Adult Social Care and Health Directorate

Care and Support Planning Practice Guidance

To be read with Tri.X Meeting Needs - Care and Support Plan policy provisions located Kent Adult Social Care & Health Documents and Templates (proceduresonline.com)

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11	July 21	General review and rewrite of the document	Yolaine Jacquelin

10	Oct.19	B2.4 Client signature to the Plan: expectation the plan will include the signature of the person whose plan it is. Default position in absence of person's signature of agreement to plan after 2 weeks in appropriate circumstances only B4.9.2 Referral for Authorisation of the plan may occur before signature of the person.	Cathy Worden Hodge
9	June 2019	B6.7 new -packages of care in the home that include Complex rates Addition of Appendix : Care and Support in the HomeComplex rates guidance	Cathy Worden Hodge
8	29 June 2019	Section B3 Choice of accommodation and Top Ups. This section partly rewritten and expanded to explain an adult's legal right to choose the provider and location (even outside Kent) of specified accommodation type. The Charging Policy for Residential and Nursing Care Home provides more details. B4.1.5 Rewritten in line with GDPR and the legal basis share information in line with directorate Privacy Notice	Jean Wells t
7	Dec.17	General refresh of document Updated information about Disabled Young People Updated information for MH practitioners & Care Act requirements	

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Care and Support Planning Guidance

1. Introduction

On determining that a person has eligible needs for care and support that the Local Authority intends to meet, pursuant to the Care Act 2014 (the Act), a Care and Support Plan must be prepared (Section 24 the Act).

This guidance describes how good Care and Support planning is achieved within Kent Adult Social Care and Health (ASCH) and must be read in conjunction with the Care and Support Planning principles and legislative requirements (duties) as detailed within ASCH Procedures, Practice Guidance and Tools on Tri.x .

Further detailed explanation of Care and Support Planning process and legal requirements can be referenced in the Care and Support Statutory Guidance and Regulations issued under the Care Act 2014 by the Department of Health.

2. Definitions

Care and Support Plan	a Plan that has been achieved together with the cared for adult and contains the required essential elements
Carer	the unpaid relative/ friend offering support to the cared for person.
Contingencies	provisions included in the Plan to cover emergency or sudden change
Eligible needs	the person's needs that meet the Care Act 2014 eligibility criteria
MADE	Making a difference everyday vision and strategy
Meeting needs	more than the provision of services. An important Care Act concept which enables a greater variety of approaches in how needs can be met
Met needs	Eligible Needs that are being met informally by a carer (family/ friend willing and able to provide support) or met via /club membership / community resource/ equipment
Needs	the issue/ difficulty the person has...The question the professional is asking is not "what is it you need?" but: "what are you struggling with at the moment?"
Non-eligible needs	those of the person's needs which do not meet the 3 steps of the Care Act eligibility criteria

Personal Outcomes	the person's personal goals, objectives
Support Plan	a Plan written specifically to support a Carer in their own right
The Plan	either the Care and Support Plan (re adult with care and support needs) or the Support Plan (re a carer).
Pathway Plan	for a young person (aged 16-18yrs) in Care or a Care Leaver
Young Person's Plan	for a disabled young person

3. Key principles of Care and Support Planning

- An assumption that the person is best placed to judge their own well-being
- A focus on the fact that the person's views, wishes, and feelings are critical to a person-centred Plan
- The importance of the person participating as fully as possible in decisions about them and being provided with the information and support necessary to enable them to participate in the process
- Helping adults to achieve the outcomes that matter to them in their life
- Everyone's needs for care and support are different and needs can be met in many different ways
- Use a strengths-based approach: risk can be an enabler, not just a barrier. Support the person in managing or mitigating risks.
- Put people in control of their care and support through allocation of a personal budget to make informed choices
- Having effective interventions at the right time can stop needs from escalating support the person to maintain their independence for longer

4. Use a Strength-based Approach

Care and Support Planning should use a strengths-based approach of looking with the person at what they can do with their skills and their resources and what the people around them do in their relationships and communities rather than making the deficit the focus of the intervention.

Refer to Tr-ix proceduresonline Practice Guidance-On-Approaches-To-Support.docx and Kent Adult Social Care's Practice Framework (Including one page overview)'Making a difference every day'

5. Context of Care & Support Planning

5.1 Care and Support planning occurs:

- after an assessment has been carried out (so the practitioner is clear about the totality of needs the person has) **and**
- after the national eligibility criteria has been applied determining which of the person's needs, if any, are eligible

5.2 Based on assessment

Care and Support planning draws on information gathered and analysed in the assessment. This means that the Care and Support Plan is only as good as the assessment of needs. Refer to Tr-ix proceduresonline Assessment Policy and Practice Guidance pdf and Kent Adult Social Care Policy, Procedures and Guidance (proceduresonline.com)

5.3 The Plan is used to:

- focus on what the person can do using a strengths-based approach
- provide a summary of assessed needs and the outcomes desired as identified by the person.
- Identify what needs are being supported and by whom/how i.e. by a carer or by their wider support network?
- provide information about the cost of their care and support (if applicable).
- identify individual specified outcomes and identified service provision where appropriate, i.e how the provision of care and support is contributing to the achievement of the outcomes.
- provide individualised information and advice about how to delay and/or prevent those needs that are not eligible for support.

6. Care and Support Planning is always done with the adult whose Plan it is

6.1 Personal Decisions

- no one should be assumed to lack the capacity to make their own decisions and the Care and Support Plan should be agreed with the adult
- where an adult needs help with making specific decisions, a clear agreement should be drawn up that reflects supported decision-making principles. The adult should select who will help them to make specific decisions. Different representatives could be selected for different issues; a record of who provides assistance (the representative) and their relationship to the adult will be recorded in the person's case notes.
- the representatives must involve the adult in decisions about their care and support and make decisions they think the adult would make if they were able to make them on their own.

6.2 Advocacy

- Where there is no one appropriate to support and represent the adult's wishes and the adult has substantial difficulty in being involved in the care and support planning processes, an independent advocate must be arranged to facilitate the involvement of the adult.

6.3 Capacity

- Where there is uncertainty about whether an adult has capacity to be able to make their own decisions in their Care and Support Plan, it will be necessary to undertake an assessment of capacity in accordance with the Mental Capacity Act 2005.
- Assessing capacity and seeking consent should not be seen as a one-off activity as there is a need to continually address this particularly when supporting someone with fluctuating or rapidly changing health conditions that impact on their capacity. All decision-making agreements should therefore be regularly reviewed.
- Where an adult's capacity fluctuates and/or is likely to deteriorate over time, forward planning with the adult should provide clear guidance to enable decisions to be made at all times in the adult's best interests.
- Full consideration to be given to any advanced statement for care and support.

7. Communication

- Communication is key to the Care and Support Planning process and should be carried out through the person's preferred method of communication.
- We sometimes assume that information shared is information understood. It is important to check the person has understood what you have said to them.
- If the person is d/Deaf, has a hearing loss or a dual sensory loss (sight and hearing) the Sensory Services team can contribute to the care and support planning process. Contact 03000 421344 or sensoryservices@kent.gov.uk
- KCC has its own language translation (written word) and interpreting (spoken word) service called Connect 2 Staff.
  Email: interpreter.bookings@connect2kent.co.uk or call 01622 236726.

8. Essential Elements of a Care and Support/ Support Plan

Certain elements must (by **legal requirement**) be incorporated in the final Plan no matter what format the Plan is in. They are the **essential elements** of a Plan and are the following:

- the needs identified by the assessment.
- whether, and to what extent, the needs meet the eligibility criteria.
- the needs Kent is going to meet, and how it intends to do so.
- evidence and record the decision when needs can only be met in one of the *specified types of accommodation*.
- for an adult needing care, the relevant personal outcomes recorded.
- timeframes for how and when these outcomes will be monitored and reviewed.
- For a carer, the outcomes they wish to achieve, their wishes around providing care, work, education and recreation where support could be relevant
- the Personal Budget that includes the adult's financial contribution (if any)
- 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.
- 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.

- a KCC representative's signature
- a planned review date.

9. Additional recorded elements

9.1 Informal Support

- In addition to the prescribed essential elements above, ASCH practitioners are expected to record **which needs are being met by the carer** (and other informal support) in order to plan should there be a breakdown in the caring relationship.
- Where the person has fluctuating needs the Plan must include comprehensive provisions to accommodate this

9.2 Section 117 Mental Health Act After-Care needs

- Where the person is eligible for S.117 after-care services it is **essential** that those needs which relate to their mental disorder are identified (jointly with Health) as s117 after-care needs.
- S117 after-care needs must be recorded on the S117 Entitlement Form A located on Tri-x proceduresonline.com and uploaded to Mosaic.
- the person's Care and Support Plan must clearly identify the s117 after-care needs and which services are being provided to meet s117 after-care needs as these services will be provided free of charge and will remain free to the person until the person's eligibility for s117 after-care is ended (which is determined jointly with Health).

Refer to: Section 117 After-care Mental Health Act 1983 Policy and Practice Guidance located on Tri-x proceduresonline.com.

9.3 Contingency Planning

Contingency planning is an integral part of the care and support planning process, and not something decided when someone reaches a crisis point.
Arrangements should be recorded in the Plan to cover the event of a sudden change or emergency such as:

- cover for Personal Assistants, for agency carers when unable to attend, Day Opportunities close
- plans the person made for their pets/ house in the event of a hospital admission or provision of care home accommodation -refer to Protection of Property (includes care of pets) Policy (located on Tri-x proceduresonline.com)
- Emergency contacts/ Who has keys to the house?

9.4 Other plans relating to the person

- take into account other plans will that relate to the person which already exist or are themselves still being compiled such as those relating to carers or family members, to Education, Health and Care, multi-agency co-ordinations or assessments, plans relating to the Mental Health Act (including s.117 of the MHA) and Fire Safety Personal Emergency Evacuation Plan (PEEP)

- take into account any advance statement or advance directive/decision/living will, the person may have
- Relevant information relating to such plans, advance statement or advance directive/decision/living will is to be recorded in the Plan using summary box provided in the Mosaic template, and where appropriate this should include a description of how the person's needs are being met.

Note: Advance statement: a written statement of the person's preferences, wishes, beliefs and values regarding any aspect of their future health or social care or any other matters not directly related to their care. This may include what the person wants to happen as much as what they would prefer not to happen (s9.4. & s9.5 Mental Health Act 1983 Code of Practice). The aim of an advance statement is to guide best interest decisions that may need to be made.

Advance Directive/ Advance Decision/ Living Will: concerned only with the refusal of medical treatment made in advance by a person who has the mental capacity to do so.

9.5. Risk

The Care and Support Plan should set out how the adult considers risk(s) and how they will address these risks. Where the risks are considerable and significant this must include a formal risk assessment to inform the Care and Support Plan. However, an adult can choose to live with a level of risk to themselves provided it is legal and does not affect the safety and wellbeing of others. This is in line with Kent Risk Assessment & Management Policy and Operational Guidance located on Tri-x proceduresonline.com

10. Personal Budget (PB)

10.1 Duty to inform

As part of the adult care and support planning process, there is a **duty to inform** the person about their Personal Budget.

10.2 Indicative Personal Budget (formerly referred to as Estimated personal budget)

An Indicative Personal Budget provides a guide to how much KCC think it will cost to meet the agreed unmet eligible needs. Not all service solutions will have a cost and therefore it may be possible to have a much lower agreed Personal Budget following the care and support planning process.

10.3 Allocation and sufficiency of Personal Budget

- All people with eligible care and support needs **must** be allocated a Personal Budget, including those whose needs are going to be met in residential care and short breaks. The Cost Setting Calculating tool will determine the Indicative Personal Budget (unless their needs dictate a higher price).

- The Personal Budget allocation **must be an amount sufficient to meet the person's care and support needs** and must include the actual cost to Kent of meeting the person's needs.

Refer to Cost Setting Calculating Tool located on Tri-x proceduresonline.com

10.4 What can be included in a Personal Budget

Any activity or service that is legal can be purchased by the person with their Personal Budget, as long as it meets their eligible care and support needs.

Refer to Personal Budget and Cost Setting Guidance located on Tri-x proceduresonline.com

10.5 Exclusions

The following enablement services, and services forming part of an assessment, are excluded from a Personal Budget allocation because they are provided for free and therefore would not contribute to the Personal Budget amount:

- Kent Pathways Service
- Family Support Worker (Young People's teams),
- Kent Enablement and Recovery Service (KERS) (Mental Health)
- Kent Enablement at Home (KEaH)

Other than those services listed above, KCC in house services costs should be included in the Personal Budget allocation.

10.6 Ways to receive a Personal Budget

The Plan must describe how the person would like to receive KCC financial contribution to their Personal Budget and how their Personal Budget will be managed if using a Direct Payment

10.7 Personal Budgets and Best Value

- If the proposed cost is less than, or the same as, the indicative Personal Budget, then the cost will be agreed, and this becomes the Personal Budget recorded in the Plan.
- If the proposed cost is more than the Indicative Personal Budget, then the Plan must be checked to see it supports only eligible needs and represents *best value* before it can be agreed. It may be necessary for the person to look at a cheaper alternative or top up the Personal Budget themselves.
- In some cases, additional resources may constitute *best value* if significantly better outcomes can be achieved. This is a professional judgement that will need to be made with clear evidence, supported by a risk assessment and management approval within delegated authorisation levels.

10.8 Use of Complex Rates

Where it is not possible to meet the needs of the person with a standard care and support in the home service, a package of care including complex rates may be appropriate. Complex rates will only be of benefit to a very small number of people and would be used for a specified period of time.

Any packages of care that include the complex rate must be agreed by an Assistant Director and must include a recommendation from the Practice Assurance Panel and have the support of the Community Team Manager.
See Appendix 3 : Care and Support in the Home – Complex Rates Guidance

10.9 Provide charging information and issue Charging Letter

- Information about care and support charges must be provided to the person and/or representative during the Care and Support planning process.
- To supplement the practitioner's conversation about charging, a Charging Letter should be issued.
- it is established practice the person signs and returns the Charging Letter. The signed letter is a record of understanding they have been told about care and support charges pertaining to their circumstance.
- Where there is a delay in signing and returning the letter it is essential to record on the person's record the date the letter was issued, why it is not signed, the discussions had, and actions taken. A delay returning the signed Charging Letter must not delay meeting a person's assessed eligible needs.

Refer to: relevant charging letters located on Tri-x proceduresonline.com.

11. Direct Payments

- As part of the Care and Support planning process there is a **duty** to provide general information and advice about **Direct payment** and support access to a Direct Payment to meet all or part of their eligible needs identified in their Plan.
- The ability to meet needs by using Direct Payments must be explained at the time of care and support planning.
- Where the employment of a personal assistant(PA) is being considered, it must be explained to the person they will need to have adequate insurance for redundancy payments due to circumstances such as moving home, a change in care and support needs, or the result of the death of the direct payment holder, or care recipient.

Refer to: Direct Payments (proceduresonline.com) and Direct Payments Policy and Practice-guidance pdf located on Tri-x proceduresonline.com.
See also Your guide to employing personal assistants (kent.gov.uk)

12. Financial assessment

- A financial assessment will determine the level of the financial resources and the amount the adult is likely to be able to afford to pay towards their care and support costs.

- Having determined whether the adult has eligible needs, the practitioner should make reasonable efforts to determine whether the adult has over the upper capital limit.
- A full financial assessment may not be required if KCC is satisfied the adult has assets above the upper capital threshold.
- Practitioners must fill in the Financial Assessment Referral work step on Mosaic whether or not a full financial assessment is required.

12.1 When and who to request the means tested assessment.

Effective from 10 May 2023 (5pm), the Practitioner will be responsible for requesting a financial assessment at the end of the care needs eligibility via a "next action" on the System Record (Mosaic). This enables the financial assessment to be completed by Client Financial Services in parallel with the care and support planning. This is a change to the practice whereby the Purchasing team made the request after the commissioned care service had been arranged.

A guidance video explain the changes to Mosaic can be found here.

13. Other sources of funding

There may be instances when a particular item, activity or service in a Care and Support Plan should be funded more appropriately by another agency, for example all major and some minor adaptations receive statutory funding from district and borough councils under the Disabled Facilities Grant. Residents in a care home setting that require nursing care will have the nursing care contribution paid directly to the care home by the NHS

14. Self-funders

14.1 Arrangement of own care

Those adults who have over the upper capital limit will self-fund the cost of their care and will normally be expected to make their own care and support arrangements.

14.2 Duty to arrange care provision if requested.

However, if a self- funder (regardless of mental capacity), living in Kent, requests KCC to meet their eligible needs, KCC **must arrange the provision** of care and support in the **community** (this includes accommodation in supported living, extra care housing, shared lives placement or home care – does **not include a care home**) and should prepare a Care and Support Plan for the person and undertake statutory reviews

Reasons why a self-funder, with eligible needs requests KCC to arrange care and support on their behalf include:

- Lacks capacity (and there is no one authorised under MCA) to arrange the provision of care and support; or
- the arrangements are too complex; or
- want to take advantage of KCC local market of care and support services.

14.3 Arrangement fee

Where KCC makes the arrangements for home care support for a self-funder Kent will charge the self-funder the full costs of their care. In this circumstance the self-funding adult, sometimes referred to as a 'full-coster', will be required to pay an arrangement fee (unless the adult lacks capacity and has no-one appointed to act for them). The practitioner **must** advise the person of the arrangement fee.

Refer to Charging-Policy and Procedures for Home Care-and-other Non-residential Services-pdf located on Tri-x proceduresonline.com

15. Who produces the Draft Plan

It is usually an ASCH practitioner who will produce the Plan document based on what was agreed with the person. However, the person can complete their Plan themselves, ask an advocate, or an independent broker: nonetheless the 'essential elements' must be included in the Plan.

16. Plan format

ASCH practitioner will use the Plan format on Mosaic (Mosaic MADE strengths based approach documentation), which is designed to include the essential elements when correctly completed in full.

The person may request or require their Plan in a format more relevant and appropriate to their needs e.g. it may be short or lengthy, with pictures and/ or text, audio or visual (DVD). Where possible, the person's preferred means of communication should be respected, including alternative languages.

Should you need to develop an easy read Plan, go to:
https://kentcountycouncil.sharepoint.com/sites/KNet/asch/Pages/easy-read.aspx

17. Agreeing the Draft Plan

17.1 Person's signature

The best evidence of the person's involvement in the care and support planning process and agreement to the Plan to meet their eligible needs is their signature (or their **legal representative** or the best interest's decision maker: NB not an independent advocate).

17.2 Record Reasons if unsigned

In the event the Plan is not signed by the person or their legal representative, the practitioner must record the reasons the Plan is unsigned. When the person lacks capacity to understand and agree their Plan, if there is no relevant person to sign, the Best interest decision maker will sign; any supporting Best Interest decisions must be recorded.

17.3 Default position when no signature

- Where it has not been possible to obtain the signature of the person or their legal representative despite best efforts at each stage of the process i.e., draft planning, 8 week light touch review, follow up calls to return the signed Plan;

and where there is no evidence of the Plan being in dispute; agreement to the Plan can be assumed if not returned by the person or their legal representative within two weeks of being presented with the Plan.

- The default position **can only be relied upon if** the person or their legal representative has been advised when presented with the Plan for signature that the local authority will assume their agreement with the content if the signed Plan is not returned within two weeks.

18. Authorisation of Draft Plan

Interim Practice Assurance Process -A consistent practice assurance form for all adults is currently in progress and will be built into Mosaic. This is expected to be ready in early May for all practitioners to use. For the time being follow the interim arrangements described below.

- Practitioners needing to use the practice assurance panel process for people with Mental Health needs, Autism or Learning Disability (LD) are to complete the LD Practice Assurance Form (in Mosaic).

- Practitioners needing to use the practice assurance panel process for older people or physical disability are to continue using the current OPPD practice assurance Form (in Mosaic).

- Please refer to your Community Team Manager for confirmation of which Practice Assurance Virtual Tray in Mosaic you are to use. The Cost Setting Guidance Tool should be used to estimate costs for the practice assurance panel.

The practitioner must advise the person that a draft Plan, including the Indicative Personal Budget is not agreed until signed by a KCC representative.

When the draft Plan fully details how needs will be met, and the person agrees to the contents, it will be authorised by appropriate line management in accordance with approved authorisation levels.
Refer to: Authorisation-of-funding-levels-policy pdf located on Tri-x proceduresonline.com

Practice Assurance Panel (PAP) requires certain draft Plans to be presented to the panel for authorisation. For criteria for mandatory presentation to PAP Refer to: Practice Assurance Panel - Guidance and Procedures.pdf (sharepoint.com)

19. Final Plan

Once the draft Plan has been checked and authorised by appropriate line management, it becomes an agreement between that person and Kent. This agreement will allow Kent to make sure that the care and support chosen by the

person is meeting their needs, in the way they want and enabling them to achieve their desired outcomes. The care and support if arranged by KCC, must be provided in the way the person has specified it in the Plan. (Do not forget that if a person chooses to have a Direct Payment (DP), they will also need to sign a DP agreement which is the formal contract governing the DP- Refer to the Direct Payment policy for further details.)

The practitioner will scan the original signed copy of the Plan on the person's case file, updating Mosaic accordingly.

20. Sharing the Plan

A copy of their Plan must be given to the person and in a format that is accessible to them. The Plan is a confidential document that may be shared securely with other people or agencies identified in the Plan in line with General Data Protection Regulation and the legal bases identified in the directorates Privacy Notice.

21. Arranging care and support -delay resulting from shortage of availability

21.1 Priority Rate

Once the Plan is agreed by KCC, the practitioner will refer the person to the local purchasing team and use the rating/risk matrix to priority rate the person they are referring ensuring a consistent approach to prioritising need across the County.

21.2 Delay and managing risk

- The local purchasing team will endeavour to find services as soon as is practicable to meet the eligible needs of the person as specified in their Plan. However, where there are significant shortages of available required services in the local area there may be a delay in finding the service that will meet the person's needs.
- Practitioners will consider how any risks, caused by the delay in finding a service, can be reduced and together with the person, consider alternative/interim solutions to meeting the person's needs

Reference must be made to *Guidance for priority ratings/risk matrix for people waiting for a community care package* found on Tri-x proceduresonline.com **Guidance-for-priority-ratings-risk-matrix-for-people-waiting-a-community-care-package.pdf**

21.3 Person with Direct Payment arranges their own support

Where the person chooses to receive all or part of their Personal Budget as a Direct Payment, they will arrange their own support for the Direct Payment element of their Personal Budget. Refer to Direct Payment Policy and Guidance.

22 Disagreement

22.1 Issues arising

The practitioner and the family may not always agree about how to meet the adult's needs. Quite often issues have centred around risk taking or finances but

reduced choice resulting from limited resource in the community can also lead to issues arising. We must continue to work with the person to resolve any issues or to agree a compromise. (See 22.6 Undischarged Care Act duties)
In reaching a compromise the expectation is not that the adult will make all the compromises.

22.2 Risk issues

It is important to remember the principle of "promoting independence" is at the core of the Care Act 2014 and that it is better to start with just enough support and then increase the help given if needed.

22.3 Finance issues

- Keep in mind that the local authority is allowed to take into reasonable consideration its own finances. The local authority must comply with its related public law duties which include the importance of ensuring that the funding available to the local authority is sufficient to meet the needs of the entire local population.
- When determining how a person's needs should be met (but not whether needs should be met) the local authority may reasonably consider how to balance their public law duties with the duty to meet eligible needs
- The local authority is not allowed to set arbitrary upper limits on the costs it is willing to pay to meet needs through certain routes.
- The local authority may take decisions on a case-by-case basis. Cost can be a relevant factor in deciding between suitable alternative options for meeting needs. This does not mean choosing the cheapest option; but the one which delivers the outcomes desired for the best value.

22.4 Limited resource

Where community resource is limited, it may not be possible for the person to have their choice of care provider, care worker or time of service delivery. In addition, there may be a delay in the start of a service. This must be clearly explained to the person during the Care and Support Planning stage in effort to manage expectation in a realistic way.

Refer to Guidance-for-priority-ratings-risk-matrix-for-people-waiting-a-community-care-package.pdf located on Tri-x proceduresonline.com

22.5 Issues of Vexatious and Unacceptable Behaviour

Incidents of vexatious and/or unacceptable behaviour from the person we support, or their families, toward in-house service provision care staff and other providers' care staff must be addressed. All care staff, whether directly employed by KCC or a private agency contracted to KCC, have the right to work free from abuse, discrimination, harassment and bullying. KCC cannot however in response to such incidents, choose to end our involvement with the person we support. (see 22.6 Undischarged Care Act duties)

- Where vexatious/unacceptable behaviour from the cared for person or their family is reported a face-to-face meeting should be arranged by the relevant practitioner with the person including their family (where appropriate). The purpose of the meeting is to discuss the allegations made and whether they are accepted, to consider any reasons (including issues of capacity) for the behaviour and work toward a resolution. Proportionate records must be made of any conversations had in attempts to resolve the issue. (see below)
- It must be explained to the person that any validated claims of vexatious/unacceptable behaviour toward care staff risks the service being ended by the provider. In areas of shortage of local resources there will be a further risk to the person that despite KCC's best efforts to find an alternative service provider there may be delays in finding a new service provider. The person could therefore be without a care service for a period of time.
- The effects to the person and their family of any delay in finding an alternative care provider should be risk assessed and the risks shared and discussed with the person and their family (where appropriate) in efforts to find an acceptable resolution or compromise.
  Refer to:
  Handling unreasonably persistent and vexatious complaints.pdf (sharepoint.com)
  Dignity and Respect at Work Policy.doc (sharepoint.com)
  Dignity and Respect at Work Guidance.docx (sharepoint.com)

22.6 Undischarged Care Act duties

The local authority has Care Act legal duties to promote wellbeing and to meet a person's unmet eligible needs. Where the person won't work with us in agreeing/finding solutions to promote their wellbeing and/or meet their eligible needs, or where there are issues of vexatious/unacceptable behaviour leading to services being withdrawn, we cannot discharge our Care Act duties. Our legal duties remain and we cannot simply end our involvement. In the same way, our S.117 MHA legal duties to identify and meet a person's after-care needs continue even if the person doesn't want to work with us. In all cases we must continue to try to work with person.

22.7 Record steps taken to resolve issues

It is important Practitioners record in the person's case file all steps taken including:

- what has been offered
- What has been declined and the reason given
- What steps have been taken to work toward a resolution of the issue
- Capacity of the person to decide on Care options has been considered and whether it is at issue.

- A Risk Assessment has been completed and the risks to the person and family/friends of the person not receiving care and support have been shared and discussed with them.
- A direct payment has been offered and declined by the person or is not appropriate (and why).
- Information advice and signposting has been provided to the person including any referrals to local charities or other support services.
- The person/carer has been made aware of their right to complain and has been provided with the necessary Complaints procedure information.

22.8 Escalation

Continued disagreement must be escalated up to the very senior levels.

23. Review of the Plan

23.1 Legal duty

- We have a statutory duty to ensure that the person's needs continue to be met. The Plan provides the basis for the statutory review and must be revised as appropriate and at least annually.
- The frequency and method of review must be proportionate to the assessed needs, identified risks, circumstances and support arrangements of the person.
- Review of the Plan can be triggered at any time if circumstances change in a way that affects the Plan.
- Review must not be used to arbitrarily reduce a care and support package.

23.2 Process of review

- Involve the adult, any carer the person has and others who the adult wants involved. For a carer's review: whoever the carer wants to be present.
- Ensure the person's outcomes are being met and review how the provision of care and support is contributing to the achievement of the outcomes
- Look at how risks are being managed and whether there are any new risks. (consider Fire Safety and the need for a Personal Emergency Evacuation Plan (PEEP), review any existing PEEP to ensure it continues to meet the person's need)
- Identify any changes in the person's needs or circumstances and consider whether a reassessment is needed. Minor changes which can be accommodated with the personal budget may make it inappropriate for the person to go through a full review. Significant changes will always lead to a proportionate assessment and formal revision.
- Review the Personal Budget allocation (including the Direct Payment)
- Check the person has been paying their assessed financial contribution
- Refer to Care and Support Plan Review Practice Guidance located on Tri-x proceduresonline.com

23.3 Review circumstances of a Deprivation of liberty

- Where an adult is subject to a Deprivation of Liberty review the adult's capacity and circumstances which led to the deprivation of liberty to consider whether any changes should be requested in their best interest.
- Where there is a DoLS or order of the Court of Protection, check the wording of the authorisation if considering changes to the Care and Support Plan that may result in the care regime becoming more restrictive.
- If a change or changes to the Care and Support Plan that render it more restrictive are proposed, the practitioner must apply to the managing authority or Court for review of this Order before any such changes are made. If changes are a matter of urgency, contact Legal services for advice.
- Ensure that the adult's Relevant Person's Representative" (RPR) monitors the implementation of the Care and Support Plan in accordance with the authorisation of deprivation of liberty Court Order.

24. Planning for young people aged 16-25

It is important for a young person aged between 16-25 that practitioners within ASCH teams, Children in Care, 18+ Leaving Care teams and Strengthening Independence Service (previously known as Disabled Children and Young People Service) teams consult and work collaboratively to ensure required processes are followed, including a transition assessment and to ensure the appropriate team is supporting the young person at the appropriate time with the required Plan in place.

24.1 **For young people in care and care leavers**

- A Pathway Plan must be produced from the age of 16 and regularly reviewed. The Pathway Plan will detail the care and support they are likely to have when they reach 18 and beyond.
- under The Children Act 1989, a local authority continues to have responsibility to provide a personal advisor and a Pathway Plan for care leavers, up to their 21st birthday and up to age 25 if they request ongoing support between the ages of 21 and 25. If an adult team has the lead responsibility for the care leaver, then the adult practitioner can fulfil the personal advisor role and will need to ensure that all entitlements are provided to the care leaver.

Refer to kcc-joint-Transition-policy-for-young-people-aged-16-25-years.pdf and Leaving Care and Transition located on Tri-x proceduresonline.com

24.2 **For a disabled young person**

- A Young Person's Plan will be developed.
- Disabled young person who is also a care leaver will require a bespoke Pathway/ Care and Support Plan to ensure Care Act eligible needs continue to be met after their 18th birthday.

Appendix 1 **Care and Support Planning Resources**

References available on Kent.gov.uk Adult Social Care and Health Procedures Practice Guidance and Tools see under Tri.x Contents and Local Resources

ASCH Practice Framework https://kentcountycouncil.sharepoint.com/sites/AdultSocialCareandHealth/SitePages/Making-a-difference-every-day.aspx?csf=1&web=1&e=Vk1ZYh&cid=5c3f4ab0-3b56-412e-8d81-47a9ccc6a267
After-Care Section 117 Policy
Assessment
Authorisation (of Funding) levels Policy (levels of delegation)
Care and Support Plan Review Practice Guidance
Case Law: (BG and KG) v Suffolk County Council [2022] EWCA Civ 1047 Providing recreational activities and holidays under the Care Act 2014: R (BG and KG) v Suffolk County Council [2022] EWCA Civ 1047 - Adults (ccinform.co.uk)
Charging Policy and procedures for Home Care and other non-residential services
Charging Policy and procedures for Residential and Nursing Homes Placements
Continuity of Care Practice Guidance (Ordinary Residence)
Cost Setting Calculating Tool
Developing an Easy Read Plan https://kentcountycouncil.sharepoint.com/sites/KNet/asch/Pages/easy-read.aspx
Dignity and Respect at Work Guidance.docx (sharepoint.com)
Dignity and Respect at Work Policy.doc (sharepoint.com)
Direct Payment Policy and Guidance
Eligibility Criteria
Guidance for Priority Rating risk matrix
Handling unreasonably persistent and vexatious complaints.pdf (sharepoint.com)

Leaving Care Practice Guidance (Transition)
Making Out of County Arrangements and Notifications
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy and Practice Guidance
Ordinary Residence Practice Guidance
Personal Budget and Cost Setting Guidance
Practice guidance on Approaches to Support
Protection of Property (includes care of pets) Policy
Residential and Nursing Care Home Placement Guidance (Older persons only) -**under review**
Risk Assessment and Management Policy and Guidance
Service Provider information and service specifications Adults Strategic Commissioning Frameworks & (Indi) Spot Purchasing - Home (sharepoint.com)
Supporting Carers Policy
Your guide to employing personal assistants (kent.gov.uk)

Appendix 2
Care and Support Planning - aide memoire
Practice Development Team
V1 November 2022

The Care and Support Plan should always be a collaborative document between you and the person and/or their representative. It is based around trying to meet the person's agreed personal desired outcomes in relation to the needs that they have. It is prepared as a result of needs having been identified in the assessment stage and their significant impact having been evaluated in the eligibility document.

- ***Read the Assessment and Eligibility documents again before you visit***: In the Care & Support Plan there is a reminder of the domain areas that have been assessed as eligible and non-eligible but the exact description of the needs is not repeated again since both you and the person will be familiar with, and have copies of the assessment and eligibility documents already.
- ***Be familiar with other relevant Plans that may be in place for the person before you go to see them*:** When preparing a plan for someone's care and support it is important to take into account other plans that relate to them which already exist or are themselves still being compiled such as those relating to carers or family members, to Education, Health and Care, multi-agency co-ordinations or assessments and plans relating to the Mental Health Act (including s.117 of the MHA). Relevant information relating to such plans should be recorded in the summary box provided, and also where appropriate in the description of how the person's needs are being met.
- ***The starting point for planning the care or support to meet a need is the person's desired outcomes, which will have pulled through from your recording of their views on their eligibility document*:** The person's previously expressed personal desired outcomes for both eligible and non-eligible have been pulled through from the eligibility document into the Care & Support Plan and appear in an editable box for each individual domain, as a prompt to help begin planning to meet them. Sometimes people's outcomes have changed or modified during the time that has elapsed between the completion of the assessment/eligibility stage and the drawing up of the Plan so checking with them the content of what was identified is essential. If outcomes are now expressed differently these can be adjusted at this point.
- ***Collaborate with the person by sharing their objectives in order to establish realistic expectations and outcomes*:** A Care & Support Plan that meets people's own desired outcomes (or realistically strives to get as close as possible to them) is going to be entirely relevant to the person. You and they will be planning for a shared objective. It is often the case that a person's needs impact on them and result in a specific outcome or collection of identified issues that the person equates with things that they really want to do or have lost the chance to undertake. Meeting these 'peaks' may mean that the person is able to tolerate other areas of the needs on them because they are of less significant impact on them. Conversely, meeting overall needs with a service that does not address the 'peaks' leaves the person still aggrieved at the things that upset them most, making it appear less effective and less personal. A plan into which a person is personally invested, and which

meets their personally identified outcomes is more robust and sustainable when difficulties arise.

- *Be clear about all aspects of how a person's need is to be met, both informally and formally:* Clarity will highlight the structure of a person's support network which is essential for considering what contingencies need to be in place. Informal care and support may come from a friend or relative who is a carer but can also come from the use of equipment or technology, both of which can help reduce dependency on the interventions of other people and allow a person to direct their lives independently. Consider ways that a person can utilise technology they already have and are familiar with, as well as considering the introduction of new technology or equipment.
- *You do not need to be specific about every detail but you do need to be very clear in recording expectations for how care and support needs will be met*: A Care & Support plan is both a two-way contract of the scope of commitment towards meeting the person's needs and a clear statement of what is expected from everyone (including the person themselves through their actions and behaviours) in order to do so.
- *Be prepared to discuss the situation and provide information and advice where appropriate in the plan:* Care & Support needs change dynamically over time, so information and advice aimed at preventing, reducing and delaying the development of needs has to be considered and recorded where appropriate. The person's role in their own care and support is often a key component in the success of any plan: however limited a person's ability to make choices or to exert influence on their care may be, being able to do so promotes people's self-esteem and self-worth.
- *Record all expectations and commitments relating to informal carers, and be sure to consider and record any impact that caring responsibilities may have on them*: Eligible needs may be being met informally by a carer. Their expectations and commitments should be clearly recorded, as should their ability and willingness to continue to do so in the future. There will always be an impact upon a carer in doing this which may in turn reflect back on the person themselves. Whether the carer has undertaken or declined a full carers assessment of their own the salient points are relevant to the Care & Support plan and should be recorded within it.
- *Be prepared to discuss the situation and explore contingencies for what **might** happen in the future*: Contingency planning should be proportionate and thorough. Planned actions in the event of problems arising are reassuring for the person and make an appropriate and timely response possible for those around them and for the local authority. Pro-active Care & Support planning will approach the wider area of Advance Statements for a person to outline their wishes, feelings and intents regarding issues that concern them and their care should they lose the capacity to be able to state them in the future. Encouraging a person to compile one (or in some circumstances, directly supporting them to do so) is best practice and reflects the collaborative aims of Care & Support planning.

Appendix 3: Care and Support in the Home - Complex rates guidance

It is expected that Complex rates will only be of benefit to a very small number of OPPD adults and would be used a specified period of time.

The complex rate will only be considered where it is not possible to meet the needs of the adult with the standard care and support in the home service and the practitioner has evidenced that they have considered and exhausted all avenues of support available from specialist services that would be better able to treat and/or work with adults to meet their needs.

Services to be considered include, but are not limited to: NHS Continuing Health Care, Mental Health, Sensory and Autism, Learning Disability, Kent Pathway Service (KPS), Kent Enablement and Recovery Service (KERS) and Kent Enablement at Home (KEaH).

The Homecare contract clearly outlines the expectations of the provider in relation to the Complex Service. If a provider is contacting KCC to request consideration of the complex rate, the practitioner will evidence the reasoning in the Care and Support plan and the expected timeframe for delivery.

The Care and Support in the Home Complex Service requires the Provider's Staff to be trained to a higher level to meet the greater complexity of needs of the people requiring Support. In addition to the general standard Providers will:

a) Prepare in depth risk assessments around the areas of higher risk and/or specific behaviour(s) together with what has been put in place to minimise and manage those risks;
b) Provide clear Behavioural Support Plan for people requiring Support that details: the identified behaviour(s); how the behaviour(s) manifest; clear guidelines as to how the person requiring Support should be Supported to reduce the behaviour(s) and what alternative solutions have been considered and/or implemented;

c) Have clear boundary settings;

d) Evidence that Care and Support Workers have had training appropriate to the complex needs of the individual, in particular where there are clinical presentations of mental health issues; Dementia and Neurological function;

e) Evidence that Care and Support Workers have had training in the delivery of intervention strategies;

f) Engage with professionals from other agencies who provide specific Support and guidelines and that you follow their guidelines as required; and

g) Engage with relevant professional Support networks.”

Having received a request, the practitioner when requesting Authorisation of Complex rates must provide:

- Standard paperwork for PAP relevant to the case being presented
- Evidence of the other services considered / Evidence work undertaken by the provider
- Clearly defined outcomes for the complex service with timescales
- Forward plan for end of the complex service

Any packages of care that include the complex rate can only be agreed by an Assistant Director and must include a recommendation from PAP and the support of the Service Manager.

Appendix 4: Quality checklist for a Care and Support Plan
Checklist (createmysupportplan.co.uk)

For both the practitioner and their line manager:
On content:

- Do I get a sense of who the assessed person is: are specific needs clear?
- Are outcomes personalised/ time specific/ realistic/ achievable/ measurable?
- Are all the needs identified by the assessment written out?
- Is it clear which of these needs are eligible using the national eligibility criteria?
- Is it clear **which needs** the Local Authority is going to meet and **how** it is going to meet them?
- Are the needs met by a carer/friend clearly spelled out?
- Are there other plans the person has that should be included ie PEEP, relating to education, plans relating to the Mental Health Act (including s.117 of the MHA).
- Is there a personal budget allocated?
- Is there personalised information about what can be done to meet or reduce the needs in question?
- Is there personalised advice/ information about what can be done to prevent or delay the development of needs for Care and Support in the future?
- If a direct payment has been chosen, is it clear which needs are to be met by the DP and the amount and frequency of the Direct Payment
- Is the document signed and dated by the practitioner and the adult concerned or their legal representative?
- If the adult has specific communication needs, are we clear about how they need this C&SP formatted?

On style:

- Is there anything in my writing that could be thought of as discriminatory?
- Is it jargon free? Have I used the person's own words? (Do they really say: "I need social interaction"?)
- Have I checked spelling/ grammar / use of slang or colloquial expressions?

On critical review:

- If I needed to have a care and support plan, would I be happy to be written about the way the person has been written about? If this care & support plan were to be used in a court of law as part of the evidence, would it stand up to scrutiny?