

Care Act Bulletin

Edition 10

18 February 2015

Welcome to the tenth edition of the Care Act Bulletin. This is a series of Bulletins which have been produced to provide an outline of the key elements in the Care Act, to prompt thinking about how these changes may impact on your organisation and what opportunities it may bring. Each bulletin will cover a chapter in the Care Act Guidance issued by the Department of Health. Links to the guidance and relevant fact sheets are detailed at the end of the bulletin.

CARE AND SUPPORT PLANNING

When the local authority has identified that it has a duty to meet a person's needs (because it is required to or decides in its discretion to meet those needs) it must help the person decide how their needs are to be met. This will be done by the preparation of a care and support plan for those with on-going needs, or support plan for carers.

'Meeting needs' is an important concept under the Act and moves away from the previous terminology of 'providing services'. The Act aims to encourage diversity and innovation in the way in which a person's needs are met, rather than prescribing a service that may be neither best for the person nor what they want. Therefore care and support planning will focus upon the person, their needs and outcomes they want to achieve, not focusing upon existing service provision. This is referred to as person centred care and support planning; it puts people at the heart of their care, and offers them the opportunity to take choice and control over their care and support.

The plan must describe whatever needs the person has presently, on-going and fluctuating, the outcomes the individual is looking for to achieve, maintain or improve their wellbeing and whether, and to what extent, the needs meet the eligibility criteria. The plan must consider any needs that are already being met, for instance by a carer, and this must be clear within the care and support plan so that the authority is able to respond effectively to any changes in circumstances. In addition, where a local authority is meeting some needs but not others, for example; needs which do not fall within the eligibility criteria, the person must receive a care and support plan for the needs the local authority is required, or decides, to meet. The plan must include a tailored package of information and advice on how to delay and/or prevent the persons present or future needs that the local authority is not currently meeting

Everybody will have a personal budget as part of their care and support plan, this identifies the cost of their care and support, and the amount the local authority will make available, regardless of their care setting. The person will be made aware of the meaning of their personal budget and the amount allocated.

Person-centred care and support planning means that a person can choose to receive a part of, or their entire personal budget, as a direct payment, depending on how much control and responsibility they wish to take over the arrangement of their care and support. The local authority must inform the person which, if any, of their needs may be met by a direct payment and provide appropriate information and advice on how to use and manage this. (See other information regarding personal budgets and direct payments).

Person-centred care and support planning takes a holistic approach, which takes into account people's wishes, feelings, strengths, needs, values and aspirations. It puts people in control of their care and they should be free to take ownership of the development of their plan if they wish, or be encouraged to be actively and jointly involved in the preparation of their plan with the local authority. Genuine involvement and ownership can both aid the development of the plan and increase the likelihood that the person may achieve the outcomes that matter to them.

The plan 'belongs' to the person it is intended for. The content of their plan must be in a format that makes sense to the individual concerned and be finalised with them, and with any other people that person has requested to be involved, within the process. Plans can be written using the first person 'I' to emphasise that the care and support plan is owned by the individual. Sometimes people will have developed their own plan to which the local authority has approved.

Once a plan is finalised and agreed it has to be shared with the person for whom the plan is intended, any other person they request receive a copy and their independent advocate, if they have one.

The starting point of the process is that the person has the capability to plan for themselves; therefore there is a requirement to focus upon peoples' strengths and assets, rather than their deficits. This should include both the strength of, and the support that they have within their community, as well as their own personal capabilities. Therefore consideration will be given to how universal services and community-based and/or unpaid support could be contributing factors in the plan. People will be allowed to choose – and source – their own innovative forms of care and support, including 'non-service' options, such as Information and Communication Technologies (ICT) equipment, club membership, or massage. The local authority should avoid lists of allowable purchases or 'prescribed providers'.

The Local Authority will also take steps to ensure that people who may benefit from a type of preventative support receive information and advice about its importance, what it might help with, and how to access it.

In line with the Mental Capacity Act, if the local authority thinks a person may lack capacity to be involved in making a decision or a plan, even after they have offered them all practicable support, a suitably qualified professional needs to carry out a capacity assessment in relation to the specific decision to be made. Even if lack of capacity is established, it is still important that the person is involved as far as possible in making decisions. If a person has substantial difficulty being involved with the planning process, and there is no 'appropriate person' to facilitate their involvement, an independent advocate must be appointed early in the process.

Effective care and support planning should not encourage a lengthy process where this is not necessary, or fixed decisions that cannot be changed easily if the person wishes to make adjustments. The maximum flexibility should be incorporated to allow adjustment and creativity.

A person may also have a care and support plan as a result of a safeguarding enquiry, all the principles of care and support planning outlined above equally apply when working with adults at risk of harm. The aim is to provide support and protection in a least restrictive way possible while helping the

person to achieve the outcomes they want. (See other information regarding safeguarding)

Where a person has more than one plan, such as an education, health and care or safeguarding plan, the plans may be combined to avoid duplication and ensure that the package of care and support is developed in such a way that fits within whatever support is being received or developed, although this will not always be the case. Similarly, where their carer also has eligible needs, the combining of the plans of the adult requiring care and their carer will be considered.

You can view the Department of Health Care Act Guidance by visiting:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_2390277_7_Care_Act_Book.pdf

The factsheet regarding general responsibilities is available on:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366080/Factsheet_1_-_General_responsibilities.pdf