The process of developing outcomes focused care and support arrangements.

This illustration is largely drawn from the pilot in the Vale of Glamorgan with All Care Ltd (Provider) but similar approaches are being developed in other parts of Wales.

- The individual has been identified as likely to need care and support. The social worker/nurse/occupational therapist or member of a multi-disciplinary team undertakes a proportionate assessment and has a ‘What Matters conversation with the individual and their carer / family where appropriate. The need for any assessments required from other professionals are identified and sought at this stage. The need for an advocacy may also be identified where appropriate. The individual may have already benefitted from a reablement service which will certainly assist with any assessment.

- This approach complies with the Part 3 Code of Practice of the Social Services & Wellbeing (Wales) Act 2014 which states that the purpose of the assessment for care and support is to work with an individual, carer and family, and other relevant individuals to understand their needs, capacity, resources and the outcomes they want to achieve, and then to identify how they can best be supported to achieve them. At the core of this is a conversation about promoting independence and development by maximizing people’s control over their day to day lives and helping address difficulties or problems which are stopping them achieving this. It is essential that people are enabled to identify their own personal outcomes, and how they can achieve those outcomes.

- Eligible needs are identified together with the outcomes the individual and his / her family want to achieve through the care and support arrangements. Part 4 Code of Practice notes that “determining eligibility is not about giving away a right to any one service, it is about guaranteeing access to care and support where without it the person is unlikely to achieve their personal outcomes. Fundamental to this determination is an understanding of what actions the person can contribute to achieving their outcomes, with the support of their carers, family and community where available.” The outcomes focused approach being piloted in the Vale of Glamorgan appears to offer greater opportunities to integrate individuals back into community resources and reduce isolation.

- Rather than identify a time and task timetable the social worker will identify a bundle of support – perhaps 20 hours per week to deliver the outcomes and respond to need.
- The assessment and bundle of care is authorized by manager.

- Brokerage team seek care agency to provide bundle of care – a provider is selected through brokerage.

- Social worker, provider and individual will meet – and care and support plan will be completed – this may take more than one meeting.

- Social worker finalizes care and support plan with care agency. The content of the care and support plan should include the actions to be taken by the local authority, the care agency, the individual, /family/ carer and other persons to help the person achieve those outcomes and the process for monitoring and measuring their achievement. This is important because home care providers as well as other providers need to understand what outcomes they are responsible for helping the individual to achieve. There may well be other outcomes for which they have no responsibility.

- The Home care provider is required to undertake an assessment of how the individual's care and support needs can be met and how they can be supported to achieve their personal outcomes.

- Social worker steps back and Home Care Provider works with the individual and family to develop personal plan. This will describe how outcomes / needs will be met. This complies with the statutory guidance issued under the Regulation and Inspection Wales Act 2016 which requires providers to prepare a plan for the individual which sets out how on a day today basis the individual’s needs are met and how the individual will be supported to achieve their personal outcomes.

- The fit between the personal outcomes identified and national outcomes will be identified for future measurement purposes. The progress in the achievement of personal outcomes will be measured and aggregated to measure their contribution towards the achievement of national outcomes.

- The social worker will be able to sign off minor changes if no longer term change of circumstances. This frees up both management and practitioner time.
In the pilot in the Vale of Glamorgan, the personal plan is intended to be flexible to meet needs allowing variation in hours from week to week without the need for the authority to sign off provided changes to the care and support plan equate to a + or – 8% variation in hours over a 13-week period. Hours not used can be banked for an individual and used for another purpose or they will be returned to the authority. This has, for example, enabled individuals to engage in community activities. The indications are that the 8% variation balances out.

There is an opportunity to seek an early review should circumstances warrant it.

The Home Care Provider monitors cases every thirteen weeks using an outcomes tool. This information informs the meeting with the social worker identified to work with each agency.

In the pilot in the Vale of Glamorgan an identified social worker works with each home care provider and meets with them every thirteen weeks to discuss every case.

This approach offers more scrutiny than the existing system and reduces bureaucracy allowing more time for qualitative monitoring and evaluation.

In relation to joint packages with health or health packages of care and support home care workers may work alongside health staff and Health will provide training in relation to specific health tasks. The Home care provider should attend multi-disciplinary team meetings.

**How are you achieving an outcomes focused approach?**