

2023

# HARINGEY ADULTS OUTCOME BASED SUPPORT PLANNING MANUAL

BETTER OUTCOMES BETTER LIVES

HARINGEY COUNCIL | River Park House, 225 High Road, Wood Green, N22 8HQ  
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## Outcome Based Support Planning Manual

### **1. Introduction**

This practitioner manual has been designed to support staff in developing and improving their skills around outcome based support planning. Although we have always had a focus on meeting outcomes, we knew this was a particular area where we could make some significant improvements and by doing so ensure that our practice was more person centred and strengths based.

This manual will look at some of the fundamental reasons for the change and how it aligns itself to both the legislation and best practice. It will provide practical examples of how to undertake your assessments to support the identification of outcomes and give examples of how to structure your support plans so that we can ensure the identification of individualised outcomes and quality of life improvements for those that we support.

### **2. Care Act**

We often talk about the importance of legal literacy and the essential role it plays in our approach to service delivery and practice. The Care Act represents a fundamental pillar of social care legislation and provides clear guidance as to the roles and responsibilities of local authorities and social care practitioners.

One of the most referenced words within The Care Act Guidance is that of outcomes. Whether it is being referenced for strategic purposes, commissioning, integration, assessment, review or support planning a focus on outcomes is fundamental to the work we do. A clear indication for this and how important outcomes are can be seen early in the guidance **'The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life.'** (1.1). The guidance is not merely stating that outcomes are important or that they should be considered but instead sees outcomes as an essential element in how we support our residents. What is also important to take from this



statement is the focus on outcomes that matter to the individual, moving away from off the shelf care and support and ensuring a more person centred and individualised approach to understanding those we work with and tailoring support that meets their outcomes.

Given the importance that the act places on the principle(s) of outcomes and the requirement for it to be integrated into all aspects of how we operate it is crucial that our practice reflects this way of working.

### **3. Strengths-Based Practice**

We have recently implemented our new strengths-based model of practice. In developing our model, we wanted to ensure it had very clear Haringey DNA embedded throughout, a model of strengths-based practice that was designed by our practitioners for our practitioners. This work was led through our pilot strengths-based team who planned, developed and tested the new model of practice while working from a locality-based approach in Tottenham. This work has been supported by Research in Practice who have supported the team in the development of the new model and with it the development of our Head, Heart, Hands philosophy.

Head, Heart, Hands speaks to the way in which we connect and undertake our roles in adult social care. The importance of this approach is that all three need to be aligned to ensure that we are mentally, physically and emotionally competent in delivering a true strengths-based intervention. Below outlines how each of these elements directly influence how we undertake our interventions.

Our strength-based model focuses on relationship-based practice enabling practitioners to work creatively, ensuring a person-centred approach with residents which is essential in being delivering meaningful outcomes that support independence and quality of life. Practitioners should ensure that they have read and refer to the [Strengths-Based Practitioner Manuel](#).

#### **4. Quality of Life measures and improved independence**

A fundamental principal for practitioners when working with residents should always be *'how can we help to improve this person's quality of life'*? It is our role to understand the individual and their circumstance and work with them to determine what meaningful and positive change looks like. This can be a number of different things in a number of different areas, dependent on the person, such as feeling safe, being treated with dignity and respect, seeing people, having things to do, being as well as they can, living where they want or being able to do more things for themselves.

A key facet of our work in adult services is to support residents to be as independent as possible. Helping people to do things for themselves no matter how small is incredibly important in ensuring people feel they have control of their lives and supports physical and mental wellbeing. However, it is not always possible to improve independence for all those that we support. In such cases we must be clear as to what improvements the person wishes to achieve through their outcomes. It is no longer satisfactory to generically look at meeting outcomes (see section 6) the outcomes must be specific to each individual and to do so means that we must better understand the person we are supporting.

#### **5. Getting the conversation right**

For us to understand those quality of life measures our resident want to achieve through their outcomes we have to look at the type of conversation we have with them. Historically in social care we have been focused on a repair model of care that has meant we look at what is wrong not what is strong. This has led us to defining people by their disability not by who they are. The result of this has meant that support plans have historically been generic in need/outcomes, deficit based with an overreliance on formalised care that does not speak to the views or circumstances of the individual.

Whether at assessment or review we must ensure that we change how we engage with our residents. We cannot provide person centred support if we do not know the person at the

centre of that support. Practitioners should take the time to know who the person is. Understanding someone's circumstance, life history, their achievements, their worries, their passions, their hopes and aspirations will ensure that support plans can have clear outcomes that relate to quality of life measures that are meaningful for every person we support.

The new strength-based assessment and review documents have been designed to support open and meaningful conversations for those that we are supporting. These have been significantly reduced in size with the focus now on the quality of the conversation that should be led by the person. The key here is to learn as much about the resident as possible.

Where the individual lacks the ability to be meaningfully involved in the process practitioners must ensure the views of their advocate (family, friend or appointed) are gathered and reflected in the support plan. Practitioners should take all reasonable steps to obtain as much information as possible. In exceptional cases where only very limited information is available practitioners should highlight what steps they have taken to obtain the information and the rationale as to why only limited information is available within the assessment or review.

## **6. How to complete the Support Plan**

This section will look at each of the individual elements to the Support Planning process to provide practitioners with a clear understanding of what is required. It is essential that practitioners supply sufficient detail under each of the headings and that these are not generic or repetitive. Practitioners must ensure that no areas of the support plan are left blank.

### **Articulating the Residents Voice Outcome**

The support plan should be written in a way that best relates to the conversations that have taken place with resident and/or their advocates. If the person has been very active in defining their outcomes and taken ownership of their support plan you may decide to write in the first person. Alternatively, you may decide to write it in the third person

documenting what the resident/their advocate has said. Be sure that whichever approach you chose best demonstrates the discussions that have taken place. Do not write from the first person if the individual has been unable to provide you much in the way of their direct views or if an advocate has provided you with the information. If you are unsure as to the best way to articulate the individuals' views in the support plan, ask them how they would like it presented as this is a document you will be sharing with them.

### **Outcome/goal I wish to achieve**

It is not possible for the practitioner to be able to document the individual outcome/goal if the right conversation has not been undertaken to get the resident/advocates views as to what this should be. It is easy to notice in this section where practitioners have had a conversation with the resident/advocate and where they have not. There should always be the persons voice coming through in the documentation and practitioners should avoid making any generic outcome statements. Practitioners simply asking 'Why?' questions to better understand stated outcomes are important to an individual can provide clear insight into the individuals perspective. Below are examples of how this should and should not be documented.

**Note: All examples provided have been taken from recent audits and anonymised accordingly.**

### **Correct**

<b>Outcome/goal I wish to achieve</b>
Stephen wishes to become more comfortable doing laundry at home or using the local laundromat with support. Stephen said nobody has taught him to do it in the past but he thinks it is something he could learn to do himself with some help.

This support plan has been done in the third person and although succinct it is evident Stephen has been involved in defining this outcome through discussion with the practitioner.

**Outcome/goal I wish to achieve**

Cooking is something I used to do a lot and really enjoyed. I would like to continue to cook some of my meals but will need some support as I do not always remember what to do in the kitchen.

I would like to choose my own food and plan my diet. However, I do recognise I need some help making healthy choices as I have put on weight recently.

This is an example of a support plan that has been written in the first person. This appears appropriate as it is presented as a narrative of the conversation had with the individual. It clearly states the importance of this to the individual and what it is that they would like while also showing the persons insight into ability to make healthy choices.

**Outcome/goal I wish to achieve**

Mr Smith said he wishes to be clean and presentable, he likes to have a shower every morning. He recognises he needs help due to his Parkinson's condition and mobility problems. He said "his muscles do not do what his brain tells them to do." The carers assist him to shower, brush his teeth, dress, shave, nail care and accessing his clothes as he



experiences certain difficulties at different times such as raising his arms or bending his legs or hand tremors, due to jerky movements or rigidity.

Here we have another example of an outcome being written in the third person. Although this relates to an individual in a residential home who requires a lot of support around this personal care the practitioner is still able to clearly capture what the residents wants from this outcome.

**Incorrect**

**Outcome/goal I wish to achieve**

To be able to access the community safely.

This is a generic statement which has no sense of identity of the person. What does 'accessing the community safely' look like to this person? What would it mean/feel to them if this outcome was met?

**Example:** William stated that he is concerned about his balance as his legs 'aren't what they used to be'. He said that he is really keen to go outdoors as he has always loved getting out of the house for some exercise but is worried he may fall. He would like to feel confident in accessing the community independently.

**Outcome/goal I wish to achieve**

I am unsafe to be in the kitchen without supervision. Due to my dementia I lack safe awareness around the stove and risk hurting myself.

This is an example of when not to use the First Person. It was clear from having read the review that this person had very advanced dementia and it was in fact the family who had articulated the issues around kitchen safety not the person. A better way of expressing this would have been; ‘Mrs White’s daughter, Sarah, stated that it was unsafe for her mom to use the kitchen due to her dementia. She highlighted that on several occasions she burnt herself on the cooker and cut herself with a knife due to lack of safety awareness.’

**Outcome/goal I wish to achieve**

Ms Brown wishes to attain daily nutritional requirements which will impact on quality of life, health and wellbeing.

This is another example in which the person’s specific outcomes are not being identified and instead we have stock generic answer that could relate to anybody. It is important that the person’s voice is present throughout the support document

**Example:** Ms Brown spoke about how important food was to her given that she has so little independence and therefore enjoyment in other areas of her life. She explained that she has always had a ‘love affair’ with food joking it was the only love that had never disappointed her. Ms Brown is keen that she can continue to prepare and eat the food that she loves but feels this is difficult due to being unable to stand for long periods.

**Timeframes to achieve it**

It is important that practitioners provide, where practical to do so, timescales in which we are looking for outcomes to be completed in. This is particularly important when we are looking at ways in which we can support greater independence for our residents. Having clear timescales ensures that providers can be held accountable for the work they are undertaking with residents and ensures the right support is delivered. In some cases, and due to the

individuals presentation it may be reasonable for the timeframe for the outcome be 'ongoing' but this should only be used if absolutely necessary. Given that all packages of care will be reviewed on an annual basis practitioners should consider whether making the outcomes 12 monthly would be more appropriate.

**Commented [AC1]:** Is this something we want to make as a directive that practitioners do, leave it as it is or remove it as not to be ambiguous?

Correct

**Timeframe to achieve it**

This is an ongoing outcome and to be reviewed after 6 weeks. Wellbeing score to be reviewed and updated to reflect any changes

Although the timeframe has been identified as ongoing there is a 6-week review date that has been included and the practitioner will also be rescoring to check to see what improvements around their wellbeing have been made.

**Timeframe to achieve it**

November 2020 to March 2021 (5 months)

Practitioner has articulated not only what the person wants to achieve for outcomes but has been clear as to expectations as to when this could be done by and by providing this provides a clear indication to the provider as to their timescales. This is further strengthened in the support plan by having progress measurements and actions taken.

Incorrect

**Timeframe to achieve it**

Ongoing - to review and monitor by team via annual social care review

Although there is nothing wrong with having timeframes as ongoing where it is relevant to do so this has been used, incorrectly, for every one of the timeframe boxes in this resident's support plan. In this support plan it is clearly evident that this resident has a lot of potential to develop skills which have been well highlighted but instead of setting times in which these could be achieved the practitioner has gone for copy and paste approach to all these areas.

#### **How will I utilise my individual, community and family strengths?**

This section of the support plan speaks to our Strengths-Based approach and how we can support someone to understand their individual and external strengths and assets in being able to meet or partly meet their outcomes. Again, the key to this is the quality of the conversation that we have with the individual at the assessment or review. We have specifically designed sections of these documents to support practitioners in undertaking conversations that are more focused on who the individual is and what their strengths are.

The three areas of individual, community and family strengths must be explored thoroughly with the individual before any recommendation for long term commissioning support is made. It is crucial that practitioners support the individuals to identify any strengths they have, even if it is just being able to undertake small elements of tasks which they may largely require support with.

It might be that in meeting an outcome some support is provided by the individual/community/family as well as a commissioned service. Practitioners must not place the commissioned care services under this section. If there is a requirement for the need to be fully or partly met by a commissioned service this should be included under the '*Actions taken and ongoing support needed*' section of the support plan.

Below are examples of how this section should and should not be completed.

#### **Correct**

**How will I utilise my individual, community and family strengths?**

I am able to manage certain aspects of my personal care. I can wash my upper body, brush my teeth and comb my hair. I can also take my own medication from a blister pack but I can have difficulties if getting it from other containers.

For managing my personal care below my waist I'm being supported by my husband who supports with showering three times a week.

Keeping my independence is very important to me so I would like to continue to do as much for myself as I can.

This is a good example of being able to demonstrate the strengths of the individual even if there are some aspects she is unable to complete independently. In this case she has the family strength of her husband supporting her with the areas that she has difficulty. It is also very evident she has been involved in discussing her outcomes and the support plan is shaped by that. This support plan went on to explore how she could, as requested, be even more independent with her personal care through aids and adaptations.

**How will I utilise my individual, community and family strengths?**

Mrs Wright stated she will continue to carry out tasks that she is able to such as

preparing/eating cereals and making a cup of tea in the morning.

At lunch Mrs Wright explained that she has ready meals delivered and is able to mobilise to the door, collect and sit down and eat independently.

At present Mrs Wright is supported with food shopping from her neighbours, Sarah and Paul, which they do online with her. Sarah will also offer to pick things for her from the local shop when required.

In this example we can see both the strengths of the individual and that of the support being provided from her neighbours. Once again, we can clearly identify not only the areas that the person has identified they can undertake themselves but also the support of others, in this case her neighbours.

**Incorrect**

**How will I utilise my individual, community and family strengths?**

Support staff to ensure that the home is maintained to a good standard of cleanliness. All fixtures and fittings are checked and safe and the home is in a good state of repair.

This section is about the strengths of the person, community and their family not about formalised care. This information should be included in the final column of the support plan.

### How will I know I am making progress/have achieved this?

With any outcome we must be able to measure what progress is being made against it and how we will know it has been achieved. This will again be dependent on each individual as to the markers or milestones they think will demonstrate that progress is being made. As has been highlighted previously if we do not define outcomes with the individual/advocate it will not be possible to define other areas of the support plan including how we measure the successfulness of the intervention being provided.

How we define the progress/achievement of each outcome will depend on the individual and their circumstances. As we have previously discussed not everyone will be able to make progress with becoming more independent, but this section is just as much about measuring the quality of life improvements as it is steps toward being able to do more for themselves. Dignity, Respect, Enjoyment, Access, Frequency, Quality, Comfort, Safety and Happiness are all areas in which someone might define progress or achievement of their outcome. Like all of us these will be specific to each individual and as such we must get our conversation right.

Below are examples of how this section should and should not be completed.

#### Correct

#### How will I know I am making progress/have achieved this?

My stoma management is improved and in doing so there are:

1. no incidents of stoma blockage
2. No infection
3. No irritation of skin around the stoma

Here we see very specific outcomes identified around the individual's stoma care and very clear indicators as to how she will now that this outcome is being met. This is something that can easily be tracked at each review meeting.

**How will I know I am making progress/have achieved this?**

Mr Willis' advocate stated that positive progress will be that he feels happier and more content within the home.

If he is actively participating with the activities in a care home and staff support him to become more involved in activities that he has interest in will be a way of achieving him to feel happier.

A reduction in symptoms of anxiety and depression i.e tearfulness/crying will show progress in being made

Here we can see that the successful outcome is linked to an improvement in Mr Willis mood. The aim being to support better social engagement thus reducing his depression through more social interaction and activities.

**Incorrect**

**How will I know I am making progress/have achieved this?**

When the carers can support me with all my care and support needs.



Here we can see that the person and their outcomes are missing and therefore the practitioner is unable to identify what progress would look like and as such we have a generic stock answer provided. The care and support should be achieving and outcome, it isn't the outcome.

**How will I know I am making progress/have achieved this?**

Ongoing

A timeframe might be ongoing but a progress marker or an achieved outcome cannot be.

#### **Actions taken and ongoing support needed**

The last section provides practitioners with the opportunity to define any steps, actions or commissioned care that is required to ensure the outcome can be successfully met. This may include referring to other services or professionals, utilisation of equipment or assistive technology, actions being taken by practitioner(s) or family/friends or the support of a commissioned service. Given there might be several different elements that are required to ensure that the outcome is met they should all be recorded here to ensure there is clarity as to what the next steps will be.

When looking at commissioned services practitioners should avoid defining the support in a time and task format. The focus should always be on meeting the outcomes and this should be done in conjunction with the service user/advocate and those providing the care.

Practitioners will now be asked to simply define the total number of hours needed to meet all outcomes at the end of the support allowing for a more flexible partnership approach between those providing care and those receiving it.

Below are examples of how this section should and should not be completed.

**Correct**

**Commented [AC2]:** I had asked that this feature was put into the support plans so we had a total hours request to meet outcomes but it isn't on the documents which might be a reason for time and task elements still being present. We will need to action.

**Actions taken and ongoing support needed**

Double handed support daily in place with care agency to support with toileting needs as per allocated care calls. Hoist in place to support transfers. Commode in place to support toileting needs

This resident has a high level of person care support needs and here this has been succinctly and accurately recorded by the practitioner without the need to provide it in a time and task format.

**Actions taken and ongoing support needed**

Referral to community alarms team has been made. Community Alarms to undertake assessment with recommendations for pendant alarm, fall sensors and key safe.

Family to continue with daily contact via telephone to check on Mrs Williams wellbeing.

Social worker to make referral for OT assessment given mobility issues and risks of falls. Mrs Williams would benefit from mobility aids and potential adaptations such as hand and grab rails.

Here we have actions taken and to be taken by the practitioner, actions to be taken by the community alarms team and actions for the family. All 3 of these areas identify the tasks and those responsible for ensuring that this outcome is met.

Incorrect

**Actions taken and ongoing support needed**

24-hour placement

This is lacking any detail or definition as to how the support will ensure that this outcome is met. Detail is needed to ensure that there is clarity as to what is expected of the provider. Without this we cannot hold the provider accountable for ensuring the outcome is met for the resident.

**Actions taken and ongoing support needed**

Mrs Phillips would benefit from assistive technology in place to ensure she can remain at home safely.

It is positive the practitioner has identified AT as being required but who is responsible for referring to them? Be specific as to who has responsibility for the tasks identified in the support plan and be sure that they are aware of this.

## 7. Principles to follow

Ensuring that the support planning process is person centred, holistic and strengths-based is essential to ensuring that the individuals' outcomes can be met. Below we have highlighted the key principles that will support better outcome-based support planning.

1. Get the conversation right. Ensure the individual/advocates voice is central in defining their outcomes.
2. A focus on 'What's Strong, not what's wrong'

3. All aspects of strengths, no matter how small, should be recognised and documented.
4. Be specific as to what the outcome for that individual is. Do not provide generic statements that are not meaningful to the person.
5. The outcomes should be clear as to the quality-of-life improvements for the individual.
6. Timeframes and progress measurements are essential in ensuring that outcomes are met and that providers are clear as to expectations of them.
7. Do not leave any sections of the support plan blank.