Derbyshire County Council Adult Social Care and Health

Strength Based Support Policy

Version 5

Contents

If you would like to make any comments, amendments, additions etc. please email ASCH.AdultCare.Policy@derbyshire.gov.uk

1. Introduction

The Care Act 2014 placed a range of legal duties and responsibilities on local authority adult social care departments to work with people to enhance their wellbeing through person-centred, strength based, outcomes focused approaches that seek, where possible, to work in partnership with the person and their carer/s.

This in turn is underpinned by approaches that seek to mobilise and build upon the person's existing strengths, resources, and networks, including any support from family, friends, or others in their community that they might draw upon. This ambition seeks to reinforce the role of people as active participants in their care, i.e., understanding and shaping how their needs may be prevented, reduced, or delayed by actions they or others within their community might take, either instead of, or alongside more formal services.

Consequently, this policy seeks to ensure that wherever possible people requiring social care support will have access to the necessary information, advice, and support to enable them to exercise choice and control over their lives, determine their own outcomes, make decisions, and manage their own risks.

This overarching policy sets out the fundamental principles underpinning the Derbyshire offer to local people with eligible care and support needs and their carer's and seeks to ensure that the council's responsibilities for public funds are discharged lawfully, equitably and on a cost-effective basis.

This and other policy and procedures will promote systems, processes, and support to both staff and the people they work with that are fair, equitable and accessible.

The core legislative requirements upon local authorities are set out in the Care Act 2014 and related care and support statutory guidance and regulations. This introduced some new duties in relation to carers who now have a statutory basis for assessment and support in their own right.

The Care Act 2014 also introduced 'wellbeing' as a guiding principle.

The focus is on meeting eligible unmet needs and their related outcomes rather than providing services.

The duty of care, safeguarding, and risk management responsibilities and other statutory duties remain in place and will continue to shape our approach.

Duties and responsibilities contained within the Human Rights Act 1998, the Equalities Act, 2010 and other relevant legislation (for example, the Mental Capacity Act 2005) also remain.

The principles of self-directed support were developed through national publications, professional debate and stakeholder engagement at both national and local levels and are now embedded in statute.

Milestone documents include:

- Valuing People (2001)
- Valuing People Now (2009)
- Improving Life Chances of Disabled People (Prime Minister's Strategy Unit 2005)
- Carers at the Heart of the 21st Century (2008 – 2018) National Strategy
- Putting People First – A Shared Vision and Commitment to the Transformation of Adult Social Care (15 Sept 2010)
- The Care Act (2014)
- Health and Care Act 2022
- Best Life Derbyshire – Adult Social Care Strategy 2022 - 2025
- The Derbyshire Adult Social Care Practice Framework 2023

Derbyshire County Council Adult Social Care and Health (ASCH) has a long-standing commitment to the delivery of a safe sustainable system of personalised self-directed adult social care and support through a focus on the needs of local people and local communities. This approach embeds the principles of promoting individual wellbeing, prevention, and maximising the capacity of local people and their communities (where appropriate) to make decisions and arrangements for themselves.

In addition, changes at both a national and local level within the National Health Service (NHS), public health and related service areas which promote integrated services working around the person, require that this policy and any related procedures continue to remain relevant and be shaped by both the recent changes in legislation which accompanied the Health and Care Act (2022) and the experience of all key stakeholders.

This policy and related procedures are to be applied alongside other policies and guidance of relevance to self-directed support and other Adult Social Care policies, for example, Recording Policy and Procedures, Eligibility Framework and the range of additional Self- Directed Support Practice Guidance (e.g. assessment, risk enablement, carer's guidance).

This document should be read in conjunction with the Derbyshire Adult Social Care Practice Framework. The Framework is designed as a tool to support best practice under the Care Act and is a way of combining some of the many and varied practice methods, theories and approaches we use as frontline practitioners to discharge our duties. The Derbyshire practice framework incorporates our Adult Social Care Best Lives Derbyshire - Adult Social Care Strategy 2022- 2025 vision and priorities to translate into person led, strengths based, proportionate and outcome focused practice and ways of working.

Wherever a person chooses to take their personal budget as a direct payment (wholly or in part), the Direct Payment Policy And Procedures must be followed.

Purpose of Strength Based Support

Strength based Support is an approach which aims to give more control and greater choice to those people with eligible care and support needs, and carers with eligible support needs. It places the individual (adult or carer) at the centre of their own assessment and support planning on the basis that most people are best placed to understand their own needs and what is likely to work well for them. We should be exploring the simple question "If you could resolve the things that are difficult for you right now, what would change for you?"

We will work with people to enable them to be as independent as possible for as long as possible. To achieve this, we consider: what the person is working toward and their desired outcomes; what could support them to be more independent or maintain their independence; and how to mobilise the person's own strengths and capabilities, along with any support that might be available from their wider networks or within their community.

Strengths-based approaches will also include co-production of services with people who are receiving care and support to foster mutual support networks within their local community. Additionally, the ways in which a person's cultural and spiritual networks can support them in meeting needs and building strengths, should be explored with the person.

Support available from family and friends should consider the appropriateness, willingness, and the ability to sustain this support, including the impact on the person/s providing this. Such arrangements must take place only with the agreement of the person and/or carer/s in question.

Meaningful involvement in the assessment and planning process is a key element of Strength Based Support, including self-assessment. In addition to the provision of effective, accessible information and advice, independent advocacy will be made available to promote involvement where the person would have substantial difficulty in being involved, and there is no one else suitable to support them within their own support network. For further guidance please see the Independent Advocacy Practice Guidance.

In implementing Strength Based Support, we will ensure that effective information, advice, and support are also made available to:

- people who wish to self-assess prior to quality assurance by adult social care (i.e., supported self- assessment, care and support plan/support plan and self-review)
- people who are funding and organising their own care and support
- people who have needs but do not meet our eligibility threshold.
- carers who have needs but do not meet our eligibility threshold.
- supporters of people with social care needs
- individuals and communities who do not easily engage with services.

The overall purpose is to enable:

- increased choice and control - support individuals to be involved in the assessment and planning process
- more effective deployment of the persons own individual and collective skills, strengths, and resources and to improve self-management of their own income streams (e.g., other state benefits related to disabilities) including where relevant any personal budget
- greater flexibility – so that individuals can better shape their support arrangements to suit their individual circumstances and requirements
- social inclusion – better support individuals to identify, participate in and contribute to their local community to better meet their eligible needs and associated outcomes

In practice, for both people and carers who need the support of Adult Social Care, they will have the opportunity to:

- experience greater control over their support arrangements.
- access a wider range of support options.
- have their needs met in ways which better reflect their cultural needs and requirements.
- share control of their risks and safety choices
- receive adequate support in managing their personal budget
- experience improved quality of life and social inclusion

And where appropriate, they will be responsible for:

- entering an agreement based on the care and support plan (for people with care and support needs) or a support plan (for carers with support needs) and the associated expenditure
- spending the personal budget only to meet their assessed unmet eligible needs and associated outcomes agreed within their care and support plan/support plan
- provide information so that outcomes and expenditure can be monitored
- where appropriate pay an assessed contribution under Derbyshire County Council's Co- Funding Policy

2. Strength Based Support in Context: Key Components

Strength Based Support sits within the context of a proportionate approach which deploys a range of graduated interventions appropriate for the persons individual circumstances. These include:

- provision of information, advice, and signposting
- the use of low-level mainstream or universally available services

- the use of more specialist equipment and assistive technology as required
- the use short-term enabling services
- Care Act (2014) compliant assessment

Overall, the key components for people receiving Adult Social Care support are as follows:

Prevention (applying the universal offer at all points of contact with Adult Social Care)

This is a graduated approach which ensures local people's rights to timely information and advice to inform their choices and enable them to mobilise their strengths and resources at each stage. This can include information on widely available ordinary solutions, changed techniques and access to local preventative services which might best meet their own health and wellbeing needs.

The Universal Offer

This ensures where possible, the person's care and support needs will be met by freely available or pre-invested services. This includes maximising access to preventative support opportunities and services that help build independence. Further information is available on the public website

Advocacy

Ensure that people who would experience difficulties due to a lack of capacity or other impairment to engage in the Strength Based Support process are able to have their voice heard using person-centred tools and where appropriate, access to independent advocacy. See separate Advocacy Practice Guidance.

Strength-Based Approaches

Applying strength-based approaches including supporting the person to deploy their own informal support and resources plus the use of the universally available services prior to the application of the Resource Allocation System (RAS) to identify a personal budget.

Use local multi-disciplinary peer group discussions to identify approaches that deliver the most independent outcome. See the Peer Group Discussion Practice Guidance.

Our initial response will ensure that where interim support is necessary to meet essential safety and wellbeing outcomes prior to a full assessment, this will be available.

As far as possible, people who would benefit from short term enablement services should be offered this to assist them to re-learn any lost skills or adopt different approaches/techniques which can maximise their independence.

Where appropriate, simple mainstream solutions should be the first consideration when seeking to meet eligible needs and outcomes; increasing as necessary to encompass more specialist support such as equipment (including assistive technology) and adaptations.
Those who after the application of the above appear to still have unmet eligible needs with their associated outcomes, will have a more detailed professional assessment supported by assessors

from their local Adult Social Care (ASC) Social work and/or Occupational therapy teams.

The Assessment

In line with the overall approach this should be proportionate in that it provides the right level of response to suit the needs of the person, the situation or the level of risk. Further information can be found at Proportionate assessment approaches: a guide from the Chief Social Worker for Adults, principal social workers and principal occupational therapists.

This will seek to identify, differentiate, and agree the person's:

- presenting needs
- assessed needs (eligible and ineligible)
- unmet eligible needs

Where, following the application of universal and preventative services the person still has unmet eligible needs, we will calculate an indicative budget using the resource Allocation System (RAS).

The Care and Support Plan

Where the person has ongoing unmet eligible needs, we will develop with them a Care and Support plan which will set out how these, and their associated outcomes, can be met.

We will assist individuals to identify, plan, and where necessary, purchase the support they need to ensure that they have a viable, safe, and legal care and support plan that meets their agreed outcomes. This may include signposting to other services, ensuring that, where appropriate, people are offered independent support to manage personal budgets and care and support plans including those provided through direct payments.

Direct Payments

We will ensure that we promote the use of, and offer to everyone, a Direct Payment as a means of receiving their personal budget. This provides a more flexible way of meeting their agreed eligible needs and associated outcomes.

3. Assessment and Support Planning

Eligibility for Assessment

Under Section 9 and Section 10 of the Care Act (2014), the department is required to undertake a 'needs assessment' if it appears that the person 'may have needs for care and support' and, in the case of carers, a 'carer's assessment' where it appears that carers 'may have needs for support'. The purpose of the assessment is to identify the person's needs and how these impact on their wellbeing and the outcomes that the person wishes to achieve in their day-to-day life.

For people with fluctuating needs, the assessment will need to consider their care and support history

over a period that is sufficient to establish the ongoing level of need.
Further guidance on assessment can be found in the guidance SDS Assessment and Care and Support Planning. The criteria are laid down in Section 13 of the Care Act 2014 and the eligibility regulations.

Staff guidance on making eligibility decisions can be found on the policies and procedures for Adult Care staff page. For guidance around carers assessments and support planning please go to the Carers Practice Guidance.

The joint protocol for Preparing for Adulthood, developed between Childrens Services and Adult Social Care along with other agencies, provides a framework for supporting young people as they move into adulthood. This enables assessment and any necessary support planning to take place in anticipation of a person reaching adulthood.

Assuring Quality

Our objective is to ensure that our assessment and support planning casework is person-centred as well as consistent in the way we allocate funding for the care and support people need that isn't available from any other means. The quality and performance of our work can be assessed using these two dimensions.

Assessments and plans are quality assured by senior practitioners or service managers as part of operational management. This includes ensuring that:

- strength based approaches have been used consistently throughout the assessment
- universal and preventative responses have been applied correctly to defined needs and outcomes
- the use of equipment and assistive technology has been applied where appropriate
- the assessment has accurately identified both met and unmet eligible needs and outcomes
- where appropriate a peer group discussion has taken place
- there is evidence of a person-centred approach – a good sense of who the person is (either person with care and support needs and/or carer with support needs) and what is important to and for them
- the appropriate assessment documentation has been used including associated risk assessments.
- the 'This Is Me Plan' person centred planning tool has been used to support the assessment of all people with a learning disability and/or Autism and that consideration of its use has been made when working with people with other cognitive impairments such as those with dementia
- eligibility has been applied correctly

Care and Support Planning/Support Planning

The care and support planning process will result in the completion of a person-centred care and support plan which recognises the individual's own strengths, identifies the informal resources already available to them, outlines how these are to be mobilised, and identifies any further support that they might need to enhance their wellbeing.

People will be advised of the range of options for developing a plan, which includes completing it independently, with the help of friends/family or with the support of an adult care worker. Plans can be completed in alternative formats to meet individual client needs alongside that information embedded in the client record system. These should always contain the agreed necessary information to enable contributors / providers to deliver a robust care and support response.

All plans must include:

- the needs identified by the assessment and the associated outcomes the person wants to achieve
- a distinction between eligible and ineligible needs
- 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
- those needs and outcomes that are to be met from the persons own resources and networks
- any remaining unmet eligible needs and their associated outcomes that the authority is going to meet, and how it intends to do so
- the personal budget (if required)
- where some or all needs are to be met via a direct payment, the needs to be met via the direct payment and the amount and frequency of the payments

In all cases the care and support plan will need to reflect what is **important 'to' and 'for' the person**, as well as include details of:

- how any risks will be managed
- a contingency plan which set out how the person will be supported in unforeseen circumstances including any amount of personal budget set aside for this
- how the person will make decisions and stay in control of their life

Further worker guidance is available in the document SDS Practice Guidance - Assessment and Care and Support Planning. Support for people to draw up their own plans is described later in section 8.

For carers, support planning should include:

- details of the needs identified in the carer assessment
- information and advice to support the carer in their role as a carer and to support their eligible needs (e.g., carer's services and support groups)

- the outcomes the carer wants to achieve, including social, educational and employment outcomes
- which needs meet the eligibility criteria
- which needs the local authority will meet and how these will be met
- any risks identified and information on how these will be managed, contingency arrangements and who the carer will contact in a crisis
- where eligible, information about the personal budget available (the amount of money it will cost to arrange the necessary care and support for the carer)

Not every carer's support plan will include all of the above.

Where appropriate, ordinary solutions, universal, and preventative services, should always be considered initially to assist the carer to meet their outcomes.

If the carer's outcomes cannot be achieved in this way, the eligibility criteria for a carer's personal budget should be considered (see the Carers Practice Guidance for further guidance). The support plan must be recorded in a way that is meaningful to the carer and agreed and shared with the carer and a copy provided.

4. Personal Budgets (Scope and Exclusions)

Who is eligible for a Personal Budget?

People Living in the Community

This will apply to adults and carers living in the community who are assessed as being eligible to receive social care funding under the terms of the Care Act 2014 and the eligibility regulations. Eligibility for funding will be applied 'net' of support available, and sustainable from the individuals own care and support network, either currently or planned.

Where eligible, people in crisis situations will receive temporary interim support until their longer- term needs become clear and it is appropriate to begin the self-directed support process by determining an indicative budget.

People Living in Residential Care

If assessment or support planning leads to a decision that long-term residential care (either funded by the local authority or other means) is the most appropriate way to meet the assessed eligible needs, then the principles of Person Centred Support will still apply.

In these circumstances the Personal Budget will be agreed at the level required to contract a service that can meet the assessed needs and outcomes i.e., the current cost to the local authority of meeting those needs (HSCA 2022 section 26. 1 a).

A personalised care and support plan will be developed with the person. This will be used to enhance

choice and control over care arrangements. The care and support plan must also be offered to those who fund their own care.

This will be reviewed in the light of the eventual implementation of changes proposed in the Health and Social Care Act (2022) which will require where the amount referred to in section 26 1a (above) includes daily living costs, the amount attributable to those daily living costs."

Who is not Eligible for a Personal Budget?

People who do not have Unmet Eligible Needs

Following assessment, where a person or their carer does not meet the eligibility criteria they will not be entitled to publicly funded care and support.

However, assistance will be given by providing information and advice, and where required signposting to appropriate services including the Brokerage service.

5. How is the Funding for Personal Budgets Determined?

The Resource Allocation System (RAS) is the tool we use to create an indicative budget (IB) which is the starting point for someone to develop a viable care and support plan.

The Derbyshire RAS has been developed with Imosphere (formally FACE Recording and Measurement Systems Ltd) and involves an automatic calculation of the likely cost of care and support for a given level of need. This first step generates an initial sum based solely on the assessed needs of the individual. This considers the impact of equipment but does not at this stage include consideration of any informal support.

The figure is then moderated by including of the impact of any sustainable informal support which then results in the indicative budget.

This approach aims to give people a realistic, fair, and reliable indication of how much their care might cost. It provides a starting point to enable the person to develop their care and support plan and should not be seen as the definitive funding amount. Please note that the final amount of personal budget (PB) a person may eventually receive may be higher or lower than the calculated IB following the care and support planning process. The Derbyshire RAS will provide an allocation of funding that, for most people most of the time, is a realistic and reasonable starting point for their care and support planning.

Only at the point that the agreed Care and Support plan is signed off is the personal budget (PB) confirmed.

Decisions about actual levels of funding for each personal budget will be based on the most cost-effective way to meet the identified unmet eligible needs of that individual based on the assessed need, potential risks, and personal circumstances.
A guide has been developed to help people who may require Adult Social Care support understand

the RAS – Derbyshire Adult Care RAS Summary.

A more detailed explanation of how the RAS works (known as 'Detailed Summary of the Derbyshire FACE RAS is available on DCC website.

Further details of the case review decision-making framework and recording requirements are available in the practice guidance.

6. How Can the Personal Budget Be Used?

What it can be Used for?

In principle a personal budget can be used for any expenditure that meets the person's assessed unmet eligible needs and associated outcomes as defined in the agreed care and support plan (or support plan) where that expenditure is lawful, effective, and affordable.

Lawful - the expenditure identified as part of the care and support/support plan is legitimate and does not contravene any national guidance on how funds can be used.

Effective - the proposals in the care and support/support plan relate to the agreed outcomes which will meet the assessed unmet eligible needs.

Affordable – the total planned expenditure identified as necessary to meet the person's unmet eligible needs can be accommodated within the individual budget. While the Care Act 2014 does allow local authorities to consider the affordability of the services it provides, any legal judgment would likely to rest on the reasonableness and clarity of decision making by the assessor.

NB: The cost of short-term preventative services provided as part of an extended rehabilitative or assessment process is excluded from any personal budget.

For detailed examples of how funding can be spent please see the Strength Based Support Practice Guidance Assessment and Care and Support Planning.

How a Personal Budget can be Managed?

Direct payments - the individual or their representative receives regular payments and manages the personal budget to meet the persons agreed identified needs and outcomes.

OR

Virtually managed - the individual or their representative asks the council to manage all the arrangements.

OR

A combination of the above - the individual takes direct payments for some of the support and asks the council to manage other areas of need on their behalf.

Direct Payments and Risk Management

The establishment of personal budgets in the Care Act (2014) means that over time more people may choose to use a Direct Payment to purchase services or support. This includes people with a degree of vulnerability. Consequently, we need to ensure Direct Payments are a realistic option for most people so they are able exercise the choice and control they wish, while having sufficient oversight to protect those who may be at risk of exploitation.

Further guidance on this is available within Direct Payments Policy and Procedure document.

NB: Where a person is unable to consent or to manage a direct payment, a risk assessment of any 'suitable person' who may take on this role needs to be undertaken.

Personal Budget Taken as a Direct Payment Cannot be Used For

If a person takes their personal budget as a direct payment, by law there are some restrictions on what people may purchase with it. This means people cannot spend a direct payment to:

- buy long term residential or nursing home care (other than limited to short stays of up to four weeks separated by a further period of four weeks)
- pay for healthcare
- buy anything (services or items) that would put them in conflict with the law
- employ their spouse, partner or close relative living in the same household unless there are exceptional circumstances
- purchase services from Derbyshire County Council or another council (there are exceptions to this – see direct payment guidance)
- purchase equipment*

NB. In Derbyshire, most equipment items are supplied through the pre- invested Integrated Community Equipment Service (I.C.E.S.) and are recycled when no longer required. Assistive technology equipment/sensors or other kit are 'loaned' to people on a similar basis, consequently, due to the need to consider best value, a direct payment for such equipment would only be available in exceptional circumstances.

Outside of these prohibitions the government guidance clearly indicates personal budget holders must be able to use the funding in ways and at times of their choosing where this supports them to achieve the agreed outcomes in their care and support plan.

More detailed guidance is available in the Direct Payments Policy and Procedure and practice guidance documents.

It must be evidenced that each person will be spending their direct payment in ways that:

- will meet the unmet eligible needs and associate outcomes as identified in their care and support plan (or support plan, if a carer)
- will maintain the persons wellbeing

- will be of a reasonable cost and take up a proportionate amount of the personal budget

7. Support to People and their Carers or Representatives

It is important to recognise the diversity of the population within the county and the different needs of individuals and communities particularly around communication that is essential enable them to participate fully in the assessment and care and support planning process.

We can provide information in a variety of alternative formats including other languages, easy read, large print, and Braille and have access to interpreter services.

Each team will understand the communities in their area and should develop a knowledge of the local resources available to them which will assist in them in reaching all sections of their communities.

In addition to the support available from the Adult Social Care Social Work teams, there are several other support services available in Derbyshire.

Support Brokerage Services

A range of User Led Organisations (ULO's) and independent or voluntary sector organisations may support people to develop their care and support plans/support plans and broker services. Any costs associated with this should be met by the individual personal budget recipient.

Independent Advocacy

People and /or their carers/representatives may choose to seek support from other organisations, where they have specialist needs or require an advocate. Advice will be given to individuals about alternative sources of information, guidance, or advocacy services where required. Where people are identified as having substantial difficulty in being involved in the process then Adult Social Care have to a duty to involve an independent advocate and will make these arrangements.

Adult Care Brokerage

Brokerage is the process of finding and matching providers with people's specified support outcomes. The service aims to increase choice and control for people when deciding upon their service provision. This will include how their budget is spent, how support is provided and who by. The Brokerage Service Practice Guidance provides more details about this service.

Direct Payments

A range of resources are available to support people to manage Direct Payments including guidance on the responsibilities of being an employer (see Skills for Care webpage).

8. Positive Risk Management and Safeguarding

Safeguarding responsibilities require us to demonstrate that the following guiding principles have been utilised in the context of risk management:

- a person-centred approach has been used to identify good person-centred outcomes
- capacity and consent issues have been fully considered; and
- defensible decisions are evidenced with any conclusions reached having a clear rationale

Risk Enablement

Risk is part of everyday life and is inherent in everything we do. Positive risk taking can enable people to learn from experience, discover new skills, and develop as a person. It is impossible and undesirable to live in a risk-free world. People who use services from Adult Social Care should not have less opportunity than other citizens to strive towards interesting and rewarding lives.

Risk enablement is an approach to decision making which is based on the premise that everyone we work with should be supported to make their own choices and take actions which improve their quality of life. At times this may include making choices or actions that are considered by others as risky or unwise.

Risk enablement does not mean the disregard of potential risks to the person or others but needs to be balanced along with our safeguarding responsibilities, health and safety procedures, and our duty of care to people and/or carers.

It is not about keeping people safe from all forms of harm, but to provide a structure that endeavors to assist the person and, where appropriate, their friends, family, and professionals to make safe, informed and considered decisions about specific situations that lead to the best outcomes for them.

For detailed guidance see Self Directed Support Risk Enablement Practice Guidance. Risks specific to direct payments usage are dealt with earlier in section 7 of this document and fully within the Direct Payments Policy and Procedure.

Safeguarding

If it appears there are safeguarding considerations that impact on the person and/or any other potentially vulnerable person who meets the definition within the safeguarding procedures, then the safeguarding procedures will be implemented.

The safeguarding adult's policy and procedures contain further information about actions that should be taken by organisations and in individual work practice to reduce the potential abuse of vulnerable adults.

9. Care and Support Plan/Support Plan Review

The Care Act (2014) requires Adult Care staff to carry out regular reviews of the needs and arrangements for people and those carers in receipt of publicly funded care and support.

Further guidance is available in the document Practice Guidance – Self Directed Support Reviews.

Case Co-ordination

Due to the complexity of their situation, some people will have a nominated case coordinator who will work with them to provide oversight of their care and support arrangements and will coordinate any review. This may include people who are wholly funded or joint funded with health and for some people this role will be undertaken by a nominated health professional.

Ideally, we would like to support those people who can and are willing (or have a family member or carer who could do this) to coordinate and review their own care and support plans.

We will also have a responsibility to ensure arrangements are in place to oversee the care and support arrangements for those people who are self-funding their care but are unable to co- ordinate this for themselves and have no one else to do so.

Reviews

Reviews should be outcome focused, person-centred and proportionate in depth and scale including, where necessary, a re-assessment to ensure the support for the individual remains consistent with any changes that they may experience in their needs, circumstances, and outcomes over time. This approach avoids increases or reductions in support to people before sufficient information is known about them and is in line with the eligibility regulations and local guidance. In accordance with Section 27 of the Care Act 2014 and statutory guidance, the projected timing of the review will be established with the person and where appropriate their carer, at the commencement of their support.

Other Review Systems

Where there are other review systems operating (e.g., care programme approach, safeguarding, Continuing Health Care (CHC), Community Treatment Reviews (CTR) and Care Quality Commission (CQC), reviews and those undertaken under Local Area Emergency Protocols (LAEP)), the dates of these reviews should be considered and where possible coordinated through the MDT to reduce duplication. The person should experience as seamless a process as possible.

The Review Process

The review process should, in all cases, consider whether the needs and circumstances of the individual have changed over time and highlight any emerging or known needs, risk and vulnerabilities. It should also include the views of the individual concerned and other professionals/agencies.

Reviews should always include an up-to-date determination of eligibility.

Triggering a Review

A review can be triggered at any time depending on changes in circumstances. In Derbyshire, the recommended best practice interval for reviews is:

- informal review at 72 hours where appropriate
- first formal review of the support package within 6-8 weeks (statutory guidance)
- further reviews will be at an interval no greater than 12 months (statutory guidance)

Individuals and carers who are in complex circumstances with rapidly changing needs are likely to need more frequent reviews, determined on a case-by-case basis with the agreement of the service manager.

Equipment

One-off pieces of simple equipment need only an initial confirmation of suitability, but other specific equipment such as bed rails or major items provided as part of a package of support should be reviewed on an annual basis or more frequently if needs change.

Major adaptations should be treated as equipment for the purpose of review arrangements. Where this is the only service provided (e.g., a wet room shower adaptation) once completed and working appropriately, this will not require a regular review and the onus would be on the homeowner/tenant/carer to alert Adult Social Care to any concerns that might later arise.

If, however, the person does receive an ongoing package of support, any adaptions they have would need to be considered as part of the regular review of that support.

Transfer of Care

Where there needs to be a transfer of case responsibility from hospital to a community setting, the hospital-based worker is responsible for ensuring that the persons local Social Work team and/or Occupational therapy team is aware and if there is a change in need follow the discharge protocols.

The agreed hospital protocol should always be followed.

Further guidance is available in the document Practice Guidance – Care and Support Plan Reviews

Where there is a transfer of care to another area the persons local team is responsible to ensure (with the persons agreement) that essential information regarding their needs including a copy of the current assessment and care and support plans is made available to social services in the area they are moving to. Funding responsibility remains with Derbyshire for up to 6 weeks post the move to a new area to enable the receiving team to make their own assessment of need should they so wish to

10. Complaints and Representations

At any stage throughout the self-directed support process, people are eligible to formally register any dissatisfaction through the Adult Social Care complaints process.

Typically, there are generally 4 basic reasons for challenging an assessment or care and support plan:

- the assessor did not consider important information that was available at the time of the assessment
- that additional information about the persons circumstances has subsequently become available which now should be considered
- the assessor did not give sufficient weight to information that is salient to the persons wellbeing
- as a consequence of the above, a viable care and support plan which meets the assessed unmet eligible needs and outcomes cannot be created.

Complaints can be avoided or reduced by ensuring the assessment is always person-centred, expectations are managed, and that the assessor seeks to achieve, where possible, a consensus with the person and/or their carer as to the eligible needs and outcomes.

It is particularly important that people can see themselves in their assessment documentation and that draft assessments are shared with the person and/or their carer for comment. The test of any assessment and/or care and support plan is the reasonableness of decisions made in creating it. This should include identifying who contributed to the assessment (including information form short term enablement activity, occupational therapy, or health professionals) and the steps taken to try and ensure agreement on the outcomes was achieved.

NB: The size of any given personal budget in isolation is not a basis for complaint. The test would be whether the budget, (in conjunction with the persons resources, informal networks that can be deployed and sustained) appears sufficient to develop an effective care and support plan which can meet the persons assessed unmet eligible needs and their associated outcomes.

Should local negotiations prove unsatisfactory there is the right of further review under the Adult Social Care Complaints Policy and Procedures. People are expected to have at least attempted to complete a care and support plan/support plan before recourse to this process.

11. Quality Assurance

Strength Based Support is now the established method of delivering our Adult Social Care responsibilities. As such it is subject to on-going monitoring and review.

Quality Assurance Methods

Quality Assurance methods including complaints analysis, together with a significant level of

operational management overview of individual case files, are added to the views and experience of clients and carers when checking standards and looking to deliver service improvements.

Author History

Authorisation History

Authored by: Jenny Hudson

Authorised by: Senior Management Team March 2014

Change History

Version	Date	Name	Reason
Version 1	March 2014	Jenny Hudson	New Policy
Version 2	February 2015	Jenny Hudson	Reviewed & updated
Version 3	April 2017	Jenny Hudson / Dominic Sullivan	Reviewed & updated
Version 4	May 2021	Josie Hill / Dominic Sullivan	Reviewed & updated
Version 5	November 2023	Josie Hill / Dominic Sullivan	Reviewed & updated