Person-centred care and support planning
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Using this document

This document includes extracts from the Care Act 2014 Statutory Guidance – the full guidance is available online. gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

Survey results in this document are taken from an ADASS Carers Policy Network survey completed by 47 local authorities in June-August 2018. Comments and responses are included in this document to indicate the direction of travel in practice since the implementation of the Care Act.

Case studies in this document provide examples of the application of practices discussed.
Chapter 3A

Care and support planning

Statutory guidance

10.1 Care and support should put people in control of their care with the support that they need to enhance their wellbeing and improve their connections to family, friends and their community. A vital part of this process for people with ongoing needs which the local authority is going to meet is the care and support plan or support plan in the case of carers (henceforth referred to as ‘the plan’).

10.2 The person must be genuinely involved and influential throughout the planning process, and should be given every opportunity to take joint ownership of the development of the plan with the local authority if they wish, and the local authority agrees. There should be a default assumption that the person, with support if necessary, will play a strong pro-active role in planning if they choose to. Indeed, it should be made clear that the plan ‘belongs’ to the person it is intended for, with the local authority role to ensure the production and sign-off of the plan to ensure that it is appropriate to meet the identified needs.

10.3 The personal budget in the plan will give everyone clear information regarding the costs of their care and support and the amount that the local authority will make available, in order to help people to make better informed decisions as to how needs will be met. The ability to meet needs by taking a direct payment must be clearly explained to the person in a way that works best for them, so that they can make an informed decision about the level of choice and control they wish to take over their care and support. This should mean offering the choice more than once in the process and enabling that choice by providing examples of how others have used direct payments, including via direct peer support, for example from user-led organisations.

See chapter 10 of the statutory guidance
Person-centred care and support planning

The statutory guidance provides further detail about:

- when to undertake care and support planning
- what it means to ‘meet needs’ and considerations in deciding how to meet needs
- how to undertake care and support planning, and support planning
- production of the plan
- involving the person
- authorising others (including the person) to prepare the plan
- care planning for people who lack capacity
- minimising and authorising a deprivation of liberty (DOL) for people who lack capacity
- combining plans
- sign-off and assurance
- protecting property of adults being cared for away from home.

Whole family approaches to care and support planning

Adopting a whole family approach to developing a plan can provide new opportunities to achieve best outcomes for the whole family. Where there are multiple family members requiring care and support, and multiple support plans, the plans should not be developed in isolation. Where it is not possible to combine plans they should at very least be coordinated.


Examples of where combined plans can be useful are:

- mutual caring where both people involved have needs and also caring responsibilities
- people in receipt of local authority and NHS healthcare
- where budgets are pooled
- carers (including young carers) and person with support need.

Efficient and effective interventions to fulfill these duties

A number of authorities have developed their approaches to care and support planning. The key themes emerging from the examples include:

- the importance of linking the outcomes identified within the assessment process with the support plan development
- encouraging carers to be at the centre of the support planning process, identifying how they want their outcomes to be met
- when meeting the needs of multiple people in the same family, there is benefit in producing a combined support plan with a joint person budget here
- where a range of needs exist and opportunities arise, maximise joint care planning with health.

Survey results

Many councils use a whole family approach to care and support planning as well as assessments. When asked what kinds of additional services have been provided to adults in order to alleviate young carers’ responsibilities, councils mentioned providing respite and assistive technology as well as putting emergency plans in place and making referrals to social care and occupational therapy. A few respondents mentioned that their area focuses on helping families to build a wider support network so that there are other people to rely on and not just the immediate children in the family. Care and support planning may be focused on critical times for a family to enable young carers to get to school on time.
Many authorities have adopted good practice in this area demonstrating different approaches to working in a whole systems way. Given the requirements of the Care Act around early intervention and prevention, it is essential all local authorities look at their current practice and seek to develop approaches which are proactive and cross the care and health system. Further, they must also consider how universal services can be accessed in different ways in their area.

Liverpool City Council’s care and support planning

Liverpool City Council commission an external organisation to undertake the development of their care and support plans. The plan is designed to be completed by the carer and carer’s development worker and is designed to ensure it meets the requirements of the local authority in terms of reporting, quality and outcomes. The plan is designed to ensure the appropriate outcomes are considered and identifying how these will be met. A health and wellbeing scale is included alongside a focus on how broader carer outcomes will be met and supported. The plan links directly to the allocation of resources to meet the identified needs and outcomes and approval processes. [londonadass.org.uk/wp-content/uploads/2014/10/Liverpool-Carers-Support-Plan.pdf]

Think Local Act Personal resources

Delivering Care and Support Planning has been developed by Think Local Act Personal (TLAP) with people who use services, families and carers to show what good care and support planning looks like in practice.

It is backed up with examples from councils across England that are leading the way in this area. The guide describes what people want in a care and support planning process and the elements that need to be in place to make this happen. There are also a set of recommendations for councils so that they can be both Care Act compliant and person-centred in their approach. [thinklocalactpersonal.org.uk/Latest/Resource/?cid=10464]

This guidance has more recently been enhanced by the production of an online tool on integrated care and support planning. [thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool]

Case study one

Paul is a 21-year-old university student and has been the main carer for his father Greg for three years. Paul was finding it difficult to maintain his relationships and his own support networks with his friends. He wanted a break to recharge his batteries and spend time with his friends to keep up his social life alongside his studies and caring role. Paul wanted to go on holiday with his friends and requested support for his father when he goes away.

He was providing substantial assistance, especially in the evening and over the weekend and was providing 15 hours support to his father each week.

Paul wanted to continue caring for his dad as long as he was also supported to have a break when he needed one. Following the outcome of both assessments, Greg’s package of support and support plan were amended to ensure that replacement care was provided.

Paul was given a personal budget to reflect his needs as a carer and the outcomes he wanted to achieve. Paul used his personal budget to go on holiday with his friends.

This break allowed Paul to spend time with his friends and maintain his own social support network. He felt the break had significantly improved his wellbeing allowing him to maintain his studies and continue his caring role for his father.

Paul: “Being able to spend a few days away from looking after my Dad gave me a chance to relax. I was confident he was safe and well looked after so I didn’t have to worry.”
Case study two

Harry is the carer for his wife Margaret who has dementia and significant care and support needs. Whilst Margaret has daily support from commissioned carers three times a day, Harry provides substantial care and support the remainder of the time. Harry has very little time to himself outside of his caring role and was starting to feel stressed by the situation and wanted to have some time to himself.

In the past, Harry used to enjoy playing the organ and found it to be a good means of relieving stress. He had said he would like to take this hobby up again but Margaret does not like any noise in the house and becomes distressed.

Following a carer’s assessment, Harry was awarded a personal budget and supported with developing his support plan. Harry chose to meet his identified outcomes through the purchase of an organ and a pair of headphones so that he could enjoy his hobby without creating any noise in the family home. Harry found this to be a good way of unwinding, and over time improved his wellbeing and reduced his stress levels improving his ability to maintain his caring role.

Harry: “It’s great to have a chance to unwind and have a bit of me time. I feel less stressed and more able to carry on looking after my wife.”

Case study three

Barbara is 69 and looking after her mother Eleanor who is 93 and has dementia. Eleanor lives with her daughter and can still manage most of her own personal care with a bit of help, but cannot be left alone at home as her memory problems are now quite significant and she also struggles with mobility and has fallen a number of times.

Barbara wanted to take a break to have some time to herself but Eleanor had in the past been adamant that she only wanted Barbara looking after her, meaning this hadn’t been possible. Barbara was exhausted and at breaking point meaning her own mental health was suffering.

After an assessment of both of their needs, it was clear that a solution needed to be found as the situation was unsustainable.

Barbara worked with a local carer support organisation to agree that a care support worker, Linda, would come to visit them in their home over a number of weeks, to help whilst they were both there, explaining that she was there to help Barbara. Linda had been carefully chosen as a good match for this role based on Eleanor’s interests – Eleanor and Linda shared an interest in piano playing which helped with them giving something to talk about together.

Over a number of weeks, Eleanor got to know Linda. All three spent time together and went out on short trips together. When Barbara felt happy with it, and with Eleanor’s agreement that she would be back soon, Barbara tried nipping out to the shops for half an hour whilst Linda stayed with Eleanor.

Barbara: “It’s great having Linda come round to support with mum because I don’t have to feel guilty about wanting a break. I enjoy having time to myself and I come back from my time away feeling refreshed.”
Chapter 3B

Personal budgets

See chapter 11 of the statutory guidance

Statutory guidance

11.36 Specific consideration should be given to how a personal budget will be used by carers. The Act specifies that a carer’s need for support can be met by providing care to the person they care for. However, decisions on for whom a particular service is to be provided may affect issues such as whether the service is chargeable, and who is liable to pay any charges. It is therefore important that it is clear to all individuals involved whose needs are intended to be met by a particular type of support, to whom the support will be provided directly, and therefore who may pay any charges due. Where a service is provided directly to the adult needing care, even though it is to meet the carer’s needs, then that adult would be liable to pay any charge, and must agree to do so. Section 14 of the Act makes clear that where the needs are met by providing care and support direct to the adult needing care, the charge may not be imposed on the carer.
11.37 Decisions on which services are provided to meet carers’ needs, and which are provided to meet the needs of the adult for whom they care, will therefore impact on which individual’s personal budget includes the costs of meeting those needs. Local authorities should make this decision as part of the care planning process, in discussion with the individuals concerned, and should consider whether joint plans (and therefore joint personal budgets) for the two individuals may be of benefit.

11.38 Local authorities should consider how to align personal budgets where they are meeting the needs of both the carer and the adult needing care concurrently. Where an adult has eligible needs for care and support, and has a personal budget and care and support plan in their own right, and the carer’s needs can be met, in part or in full, by the provision of care and support to that person needing care, then this kind of provision should be incorporated into the plan and personal budget of the person with care needs, as well as being detailed in a care and support plan for the carer.

11.39 ‘Replacement care’ may be needed to enable a carer to look after their own health and wellbeing alongside caring responsibilities, and to take a break from caring. For example, this may enable them to attend their own health appointments, or go shopping and pursue other recreational activities. It might be that regular replacement care overnight is needed so that the carer can catch up on their own sleep. In other circumstances, longer periods of replacement care may be needed, for example to enable carers to have a longer break from caring responsibilities or to balance caring with education or paid employment. In these circumstances, where the form of the replacement care is essentially a homecare service provided to the adult needing care that enables the carer to take a break, it should be considered a service provided to the cared-for person, and thus must be charged to them, not the carer.

11.40 The carer’s personal budget must be an amount that enables the carer to meet their needs to continue to fulfill their caring role, and takes into account the outcomes that the carer wishes to achieve in their day to day life. This includes their wishes and / or aspirations concerning paid employment, education, training or recreation if the provision of support can contribute to the achievement of those outcomes. The manner in which the personal budget will be used to meet the carer’s needs should be agreed as part of the planning process.

11.41 Local authorities must have regard to the wellbeing principle of the Act as it may be the case that the carer needs a break from caring responsibilities to look after their own physical / mental health and emotional wellbeing, social and economic wellbeing and to spend time with other members of the family and personal relationships. Whether or not there is a need for replacement care, carers may need support to help them to look after their own wellbeing. This may be, for example, a course of relaxation classes, training on stress management, gym or leisure centre membership, adult learning, development of new work skills or refreshing existing skills (so they might be able to stay in paid employment alongside caring or take up return to paid work), pursuit of hobbies such as the purchase of a garden shed, or purchase of laptop so they can stay in touch with family and friends.
11.42 The Act makes clear that the local authority is able to meet the carer’s needs by providing a service directly to the adult needing care. However, there may be instances where the adult being cared for does not have eligible needs, so does not have their own personal budget or care plan. In these cases, the carer must still receive a support plan which covers their needs, and how they will be met. This would specify how the carer’s needs are going to be met (for example, via replacement care to the adult needing care), and the personal budget would be for the costs of meeting the carer’s needs.

11.43 The adult needing care would not receive a personal budget or care plan, because no matter what the service is in practice, it is designed to meet the carer’s needs. However, it is essential that the person requiring care is involved in the decision-making process and agrees with the intended course of action.

11.44 In situations such as these, the carer could request a direct payment, and use that to commission their own replacement care from an agency, rather than using an arranged service from the local authority or a third party. The local authority should take steps to ensure that the wishes of the adult requiring care are taken into account during these decisions. For example, the adult requiring care may not want to receive replacement care in this manner.

11.45 If such a type of replacement care is charged for (and it may not be), then it would be the adult needing care that would pay, not the carer, because they are the direct recipient of the service. This is in part why it is so important that the adult needing care agrees to receive that type of care. The decisions taken by the carer and adult requiring care and charging implications should be agreed and recorded in the support plan. If a dispute arises and the person refused to pay the charge, the local authority must, as far as it is feasible, identify some other way of supporting the carer.

11.46 For the purposes of charging, the personal budget which the carer receives must specify the costs to the local authority and the costs to the adult, based on the charging guidance (see chapter 8). In this case, ‘the adult’ refers to the carer, because they are the adult whose needs are being met. However, in instances where replacement care is being provided, the carer should not be charged. If charges are due to be paid then these have to be met by the adult needing care. Any such charges would not be recorded in the personal budget, but should be set out clearly and agreed by those concerned.
The statutory guidance provides further detail about:

- the personal budget
- elements of the personal budget
- elements of care and support that are excluded from the personal budget
- calculating the personal budget
- agreeing the final budget
- use of the personal budget
- use of a carer’s personal budget
- carers’ personal budgets where the adult being cared for does not have eligible needs
- appeals / disputes.

Efficient and effective interventions to fulfill these duties

A number of authorities have developed their approaches to personal budgets and how they may need to be amended to meet the duties within the Care Act. The key themes that have emerged include:

- effective use and administration of personal budgets can improve choice and flexibility and impact positively on individual outcomes
- a clear and transparent process for establishing the personal budget should be in place to ensure that both practitioners and individuals are clear about how the budget is calculated
- budgets must meet the sufficiency principle and be administered in a timely way
- maximise opportunities for integrating personal health and care budgets for individuals, to ensure minimal monitoring arrangements and duplication.

Survey results

Just under half of respondents to the ADASS CPN survey said that they have a Resource Allocation System (RAS) for carers, although three of these were pilot schemes still in evaluation stage. These RAS offer an indicative budget which is then personalised and amended in a care plan. It should be noted that use of any RAS needs to be flexible enough to meet individual needs. Those who don’t use a RAS often said their decisions are done on a case by case basis based on outcomes and the necessary budget to achieve this. One local authority had moved to a more flexible system after it found the RAS did not provide the flexibility to tailor support to carers’ needs.

When asked about their processes with carers’ personal budgets, all respondents’ answers included reference to developing and costing a plan after assessment and then a form of validation. Some had boards or panels that have to approve decisions, for others it is at staff (council or commissioned service).

Think Local Act Personal tool for personal budgets

The TLAP Personal Budgets Minimum Process Framework is an interactive tool. It is designed to help improvement officers and managers working in councils, and their partner organisations, deliver Care Act compliant lean social care systems and processes which relate to personal budgets. It also addresses other common issues related to delivering the best outcomes for personal budget holders.

[thinklocalactpersonal.org.uk/Personal-Budgets-Minimum-Process-Framework](thinklocalactpersonal.org.uk/Personal-Budgets-Minimum-Process-Framework)

East Sussex whole family budget

In East Sussex a whole family budget is available. Applications for this can be made by a professional supporting any member of the family. Supporting needs assessment evidence is needed to meet the criteria. This is a one-off allocation and can be made by a direct payment or direct purchase of goods or services.

[eastsussex.gov.uk/socialcare/carers/fpb](eastsussex.gov.uk/socialcare/carers/fpb)
Chapter 3C

Direct payments

See chapter 12 of the statutory guidance

Statutory guidance

12.1 Direct payments are monetary payments made to individuals who request to receive one to meet some or all of their eligible care and support needs. The legislative context for direct payments is set out in the Care Act, Section 117(2C) of the Mental Health Act 1983 and the Care and Support (Direct Payments) Regulations 2014.

12.2 Direct payments have been in use in adult care and support since the mid-1990s and they remain the government’s preferred mechanism for personalised care and support. They provide independence, choice and control by enabling people to commission their own care and support in order to meet their eligible needs.

12.3 Direct payments, along with personal budgets and personalised care planning, mandated for the first time in the Care Act, provide the platform with which to deliver a modern care and support system. People should be encouraged to take ownership of their care planning, and be free to choose how their needs are met, whether through local authority or third-party provision, by direct payments, or a combination of the three approaches.
12.4 For direct payments to have the maximum impact the processes involved in administering and monitoring the payment should incorporate the minimal elements to allow the local authority to fulfill its statutory responsibilities. These processes must not restrict choice or stifle innovation by requiring that the adult’s needs are met by a particular provider, and must not place undue burdens on people to provide information to the local authority. An effective monitoring process should also go beyond financial monitoring, and include aspects such as identifying wider risks and issues, for example non-payment of tax, and provision of employers’ liability insurance where this is appropriate.

12.5 The local authority also has a key role in ensuring that people are given relevant and timely information about direct payments, so that they can make a decision whether to request a payment, and if doing so, are supported to use and manage the payment appropriately. The route to a direct payment is for a person to request one, but the local authority should support the person’s right to make this request by providing information and advice as detailed above. People must not be forced to take a direct payment against their will, but instead be informed of the choices available to them.

The statutory guidance provides further detail about:
- making direct payments available
- considerations for adults with and without capacity
- administering, monitoring and reviewing direct payments
- using the direct payment
- paying family members
- short-term and long-term care in a care home
- becoming an employer
- direct payments and hospital stays
- direct payments for local authority services
- direct payments in the form of pre-payment cards
- harmonisation of direct payments
- terminating direct payments.

Efficient and effective interventions to fulfill these duties

A number of local authorities have developed good practice and efficient processes for administering direct payments. Key themes in good practice approaches to direct payments include:
- processes for administering direct payments should be simple and proportionate whilst also ensuring that risks are enabled and managed
- direct payments provide an appropriate mechanism for delivering flexible personalised care and support
- information on direct payments and their benefits should be available and promoted.

Pre-paid cards

Pre-paid cards offer a resolution to problems generally associated with direct payments including:
- transferring funds
- monitoring and auditing funds against agreed support plans
- reclaiming unspent funds and managing fraud.
Pre-paid cards enable good care and effective monitoring to be carefully balanced. Funds can be uploaded to the card and then spent in a similar way to a debit card. This includes the setup of direct debits, standing orders, online payments and cash withdrawals. The cards cannot become overdrawn as there is no credit element associated with the cards.

In most cases carers can have a companion card which can allow access to a defined pot of funding as part of the cared for person’s personal budget. They can also have a card in their own right for carers’ assessed services.

Service users can monitor and manage their funds through an online portal or via a telephone banking facility. Service users no longer have to submit bank statements and the high volume of paperwork traditionally associated with receiving a direct payment.

Funds can be uploaded to the cards in an instant, 24/7, to deal with emergencies and accounts can be suspended if a problem is identified.

Other benefits include:

- service users no longer need to open a separate bank account
- pre-paid card available to both service users and carers
- emergency payments can be made instantly
- monitoring officer’s work is less bureaucratic and can be targeted
- focus on service user outcomes and not on completing financial monitoring form
- any discrepancies not in accordance with the care plan is addressed in a timely fashion
- safeguarding of individuals including earlier identification of potential financial abuse;
- clawback of funds becomes much easier as both the cards and any unspent funds remain the property of the local authority
- missing service user contributions are automatically notified.

Over 100 councils are using pre-paid cards to deliver direct payments and other services. The National Prepaid Card Network website (prepaidnetwork.org.uk) explains that transferring money in this way enabled a careful balance of good care and effective monitoring. Their online guide includes case studies from Camden council, Brent council and Derbyshire County council. prepaidnetwork.org.uk/web-cont1001/uploads/Guide-to-the-use-of-Prepaid-Cards-2nd-edition.pdf

Survey results

In the ADASS survey, there was a variety of practice in relation to the use of pre-paid cards for carers. Given that carers’ personal budgets will generally be far smaller than those of a person needing care, pre-paid cards may not be the most efficient mechanism. As such, there are mixed approaches with some using pre-paid cards, other authorities prefer to pay money directly to carers.

Other useful resources

Carers UK’s guide to direct payments has useful information for carers. carersuk.org/help-and-advice/practical-support/getting-care-and-support/direct-payments

HMRC has a number of resources which can help direct payment recipients to understand their responsibilities.

gov.uk/browse/employing-people
See chapter 13 of the statutory guidance

Statutory guidance

13.1 Ensuring all people with a care and support plan, or support plan, have the opportunity to reflect on what is working, what is not working and what might need to change is an important part of the planning process. It ensures that plans are kept up-to-date and relevant to the person’s needs and aspirations, will provide confidence in the system, and mitigate the risk of people entering a crisis situation.

13.2 The review process should be person-centred and outcomes focused, as well as accessible and proportionate to the needs to be met. The process must involve the person needing care and also the carer where feasible, and consideration must be given whether to involve an independent advocate who local authorities are required to supply in the circumstances specified in the Act.

continued over
13.3 Reviewing intended outcomes detailed in the plan is the means by which the local authority complies with its ongoing responsibility towards people with care and support needs. The duty on the local authority therefore is to ensure that a review occurs, and if needed, a revision follows this. Consideration should also be given to authorising others to conduct a review – this could include the person themselves or the carer, a third party (such as a provider) or another professional, with the local authority adopting an assurance and sign-off approach.

13.4 The review will help to identify if the person’s needs have changed and can in such circumstances lead to a reassessment. It should also identify other circumstances which may have changed, and follow safeguarding principles in ensuring that the person is not at risk of abuse or neglect. The review must not be used as a mechanism to arbitrarily reduce the level of a person’s personal budget.

Efficient and effective interventions to fulfill these duties

The key themes emerging from good practice in this area include:

- processes for reviewing care and support plans should be proportionate and take into consideration risk and fluctuating needs
- consideration should be given to the method of review and making a range of review options available
- review processes should be person-centred and outcome focused
- the review and revision of the care and support plan should be intrinsically linked especially where it relates to a change in circumstances or presenting need
- at the assessment and support planning stages, consideration should be given to timing of the first review and subsequent reviews.

Newham risk management and enablement guidance


The statutory guidance provides further detail about:

- review of the care and support plan, or support plan
- keeping plans under review generally
- planned and unplanned review
- considering a request for a review of a care plan, or support plan
- considering a review
- revision of the care and support plan, support plan
- timeliness and regularity of reviews.
Chapter 3E

Safeguarding

See chapter 14 of the statutory guidance

Statutory guidance

14.45 Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- a carer may witness or speak up about abuse or neglect
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with, or
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

14.46 Assessment of both the carer and the adult they care for must include consideration of both their wellbeing. Section 1 of the Care Act includes protection from abuse and neglect as part of the definition of wellbeing. As such, a needs or carer’s assessment is an important opportunity to explore the individual’s circumstances and consider whether it would be possible to provide information, or support that prevents abuse or neglect from occurring, for example, by providing training to the carer about the condition that the adult they care for has or to support them to care more safely. Where that is necessary the local authority should make arrangements for providing it.
If a carer speaks up about abuse or neglect, it is essential that they are listened to and that where appropriate a safeguarding enquiry is undertaken and other agencies are involved as appropriate.

If a carer experiences intentional or unintentional harm from the adult they are supporting, or if a carer unintentionally or intentionally harms or neglects the adult they support, consideration should be given to:

- whether, as part of the assessment and support planning process for the carer and, or, the adult they care for, support can be provided that removes or mitigates the risk of abuse. For example, the provision of training or information or other support that minimises the stress experienced by the carer. In some circumstances the carer may need to have independent representation or advocacy; in others, a carer may benefit from having such support if they are under great stress or similar, and

- whether other agencies should be involved; in some circumstances where a criminal offence is suspected this will include alerting the police, or in others the primary healthcare services may need to be involved in monitoring.

Other key considerations in relation to carers should include:

- involving carers in safeguarding enquiries relating to the adult they care for, as appropriate
- whether or not joint assessment is appropriate in each individual circumstance
- the risk factors that may increase the likelihood of abuse or neglect occurring, and
- whether a change in circumstance changes the risk of abuse or neglect occurring.

A change in circumstance should also trigger the review of the care and support plan and / or support plan.

The statutory guidance provides further detail about:

- review of the care and support plan, support plan
- adult safeguarding – what it is and why it matters
- abuse and neglect
- understanding what they are and spotting the signs
- reporting and responding to abuse and neglect
- carers and adult safeguarding
- adult safeguarding procedures
- local authority’s role and multi-agency working
- criminal offences and adult safeguarding
- safeguarding enquiries
- Safeguarding Adults Boards
- Safeguarding Adults Reviews
- information sharing, confidentiality and record keeping
- roles, responsibilities and training in local authorities, the NHS and other agencies.
ADASS safeguarding review paper

The ADASS review paper on carers and safeguarding explores issues around improving practice and securing desired outcomes for:

- carers speaking up about abuse or neglect within the community or within different care settings
- carers who may experience intentional or unintentional harm from the person they are trying to support or from professionals and organisations they are in contact with
- carers who may unintentionally or intentionally harm or neglect the person they support.

Case study four

Vivian is a 73-year-old woman who was diagnosed with dementia two years ago. John, her son, who is 50, was divorced last year and as a result moved into his mother’s home. He works from home as an IT consultant and is the main carer for his mother. Vivian is able to move around the home fairly independently using a walking stick. She manages her own personal care requirements by using the equipment provided by the community occupational therapist (bath board). John confirmed that he supported his mother with the shopping, cleaning, laundry and meal preparation. He had become overwhelmed with the situation and stated that it is difficult to witness his mother’s memory loss, repetitive questions and anxiety.

John confirmed that his mother had recently wandered out of the house at midnight. He contacted the GP and Vivian was being reviewed by a psycho-geriatrician.

He felt under a “great deal of strain” with the caring role and was reaching out for advice and support. He indicated that there had always been “tension” between him and his mother. John stated that when his mother had wandered he took her inside the home and was “so angry” that he “yelled at her and punched a hole in the wall.” He asserted that he would “never hit” his mother. He expressed feelings of frustration and reported the situation was “suffocating... he was exhausted... and was frequently yelling at his mother.”

Client and carer’s desired outcomes:

Vivian: “I keep forgetting things…. My son gets upset… I want my son to be happy. I don’t want to go into a home.”

John: “I want to look after my mother, yet I need help to do this. I want to feel I am in control of my emotions, and able to manage without getting angry all of the time.”

Included are seven key messages arising from the review:

## Case study four continued

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Intervention</th>
<th>Outcome</th>
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</thead>
<tbody>
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<td>Mental and emotional wellbeing: risk assessment conducted</td>
<td>1:2:1: assessment and support for Vivian: Referred to the Alzheimer's Society and is now attending weekly groups</td>
<td>Vivian reported she enjoyed getting out of the house and meeting people emotional support provided to Vivian. This is ongoing and the situation will be monitored</td>
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<tr>
<td></td>
<td>John was referred to counselling</td>
<td>John feels more confident as he understands and can deal with dementia better</td>
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<td></td>
<td>John explored and adopted relaxation techniques</td>
<td>John has attended his first counselling session. He stated he had initially struggled with the concept</td>
</tr>
<tr>
<td></td>
<td>John has accessed self-help websites</td>
<td>1:2:1 session provided to John: provision of information and support is ongoing to both John and Vivian</td>
</tr>
<tr>
<td></td>
<td>1:2:1 meeting outside of the family home for emotional support – whilst Vivian was at the Alzheimer’s Society.</td>
<td>a family conference was held with the GP and social worker.</td>
</tr>
<tr>
<td>Social interaction: Vivian</td>
<td>Alzheimer's Society: attending a community group, luncheon group and an art class.</td>
<td>Vivian has attended the weekly groups and enjoyed her time away from home socialising. This also provided space for her son to have time for himself. Attending the groups has reduced the levels of tension in the home.</td>
</tr>
<tr>
<td>Physical health needs</td>
<td>the GP is reviewing Vivian and her medication has been changed</td>
<td>a follow-up appointment had been made and Vivian's situation is being monitored closely</td>
</tr>
<tr>
<td></td>
<td>John has had sensors fitted in the home so that he will be alerted should his mother wander / be away from her bed for too long at night. He is also looking into new digital forms of Assistive Technology (AT) eg voice recognition software and is using an app to organise care.</td>
<td>John believes the situation is less worrying, and he is continuing to explore other forms of AT to support his mother and himself.</td>
</tr>
<tr>
<td>Carer's support</td>
<td>Assessment and information provided:</td>
<td>John arranged a sitting service for his mother. He reported he was able to go to the football for the first time in a year, which was “great”</td>
</tr>
<tr>
<td></td>
<td>learning online and in groups in understanding and responding to dementia</td>
<td>John has joined an online carers’ group.</td>
</tr>
<tr>
<td></td>
<td>digital online forum and online resources to access 24 hour help</td>
<td></td>
</tr>
<tr>
<td></td>
<td>local carers’ organization contacts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>local breaks services in additional to the Alzheimer’s Society local group.</td>
<td></td>
</tr>
</tbody>
</table>
**Case study four continued**

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>■ John was immediately given the link to online benefits information and tools</td>
<td>■ Vivian is now in receipt of Attendance Allowance and her benefits were maximised. She now receives a council tax discount in addition</td>
</tr>
<tr>
<td></td>
<td>■ a referral to the local benefits advice service.</td>
<td>■ John has now looked into costs and planning for the future.</td>
</tr>
<tr>
<td>Hair, beauty and dental requirements</td>
<td>■ local college: hair and beauty school</td>
<td>■ John took his mother to the local college where students cut her hair and she had a manicure. Vivian said she “thoroughly enjoyed” the experience and wants “a massage next time”</td>
</tr>
<tr>
<td></td>
<td>■ list of dentists: appointment for a check-up and new dentures.</td>
<td>■ Vivian had new dentures fitted.</td>
</tr>
<tr>
<td>Safeguarding adults</td>
<td>■ the approach to safeguarding Vivian was to involve both parties in a conversation (family conference) about the situation and to ensure the family had access to support, information and resources.</td>
<td>■ John and his mother are able to contact the social worker and seek ongoing support, as they require it.</td>
</tr>
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<td></td>
<td></td>
<td>■ Vivian said her son is “happier”</td>
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<td></td>
<td></td>
<td>■ John stated he feels “calmer” and enjoys going to the football.</td>
</tr>
</tbody>
</table>

**Six week: follow-up review comments:**

Vivian: “Very nice, you’re good and you listened to me….. Thank you….I am glad I did not have to move into a home.”

John: “I know so much more than I did before; about dementia, myself and my mother. It’s nice to have a back-up, and information. It is good we both have regular breaks and time apart.”
The ADASS Carers Policy Network would like to thank organisations and individuals who submitted practice examples and supported the development of this document.