Bath & North East Somerset Council

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Care and Support Planning Policy

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Care and Support Planning Policy

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Care and Support Planning Policy

1. INTRODUCTION

If, as a result of the assessment and eligibility process, a person is found to have unmet eligible needs for care and support that the council must meet,
there is a statutory duty under section 18 or 20(1) of the Care Act (2014) to help the person decide how their needs will be met through the preparation of a care and support plan.

This policy sets out the framework for care and support planning in Bath &North East Somerset and should be read in conjunction with the council's Care and Support Assessment and Eligibility Policy and Carers Guidance. It applies to all:

- Bath &North East Somerset Council employees who are responsible for helping individuals to develop their support plan.
- Staff of any organisation to which Bath &North East Somerset Council has delegated this duty to.

Consideration should also be given to the Occupational Therapy Equipment Policy (forthcoming) when determining if support planning should commence for equipment /aids or adaptions or whether these should be provided under the preventative duties of the Care Act.

Throughout this document the Care Act is referred to as "the Act" and the council and delegated organisations are referred to as the "responsible organisation".

The language used in the Act distinguishes between plans for service users and unpaid carers; describing plans for service users as "care **and** support plans" and plans for carers as "support plans". For the purposes of this document the term "plan" will be used in relation to both adults and unpaid carers and it will be specified if there are any different requirements for service users and carers.

This policy applies equally to adults, unpaid carers and young people in transitions (including young carers), unless otherwise specified.

It is the expectation that when undertaking the support planning process, staff will operate within the decision-making arrangements of the Mental Capacity Act 2005 (hereafter referred to as "the MCA") and the B&NES Multi-Agency Safeguarding Adults at Risk of Abuse Procedures.

2. WELLBEING AND PREVENTION

Sections 1 and 2 of the Act place overarching duties on local authorities to promote an individual's 'wellbeing' and to provide preventative information and/or support that could delay or reduce any needs identified during the support planning process.

The principle of wellbeing requires that the wellbeing of all people who appear to be in need of care and support is promoted, including during the planning process. The Act defines wellbeing for individuals as:

- 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 their day-to-day life (including over care and support provided and the way they are provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal wellbeing
- suitability of the individual's living accommodation
- individual's contribution to society

There is no hierarchy in the areas of wellbeing listed above — all are equally important. Wellbeing is a broad concept applying to several areas of life and there is no single definition of wellbeing. How it is interpreted will depend on the individual, their circumstances and the outcomes they want to achieve. Therefore, using a holistic approach during the planning process will be vital in achieving their wellbeing.

The duty to take action to prevent or delay the development of needs must be applied. Consideration should be given throughout the planning process to what else, other than formal services, could meet the person's unmet eligible needs and support them to meet the outcomes they want to achieve. This includes identifying the strengths, capabilities and resources available within the person's network that they could draw on and the use of small adaptations, equipment (including Telecare) or reablement.

3. CONFIDENTIALITY AND CONSENT TO SHARE INFORMATION

At the start of the planning process, the person must be made aware of how the information documented in their support plan will be shared and their consent obtained. The person has the right to refuse consent or to withdraw consent at any time. If they lack capacity, a best interests decision will be required if the person lacks the mental capacity to make this decision themselves.

However, if the person's safety or the safety of others is at risk, professionals have a duty to share confidential information in line with the Bath & North East Somerset Multi-Agency Information Sharing Protocol.

The Health and Social Care Information Centre has published 'A Guide to Confidentiality in Health and Social Care' which can be referred to for additional guidance.

4. PERSONALISATION

An essential principle of the Act is that the process of developing plans should be person-centred and person-led, so that the person's needs and outcomes are met in ways that work best for them as an individual or as a family member. Support planning and its intended outcomes should be built holistically around people's

wishes and feelings, and their abilities, strengths, needs, networks, values and aspirations.

Bath & North East Somerset Council is committed to The Making it Real agenda, which places people with care and support needs at the centre of the decision-making process about their lives. By using the Markers for Change (Appendix A), responsible organisations can continue to ensure that planning is personalised and focused on the person's aspirations and the outcomes they want to achieve.

5. MEETING NEEDS

The Act introduces the concept of meeting needs rather than providing particular services. The duty is to ensure that a person's eligible assessed needs are met. However this does not necessarily mean that the council or those acting on its behalf must meet those needs. The intention is to allow for a broader range of support options.

Consideration must be given to what, other than the provision of care and support, might help the person to achieve their chosen outcomes. This will include working with the person to explore their strengths, capabilities and what support might be available within their wider support network or the community that they could draw upon. This should be the starting point; and formal interventions or services should only be considered when these potential sources of support have been evaluated.

The options for meeting needs include:

- Informal support from community groups or voluntary services
- Universal services
- Support from family or friends
- Assistive technology, equipment or adaptations
- Direct payments — enabling the person to buy their own care and support
- Care and support from a voluntary provider
- Support commissioned directly via the responsible organisation.

Through the planning process, the responsible organisation needs to assure itself that, whatever means of meeting the person's eligible needs are used, they are an effective way of meeting those needs and that the person agrees to the approach.

6. BEST VALUE

When determining how to meet a person's eligible needs and achieve their chosen outcomes, there must also be regard to the council's available resources. This means that decisions must be made on a case-by-case basis, weighing up the total costs of different potential options for meeting a person's eligible unmet needs. Decisions should include no-cost options, such as support available from the community, and consideration should be given to the cost as a relevant factor in deciding between suitable alternatives. This does not mean choosing the cheapest option, but the one which delivers the desired outcomes for the best value.

7. PERSONAL BUDGETS AND DIRECT PAYMENTS

The Act places personal budgets in law for the first time. Everyone whose eligible needs are to be met by or on behalf of Bath & North East Somerset Council must receive a personal budget as part of their plan.

As the plan is developed, the person must be informed which, if any, of their needs could be met by a direct payment. Advice and information should be given about how direct payments can be used, how they differ from traditional services, how the payments will be administered, signposting to organisations that provide direct payment support, the responsibilities that arise from being an employer, managing the payment, and the option to have a mixed package of some needs met by direct payments and other forms of support.

For further guidance (including where exclusions for direct payments may apply), please refer to the council's Personal Budget and Direct Payments Policy [forthcoming].

8. RESOURCE ALLOCATION

At the beginning of the support planning process, the person will be given an indicative personal budget. This is a guide amount calculated using the council's Resource Allocation Systems (RAS) which is an estimate of the amount of money that will be required to meet a person's eligible unmet needs. This is subject to refinement and re-evaluation through the support planning process and may fall or rise. The person should be encouraged to consider creative ways of meeting their needs, with a view to making the budget go as far as possible in line with best value principles. It is important to note that people whose outcomes are to be met in residential care must also be given an indicative and final personal budget using the RAS.

The RAS, however, cannot always calculate an accurate indicative budget for complex cases that involve high levels of need or specialist support. In these cases it will calculate an indicative budget up to a maximum threshold. This does not mean that the council will not fund support above this threshold. The council must meet the person's eligible unmet needs regardless. However such cases are likely to involve a higher degree of complexity and will require more careful consideration to ensure that the person's needs are met appropriately*

Team Managers and Assistant Team Managers can authorise personal budgets for people with care and support needs and unpaid carers up to the financial thresholds set by the council. It is the council's policy that budgets calculated above these thresholds will be referred to the "Integrated Single Panel", which provides additional guidance and support during the planning process to ensure plans represent value for money and maximise the person's independence and wellbeing.

*There may also be circumstances where a one-off payment is required that cannot be calibrated by the RAS. For example, where a person has been living in unsanitary conditions and a "deep clean" is required to ensure their safety. Such a service is usually commissioned directly and it may not be practicable to calculate into the person's personal budget. In these circumstances, Team Managers should use their

discretion, giving consideration to the individual circumstance of each case, taking into account the severity of the risk posed to the person and if it is practicable/appropriate for the person to contribute from own financial resources. Any request for the necessary payment will be sent to the Council Client Finance Team and such payments are usually made from the Council's community support budget.

9. CARE AND SUPPORT PLANNING

9.1 *What is a Care and Support Plan?*

The main function of a care and support plan is to demonstrate how a person's unmet eligible needs will be met. It must link back to the outcomes that the person wishes to achieve in order to improve their wellbeing, as identified in their assessment. The plan will reflect the person's wishes, their needs and aspirations, and what is important to them, while evidencing how their strengths, capabilities and existing networks of support can be drawn upon to meet their needs.

9.2 *When to undertake care and support planning*

A plan must be completed if, as a result of the assessment and eligibility process, one or more of the following applies:

- The person (including an unpaid carer) has unmet eligible needs as defined by the national eligibility criteria
- The person has been assessed under transitions arrangements as having ongoing eligible care and support needs which are to be met by adult care services.
- The person has unmet needs that have been assessed as not eligible, but the council has agreed to exercise its power to meet some or all of these needs.
- A person who is self-funding requests care and support planning

In some cases **all** of a person's identified eligible needs may be met by other services, such as education, disability benefits, housing, and health, or by an unpaid carer, or by a combination of both. If the responsible organisation is satisfied that these services are or will be in place and/or the carer is able and willing to continue meeting those needs there is not a requirement to undertake support planning. However, those needs and how they will be met must be recorded within the assessment and eligibility process.

There may be circumstances where an individual has been assessed as having needs that do not meet the eligibility criteria but the relevant council commissioner has agreed that the council will meet some or all of these needs, for example where the person has been assessed to be at significant risk of harm if services were not to be provided. In these circumstances support planning must proceed.

People who fund their own care should be encouraged to make their own arrangements. Advice and information about how and where they might access the support they need should be provided.

There will, however, be circumstances where a person, who funds their own care, asks the responsible organisation to arrange care to meet their eligible needs (including where they themselves have previously arranged support) or where they do not have the mental capacity to support plan themselves **and** they do not have an appropriate person who can effectively support them to do this. In such circumstances, care and support planning should proceed.

The responsible organisation may also act as a broker for the person who is self-funding if requested, supporting them to choose a provider and enter into a contract with that provider. This does not however apply to placements in residential care homes. While the council does not currently charge a fee for this brokerage service, there is provision within the Act for it to do so.

9.3 Involving the Person and their Carer(s)

The support plan must be person-centred so that the person has every reasonable opportunity to be involved in the planning to the extent that they can make choices and are able. They must be actively involved and influential throughout the process to ensure that the plan is holistic and takes account of their wishes, feelings, strengths, needs and aspirations. It should be made clear that the plan belongs to the person it is intended for.

All reasonable steps to involve the person and any other person they want to involve should be taken. This means that the person should be supported to understand how they can be involved and what options are available for them. This may involve requesting a Care Act advocate supports the individual during this process. The level of involvement should be agreed with the person and should reflect their needs and preferences.

Where the person lacks the mental capacity to request involvement from others in the development of their plan, all reasonable steps should be taken by the responsible agency to involve any person who appears to be interested in their welfare, including a Care Act advocate if one is required

Where it has been identified that there is an unpaid carer(s) for the cared-for person, there is a new duty under the Act for responsible organisations to take all reasonable steps to involve carer(s) in the preparation of the person's plan.

There may be unusual circumstances however, where the cared-for person refuses any information to be shared with their carer. In these situations, all efforts should be made to agree with the person about what information they will allow to be shared and how their carer might be involved. If the matter cannot be resolved, then advice should be from the relevant council commissioner who can, if necessary, refer the matter to the council's legal advisor.

If the person would have difficulty being involved, it must be established whether their involvement could be supported through changes to the planning process. Under the Equality Act there is a duty to make reasonable adjustments to meet the needs of people with particular accessibility requirements.

If a professional with expertise or training in a particular condition (for example, deafblindness) has carried out or was involved in a person's assessment, then the same professional, ideally, or another professional with similar expertise, should also be involved in the production of the plan to ensure continuity.

9.4 Advocacy

If the person has substantial difficulty in being involved, and adaptations to the process cannot overcome this, all steps must be taken to ensure there is an appropriate individual, such as a friend or relative, who can facilitate their involvement. If there is no-one who can fulfil this role, an independent advocate must be arranged early in the process to support the person's participation.

Please also see the Care and Support Assessment and Eligibility Policy for further guidance about when an independent advocate must be instructed.

9.5 Producing the Plan

The Act stipulates that the following elements must be included in the plan:

- the needs identified by the assessment
- whether, and to what extent, the needs meet the eligibility criteria
- the needs that the council will meet, and how it intends to do so;
- for a person needing care, which of the desired outcomes for care and support could be relevant;
- for a carer, the outcomes the carer wishes to achieve, and their wishes around providing care, work, education and recreation where support could be relevant;
- 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
- needs to be met via direct payments, if applicable, and the amount and frequency of the payments.

Where it has been identified that some, but not all, of the person's needs will be met by the council, the plan must detail how these needs will be met along with tailored advice on how to delay and/or prevent the needs that the council will not be meeting. This information should be given to the person in a format that is accessible to them so that they are clear what needs are being met by the council.

The plan should also record which needs, if any, a carer is meeting. This should also be recorded in the carer's support plan, if there is one. It is good practice to put in place a contingency plan in case the carer is unable to fulfil their caring responsibilities.

Where a person has fluctuating needs, the plan should make comprehensive provision to accommodate this. It should also include contingency plans in the event of a sudden change or crisis in the person's condition.

9.6 *Proportionality*

While the Act specifies what must be included in the plan, planning should not be an unduly lengthy process. Planning should be proportionate to the level of needs and the complexity of the situation, and reflect the wishes of the person to whom the plan belongs, addressing any communication needs they may have.

Flexible and creative approaches are encouraged, so that people can individually plan for how their outcomes may be achieved. For example, a person may choose to incorporate personal elements into their plan which are not included on the standard support planning forms, or to create their own plan that may provide further details about their preference and choices as to how their needs will be will met.

9.7 *Joint Planning*

The person should be given the opportunity to prepare the plan in conjunction with the responsible organisation and/or others if they wish. The test for allowing others to have a role in preparing the plan begins with the understanding that the person has consented to others being involved and there is no conflict of interest.

Circumstances where it **may** not be appropriate for others to be involved include:

- The person does not wish their family to be involved
- Family members have conflicting interests
- The third party lives so far away from the person they are unable to prepare the plan in a timely fashion.
- The third party has been implicated in an enquiry into abuse or neglect or has been considered during safeguarding procedures to have failed to prevent abuse or neglect

Where a person lacks the mental capacity to decide who should be involved in the preparation of their plan a best interests decision will be required, taking into account the above.

Regardless of who is involved in developing the plan, the responsible organisation maintains the obligation to oversee the production and completion of the plan.

9.8 *Combining Plans*

Combined support plans should be considered to avoid duplication and ensure that the person's package of care and support is developed in a way that fits with support that the person is already receiving or is to be developed. This can be done only if all relevant parties agree or, where a person has been assessed as lacking capacity to make decision, it has been concluded that this approach would be in their best interests. Combined plans should be considered where:

- The carer has eligible needs arising from their caring role
- The person has more than one plan, such as an Education, Health and Care Plan, Safeguarding Plan, Care Programme Approach, NHS Care Plan

- Budgets are pooled, either with people in the same household, or among members of a community with similar care needs

When a plan is to be combined, a 'lead' organisation who undertakes monitoring and assurance of the combined plan must be identified. This may also involve appointing a lead professional, and detailing this in the plan, so the person knows who to contact. Particular consideration should be given to ensuring that processes are aligned, coherent and streamlined to avoid confusing the person with different systems. Plans should detail any areas where a joint approach has been agreed.

9.9 Refusal of Support Planning

There may be occasions where a person will decline planning following their assessment. There is no requirement to carry out support planning if the person (if they have capacity) does not wish to proceed, but it should be made clear to them that this will mean that they will not receive a personal budget to meet their eligible needs.

It is good practice to maintain contact with the person, supporting them to consider the implications of their choice and to understand other choices open to them. If the person decides not to have a support plan, they should be provided with details of who to contact should their decision or circumstances change.

If someone who refuses support planning appears to lack the capacity to do this, then a mental capacity assessment and best interest decision should be carried out within the requirements of the MCA. Where there is reason to believe that the person may be at risk from self-neglect or abuse, a safeguarding alert must be made.

10. RISK ENABLEMENT

The council recognises that risk is an inevitable consequence of people exercising choice and making decisions about their lives. A person who has the mental capacity to make a decision and chooses voluntarily to accept a level of risk, is entitled to do so.

To make good choices about how their care and support needs will be met, people need to be able to understand the consequences of their decisions and take some responsibility for them. Individuals should be supported to exercise choice and make reasoned, responsible decisions.

Enabling people to take an informed, reasonable risk is not the same, however, as putting them at risk. Responsible organisations must therefore develop their own policies and procedures for managing risk which should take into account the following considerations:

- **Mental Capacity**

If an individual has the mental capacity to take a decision and knowingly chooses to accept a level of risk, they are entitled to do so, even if it appears to be an unwise decision.

People with learning disabilities, mental health conditions or other conditions that may affect their mental capacity are still entitled to make choices about their life.

It is not always an acceptable or achievable goal to seek to eliminate risk, especially where this would compromise the individual's freedom, dignity or quality of life.

- **Informed Consent**

The individual must be involved in the decision and be supported to understand the alternatives available and the consequences of their decision. They may require additional support or advocacy to help them do this.

- **Risks to Third Parties**

Sometimes people's choices will conflict with those of others. This is not an automatic reason to prevent an individual from exercising choice.

It is important to manage any risks to others with all parties involved, and to find an acceptable resolution that balances both sets of needs. If this is not possible and the level of risk is unacceptable, this could be a reason to refuse to support a particular course of action.

- **Accountability**

Individuals will not be supported to take a course of action that is illegal or dangerous to themselves or others.

The council remains accountable for the proper use of public funds. While the person is entitled to choose a course of action that involves a level of risk, the council is not obliged to fund it. In difficult cases, there must be a robust process to assess and resolve any conflict of interest between the person and the organisation responsible for the person's support plan.

- **Safeguarding**

Where risks to a person appear to be resulting from abuse or self-neglect, a safeguarding alert must be raised and the multi-agency procedures followed.

11. Deprivation of Liberty Safeguards (DoLS)

In line with the least restrictive principle in the MCA, professionals responsible for drawing up plans must minimise planned restrictions and restraints on the person as much as is possible. The MCA provides legal protection for acts of restraint only if they are necessary to prevent harm to the person, are a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm, and are in the person's best interests.

Planned restrictions and restraints must be documented and disagreements should be resolved through formal best interests meetings (if the person lacks capacity), or

a multidisciplinary meeting, involving a wide range of people, including family members and/or an advocate to support and represent the person if required.

If arrangements proposed for the care or treatment of someone who lacks capacity would amount to a deprivation of liberty, this must be authorised in accordance with MCA or Mental Health Act requirements. A deprivation of liberty arises if the person will be under continuous supervision and control, is not free to leave, and lacks capacity to consent to these arrangements. This includes domestic settings, such as a supported living placement, if the council or those acting on its behalf have facilitated the arrangement. The purpose of the placement or the person's compliance or lack of objection to it are not relevant to whether there is a deprivation of liberty requiring authorisation.

The legal judgment of AJ vs a Local Authority (2015, EWCOP 5) confirmed the importance of taking appropriate steps in advance where it is clear (or should be clear) that a person will be deprived of their liberty. It emphasized that, in the vast majority of cases, it should be possible to plan in advance so that a standard authorisation under the deprivation of liberty safeguards can be obtained before the deprivation begins. It is only in exceptional cases, where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered, that a standard authorisation need not be sought before the deprivation begins.

For example, if a best interests decision has concluded that the person is to be admitted into a care home, the organisation responsible for the placement **must** ensure that the home applies to the council for a standard authorisation, unless it is an unplanned move due to an immediate risk to the person's safety.

If it appears that a DoLS application may be required, this should be done without delay. For further advice, the council's DoLS Team can be contacted on 01225 477900

12. SIGN OFF AND ASSURANCE

Those responsible for signing off plans must be satisfied that the plan will meet the person's assessed eligible unmet needs. This will also include assurance that any identified risks to the individual have been properly identified and addressed and that the plan is within the requirements of best value.

The measures proposed in the support plan must represent an effective use of the personal budget in relation to the person's needs and desired support outcomes. There must be evidence that the person's strengths, capabilities and sources of informal support within their network and the wider community have been used to the full before considering formal care and support services or interventions.

It is important to note, that where an independent advocate has been involved, they should not be asked to sign off the plan as this is the responsibility of the responsible organisation.

In the event that the plan cannot be agreed with the person or with any third party involved, the responsible organisation should state the reasons for this and the steps

which must be taken to ensure that the plan is signed off. This may require going back to earlier stages of the planning process.

A copy of the plan must be given to the person for whom it is intended and, if the person asks the council to do so, the carer, advocate or any other relevant person.

13. DISPUTES AND COMPLAINTS

All reasonable steps to limit disputes through effective person-centred planning and transparency in decision-making should be taken. People must not be left without support while a dispute resolved.

If a dispute cannot be resolved, the person should be advised that they can complain to the organisation which is responsible for signing off the support plan or directly to Bath & North East Somerset Council:

Complaints Team
Bath & North East Somerset
Freepost SWB10433
Bath BA1 1BF
Tel: 01225 477752
Fax: 01225 396115
Email: complaints_cypandadults@bathnes.gov.uk
Web: www.bathnes.gov.uk

APPENDIX 1

Making it Real
Markers for change

Information and Advice. Having the information I need, when I need it

- I have the information and support I need in order to remain as independent as possible.
- I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date.
- I can speak to people who know something about care and support and can make things happen.
- I have help to make informed choices if I need and want it.
- I know where to get information about what is going on in my community.

Active and supportive communities. Keeping friends, family and place

- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I have a network of people who support me — carers, family, friends, community and if needed paid support staff.
- I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.
- I feel welcomed and included in my local community.
- I feel valued for the contribution that I can make to my community.

Flexible integrated care and support. My support my own way

- I am in control of planning my care and support.
- I have care and support that is directed by me and responsive to my needs.
- My support is coordinated, co-operative and works well together and I know who to contact to get things changed.

Workforce. My support staff

- I have good information and advice on the range of options for choosing my support staff.
- I have considerate support delivered by competent people.
- I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers.
- I am supported by people who help me to make links in my local community.

Risk enablement. Feeling in control and safe

- I can plan ahead and keep control in a crisis.
- I feel safe, I can live the life I want and I am supported to manage any risks.
- I feel that my community is a safe place to live and local people look out for me and each other.
- I have systems in place so that I can get help at an early stage to avoid a crisis.

Personal budgets and self-funding. My money

- I can decide the kind of support I need and when, where and how to receive it.
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a council managed personal budget).
- I can get access to the money quickly without having to go through over-complicated procedures
- I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this.