

Care and support planning workbook

1. How to use this workbook

This work book forms part of the suite of learning materials that have been developed to support the implementation of part one of the Care Act 2014. These materials summarise and explain the ‘Care and Support Statutory Guidance’ (October 2014) [“the guidance”] and are designed to help those involved in care and support services to understand and implement the Act.

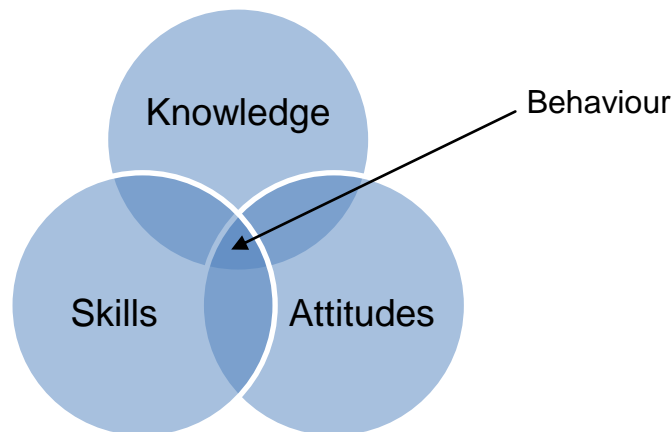
The suite of learning materials contains workbooks, PowerPoint presentations and other material for each of the following topic areas:

1. [Introduction and overview](#)
2. [Information and advice](#)
3. [First contact and identifying needs](#), including assessment and eligibility, and independent advocacy
4. [Charging and financial assessment](#), including deferred payment agreements
5. Person centred **care and support planning**, including personal budgets, direct payments and review
6. [Transition to adulthood](#)
7. [Integration, cooperation and partnerships](#)

This workbook is about the care and support planning requirements of the Act and its statutory guidance. It has been written for learning facilitators and includes exercises, suggested group discussions, points of reflection and case studies that facilitators can use either in their entirety or to pick and choose from as they see fit when designing a learning programme based on the [PowerPoint presentation](#). The workbook can also be used by individuals who wish to learn more about this topic area. You can watch the presentation, read the notes below, and undertake the exercises at a pace and time to suit you.

As well as this workbook and PowerPoint presentation, there are also [handouts](#) and a shorter, [overview presentation](#) on this topic area. Handouts provide easy to print resources that summarise key factual information from the guidance.

The implementation of the Act requires whole systems change and underpinning this is a need for cultural change. These learning materials alone will not affect such change, but they are one tool that can be used to support people along the journey. In many instances, implementing the Act successfully will require those involved in the care and support system to change the way they work i.e. behaviour change. Research suggests that the way people behave is influenced by their knowledge, skills and attitudes:



The PowerPoint presentation and handouts are designed to increase knowledge about the Act or guidance. The questions and exercises in the workbook are designed to spark conversations that encourage people to reflect on their own attitudes and the attitudes of others. They aim to give learners the opportunity to discuss the complexities of implementing the changes in practice, and/or provide a safe way of challenging attitudes that go against good practice. The case studies are designed to provide an opportunity for people to analyse and practice their skills.

Key learning point

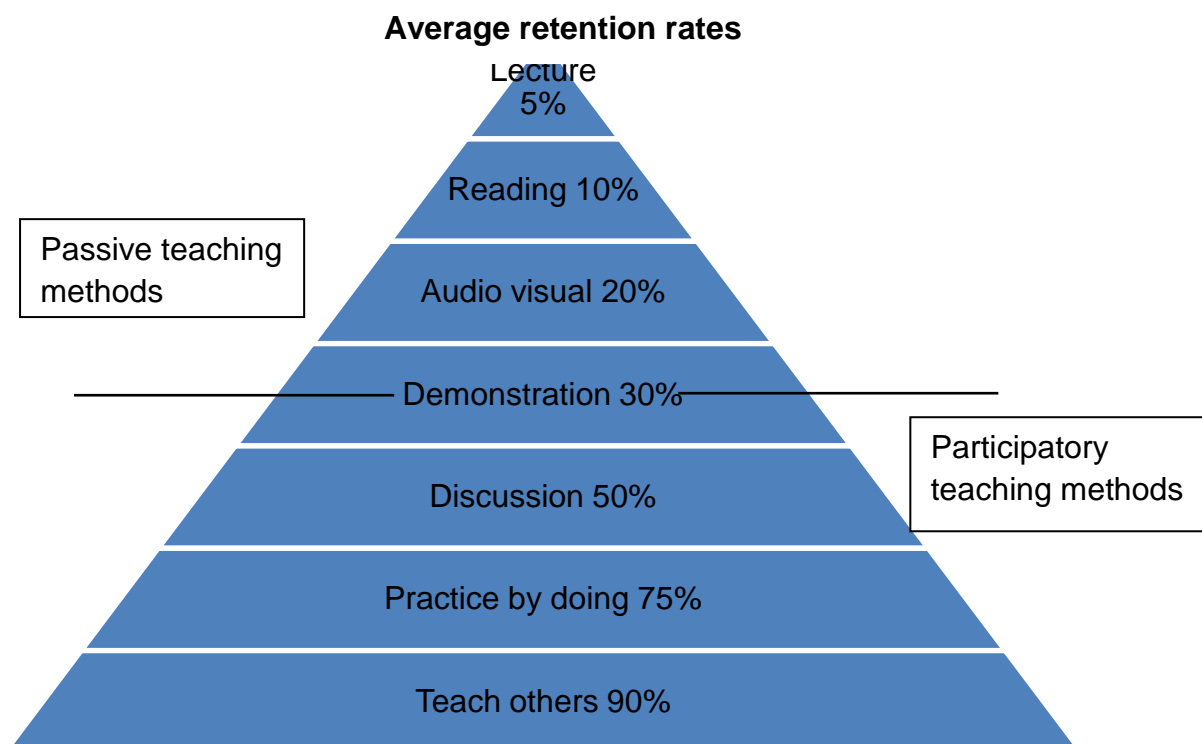
These are used in the workbook as a way of highlighting changes that are likely to have a significant impact on practice i.e. the major changes that the Act brings in.

The facilitators' hints and tips in the workbook signpost facilitators to existing good practice resources on this topic area and/or highlight key changes that are likely to have the most significant impact on practice. The aim is to help facilitators to design interactive learning programmes that are appropriate for their audience.

Facilitator's hints and tips

To successfully facilitate this module we suggest that you need to:

- have read the relevant sections of the Act, regulations and guidance
- have a good understanding of best practice in this topic area
- remember that there are various modules available and you need to choose the most suitable ones for your learning programme
- also remember that you can pick and mix questions, exercises and case studies from this workbook or from other topic areas
- design your training session in a way that accounts for the learning pyramid so as to maximize the experience and learning outcomes for your participants.



Source: Adapted from National Training Laboratories, Bethel, Maine

2. Who is it for?

This workbook is about person centred care and support planning. It explores sections 24 - 25 of the Care Act and chapter 10 of the statutory guidance. It is intended to be used to develop learning programmes for:

- people who have a role in care and support planning
- staff employed by local authorities and other organisations who are responsible for care and support planning
- managers of people undertaking care and support planning.

3. Contents

This workbook starts with an [overview](#), which summaries the topic area, and identifies relevant [key words](#). It then contains the following sections that match the slides in the PowerPoint presentation:

- [Introduction](#)
- [Production of the plan](#)
- [Planning for people who are at risk of harm](#)
- [Planning for people who lack capacity](#)
- [Combining plans](#)
- [Sign off and assurance](#)
- [Summary](#)

Appendices: [links to key resources; handouts.](#)

4. Overview

Person-centred care and support planning puts people at the heart of their care, and offers them the opportunity to take choice and control over their care and support. A person with eligible care and support needs will have a care and support plan and carers will have a support plan. The plan describes what eligible needs the person has, and which needs the local authority will meet, taking into consideration any needs that are being met by a carer, for instance. In addition, it must include a tailored package of information and advice on how to delay and/or prevent the needs the local authority is not meeting.

Everybody will have a personal budget as part of their plan that identifies the cost of their care and support and the amount that the local authority will pay towards it, regardless of their care setting. When someone has a personal budget they can request a direct payment. The local authority must inform the person which, if any, of their needs may be met by a direct payment and provide appropriate information and advice on how to use and manage direct payments.

Local authorities must ensure that sufficient time is taken to enable the plan is appropriate to meet the needs of the person, and is proportionate to the needs to be met. The content of the plan must be finalised with the person and any other people that the person requests and be compiled in a format that makes sense to them. The local authority is under an ongoing duty to keep the person's plan under review, to ensure that the needs continue to be met.

To ensure that the planning process takes a holistic approach, which takes into account people's wishes, feelings, strengths, needs, values and aspirations, the person must be actively involved and influential throughout. Genuine involvement and ownership can both aid the development of the plan and increase the likelihood that the person may achieve the outcomes that matter to them. When involving the person or their carer the local authority has a duty to take all reasonable steps to reach agreement - with the adult or carer for whom the plan is being prepared - about how the local authority should meet the needs in question.

To facilitate genuine involvement, information about the choices and options available need to be provided in an accessible format to help people make informed decisions about their care. If a person has substantial difficulty being involved with the planning process, and there is no 'appropriate person' to facilitate their involvement, an independent advocate must be appointed early on in the process. If a local authority thinks a person may lack capacity to be involved in making a decision or a plan, even after they have offered them all practicable support, a suitably qualified professional needs to carry out a capacity assessment in relation to

the specific decision to be made. Even if lack of capacity is established, it is still important that the person is involved as far as possible in making decisions. Where the local authority has a duty to meet a person's needs, it must help the person decide how best to meet their needs through the preparation of the plan. The plan must describe what needs the person has, ongoing and fluctuating, the outcomes the individual is looking to achieve to maintain or improve their wellbeing and whether, and to what extent, the needs meet the eligibility criteria. The local authority should also record where they will not be meeting the eligible needs, so that the authority is able to respond to any changes in circumstances more effectively.

Where a person has more than one plan, such as an education, health and care or safeguarding plan, combining plans should be considered, preferably early on in the planning process to avoid duplication and ensure that the package of care and support is developed in a way that fits with what support is already being received or developed.

5. Key words

The suite of learning materials contains a [glossary](#) of key words used in the statutory guidance. The following key words, which are defined in the glossary, are relevant to this topic area: assessment, care and support plan, deprivation of liberty, direct payment, eligible needs, independent advocate, lack of capacity, outcomes, personal budget, substantial difficulty, supported decision making, support plan, wellbeing.

6. Introduction

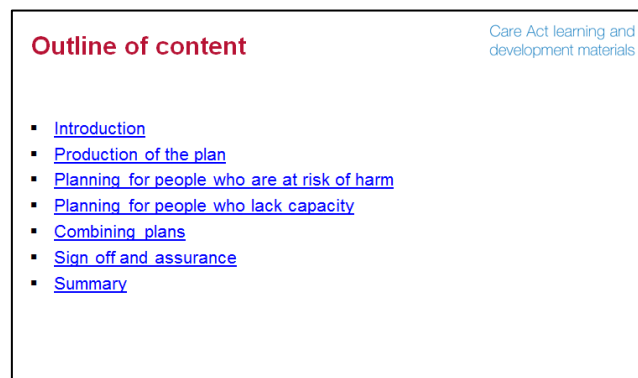
Slide 1

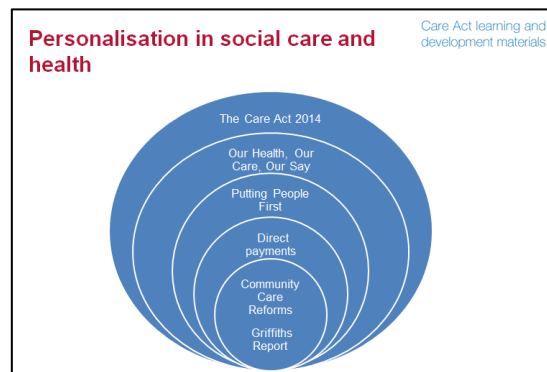


Notes

1. This work book forms part of the suite of learning materials that have been developed to support the implementation of part one of the Care Act 2014. These materials summarise and explain the statutory guidance and are designed to help those involved in care and support services to understand and implement the Act.
2. This presentation is about person-centred care and support planning. It is intended for:
 - people who have a role in care and support planning
 - people employed by local authorities and other organisations who are responsible for care and support planning
 - managers of people undertaking care and support planning.
3. The aim of the presentation is to help you reflect on the implications of the Act for your role, so that you will know what you must do differently and what you may need to do differently.

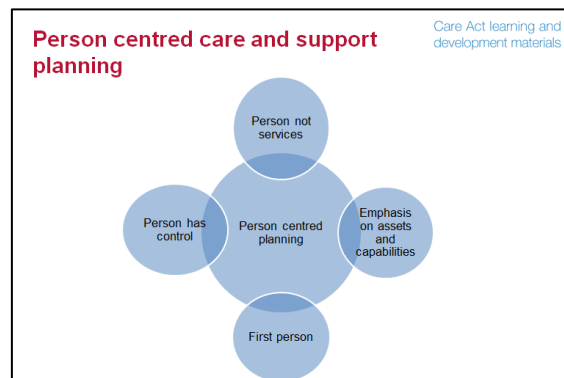
Slide 2



Slide 3**Notes**

1. The personalisation agenda in social care has a long history characterised by a deliberate shift away from care delivered in long-stay institutions towards more tailored support in the community and underpinned by the demands of disabled people and their families for independent living and full involvement in society.
2. The Community Care reforms (1993) which followed the Griffiths Report (1983), led eventually to the closure of nearly all long-stay institutions for disabled people and a significant shift of care for people with long-term conditions, including mental health problems, into community-based settings.
3. The right to take cash in lieu of services as a direct payment was enshrined in law in 1996.
4. Personalisation has a wide agenda encompassing universally accessible information and advice, prevention and early intervention, community capacity building, making greater and more creative use of universal services and tailoring the formal support people need. This transformation was initially signalled in the social care Green Paper, Independence, Well-being and Choice in 2005, then reinforced in the White Paper, Our Health, Our Care, Our Say in 2006 and confirmed in Putting People First in December 2007. The Putting People First concordat described a shared vision and commitment to transform adult social care through a programme of reforms “coproduced, co-developed, co-evaluated” with the sector.
5. The evidence suggests people want to be more actively engaged as partners, that services frequently underestimate their willingness and that the potential impact of harnessing this contribution could have huge economic value and lead to better outcomes.
6. The Care Act 2014 mandates that all people with an eligible care and support need and carers should have their support planned and managed in this way in future.

Slide 4

Notes

1. Person centred care and support planning refocuses the priority from services to ensuring better lives for people. This means focusing upon the person and their needs and not focusing upon existing service provision.
2. The person **must** be actively involved and influential throughout the planning process, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community.
3. The starting point is believing that the person has the capability to plan for themselves i.e. there is a need to focus upon peoples' strengths and assets rather than the deficits. This should include the support and strengths that they have in their communities as well as their own personal capabilities.
4. Person centred care and support planning puts people **in control** of their care and they should be free to take ownership of the development of their plan if they wish, or be encouraged to be actively involved in the preparation of the plan jointly with the local authority.

Key learning point

Person centred care and support planning refocuses the priority from services to ensuring better lives for people.

Facilitator's hints and tips

It might be useful to ask learners to complete the [care and support planning self-assessment tool](#). The self-assessment is based upon the Think Local Act Personal resource 'Making it Real. The 26 "I" statements were developed by people who use services, carers and citizens and describe the sort of feelings and experiences that people want from support services. In this self-assessment tool they act as a benchmark for good person-centred care and support planning.

The self-assessment tool is divided into the six sections of the "I" statements and requires you to think about what is working well within current practice, at an individual, team and /or

organisational level, and what is not. Once completed you can use this information to develop your action plan at the end of the workbook. The self-assessment tool can be used by anyone working within health and social care and within any role.

Slide 5

The Care Act and person-centred planning

- Care and support planning should put people **in control** of their care
- The person **must** be actively involved and influential throughout the planning process
- Independent advocates **must** be instructed early in the planning process for those who have substantial difficulty and have no other means of accessing appropriate support to facilitate their involvement

Care Act learning and
development materials

Notes

1. Care and support planning should put people **in control** of their care and they should be encouraged to be actively involved in the preparation of the plan jointly with the local authority. Clear information is needed to help people to make informed decisions; options and choices should be presented simply and clearly.
2. The person **must** be actively involved and influential throughout the planning process, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community.

Example

Making It Real – how it feels when I am in control

- “I am in control of planning my care and support”.
- “I have care and support that is directed by me and responsive to my needs”.
- “My support is coordinated, cooperative and works well together and I know who to contact to get things done”.
- “I have a clear line of communication, action and follow up”.

3. For those who have substantial difficulty in engaging with the care system, and have no other means of accessing appropriate support through friends or relatives to facilitate their involvement, independent advocates **must** be instructed early in the assessment and planning process. See the [independent advocacy workbook](#) for further information.
4. The planning process and outcomes should be person-centred and person-led and built **holistically** around people’s wishes and feelings, their needs, values and aspirations, irrespective of the extent to which they choose or are able to actively direct the process.

Key learning point

Care and support planning should put people **in control** of their care and they should be encouraged to play an active role in the preparation of the plan jointly with the local authority.

Facilitator's hints and tips

Whilst organisations may have many processes aimed at ensuring their services are person-centred, experiencing person-centredness is often down to the actual interaction between the individual in need of support and the staff member. The quality of the interaction is influenced by the attitude and skills of the staff member. Some suggestions as to how you could explore the attitudes and skills of your participants include:

- use the [Gibbs model of reflection](#) and ask people to reflect on an occasion when they have been involved in a decision that impacts on them. Get them to reflect on an occasion when they haven't been involved in a decision that impacts on them. Compare and contrast experiences
- watch a video clip of good person-centred planning and ask how it compares to their own practice
- design a role play activity so that people can practice the skills.

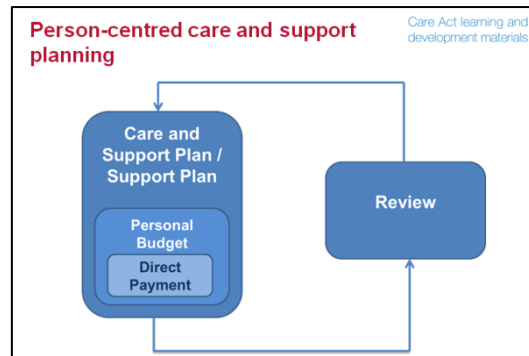
Exercise

Jacinta is 26 and lives with her mother and father. She has 2 siblings aged 28 and 23 who have left the family home. Jacinta would also like to move to living more independently. Jacinta has moderate learning disabilities and finds it hard to retain information. Jacinta's parents are very worried that she won't be able to cope living in her own home and are against her doing so.

Question

- What measures could you take to ensure that Jacinta remains in control of her care and support plan?

Slide 6



Notes

1. This diagram illustrates the main elements of the care and support planning process.
2. If the local authority has a **duty** to meet a person's needs (because it is required to or decides in its discretion to meet needs) it **must** help the person decide how their needs are to be met, through the preparation of a **care and support plan** for those with ongoing needs or **support plan** for carers. The plan **must** describe what needs the person has, and which needs the local authority is to meet.
3. 'Meeting needs' is an important concept under the Act and moves away from the previous terminology of 'providing services'. The Act aims to encourage diversity and innovation in the way in which a person's needs are met, rather than prescribing a service that may be neither what is best nor what the person wants.
4. The plan 'belongs' to the person it is intended for.
5. Information and advice **must** be given on how to delay and/or prevent the needs the local authority is not meeting.
6. Where a local authority is meeting some needs, but not others, a combination of the two approaches above **must** be followed. The person **must** receive a care and support plan for the needs the local authority is required, or decides to meet, and which includes a tailored package of information and advice on how to delay and/or prevent the needs the local authority is not meeting.
7. Everybody will have a **personal budget** as part of the care and support plan that identifies the cost of their care and support and the amount that the local authority will make available irrespective of their care setting. The amount must be lawfully and transparently arrived at.
8. People can receive part of, or their entire **personal budget**, as a **direct payment**. Most people can request and be given a **direct payment** i.e. people

can choose how much control and responsibility they wish to take over the arrangement of their care or support. The option to meet needs by taking a direct payment **must** be clearly explained, and that choice should be available more than once in the process.

9. The local authority is under an ongoing duty to keep the person's plan under **review**, to ensure that the needs continue to be met. They will review the plan periodically, involving the person in any discussions about changes in need before applying any changes to the plan.

Key learning point

Everybody will have a personal budget as part of the care and support plan that identifies the cost of their care and support and the amount that the local authority will make available, irrespective of setting.

Facilitator's hints and tips

The notes above outline the 'musts' highlighted in the guidance. Some, if not all of these things will be common practice for some organisations and practitioners as the 'musts' reflect good practice. However, for other organisations and practitioners the 'musts' mean working in a new and very different way. It might be useful therefore to spend some time discussing what common practice is for your learners.

Secondly, no matter what their common practice is, one of the key concepts to emphasise with learners is the need for good, clear, transparent communication all the way through the process. It is the quality of these interactions and the transparency of the communication that will help individuals who need support to feel involved. It might therefore be helpful to have a discussion about the current style of communication that happens at different points in the care and support planning process, whether this needs to be improved and if so how? The following table may help you to facilitate this discussion. Before facilitating this discussion it might also be useful as a facilitator if you have a firm understanding of good practice in relation to co-production (see links to key resources).

| Stage in the care and support planning process | Communication - providing information | Consultation - getting feedback | Negotiation - seeking agreement | Co-production - working together |
|--|---------------------------------------|---------------------------------|---------------------------------|----------------------------------|
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7. Production of the plan

Slide 7

Care Act learning and development materials

Production of the plan

- Involving the person
- Key elements
- Context
- Further considerations
- Direct payments
- Constraints



Notes

1. These six points need to be taken into consideration when producing a plan. They are explored in more detail over the next six slides.

Slide 8

Care Act learning and development materials

Involving the person

- The local authority **must** take all reasonable steps to involve the person, their carer and relevant others
- The local authority **must** instruct an independent advocate if there is no one else that can facilitate involvement

Notes

1. The person should have support and time to consider their options. Support might also include web-based resources, written information and peer support.
2. There should be a range of means provided to support involvement. For example:
 - support for the person to prepare the plan jointly with the local authority: themselves, with their family and/or friends, or whoever they may wish to involve
 - one-to-one support from a paid professional, such as a social worker, which may be the same person who undertook the assessment

- an independent advocate must be provided to represent and support the person to facilitate their involvement if they have substantial difficulty in being actively involved with the planning process, and they have no family and friends who are able to facilitate the person's involvement in the plan.
3. Where a person with specific expertise or training in a particular condition has carried out the assessment, someone with similar knowledge should also be involved in the production of the plan.
 4. There may be cases where a person wishes to have a greater involvement in the care planning process, has no family or friend who can help, and therefore requires an independent advocate to understand the relevant information provided by the local authority, and to be able to use it to effectively plan for their care and support.
 5. The value of genuine involvement will:
 - aid the development of the plan
 - increase the likelihood that the options selected will effectively support the adult in achieving the outcomes that matter to them
 - may limit disputes as people involved will be fully aware and have discussed the decisions that are made.
 6. Enabling the person to take control of their plan and the process can be enhanced by:
 - beginning early and keeping it simple
 - agreeing the best format for the plan
 - letting people do it their way in their own environment. Use the tools available to help people think about how best to plan for themselves. Tools could involve devising simple step by step guides, charts or cards
 - allowing sufficient time and being flexible
 - providing clear and simple information on options and choices in a format that is best suited to the individual and by someone who is known and trusted
 - not taking over or over-supporting people
 - being clear about the outcomes and agreeing those that are useful and realistic.
 7. Developing and writing the plan using the first person "I", gives a powerful message that the care and support plan is owned by the individual. Independent advocates **must** be instructed early in the planning process for those who have substantial difficulty and have no other means of accessing appropriate support to facilitate their involvement. See [independent advocacy workbook](#) for more details.
 8. The process and outcomes should be person-centred and person-led and built **holistically** around people's wishes and feelings, their needs, values and

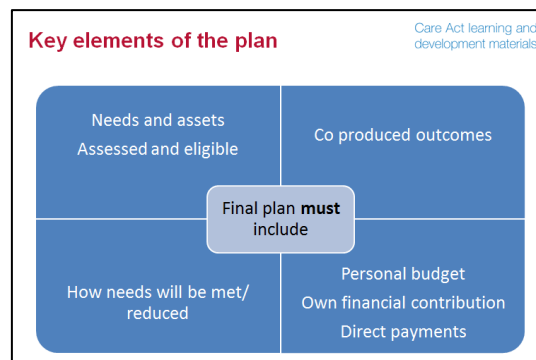
aspirations, irrespective of the extent to which they choose or are able to actively direct the process.

9. The [POET](#) survey asked whether personal budget holders felt their views were fully included in their support plan. 80% of personal budget holders felt their views were fully included with little difference across social care groups and types of personal budget and that having their views fully included in planning was very strongly linked to positive results.

Questions

- What might be some of the difficulties related to involving the person or anyone else the person requests?
- What changes might you have to make in order to facilitate genuine involvement?
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Slide 9



Notes

1. When developing the plan, there are certain elements that **must** always be incorporated in the final plan:
 - the **needs** identified by the assessment
 - the outcomes the individual is looking to achieve to maintain or improve their **wellbeing**
 - the person's own capabilities, assets and strengths and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for from day-to-day life

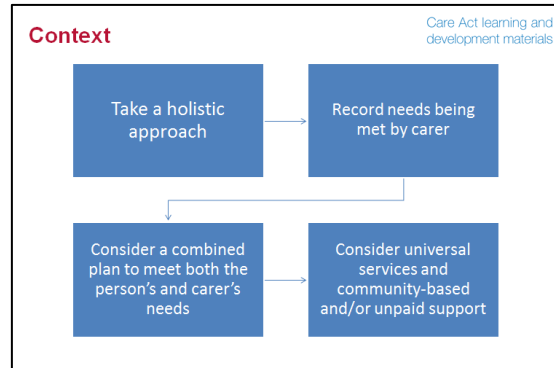
- whether, and to what extent, the needs meet the **eligibility criteria**
 - the needs that **the authority** is going to meet, and how it intends to do so
 - for a person needing care, for which of the **desired outcomes** care and support could be relevant
 - for a carer, the outcomes the carer wishes to achieve, and their wishes around providing care, work, education and recreation where support could be relevant
 - **the personal budget, direct payments** and the amount which the person must pay towards the cost of meeting the 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
 - 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.
2. It is important that these aspects are not viewed as a fixed list. People can influence additional aspects to plans that are important to them i.e. outcomes not necessarily linked to needs the local authority has a duty to meet, etc.
 3. These requirements should not encourage a lengthy process where this is not necessary, or fixed decisions that cannot be changed easily if the person wishes to make adjustments. The maximum flexibility should be incorporated to allow adjustment and creativity.

Facilitator's hints and tips

One of the key concepts to pull out here is the concept of proportionality. You may want to source and use as examples different care and support plans to demonstrate this principle. Helen Sanderson Associates have developed a range of tools and [resources](#) that can support proportional care and support planning. Think Local Act Personal are developing a 'What good looks like' guide that will be published on their website.

Questions

- What arrangements do you have or can you make to ensure that the development of Care and Support plans are proportional?
- How many Care and Support plans are currently developed by the person needing care? What are the barriers? How could you overcome them?

Slide 10Notes

1. Consideration of how the needs are to be met should take a holistic approach that covers aspects such as the person's wishes and aspirations in their daily and community life, rather than a narrow view purely designed to meet assessed eligible unmet need.

Facilitator's hints and tips

There are lots of resources available that demonstrate what a good holistic approach looks like. Depending on the current practice of your participants and what you feel their understanding might be you may want to consider exploring what a good holistic approach looks like practically (see links to key resources in the appendix).

2. In considering the person's needs and how they may be met, the local authority **must** take into consideration any needs that are being met by a carer. The person may have assessed eligible needs which are being met by a carer at the time of the plan and the carer remains willing and able to continue caring. In these circumstances the local authority is not required to meet any of the assessed eligible needs, but the carer should be involved in the planning process. These aspects should be recorded in both the care plan and care and support plan.

Example

Making It Real – what do carers want?

- Carers want clear, consistent, coordinated information that is easy to access, and information-giving to be a two-way process, where their voice is heard.
- Carers want the space to be someone other than a carer and to engage in activities in their community.
- Carers want services that talk to each other and are coordinated.
- Carers want care workers they can trust and who are appropriately skilled for the particular needs of the person they support. They also want access to a good range of support services.
- Carers want to know there is help available if things go wrong and that they can access the support they need to get on with their lives without worrying.
- Carers want to be sure that the money available for support can be used in ways that work well for the person they care for and for the whole family. They want good value, safe and high quality support to be available.

3. The local authority should record where they will not be meeting the eligible needs, so that the authority is able to respond to any changes in circumstances (for instance, a breakdown in the caring relationship) more effectively.
4. Where the carer also has eligible needs, combining of the plans of the adult requiring care and the carer should be considered provided both adult and carer agree.

Key learning point

Plans should be prepared using a holistic approach that includes the person's wishes, beliefs and aspirations in daily and community life.

Example

Yvonne and John have been married for 25 years. Recently Yvonne had a brain tumour removed and it has left her paralysed down one side. Yvonne needs assistance to get washed and dressed. John works as a school bus driver which involves him leaving the house at 6.30am every week day morning. John would like to continue working but this means he is unable to help Yvonne get washed and dressed in the mornings. John would also like to continue to take his grandson to swimming training on a Saturday morning but again this leaves Yvonne without anyone to help her get washed and dressed.

Yvonne and John agreed to a combined care and support plan.

| Who | Desired Outcome | The challenge | Use of direct payment |
|--------|---------------------------|----------------------------------|--------------------------------------|
| Yvonne | Maintain personal hygiene | Yvonne cannot manage this on her | Employ a PA from 8am until 9am every |

| | | | |
|------|---|---|---|
| | | own due to her paralysis. | week day morning. |
| John | Maintain his relationship with his grandson | Swimming training starts early and it means leaving Yvonne unable to get washed and dressed until he returns at lunch time. | Employ a PA from 8am until 9am on a Saturday morning. |

5. Local authorities should have regard to how universal services and community-based and/or unpaid support could contribute to the factors in the plan. The Local Authority should take steps to ensure people who may benefit from a type of preventative support receive information and advice about why it is important, what it might help with and how to access it. See [information and advice](#) and the [assessment and eligibility](#) workbooks for further information.

Example

An older man lives alone with some support from his daughter who works full time. He needs occasional personal care to remain living independently with dignity, and it is likely that these needs will increase. He has lost contact with family and friends following his wife's death and rarely goes out without support from his daughter who is restricted to taking him out at weekends because of work commitments.

Community groups, voluntary organisations, and buddying services could support the man to maximise opportunities to look after his own health and wellbeing and participate in local community activities. This, in turn, could lessen the impact of caring on his daughter and enable her to continue to support her father effectively alongside paid employment. Such support can be identified/suggested alongside other, perhaps more formal services to meet personal care needs.

Key learning point

Local authorities should have regard to how universal services and community-based and/or unpaid support could contribute to the factors in the plan.

Exercise

What things might you need to consider when deciding whether to combine the

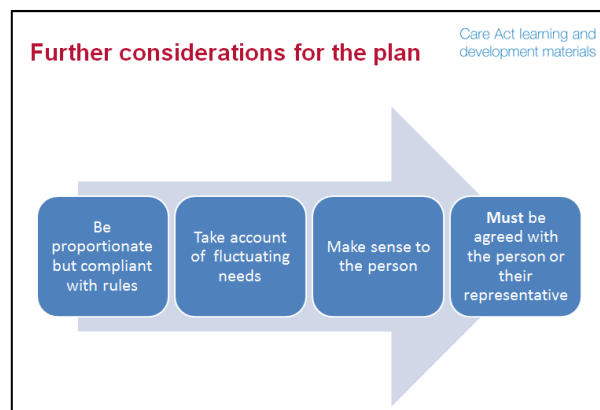
plans of the adult requiring care and the carer?

Suggested answer

Some suggestions of things to consider taken from the guidance:

- Do both parties agree and understand the implications of sharing data and information?
- Is there likely to be a conflict of interest?
- Is there scope for pooling budgets?
- Does the combined plan clearly reflect individual needs and preferences as well as any joint approach?

Slide 11



Notes

1. Where a person has fluctuating needs the plan should make comprehensive provisions to accommodate this. This should be an integral part of the care and support planning process, and not something decided when someone reaches a crisis point.

Example

Miss S has Multiple Sclerosis and requires a frame or wheelchair for mobility. Miss S suffers badly with fatigue, but for the majority of the time she feels able to cope with daily life with a small amount of care and support. However, during relapses she has been unable to sit up, walk or transfer, has lost the use of an arm or lost her vision completely. This can last for a few weeks, and happens two or three times a year; requiring 24 hour support for all daily activities.

In the past, Miss S was hospitalised during relapses as she was unable to cope at home. However, for the past three years, she has received a care and support package that include direct payments which allows her to save up one month's worth of 24 hour care for when she needs it, and this is detailed in the care and support plan.

Miss S can now instantly access the extra support she needs without reassessment and has reassurance that she will be able to put plans in place to cope with any fluctuating needs. She has not been hospitalised since.

Question

- Can you think of another example of fluctuating needs and how this could be planned for in the care and support plan?

2. It should be possible for the person to prepare their plan jointly with the local authority in a format that makes sense to them, rather than this being dictated by the recording requirements of the local authority. In all cases, additional content to the plan **must** be agreed with the adult and any other person that the adult requests, and should be guided by the person the plan is intended for. There should also be no restriction or limit on the type of information that the plan contains, as long as this is relevant to the person's needs and/or outcomes.

Key learning point

It should be possible for the person to prepare their plan in a format that makes sense to them, rather than this being dictated by the recording requirements of the local authority.

Questions

Thinking about individual needs:

- What might be some of the formats that people require their plans to be presented in?
- What other extra elements could people want their plans to include?
- What are the implications for your recording systems?

Slide 12

Direct paymentsCare Act learning and
development materials

- The local authority **must inform** the person which, if any, of their needs may be met by a direct payment
- The person should be provided with appropriate information and advice concerning the usage of direct payments and how they differ from traditional services

Notes

1. Advice on direct payments should include:

- the difference between purchasing regulated and unregulated services
- an explanation of responsibilities that come with being an employer, managing the payment, and monitoring arrangements and how these can be managed locally without being a burden
- signposting to direct payment support and support organisations available in the area
- an explanation that there is no curtailment of choice on how to use the direct payment (within reason and in light of the statutory purpose for the direct payment), with the aim to encourage innovation
- local examples and links to people successfully using direct payments in similar circumstances to the person
- the option to have a mixed package of direct payments and other forms of care and support.

2. See the workbook on [direct payments](#) for more information.**Slide 13****Constraints**Care Act learning and
development materials

- There should be **no constraint** on how assessed, eligible, unmet needs are met as long as this is reasonable
- The local authority has to satisfy itself that the decision is an **appropriate and legal** way to meet needs
- Limited list of prescribed providers **must** be avoided

Notes

1. However the person chooses to have their needs met, whether **by direct payment**, local authority or third-party provision, or a mix of the three, there should be no constraint on how the needs are met as long as this is reasonable.
2. Above all, the local authority should refrain from any action that could be seen to restrict choice and impede flexibility.

3. It is important that people are allowed to be very flexible to choose innovative forms of care and support, from a diverse range of sources, including quality providers but also “non-service” options such as Information and Communication Technologies (ICT) equipment or club membership.
4. Limited lists of ‘prescribed providers’ (often in relation to direct payments and in particular prepaid cards) that are offered as a default only option (or as ‘take it or leave it’) do not fit with the Government’s vision of personalised care and **must** be avoided.
5. Where local authorities operate lists of quality accredited providers to help people choose, the use of such lists should not be the only **choice** offered to people.

Key learning point

The local authority should refrain from any action that could be seen to restrict choice and impede flexibility including limited lists of ‘prescribed providers’.

Questions

- Do you have a preferred provider list for direct payments?
- What action might you need to take to ensure that you maximise flexibility and innovation?

Example

Daniel is 39 and moved out of a small group home into his own house 15 years ago. He has learning disabilities and some associated health problems and needs considerable support.

Daniel has a personal budget. His detailed care plan is worked out with him and his family alongside his support workers and the local authority. It is reviewed annually.

Daniel's support is focused on Monday-Friday, with his family providing support at weekends and over holiday periods. The support includes three days at a horticultural project. He has daily support during the week, and two full days with a support worker when he volunteers on a local ecology project. He has also been able to participate in a community arts project led by a local gallery.

He is anxious to be as independent as possible and uses telecare to cover nights and additional daytime security when needed. The additional support of telecare, together with reliable but flexible and creative weekday support has enabled his parents to work and to undertake other family responsibilities.

Slide 14**Notes**

1. It is important that local authorities give people (and/or others) every opportunity to prepare their own plan jointly with the local authority if they wish.
2. The local authority's role where the person or third-party are undertaking the development of the plan jointly with the local authority should be to oversee production and completion of the plan, and ensure that the plans to meet needs are appropriate and represent the best balance between value for money and maximisation of outcomes. The local authority should avoid developing processes that undermine the self-development of plans, such as excessive quality control measures or procedures.
3. A local authority may have arrangements or contracts with outside organisations/individuals to provide peer support for planning. An important part of this contract will be to agree non-restrictive approaches that enhance the

quality of plans and the local authority's trust in the detail as well as removing issues that can cause delay and problems.

4. Examples of circumstances where it may not be appropriate for others to develop the plan are where:
 - a person may not wish their family to be involved
 - family members may have conflicting interests
 - they may live too far away from the person such that the plan is unable to be developed in a timely fashion, despite efforts to involve them.
5. Although it should be noted that in the case of a person lacking capacity, the Mental Capacity Act requires consultation of the people listed as best interest consultees, other than where it is not practicable or appropriate in the authority's opinion.
6. The test for allowing others to have a role in preparing the plan jointly with the local authority, should start with the presumption that the person at the heart of the care plan should give consent for others to be involved; and should also have safeguarding principles embedded to ensure that there is no conflict of interest between the person and the person or persons they wish to involve.

8. Planning for people who are at risk of harm

Slide 15

Planning for people who are at risk of harm

Care Act learning and development materials

- The person will have been subject to and/or remain at risk of abuse or neglect
- They will have been subject to a local authority section 42 enquiry into their situation and will have an agreed safeguarding plan
- The plan must actively involve the person in agreeing what outcomes they want and how they will be achieved
- While aiming to meet the person's outcomes the plan must also balance risk appropriately by using the least restrictive options
- The plan will be subject to review under the local multi-agency safeguarding procedures

Notes

1. The Act has made new statutory requirements for protection from and prevention of abuse which embody the person-centred approach. Local authorities are signed up to the national programme "Making Safeguarding Personal" which promotes and disseminates tools and methods for achieving a person-centred approach with people at risk of harm.
2. All the principles of care planning outlined above apply equally when working with adults at risk of harm. The aim is to provide support and protection in the least

restrictive way possible while helping the person achieve the outcomes that they want.

3. Where an adult has suffered abuse or neglect or if they are still at risk of being harmed, then they will have a safeguarding plan resulting from a section 42 local authority enquiry into their circumstances. In such cases the local authority has a duty to provide any services that are prescribed within it regardless of eligibility criteria. The plan will be subject to the local multi-disciplinary procedures and in most cases there will be other agencies involved or maintaining an interest. The local procedures will state how and when the plan should be reviewed and who should be involved in the review.
4. Usual rules of confidentiality apply but there is a duty to inform relevant agencies about information which would prevent further harm or stop ongoing abuse.
5. If there is a criminal investigation then it will usually take precedence but the local authority will need to ensure steps are taken to safeguard and support the adult during that time. There will be occasions where other enquiries can proceed alongside to ensure minimum delays.
6. Care must be taken where an advocate is required to support the person at risk when the abuser is a family member or close to them.

Questions

- Are you aware of your role within the multi-disciplinary safeguarding policies and procedures covering your geographical area?
- Do you know what to do if you come across adult abuse or neglect in your everyday working practice?
- How would you involve the person who has been abused to meet their desired outcomes?

Example

Putting the person at the centre of your practice is the only way to ensure the achievement of the life outcomes that they want and deserve, and it is also the best way to help people at risk of harm to deal with abuse and stay safe. The six stage approach takes the practitioner from first meeting to case closure.

Stage 1: Building a trusting relationship

The first meeting with someone who has reported being abused is crucial. So make clear that you take them seriously and acknowledge the impact the abuse has had on their life. Reassure them that it is natural to have conflicting feelings and fears and say that protection is available.

Stage 2: Helping people to disclose

The disclosure of evidence can be both therapeutic and cathartic. Use the person's own language and constantly check your understanding; don't assume what they think or feel. Record what they have said in their own words. The person's account, and your record of it, is important evidence and can make the difference between a successful or disastrous outcome for them.

Stage 3: Establishing what the person wants

Do not make any assumptions about what the person needs, they may have a very clear view but often they have not thought that far ahead. Do not immediately discount the unrealistic outcomes and understand that their views on outcomes will often change as the case progresses.

Stage 4: Personalising risk management

Safety is relative, people often want to be both safe and to maintain unsafe relationships. There is an important distinction between putting people at risk and enabling them to choose to take reasonable risks. The emphasis must be on sensible risk appraisal, not risk avoidance. Always look for the least restrictive option and go through the alternatives with the person. Use the multi-agency team to analyse the risks and to manage them in a balanced way. Always appraise the risks with the person and take them through the consequences of the options so that they actively develop their own risk management plan.

Stage 5: Putting the person in control

Put the person at the centre of the whole process by giving them as much control of the decision-making as possible. They had power stripped away from them, but you can rebuild their confidence and power over their own life. Explain what the options are, the extent of your own powers and those of the police, the legal protections and procedures and how they can get justice. While you will have your own ideas on how the case should progress, it is important that you share them with the person and build the safeguarding plan around what they want.

Stage 6: Finding the right time to end

The safeguarding process will usually finish at the point when the person's outcomes are achieved. However they may only be partially achieved or some not even reached at all, in which case it should be when the person says that they now feel safe and are confident that they will continue to feel safe. Re-evaluate with the person the levels of risk that remain and how they will deal with them, leaving them with knowledge of their support system and what

to do if they feel at risk again.

Reference: Briggs, M in Community Care (September 3, 2013), A six-point guide to how social workers can improve the lives of abused adults.

9. Planning for people who lack capacity

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Care Act learning and
development materials

Planning for people who lack capacity

- The Mental Capacity Act 2005 (MCA) **requires** local authorities to assume that people have capacity and can make decisions for themselves, unless otherwise established
- A person **must** be given all practicable help to make specific decisions before being assessed as lacking capacity
- Where an individual has been assessed as lacking capacity, the local authority **must** commence care planning under the 'best interests principle' within the meaning of the MCA
- The duty to involve the person remains throughout the process

Notes

1. Every adult has the right to make his or her own decisions in respect of his or her care plan, and **must** be assumed to have capacity to do so unless it is established otherwise. This means that local authorities cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability, or because they make decisions with which the authority does not agree.
2. The local authority **must** support the person to understand and weigh up information, to offer choices and help people to exercise informed choice.
3. People have the right to make what others might regard as an unwise or seemingly eccentric decision - the question to explore is whether it will feasibly meet the assessed needs and lead to the desired outcome.
4. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. People cannot be treated as lacking capacity for that reason.
5. If a local authority thinks a person may lack capacity to make a decision about a care or support plan, even after they have offered them all practicable support, a social worker or other suitably qualified professional, needs to carry out a capacity assessment in relation to the specific decision to be made. For example the local authority may need to assess whether the person has the capacity to decide whether family members should be involved in their care planning, or

whether the person has the capacity to decide on whether a particular support option will meet their needs .

6. Furthermore the person making a decision about a plan on behalf of a person who lacks capacity **must** consider whether it is possible to make a decision or a plan in a way that would be less restrictive of the person's rights and freedoms of action. Any intervention **must** be proportionate to the particular needs of the individual.
7. If lack of capacity is established, it is still important that the person is involved as far as possible in making decisions. Planning should always be done with the person and not for them, should always start by the identification of their wishes, feelings, values and aspirations, not just their needs, and should always consider their wellbeing in the wider context of their rights to security, to liberty, and to family life.
8. Where a person lacks capacity to be fully involved in their care planning they should be supported by family members or friends.
9. If a person has no family member or friend who is available and willing to facilitate the person's involvement in their care planning, then an independent advocate **must** be provided.

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Minimising and authorising deprivation of liberty for people who lack capacity

Care Act learning and development materials

- The Mental Capacity Act 2005 (MCA) provides legal protection for acts of restraint only if the act is:
 - necessary to prevent harm to the person
 - a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm, and
 - in the person's best interests
- If the degree and intensity of restrictions and restraints are so significant that they amount to a deprivation of liberty, this **must** be authorised under the Deprivation of Liberty Safeguards (DOLS) under the MCA

Notes

1. Developing effective person-centred processes for planning in line with the guidance and the Act in general will in most cases avoid circumstances where a deprivation of liberty will arise.

10. Combining plans

Slide 18

Combining plans

Care Act learning and development materials

| |
|----------------------------------|
| Consider if multiple plans exist |
| Obtain consent from all parties |
| Establish a lead organisation |

Notes

1. Local authorities should have regard to all of the person's needs and outcomes when developing a plan, and should not develop plans in isolation from other plans (such as the plans of carers or family members, or education and health and care plans).
2. Consideration should also be given to how plans could be combined where budgets are pooled, either with people in the same household, or between members of a community with similar care needs.
3. Combining plans should be considered early on in the planning process to ensure that the package of care and support is developed in a way that fits with what support is already being received or developed. For example, this may be where the plan can be combined with a plan being developed to meet other needs, or

where a plan might usefully be combined with that of a carer, or family member. In all circumstances, the plan should only be combined if all parties to whom it is relevant agree.

4. One key area where plans can be combined, are cases where the person is receiving both local authority care and support and NHS health care. An example would be a person with mental disorder who meets the criteria for care and support under the multi-agency Care Programme Approach. The introduction of personal health budgets in health, similar to personal budgets in social care, provides a powerful tool to enable integrated health and care provision which focuses on what matters most to the person.
5. Local authorities should provide information to the person of the benefits of combining health and social care support, and should work alongside health and other professionals where plans are combined to establish a 'lead' organisation that undertakes monitoring and assurance of the combined plan.
6. In combining plans it is vital to avoid duplicating processes or introducing multiple monitoring regimes. Information sharing should be rapid and seek to minimise bureaucracy.

Example

Swada is a 22 year old lady with profound and multiple learning disabilities. Swada lives at home with her parents. In the past Swada has received a personal budget to enable her social care needs to be met. As well as social care support, Swada also requires specific health care input around bowel care and peg feeding. This support was previously provided by the district nurse and involved Swada and either her Mum or her PA spending hours waiting in for the district nurse to arrive.

Now Swada receives an integrated personal budget that combines her personal budget for her social care needs and a personal health budget for her health care needs. Swada still employs a PA three afternoons a week, but Swada has also used her integrated personal budget to train her Mum and her PA to support her health needs around bowel care and peg feeding. Swada no longer has to spend time waiting in for the district nurse.

Key learning point

One key area where plans can be combined is cases where the person is receiving both local authority care and support and NHS health care.

Questions

- Which departments / organisations do you currently develop combined plans with?
- What are some of the barriers to developing combined plans?
- How might you start to address some of these barriers?

Case study

Florence Brown is 75 years old and lives alone in a house that she used to share with her husband (who died six months ago) and her two daughters. She suffers from COPD¹, is frail and has restricted mobility. She has been admitted to hospital several times for short-periods because of respiratory infections. She used to smoke heavily but gave up when she was first diagnosed five years ago.

She receives practical and emotional support from one of her daughters (Mary) who lives nearby, who is divorced with no children. She also has supportive neighbours. The other daughter (Jane) is willing to do what she can, but lives 100 miles away with her husband and three young children and works full-time.

Assessment Summary

Florence has two eligible needs:

- Maintaining a habitable home environment – Florence is unable, without assistance, to keep her home sufficiently clean to make it safe for her, given her respiratory condition.
- Maintaining and managing nutrition – Florence is able to consume food and drink, and do some food preparation with assistance, but she would be unable to access it without assistance.

The first need is an unmet need. Even after pulmonary rehabilitation Florence is unable to meet this outcome. The second need is currently being met by Mary who prepares her Mum's evening meal every night and takes her shopping.

Florence has one ineligible need:

- Accessing necessary facilities or services in the local community – Florence is unable to meet this outcome without assistance but accessing the community is not something Florence is bothered about and hence it does not have a significant

¹ Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing.

impact on her wellbeing.

Mary also has eligible needs:

- Engaging in work, training, education or volunteering – it appears that Mary's caring responsibilities are preventing her from training to be a teacher.
- Engaging in recreational activities – it appears that Mary's caring responsibilities are preventing her from engaging in recreational activities

Florence and Mary agree to a combined care and support plan.

Questions

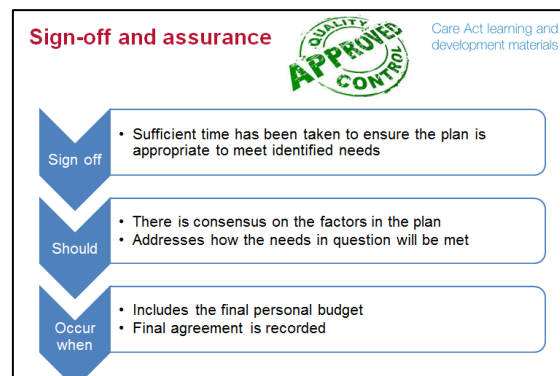
1. What might be included in a combined care and support plan for Florence and Mary?
2. What would you do if Mary doesn't agree with the proposed care and support plan for Florence?
3. How much of a say should Jane have in the decisions about her mother's care and support plan?

Suggested answers

1. See Notes under slide 9 for a list of things that **must** always be incorporated into a care and support plan. The fact that this is a combined plan means that these elements will need to be included for both Florence and Mary. The section that relates to Florence in the plan should include information about her health needs and how these are being managed, as any deterioration would result in her needing more social care support.
2. Florence has clearly agreed that Mary be involved in the care and support planning process for her, so she has a right to have her views considered. Also the extent to which the local authority must meet Florence's eligible needs is dependent upon what Mary is willing to do, and if she is in disagreement she may withdraw altogether. However if a dispute remains then Mary should be advised about the local complaints procedure.
3. As Jane has not been directly involved and Florence has expressly said that she didn't need to be involved in the care and support planning meeting, then any information about the assessment and care plan could not be passed on to her without Florence's agreement. If she did disagree with the proposed care and support plan the view might be taken that this did not constitute a dispute.

11. Sign off and assurance

Slide 19



Notes

1. Local authorities **must** ensure that sufficient time is taken to ensure the plan is appropriate to meet the needs in question, and is agreed by the person the plan is intended for.
2. Due regard should be taken to the use of approval panels in both the timeliness and bureaucracy of the planning and sign-off process.
3. In some cases panels may be an appropriate governance mechanism to sign-off large or unique personal budget allocations and/or plans, but local authorities should refrain from creating or using panels that seek to amend planning decisions, micro-manage the planning process or are in place purely for financial reasons.
4. In the event that the local authority decides that it **cannot** sign-off a care or support plan, or where a plan **cannot be agreed** with the person, or any other person involved, the local authority should state the reasons for this and the steps which must be taken to ensure that the plan is signed-off.
5. In cases or circumstances where a panel is to be used, and where an expert assessor has been involved in the care and support journey, the same person (or another person with similar expertise) should give evidence to the panel to ensure decisions take into account complex or specialist issues.

Key learning point

Local authorities should refrain from creating or using panels that seek to amend planning decisions, micro-manage the planning process or are in place purely for financial reasons.


Questions

- What are your current governance arrangements?
- Thinking about the key learning point above; is there a need to make any changes to your current governance arrangements?

Slide 20

Sign-off and assurance

- In the event that the local authority decides that it cannot sign-off a plan, or where a plan cannot be agreed, it should state:
 - the reasons for this
 - the steps which **must** be taken to ensure that the plan is signed-off
- The local authority **must** give a copy of the final plan to:
 - the person for whom the plan is intended
 - any other person they request to receive a copy
 - their independent advocate if they have one



Care Act learning and
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Notes

1. If the plan cannot be agreed or signed off, the steps to be taken may require going back to earlier elements of the planning process. If a dispute still remains, and the local authority feels that it has taken all reasonable steps to address the situation, it should direct the person to the complaints procedure. However, by conducting person-centred planning and ensuring genuine involvement throughout, this situation should be avoided.
2. This should not restrict local authorities from making the draft plan available throughout the planning process - indeed in cases where a person is preparing a plan jointly with the local authority, the plan should be in their possession.
3. The local authority must give a copy of a care and support plan to:
 - the adult for whom it has been prepared
 - any carer that the adult has, if the adult asks the authority to do so
 - any other person to whom the adult asks the authority to give a copy
 - their independent advocate if they have one.
4. Consideration should also be given to sharing key points of the final plan with other professionals and supporters, if the person agrees.

12. Summary

Slide 21

Summary

Care Act learning and
development materials

- The person **must** be actively involved throughout the planning process
- An independent advocate **must** be instructed at an early stage if a person has substantial difficulty in engaging in the process
- The plan **must** describe what needs the person has, and which needs the local authority is to meet
- The plan **must** include: the personal budget and direct payments
- The local authority **must inform** the person which, if any, of their needs may be met by a direct payment
- The local authority **must** give a copy of the final plan to the person and others requested by the person in an accessible format
- The local authority has a duty to keep the person's plan under review

Questions

- What has struck you most about this session?
- Thinking about what you have learnt about this topic (and on any other modules you have completed so far):
 - What links can you make between topic areas?
 - How might the necessary changes impact on your current arrangements?
 - What might the key challenges be?

Exercise

- What are your top three priorities in relation to care and support planning?
- Complete the [action plan](#) to identify the next steps for each priority.

Appendices

Links to key resources

Cumbria County Council: In Control (2005) [The 7 essential criteria of support planning](#). *This link takes you to a guide for people with health and care needs and/or carers to help them understand the practicalities of support planning and individual budgets based upon seven key questions.*

Department of Health (2010) [Personalisation through person-centred planning](#). *This joint good practice guidance published by the Putting People First and Valuing People Now teams has been developed to help local areas understand how person-centred planning can help to deliver Putting People First. It is one of the commitments in Valuing People Now. It includes a range of tools and good practice examples on person-centred planning and support planning to help give people more choice and control over their lives.*

Groundswell (2012) [Empower and enable – a people led approach to support planning](#). *This short paper explores the question of what it takes to make really good asset-based support planning simple and universal. It looks at the practical steps which providers and councils need to take to demystify the planning process and make good support planning achievable and affordable. The approach is called Empower and Enable.*

The National Centre for Independent Living (2008) [Peer support and the personalisation of adult social care](#). *This report looks at the evidence on peer support and links to personal budgets. The message from the report is that availability of peer support is essential in the drive to transform adult social care to give service users choice and control in how their individual support needs are met. The report includes a review of evidence from research, examples of good practice and recommendations for making peer support more widely available.*

National Development team for Inclusion - Personal budgets and mental health (2013) [Paths to Personalisation](#) is a practical guide to help make personalisation a reality for people with mental health needs. *It is aimed at all those involved in mental health, such as people with mental health needs and carers, health and social care commissioners, providers, practitioners, care co-ordinators and staff from all sectors.*

National Voices (2013) [Principles of care and support planning](#). *An interactive guide helping people to understand the principles of care and support planning.*

National Voices (2014) [Care and Support Planning Guide](#). *The guide is designed for anyone who has health and care needs over time, or cares for someone who does. It*

helps people to understand what care and support planning is and how it might help. It is available as an interactive guide, plain text and easy read.

NHS England (2012) [Personal health budgets guide: Implementing effective care planning](#). *This good practice guide is for people working in the NHS who are implementing personal health budgets and may also be of interest to people who are eligible for a personal health budget and their families. It defines what a personal health budget is, its purpose, and what is distinctive about this way of working with people, and describes the necessary preparatory work needed in order to develop a local framework to enable best practice.*

Putting People First (2009) [Planning together: peer support and self-directed support](#). *This report shows how it is possible to build disabled people's and carers' own support planning skills, rather than relying solely on professional solutions. It includes examples of how councils have worked in partnership with local people using services, user led and voluntary organisations, to transfer planning skills to other people using services.*

Putting People First (2008) [Good practice in support planning and brokerage](#). *This paper collates learning and best practice on support planning and brokerage.*

Putting People First (2010) [Support planning and brokerage with older people and people with mental health difficulties](#). *This guide responds to the findings of the Personal budgets pilots evaluation, which concluded that more work was required to develop approaches to support planning and brokerage that work for all groups of people rather than just some. The guidance offers effective methods for support planning with older people and people with mental health problems that can be built upon by councils and other stakeholders in their local development of self-directed support.*

Think Local Act Personal (2011) [Rethinking support planning: ideas for an alternative approach](#). *This paper reconsiders approaches to support planning that have taken hold as common practice in the giving of Personal Budgets. It is clear that current practices can often be very bureaucratic, as well as offering little in the way of choice and control to individuals. This threatens to prove unsustainable for Councils in the longer term. There is now a pressing need for an efficient approach, which empowers people to make the best of the resources available to them.*

Skills for Care: [Employing Personal Assistants](#). *An interactive online toolkit with easy read version, guides you through the process of employing a personal assistant, what to do when they are working for you as well as helping you to understand your responsibilities as an employer and your legal obligations. There are some really useful templates that you can use such as job descriptions, application forms and contracts of employment.*

Skills for Care: [Employing your own care and support staff](#). The link takes you to the Skills for Care website where you can find a range of products and services to help individual employers with the process of employing a personal assistant and the responsibility of being a manager, as well as providing support to personal assistants.

Skills for Care: [Common Core Principles to Support Self Care](#). This link takes you to the Skills for Care website where you can find a number of resources, co produced with Skills for Health, including [Common Core Principles to Support Self Care](#), a [Self Care Training Manual](#) aimed at domiciliary workers and a [Personalised Questionnaire](#) that can be used by to help an individual to take responsibility for their own health and wellbeing.

Skills for Care: [Carers' rights](#). This link takes you to the Skills for Care website where you can find a number of resources that have been created to help employers and staff to better support the carers they come into contact with as part of their work, by being aware of how to identify a carer and any needs they may have. Titles include: *The common core principles for working with carers*,

The graph below shows the common core principles for working with carers:



Skills for Care: [Carers Matter - Everybody's Business](#). This is a resource to help employers and their staff better understand the needs of carers through the learning and development of staff. The resource is available in three parts which act as tools to help enable training courses.

13. Handouts

Handouts, exercises and case studies relevant to this topic area:

- [Exercise: Care and support planning self-assessment tool](#)
- [Case study: Florence and Mary Brown \(person-centred care and support planning\)](#)