suggest that any particular model is more cost-efficient than the others. Furthermore, the outcomes of the care and support plans need to be considered for any cost-effectiveness or cost-benefit analysis to be undertaken.

CREATIVE APPROACHES TO IDENTIFYING AND ACHIEVING GOOD LIFE OUTCOMES THROUGH CARE AND SUPPORT PLANS
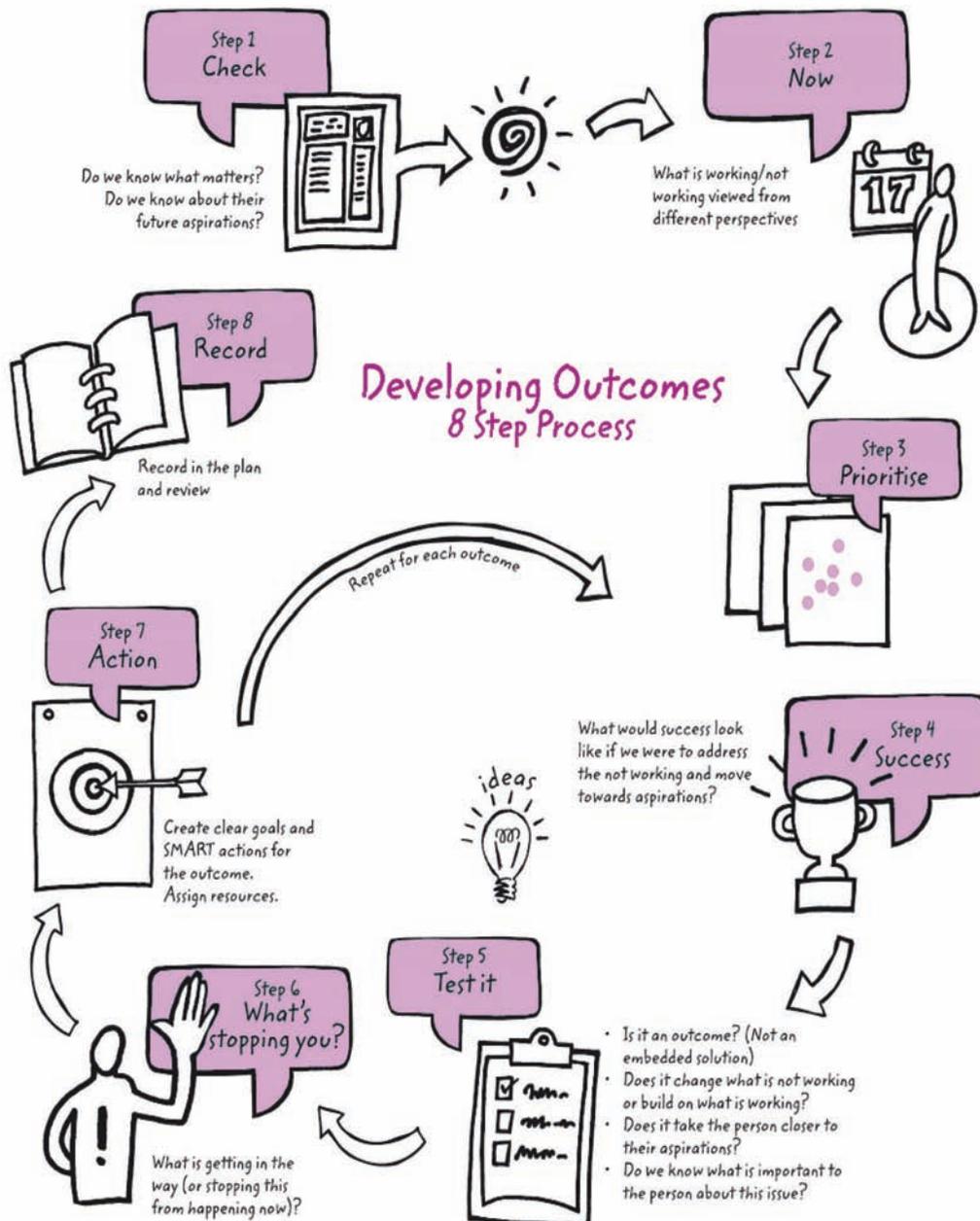
EXAMPLE OF A PERSON-CENTRED CARE AND SUPPORT PLAN

Draft Care and Support Plan

1) MY PERSONAL DETAILS

Title	Full Name	Date of Birth	
Address		CareFirst Number	NHS Number

2) MY SUPPORT NEEDS AND MY PERSONAL OUTCOMES

My Care and Support Needs	My Personal Outcomes/ Goals	How this need will be met informally through preventative, otherwise available support from my community, or my circle of support (if relevant)	Is this particular need considered eligible for Council assistance?	How this need will be met by my Personal Budget? (if relevant)
Accessing work, accessing and engaging in work, training, education or volunteering				
Being part of the community, including making use of facilities				

My Care and Support Needs	My Personal Outcomes/ Goals	How this need will be met informally through preventative, otherwise available support from my community, or my circle of support (if relevant)	Is this particular need considered eligible for Council assistance?	How this need will be met by my Personal Budget? (if relevant)
Carrying out personal care				
Carrying out toileting needs				
Carrying out tasks of being a parent				
Communication/ Sensory Needs				
Household Activity/ Management				
Keeping safe in and around my home and elsewhere				
Mental Wellbeing				
Preparing and having food and drink				
Relationships with family/ friends				
Complex health needs				

3) BUDGET MANAGEMENT OPTION DECISION

To be completed by your Social Care or Health Worker.

This part of the form is for your social care worker to record the budget management decision option.

Budget Management Option
Please tick as appropriate:

☐ Direct Payment　　　　　　　　　☐ Managed Account by social worker

☐ Direct Payment paid to a nominee or authorised person

Reason for Chosen Budget Management Option
If the person has not had a direct payment, this is where the social worker indicates why. The only lawful justification for refusing a direct payment is that the person is excluded from being entitled to one by reason of their status, or that they lack capacity to request one and have no other person fit to be authorised as an authorised person, or that it is not seen to be an appropriates way of meeting the eligible unmet needs. If the social worker believes that a direct payment is not an appropriate way of meeting the eligible unmet needs then the reasons why must be summarised here with reference to risk assessment and decision support tools used.

4) BUDGET

My starter budget amount (annual): _____

My contribution (annual): _____

Direct Payment Amount (if relevant): _____

Frequency of payments: _____

Planned payment/service start date: _____

Any further relevant information (this may include weekly or monthly amount, weekly or monthly contribution, one-off payment information):

5) SERVICES PROVIDED BY THE COUNCIL

If some or all of the budget will be taken as Council commissioned services, please note the details here. These details will be used to help set up service arrangements.

6) DIRECT PAYMENT PAID TO A NOMINEE OR AUTHORISED PERSON

This person is called the 'nominated person'. All correspondence about your Direct Payment will be sent to this person.

Name	
Address	
Postcode	
Telephone Number	

7) INFORMATION AND ADVICE

i) What can be done to meet or reduce the needs in question?

ii) What can be done to prevent or delay the development of needs for care and support or the needs for support in the future?

8) FIRST PLANNED REVIEW DATE

9) SIGNATURES

Customer signature: _____ Date: _____

Nominated Person signature: _____ Date: _____

Carer signature: _____ Date: _____

Worker signature: _____ Date: _____

Team Manager signature: _____ Date: _____

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The Mental Capacity Act (2007)
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The Mental Health Act (2007)
Available at: *www.legislation.gov.uk/ukpga/2007/12/contents*

Working Together For Change
Available at: *www.thinklocalactpersonal.org.uk/_library/WTFC_Final.pdf*

Think Local Act Personal

Think Local Act Personal (TLAP) is a national strategic partnership of more than 50 organisations committed to supporting the continued implementation of personalisation and community-based health, care and support.

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