

ConnectedLives

A model for social care in Hertfordshire



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1. Introduction to Connected Lives

Overview

Connected Lives is Hertfordshire's whole service approach to community practice, personalised enablement and new models of commissioning.

Bringing together practitioners, commissioners and providers, it supports the transformation of our service. It is underpinned by the core concepts of the Care Act, ensuring community opportunities, citizenship and personalised outcomes and is now core to Hertfordshire's social services plan for the next 15 years.

The model itself sets out standards, principles and approaches for staff delivering services. It places more emphasis on prevention and enablement and supporting people to live the life they want.

It can be applied to every area of work – from frontline social work to systems, leadership and commissioning. This systemic approach is underpinned by a culture change and learning and development programme to ensure sustainability.

Connected lives is overseen and monitored by a board of senior leaders to ensure there is no ambiguity and no compromise in our aspirations for Hertfordshire residents.

We have embedded the learning from previous community practice and citizenship initiatives, developed both in Hertfordshire and national evidence based models and initiatives.

Professional values

Connected Lives is built on a foundation of values and ethics set out in the professional standards of social workers and occupational therapists. By reducing form filling, slimming down our processes and reducing the need for management sign-off, we are allowing our professional staff autonomy and freedom to practice value-based, person-centred social work and occupational therapy – unhindered by directive policies and processes.

Our ambition for people in Hertfordshire hasn't changed, but the expectations on our staff have shifted to ensure they move from transactional practice to relationship based practice and take responsibility to deliver outcomes and help adults live the life they want.

It is skilled and difficult work, with the focus on staff using their professional skills to help adults live their lives rather than just narrowly prescribing packages of care. It's also about recognising that care can be as disabling as it is enabling if done incorrectly or in a risk averse way.

The Connected Lives Model



The overarching Connected Lives principles



The foremost principle of connecting people to people, services, technology, networks, communities, aspiration and real lives. Some people need a little support to live independent and fulfilling lives.



A new assessment framework and approach for everyone that places more emphasis on prevention and enablement. A proportionate, outcome focussed approach that ensures everyone, regardless of eligibility and care and support needs can benefit from having with a strength based conversation based on professional analysis



Independence
& Citizenship

Everything we should do should enable citizenship and the rights and responsibilities that go with this. By making a commitment to citizenship for everyone, we are putting in place the building blocks for stronger communities.

Independence for people gives them the means and motivation to have choice and control over their life and over their care and support. Independence doesn't just mean not having a service. Very often a service may give people independence.



Connect
people,
sustain
relationships

Connecting people is not just about connecting people to others nearby. Social care staff and providers should be motivated to think beyond just 'good care'; and look wider than their own care regime to initiate and supporting people to sustain relationships. Generally people who are socially isolated experience poorer wellbeing outcomes.



Strength &
Risk Positive

- What will help people manage their own lives?
- Focus on peoples' own strengths and capacity for independence
- Taking risks is something we all do to make our lives better and achieve our personal goals, this should be reflected in the care and support we offer too
- Support people to be more in control
- Ensure providers support people to choose how and what they want to achieve
- Care should make lives better, not restrict and disable

2. Connected Lives Assessment Framework

The Connected Lives assessment is a new approach to assessments and reviews in adult social care, to continue our strength based and person centred approach. It is fully aligned with community and outcome focused practice.

“We’re putting the power back into the hands of social workers and citizens to shape more positive and responsive social care.”

The approach gives a renewed emphasis on professional practice and accountability and will deliver a preventative and outcome focused approach to care planning. At the core of connected lives is a steadfast belief in social workers’ and occupational therapists professional judgment, values and practice. Prescriptive assessments have been replaced with citizen and professionally-led assessments that don’t require management sign off.

Every social worker now controls a budget they can use in whatever way they believe will deliver outcomes for the adults they support and social work policies are slimmed down to give practitioners more freedom in their practice.

The new model has:

- An emphasis on exploring personal, family, network and community assets
- A greater emphasis on enablement
- A focused and short-term response to crisis
- Streamlined assessment processes
- A check back built in to prevent escalation of need
- A risk positive approach reliant on professional responsibility and accountability

Connect and Prevent

This is the first contact with people following a referral or a review where the person’s needs have changed. This isn’t a tick box exercise or an assessment for formal care services. It is a person-centred, solution-focused conversation to find out what outcomes the person wants to achieve. Over 60% of our assessments happen in the Connect and Prevent stage.

Workers explore a person’s strengths and those of their family, friends and neighbours; as well as the local community and what they can all offer to enable people to achieve outcomes and prevent deterioration.

This might mean offering information and advice, or signposting a person elsewhere. We are asking our professional workforce to tap into local resources and think of innovative solutions for prevention strategies.

We are developing our own resources that the workforce can call on including HertsHelp commissioned information and advice service, the Hertfordshire Directory, social care signposting in libraries and our website and factsheets.

Staff approve their own assessments (there's no manager authorisation required). Staying in touch is an important part of the assessment and a check-back date is set within four weeks, to see if everything has gone okay; but staff stay in touch as much as needed during this time.

There are no resources committed at this stage of the assessment. Where more focused support is required that may require care or professional intervention staff move on to **Connect and Enable** stage.

Connect and Enable

Connect and Enable is geared towards helping people meet their outcomes but which may need time-limited professional input (social work or occupational therapy), minor resources, one-off payments or purchases to do so. This stage is aimed at reducing or removing the need for more permanent or costly care.

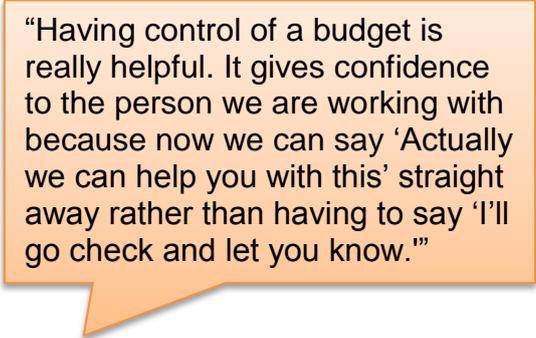
Enabling people may mean people gain confidence to learn and/or regain some of the skills and independence they may have lost because of poor health, disability or after a spell in hospital. It may be we can support people to develop new skills that they have never had the opportunity to do so before; due to their care environment or perceptions about their disability. This may be particularly relevant to people with learning disabilities who may not have had such opportunity before.

Independence will be different for everyone – it isn't just independence from care and support, but could be independence to access services that give people better lives. Traditional enablement outcomes such as the ability to use the home safely and get out and about are important, but the quality of life outcomes that make life worth living are just as important – having a purpose to be able to use these skills and independence.

In order to achieve these outcomes we might look at:

- Up to four weeks' professional support, for example a number of visits by an occupational therapist to enable confidence in completing tasks required in and around the home.
- Commissioned services to enable agreed outcomes to be achieved over set time period
- A one off direct payment;
- equipment; or
- crisis response.

Staff have access to a small budget for short-term enabling interventions that allow people to retain and or regain control over their lives. They are encouraged to consider using any budget in a way that supports outcomes and not just think about buying care visits. Social workers and OTs are also encouraged to



“Having control of a budget is really helpful. It gives confidence to the person we are working with because now we can say ‘Actually we can help you with this’ straight away rather than having to say ‘I’ll go check and let you know.’”

consider themselves as the intervention. Spending time with a social worker completing specific work may be more powerful than any care plan that can be commissioned.

If needs change before final check-back or the person needs long term support staff move on to the Connect and Support stage.

Connect and support

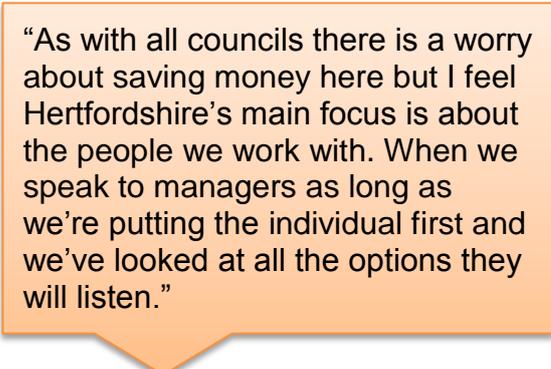
Although our emphasis is to set and achieve outcomes in Connect and Prevent or Connect and Enable, some people do need more long-term or intensive support.

Care Act eligibility is established at this stage and is evidenced in the recording, drawing on all of the information that has been shared up to this point.

The emphasis remains on what is important to the person and achieving wellbeing outcomes. There is the opportunity to explore further relevant information if more depth is needed to aid support planning and understanding the outcomes to be achieved before the support plan is co-produced.

The consistent message to staff is supporting the person to achieve these outcomes rather than just directing care. We are clear that the wrong care for people can be just as disabling as no care at all.

Needs can still be met by the person's own strengths, community services, family and information and advice. It may also mean that the focus of any support provided enables people to use their strengths and achieve the relevant Care Act wellbeing principles.



“As with all councils there is a worry about saving money here but I feel Hertfordshire’s main focus is about the people we work with. When we speak to managers as long as we’re putting the individual first and we’ve looked at all the options they will listen.”

3. Connected Lives and Commissioning

We recognise that the Connected Lives approach can't end with our involvement. We want all care in Hertfordshire to embed Connected Lives principles in commissioning, strategy, procurement and monitoring. This will start with development of strategies and the design of services to ensure they are aligned with the Connected Lives principles.

We will support providers to incorporate Connected Lives into their business models and develop clearer pathways for people to enter and exit care especially where they have fluctuating needs.

Keeping the principles of Connected Lives at the heart, we can want to shape a market that offers more prevention options, that may not be a funded service, and services that offer time limited enablement support.

We will incentivise providers' to enable outcomes for people and make it a requirement in future contract and business arrangements with us. In turn, we will contract monitor against outcomes for people.

Our Community Commissioning teams have embraced the Connected Lives principles, recognising that the impact is on all parts of the commissioning cycle as outlined in the diagram below.



The work already carried out and working well is:

- Inclusion of the Connected Lives principles in contract specifications for future procurement processes ensures future Providers are clear about the need to provide enabling, community focused support.
- Monitoring of these Providers against this approach is leading to honest, forward looking discussions about the shape of current services and how they can be developed to meet the needs of individuals.

- Analysis of population needs taking into account a new focus on preventative, enabling support is ensuring consideration of innovative approaches and a focus on outcomes even before the design and planning of future services.
- Ensuring Connected Lives is at the forefront of planning discussions means ensuring it happens after procurement is already designed in.
- In the next phase of Connected Lives we will be developing our care workforce meant to ensure all professionals across all health and social care organisations move to an outcome focused way of working with individuals.

4. Culture change and staff development

It was important that we set out a coordinated and combined approach to ensuring our staff, managers and partners had the knowledge, skills and enthusiasm to embed Connected Lives to ensure a whole-system and integrated approach across the service.

The model of staff development we designed was based on mentoring, coaching and self-directed learning. Staff are supported to develop skills to implement outcome focussed and evidence based practice – including positive risk taking and to make effective and efficient use of the processes and systems that support the delivery of the new model.

Senior managers and Advanced Practitioners are key to communicating the vision and engaging with staff so they are committed to the new model and understand the vision.

The senior leadership team have taken collective responsibility and accountability for the programme. They are visibly supportive of the model and ensure Connected Lives is integral to any message they deliver.

Advanced Practitioners and senior social workers and occupational therapists are used as effective change agents, providing tangible coaching and support to colleagues and also ensuring we reflect the reality of pressures faced by frontline staff.

A comprehensive suite of resources is available to support staff and managers. This includes a programme of RiPFA evidence informed taught courses, theoretically informed training and supervision in Systemic and Psychodynamic thinking and practice from The Tavistock Clinic, Brief Solution and Motivational Interviewing courses and a tailored leadership programme.

Beyond the classroom a range of guides were commissioned which included written guides, case study videos, animations and FAQs.

Aside from a comprehensive system guide, the materials were reflective and empowering. There were no checklists or step by step instructions, with staff encouraged to develop their analytical skills and rely on their professional judgements.

5. Monitoring and evaluation

It is expected that the new assessment framework will take three years to fully embed and enable Adult Care Services to be able to demonstrate the impact on social care in Hertfordshire. A commitment to reviewing the assessment framework after six months was undertaken as an early snagging exercise, to identify any system and practice improvements and ensure we are on track to deliver the anticipated benefits.

In summary the review found:

- There are good examples of innovative practice and evidence that the process allows more time to focus on what matters to the person.
- Staff have embraced the principles of Connected Lives and welcomed the flexibility and freedom to improve the lives of the people they worked with.
- Assessment numbers are consistent with previous years; and people receiving long term, formal care and support has reduced
- There are certain business process and system issues that need improving.
- The culture change programme should continue to ensure the anticipated benefits of the new way of working are fully realised.

As a result of the interim review, the following actions are planned:

- A full business pathway and system review.
- A comprehensive data and audit framework.
- Further training and resources.
- Renewed communication and engagement.

ConnectedLives

Supporting Information

ConnectedLives

PRACTICE PRINCIPLES

Introduction

In Hertfordshire we want to empower and support our staff to deliver excellent professional practice leading to positive outcomes for people.

Our Connected Lives model puts choice, independence, enablement and citizenship at the heart of everything we do. It gives us an opportunity to look at real and innovative solutions that enable people to live their lives to the full.

Based on evidence of what works for people, we respond to the challenges we face in a changing society by offering help and support that is enabling and cost effective and ensures fair distribution of resources according to need so we can meet our responsibilities to all.

These **Practice Principles** seek to make excellent practice consistent and let staff know they have support in implementing difficult decisions.

They apply directly to all staff who carry out assessments and care management on behalf of Adult Care Services (ACS); but all ACS staff need to be aware of these principles and to work to them where applicable.

The **ConnectedLives Practice Principles** are in line with our Care Act duties, the BASW Code of Ethics and the Royal College of Occupational Therapy Code of Ethics.

ConnectedLives

A model for Hertfordshire



Connect and Prevent
Connect and Enable
Connect and Support



Strength Based
Risk Positive



Connect People
Sustain Relationships



Independence
Citizenship

Search 'Connected Lives' on the intranet for information and resources

Adult Care Services



The **ConnectedLives** Practice Principles:

1. Independence and citizenship

Independence and the ability to maintain/develop roles as citizens is our ultimate aim, but this means different things for different people. For some, this may be learning new skills to build upon independence whilst for others, this may mean exploring the potential for further recovery and rehabilitation. With the right support, everyone can achieve some independence. We want to support people to maximise their own potential for control over their lives.

2. Every contact is strength based and risk positive

Strengths-based practice emphasises people's self-determination, skills and assets and should underpin every conversation and contact.

Risk-taking is a part of life and a part of social care too. It's something we all do every day to make our lives life better and achieve our goals. Risk involves the potential for benefit as well as harm so we would never want to remove it completely. By taking a proportionate approach to reducing and mitigating the potential for harm, we can reach a balance between independence and personal autonomy against the risk of harm.

3. Alternatives to traditional care services

We should work creatively with people to source alternatives to traditional care services and should explore options and choices of services to meet assessed eligible needs in collaboration with the service user so a joint decision can be reached about their most appropriate option. Wherever possible the person's choices will be supported.

Awareness of 'value for money' is essential. Where Personal Budgets are offered, this must be based on the most cost-effective way of meeting needs.

Telecare and technology can also enable people to remain at home longer and can help in managing risks.

Non-traditional services should:

- Meet assessed needs and outcomes
- Be safe, lawful and appropriate
- Either cost no more than the Personal Budget offered, or the person is willing to fund the difference themselves

4. Safeguarding

Safeguarding people at risk of abuse or neglect is one of our most important tasks and we should adhere to our Safeguarding Adults Policy and guide. Safeguarding is

everyone's responsibility so we all have a role to celebrate good practice and take immediate action where practice falls short of our own standards.

5. Clear Understanding of the legal framework for adult social care

This includes The Care Act 2014, Mental Capacity Act 2005 and the Mental Health Act 1983.

Where key decisions such as in eligibility, care assessments, care and support planning, best interests and safeguarding are made, professional case notes must evidence how appropriate social care law has been applied and how required legal and professional processes have been followed.

The wellbeing principle means we should actively seek improvements for people and their carers and this should be central to our involvement. The council's duty is to *promote* people's wellbeing not provide resources for everyone to be well or achieve their wishes. We do this by giving preventative messages and signposting to sources/places of potential interest or help.

The person should be at the centre and fully involved in their assessment and care planning process. Advocacy services should be used where needed. The person must be provided with a copy of the assessment, eligibility determination and a copy of the Care and Support Plan.

6. Timely and Defensible Decision making and recording

Recording must evidence robust decision-making - with an analysis of why a particular decision has been reached and why other options were not appropriate.

The level of recording is to be proportionate to the complexity of the case and must always be written in plain English to be understandable by the person and their family. Recording on ACSIS must be completed within two working days of contact with the person, including provisional care packages where these are available.

7. Value for money, effectiveness and efficiency

Where resources offered, this must be defensible and based on your professional judgement, but people should be encouraged to make their own choices about how their available resources are used. Direct Payments should be considered but must be within people's personal budget.

All other options to promote people's wellbeing, enablement and meet their needs should be explored before long term support is considered.

Similarly, eligibility for Funded Nursing Care (FNC) or Continuing Healthcare (CHC) should be checked before consideration for a permanent placement.

Within a multi-professional setting such as a hospital, the opinion of other professionals should be taken into account but adult care services practitioners have the ultimate professional responsibility for the assessment of a person's social care

needs and would be expected to challenge other professionals where their opinion differs.

8. Working with partners and providers to deliver good outcomes

Our work doesn't finish with commissioning good care. We have a responsibility to make sure providers and partners understand their role in achieving outcomes and enabling people to live independent lives.

Services, care and pathways should always be designed to prevent needs from escalating.

9. Support for our staff

Working directly with people and their families is highly skilled and complex work. It can create emotional as well as practical and intellectual challenges. Practitioners can expect clear leadership from managers, regular reflective supervision and good, varied opportunities for development to support us in our roles.

The Practice Principles provide support for staff in their practice. Staff and managers can advise, challenge and support any decision made within this framework. When complaints or representations are received – adherence to these principles is what will be tested.

ConnectedLives

Social Care Professionals' Feedback

Hertfordshire County Council
Adult Care Services
www.hertfordshire.gov.uk/adults



Yvonne Manyangadze - Social Worker, East Herts and Broxbourne Adult Disability Team

The **ConnectedLives** model draws from core social work principles of strength based and person centred practice, systems theory and promotes independence, enablement and positive risk taking. It is a move away from being policy and process driven to being outcomes and solution focussed. The streamlined assessment and review process has made my interventions more efficient and flexible as I have been able to tailor my approach with the individuals I work with; so that conversations are more meaningful rather than about ensuring all the 'boxes' have been ticked. This has led to service users feeling more empowered as what they want to achieve is at the heart of the process. I have been able to implement support packages in a timely manner as there is no requirement for the manager to sign off the assessment or review once it has been completed.

The ConnectedLives approach is like a breath of fresh air to my daily practice. Its emphasis on analysis in assessment and decision making provides professional freedom and has boosted my confidence

It came as a shock that workers would hold a small personal budget that can be used for prevention or short term enablement with no requirement of management approval. Throughout Hertfordshire County Council, there has been great examples of how this has been utilised to support service users to meet their needs and prevent the need of long term commissioning of services where it has not been necessary.

As a social worker in the Adult Disability Team, the personal budget can be used to support an individual to acquire a new skill in a time limited period. For example travel training or confidence at a new social group or voluntary opportunity which the service user can attend independently in due course. Hence, empowering them and maximising their independence. As a social worker in the 21st century, greater consideration should be given for alternatives to traditional care as the day centre provision is not suitable for everyone. Furthermore, community assets should be explored as promoted by **ConnectedLives**.

The **ConnectedLives** approach is like a breath of fresh air to my daily practice. Its emphasis on analysis in assessment and decision making provides professional freedom and has boosted my confidence. It has made me feel that my professional judgement and skills are believed in, which makes me feel valued and has led to greater job satisfaction. ConnectedLives is a great example to how innovative Hertfordshire County Council is and makes me proud to work for them.

We have embedded the learning from previous community practice and citizenship initiatives, developed both in Hertfordshire and national evidence based models and initiatives.

ConnectedLives Short Stories

A family under significant stress in negotiating numerous health appointments for their disabled adult son used a one-off direct payment for a short holiday break. This helped them re-build their resilience and remind themselves of who they are as a family when not just focusing on health needs. The cost compared favourably to respite care for just one person and bought all the added benefits to the family.

Adam Taylor – Advanced Practitioner East and North Herts Post Hospital Review Team

ConnectedLives has had a positive impact on practice in our service. In many ways it's a continuation of the good practice that was already happening but the approach really challenges us to think in terms of strengths of the person. This has encouraged more dynamic and creative thinking as we focus on the networks already available to people and tap into these before considering long term support options. This has encouraged us to develop stronger links with community groups and resources as well as with our Community Navigators who have great knowledge of local resources.

Assessments have become less of a tick box exercise and are more focussed on the person's needs, wishes and desired outcomes.

There's been a noticeable shift in the outlook of team members to be more outcome focussed. In other words, our aim is very clearly to understand and work towards the person's aims and wishes. Previously, assessment could feel process-driven and constrained by the services available, but assessments now seem to be more focussed on the individual and what's important to them.

The framework fits well with the remit of the Post Hospital Review Team – reviewing people on the enablement pathway or short stay residential placements – encouraging an enabling approach that focusses primarily on preventative and community options. The approach also works well within the Integrated Discharge

team as a whole, allowing for good quality and timely, person-centred assessments and care planning within the acute hospitals.

On a practical level, the amount of time it has taken to write assessments and complete paperwork has reduced significantly, allowing for more time with people. Assessments have become less of a tick box exercise and are more focussed on the person's needs, wishes and desired outcomes. There is a natural flow to assessments as cases are handed over from practitioners in the hospital who complete an initial assessment, to the post hospital review team for further assessment, thus reducing duplicated work, and actually improving the quality of handovers.

On the whole, I feel the approach has given more control back to individual workers and encourages trust in professional judgment. As a social worker, this makes me feel that my professional opinion is more valued.

Ian Lawrence – Team Manager, ACS

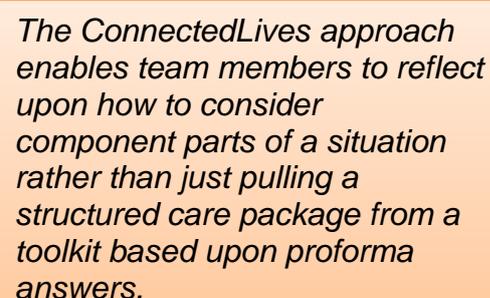
For me as a manager the move to the **ConnectedLives** model has enabled me to change the conversations I have with team members. The focus has really started to shift from a form and directed question driven approach to discussion with people and an open ended conversational approach. This enables freedom of discussion and an opportunity to truly explore individual contexts and

then the identification of solutions to personal problems can be broader and less reliant upon purchased services.

The most effective changes can often result from softer or less structured approaches without a reliance upon purchased services. The **ConnectedLives** approach enables team members to reflect upon how to consider component parts of a situation rather than just pulling a structured care package from a toolkit based upon proforma answers. There are obviously times when urgent situations will still require quick responses but this does not prevent the opportunity to return to conversations once the immediate crisis point has lifted.

Conversations with team members have become much less about budget, despite this still being a part, and more around considered decisions based upon information gathered, focussing upon the journey to be travelled in the future. This also changes thinking about commissioning and the real value of some services provided. This is starting to enable thoughts about reshaping services on a much broader level.

I feel that a fundamental change for me has been greater opportunity to generate reflective debate based upon much richer information. I hope that the written product of conversations will also be much simpler to read and be more meaningful for the person they are written about.



The ConnectedLives approach enables team members to reflect upon how to consider component parts of a situation rather than just pulling a structured care package from a toolkit based upon proforma answers.

ConnectedLives Short Stories

An older person following a stroke required support with personal care and getting dressed. The District nurse recommended a day centre due to limited mobility and communication difficulties. The social worker knew that he had enjoyed bowls before his stroke. Although he could not play anymore some of the personal budget was used to arrange support and transport to go to bowls to be in the company of old friends instead of having daily homecare visits and day care.

Catherine Greenlaw - Head Occupational Therapist

For occupational therapists, **ConnectedLives** is a validation of the practice and ethos of occupational therapy. **ConnectedLives** legitimises occupational therapy interventions in social care beyond traditional equipment and adaptations. **ConnectedLives** enables occupational therapists to truly enable individuals to live the lives they chose.

...it is not enough to enable an individual to transfer out of bed, but to ensure there is a reason to get out of bed and make that happen too.

ConnectedLives views the individual as a unique person with their own strengths, aspirations, choices and priorities. Occupational therapists view individuals as active beings, for whom participation in occupations (activities meaningful to them) is fundamental in order for the person to achieve health and well-being. A core assumption of **ConnectedLives** mirrors that of occupational therapy: that people cannot truly be well if they cannot participate fully in their lives.

Models of occupational therapy demand an appreciation of the intrinsic and extrinsic factors impacting on an individual's occupational performance and emphasise that identified goals are determined by the person. This aligns with the practice principles of **ConnectedLives**.

In practice occupational therapists in Hertfordshire have had to reset their thinking, to rediscover their skills around rehabilitating or enabling the person's own skills and abilities rather than limiting their intervention to adapting the environment around them. To

take the time to really know the people they work with, to explore and identify outcomes beyond immediate, often crisis-led, interventions. To adopt the approach that it is not enough to enable an individual to transfer out of bed, but to ensure there is a reason to get out of bed and make that happen too.

Working in this way has meant not only very positive outcomes for individuals but better, more focused use of the limited resources available for those who need ongoing support. **ConnectedLives** has given occupational therapists a platform where they are able to demonstrate how their intervention can achieve both these goals.

ConnectedLives provides the practice environment to facilitate this change in approach. As an organisation wide philosophy it allows for a shared understanding between colleagues including those in provider services and partners in other organisations. It provides a shared language for professionals with different qualifications to appreciate the intended outcome of an intervention or plan. **ConnectedLives** ensures the whole system is pulling together to achieve the very best for every individual.

ConnectedLives values professional analysis and decision making; it recognises that professional expertise is one of the strongest offers we can make to individuals, if those individuals are to achieve their ultimate outcomes. **ConnectedLives** allows professionals to fulfil what I expect to be two of their own ambitions – to work in an effective and meaningful way with individuals and to utilise their professional knowledge and skills.

It gives me real pleasure and professional satisfaction to see how the implementation of **ConnectedLives** has allowed occupational therapists to fully realise their potential in making very real and positive differences to the lives of individuals.

ConnectedLives Short Stories

A new mum with long term epilepsy came off medication to conceive and happily, for a time, experienced few seizures. After giving birth, she experienced a number of seizures and was frightened to go out of the house because of risk to her baby. A one-off direct payment was used to buy a special pram that stops whenever you let go of the handle. So now she can go out knowing even if she has a seizure the pram won't roll away.

Iain MacBeath - Director of Adult Care Services

Our vision is for Hertfordshire to be a place where citizens can live healthy, purposeful and self-supporting lives. Where people do need extra help, we want to offer this in a way that maximises their independence and respects everything that's important to them. We needed a model that enabled us to do this whilst meeting our Care Act duties and responsibilities. But we also needed to find a way to make the very best use of our resources.

ConnectedLives demands a whole system change. Our staff are committed to its principles and supporting the change and our citizens are beginning to see the benefits.

So we designed **ConnectedLives** as a model to make the most of the professional skills of our practitioners and the experience, insight and knowledge of our citizens. It asks our workers to have conversations with citizens about their strengths and what matters to them most. It moves away from traditional transactional approaches to care provision to relationship based exchanges in which highly skilled staff help people think through their options. Most people aren't aiming for good care; they're aiming for good lives so the **ConnectedLives** conversation is about just that.

ConnectedLives is an effective practice model but very importantly, it's also a system model; it shapes the way we deliver social care across Hertfordshire. So we have invited all social care and NHS providers in Herts to join us in our work towards **ConnectedLives**. This means any conversation about health and social care in Herts encompasses **ConnectedLives** principles and philosophy and we can have a single approach to achieving better outcomes for people. This is what we'd call 'a well-planned bit of support so people can get on with their lives'. It will of course take time for every colleague to get there, but we've started.

We took the decision that we'd commit to **ConnectedLives** for a minimum of three years, to give it a chance to embed. But there's a lot to be done in this time; as well as the overhaul of our recording and business framework, we've been working within the council and partners to make sure everyone engages and signs up to the principles of **ConnectedLives**. This is because it isn't just about practice; **ConnectedLives** wouldn't work without full sign-up from our colleagues; Commissioners need to follow a model of social interaction in order to make this work and to do great professional social care, we need our partners; leisure, public health, housing etc all to be on board with us.

As a Director I think it's important that every part of our department thinks in a strengths-based way that prevents dependency and enables independence yet can apply good support when people are eligible or require ongoing care. For our professional social care staff, this has meant trusting them to be the very best skilled and creative practitioners they can be. To support them in this, we've delegated authority to spend (or give in a direct payment) up to £500 without going through any complicated funding applications.

If there were any anxieties about the way these one off payments might be used, they haven't been realised. 'Value for money, effectiveness and efficiency' is one of our practice principles and to date, we can see that staff are putting this money to best effect.

We're moving into our second phase now which is to bring colleagues from our local mental health trust as well as private, voluntary and independent sector services to join us in establishing ConnectedLives across Hertfordshire. We're also trying out different approaches to auditing that will give us an understanding of the human impact of **ConnectedLives**.

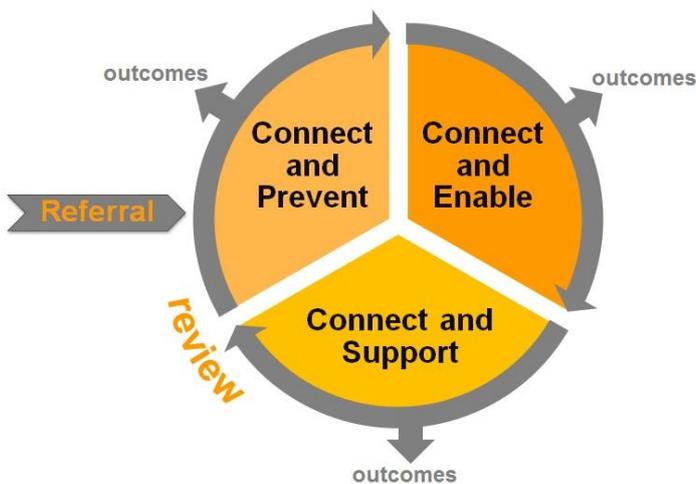
ConnectedLives demands a whole system change. Our staff are committed to its principles and supporting the change and our citizens are beginning to see the benefits.

ConnectedLives

PRACTICE GUIDE 1: Assessments

1. Back to basics

An assessment is the means by which we begin to work with people to help them think about how they can get on with their lives and maintain or take up an active part in their local community in the way that suits them. If a person needs care and support to help them with this, an assessment would start this conversation.



The Connected Lives assessment process is based on our [practice principles](#). Professional practice and accountability are core to our work so we are:

- open and personalised in our approach;
- efficient and defensible;
- clear and transparent;
- risk positive;
- reflective;
- consistent; and
- in-line with practice governance.

The process is underpinned by strengths, enablement and independence. What does the person, their family, their friends and neighbours and local community have that can help? We understand and respect that people are all the experts about their own lives and Connected Lives encourages you to allow people to express their own wishes and preferences.

We want to make assessments appropriate and proportionate – so are only as intrusive as necessary. We need to understand from the start why we're involved, but should also explore and try to understand any underlying needs.

We want our assessments to be timely – taking into account urgent needs but being aware that things can change. This means short term solutions are appropriate for crisis situations but it is usually quite inappropriate to arrange long term solutions in a crisis. We should let people and carers know what our timescales might be – and keep them informed throughout.

We want you to trust your professionalism and skills to understand the person, what needs to happen and why. Doing our assessments this way will make them person-centred, solution-driven, strengths-based and outcome-focused.

2. Before the assessment

Having a clear idea (a good referral) of what the situation is will help focus the assessment – even if during the process other issues arise.

Depending upon the complexity of the case, we can decide how, where and how long an assessment might take. We can send out the pre-assessment booklet and potentially ring the person to let them know the types of questions we may be asking. If people are prepared and know what to expect this can reduce the intrusion and save time.

Some things to think about might include:

Communication needs:

- what means of communication are suitable for the person?
- is an interpreter needed?
- is information required in different ways?
- do they need someone to speak up for them?

Capacity and level of understanding:

- is an independent advocate needed?
- should a Mental Capacity Act assessment take place?
- is there anybody with Deputyship, Power of Attorney and so on?

How to carry out the assessment:

- can it be done by phone?
- should it be face-to-face?
- if so, where would be best for the person?
- who should be involved?
- is a specialist assessment required – carer, sensory, mobility?

3. Facts, analysis and judgement and outcomes

During the assessment we gather the facts (information or evidence), work out what those facts are telling us (analysis) and this leads us to what we think (our judgement). A good conversation should enable people to articulate what they want to achieve (their outcomes) and what should happen because of all that (any care or support planning that might be needed).

Facts

This conversation is about the person and their carer to find out about them and their current situation. Do ask about what life was like before and what life could be like next.

Analysis

Analysis is the art of fully understanding something in order to explain it. This is where the assessment comes to life: this is you making sense of the situation and

using your skills and experience to understand what's happening and to start to think what we can do about it. What are all the facts telling you?

Judgement

Having analysed the facts, you begin to form your professional judgement. This is the situation: these are the strengths, these are the needs, this is what we need to do. We're now beginning to move towards what outcomes we need to be achieving.

Outcomes

This is what the person wants to achieve eg. 'P wants to get back to work', 'P wants to help out with his grandchildren', 'P wants to be able to get herself to the loo'

4. The conversation

Talking with people, spending time with them, getting to know them means you can together, better understand them, their strengths, their needs and how to meet them.

The conversation can help individuals explain a problem themselves and decide how big a problem it is. This will also help us to appear less intrusive, as we can also avoid areas that service users don't see as a problem (unless, of course, professionally we disagree and need to explore it).

You as the assessor are the expert on change. The person or carer is the expert on what to change and how best to change it. Our role is to focus on what's possible and changeable.

During the conversation, you use your observation, questioning and listening skills to find out the relevant information to best understand a person's current situation.

Your skills, diplomacy, warmth and empathy will help you to find out what you need to know. Your experience and knowledge will suggest things to consider as part of any assessment.

Assessments are likely to think about the person in terms of:

- do they need support doing the assessment (communication or sensory needs?)
- their situation as they (and you) see it
- what's important to them
- their skills, ambitions and priorities
- who and what is available to provide care and support
- what others have to say
- physical health
- mental health
- medicines and treatments
- where they live and getting around inside and out
- managing money
- making decisions and associated risks
- staying safe from harm
- managing behaviour and any risks to others



- looking after themselves
- getting enough to eat and drink
- keeping themselves clean and comfortable
- what can prevent increased dependency and enable increased independence
- eligibility and consent

5. Professional analysis

This is where you can make sense of the situation and understand what has happened/is happening and what are the implications. Your professional knowledge and understanding as well as all that you have come to know about the person will inform your view and analysis. Here, you think creatively about what might be helpful.

The person has strongly influenced the content in “the current situation and where I want to be” section; this is where you have your say. With your professional judgement comes accountability – everything must be underpinned by the practice principles and your professional ethics.

6. Agreeing outcomes

This is the impact or result for the person or the difference it will make for the person. It's *not* the service we use to help them. A desired outcome is the way the person wants things to turn out; the impact on their quality of life. Outcomes must be specific and personal rather than vague and generic.

A desired outcome might be

Mrs P would like to get back home and for life to be as much as it was before her fall as possible

7. Care and Support Planning

We then need to work out how best to achieve these outcomes – and where support is needed, who will provide this. Sometimes this can be straightforward; sometimes we need to be more creative.

An example of a care and support plan to meet Mrs P's desired outcome might be

Mrs P's son will call in or phone her once a day to check how Mrs P is feeling and managing

Homecare 1x daily for next two weeks to help with while Mrs P regains her strength and gets used to being back at home

8. The three stages of the Connected Lives Assessment

There are three stages to our assessment framework:

- Connect and Prevent

- Connect and Enable
- Connect and Support

The focus is enablement, independence and the use of community opportunities. Wherever possible we want to prevent or reduce the need to provide more long-term services.

9. Connect and Prevent

This is the first contact following a referral or review where the person's needs have changed. This isn't a tick box exercise or an assessment for formal care services. It's a person-centred, solution-focused conversation to find out what the person wants to achieve (the outcomes). We will explore a person's strengths and those of their family, friends and neighbours and the local community to see what they can all offer to enable people to achieve outcomes and prevent deterioration.

This might mean offering information and advice, or signposting a person elsewhere. There are plenty of resources to tap into eg:

- HertsHelp
- Hertfordshire Directory
- local libraries
- the person's, your and your team's local knowledge
- our website and factsheets
- there's always Google!

Once you have agreed what to do – you can record your conversation and plan on ACSIS. You can approve your own assessment (there's no manager authorisation required). You should set a check-back date within four weeks, to see how things are working out but you can stay in touch as much as you need to during this time.

If, following the check-back, the outcomes have been achieved, the case can be closed. Sometimes if the outcomes have not been met this may be ok. If the person has managed or found alternate ways to remain in control you can still close the case. If not, or the needs change before final check-back, you could extend your *Prevent* period and explore further *Prevent* options. There are no resources committed at this stage of the assessment. If you need to look at more focused support that may require care or professional intervention, you should move on to *Connect and Enable* stage.

9. Connect and Enable

The information recorded at the Connect and Prevent stage is now pulled through to this stage (so no need for repetition). Connect and Enable is also geared towards helping people meet their outcomes but recognises they may need time-limited professional input (social work or occupational therapy), minor resources, one-off payments or purchases to do so. This stage is aimed at reducing or removing the need for more permanent or costly care.

Enabling people may mean people gain confidence to learn and/or regain some of the skills and independence they may have lost because of poor health, disability or after a spell in hospital. It may be we can support people to develop new skills that they have never had the opportunity to do so before; due to their care environment or perceptions about their disability. This may be particularly relevant to people with learning disabilities who might not have had such opportunity before.

Independence will be different for everyone – it isn't just independence from care and support, but could be independence to access services that give people better lives. Traditional enablement outcomes such as the ability to use the home safely and get out and about are important, but the quality of life outcomes that make life worth living are just as important – having a purpose to be able to use these skills and independence.

In order to achieve these outcomes we might look at:

- up to four weeks' professional support, for example a number of visits by an occupational therapist to enable confidence in completing tasks required in and around the home
- commissioned services to enable agreed outcomes to be achieved over set time period
- a one off direct payment
- equipment or
- crisis response



Provided the one-off or short-term cost is under £500, you can approve your own assessment. There's no eligibility test at this stage although as part of your assessment you will be considering how you are enabling someone to not need to further eligible services or minimising the amount that may be needed. You can set a final check-back date dependent on the involvement, to see if everything has gone well; but you should stay in touch as much as you need to during this time.

If, following the final check-back, the outcomes have been achieved, the case can be closed. Sometimes if the outcomes have not been met this may be ok. If the person has managed or found alternate ways to remain in control you can still close the case. If not, or the needs change before final check-back, you could explore further enable options. If this is not possible, you should move on to *Connect and Support* stage.

You can find further guidance in our *Connect and Enable Guide*.

10. Connect and support

Although our emphasis is to set and achieve outcomes in *Connect and Prevent* or *Connect and Enable*, some people will need more long-term or intensive support. They will meet the eligibility criteria and require a personal budget. The information recorded at the *Connect and Prevent* and *Connect and Enable* stages are pulled through to this stage (so no need for repetition).

Care Act eligibility must be established:

- if the person has a condition as a result of either physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury
- as a result of the person's needs, they are unable to achieve two or more of the outcomes set out in the regulations without assistance
- as a consequence there is, or there is likely to be, a significant impact on their wellbeing
- you will need to evidence this in your recording, drawing on all of the information that has been shared up to this point

Agreeing the plan

You can add further relevant information if more depth is needed for good support planning and for understanding the outcomes to be achieved. Once you and the person involved feel you have all the information needed to clarify the outcomes you are aiming to meet then you can start to pull together the support plan.

Outcomes

Outcomes are key. What does the person want to achieve and how will the support plan help them to do this? The focus must be on supporting the person to achieve their outcomes rather than just directing care. We know the wrong care for people can be just as disabling as no care at all.

Needs can still be met by the person's own strengths, community resources, their family, information and advice.

The focus of any support provided is likely to enable people to achieve the relevant Care Act wellbeing principles.

Charging

At this stage you'll inform individuals that a financial assessment will determine whether or not they pay towards their care and support, but this must have no bearing on the assessment process itself.

Continuing Healthcare

You may also need to consider if the person is eligible for Continuing Healthcare. The NHS Decision Support Tool (DST) supports practitioners in the application of the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. As such you should capture the required information at this point in the assessment process to enable relevant CHC processes. There is further guidance in our Connected Lives CHC guide.

PRACTICE GUIDE 2: Recording Standards

Our recording standards:

We will keep clear, up-to-date and secure written and electronic records for each service user and carer.

Each record will:

- be written with the person or their family in mind
- contribute to an understanding of their life and our involvement in it
- be written in plain English
- meet our legal requirements.

Introduction

At the heart of our service is our face-to-face work with people. Through this we help people be safe, take care of their welfare and meet their needs. We do this so they can enjoy their life as best they can.

We do this by:

- listening to what they have to say
- recognising people as individuals
- promoting their identity and self-esteem
- supporting, where possible, their family and other relationships
- supporting their education or work
- providing opportunities to develop their skills and talents
- training and managing our staff well

However, we also need to record what happens, what we did, why we did it and what we're planning for each person. It's clear that recording has become more time-consuming. We want to change that. Our approach will lead us to recording less but making it more effective, more relevant and more meaningful.

Part 1: Before we record

Standard 1

We will understand clearly the reason why we are recording

We will understand why we are recording each piece of information. We will see the value in recording; if we do, we are more likely to do it well.

We record to:

- provide basic and essential information;
- provide the person's relevant history and our involvement in their life;
- explain decisions that are made and the person's views about these;
- help communication between all those involved with the person;
- promote consistency throughout our involvement in a person's life even if workers change; take responsibility for our work; provide evidence for our workers to reflect on their practice and its success;
- help collect information;
- promote analysis and decision making;
- provide evidence for court, inspections, investigations and enquiries; and
- check the quality of our work.

Part 2: Recording

Standard 2

All our recording will be written with the person, carer or family's needs and understanding in mind.

All our records will be in plain English – using words that the person or family will understand. We will listen to and include the voice of the person. We will encourage them where possible and as often as possible, to contribute to their records, to read them and, where appropriate, sign them.

Writing in plain English will also help make it easier to translate into other languages if needed.

Standard 3

We will always aim to be clear and precise

We should always look to be precise and specific. ***Be precise:*** a person's home is not a "residential care establishment" - it's a "home". ***Be specific.*** It's not "the home environment" - it's "home". Remember the more precise you are, the clearer you will be.

Standard 4

We will always aim to be concise

It's important that we say what we have to say in a thoughtful, relevant, sensitive and meaningful way. However, this should take as few words as possible – although not to appear as blunt or rude. Sometimes we need to explain things more fully – and that's fine.

Equally, we should aim to avoid duplication. Saying the same thing more than once is a waste of time.

Standard 5

We will always aim to use everyday words

To be crystal clear we need to use everyday words: the words we would use when we speak. This means, for example, preferring “find out” to “ascertain”; and “talk” or “meet” to “liaise”.

Standard 6

We will always aim to use short sentences

Long sentences make things difficult for the reader. Our sentences should only hold small amounts of information and we'll aim to average between 15-20 words a sentence. This doesn't mean we can't have a 30-word sentence (provided it is easy to read) but by *averaging* 15-20 words a sentence our writing will become more readable.

Standard 7

We will always aim to avoid jargon

Jargon can be useful shorthand for those who understand that shorthand. However, jargon, by definition, is *exclusive*. For us, however, our work is all about being *inclusive*. We understand the desire to be seen as “professional”. However, we believe that plain English is the professional language of our workers.

Standard 8

We will always aim to make clear what is “fact” and what is “judgement”

Often records and reports fall down because it's difficult to sort out what is *fact* and what is professional *judgement* (or opinion). We want to be very clear what are the facts and what are our judgements. However, judgements should also be backed up. Say why you think what you think. The reader then can judge the quality of your judgement.

Standard 9

We will always aim to be more analytical

The more analytical our thinking, the more effective our recording. It's that simple. By analysing information, we are actively deciding what is relevant and what is not. We are questioning the information, weighing it up and making sense of it all. Essentially, this is all about working out what the facts are telling us. And why.

Try using the "what, why, so what?" approach. What happened? Why did it happen? What are the implications?

Standard 10

We will always aim to keep our recording up to date

We recognise that time pressures and circumstances often mean that recording gets delayed. However, being more analytical will mean we will be more concise. This should help us to record in a more-timely way.

We do expect, wherever possible, you to record relevant and meaningful information while it is still fresh in your mind. Preferably, this should be the same day but always aim to do so within three days.

Standard 11

We will always aim to be respectful in what we write, how we write it and how we present it

We have seen that sometimes hurtful and unfair statements are recorded; or negative opinions are not substantiated; or sometimes what we consider to be facts are simply wrong. We don't want to shy from having to say difficult things but what we do say will be sensitive, reasonable, fair and as positive as possible.

We will always, where possible, talk through what we need to record with the person – so should they ever read their file there should be no surprises. Where possible, we will check the accuracy of our recording with the person. We think it's a good idea that we should always imagine that the person you are writing about is sitting next to you while you are writing.

Standard 12

We will always aim to be human in our writing

If we are to connect with people in a meaningful way we need to be seen as approachable. So, be polite and conversational in your tone. Call and record people's names in the way they prefer. Use contractions (I'm, we've, they've), pronouns (I, me, you, us) and say "please" and "thank you".

That said, where formality is clearly required then our written work will also be formal. But still respectful.

Part 3: Monitoring

Standard 13

We will regularly monitor and review the success of our writing and recording standards. This will include making sure we are reducing the time we spend on paperwork.

The recording standards should ensure a consistent approach.

We will monitor this through practice audit. We will ask managers to seek feedback from their staff (through supervision and team meetings) about the practical outcomes of our approach. We also want you to let us know what is working well and what isn't; and to suggest ideas for improvement.

MINI-GUIDE: PROFESSIONAL ANALYSIS

Our standards:

Analysis is the art of fully understanding something in order to explain it. Workers are often unsure about analysis. But all you are doing in an assessment is simply working out what the evidence is telling you.

This is where our assessment comes to life: this is you making sense of the situation, understanding what's happening and why; and beginning to think what we can do about it.

This is the whole point of “assessing”. When we assess information we are analysing it. It's what we do. By freeing you up to practice, we are freeing you up to think. That's analysis.

Professional analysis:

We use our conversation with people to find out what their life is like at the moment and where they would prefer to be. It is then your job to understand this and make some sense of it and think creatively: you analyse the situation.

You'll need to decide what is the relevant evidence to use in the assessment. Remember we need to be proportionate. Don't record information just because you have found it out. It needs to be telling us something that leads us, ultimately, to agreeing well-formed outcomes. The information we record has to be relevant. And, if it is relevant, you need to make it meaningful. Analysis makes information meaningful. It turns information into knowledge.

So, ask yourself: what happened, why did it happen and what are the implications? In this way you are addressing the present by looking to the past (why it happened, what was the cause) and the future (what might happen as a result).

So...

- get a good idea of what life is like at the moment for the person (what does a typical week look like, is there a typical week?) – gather the facts, gather the evidence;
- try to understand what it must be like for that person, knowing them as you do, to be living in their home (wherever “home” is);
- remember: your analysis will only be as good as your facts or evidence;

- do the facts confirm the original reason for assessment – and have any other issues been brought to light?;
- what impact on the person do the facts suggest – and make it clear why you think that;
- what does the person want to achieve – do you agree or are there other issues we need to think carefully about?;
- what are the risks if things do not change or we do not do something about it?;
- what are the risks if things do change and we do do something about it?;
- is there any knowledge, experience or research you can draw on that backs up your thinking?;
- all of this thinking will lead you to where the person needs to be – what could their future look like (this is their desired outcomes)

Remember:

You are being given the freedom to practice: so, this is your opportunity to tell us, professionally, what you think. Whereas the service user has strongly influenced the content in “the current situation and where I want to be” section; the “professional analysis” section is where you have your say. These sections are then combined to lead to us our shared outcomes.

From our point of view, the three sections are, in essence, “this is you” (the situation, the facts), “this is me” (the analysis), and “this is us” (the agreed outcomes).

ConnectedLives

MINI-GUIDE: Outcomes

An outcome is the impact. When we talk about outcomes, we mean the impact on or the difference it will make to the person we're supporting.

If a person feels they need care and support, a conversation about outcomes helps us to understand what it is they'd like to achieve by having that support. Or, a conversation about what outcomes a person is hoping to achieve might lead to a discussion about how some care and support might help them with this. We want to understand what impact or outcomes the person is hoping for and then we can help them think through how they might achieve these.

Outcomes are not services; homecare or direct payments aren't outcomes. They might be the support someone needs in order to achieve their outcomes.

For example,

Outcomes wanted to achieve;

Mrs K would like to get back home and for life to be as much as it was before her fall as possible

These outcomes will be achieved by;

Mrs K's son will call in or phone her once a day to check how Mrs K is feeling and managing

Homecare 1x daily for next two weeks to help with while Mrs K regains her strength and gets used to being back at home

Connected lives – agreeing outcomes

This is ultimately where our assessments are heading. It's in essence, the whole point of assessment: what does the person want or need to achieve?

Just as the information we record should be appropriate and proportionate – or as we prefer to say, relevant and meaningful – so should the outcomes we set. We recognise The Care Act is unhelpful (there, we said it) with its generic headings (maintaining independence) and its confusing language: an outcome, for example, can be a “goal” but can also be a “result”. For the people we work with, we want to think in terms of “desired” outcomes – things they want to achieve. Our outcome, of course, is to make those outcomes happen (our results).

We then need to work out how best to achieve these outcomes – and who will do it. Sometimes this can be straightforward; sometimes we need to be more creative. This means desired outcomes must be specific and personal (“Mrs P always likes to

feel fresh and look lovely but particular when her daughter visits' rather than vague and generic ("maintaining personal hygiene").

This means not thinking in terms of "need" or "services". But thinking in terms of "outcomes" – so a person might say they want to:

- live in my own home
- feel safe and secure
- be listened to and understood
- have enough money to get by on
- know that help is available should I need it
- be able to get out more
- be treated well
- feel useful – not a burden
- feel on top of things.

And then, if we agree, how can we achieve these things through our care and support planning.

So...

- what is the difference we want to make?
- how can we make it happen?
- who's going to help?
- how will we know if we're making a difference?

ConnectedLives

Mini Guide: Aide Memoire for Continuing Healthcare (CHC)

This information helps the Multidisciplinary Team (MDT) complete the Decision Support Tool (DST) and aids the weighting of the 12 domains. A CHC assessment is for NHS funded care and has different eligibility criteria to a social care assessment.

It's a **social care report** and **not** a repeat of the other health reports used in the CHC process. It needs to give an overall picture of the individual. Looking at their social situation and also the impact a condition/situation has on their day to day needs:

- What input and support is needed to meet their needs on a daily basis.
- What does it entail (**Nature**)
- Is there a **complexity** to their needs
- Are their needs **intense**
- Is there an **unpredictability** to their needs.

The assessment should **not state** a recommendation on eligibility for CHC as this is done within the DST process.

Suggested headings within the free text of the connected lives assessment are:

- **People involved in the assessment** – family and carers etc
- **Background information** - to include social history
- **Current situation**
- **The person's view** - if the person is no longer able to give their view consider different methods of communication. If other methods are used, what are they and how long does effective communication take?
- **Carers view** - consider carer's interventions and the impact on them.
- **Physical health** - areas to consider include: what is the impact of any relevant condition on day to day needs, time spent and what the support is

required. Include management and monitoring of nutritional needs, skin, medication and continence and any specialist input such as dietician, speech and language therapist or specialist nurse etc.

- **Mental health/cognition** - areas to consider: is there a MCA, Best Interest Decision in place where appropriate? Any worrying or seemingly aggressive communication or behaviour and what support is needed? Behaviour management plans? Risk assessments? Complexity? Management and monitoring of medication?
- **Psychological and emotional needs** - areas to consider: Does the person show signs of distress and how is this managed? Do they respond to reassurance easily and what is the timescale of this level of input? Is there medication for depression? Has there been any previous involvement from other professionals such as the mental health team?
- **Sensory needs and communication** - consideration to those who are d/Deaf and use sign language or have other sensory needs such as deaf blind or are visually impaired. Also communication needs for those with speech/communication issues following a stroke, dementia and other long term conditions. What actions are being taken to address these? Can the person make their needs known, and if not, in what ways do those supporting them ensure that they understand what is needed?
- **Mobility/accommodation** - Including adaptations and equipment. Is the person at risk of falls? What is the frequency of any falls? Can they change position independently or what support is needed? Do they have contractures? Is there a falls risk assessment or any moving and handling risk assessments in place?
- **Palliative/end of life** - Is there an advanced care plan in place? Advanced Decisions such as DNAR. Do their needs show sudden deterioration?
- **Lasting power of attorney (LPA)** - Is there an LPA in place for Health and Welfare? Property and Affairs? Or both? Remember, if only in place for Property and Affairs an MCA/BI will be required. Be clear on the decision maker and who is making the best interest decision.
- **Current Support Network** - What are the roles of these networks? What time is required to provide this support and what would the impact be if this support was not available? Care home daily reports, home care reports will need to be analysed to get this detail if paid carers are in place.

See how **ConnectedLives** works in practice for our service users:

Brief overview of Connect and Protect

<https://www.youtube.com/watch?v=fYNab9NsusQ>

Brief overview of Connect and Enable

<https://www.youtube.com/watch?v=iZfQVezV4ww>

Ashara's Story

<https://www.youtube.com/watch?v=U1UJ79MfHs4>

Magda's Story

https://www.youtube.com/watch?v=_Z77wHhuPEE

Arthur's Story

https://www.youtube.com/watch?v=5fsOPK_pVOM

Ivan's Story

https://youtu.be/dh9eeNF_5jM

Sara's Story

<https://youtu.be/Aybc37PpWZo>