Appendix D

LONDON BOROUGH OF HARINGEY

DRAFT POLICY, PRACTICE AND PROCEDURE

FOR THE IMPLEMENTATION OF

PERSONALISATION AND SELF DIRECTED SUPPORT

MARCH 2011

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INTRODUCTORY LETTER FROM M T PHUNG,
DIRECTOR OF ADULTS, CULTURE & COMMUNITY SERVICES

ALL RECIPIENTS OF THE
PROCEDURES GUIDANCE

Your Ref:
Our Ref: TP/
Date; March 11

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Dear Colleagues,

Re: Policy, Practice and Procedure Guidance for the Implementation of Self Directed Support

I am pleased to introduce all Care Management Teams to this new, updated Practice and Procedures guidance which brings together all the policies, practices and procedures, which Care Management Teams should be following so that we can help achieve successful outcomes for service users and their carers in Haringey using self directed support.

The Pathway to Service set out in the guidance should now be familiar to us all. Each Section of the guidance provides all the detailed information and guidance necessary to enable us to complete each stage of the Pathway successfully, whether as Social Worker, Care Manager, Practice Manager or Service Manager.

As I read the guidance, I am particularly aware of just how much our services depend on working in close and effective partnership with service user, carer, our partners in the NHS, voluntary sector and with service providers. The guidance also provides us with a clear link between the aims and strategies of Corporate Management and the front line of services, so that Haringey Council's policies are carried out by yourselves when you meet with service users and carers, work with them to carry out supported self assessments of their needs and ensure they have choice and control over the services

they purchase to meet their needs with their personal budget or ask us to purchase on their behalf .

I know that this Practice and Procedures guidance has been completed with the assistance and contributions of many members of care management and some of our partners, and therefore it is an example of our collective effort to provide the best possible services to Older People and Disabled Adults in Haringey .

For the future, I am committed to ensuring that the guidance is updated regularly. For the present I ask all my colleagues to read carefully and implement the guidance and procedures provided.

Finally this guidance is essential reading and a good tool kit for us in the provision of safe, quality services.

Yours sincerely,

M T Phung
Director of Adult Culture & Community Services

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Putting People First – the Bigger Picture

Putting People First is an agreement between central government, local government, the NHS and others to Transform Social Care. There are four parts:

- **Universal Services** are accessible to all adults free of charge, improving their health and 'wellbeing', and reducing their dependency on social and health care.

- **Social Capital** is about supporting people to make use of community resources e.g. volunteering, advocacy, co-production, social enterprise and neighbourhood networks.

- **Early Intervention and Prevention** includes 'reablement', rapid response, emergency and out-of-hours services, adult protection and safeguarding.

- **Self Directed Support** is the way people assess their own care needs, create their own support plans, choose services that help them to achieve their desired outcomes, and make decisions about how to spend their personal budget.

Personalisation is all about Independence, Choice and Control:

Independence The purpose of self directed support is to promote the ability of 'vulnerable' adults to live their lives as independently as possible, by exercising choice and control over the kind of support they need.

Choice means that the individual decides what support or services they need.

Control means that people have the opportunity to manage their own budget and make decisions about their care.

There are, however, limits to the support we can provide to help people to achieve their independence, or in exercising greater choice and control over their care, and over their lives. For instance,

- The person's level of need and FACS eligibility if they do not self-fund
- The amount of money allocated to their personal budget
- Their capacity to make particular decisions for themselves

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- The level of risk and the 'vulnerability' associated with any lack of mental capacity

Social workers, managers and anybody else involved in supporting people on the self-directed support pathway, need to understand this wider context. Both the policy of enabling individuals to exercise choice and control, and become more independent; and the limitations imposed by eligibility criteria, allocated budgets and the capacity and/or vulnerability of the individuals concerned.

Teams, organisation and responsibilities

The **Integrated Access Team** is the 'front-door' to all Adult Services in Haringey, with the exception of Community Mental Health referrals. These are routed to the START team at St Ann's Hospital. It provides information about provision throughout the Borough and from across the public and independent sectors, receives and records new referrals for self-directed support and/or signposts individuals (including self-funders) to the most appropriate sources of support.

The **Self Directed Support Teams** support people with self-assessments, ensure they are allocated a personal budget, and help them with support planning. This includes all eligible persons aged 65 or over, younger people with physical disabilities / long term conditions, people with learning disabilities (Combined Team for People with Learning Disabilities) and the Community Mental Health Teams for people with longer term mental health needs.

The **Personal Budget Support Team** receives completed support plans and helps individuals to implement them using their personal budget. They may choose to take this as a direct payment and purchase their own services themselves (with or without advice from the team). Alternatively, they may ask for advice about the choice of services available to them and request for these to be purchased on their behalf.

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Eligibility Criteria

Adult, Culture and Community Services
26 September 2008

Adult, Culture & Community Services

Document Control

Version
2
Status
September 2008 Policy
Author
Naomi Lowde, Policy Support Officer, Commissioning and Strategy: Adult, Culture and Community Services
Document Objectives:
Sets out the approach taken within Adult Services to provide community care eligibility criteria for assessments
Intended Recipients:
All ACCS Adult Services division staff who assess service users' eligibility criteria
Monitoring Arrangements:
Eligibility criteria assessment audits
Training/Resource Implications:
To be determined
Approving Body and Date Approved
DMM
September 2008
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Scheduled Review Date
September 2009
Lead Officer Assistant Director - Adult Services, ACCS
Path and file name
Via:
http://harinet.haringey.gov.uk/intranet/directorates/adultcultureandcommunity/commissio

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Contents

1. Introduction

Eligibility criteria determine whether an individual is eligible for community care services. Eligible needs are those needs that are assessed as falling within the council's eligibility criteria. The needs of the service user will be balanced against their resources (including mental resources, strengths and abilities, carer and support networks, as well as material resources).

This policy sets out the circumstances that make individuals eligible for help. It is based on the impact of eligible needs that are key to maintaining an individual's independence.

The decision as to whether someone has eligible needs, and how they will be met, is based on an assessment. The assessment will focus on the factors which will help maintain an individual's independence over time and will consider associated risks. It will take immediate needs and possible future needs into account.

Services will be provided to people who are most in need through incapacity and/or vulnerability. People who experience a limited degree of disability or social isolation may not be eligible for a service.

2. Scope

The policy is for all Haringey Adult Services staff who have responsibility for implementing the eligibility criteria. It applies to all service users and potential

service users.

3. Aim

Our aim is to ensure that we provide or commission services to meet the eligible needs of service users and enable them live as independently as possible.

4. Roles and responsibilities

The Director:
has a particular responsibility for ensuring that the Directorate meets its legal responsibilities corporately and so has overall responsibility for the eligibility criteria policy in the Directorate.
Assistant Director, Adult Services:
is responsible for the eligibility for services consideration for all service assessments in their service
Line managers:
are responsible for ensuring that:
• the eligibility criteria are adhered to for all service assessments in accordance with the policy, government guidance and requirements.
• audits of eligibility criteria assessments are carried out
The Adult Services division staff:
who assess service users' eligibility criteria are responsible for ensuring that they follow the appropriate measures in keeping with this policy and with associated guidance and protocols.

5. The legal context

The National Fair Access to Care Services (FACS) policy guidance was issued to local authorities by the Department of Health in May 2002. It formed statutory guidance which social services authorities are obliged to take account of and implement at the local level.
The guidance provides a common framework for all local authorities to use when setting their eligibility criteria for adult social care services.
The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:
• Critical
• Substantial
• Moderate
• Low
The Government has told councils' to look at their financial position and make a decision about who can receive community care services. The different categories are important in determining the level of assessment required and the speed with which an initial assessment will be undertaken.
In January 2008 the third annual State of Social Care report found that most

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council's now assist people with 'substantial' or critical' needs.
As a result of these findings the care services minister, Ivan Lewis asked CSCI to carry out a major review of the issues and problems associated with the National Fair Access to Care Services (FACS). The review is process now.
http://www.csci.org.uk/about_us/news/review_of_eligibility_criteria.aspx

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6. Principles

People will be assessed as being eligible for a service according to the following level of need.
• If an assessment shows that the person's need is critical or substantial, they will receive a service for that need.
• If the person is assessed as having moderate or low needs, they will not be provided with a service to support that need. However, we will provide advice and information on other possible sources of help.
• In the case of having both an eligible and non-eligible need, the person will be entitled to receive a service which addresses the eligible need only.
We have determined our own eligibility criteria with reference to the common set of standard criteria that were detailed in the guidance.
Below are the two types of need that we will use for our assessment:
• People with critical needs:
○ an inability to protect yourself, maintain your own personal or others' safety, or carry out self-care tasks resulting in a threat to life
○ the risk of becoming seriously mentally ill
○ the risk of requiring immediate admission to hospital or residential care if services are not provided
○ a severe restriction of opportunity within the family, work and the wider community which threatens life.
• People with substantial needs:
○ an inability to protect yourself, maintain your own personal or others' safety, to carry out self-care tasks resulting in significant risks to life or wellbeing
○ the risk of becoming mentally ill
○ the risk of requiring hospital or residential care
○ a significant restriction of opportunity within the family, work and the wider community.
http://www.haringey.gov.uk/index/social_care_and_health/social_serviceseligibility/social_services-facs.htm

7. Equalities and diversity

7.1 Equalities monitoring and mainstreaming
Recording of equalities data is mandatory.
CSCI requires equalities monitoring data on age, gender and ethnicity. This data must be recorded on Framework-i.
Framework-i collects data on religion as well as age gender and race. All these fields should be completed.
Haringey Council decided in July 2007, when the revised Equal Opportunities Policy was adopted, to introduce and roll out monitoring of sexuality in service provision. Guidance will be given when Framework-i has been updated to record this information in Adult Services.

In order to evidence that the needs of service users are met the following should be recorded:
• All equalities strands should be considered throughout case records; disability, HIV/AIDS, gender, race, nationality, religion, sexuality.
• The communication and language needs of service users and carers should always be considered for example where a service user or carer may need interpreter, written material in an alternate format or a language other than English.
• Arrangements should be made for advocates, interpreters, relatives or friends, to assist any user or carer where necessary.

8. Audit
We will audit and monitor performance of the eligibility criteria policy to ensure that the care provided to individuals is still required and achieving the aims and desired outcomes. We will:
• Monitor the extent to which different groups are referred, which groups receive an assessment and, following assessment, which groups go on to receive services.
• Monitor the quality of the assessment and the eligibility decisions of staff.
• Monitor which presenting needs are evaluated as eligible needs and which are not.
The results of audits will be reported to relevant service managers at performance callovers.

9. Training
The Adult Services staff who assess service users' eligibility criteria will be made aware of their responsibilities for implementing Fair Access to Care Services.

10. Review
The policy will be reviewed annually (or sooner if new legislation, codes of practice or national standards are introduced) to ensure that the care provided to individuals is still required and we are achieving the desired

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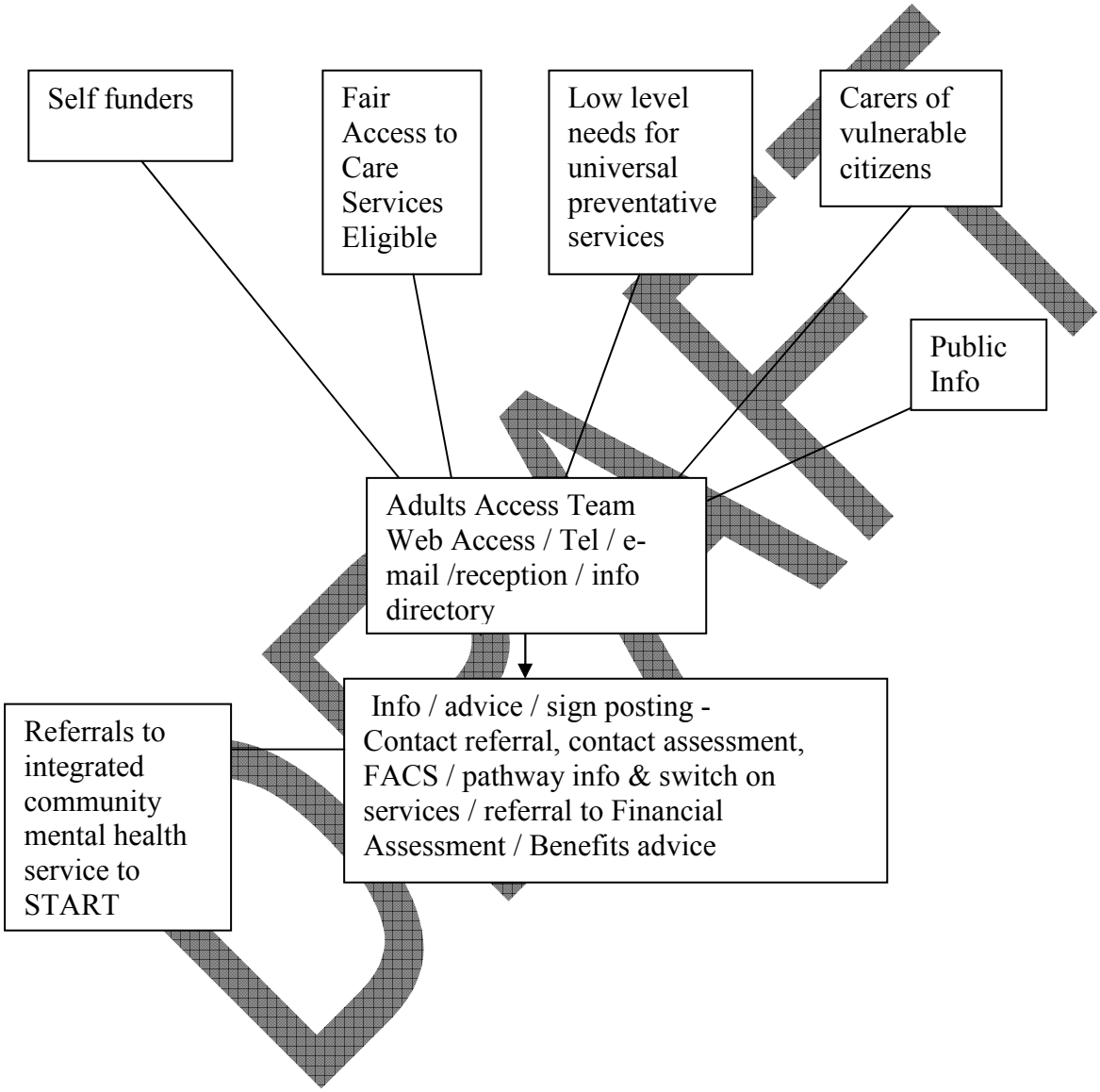
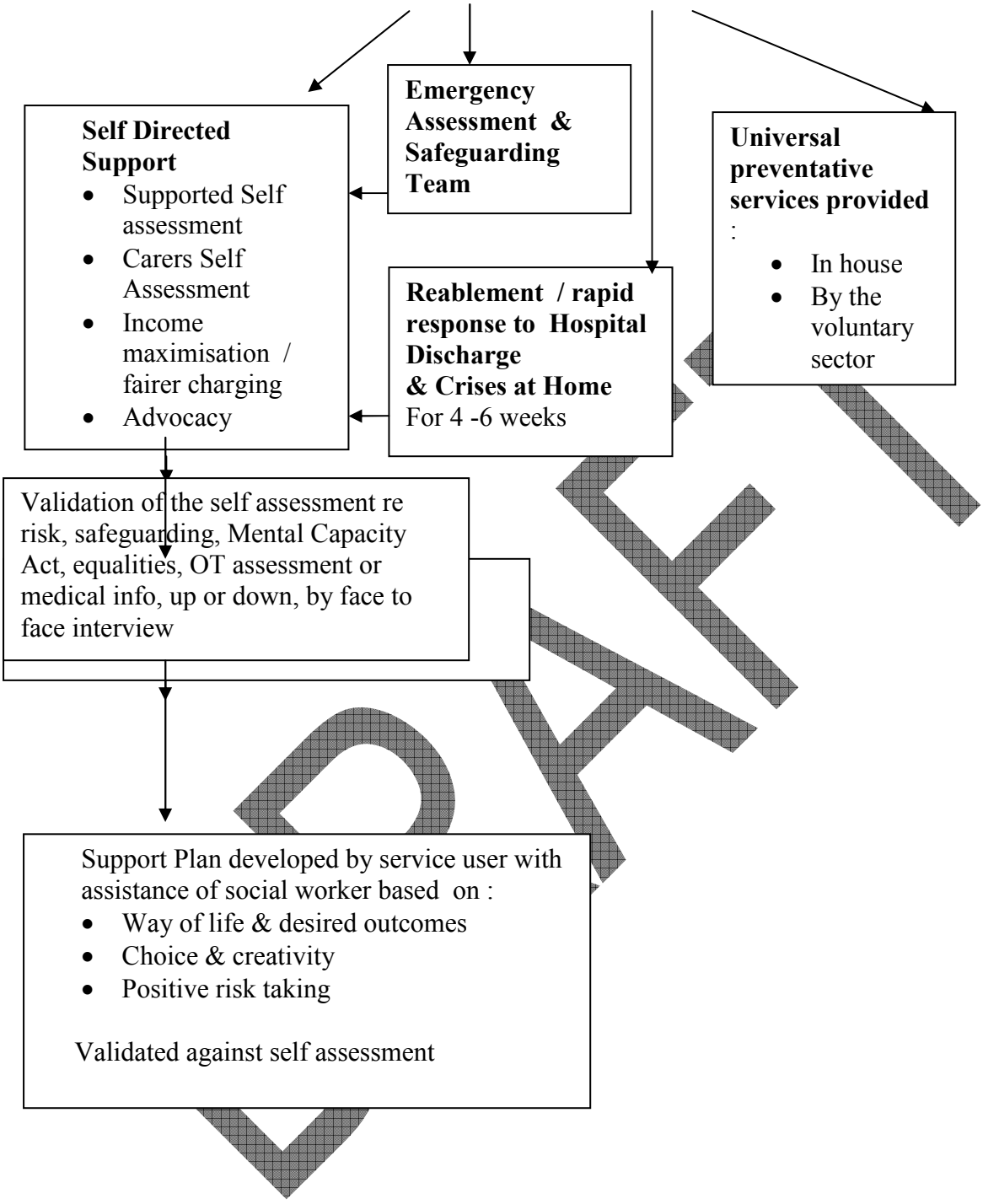
outcomes
Next review date – September 2009

ACCESS & SELF DIRECTED SUPPORT PATHWAY TO SUPPORT
choice & control passes to the vulnerable citizen




Emergency Assessment & Safeguarding Team
Self Directed Support
Supported Self assessment
Carers Self Assessment
Income maximisation / fairer charging
Advocacy
Reablement / rapid response to Hospital Discharge & Crises at Home
For 4 -6 weeks
Universal preventative services provided :
In house
By the voluntary sector
Validation of the self assessment re risk, safeguarding, Mental Capacity Act, equalities, OT assessment or medical info, up or down, by face to face interview
Support Plan developed by service user with assistance of social worker based on :
Way of life & desired outcomes
Choice & creativity
Positive risk taking
Validated against self assessment

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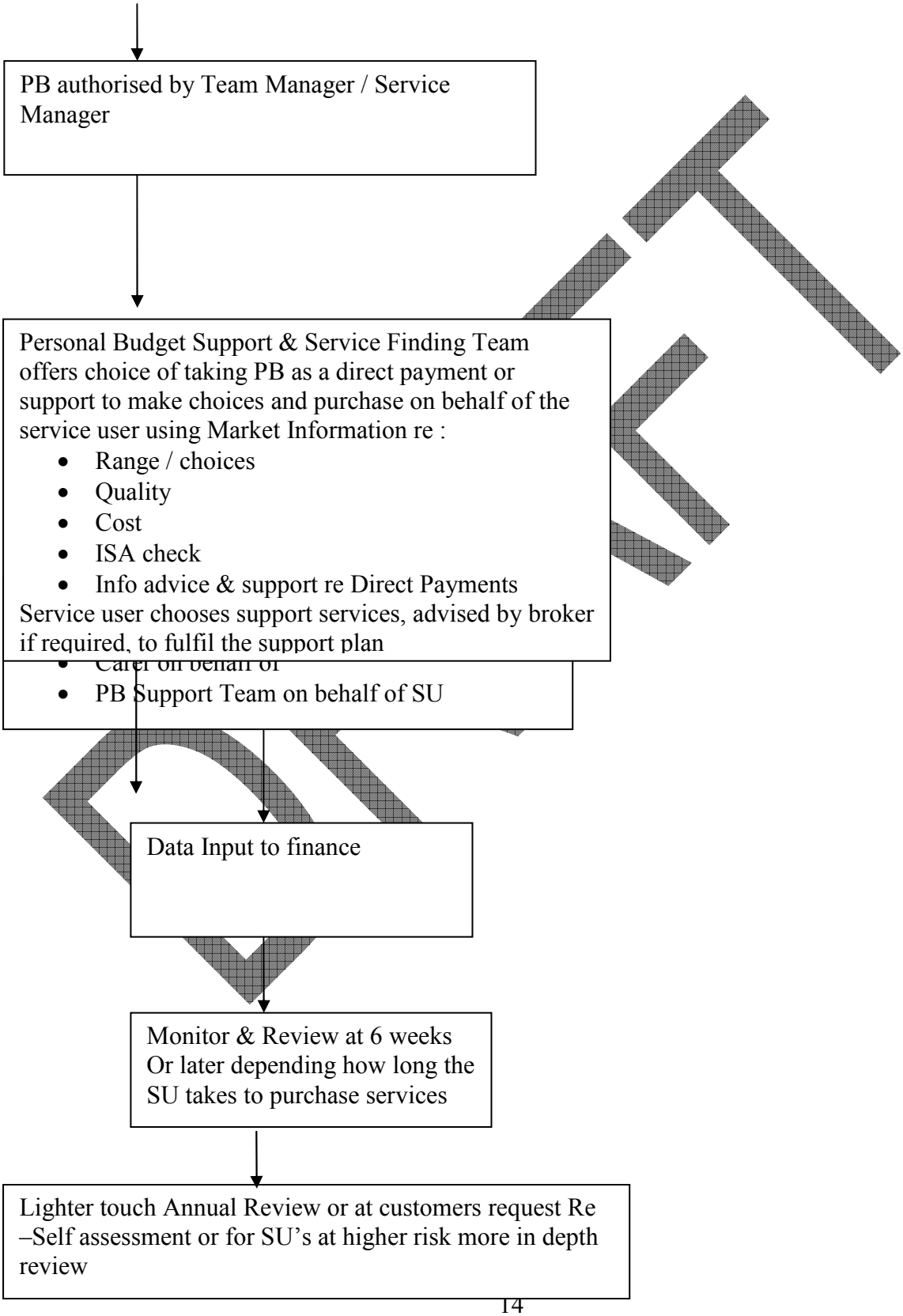
PB authorised by Team Manager / Service Manager
Personal Budget Support & Service Finding Team offers choice of taking PB as a direct payment or support to make choices and purchase on behalf of the service user using Market Information re :
Range / choices
Quality
Cost
ISA check
Info advice & support re Direct Payments
Service user chooses support services, advised by broker if required, to fulfil the support plan
Carer on behalf of
PB Support Team on behalf of SU
Data Input to finance
Monitor & Review at 6 weeks Or later depending how long the SU takes to purchase services
Lighter touch Annual Review or at customers request Re –Self assessment or for SU's at higher risk more in depth review

Supported Self Assessment Procedure

1. A resident contacts the Integrated Access Team (IAT).

2. Where appropriate they are asked to complete Supported Self-Assessment Questionnaire (SSAQ) – this can be completed electronically and emailed back, or mailed out.

3. The case is referred on to service team using Framework-i.

4. The referral is allocated to social worker or care manager on home visit interview booking system.

   Note: Where possible, and with the agreement of resident, their carer (should they have one) should also be available, and will be asked to answer questions pertaining to them.

5. Social worker reads referral and prepares for visit or interview.

6. Social worker supports resident (and possibly carer) to undertake and complete SSAQ, or discusses completed SSAQ as appropriate.

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7. If there is disagreement between service user and carer in completing the SSAQ, this is resolved either during the visit or on a return visit to the resident (in the absence of carer if necessary).

8. Social worker completes Risk Assessment and seeks agreement with the resident as to its contents. Any differences between the two assessments, and between the parties, must be recorded.

9. A Mediated Assessment (i.e. the collation of any other information which could influence the outcome of the self assessment) must also be completed.

10. Where it is apparent that the resident would benefit from an Occupational Therapy (OT) Assessment, and this has not already been arranged by IAT, the social worker ensures this is undertaken.

11. This must happen before any decisions are made as to the outcome of the assessment, and this should be explained to the resident.

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HARINGEY COUNCIL
ADULT SOCIAL CARE
Self Directed Support

SUPPORTED SELF ASSESSMENT QUESTIONNAIRE

NAME

ID NUMBER

DATE

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About Self Directed Support

Self directed Support is about people organising and having control over their support needs. Other words used to describe this are being "In Control" and having a "Personal Budget". They are all words used to describe how people with support needs can be in control and have more choice over how they live their lives.

Self Directed Support is the way we now offer help to people living in the community who need support to live their lives.

About the Supported Self Assessment Questionnaire

This Supported Assessment Questionnaire is designed to help you tell us about your support needs. We will use it to help us work out the amount of money that may be available from Adult Social Services to meet your needs.

This is an assessment for people who are eligible for support under Fair Access to Care Services (FACS)

The Supported Assessment is designed to assess how your support needs affect your day-to-day life. It is not just about how disabled you are, but is about the life you lead.

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Help with completing this form

You can complete this form yourself or you can ask someone else such as a family member or friend or someone who is supporting you to assist you.

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Please choose one answer to each question. If none of the responses fits your needs please choose the one that is closest

We will send a Social Worker or Care Manager to complete the form. If you have not been able to complete the form they will help you. If you have already filled in the form they will go through the form and discuss it with you.

If English is not your first language you can ask the Social Worker or Care Manager to arrange for an interpreter.

If you have any questions please contact Haringey Integrated Access Team

- Tel: ***020 8489 1400*** (from 9am - 5pm Mon-Fri)
- Fax: ***020 8489 4900***
- In writing to: Integrated Access Team, London Borough of Haringey, 1st Floor, Cumberland Road, Wood Green, N22 7SG
- Email: IAT@haringey.gov.uk
- By SMS: Text IAT to ***80818*** (charged at standard rate depending on provider and subscriber's package)

Please ask us if you need to have this form transcribed into a different format such as Braille or large print.

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1. Looking after yourself – personal needs

This part is about looking after yourself and your personal appearance – things like washing, dressing and going to the toilet

Please note there are six choices A, B, C, D, E, F		Examples of things to consider to help you decide your support needs	Office use
A. I do not need help with my personal support needs	☐	• I can manage my personal care	☐
B. I need help from someone else for some of my personal support needs (2– 3 times per week on average)	☐	• My needs vary but on some days I need help with personal care • I am able to strip wash daily but would need help to bath or shower • I need prompting and encouragement to wash myself and wear clean clothes	☐
C. I need help once every day from someone else for some of my personal support needs	☐	• I need someone to help me with getting out of bed • I need help with washing and/or getting dressed every morning • I need someone to lay out my clothes because I have difficulty seeing • I need support selecting appropriate clothes and reminding me how to put them on	☐
D. I need help more than once a day or for more than an hour every day from someone else for my personal support needs	☐	• I need someone to help me with getting out of bed, washing and dressing in the morning, and getting ready for bed at night • I need someone to empty a commode for me more than once a day • I need support to wash every day and this takes a long time due to my condition	☐

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E. I need help from someone else for my personal needs, several times a day	☐	• I need help to be taken to the toilet or use pads or empty my bag or the commode • I need to have everything I need brought to me because I am unable to stand up by myself and cannot propel a wheelchair or use a powered chair in my home.	☐
F. I need someone to be available to help me with personal care needs throughout the day and night	☐	• I am bed bound • I am incontinent and need help to change pads, use the toilet or empty my bag during the day and night • I need help with turning and positioning several times a night	☐

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1a – Looking after yourself, support from 2 people

This part is about whether you need two people working together at the same time to support you with personal care

Please note there are four choices A, B, C and D		Examples of things to consider to help you decide your support needs	Office use
A. I do not need two people to support me with my personal care	☐	• I do not need any support with moving or transferring • I can make all transfers safely by myself or with the support of one person	☐
B. I need two people to support me with personal care once or twice a day	☐	• I need two people to support me with transfers when I get up and when I go to bed	☐
C. I need two people to support me with personal care three o r four times a day	☐	• I need two people to support me with transfers and I have to make transfers 3 or 4 times a day, for instance to use the toilet or to get bed rest in the afternoon	☐
D. I need two people to support me with personal care five or more times a day	☐	• I need two people to support me with transfers and I have to make transfers 5 or more times a day, for instance to use the toilet or to get bed rest in the afternoon	☐

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If you have unpaid carers such as your family or friends will they be able to continue to meet your personal care needs?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

Additional Comments:

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2. Looking after yourself – Risk and Safety in the home

This part is about staying safe. Staying safe is about different things for different people. It could be about a risk of falls, wandering, getting lost, forgetting to take medication, risk of abuse or exploitation or self neglect
The question is about safety at home: if you are at risk when you go out please see question 6 and 7. If you are at risk of falling while you are doing your personal care please consider this in your answer to question 1. If you are at risk of an accident when you cook or eat food please consider this in your answer to question 3. This question is about other risks at home

Please note there are five choices A, B, C, D and E		**Examples of things to consider to help you decide your support needs**	**Office use**
A. I am at little or no risk	☐	• I feel safe and there are no current issues to my safety	☐
B. I need support to stay safe at home sometimes	☐	• I have had falls in the past but none recently • I need support to stay safe if I go out • I would need a lot of support to stay safe in unforeseen circumstances • I have had seizures in the last six months, but I am not at risk of injuring myself	☐
C. I need some help to stay safe every day at home	☐	• I am at risk of falls but have had less then three in the last month • I need daily monitoring to ensure I am taking my medication • I need monitoring every day because am at high risk of abuse or exploitation. • I have had seizures in the last six months, and I need support to take precautions for my safety	☐
D. I need some support several times a day to ensure I stay safe at home	☐	• I have had three or more falls in the last month • I have had seizures in the last six months, and I need support immediately after they happen • I need monitoring at least three times a day to ensure I have taken my medication • I am disorientated or have severe short term memory problems, but I do not wander or do anything risky if I am left alone for some time.	☐

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E. I need support all the time to ensure I stay safe at home	☐	• I am disorientated or have severe short term memory problems and without constant supervision I am very likely to wander • I have frequent unpredictable seizures and I am at risk of hurting myself when they happen	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you support you need to stay safe?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐
Additional Comments:			

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3. Mealtimes, Eating and Drinking

This part is about looking after yourself by preparing meals and eating and drinking properly

Please note there are five choices A, B, C, D, E,		Examples of things to consider to help you decide your support needs	Office use
A. I do not need help with preparing meals or eating and drinking	☐	• I can prepare, eat and drink my own meals	☐
B. I need some help to prepare a cooked main meal or I sometimes need help with eating a meal	☐	• I need some help to prepare meals such as chopping vegetables, lifting pans of hot water • It is unsafe for me to handle hot pans or use a conventional oven without support • I am unable to stand or sit in the kitchen for long enough to prepare a meal without severe discomfort • I can prepare a meal but need some help to eat or drink such as cutting up some food • I need support every day to understand/make appropriate choices around food and drink • I need reminding or encouraging to prepare my meals every day • I occasionally need prompting, otherwise I forget to eat and drink	☐
C. I need some help every time I eat	☐	• I am unable to get myself a meal or snack without support • I need support to present my meals in the right way, such as pureed food, giving me specific cutlery • I can prepare meals but I need support to supervise my eating/drinking • I always need prompting, otherwise I forget to eat and drink	☐

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D. I need a lot of help every time I eat or drink	☐	• I have swallowing difficulties and need supervision because of the risk of choking • I am not able to remember or focus my attention enough to eat or drink unless someone reminds me or prompts me throughout my meal • I have lost a significant amount of weight or had significant infections because I do not eat or drink regularly or healthily and I need supervision at every meal time	☐
E. I need intensive and or specialised help to eat or drink	☐	• I have nutritional needs through a PEG feed (fed via a tube), or • I need specialist health input i.e. Massage or suction to help me eat/swallow safely • I need someone to feed me each mouthful	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you the support you need with meal preparation, eating and drinking?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

Additional Comments:

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4. Choice and Control

Please note there are four choices A, B, C, D		Examples of things to consider to help you decide your support needs	Office use
A. I **am able** to make and communicate all the decisions about my life	☐	• I am able to make all own my decisions and have an understanding of the risks or consequences of my decisions, and I can communicate these decisions to others	☐
B. I am **able** to make and communicate most decisions about my life but **I need some** support at times	☐	• I have communication difficulties which make it difficult to explain my decisions to people who do not know me well • I need a lot of time to consider my decisions or need to have the issues explained carefully to me	☐
C. I need **support** from others to make or communicate most important decisions about my life	☐	• I have communication difficulties that mean I always require specialist assistance such as Makaton, using a lightwriter, and I cannot use any alternative means such as written communication • I am unable to make important decisions because of my cognitive difficulties or mental health issues, but I am able to some make decisions about day to day activities • An Independent Mental Capacity Advocate (IMCA) or advocate helps me make some decisions	☐
D. I have very severe communication difficulties **or** I am **unable** to make any decisions	☐	• I have severe communication difficulties, I can only indicate yes or no • I am unable to make any decisions because of my cognitive difficulties • An independent Mental Capacity Advocate (IMCA) or advocate helps me make all important decisions	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you the support you need with communicating your decisions?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

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Additional Comments:

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5. Practical Aspects of Daily Living

Please note there are four choices A, B, C, D		Examples of things to consider to help you decide your support needs	Office use
A. I don't need help around the home or with paying bills or managing my money	☐	• I am able to do my own domestic tasks	☐
B. I occasionally need support with things around the home	☐	• I need some help with specific tasks occasionally, such as managing my finances and dealing with correspondence. • I need one off specific help such as support to buy a washing machine, or getting something repaired.	☐
C. I need help with some things around the home	☐	• I need help at least once a week with some specific tasks • I need help with keeping my home clean, doing laundry • I need help with budgeting for my weekly shopping • I need help to go to the shops or to access online shopping • I sometimes need support with laundry because I am incontinent	☐
D. I need a lot of help with things around my home	☐	• I am incontinent every day and cannot wash my clothing and bedding without support • I have breathing difficulties and need help to keep my home as free from dust as possible • I need support to go shopping, or someone to shop for me and I have to follow a specific diet for health or cultural reasons, so I need to buy food from specialised shops • I am unable to deal with my own money at all and rely on others to manage my money on my behalf	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you the support you need with practical aspects of daily living?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

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Additional Comments:

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6. Relationships, roles and being part of the local community

This part is about how you meet people, make and keep positive relationships and the different roles you have in your life, such as being a parent or caring for a friend or relative. It is also about doing things in your community – like using local shops, the library, going to the cinema, to clubs, community centre, going swimming or to a gym, attending a religious service or helping neighbours and belonging to local organisations.

Please note there are four choices A, B, C, D		**Examples of things to consider to help you decide your support needs**	**Office use**
A. I am happy with my relationships and different roles and do not need any help to get involved with things	☐	• I have regular contact with the people I want to spend time with • I am able to carry out my different roles without help. • I do not wish to have any social contact	☐
B. I need some support to make and keep relationships or carry out my role or get involved in things I enjoy	☐	• I need encouragement to keep in touch with my family or friends • I need advice on how to build social contacts and become more involved in my community • I need support to make contact with people and organisations • I need equipment or adaptations to enable me to go out or to socialise, for instance a wheelchair, walking aid, communication aid • I need help with travel, such as Dial-a-Ride, Taxicard, DLA mobility component, Motability car	☐
C. I need support to make and keep relationships or carry out my role or get involved in things I enjoy	☐	• I am only able to leave the house with someone to support me • I need someone to support me each time I socialise and interact with other people • I need support to make plans and arrangements for every time I go out • I need weekly support to carry out care responsibilities to my children, or a friend or relative who also has social care needs	☐

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D. I need intensive and/or specialised support to make and keep relationships, carry out my different roles or get involved with the community.	☐	• Without daily support I am unable to carry out roles such as being or childcare responsibilities, or caring for my spouse with social care needs • I am unable to make any plans or arrangements due to my cognitive impairment • I am not able to be involved in social or leisure activities without specialised one to one support, for example someone who has had training in dealing with my communication needs	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you the support you need with relationships, roles and being part of the community?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

Additional Comments:

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7. Work and Learning

This part is about work, including training for work including voluntary work, education and learning new skills and helping to organise activities for others. You should consider if there are organised activities you wish to get involved with but need support from others to do so. For example voluntary work, adult education classes, swimming lessons, sports coaching, being on the committee of a club or society, helping to run activities at a place of worship, being active in campaigning and community action groups

Please note there are four choices A, B, C, D		**Examples of things to consider to help you decide your support needs**	**Office use**
A. I don't need any help to work or learn new things	☐	• I am already working or involved in education or other activities and I do not need support • I don't want to work or learn or take part in any new activities	☐
B. I need some support so I am able to take more advantage of the opportunities that exist to work, learn or get involved in other structured activities	☐	• I need specific equipment or technology to be able to work or learn • I need specific guidance to help me access work • I would need training to help me do a job or go on a college course or other activity. Once trained I could manage by myself • I need information about what opportunities there are for educational and other activities that would be suitable for me	☐
C. I need support to take part in work, education or leisure activities	☐	• There are activities I wish to take part in but I will need support from someone every time I do this	☐

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D. I need a lot of help to enable me to work or learn or take part in other structured activities	☐	• I need specialised one to one support to take part in work or educational or other activities. For example an assistant who has had training in dealing with my communication needs • I need support with specialised training because of my mental health issues	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you the support you need with work and learning?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

Additional Comments:

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8. Complex Needs (Actions and choices)

This section is about people who do not have mental capacity to understand all the consequences of their choices or to always control their own actions. If this does not apply to you please select A

Please note there are four choices A, B, C, D		Things to consider to help you decide your support needs	Office use
A. I have never done things that could hurt me or others. There are no concerns about my behaviour being a risk to the physical safety of myself or others	☐	• I do not act in a way or make choices that could cause harm to myself or others • I have full mental capacity to understand the consequences of my choices and control my actions	☐
B. I occasionally do things that people find difficult, and there is some risk of minor physical harm to either myself or others	☐	• I can be verbally aggressive to my carers on occasions • My actions can be difficult for my carers to deal with occasionally • I can occasionally be impulsive or lack control which is of concern to my carers • I require some help to manage my actions and choices.	☐

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C. I occasionally do things that are dangerous and could cause harm to either myself or other people	☐	• I can sometimes be verbally aggressive to my carers but not on most days • Regularly I need support because I do things that are socially inappropriate. • My actions can regularly be upsetting and difficult for my carers to deal with but not everyday • I can sometimes be impulsive or lack control on occasions which is of concern to myself and others • I require daily help to manage my actions and choices.	☐
D. I often (daily) do things that are dangerous and could cause serious harm to myself or other people. There is a very real risk of serious physical harm to myself or others – I need someone with me at all times	☐	• I can be verbally aggressive to my carers on most days • On most days I need support because my actions are socially inappropriate • My actions can be upsetting or difficult for my carers to deal with throughout the day or night • I am resistant to support or care that I need from others on most days, and/or • I purposefully harm myself • I require help and encouragement, throughout my waking hours to manage my actions and choices	☐

If you have unpaid carers such as your family or friends will they be able to continue to give you the support you need to manage your actions and choices?

All the time ☐	Most of the time ☐	Some of the time ☐	I do not have anyone who can give me this support ☐

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Additional Comments:

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9. Where I Live

This part is about the place in which you live, how comfortable you feel in your surroundings, if you feel safe and secure, happy about the type of home you have, if its location makes it easy to access places you wish to go on a regular basis. Think about how easily you can move around your home and it fits your needs when answering this part.

Please note there are four choices A, B, C, D		Examples of things to consider to help you decide your support needs
A. I am happy about where I live	☐	• I am comfortable where I live • I can easily get in and out, and to every part of my home • I am safe living where I do. • I live close to my friends and family and places I wish to go
B. I am fairly happy about where I live	☐	• I am fairly comfortable where I live • It is sometimes difficult to get out, or there may be parts of my home I cannot easily access • I am fairly safe living where I do. • Friends and family and places I wish to go are reasonably easy to get to
C. I am unhappy about where I live	☐	• I am not comfortable where I live • Getting in and out is often difficult, or there are parts of my home I cannot access • I feel unsafe living where I do. • I am a long way from my friends and family or places I wish to go
D. I am extremely unhappy about where I live.	☐	• I dislike and do not feel at home where I live • I cannot get out at all, or I am stuck in one or two rooms • I feel very unsafe living where I do. • I cannot go out, and my friends and family do not come to visit at all because it is too far • It makes me feel socially excluded

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Additional Comments:

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10. Health and Wellbeing

This part is about support you may need to manage a long-term health problem.
This could be things like diabetes, heart or respiratory failure, stroke or epilepsy. It could also include mental health difficulties like depression, anxiety state, bereavement or dementia.

Please note there are four choices A,B,C, D		**Examples of things to consider to help you decide your support needs**
A. I am generally well and have no concerns or problem with maintaining my condition	☐	• I have no physical or mental health issues
B. I need some help from others, (2 -3 times per week) to make sure I stay well and/or stable, and there is some concern about my health needs	☐	• I have a physical and/or mental health condition that is relatively well controlled and I am able to seek support if needed • I have a learning disability, dementia or other cognitive impairment but I am generally well. I can recognise and seek support if I am unwell.
C. I need a lot of help from others to make sure I stay well, and there are major concerns about my complex health needs	☐	• I have significant physical and/or mental health problems which impact on my independence, choice and control • I need regular monitoring from my GP, District Nurse, Community Psychiatric Nurse • I have a learning disability or dementia or memory problems that create some risks, such as forgetting to take medication

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D. I need daily support from others because I have complex health needs. I need daily specialised care to help me to remain stable.	☐	• I have a major physical and/or mental health problem which impacts on my independence, choice and control • I have more than one chronic health condition, or my health is generally uncontrolled requiring specialist support from GP, District Nurses, Community Psychiatric Nurses. • My health fluctuates because of a condition, such as Parkinson's disease, severe uncontrolled epilepsy, or Multiple Sclerosis • I have a learning disability or dementia and have behaviours that make it difficult for me to stay well for example refusing to take my medication, self harming or neglect

Additional Comments:

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Your Signature: ……
Date: ……

Haringey Adult Social Care
Risk Assessment and Management Plan

Name of service user:	Date:

Address:	Social Worker: G.P: District Nurses:

IDENTIFIED PROBLEMS/ NEEDS/ CONDITIONS	IDENTIFIED RISK OR HAZARD EXACERBATING FACTORS	ACTION PLAN TO REDUCE R REFERRALS TO BE MAD
Medical Condition/diagnosis (including not adhering to medical advice about managing condition)		
Physical Health [state of general health, including pressure care]		
Medication (including refusal to take medication, polypharmacy, confusion arising from overmedication)		
Mobility and transfers (including risk of falling)		
Mental Health		
Emotional Well being		
Cognitive Impairment		
Sensory impairment		
Communication		
Health & Safety (including domestic appliances)		

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IDENTIFIED PROBLEMS/ NEEDS/ CONDITIONS	IDENTIFIED RISK OR HAZARD EXACERBATING FACTORS	ACTION PLAN TO REDUCE R REFERRALS TO BE MAD
Housing		
Food and Diet (Including malnourishment and dehydration)		
Personal Care (including self-neglect, continence issues)		
Physical/Home Environment		
Social , Cultural and Leisure [risk of social isolation]		
Vulnerability		
Unsafe Actions (includes wandering and getting lost)		
Substance Misuse (including alcohol)		
Finance and Debt		
Transport		
Carer Stress (includes relationship breakdown)		
Risk of Abuse (physical, emotional, sexual, financial, neglect, institutional, discrimination)		

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IDENTIFIED PROBLEMS/ NEEDS/ CONDITIONS	IDENTIFIED RISK OR HAZARD EXACERBATING FACTORS	ACTION PLAN TO REDUCE R REFERRALS TO BE MADI
Any other identified problems/needs/conditions		

Identify any areas of disagreement.

Other Comments.

Summary of Agreed Actions

Signed

Service User

Name of Social Worker

Signed

DRAFT

Mediated Assessment

1. Please give a brief history of the person's medical condition/physical disability and current medication.

2. Is there any more detail that you need to collect using the FACE Overview Assessment or other specialist assessments?
(For example, GP, Community Matron, Occupational Therapist, sensory impairment services, assistive technology, mental health assessment.) Why are these required and what referrals need to be made?

3. Are there any areas in which the person completing the assessment or their carers did not reach an agreement with you?.

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4. Are there any areas of additional need specific to the person completing the assessment that have not been identified, but we should consider when allocating resources?

5. Do you have any concerns about the person's mental capacity? Yes ☐ No ☐
If yes, specify what further action is required:

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6. Other comments

7. Summary of Agreed Actions

DRAFT

Name of Social Worker	Signed	Date

DRAFT

Supporting Independence, Choice and Risk

Introduction

12. In Haringey we are committed to promoting the independence of all adults including the most vulnerable. This means supporting them to make choices about their care and to take greater control over their lives. However, with greater personal freedom they may need more support to deal with the novel risks they encounter e.g.

    - relating to an individual's inability to undertake an activity safely
    - relating to their physical environment and the need for improvements or equipment to their home or means of transport
    - relating to the behaviour of other people e.g. fraud, harassment
    - relating to the individual's own behaviour

13. An individual's Support Plan should maximise their autonomy to meet their desired outcomes, while reflecting their assessed needs and risks. The social worker role is to advise individuals (and where appropriate, those who care for them) on how they might minimise the risks they expose themselves to (e.g. adaptations), whilst retaining their independence, choice and control.

14. In some cases, where an individual lacks mental capacity, it may be necessary to protect adults from taking or being exposed to certain situations. A person with diminished mental capacity may sometimes be lucid and in control but at other times a danger to themselves – this needs to be carefully managed.

Making decisions about risk

15. Perceptions of risk vary and tend to be understood very differently by different people, making it difficult for agreement to be reached as to the best way forward. This can be particularly complex where a number of agencies and practitioners are involved, or where there are differences in view expressed by the individual and the carer.

16. These difficulties are best managed by developing a person-centred approach to support planning, and seeking a minimum level of agreement. If difficulties persist, early resolution should be sought from the manager, if necessary following legal advice or by referring the case, in the final instance, to a panel.

Safeguarding referrals

Where an individual is thought to be at risk of abuse, neglect, exploitation or theft, immediate action must be taken to protect them from harm. An alert must be raised with the Safeg

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Support Planning

What is a Support Plan?

1. The purpose of support planning is to provide a clear account of the individual's view of the life they wish to lead, the outcomes they wish to achieve, and the support they require to address the needs assessed in their Supported Self Assessment Questionnaire (SSAQ).

2. Support planning is the mechanism by which we support an individual to consider how they wish to spend their Personal Budget. It can be produced by the individual or they may wish to enlist the support of family, friends, independent brokerage or a social worker.

3. Support Plans must be based on the individual's way of life, desired outcomes and daily activities. They are not determined by what services are available. The Service Finding Team will work with individuals to determine which services are to be put in place once an initial Support Plan has been produced.

Whose Plan is it?

4. At the moment, the majority of people completing the self-directed support pathway have been supported by their social worker to help them identify their needs and outcomes. However, Support Plans are 'owned' by the individual concerned. It is the role of the social worker and others involved in the self-directed support pathway to help them if they request or need it. This may mean helping them with the choices they make; supporting them to take control of their care arrangements and helping them live their lives as independently as possible.

5. It remains the choice of the individual as to who provides the support they may need to complete the plan. Some people may feel that they need no support at all and will be able to complete their Support Plan, and identify their own needs and outcomes entirely independently.

6. Support Plans must be sufficiently flexible that whatever a person's circumstances or difficulties, they are able to complete it with a minimum of support if they want to. If the individual wishes to use their own format this will be uploaded to the Support Plan episode and a summary of its contents recorded.

What should it include?

7. The Support Plan must explain how the needs identified in the Supported Self-Assessment Questionnaire (SSAQ) are to be met – and have regard to any other

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assessments conducted and to the impact of any other services or payments that the individual is receiving.

8. The benefits (e.g. Attendance Allowance, Disability Living Allowance etc) that may, in some cases, make up an individual's income – known as their Individual Budget – should be used as intended. The Personal Budget is one part of this and should be allocated specifically to meet the needs set out in an individual's responses to their SSAQ with reference to the individual's desired outcomes as stated in their Support Plan.

9. The Support Plan must be sufficiently detailed and robust that decisions can be made about the most appropriate services and support to meet the specific needs and desired 'outcomes' of the individual, and without the need for additional information.

10. The person completing the Support Plan should consider how the individual might be helped to live more independently and what support they might need to manage (or to recover the ability to manage) their lives.

11. They must consider areas of support they may wish their informal carer to be involved in (and which the carer is willing to provide). If substantial support needs are identified the carer will be entitled to, and must be offered an assessment of, their own needs (a carer's SSAQ) and a Support Plan.

12. It is also important to consider what matters to the person with regards family and friends, their lifestyle and (where relevant) their religious observances, as well as their interest in leisure pursuits or in education, training, volunteering or employment.

What happens next?

13. Once the Support Plan is complete the social worker forwards it to the appropriate manager and/or authorising officer for agreement.

14. The completion of SSAQ, Mediated Assessment, Risk Assessment and Support Plan are recorded as episode 'PD/OP Personalisation Support Plan' on Framework-i.

15. The Support Plan should be presented to the individual in a format that they request, can keep and can understand.

16. On an interim basis all Personal Budgets are being approved via a Learning Panel. This is to ensure the accuracy of the Resource Allocation System (RAS).

17. Once the Personal Budget is approved, the social worker records on Framework-i to notify the Service Finding Team that they may proceed – i.e. the episode 'Service Finding' begins.

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Reviewing the Support Plan

18. Once the Support Plan is agreed and the Service Finding episode is completed, it will remain unchanged for at least the first 4 to 6 weeks, at which point it must be reviewed.

19. The purpose of a Review is to check that the individual is satisfied with the services in place, to ensure initial agreed outcomes are on course to being achieved, and to determine whether or not the individual's needs have changed.

20. This first review must be face-to-face with the individual. Other parties may also be invited including the informal carer and service providers, where appropriate and agreed with the individual.

21. The format and content of all Reviewed Support Plans must be agreed with the individual and recorded. At Annual Reviews, the social worker must have spoken directly with the individual concerned and/or - where appropriate - with their carer, during or immediately prior to their review.

22. If the review finds that the individual's needs have changed significantly it may be necessary to return to the assessment stage of the self-directed support pathway. Alternatively, where appropriate, there may be agreement with the individual and the Service Finding Team to amend the Support Plan accordingly to reflect this new need.

23. Reviews may be called by the individual or any other party to the Support Plan prior to the date of their Annual Review if:

    - There is a serious problem with a service which cannot be resolved by the individual exercising their choice and control.
    - There is a significant change in the individual's needs which the service provider is not able to meet.
    - If the individual may have been put at significant risk.

24. The social worker should recommend additional funding to the authorising officer or Exceptions Panel if there are insufficient funds to maintain the individual's safety.

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Personal Budget Support Team

1. The purpose of the Personal Budget Support Team is to:

- enable individuals to implement their Support Plan
- help them identify services using their Personal Budget or their own funds
- undertake Annual (or more frequent) Reviews as appropriate.

2. The Personal Budget Support Team receives an individual's Personal Budget and Support Plan on Framework-i, and arranges a home visit or an appointment at the Winkfield Resource Centre.

3. This is to identify, from the Support Plan, how people wish to utilise their funds in order to meet their identified outcomes.

4. The team works alongside the person to obtain and maximise the services the resident identifies.

5. It enables them to purchase and arrange services to meet the outcomes set out in their Support Plan.

6. The person may choose to use their Personal Budget, should they have one, to commission their own services via the use of a Direct Payment.

7. The Personal Budget Support team will build up, over time, a resource of services underpinned by the Market Development Team and HAricare, our web-based information directory.

8. This provides a range of options of services currently being provided in-house and by the independent sector.

9. While it is of particular use to members of the Personal Budget Support Team advising people who have a personal budget, it is also publicly accessible for use by members of the public.

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