



south ayrshire
health & social care
partnership

Learning Disabilities Team Policy Document

August 2025



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Adult Learning Disability Social Work Team Eligibility Criteria

Who Are We?

We are a multidisciplinary team based in Arrol Park, Ayr. We provide a Social Work Service comprising of Social Workers, Community Care Assistants, and Support Workers. We have links with Day Care and building based services, Group Work, Volunteering Services, and Respite services. We are also co-located with our colleagues from Health including Nursing, Psychology, Dietetics, Physiotherapy and Occupational Therapy. We operate a cross-referral system as part of the holistic assessment process.

Learning Disability Strategy aims to promote positive lifestyle and wellbeing including:

- Health and Wellbeing
- Choice and Control
- Living Independently
- Active Citizenship

Who Do We Support?

- Adults over the age of 16 years who have a Learning Disability that is registered at their Doctors Practice. This is called the National Learning Disability Register.
- Adults must reside in the South Ayrshire geographical area.
- Adults must be in receipt of adult benefits for assessment of client contribution.

Alternatives to Learning Disability Team

We do not provide services to adults who have a lone diagnosis of Autistic Spectrum Disorder (ASD), Neurodiversity or those who are NOT registered on the Learning Disability Register.

Referrals can be made to the Community Care Team or Mental Health Team in these circumstances.

Referral Process

Once a referral is received by the Administration team, this is forwarded to the Duty Social Worker who completes a SCREENING TOOL.

If you have a registered Learning Disability, a worker will carry out an initial assessment of needs to identify your circumstances and what services you may require to support you. It is important to understand that Social Work are required by law to provide an assessment of need, however, are not required to provide service.

Assessment of Need

Assessment of need generates a category of risk; services are provided to those in the Critical risk category.

Critical Risk:	Indicates that there are <u>critical</u> risks to an individual's independent living or health and well-being which are likely to call for the immediate provision of social care services (extremely high priority)
Substantial Risk:	Indicates that there are <u>significant</u> risks to an individual's independence or health and wellbeing, and they may require input from Social Work or other partnership services. (high priority)
Moderate Risk:	Indicates that there are <u>some</u> risks to an individual's independence or health and wellbeing. These may call for the provision of advice and guidance including signposting to other services, or they may simply be manageable over the foreseeable future. (medium priority)
Low Risk:	Indicates that there may be some quality-of-life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care services.

If following the assessment of need – you are deemed to meet Low or Moderate risk criteria for services – you will be signposted to community resources who may be able to help you.

Carers Assessment

Adults who provide care and support to a family member or friend are referred to as Carers. Under Scottish legislation, carers are entitled to their own assessment of need, this is called an Adult Carer Support Plan.

An Adult Carer Support Plan must be completed to enable access to Respite services. Carers will be given the choice to complete the form with a Care Manager or the form can be left with the individual, and then discussed when completed.

Once this assessment is recorded on the social work system, this represents the carers assessment of need and can be used to recommend the level of respite required.

The care manager will then take the assessment of need to the Resource Allocation Group (RAG) where the Panel will make a decision regarding allocation of respite. Once this is completed it will be required on an annual basis and the worker will share this with the chosen respite service to negotiate charges on what has been approved.

Social Care Charging Policy, Adult Non-Residential and Residential Care Services 2024-25

This charging policy explains how South Ayrshire Health and Social Care Partnership considers and determines the contribution to care that adult services users will be expected to pay towards their care and support.

Charges apply where services are provided via all SDS Options, Direct Payment, Individual Service Agreement, Directly by South Ayrshire Health and Social Care Partnership or a combination of all the options.

The charges are aligned with principles of Convention of Scottish Local Authorities (COSLA) guidance, best value framework, and benchmarking against other local authorities. The charging policy is reviewed annually and any revisions to charges and financial assessment rules are approved by South Ayrshire Council as part of the annual budget setting process.

The policy is based on the following values:

- You will only be charged for the hours of care and support that you receive.
- You will not be charged more than it costs to provide the service.
- Where the charge is subject to a financial assessment, this will be means tested and income maximisation is recommended as part of the process.
- You will know in what way and why you are being charged.
- You will be treated in a fair, transparent, and unbiased manner

Legislation - Residential Care Services

Residential care services for adults refers to 24-hour care and support provided in a care home setting. The care home must be a registered service with the Care Inspectorate and meet your assessed needs of either residential or nursing basis or both. Provision of care can be on a permanent, temporary or respite basis. The legal basis for charging residential services is the National Assistance Act 1948 and the National Assistance (Assessment of Resources) Regulations 1992.

Legislation - Non-Residential Care Services

These services are provided following an assessment of need and are identified to assist you to meet your identified outcomes. The legal basis for charging non-residential social care services is the Social Work (Scotland) Act 1968, (as amended) and Community Care and Health (Scotland) Act 2002.

Financial assessments.

Individuals within the Adult Learning Disability Service can be referred from age 16. Adults are required to be in receipt of appropriate adult benefits. If the Adult lacks capacity to deal with their own finances, it is expected that appropriate legal powers are in place to enable a guardian to manage the Adult's finances on their behalf. If a person remains in School services will not be provided until they are 18.

Contribution to services is determined on an individual basis by completion of a financial assessment form, (HCC1). This will take account of income, savings, and other capital to work out how much you can afford to pay toward the cost of the services you receive.

Part of this assessment process will ensure that your income is maximized, and you are receiving all the benefits to which you are entitled. Our information and Advice Hub can support you to complete all relevant forms as required.

Carers Respite & Carers Flexible Respite

Informed by the Carers Scotland Act 2016 - [Carers \(Scotland\) Act 2016 \(legislation.gov.uk\)](https://legislation.gov.uk/ukpga/2016/12/section/1)

Carers Charter - [Carers charter - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/carers-charter/pages/introduction.aspx)

Respite care is care that is provided to unpaid carers to offer a break from their caring role. A carer is someone provides care to a relative or friend who would not be able to manage without that care.

Respite can be:

- **PLANNED** - pre-booked
- **EMERGENCY** - in response to a sudden event such as illness of the carer

Models

Traditional model:

Where the cared for person leaves the family home and attends another place for respite, such as a short breaks unit (Chalmers Road) or Hansel 'The Cabin.'

Flexible model:

Hour's equivalent to Number of Days awarded can be used in a more fluid way such as attending football matches, going to concerts, going on holiday. Respite care is offered following assessment of need. Respite care can be offered in addition to day care following this assessment.

Carers Support Plan Assessment

Carers Support Plan Assessment (CSPA) helps identify the carers needs and the support that may be required to help them in their caring role. Local authorities have a duty to prepare an adult carer support plan for anyone they identify as a carer or for any carer who requests one.

Carers are offered a CSPA of Needs by SW, this must be accepted and completed before respite can be offered.

Respite

The Local Authority agreed allocation is up to 28 days or four weeks respite per year. Learning Disability Team Respite Calculation Tool is used to identify level of respite for each individual.

The local authority agreed allocation for traditional respite is up to 28 days or 4 weeks respite per year.

In an emergency such as poor health it may be possible to offer increased respite for a period.

Flexible Respite

Flexible Respite will be paid at the contracted rate for the year. (Detailed at time of assessment)

Respite:

1 week's respite equivalency of 100 hours at the agreed provider rate e.g., 100 x £22 which equals £2200 with a maximum of 4 weeks being allotted.

Flexible Respite Equivalency:
Set at 100 hours per week.

1 Week	100 Hours
2 Weeks	200 Hours
3 Weeks	300 Hours
4 Weeks	400 Hours

Emergency Respite

5 Week	500 Hours
6 Weeks	600 Hours

For the purposes of funding the year starts once the Carers assessment has been approved at Resource Allocation Group (RAG). A carers assessment must be completed every 12 months, and the eligibility criteria is applied at each assessment. There is no automatic role-over of entitlement carried forward each year. This is to ensure the most current circumstances are reflected.

Self-Directed Support Options

- SDS Option 1:** Direct Payment to be used for flexible respite – Carer chooses provider, dates, and pays the provider directly. This is the most flexible option. Hourly rate set at contracted rate (to be discussed as part of assessment 2024/25 set at £22 per hour).
- SDS Option 2:** Carer chooses the provider and dates. The local authority pays the provider via Individual Service Fund agreement which is signed by the person being cared for or their guardian.
- SDS Option 3:** Local Authority will arrange respite and complete booking forms for dates that are available within the service.
- SDS Option 4:** A mixture any of the above.

The Care Manager will discuss all the options available to the cared for person and the carer.

Respite Provision Grading Tool/Questionnaire

Name of Service User	
CareFirst ID	
Details Of Carer	
Care Manager/Team	
Date Of Completion	

Details of Carer

AGE RANGE OF CARER	
Aged between 20 - 40	
Aged between 40 - 60	
Aged between 60 - 70	
Aged over 70 years	

Details of Current Circumstances of Carer:

Please detail any additional caring responsibilities, living conditions or any other circumstances which impacts your caring role

Physical health of carer	
Mental health of carer	
Lone carer	
Any further issues such as ill health, work commitments of carer, identified overnight support requirements	

Service User Information

MOBILITY	YES	NO
Do they mobilise independently?		
Are walking aids required?		
Is a wheelchair required?		
Is use of hoist required?		
Are they able to climb stairs?		
Do they have balance problems?		

COMMUNICATION/SENSORY NEEDS?	YES	NO
Is the service user able to read and write?		
Are they able to communicate their basic needs?		
Are any specialist aids required for communication (pecs, signing)?		
Visual impairment?		
Auditory?		
Any other sensory difficulties		

IS SUPPORT REQUIRED WITH PERSONAL CARE?	YES	NO
Independent?		
Prompting		
Full support required?		

IS SUPPORT REQUIRED WITH TOILETING	YES	NO
Independent?		
Prompting?		
Full support required?		

MENTAL HEALTH	YES	NO
Is there a diagnosed mental health illness (including anxiety)?		
Is this condition severe and enduring?		

AUTISM	YES	NO
Is there a diagnosis of autism?		
Is this a diagnosis of complex autism? Confirmed by health.		

EPILEPSY	YES	NO
Diagnosis of epilepsy?		
Is this well managed?		
Is rescue medication prescribed?		

DIETARY NEEDS	YES	NO
Are there any significant dietary needs such as modified diet or PEG or Do they require assistance and time to be fed?		

BEHAVIORAL	YES	NO
Is there a history of aggressive or severely challenging behaviours?		
Is there a history of or been suspected of inappropriate sexual behaviour?		
Is there a history of or been suspected of posing a risk to vulnerable adults and/or children?		
Are there any criminal convictions?		
Is 2:1 support required at any time?		
Any history of absconding behaviours?		
Are there any intense/severe repetitive behaviours?		

	YES	NO
Is palliative care required?		

	YES	NO
Is there a diagnosis of dementia?		

BANDING OF TOTAL SCORING

****Maximum number of nights respite provision per year = 42 nights****

Flexible respite maximum of 14 hours per day or 100 hours per week

LOW	0
MODERATE	0 - 7
SUBSTANTIAL	8 - 28
CRITICAL	29 - 42 <i>Extreme circumstances must be identified in the assessment and agreed by management.</i>

RESPITE PROVISION ALLOCATION OF RESOURCES

Eligibility and scores (maximum of 28 nights per year)

CRITERIA	SUGGESTED PROVISION
LOW	0 - No Respite
MODERATE	No respite
SUBSTANTIAL	No respite
CRITICAL	100 hours.
EMERGENCY RESPITE	Assessed on a case-by-case basis

Fair Access to Day Services

Policy Objectives

The policy objectives are underpinned by South Ayrshire Health and Social Care Partnerships (SAHSCP) vision and values. The SAHSCP vision statement is that “Empowering communities to start well, live well and age well.”

This has been supported through the LD strategy 2022-2027 where people with an LD have asked us to change the model of day care to provide support to them in the evening and weekends in the way that they would wish. This new model included 3 days maximum building based day care and 2 days individualized support for people. People remain entitled to a maximum of 5 days support following assessment, Only 3 can be building based. Therefore, people have been able to meet in supper clubs, purpose designed groups and at weekend as part of a review of the day care model in our partnership, The feedback we have received about these changes has largely been very positive. The partnership no longer provides 5 days building based day care due to the positive impact of these changes.

SAHSCP provides a range of community support services to adults with a learning disability with varying levels of support needs. A person-centered assessment is undertaken to establish the support needs of the individual. SAHSCP Adult Learning Disability Team is committed to maximising personal independence.

A comprehensive assessment will be completed to identify achievable outcomes. Assessment will also incorporate what informal support is in place from carers, families, and friends, Community-based activities within the locality will also be considered.

Access to formal support within Day Services is determined by the agreed Eligibility Criteria.

- 1 With funding being made available where an individual has been assessed as having critical needs and where the reduction of identified risks requires formal support in part or in whole, SAHSCP Adult Learning Disability Team has a responsibility to provide or secure suitable services to a standard satisfactory to meet eligible needs, through this collaborative approach. It also has the responsibility to ensure there is fair and equitable allocation of available resources such as Day Services or Opportunities within the community.
- 2 Within Day Services and Community Opportunities, the Adult Learning Disability team supports individuals to achieve their outcomes, promote independence and provide carers respite in line with the Adult Learning Disability Strategy.

- 3 This policy aims to ensure there is a fair, equitable and financially sustainable allocation of hours/days within the day service for adults with a learning disability who require this model of support. Assessment and allocation of support will consider the person/s complexity of needs, home setting and identified goals/outcomes. This policy does not in itself impact the eligible service levels but focusses on the service types and approaches to providing this support.

Policy Application

This policy applies to all adults with a learning disability from the age of 18 years (16 if they have left school and are in receipt of benefits) , as well as young people transitioning from Children & Families service to adult services. Where an adult with a learning disability has been assessed by a Care Manager/Social Worker using the “My Life My Outcomes” assessment. The full assessment will be presented by the care manager through the Resource Allocation Group (RAG). Once the assessment of the individual is agreed, transitioning phase will commence based on the individual’s needs.

Related Legislation, Policies and Procedural Mechanisms

SAHSCP’s responsibilities to adults (aged 18 and over) who are assessed and are eligible for accessing Day Services are set out in the following legislation, policies, and operational mechanisms, which may be subject to change:

- The Social Work (Scotland) Act 1968
- The NHS and Community Care Act 1990
- Community Care and Health (Scotland) Act 2002
- Adults with Incapacity (Scotland) Act 2000
- The Regulation of Care (Scotland) Act 2001
- The Adult Support and Protection (Scotland) Act 2007
- Children (Scotland) Act 1995
- Data Protection Act 2018
- Freedom of Information (Scotland) 2002
- The Human Rights Act 1998 and Equality Legislation
- The Social Care (Self Directed Support) (Scotland) Act 2013
- The Equality Act 2010
- The Mental Health(Care and Treatment) (Scotland) Act 2003
- Principles of Good Transitioning (ARC 2019)

Other Related Policies and Mechanisms

- My Life My Outcomes – Assessment and Support Plan
- Action Plan
- Transition Policy
- Positive Risk Management
- Adult Carer Support Plan
- COSLA Charging Guidance
- Resource Allocation Group

Legislative Context

The main duty to provide community care services derives from Section 12A of the Social Work (Scotland) 1968 Act:

“Where it appears to the local authority that any person from whom they are under a duty, or have a power, to provide community care services may be in need of any such services the local authority shall:

- Complete an assessment of the need of that person for those services; and
- Decide, having regards to the results of that assessment, whether the needs of the person being assessed call for the provision of any such services, taking account of:
- Care provided by (an adult or young) carer,
- The views of the person whose needs are being assessed (provided that there is a wish, or as the case may be a capacity, to express their view)

Self-Directed Support Options

The Social Care (Self Directed Support) (Scotland) Act 2013 introduced a choice and control in the provision of community care support. SDS has allowed service users in South Ayrshire to exercise choice and control. This is particularly relevant in the changes we have made to our day care services where we have moved from a one size fits all approach to tailor made individual support for those that require day care services. South Ayrshire no longer provides traditional models of day care and the lives of people with learning disabilities has improved with the support of SDS. This was completed through extensive consultation with service users and carers as part of the Learning disability strategy 2022-2027.

The Act places a duty on local authorities to offer people who are eligible for community care a range of choices over how they receive their community care and support as follows:

- Option 1:** The making of a direct payment by the local authority to the supported person for the provision of support.
- Option 2:** The selection of support by the supported person, the making of arrangements for the provision of it by the local authority on behalf of the supported person and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of that provision.
- Option 3:** The selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority and, where someone provides it other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.
- Option 4:** The selection by the supported person of Option 1, 2 or 3 for each type of support and, where someone provides it other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

The Equalities Act 2010

The Equalities Act 2010 protects the following characteristics (referred to in the Act as “Protected characteristics”):

- Age
- Race
- Sex
- Sexual orientation
- Pregnancy and maternity
- Gender reassignment
- Religion or belief
- Marriage or civil partnership
- Disability

The Act prohibits discrimination (whether direct or indirect) against people who possess one of the characteristics. Direct discrimination takes place where a person treats another person who has a protected characteristic less favourably than he or she treats or would treat others not possessing the protected characteristic. Indirect discrimination occurs where a provision, criterion or practice is applied which would put a person possessing a protected characteristic at a particular disadvantage.

Individuals who are assessed as needing community care supports often do so due to disability. While assessment of need is individualised and person – centered (and eligible services so provided), SAHSCP has an obligation to ensure that it treats people fairly and equitably in terms of levels of support with which they are provided.

The Integrated Joint Board (IJB) is delegated with the powers and duties of South Ayrshire Council and NHS Ayrshire and Arran Health Board through an “Integration Scheme,” which is established by Parliamentary Order, in relation to a wide range of health and social care functions. SAHSCP is accordingly required to perform its statutory duties under the terms of the 1968 and 2013 Acts, while exercising its discretion in performing these duties. It must also ensure that policy and practice is fair and equitable in line with the Equality Act 2010.

SAHSCP has a duty to assess needs and must ensure that assessed eligible needs are being met, but they do not have to fund the support requested by an individual or guardian, attorney, or carer if the assessed need can be met in a more cost-effective manner. SAHSCP is not required to fund more expensive models of care where alternative models of care can effectively provide support.

Assessments of Need and Eligibility for Day Services and Opportunities

- SAHSCP takes a person- centered outcome-based approach to needs assessment and support planning.
- A support needs assessment will be conducted by a qualified social worker in consultation with the individual, guardian, and carer (Formal/Informal).
- The person/s assessed for Day Services will be an Adult with a Learning Disability aged 18 or 16 if they have left school and are in receipt of benefits .

- The qualified social worker will use the “Day Service Provision Grading Tool” where the scoring will determine the allocation between 1 to 3 days provision within the day service.
- Not all assessed needs will meet eligibility criteria for qualification of allocated days within the day service, only outcomes that reduce risks to moderate level can be enrolled for an allocation day service or where determined, other opportunities.
- Outcomes not associated with eligible needs will be used to inform and shape how eligible support is best provided.

Resource Allocation

- The Social Work (Scotland) Act 1968 requires local authorities to ensure that resources are made available to meet eligible needs to a standard that will satisfy the local authority that the individuals needs are being met.
- The allocation of resources is determined to be a “Relevant amount,” as defined in the Social Care (Self Directed Support) (Scotland) Act 2013 as “The amount that the local authority considers is a reasonable estimate of the cost of securing the provision of support for the supported person”.
- SAHSCP Adult Learning Disability Team facilitates the Resource Allocation Group (RAG) was developed to determine and authorise relevant funding for the allocation of resources under self-directed support. This means that through assessment of need presented by the care manager/social worker, the Resource Allocation Group (RAG) will allocate the assessed days in line with the demands of need. The RAG funding authorisation is then applied to whichever SDS option is chosen, meaning that no individuals will be placed at a disadvantage. Following completion of the assessment an individual will be made aware of the indicative budget available to them. This will ensure that the individual is clear about resources they have been allocated as they begin the support planning process.
- Any individual who is not satisfied with the level of resources they have been allocated should in the first instance discuss this with the practitioner and their manager. If agreement cannot be reached, the individual should be made aware of the South Ayrshire Integration Joint Board Complaints Handling Procedure.
- In addition, a new higher-level RAG has been established as of April 2025. The purpose of this DMT RAG is to assess cases that are beyond the current financial limit of support at 110K. The RAG will consist of the head of service, Chief social work officer and chief financial officer. It will make the final decision in relation to complex cases where care packages of over 110K are being requested. This RAG has time slots to meet monthly or as required depending on need. The outcome of the DMT RAG will be communicated by the head of service.

Types and Levels of Support

- 1 The purpose of providing support to an Adult with a learning Disability is to primarily reduce the risk to a moderate level. Finite resources mean that the local authority may not be able to provide the level of support an individual requires within the day services. There is an inherent risk in all aspects of daily living and therefore it is not

always possible (or indeed appropriate), to completely reduce or eliminate risk in every situation.

- 2 Types and levels of support within the Day Services and Opportunities varies depending on the adult with a learning disability. Within the Day Service the staffing ratio is 3:4 clients.

- 3 Should an individual require 1:1 support, the care manager/social worker shall reassess where a 3rd sector provider may be sought to provide 1:1 community support.
- 4 There is a general principle that all eligible support to reduce risks to a moderate level must also have a secondary objective to contribute to outcomes relating to the promotion of wellbeing, social development as well as gaining new skills to live their best life. In addition to reducing presenting risk, eligible support should be designed to maximise the potential for individuals to develop the skills and confidence to safely manage with gaining the skills and independence over time. Capacity for enablement (or reablement) will vary from person to person but should always be promoted as an ongoing desired outcome of the support provided.

Further Detail and Procedural Processes

- 1 SAHSCP takes an outcome-based approach to assessment, support planning and review. An outcome-based approach focuses on delivering improved results (outcomes) for adults with a learning disability with assessed needs for Day Services. Traditionally, support was service – led, with formal structured services seen in isolation as being the most effective way to support people. Now the view nationally and locally is that results are more successful if they are outcome – led. This involves everyone working together to achieve the best possible impact on the adult with a learning disabilities life. The philosophy of this approach is one that emphasises the strengths, capacity, and resilience of individuals, builds upon informal support systems and includes consideration of wider community -based resources.
- 2 An outcomes-based approach will assess needs, identify a range of associated outcomes for an individual, not all of which will meet the assessment criteria for allocation of Day Services. The eligibility criteria in South Ayrshire are based on reducing substantial or critical risks. The needs (and associated outcomes) that can be met through reducing these risks to a moderate level can be allocated a placement within day services or other community opportunities as appropriate.
- 3 The Care Manager/Social Worker will assess the adult with learning disabilities using the “Day Service Provision Grading Tool” as part of the My Life, My Outcomes assessment. The grading tool considers all mitigating factors such as the adult with learning disability and the carers current situation to the allocation of days. Should the assessment identify that day service provision is required, minimum allocation would be 1 day per week and the maximum allocation of days is 3. Should the assessment suggest that more than 3 allocated days for day services are required, the care manager/social worker will look at other SDS options for supports out with the day service provision.
- 4 Each Adult with a learning disability receives two reviews per year. This consists of an annual review from the care manager/social worker in conjunction with the day service as well as a 6 monthly review conducted by day services in conjunction with the care manager.

- 5 Once an allocation of days/hours is in place at the start of transition for the adult, a 4-week review will be conducted to ensure the needs of the adult with a learning disability is being met within the service.
- 6 It is the expectation that Parents/Guardians/Carers will arrange drop off and collection of the Adult to and from Day Services. This will be discussed as part of the assessment of needs.

Day Services Provision Grading Tool/Questionnaire

Name of Service User	
CareFirst ID	
Details Of Carer	
Care Manager/Team	
Date Of Completion	

Details of Carer

AGE RANGE OF CARER	
Aged between 20 - 40	
Aged between 40 - 60	
Aged between 60 - 70	
Aged over 70 years	

Details of Current Circumstances of Carer:

Please detail any additional caring responsibilities, living conditions or any other circumstances which impacts your caring role

Physical health of carer	
Mental health of carer	
Lone carer	
Any further issues such as ill health, work commitments of carer, identified overnight support requirements	

Service User Information

Does the service user have identified positioning or postural needs?	YES	NO
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MOBILITY	YES	NO
Do they mobilise independently?		
Are walking aids required?		
Is a wheelchair required?		
Is use of hoist required?		
Are they able to climb stairs?		
Do they have balance problems?		

COMMUNICATION/SENSORY NEEDS?	YES	NO
Is the service user able to read and write?		
Are they able to communicate their basic needs?		
Are any specialist aids required for communication (pecs, signing)?		
Visual impairment?		
Auditory?		
Any other sensory difficulties		

IS SUPPORT REQUIRED WITH PERSONAL CARE?	YES	NO
Independent?		
Prompting		
Full support required?		

IS SUPPORT REQUIRED WITH TOILETING	YES	NO
Independent?		
Prompting?		
Full support required?		

MENTAL HEALTH	YES	NO
Is there a diagnosed mental health illness (including anxiety)?		
Is this condition complex?		

AUTISM	YES	NO
Is there a diagnosis of autism?		
Is this a diagnosis of complex autism?		

EPILEPSY	YES	NO
Diagnosis of epilepsy?		
Is this well managed?		
Is rescue medication prescribed?		

DIETARY NEEDS	YES	NO
Are there any significant dietary needs such as modified diet or PEG?		

BEHAVIORAL	YES	NO
Is there a history of aggressive or severely challenging behaviours?		
Is there a history of or been suspected of inappropriate sexual behaviour?		
Is there a history of or been suspected of posing a risk to vulnerable adults and/or children?		
Are there any criminal convictions?		
Is 2:1 support required at any time?		
Any history of absconding behaviours?		
Are there any intense/severe repetitive behaviours?		

	YES	NO
Is palliative care required?		

	YES	NO
Is there a diagnosis of dementia?		

BANDING OF TOTAL SCORING

****Maximum number of days P/W - **3 days P/W****

LOW	0 - 14
MODERATE	15 - 25
SUBSTANTIAL	25 - 43
CRITICAL	44+

DAY SERVICE PROVISION ALLOCATION OF RESOURCES

Eligibility and scores (maximum of 3 days per week)

CRITERIA	SUGGESTED PROVISION
LOW	N/A
MODERATE	No daycare
SUBSTANTIAL	No day care
CRITICAL	3 Days P/W

Social Work Learning Disability Support Worker Process

The role of the support worker is to provide supports within the community or within the homes of Adults with a diagnosed Learning Disability. The role is focused on supporting people to live their lives as independently as they can, keeping them safe, helping them to make choices, and ensuring that they lead full and rich lives in their community.

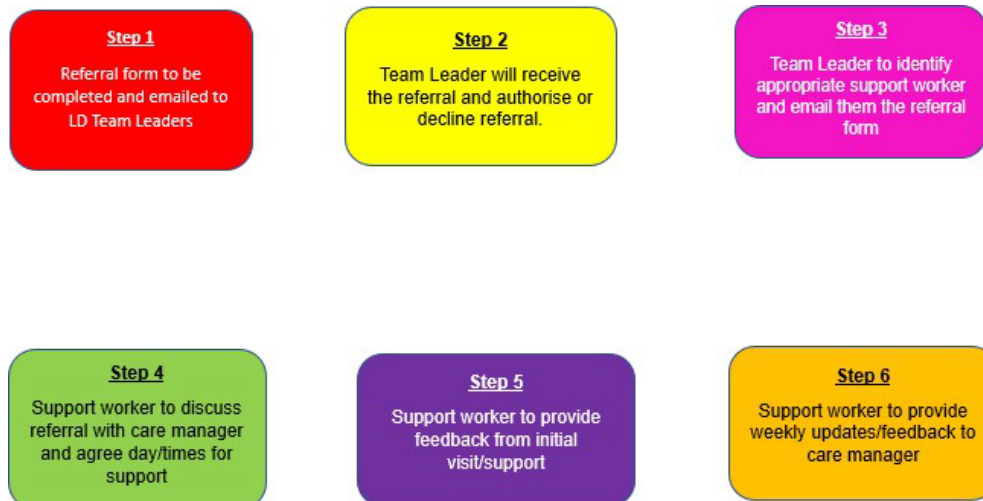
Care managers to complete support worker referral form when a need for additional supports is identified. This support could be as an addition to formal supports already in place, as an additional time limited support or to support individuals who have no formal supports.

Supports could be required as a one-off support, time limited support or ongoing support. Care manager should identify and provide justification of support requirements.

Care managers should provide details of support needs within referral and discuss this with support worker prior to supports commencing. Support workers will provide required supports as directed by care managers. The following is an example of supports that can be required:

- Collect Section 12 funds as required – Section 12 funds to be applied for and arranged by care manager.
- Support Individuals with shopping as required.
- Support individuals with batch cooking.
- Support individuals to appointments.
- Support individuals to groups when required.
- Provide support at supper clubs/grub clubs as arranged.
- Supporting individuals within a community setting to minimise social isolation.
- Monitor and report back to care manager.
- Support and motivate individuals to develop life skills and independence.
- Should support from FAST identify there is an ongoing support need, this should be discussed with care manager and support worker considered to provide ongoing supports. FAST provide intensive, focused and time limited supports only and should not be considered when support worker input would be more appropriate.

Social Work Support Worker Referral Pathway



Learning Disability Support Worker Referral Form

LEARNING DISABILITY SUPPORT WORKER REFERRAL FORM	
Name:	
CareFirst id:	
Address:	
Contact number:	
Allocated worker:	
Date of referral:	
Ongoing support	
One off support	
Information:	<i>Provide relevant information:</i>
Risks:	<i>Identify risks for lone worker:</i>
TASK TO BE COMPLETED:	<i>Details of support required and outcomes to be met:</i>
DAY:	
Number of hours/level of support:	
Weekly total hours:	
Approved by:	

FAST Process and Responsibilities

Complex or crisis situation where Social Worker/CCA and Team Leader (Social Work TL and Health TL if involved) agree FAST involvement is required, either:

- 1 Bring to RAG if planned piece of work required, i.e. for assessment purposes (if significant decline etc, or to assess how much support is required etc) This should also include detail of what Provider is currently doing and if hours or support could be changed etc.

Or

- 2 If crisis situation, Social Worker/CCA and Team Leader will agree crisis intervention/assessment required. Referral form will be completed, and Team Leader will call/meet FAST manager to discuss and agree what is required*

Process

- Social worker/CCA will complete referral form immediately after agreed at RAG and send to Team Leader. (if a crisis situation, Social Worker/CCA will discuss with Team Leader and complete referral form).
- Team Leader will sign off referral and send to FAST on same day.
- Team Leader and FAST manager will agree decision on what support is required, to meet which outcomes and timescales for planned piece of work to start and finish.
- FAST will contact service user/carer/Guardian within 24 hours by telephone.
- Joint home visit will take place within 48 hours of referral being made.
- FAST manager or FAST team member will feedback to Team Leader on progress, any issues, not engaging etc.
- Team Leader can then update/discuss with Social Worker/CCA. Social Worker/CCA should then put case note on to reflect progress or any issues.

Team Leaders will each meet with FAST manager on Tuesdays and Thursdays. Details of referrals, support provided, intervention, issues (referral agreed or not agreed), outcomes achieved (if avoided an admission etc) and timescales for each piece of work to be emailed on a monthly basis.

****Where Team Leader and FAST manager cannot agree on whether FAST should be involved or what support is required then Escalation Plan would be for Team Leader and FAST manager to escalate discussion to Senior Management. ****

FAST Referral

Referral Form

FAST TEAM REFERRAL FORM	
NAME:	
CareFirst Id:	
Address:	
Contact Name:	
Contact Number:	
Allocated Worker:	
Date Of Referral:	
Planned support/assessment	Yes/No
Crisis situation	Yes/No
Current Support in Place (Brief Details):	
Type of, and Reason for FAST Referral	
Preferred Start Date of Support:	
ONE Time SUPPORT (details)	
Number of weeks or total number of visits	
Projected End Date of Support	
INFORMATION: Please provide relevant information of the reason for the request for the support:	
TASK <i>(Including Assessments) To be Undertaken/Support Required:</i>	OUTCOMES TO BE MET <i>(if applicable):</i>
Number Of Hours/Level of Support:	
WEEKLY TOTAL HOURS:	
APPROVED BY:	

Positive Risk Assessment/Analysis

Positive Risk Assessment/Analysis				
Risk No.	Identified risk (Summarise the main risks and provide a brief analysis of the service users circumstances)	Severity of Harm (Please provide brief details and consider if Minor, Significant, Serious)	Likelihood of risk (Unlikely, Likely, Highly Likely)	Risk identified Low, Med, High
1	PHYSICAL HEALTH			
2	MOBILITY -			
3	PERSONAL CARE -			
4	MEDICATION			
5	CHALLENGING BEHAVIOURS			
6	ANY RISKS IN RELATION TO SHARING LIVING SPACE WITHIN ASSESSMENT FLAT			
7	WOULD ALTERNATIVE STAFFED OVERNIGHT SUPPORT/EMERGENCY RESPITE BED AT CHALMERS RD BE REQUIRED AND RATIONALE FOR THIS			

Areas to consider: Accommodation Family & Social Contacts Mental Health & Wellbeing Mobility Medication/Alcohol/Tobacco/Drugs Communication Finance Physical Health Personal Care Social Life/Community Employment/Training Living Independently Spiritual/Religious/Cultural Support & Protection Other (please describe)

For each risk identified please complete the Risk Management Plan, taking into consideration minimising measures currently in place and the risks already being managed under the Support Plan.

Positive Risk Management Plan				
Risk No. (Column 1 Risk Assessment)	What measures are/require to be in place to manage the risk	Further action required? Who is the responsible person and their role	New Risk Rating (Low, Med, High)	Review Date
1				
2				
3				
4				
5				
6				
7				

Eligibility Criteria at a National Level

Appendix 1

The following criteria was written several years ago. It no longer applies in the same way for all local authorities and partnerships. In South Ayrshire because of the growing demands on our resources we only offer support to people in critical need. I would therefore ask you to bear this in mind when reading this national eligibility criteria.

The 1968 Social Work (Scotland) Act recognises the central role of the local authority in determining where there is a need for the provision of community care services and how such need should be met. The legislation, as amended in 1990, describes assessment as a two-stage process: first the assessment of needs and then, having regard to the results of that assessment, the local authority shall decide whether the needs of that person call for the provision of services (12A of the Social Work (Scotland) Act 1968). The use of eligibility criteria applies to this second stage of the assessment process; they are used by councils to determine whether a person assessed as needing social care requires a service to be put in place in order to meet those needs.

National eligibility criteria for social care were agreed by the Scottish Government and COSLA in 2009 and while originally developed for older people as part of the response to Lord Sutherland's report on free personal and nursing care, the criteria were explicitly designed to apply consistently across all adult care groups (see para 1.5 of the eligibility guidance).

It is recognised that the use of eligibility criteria as a means of managing demand for social care is imperfect and unless properly deployed can result in resources being narrowly focused on individuals with acute needs or on specific client groups. There is also evidence that inappropriate application of eligibility criteria can hinder the person-centred and outcome- focused assessment and support planning that is essential to deliver Self Directed Support.

To that end, further work is being undertaken by the Scottish Government and COSLA to assess how eligibility criteria are being applied in practice and consider whether further work is required to ensure criteria support the SDS approach.

Each local authority will have their own clear locally agreed eligibility criteria that should be referred to by managers and practitioners as part of the assessment process.

Self-Directed Support Strategy

In 2010, the Scottish Government and COSLA published a Self-Directed Support Strategy for Scotland. This strategy put forward a host of recommendations, including one on access to care and support and the use of eligibility criteria. Specifically, the Strategy recommends that:

“The Scottish Government in conjunction with COSLA and the National SDS Implementation Group will review the application of the national eligibility framework in order to establish the need for national eligibility thresholds for all adults with social care needs.”

In developing the Self Directed Support Strategy it became evident that a key concern amongst people who use services is the fact that provision can vary between council areas in Scotland and that there is not sufficient clarity as to the application of eligibility criteria and the operation of thresholds.

National Eligibility Framework

The National Eligibility Framework employs a four criterion approach, categorising risk as being critical, substantial, moderate or low.

- **Critical Risk:** Indicates that there are major risks to an individual's independent living or health and well-being and likely to call for the immediate or imminent provision of social care services.
- **Substantial Risk:** Indicates that there are significant risks to an individual's independence or health and wellbeing and likely to call for the immediate or imminent provision of social care services.
- **Moderate Risk:** Indicates that there are some risks to an individual's independence or health and wellbeing. These may call for the provision of some social care services managed and prioritised on an on-going basis or they may simply be manageable over the foreseeable future without service provision, with appropriate arrangements for review.
- **Low Risk:** Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.

In these definitions, the risks do not refer only to an individual's current independence, health and wellbeing, but also to the risk that she or he may not be able to gain these outcomes without support.

As part of the overall policy discussion on Free Personal Care, it was agreed that older people who had been assessed as being at critical or substantial risk would be provided with services within a maximum of six weeks of the confirmation of need.

Section 12 (1) of the 1968 Act indicates that "It shall be the duty of every local authority to promote social welfare by making available advice, guidance and assistance on such a scale as may be appropriate for their area, and in that behalf to make arrangements and to provide or secure the provision of such facilities....as they may consider suitable and adequate".

While the advent of self-directed support requires a broad interpretation of the legislation – it is not necessary for the local authority to provide a service in response to assessed need – it remains the case that local authorities should operate eligibility criteria to determine whether or not an individual assessed as having a social care need can access formal support and if so, which of their needs are to be met by that support.

Self-directed support, as an approach, does not negate the need for the application of eligibility criteria – rather is a further evolution of relationship and partnership approaches with people and with families and heralds an expansion of choice in how support is delivered. This approach works within the context that social care support is not now, nor has ever been, an entitlement. Rather, it remains linked to a sound assessment of need.

Most people in society live most of their lives independent of formal services. There are people whose need for formal support will be short term, or variable. There are, however, many individuals who require lifelong support. All these groups deserve support that is flexible and creative in nature, and responsive to change. However, it is the latter group that is most likely to benefit from self-directed support.

Key issues:

- the Self-Directed Support Act 2013 requires transparency in decisions on allocation of resources. Experience from legal judgments in England reinforce the explicit need for those systems to be fair, equitable and transparent.
- should a person fall below the threshold of eligible need (and therefore access to an individual budget) this does not mean they don't have needs that can be met in other ways – e.g. by the provision of information and advice; signposting to community resources or through a wide range of limited interventions.
- knowing the amount of resources available to meet their intended outcomes is a key component in maximising a person's choice and control. The section on support planning describes this in more detail.
- where an adult over 65 years is entitled to free personal care to meet specific needs, this should be built into planning and those elements made clear. A creative plan can be built around the elements that won't be charged for to enhance the support experience.

The SDS Act is not prescriptive as to the means by which resources should be allocated. Regardless of whatever system is being developed locally, the following points are critical and will be included in the carers' and service users' guides:

- local authorities should have a system of deciding a budget that is fair and clear to everyone.
- practitioners should be able to advise the individual how much money is available under each of the four options.
- the amount of money allocated for support should be enough to meet the eligible needs and agreed outcomes that are agreed in the assessment.
- before deciding how much money is allocated, the local authority must take into account the view of the professional who has worked with the individual and agreed needs and outcomes.
- where people do have a requirement for formal support because their support needs can't be met in other ways, the design and shape of that support is developed as a partnership.
- resources should be provided flexibly and be personalised around the individual, making use of natural networks, with support focused on specific goals and personal outcomes.

Eligibility: Considerations for:

Practitioners

- there is an obligation to inform people of the eligibility criteria that operates locally.
- to make this accessible, practitioners need to be clear about the criteria and be able to express this in different ways or formats to meet different communication needs.
- once a local authority determines a person's needs fall within its eligibility criteria, it has a duty to meet those needs, always recognising that there are many and varied ways to 'meet a need'. The act encourages creativity and collaboration to widen the scope of support received.

- eligibility criteria should not shape the identification of ‘presenting needs’ but it may influence which needs can be met through local authority or partnership funding.
- it is important that assessments are focused on personal outcomes and that a strengths-based approach to assessment is adopted.
- a need should not automatically be seen as a deficit that requires funding or a service.
- in determining eligibility, practitioners need to take full account of how a person’s needs and risks may change over time, the impact of failure to access support and whether this would lead to more support being required in the future.
- if, after assessment, it is determined that a person does not meet the eligibility for funded support or services they should – minimally – be provided with information and advice about alternative forms of possible assistance.
- there may be a requirement for limited or ongoing involvement with some people even if their needs fall below eligibility criteria thresholds.

Organisations

- Is there clear guidance available about current eligibility at a local level and are practitioners aware of it?
- Whilst councils have different ways of doing so, they are required to have systems of allocating resources that are demonstrably fair, equitable and transparent. Local eligibility criteria should, therefore, be clear, published and accessible for anyone to access.
- Self-directed support challenges local authorities to find appropriate ways of matching need to available resources. Neither the Act nor the accompanying regulations make comment on this, other than to acknowledge local authorities are permitted to seek a charge or contribution from the recipient of an individual budget, regardless of how it is accessed.
- Financial and IT systems should be in place to support the allocation and monitoring of individual budgets.
- Is there a joint commissioning strategy that promotes preventive or alternative approaches as well as access to more formal services? Practitioners should be clear about their responsibilities if a person’s needs fall below eligibility criteria.
- A focus on co-production and locality-based approaches will reduce pressure on formal services through prevention, early intervention and ongoing support to people in communities.
- There has been a number of legal challenges to the amount awarded to meet an assessed person’s needs and the resulting judgments provide a helpful guide to the responsibilities of a local authority.

Support planning

Having identified and analysed a person’s strengths, needs, risks, capacity and aspirations during the assessment process, the development of a support plan enables the practitioner, in collaboration with the individual (and relevant others), to consider how these needs can be best met and any potential challenges or conflicts of interest addressed.

The Act requires that support must be available to ensure an individual is able to communicate their views, questions and concerns. This will ensure and evidence that choice is informed.

In the past, people assessed as being eligible for support have sometimes been expected to ‘fit’ into existing services and care planning tended to be ‘resource led’. The principles of the Act

facilitate a move towards an outcomes focus – where the individual is central to the planning of their support. It enables a focus on an individual's goals rather than on what services can provide.

Key issues

- planning for outcomes-focused support with a person requires creativity and imaginative thinking to ensure the wider resources available are recognised and valued.
- these resources should start with the individual's own personal assets, which could be their experiences, their resilience and motivation, their circumstances and life history, their family and community supports – partnered with the professional's experience, skills and knowledge of systems and potential sources of support.
- this can also involve other agencies using support planning to develop shared and joint plans with clear roles and responsibilities.
- planning activity also needs to take account of proportionality and of opportunities for time limited or time specific interventions based on the aims and objectives agreed.
- support planning also takes place in specific statutory contexts. As the new Act sits alongside other guidance and legislation – such as Adult Support and Protection – it gives practitioners an opportunity to enhance effectiveness and adapt practice in order to ensure the best possible outcomes for each person.
- good practice suggests a 'one person – one plan' approach. Practitioners should therefore aim to minimise duplicate planning and streamline existing processes.
- professional judgement needs to be applied when determining how to engage with people whose capacity is impaired. It is important to support the application of principles of participation and choice to promote the least restrictive option that is of most benefit to the person.

The safety of individuals remain the paramount concern when assessing risk. In circumstances where concerns or possible conflict of interests arise around roles within family or in other key relationships e.g. where a child or adult may be considered to be at risk, the self-directed support principles can still apply. There needs to be full consideration of the child and adult protection guidance and procedures when assessing risk and working with the supported person and their family.

There is some apprehension that the development of Self Directed Support approaches, processes and the transferring of power may increase risk for some of the more vulnerable people who engage with services. There is however increased recognition that practice based on sound relationships with the supported person, their families and wider support networks may, in fact, support greater safety and risk enablement opportunities. Helping to identify more creative solutions of support may in many circumstances, lead to reduced levels of risk and harm.

Children:

In relation to the Act, a child over 16 has the right to make decisions about their own support and the choice of the four options. Below the age of 16 the person with responsibility for a child, the 'appropriate person' should be involved in decisions about a child's support and the choice of the 'four options'. However a child's age, stage and maturity needs to be considered. Children over the age of 12 years have the right to make decisions unless it is shown that they are unable to do so. Even in that event, all attempts should be made to seek the child's view, include them in the process and keep them at the centre of decision making about any support arrangements.

An effective support plan should:

- demonstrate how the principles of the Act have underpinned the planning and guided practice throughout.
- demonstrate how identified outcomes can be achieved within available resources.
- demonstrate a shared understanding of the outcomes, objectives, tasks and decisions.
- outline clear timescales and date of review.
- explore and take account of a person's existing strengths and supports and how these can be enhanced.
- outline the roles of each person and agency involved, the part they play in effective support, and their responsibility for supporting change.
- clearly identify how areas of risk will be managed or supported and by whom.
- be reflective and responsive to changing circumstances where possible.
- demonstrate how to link the individual's eligible needs and their agreed outcomes and show how creativity and lateral thinking are effective in meeting need.
- demonstrate how the supported person has a good understanding of the process and the agreed priorities.
- outline information about any services provided.
- be written or communicated in a format that the supported person understands (considering – age, communication, language, ability etc).
- describe arrangements for what happens within a crisis situation – consider what may need to happen if things go wrong – a contingency/back-up plan.
- allow for a sufficient degree of flexibility, allowing for reasonable adjustment over time and in response to the 'real world'.

The Act requires that, for people to make informed choice and be involved, the support planning and decision making processes must be clear and understandable to each person.

The Act requires that, for people to make informed choice and be involved, the support planning and decision making processes must be clear and understandable to each person.

There are a wide range of templates or formats used to guide and facilitate both the individual and practitioner through the support planning process. Whatever method is used, it must be accessible and reflect the needs of the individual, and it must encourage and support an outcomes-based rather than 'tick box' led approach. Consideration needs to be given to age, disability, culture, communication method, ethnicity, language etc.

Agreeing the support plan:

Local arrangements for agreeing level or type of resource should be followed. Local authorities' duty of care means that it can refuse to agree to any element of a support plan where the support would:

- unreasonably endanger any person and put their safety at risk
- support an illegal act
- involve gambling or financial investments
- fund health care that should be met by the NHS unless budgetary arrangements have been put in place between agencies to permit this
- pay for anything that other sources of income should normally cover
- not contribute to the agreed outcomes within the support plan.

This applies to all of the options under the Act.

Tom's story

Tom is a young man who, just after graduating from university, sustained a brain injury following an operation on a brain tumour which has left him totally blind with no light or shade. Following discharge from hospital he moved into his own accommodation.

He now lives alone in his own tenancy with support three times per week amounting to 15 hours. He had his own flat after university and wished to continue to live the life of a young man though had to give his flat up when in hospital. He has had to make huge adjustments; the career dreams he had, the plans he had for adventures with his friends and the aspirations of his family all had to be adjusted.

His one surviving parent, his mum who was widowed when Tom was a child, lives nearby. She has recently had a crisis in her own health which has long term implications and she suddenly is not able to support Tom physically. She still provides emotional and social support through email phone and of course when he visits her home. His mum is concerned that she's not able to support her son as she'd expected and this has had profound impact on her own emotional wellbeing and her sense of being a parent and carer. She wanted the best for Tom and before her own health crisis, she ensured the support that Tom got was as good as it could be, using community and other resources to enrich Tom's life and choices and to envision a future that was positive and safe and made the best of the circumstances. She was a powerful advocate but this role has been compromised through her own ill health.

It has taken time and effort for the family to get through each challenge step-by-step.

Tom's support arrangements were set up before self-directed support and at the time, most of the arrangements were set up to enable discharge from hospital.

Tom is required to be offered the four options at his next review after 1st April.

He likes the arrangement he has, but this is still a new experience for him and circumstances have changed since it was set up. Tom's carers are his life, and part of his routine, and he would not manage without them.

Now that he has had time to adjust to his new way of living, what would an outcomes- focused review enable him to say?

What matters most?

That his family feel he is managing so they can focus on his mum. One very visible sign of this is shaving. A seemingly small thing, he is by shaved by female carers most of the time – passable but not great. He is aware his mum feels he looks unkempt at times, and this becomes a source of argument, about the quality of his carers and if he defends them, then his personal priorities are questioned.

He can cope but if there is a special occasion like visiting his mum, or other relatives and friends a sign to them of him managing is to look groomed. The only way he feels properly clean shaven is on the rare occasions he is taken to a Turkish barber – (he is totally blind and has to rely on others to escort him).

He would feel more independent if some of his support was turned into escort to a Turkish barber, and flexible enough for shaving before family gatherings, not just on a particular weekday,

but at weekends when parties happen and families gather. Then he knows and feels he is groomed.

The outcome for him, is he can trust that his appearance is how he would like to look if he could see, and secondly he feels this is one less worry for his mum, therefore, the time they spend together therefore has more quality.

Option 1 a direct payment for unpredictable escort to a Turkish barber

What else matters?

Tom likes most of his carers but wants them to remember it is his life and he wants to have friends round – for meals, coffee, film nights with carry out food and drink. He attempts to wash his dishes, but can't see how clean the plates are, and he doesn't mind anyway. He would prefer that one of his carers does not scold him for leaving plates used by others for her to wash. He wants to remind her this is his home. But he needs her support. His involvement in designing his support would enable him to make this clear at the outset, there are other tasks he would be happy to do without so that he could have friends round and live his life as normally as he can.

Outcomes: Tom feels just like any other young man learning to live as independently as he can, and to enjoy a normal life with friends.

SDS Duties confirmed. **Involvement** in designing support. **Collaboration** through more effective use of own resources and networks. **Choice** and **control** through support being designed around him with small adjustments.

Support planning: considerations for:

Practitioners

- the support plan must evidence the involvement and participation of the individual and highlight that collaborative approaches have been taken especially with the person, with other agencies and people who are important.
- the practitioner, where they consider it appropriate, should provide the individual with information about independent advocacy services provide a unique role in terms of helping people navigate and make their choices.
- the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 require consideration of independent advocacy when people are subject to duties under these acts.
- when support planning for a child or young person, the GIRFEC approach must be adopted (this will be further supported within the new Children and Young People Bill).
- the individual should have an understanding about the choices they have made and what this means for their support arrangements, now and in the future, pending review.
- the person is clear about how the plan will be monitored and reviewed and how this will support their agreed outcomes.
- the plan should make use of natural networks and other community resources where possible.
- there should be clear evidence of the person's full involvement within the process.
- capacity can be variable; this needs to be built into plan.

- clear timescales are identified and outcomes are broken down into manageable chunks. This helps make it measurable and easier to see progress if there are milestones identified along the way.
- the person should be clear about what supports are going to be provided to them, by whom, when, how and every other detail of the support plan arrangements along with how these will be managed and everyone's role within this process.
- the support plan should focus on what the person wants to achieve as well as openly discussing and recording any risk factors to the person or from the person to others.
- the support plan should consider the importance of the principle of minimum intervention – as the least restrictive options should be used.
- use of assistive technology can deliver discreet support that enables people to retain independence and dignity and this should be considered.

Organisations

- decision making and budget setting processes should be transparent regardless as to what system is adopted to determine a person's personal budget.
- practitioners need to be supported by supervisors and managers to ensure individuals are at the heart of all assessment, planning and decision making.
- the requirement to evidence involvement and choice will require coherent support plan recording methods.
- practitioners will require guidance and support in relation to a range of new procedures, structures, policies, and resources to allow them to feel clear and confident about this stage.
- these will vary across local authorities and partnership arrangements, but must be fit for purpose to ensure practitioners carry out their duties in relation to the Act.
- opportunities to contest decisions should be known to all parties (e.g. appeal or complaints processes).

Carers

There are two specific areas relating to carers in addition to those listed above:

1. they are to be fully involved in developing a support plan in their role as a key partner.
2. when support is to be provided to enable the carer to continue in role, the support plan is to be developed jointly and highlight which areas are for the supported person and which are for the carer in their own right.

A carer's story

A carer looks after her father, who lives alone, is getting older and more frail and starting to need a bit of help around the house. The carer does the more heavy-duty housework such as vacuuming and mowing the lawn, as well as going to the supermarket and running errands.

Her father has a stroke and is taken into hospital. He is in hospital for three weeks and during this time his daughter has a carer's assessment, organised by the hospital social worker. It establishes that although his daughter was able to support him before the hospitalisation, the care required when he leaves hospital will be more substantial than what has been done before, including some personal care, and it is not known how long the more substantial care will be needed for, as rehabilitation following a stroke can be variable.

The carer will not be able to cope with this level of caring as she works full-time and has two teenage children. In addition, she does not want to provide personal care for her father and he would prefer to receive it from paid care workers. She is still able to visit regularly, and helps with the housework when she visits, as well as picking up shopping, running errands and supporting him when the occupational therapist and physiotherapist visit. She is also referred to the local carers' centre, and is able to meet with other carers who are in similar situations.

Her father is offered support from the local authority, and after talking with his daughter about how the support will fit in with the care she can provide, he decides to take an individual budget, and asks the Council to arrange care from a private care agency who can come and help him with showering, dressing and cooking at times that suit him. The care agency is very flexible and will come along in the mornings and evenings to provide personal care and help with making meals. The care workers have shorter visits at weekends and on days when his daughter is not at work, as she is able to help her father with meals then and so the care workers only have to help him wash and dress.

A key safe is installed to make it easier for the care workers to access the property. It also means that the eldest grandchild can visit if required when the carer is not available.

The flexibility of the agency care workers is very important as his daughter's days off are not on a specific schedule. Likewise, if the carer needs a break, the agency uses the hours that have been 'saved' to provide extra support with shopping and household tasks.

Learning points:

The carer has been caring for a while but has only had a carer's assessment after reaching crisis/emergency. It has been recognised that her caring limit had been reached and support must be provided for her to be able to continue to care.

The cared for person is provided with support due to his condition, but this support also benefits the carer. It will be detailed in both plans. He is able to choose support that suits him and also has the help and support of the carer when choosing.

The flexibility of support suits both the carer and the person receiving care, as it allows the carer to maintain their own life, remaining in employment and having a break from caring. Neither of them wanted a direct payment, but do want some choice over who provides care, so option 2 was the best choice for them as they can 'bank' the hours they don't use for extra support when it's needed.

