With For YOU

Our Shetland - Working Together

With You For You (WYFY) Guidance for practitioners 2016

Contents.

Acknowledgements

It is important to acknowledge the hard work, commitment and support that has gone into this piece of work and to those originally involved in the establishment of the 'With You For You' (WYFY) process, from which this work is built.

Thanks to those staff that gave their time to offer feedback for the review and who helped in redesigning the tools. To Emma Miller (Co-Author of 'Talking Points') from Strathclyde University and to Julie Gardner and Ross Grieve from the Personal Outcomes Partnership and Thistle Foundation whose work has heavily influenced the growth in our 'Outcomes' approach. Finally thanks to the commitment of the staff involved in rolling out the approach through training and sharing the approach with their teams.

Background

The 'With You For You' process has recently been reviewed in 2014 and this practitioner guidance has been written as part of the actions to help address some of the identified concerns and to ensure we continue to meet positive 'outcomes' for individuals. The aim of the guidance is to build on the establishment of WYFY what is working well and fill in identified gaps in knowledge and process.

The following guidance aims to help clarify the WYFY process, roles and responsibilities of those involved and support staff when conducting Community Care/Single Shared Assessment (SSA), locally known as the 'Understanding You' (UY). The modifications that have been made to the WYFY Process and UY have been done so with consideration of the feedback received from staff throughout the WYFY Review and the independent quality assurance exercise. Also, the legislation around SSA and Self-directed Support (SDS), the Integration agenda (through the National Health and Wellbeing Outcomes) and developments in 'Personal Outcomes Approach' have influenced the revised WYFY Process and tools.

What is 'With You For You'?

WYFY is the route to appropriate support for all care groups 18+, as well as unpaid carers who need more than one service due to, for example serious illness, physical disability, learning disability, mental health problems or frailty because of old age. WYFY involves an integrated approach, including 3rd Sector, NHS and Local Authority, to ensure the best possible outcomes for individuals who are in need of community care support/resources.

The Personal Outcomes Approach

There is widespread recognition that we need to shift focus from service led provision and what we 'do to' people and consider what difference we make to the people using services and support. A 'Personal Outcomes' approach helps us to do this. This means working collaboratively with the person to identify what is important to them or what they would like to achieve and then working backwards to identify how to get there.

Many staff recognise this approach requires a shift away from 'ticking boxes' to engaging in 'good conversations' and positive relationships with people in order to encourage a person to identify what is important to them in life rather than identifying what deficits the person has which can be a very negative experience for someone.

The person centred philosophy behind this approach emphasises understanding the individual in the context of their whole life: understanding their strengths, capacity and resilience; what matters to them and builds upon natural support systems, such as family and the local community. The values and principles of WYFY are identifiably embedded in a large proportion of staff values and practice within Shetland.

The purpose of the process is to understand the individuals' situation through an 'Outcome Focused' assessment – the 'Understanding You' (UY); to identify what the individual's personal outcomes are, what strengths, resources and assets they possess or have access to, which will help them achieve their outcomes and then identify what areas they need further support to meet these outcomes. The purpose is also to determine what needs are eligible for local authority support and find solutions to meet these needs. This understanding is used to inform key decision making processes, namely support/care planning, care management and review. Capturing meaningful information about 'Personal Outcomes' also helps to inform the commissioning and development of local services.

The general principles of WYFY also identified in the Social Care (Self-directed Support) (Scotland) Act 2013 are as follows:

- Collaboration
- Involvement
- Informed choice

The WYFY process aims to be a collaborative one, involving the individual at each stage of the process. It is critical that individuals are engaged and informed in order to ensure outcomes around independence and wellbeing are promoted.

WYFY is the joint assessment of those who require support/care through Self-directed Support (SDS) and therefore it is vital that it is understood within the context of the Social Care (Self-directed Support) (Scotland) Act 2013 and the local SDS support policy.

Roles and Responsibilities

The WYFY process acknowledges the 'Integration' agenda in its aim to enable seamless integrated support for individuals. It also recognises, from the challenges identified within the review, the importance of clarifying the WYFY roles and responsibilities within the integrated multi-disciplinary teams.

Who's involved and what is their role?

3rd Sector: The 3rd sector offer tier 1 level support and preventative work that meets their own service access criteria or provide commissioned services through a Service Level Agreement with SIC to meet eligible need according to the statutory eligibility criteria. The WYFY process requires that when 3rd sector providers identify an individual's eligible needs that cannot be met through their own provision alone, that they make a referral through WYFY; with consent of the individual. During the process of referral 3rd sector services will provide appropriate and proportionate information to SIC staff completing 'Understanding You', in order to ensure individuals outcomes and needs are fully understood.

NHS: The NHS provides services to meet medical/clinical need that are condition dependent, through primary and secondary care. The WYFY process requires that when NHS staff identifies individuals with eligible needs that cannot be met by NHS that they refer into WYFY process; with consent of the individual. During the process of referral NHS staff will provide appropriate and proportionate information to SIC staff completing UY, in order to ensure individuals' outcomes and needs are fully understood within the context of their medical need. In some circumstances, it will be appropriate for NHS staff to conduct an 'Understanding You' assessment and take on the roll of Care Co-ordinator.

Local Authority/SIC: The Local Authority has a statutory duty to assess any adult who they believe may need community care or support. Assessments will be conducted using an 'Outcomes Focused' approach and recorded on an 'Understanding You' by Social Workers and Senior Social Care Workers. In some circumstances it will be appropriate for Occupational Therapists and Housing Officers to conduct an 'Understanding You' assessment and take on the roll of Care Co-ordinator. Assessors are responsible for gathering information from relevant agencies involved in the individual's lives to ensure they have a comprehensive understanding of what the individual's outcomes and needs are.

Care Co-ordination or Care Management?

The WYFY process requires the support and input of a Care Co-ordinator or Care Manager. The Scottish Government's Guidance on Care Management in Community Care, August 2004 clearly defines these roles as separate and different. In the original guidance for WYFY, it was suggested that Care Co-ordinator replaced Care Manager and this created some confusion.

The Scottish Government states that Care Management includes assessing individuals' needs and tailoring services to meet those needs. It focuses on supporting individuals with complex needs that are frequently or rapidly changing and that this role would be fulfilled by social workers, community nurses, occupational therapists or other similar professionals, with appropriate training, skills and experience. Care managers

will be found amongst these groups of professionals and will be the lead assessors for comprehensive assessments.

In particular the guidance distinguishes the difference between care management and care co-ordination, stating that care co-ordination is for individuals with more straightforward and/or stable needs who do not require complex arrangements. Care co-ordinators will be responsible for planning and co-ordinating care of these individuals and ensure that any changing needs or problems with services are identified and dealt with, averting any crisis or breakdown in care.

It is important to recognise that needs and care arrangements change and flexibility between these processes is necessary. Some people with complex needs will have stable care arrangements and, while these last, care coordination may be appropriate. Other people may have less complex needs but still require the focused approach of care management (for example to find innovative solutions or overcome problems in delivering appropriate care) to ensure that their ongoing needs are met. Whether care management or care co-ordination is more appropriate in individual cases should be a matter for professional judgement.

If a professional has concerns about the level of care management/co-ordination that is required, they should discuss this with their line manager or duty social work team.

Simple/comprehensive assessments

The Understanding You tool is designed to capture both simple/straightforward assessments for the use of care co-ordinators and comprehensive assessments used by care managers but also an initial assessment for re-ablement purposes. It is important to record what type of assessment is being completed (this is recorded in the 'Reason for referral/contact' box). The level of detail and the sharing of information will be determined by the needs of the person and recording appropriate and proportionate information will differ depending on whether it is a simple/straightforward or comprehensive assessment (see section on appropriate and proportionate information).

Appropriate and Proportionate Information

The Social Care Institute for Excellence (SCIE) has produced excellent guidance on 'Ensuring assessment is appropriate and proportionate' (2014), the following information is a summary of that guidance.

Local authorities must ensure any adult with care and support needs, and any carer, receives an appropriate and proportionate assessment to identify the extent of their need in relation to their outcomes. This applies to all assessments whether simple or comprehensive. We have a duty to take into account the preferences, abilities and situation of the individual being assessed and establish the extent to which they wish to be involved.

A proportionate assessment will be as extensive as required to establish the extent of the person's outcomes and needs in relation to their circumstances. Outcomes and needs will differ in their breadth and depth; additional exploration may be required or some may only have needs within some aspects of their lives.

Proportionality means that an assessment is only as intrusive as it needs to be to establish an accurate understanding of the outcomes and needs of the individual or carer. The person centred approach is crucial in achieving proportionality. It is important to support people to initially describe their situation, offer appropriate acknowledgement and exploration of their strengths and resilience while taking into account the person's wishes, preferences and desired outcomes. This process reveals underlying needs.

The following key elements are essential in ensuring an appropriate and proportionate assessment takes place:

- The individual is listened to with the overall purpose of establishing their outcomes and then needs and no more,
- Appropriate pace and time are given to the WYFY process,
- Recognition is given to the individuals strengths and weaknesses and the assets that exist in their immediate network and wider community,
- Clear and plain language is used in the assessment,
    - Avoiding the use of jargon/'professional' language,
    - Listening and reflecting the discussion in plain language rather than putting words into someone's mouth,
    - Talking to the individual involved in the assessment in the first rather than third person,
- Reflective, accurate and appropriate recording – i.e. who said what, using descriptive rather than interpretive language.

Sharing Information

The Shetland Island Council has a WYFY Information Sharing Agreement with WYFY partners: NHS Shetland, Police Scotland, Hjaltland Housing Association and Voluntary Action Shetland. It is crucial to remember that individuals will only be subject to the WYFY process where they have given their explicit consent. This consent must cover how their relevant and appropriate personal information will be handled during the WYFY process and whether or not they have agreed to their personal information being shared among relevant agencies.

In principle it is of benefit to share information as widely as appropriate during the WYFY process to get a full understanding of the individuals needs, however there are circumstances under which this is not always the case. It is very important to be aware of the level of consent the individual has given, and also to consider the appropriateness of sharing with all involved. This should only ever happen for the purposes of meeting the individual's outcomes and needs.

It is important to ensure a person is capable of engaging in the assessment process and has capacity to consent **before** information is shared. If the individual lacks capacity, information must only be shared where the local authority is satisfied that doing so is in their best interests. If you are concerned about an individual's capacity to consent to share information speak to your line manager or phone duty social work.

Following the assessment a copy of the Understanding You must be given to the individual and anybody else that they request the local authority to share a copy with.

Assessors should ensure that the 'Understanding You' is an accurate and clear record of the assessment that reflects everybody's views and states how eligibility was determined.

Ability to engage and Capacity

Where an individual may have substantial difficulty in independently engaging in the WYFY process, we must involve someone who can help as early as possible. This can be a family member or friend, or if neither is available we must engage with an independent advocate.

The Adults with Incapacity (Scotland) Act 2000 generally presumes that adults are capable of making personal decisions for themselves and of managing their own affairs. It is important to remember that having a diagnosis of, for example, dementia does not mean, of itself, that the person is unable to make decisions for him/herself. It is also important to remember that just because someone acts unwisely - whether or not mental disorder is present - does not mean that capacity is lacking.

For the purposes of the Act, "incapable" means incapable of:

- acting on decisions; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or
- retaining the memory of decisions

in relation to any particular matter due to mental disorder or inability to communicate because of physical disability.

When offering an assessment and considering providing community care services to meet the outcomes/needs of individuals who lack the capacity to consent the following must be considered:

- It should be clear in an individual's Understanding You if the individual has the capacity to consent to the services identified in the plan or not
- If the individual lacks the capacity to sign their Understanding You, this must be noted in the consent details box. However, if the person has a proxy who has authority to make decisions on his/her behalf, for example a Welfare Guardian or Welfare Power of Attorney then the proxy can sign on her behalf. If there is any doubt about their authority to do so then this should be checked with Duty Social Work.
- Every effort must be made to maximise the capacity of the adult to make their own decisions through providing the necessary information and the support they may need to understand and act on such information
- Any significant decision in relation to an adult who may lack the capacity to consent must be discussed with Duty Social Work. This is particularly important:
    - If the decision could be considered a deprivation of the person's liberty, i.e. moving someone into a residential care setting
    - If the adult is resisting the care arrangement being proposed or the care arrangements already in place
    - If the person is at risk by refusing or resisting the care arrangement.

Where there are concerns over an individual's ability to engage in the WYFY process, advice must be initially sought from line management and/or with the duty social work team.

The WYFY process aims to ensure information about the assessment is available and accessible. A communication toolkit has been produced to assist those individuals who may need support to engage in the process as fully as possible.

Adult Support & Protection

Anyone undertaking an UY assessment should make themselves familiar with the Shetland Inter-Agency Adult Protection Procedures and the Adult Support and Protection (Scotland) Act 2007 and ideally complete the Level 2 Adult Protection training.

If you have concerns about an individual's risk of serious harm it is important to discuss this with line management or duty social work. It is useful to be aware of the 'three point test' for adults at risk of harm, however it is not the role of someone undertaking an UY assessment to make a decision about whether the person meets the test, this duty lies with Adult Social Work. If any concerns about the safety of an adult become apparent during an assessment and 'getting to know you' process then advice should be sought from line manager or the duty social worker.

Further guidance is available in the Shetland Inter-agency Adult Protection Procedures which can be found at http://www.safershetland.com/adult-protection.

The use of Screening

The introduction of screening was identified as an important revision to the previous WYFY process. Ensuring an assessment is conducted by the most appropriate person is vital to make certain the individuals' experience of the process is a positive one and that the appropriate assessor is identified and acceptable level of assessment is completed (see above definitions of simple and complex assessments).

Screening has been introduced in Lerwick and central area via the Duty Social Work Team. If an individual's outcomes requires a plan that involves more than one service provider, if the case is complex (see above for definition of complex), if the person has multiple changing needs and agencies involved, then a referral to the duty social work team for screening is necessary.

Screening within Multi-Disciplinary Teams (MDT) is required in localities. To prevent further delays and unnecessary steps in the process, screening by the MDT in localities is strongly advised. The process for screening in localities needs to be decided by each team. However, the responsibility lies with the Team Leaders.

The responsibility of recording 'consent' to information sharing lies with the person screening. This must be recorded on SWIFT and the 'Understanding You' for new referrals and for those already known.

Where it is unclear who the appropriate assessor is then advice must be sought from the line manager or the duty social work team.

Once a decision regarding the outcome of screening is made, the individual must be notified of the outcome either face to face, by telephone or in writing.

Determining eligibility for support

One of the purposes for the 'Understanding You' is to identify what the person may need in order that they achieve their outcomes and determine whether the local authority has an obligation to meet those needs. The WYFY process determines the person's *eligibility* for support and where someone may not be eligible for local authority support it is important to explore alternative sources of support out with formal or funded services (see section on asset based approach).

In order to qualify as eligible the person must be in need of support due to infirmity, old age, illness, mental disorder or disability, or due to substantial caring role. To be eligible for support, the individual's needs will have a critical or substantial impact on their quality of life and wellbeing.

Locally we have adopted the National Standard Eligibility Criteria and Waiting Times for the Personal and Nursing Care Of Older People to determine the level of need.

When determining a person's eligibility there is a number of things that must be taken into account:

- Recognition of different types of risks to a person's wellbeing and quality of life, including their physical and mental wellbeing, participation in community life, personal and domestic care, their home environment and role as a carer.
- The current severity and urgency of risk to wellbeing and quality of life, i.e. the risk is critical/immediate, substantial/imminent, moderate/foreseeable or low/longer term.
- How a person's needs and risks might change over time, i.e. is the need likely to escalate, remain stable or improve with enablement.
- The impact of not providing support and whether this would lead to escalation of need in the future, how quickly this would happen and how significant the need would become.

The approach

Outcomes:

'Talking Points' defines outcomes as 'what matters to people', as well as the end result or impact of the activities/services on the person.

In 'Meaningful and Measurable' A Collaborative Action Research Project, Developing Approaches to the Analysis & Use of Personal Outcomes Data; Recording Outcomes In Support Planning and Review there are core criteria identified for good outcomes records. These include:

- Ensuring distinction between outcomes and outputs, where an output is what we provide and an outcome is what difference this makes,
- The outcome is personalised not service led,
- The person/family has a role instead of being passive recipients of services,
- Uses the person's own language as appropriate (Please see more on the use of appropriate language later),

- Future focused – agreeing a movement towards something desired rather than away from something undesired,
- Action oriented, using descriptive language.

Talking Points recognises three types of outcomes that are important to people:

- Quality of Life outcomes,
- Change outcomes,
- Process outcomes,

The 'With You For You' process as described earlier, offers people the opportunity to participate in an open, wide ranging discussion about what matters to them, their outcomes. Assessors can prompt the individual to consider each of the outcome themes as sub-sectioned in the 'Understanding You'. Each of the sections are described later in this guidance.

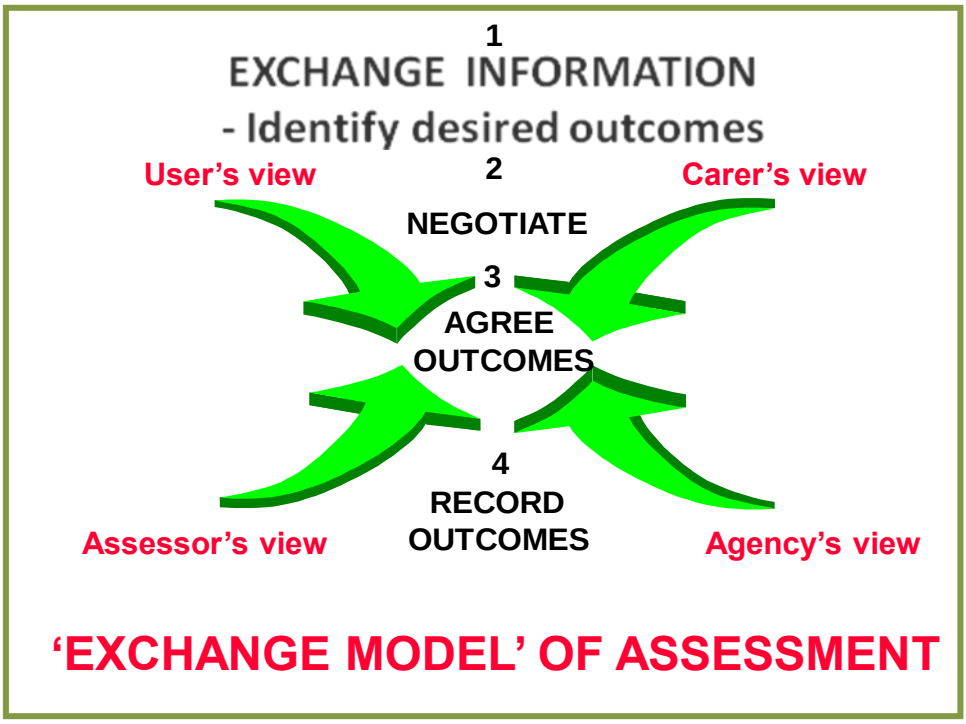
The Understanding You assessment tool is made up of two parts; part 1 is the personal information section and also details the reason for contact with an individual. (This information is also the same as the 'Understanding You Referral').

The second part of the UY is where the individual's personal outcomes are recorded, the information from others and the assessor's analysis are also recorded here. This is known as an exchange model of assessment, where negotiating and agreeing outcomes is achieved through gathering information from the person themselves, their carers, agencies and other professionals involved. The assessor then uses all this information to facilitate agreed outcomes. It is important to note that it is the 'good conversation' with the individual about their outcomes, and being attentive to what matters to carers, agencies and other professionals involved, that makes for a positive assessment for all.

Throughout the conversation you will be encouraging the individual to consider the following in relation to their personal outcomes:

- Improving confidence,
- Being treated as an individual,
- Having choices,
- Being treated with dignity and respect,
- Having a say,
- Being in control and responded to,
- Thinking about their own strengths, resilience and competences,
- Thinking about their existing self managing strategies (e.g. how they manage stress, sleep or fluctuating energy, mood and symptom levels),
- Looking at what works well,
- How they already harness support from others and their community.

This asset-based approach helps the individual to consider their own contribution to meeting their outcomes.



Asset based approach

WYFY is also based on an asset approach where individuals are supported to be as independent as possible, whilst paying attention to their quality of life. This approach coincides with the supported self-management agenda adopted by the NHS. This is a contrast and shift in how we have previously conducted assessment, moving away from traditional practice with a primary focus on problems/deficits, pathology, dysfunction and what is wrong, to one of recognising a person's inherent strengths and resources. Asset based approaches focus on what people want to be different in their lives and what strengths and resources they have to make that difference. This approach is based on a belief that, fundamentally, people are aspiring, resourceful and capable of change. It aims to promote self-efficacy even in the most vulnerable adults who have been challenged in life, or who have lost contact with their innate resourcefulness.

As part of the consideration of what the person might need to achieve their outcomes the assessor will explore **all** the appropriate resources available to the person. The main resources could be:

- The person's attributes and assets (their skills, knowledge, awareness, background, decision-making skills and contacts),
- The person's well-being and inner resilience,
- The people available to support and help; person's extended family, close friends, neighbours, work colleagues and other community members,
- The local community resources such as shops, health and education services, libraries, sports centres, community groups,
- Any other sources of information, advice and support available to the person.

It is important that the individuals' experience of WYFY helps them to identify and build on their strengths and capacities as a means to help them resolve problems and find solutions. However, focusing on strengths does not mean ignoring challenges, or turning struggles into strengths.

Solution focused approaches

While it is important to acknowledge the challenges people face, a WYFY assessment will have a focus on thinking about solutions, and using an outcomes approach can support this. Solution-focused methods fit well with the beliefs of WYFY, as it assumes that change is inevitable and that the worker's role is to focus on what matters and what people want to be different in their lives, facilitate people to notice their own strengths, to take control and to make changes in ways helpful to them. This doesn't mean 'fixing' the problems presented, but constructively listening for:

- What people hope for,
- What life will look like with these hopes realised,
- What's already working,
- How people are coping, managing, getting through,
- Small signs of progress towards outcomes.

Even where there is no prospect of reversing difficulties, such as deteriorating health, the focus should be on supporting the person to identify what needs to happen to make the most of the life they have. This includes building on past or present strategies that individuals have used to achieve their goals. Through the conversational process, people become more aware of what they want, the strengths and abilities they already possess, the support networks and community supports around them, all of which come together to increase their motivation and expectancy, that they can realise their hopes and aspirations.

The WYFY Pathway:

Pre-WYFY involvement: Individual services should use their own referral/access criteria and assessment tools which are appropriate and proportionate to service need. If there is concern about an individual's outcomes/needs that cannot be met by the individual service provider alone, then a referral using the new UY referral tool would be made to Duty Social Work for screening in Lerwick and to the Team Leader in other areas. Consent to refer must be gained and recorded within the referring agency.

Stage 1: Screening. Screening is an important element of ensuring individuals' receive the appropriate support from the most suitable person. It also ensures that for those individuals in crisis or urgent need, a period of enablement can be offered. Once Duty Social Work receive a referral they will decide if a period of enablement is needed, or whether the individual requires Adult Support & Protection or signposting to a single service for intervention. Likewise screening in localities will involve ensuring the individual is signposted to the most appropriate information, assessment and/or support. The individual may not require re-ablement and be allocated to an appropriate care coordinator/manager for an UY assessment. Consent from the individual to engage in the WYFY process would be sought at this stage if further support is identified.

Stage 2: Getting to Know You. This 'getting to know you' period allows individuals and staff a chance to understand and act upon the immediate need and offer 6 weeks free care/support for those that require a period of re/enablement. During this 6 week period, with consent from the individual, information regarding the person will be gathered, from a range of sources, in order to understand the longer term support that a person may need. For some individuals, enablement may not be required or be appropriate.

What is Enablement?

Enablement is a key part of the process to meeting outcomes for those who have reached a crisis point, had an accident, been hospitalised or whose care/support has broken down (for example, due to the loss of a main carer). This gives individuals the opportunity to learn or re-learn skills for everyday living, supports self management and promotes confidence and independence.

Whilst the Intermediate Care Team offers a dedicated Enablement Service, enablement will be offered through other services in the community and can be carried out in any setting including the individuals own home, for up to a 6 week period. Carers will work with the person to enable them to do the activities for themselves. Equipment may be provided as part of the enablement service to promote independence. There is no charge for the service for 6 weeks.

Assessment for enablement can be done using the Understanding You tool. Please mark the assessment as Initial/Enablement in the 'Reason for contact' box on page 3.

Who is Enablement for? (Please also see SIC Self-directed Support policy 5.4 – 5.6)

The circumstances where someone may require enablement include the following, but this is not an exhaustive list:

All new referrals to Community Health and Social Care where a community care response is required.

- The person has had a spell in hospital and needs to regain some of the skills and confidence they have lost.
- The person is receiving a long term service but their needs are increasing. Individuals with existing care packages will get the extra support free and continue to pay their previous package charges, again for up to six weeks. If this increased provision is established within the longer term care plan, the contributions will then be adjusted accordingly.
- Those individuals who have continuous admissions to hospital are not eligible for the 6 weeks free support as it is intended as re-enablement.

What type of support can someone get in the Enablement period?

- Any type of support can be provided in the 6 weeks period provided it is to meet an enablement outcome.

Stage 3: Understanding You Assessment.

It is during stage 3 that an assessment would be complete. Once the assessment is complete it would be recorded on the 'Understanding You' tool (see below for guidance on completing the tool). The ethos behind the assessment is to have a number of 'good conversations' based on the 'Making it Personal' training, with the individual.

Stage 4: Monitoring and Review.

Monitoring is essential to ensure support is contributing to the person's efforts to achieve their personal outcomes. Monitoring, is therefore, in a sense a form of informal ongoing review, where the 'good conversations' now serve to continue to explore people's contributions to their progress and recover/learn from setbacks as well as ensuring formal supports are contributing as intended. The level of monitoring will depend on the complexity of the individual case. Monitoring will inform the review. 6 – 12 monthly reviews are held locally and will include:

- Progress towards Personal Outcomes,
- The developing contribution and capacity for self management of the person, as a result of support, i.e. confidence, skills gained,

- Satisfaction and experience of services.

The purpose of review is to monitor progress towards outcomes; and to further identify and amplify the strengths of the individual, helping them recognise their contribution to progress and also the role of others, community supports, as well as understanding the contribution of services. The role of the 'Reviewer' is to highlight achievement, resources, qualities and coping in a hope to reinforce and consolidate change which increases the likelihood of achieving outcomes.

For the person:

- Review progress towards achieving specific outcomes already identified,
- Explore person's contribution, resources, self-management strategies,
- Explore unintended consequences – positive and negative and develop skills at managing setbacks,
- Determine what more, if anything, needs to be done,
- Determine next signs of movement towards achieving outcomes,
- Determine when to end or change (increase or decrease) levels of support,
- Identify new outcomes.

For the service:

- Capture information for improvement purposes

  (What helped, what hindered, what was the contribution that worked, what's missing)

The exchange model approach continues through into the review stage and the views of others involved will be taken into consideration, including family, Carers, agencies and other professionals.

A standard 'Outcome' review tool has been created in order to ensure we are consistently recording and monitoring the impact our support has on people's outcomes and their own contribution to meeting these. The information from this tool is crucial in completing the 'Outcomes loop', by gaining feedback on individuals progress, but will also be used for wider service development, i.e. collective information on types of unmet need can go towards identifying gaps in provision.

Further details on how to complete the review tool are found later in the guidance. (See later section on review).

The 'Understanding You' Tool:

The 'Understanding You' (UY) is a recording tool, which is part of the WYFY process. UY is not intended to be a script for conducting assessment but is a framework, based on 'Talking Points', for capturing relevant and appropriate information used for the assessment of 'Personal Outcomes' and the support needed to meet these outcomes.

There is widespread recognition that we need to shift focus from service led provision and what we 'do to' people and consider what difference we make to the people using services and support. A 'Personal Outcomes' approach helps us to do this. This means working collaboratively with the person to identify what is important to them or what they would like to achieve and then working backwards to identify how to get there.

Many staff recognise this approach requires a shift away from 'ticking boxes' to engaging in 'good conversations' and positive relationships with people in order to encourage a person to identify what is important to them in life rather than identifying what deficits the person has which can be a very negative experience for someone.

The 'Understanding You' is there to be used by multi-disciplinary staff and aims to enhance working relationships. However, it does not replace specialist assessment, common sense practice, conversations or phone calls. The Scottish Government recognises that Single, Shared Assessment is one part of the assessment and care management framework.

It is also recognised that no process or documentation can perfectly match the huge range of individual situations which WYFY framework is trying to support; or the wide range of professional approaches and methods of recording. Therefore, professional judgement and consideration is always required when analysing what is needed to meet individual personal outcomes.

What to record on the UY.

The information below is a guide to what to record on the 'Understanding You'. The writing in bold is the sections of the UY followed by an explanation of what is important to document.

Page 1: Personal Details

Title:	This is a drop down box. Please click on the word '**Title**' and select the persons title from the list.
Name:	Please complete with person's name as it appears on their birth certificate.
Date:	The date you are making the referral.
Known as:	What does the person preferred to be called?
DOB:	The person's date of birth.
House:	Number or Name of the house where the person currently resides.
SWIFT:	The person's unique identifier from their SWIFT record, if known.
Address:	The address details of the house where the person currently resides.
CHI:	The person's unique Community Health Index number.
Postcode:	The person's home postcode.
NI:	The persons National Insurance number.
Telephone:	The person's home/work telephone number and or mobile number, please state which number the person would prefer to use first.
Email:	The person's preferred e-mail address, this can be their own or one of their close contacts. Please record whose email address the person prefers to use.

In the interests of eliminating discrimination and promoting equality of opportunity, it is also important to collect equality data and other relevant personal information in order to ensure that appropriate, outcome focused support is delivered sensitively to individuals. The WYFY leaflet on sharing information can help the assessor explain why we collect this information.

Gender:	This is a drop down box. Please click on the word '**Gender**' and select the person's gender, i.e. male or female, transgender.
Marital status:	This is a drop down box. Please click on the word '**Marital status**' and select the person's current circumstances in order to identify the legal marital status of the individual.
Ethnicity:	There is a legal requirement for public authorities to collect data on ethnic group under the Race Relations (Amendment) Act 2000. This is a drop down box. Please click on the word '**Ethnicity'** and select the ethnicity the person identifies with.
Religion:	This is a drop down box. Please click on the word '**Religion**' and choose the person's religious status.
Employment:	This is a drop down box. Please click on the word '**Employment**' and choose the person's current employment status.
Lives Alone:	This is a drop down box. Please click on the word '**Lives Alone**' and choose the Yes or No.
Tenure:	This is a drop down box. Please click on the word '**Tenure**' and select the person's circumstances. i.e. Is the person a home owner, tenant, etc.
Nationality	This is a drop down box. Please click on the word '**Nationality**' and choose the nation the person legally belongs to. **'Other'** will include those not listed and also those people with dual nationality.
Do you consider yourself to have a disability	Please record the person's own consideration regarding disability.
What is your preferred method of communication:	In this free text box you will record any communication preferences the individual may have to make themselves understood, e.g. preferred language, Interpreter or translator required (Language line), speech impairments, use of family member or advocate, any specialist equipment, telephone, reading or writing etc.
Who referred you:	Name, role and contact details of referrer.
Who is your assessor	Please leave this blank at referral. This will be completed once the individual is allocated an assessor.
Your GP Practice:	Name and contact details of current GP.
Your contacts:	In this box you will include the details of any significant people involved in the person's life, e.g. who they live with, who helps and supports them (both formal and informal carers), which practitioners are involved. You **must** include any details of the legal status of these contacts i.e. Power of Attorneys, Welfare Guardians etc.
Carer's Assessment Information:	We have a legal duty to offer any Carers identified through this assessment process the opportunity to have an assessment in their own right. Record here if

	you have identified a main carer and whether you have offered an assessment. It is important to state whether it has been accepted by the person and completed.

Page 2: Personal circumstances leading to referral/contact.

Who are you, what do you enjoy doing, who is important to you, what are you good at:	In this section we ask that you include some details of the person's own story/background, their strengths and what interests them. This information is crucial in understanding what is important to the individual and therefore ensuring assessment and care plans are personalised and 'Outcome-Focused'. A brief description here allows those involved to gain a greater understanding of the person's identity and is a good start to understanding the strengths that can be utilised in an asset approach. Please ensure you highlight here if there are any concerns about the individual's capacity to participate in the assessment, or if anyone has legal authority to act on their behalf.
Reason for referral/contact:	In this section please describe the reason for referral. What does the individual feel they wish to achieve from further assessment?
Assessment Type:	Please indicate the type of assessment the individual needs based on the preliminary information you have; initial/enablement, simple or comprehensive (see information on types of assessment later in guidance).
Your current help and support:	In this section we ask you to describe what current help and support is in place for the individual. This would include both formal and informal supports, i.e. help from services, family members, neighbours, friends etc. What does the individual think is working well about that support and how would they like it to change?

How to record Personal Outcomes:

Page 3 Outcome: Looking after yourself and staying as well as you can. (Healthier Living) Your physical and mental health, including medication management.

This section is where you record what 'Outcomes' the individual desires in relation to their Health and Wellbeing and relates to the 'Healthier Living' outcome from the National Health & Wellbeing Outcomes for Integration.

During your conversation with the individual you will endeavour to capture the person's views on their physical and mental health, including self-management. Encourage the individual to consider how they stay well, how they manage their symptoms, what they would like to achieve in relation to their health and wellbeing, and to what extent they are confident and capable of contributing to achieving these outcomes.

Some examples of useful conversational prompts from 'Making it Personal' training might be:

- What do you do to keep as well as you can?
- Tell me a bit about how you have been managing your health.
- What helps you through?
- Who is good at supporting you in keeping well?

Once thorough explorations of outcomes and assets (e.g. confidence, the support they already receive to self manage and what the person already does for themselves to keep well) has been explored, then consider what support and information, if any, may be needed to support the person to achieve these outcomes.

In this section record how what you have discussed and help the individual to consider how the following may impact on their ability to achieve their outcomes:

The person's physical and mental health including:

- medication (including compliance),
- nutrition, diet, eating/swallowing,
- mobility, foot care,
- breathing difficulties,
- cognitive functioning, orientation to time or place, concentration, making decisions/planning, memory (short & long term), ability to reason, awareness of risks and dangers, restlessness and wandering,
- learning disability,
- mental illness,
- sensory impairments,
- sleep,
- disability,
- dementia,
- condition management and illness.

The person's emotional wellbeing including:

- self-esteem,
- motivation,
- anxiety,
- bereavement,
- emotional difficulties,
- verbal/physical aggression,
- intimate relationships and sexual health,
- beliefs/obsessions,
- delusions/hallucinations.

Page 4 Outcome: Living where and how you want. (Independent Living) Your personal and domestic needs, your home environment.

This section is where you record what 'Outcomes' the individual desires in relation to their living arrangements and relates to the 'Independent Living' outcome from the National Health & Wellbeing Outcomes for Integration.

During your conversation with the individual you will endeavour to capture the person's views on their quality of life at home. Encourage the individual to consider what works well about their living arrangements and how they manage around the home. Encourage them to consider what they would like to achieve in relation to independent living, and to what extent they are confident and capable of contributing to achieving these outcomes.

Some examples of useful conversational prompts from 'Making it Personal' training might be:

- How does living here suit your present situation?
- What's good about living here?
- What's it like living here?
- What are your neighbours like?
- How have things been going at home?
- How do you manage living here?

In this section help the individual to consider how the following impact on their ability to achieve their outcomes:

- Their self-care skills both personal and domestic. Personal care may include continence (urinary & faecal), toileting/commode, washing & drying themselves, bathing/showering, washing hair, dressing, dental care etc. Domestic care may include housework, shopping, laundry, using appliances and heating systems, maintaining the home (including security),
- Their independence and what hinders this, i.e. mobility (inside and outside), type of accommodation (i.e. are there stairs that cannot be managed) what would help them achieve this i.e. adaptations, support,
- Their income and ability to manage finances,
- Their housing status including homelessness or potential housing concerns.
- If their current housing situation impacts on their social inclusion.

Once thorough explorations of outcomes and assets have taken place, then consider what supports, if any, may be needed to support the person to achieve these outcomes.

Page 5 Outcome: Having contact with others. (Quality of Life) (Carers are supported) Your relationship with carers and others

This section is where you record what 'Outcomes' the individual desires in relation to their relationships with others and relates to the 'Quality of life' and 'Carers are supported' outcomes from the National Health & Wellbeing Outcomes for Integration.

During your conversation with the individual you will endeavour to capture the person's views on their relationships with others. Encourage the individual to consider what they would like to achieve in relation to having contact with others, and to what extent they are confident and capable of contributing to achieving these outcomes.

Some examples of useful conversational prompts from 'Making it Personal' training might be:

- Who have you been able to see lately?
- Who do you enjoy spending time with?
- Who are the most important people in your life?
- What do you do to keep relationships working?
- Who would you like to see more of?
- Who is the best help if things are tough?
- How easy is it to join in and feel involved?

Consideration to the following may be useful:

- Social inclusion or isolation/exclusion,
- Family support structures,
- Dependents,
- Family roles,
- Friends,
- Pets,
- Carers.

Once thorough explorations of outcomes and assets have taken place, then consider what supports, if any, may be needed to support the person to achieve these outcomes.

Page 6 Outcome: Having things to do. (Quality of Life)

Your interests, hobbies, education, work and participation in community life.

This section is where you record what 'Outcomes' the individual desires in relation to having things to do and relates to the 'Quality of Life' outcome from the National Health & Wellbeing Outcomes for Integration.

During your conversation with the individual you will endeavour to capture the person's desires in relation to having things to do. Encourage the individual to consider what they enjoy and what interests they have. In this section you would also record outcomes related to the person's engagement in their community, and to what extent they are confident and capable of contributing to achieving these outcomes.

Some examples of useful conversational prompts from 'Making it Personal' training might be:

- What have you been up to lately?
- What do you enjoy doing?
- How would you like to spend your time?
- What do you enjoy doing that you would like to do again/more of?

Consider the following:

- Employment, volunteering,
- Hobbies,
- Leisure activities,
- Religion and culture,
- Getting out and about – transport,
- Clubs and associations,
- Learning and personal development.

Once thorough explorations of outcomes and assets have taken place, then consider what supports, if any, may be needed to support the person to achieve these outcomes.

Page 7 Outcome: Staying as safe as you can. (People are Safe) How do you keep safe

This section is where you record what 'Outcomes' the individual desires in relation to their sense of safety and relates to the 'People are Safe' outcome from the National Health & Wellbeing Outcomes for Integration. The aim of this outcome is to promote the person's own ability to protect themselves from **all** types of harm. Please see earlier section on Adult Support & Protection for more information on what to do if you are concerned that an individual may be unable to keep themselves safe from harm.

During your conversation with the individual you will endeavour to capture the person's views on their safety. Encourage the individual to consider how they stay safe and what they would like to achieve in relation to feeling safe, and to what extent they are confident and capable of contributing to achieving these outcomes.
Some examples of useful conversational prompts from 'Making it Personal' training might be:

- What helps you feel safe?
- How do you manage with uncertainty?
- Who/what helps if worries begin to overwhelm you?
- Who is a good person to talk things over with?
- What helps you deal with thoughts about the future?

In this section you would record outcomes related to the person's safety and what barriers there are to them feeling safe, some examples may be:

- Breakdown of care,
- Neglect, poor personal/domestic hygiene, self-neglect
- Self harm,
- Financial harm or exploitation by friends, family or others,
- Risks to self and others,
- Risk of falls, moving and assisting – consider if level 2 falls screening needs to take place
- Violence from or towards others, including living with domestic abuse
- Fire risks,
- Animal risks,
- Substance misuse,
- Emotional or psychological harm including coercive control.

Once thorough explorations of outcomes and assets have taken place, then consider what supports, if any, may be needed to support the person to achieve these outcomes.

Following conversation with the individual and the others involved please consider if further risk assessment needs to be done and record where it is stored if it is completed. This could be Moving & Handling, Adult Support & Protection or Person-Focused Risk assessments, level 2 falls screening etc.
Under Adult Protection Procedures, anyone undertaking UY assessments has a responsibility to recognise, respond to and report any concerns that an adult may potentially be at serious risk of harm or abuse. Advice should always be sought from a line manager or from the duty social worker. Further information – including information about how to recognise harm and abuse – is contained in the Shetland Interagency Adult Protection Procedures found at http://www.safershetland.com/adult-protection

Page 8 Outcome: Being listened to and having your say. (Positive Experience of Services)

This section is where you record what 'Outcomes' the individual desires in relation to their experience of services and is what 'Talking Points' call a 'process outcome'. It relates to the 'Positive Experience of Services' outcome from the National Health & Wellbeing Outcomes for Integration.

During your conversation with the individual you will endeavour to capture the person's views on the services they would like to receive and how they would like to be treated. You will help the person consider what a positive experience would look like and what they would wish to avoid. Encourage the individual to consider what has worked well in the past and to what extent they are confident and capable of contributing to achieving these outcomes.

Some examples of useful conversational prompts from 'Making it Personal' training might be:

- What's good about the services/support you receive?
- How easy is it to give feedback to the service/support you receive?
- How friendly are people with you?
- Were you able to say what you wanted?
- Do you get a sense that people understand what's important to you?
- How confident are you that you are being listened to?
- How much choice and control do you want when deciding on the type of support you receive?
- How reliable are the people that support you?

You may wish to explore with the individual some of the barriers they encounter in meeting this outcome:

- Having a voice,
- Stigma and discrimination,
- Choice and control,
- Previous experiences of services,
- Support to access services.

Once thorough explorations of outcomes and assets have taken place, then consider what supports, if any, may be needed to support the person to achieve these outcomes.

It is important that people feel they have a voice and say in the way they receive services. Some people may need extra support to do this. Please inform these individuals of the independent advocacy support that is available and record here that you have done so.

The views of your carer's and others involved:

As described earlier, WYFY is based on an exchange model and it is vital to gather the thoughts and views from others involved in the person's life. Under each 'Outcome' subsection of the UY you will record the views of the individuals' carers and others involved. This will require gaining consent from the individual to discuss their situation with those significantly involved, including carers and the professionals that help and support them.

It is important to be attentive to the carers own personal outcomes as well as what they would want for the person and through a process of negotiation agree outcomes that will benefit all.

There may also be professional and agency outcomes that need to be recorded and included in the negotiation of agreed outcomes.

Your Assessor's views

Once you have analysed the information from both the individual and others involved, you record your views as assessor. These views may also be a record of your outcomes for the person which may include duty of care issues such as safety, or desire to achieve certain health outcomes, or your services outcomes such as prevent hospital admission - your record evidences your contribution to the negotiation and eventual agreement of outcomes the person will work towards.

Eligibility

Record how the needs identified to meet the outcome are eligible for support. Please refer to the National Eligibility Criteria for further details. It is important not only to state the severity of the need (critical, substantial, moderate or low) but also the urgency i.e. is the support required immediately, imminently, in the foreseeable or longer term.

Someone is eligible for support if the impact of not meeting outcomes puts the individual at critical or substantial risk.

Agreed Outcomes

Under each section please record the agreed outcomes, which may be the person's individual outcomes or negotiated outcomes where there may have been conflicting views between the person and/or carer, professional and agency (see exchange model). Please ensure the agreed outcomes are specific, defined by the person and maintains as a central focus on what is important to them. Describe the particular details that relate this Outcome to the individual.

In 'Meaningful & Measurable'; A Collaborative Action Research Project; Developing Approaches to the Analysis & Use of Personal Outcomes Data' Recording Outcomes in Support Planning & Review; Practice Examples it suggests a number of important things to consider when recording personal outcomes.

What is important to consider when recording personal 'outcomes':

- Should clearly distinguish between outcomes and outputs, representing a shift away from service led recording,
- Gets beyond the what to the why, thus providing clarity of purpose,
- Should involve the person, natural supports and community based considerations, including the contribution they want to play towards the intended outcomes, reflective of an enabling and inclusive approach,
- Given that the person should be involved as far as possible in identifying their outcomes, it provides an account in which the person is recognisable to themselves/their family,
- In a period of organisational transition (from needs led to outcomes focused assessment), the record provides a means of identifying where practitioners are in their understanding of outcomes, helping to pinpoint support needs.

Furthermore, the Meaningful and Measurable project found core criteria for good recording of outcomes and suggest the following are taken into consideration:

- Distinction between outcomes and outputs,
- The outcome is personalised,
- The person/family has a role,
- Uses person's own language as appropriate,
- Action oriented (usually).

What recording outcomes you need to consider:

- What change do you expect as a result of those outputs/activities?
- Why is this important?
- Does that lead onto anything else?
- What will happen immediately, what is the longer term change and what can happen along the way?
- What is a typical journey for the individual?

Further examples of recording outcomes can be found in the 'Meaningful & Measureable' document.

Chronology

The WYFY process recognises the role of chronologies as part of assessment. The chronology is intended to be a clear, concise and up-to-date snapshot of relevant significant events in an individual's life. This helps us understand the history of events that are important to the person and their current situation. It is important to remember that only relevant information to the current need would be included here. Therefore in a simple/straightforward assessment this may not be a great deal of information, however a comprehensive/complex assessment chronology may contain more detailed information.

A good chronology can be useful in the early identification of patterns of risk or concern and for the WYFY process is where possible, a multi-agency chronology. Integrated chronologies can often be more useful in identifying potential critical events by bringing together issues identified and presenting them coherently. They can also help to strengthen partnership working between practitioners and the individual.

The chronology should not become a substitute for recording information elsewhere or a contact log.

In the Scottish Governments 2010 Social Work Inspection Agency Practice Guide to Chronologies it suggests the following core elements would be considered in a chronology:

- Key dates of life events; births, deaths, marriage, transitions, house moves,
- Facts about professional interventions; Child Protection, Adult Protection, Hearings, Tribunals, prison sentences, hospitalisation,
- A very brief note of a health event e.g. a fall down stairs, discovering a bruise on an individual,
- Achievements,
- Does not include opinions.

A chronology must be analysed and reviewed as part of the assessment and not merely copied from previous UY as it may then be out of date or not relevant.

Additional information relevant to achieving outcomes:

It is important to consider some of the functional barriers to someone achieving their personal outcomes. This table enables a brief functional assessment to be carried out. It does not replace the need for an Occupational Therapy Assessment which is extremely useful in certain circumstances. However, it may help to determine if a further functional assessment or level 2 falls screening is required.

Please include in the details section any relevant information to the need identified and to which outcome it relates. Under 'Other issues' please record any details of any other functional, behavioural, sensory/ cognitive barriers that impacts on the individual achieving their outcomes. If the individual answers 'yes' to the question about falling in the last 12 months a further level 2 falls screening is required.

Summary of your assessment

In this section please give a concise overview of the whole assessment. This is meant to be quick and easy to read and enable others to easily understand the situation and react quickly if necessary; i.e. in an emergency**.**

Other relevant assessments or plans

In this section please record any other relevant details of assessments or plans including previous UY, OT assessments, medical assessments, Wellness and Recovery Action Plans (WRAP) Anticipatory Care Plans, Contingency Plans relevant and appropriate to the assessment purposes. Please ensure you have consent to share this information.

Does a contingency plan need to be done?

Once the plan is complete it is helpful to consider what might need to be in place in case circumstances change temporarily. For example a carer may fall ill, or the individuals' condition may fluctuate. It can be really useful to help a person consider in advance what they might do and need in these circumstances, so that they are prepared and manage more resourcefully when setbacks happen. This may include consideration of the following, for example:

- If a carer falls ill who will be a back up?
- If the person has an episode of poor health (including mental health) how do they wish services respond?

Please state where this plan is stored and the brief details of what it includes.

Contributing to Care explained

It is important that people understand from the start of this process that they may need to contribute financially to services provided to meet their needs. Please ensure people are fully aware of this. The leaflet *'Frequently asked questions – Charging for non-residential care'* can help answer many of the questions someone may have.

More information on contributing to care can be found in the Community Health and Social Care and Support Charging Policy.

Financial Assessment complete
It is also important to ensure the financial assessment is completed as soon as possible. Decisions around how someone receives their budget for eligible need and delays in service provision can become distressing for individuals. Further information on financial assessment can be sought from lorne.anderson@shetland.gov.uk

Latest UY placed in home file
Please ensure a signed copy of the UY is stored in the individuals' main records.

SWIFT Updated
It is important to ensure that SWIFT is updated with the details of the assessment and any other related information. Please see UY SWIFT guide on which fields to complete in relation to recording 'Outcomes'. For further guidance on how to record on SWIFT please see guidance on SIC Intranet 1.

Review date
Please enter the date set for review. Locally, this is usually 6 months after an assessment. However, review or re-assessment will be conducted within the 6 weeks following an Initial/Enablement assessment.

Your Support Plan
The support plan is where the assessor brings together all the agreed outcomes into one table. It is a summary record of all the agreed outcomes from each section, what the person needs to meet those outcome, how the needs are eligible, who and how they want help, and by when. Please choose which **'Overall aim'** in the first column. See the key at the top of the page to select which overall aim the agreed outcome relates to. Please record the individual personal outcomes under the **'Agreed Outcome'** column. Please ensure it is specific and defined by the person, identifying what is important to them. Under the column **'What do you need to meet these agreed outcomes?'** please give details of the needs that relate to the outcome on that row. Under the column **'Eligibility; how do your needs meet the criteria?'** please use the drop down boxes to

state the severity and urgency of the need identified.

Under the column **'Who will help you achieve your agreed outcomes?'** please consider the persons assets and wider community support i.e. family, carers, friends, community, services.

Under the column **'How do you want your help delivered?'** please use the drop down box to choose the Self-directed Support option the person wishes to utilise. If the person is going to utilise their own assets to meet this outcome please leave this blank.

Under the column **'When should this happen?'** please record the agreed timescale for meeting the outcome and needs.

This plan is vitally important as it will give an overall picture of what the person would like to achieve and how. The plan will inform the care co-ordination/management and services that are delivered. It will help monitor progress and be the basis of review.

Signatures:

It is crucially important to ensure that the individual and all those involved are in agreement with the content of the assessment, or record otherwise. The assessor should try to seek agreement from all involved on the final content of the assessment, but if this is not possible, it is important that the assessment reflects who is in agreement and who is not.

If you have concerns around whether an individual has capacity to sign and agree to an assessment it is important to seek advice from your line manager or Duty Social Work (see section on capacity).

Once the assessment is written up on the 'Understanding You' the assessor must print off a copy and get it signed by all those involved. The signatures give confirmation that the individual has seen all of the information contained and agreed to the plan.

It is important to record on the electronic version of the form where the signed paper copy is stored.

Information sharing explained:

It is crucial to discuss information sharing with the individual, give them the leaflet and talk them through it. Sharing information should only happen if the individual provides informed consent to do so.

Leaflet given:

A prompt to remind you to give the information sharing leaflet.

Consent:

Record the individual's level of consent on the form. If the individual only wishes you to partially share their information, please record in the details box who they do or don't want you to share information with.

What to record on the UY Review:

The UY Review tool is a new addition to the process. The aim of the new review tool is to focus reviews on the progress towards outcomes and to standardise recording in order to help inform future planning at an individual level, but also for us to gather meaningful information that can be used to determine service development. See further information above (page 15-16).

The first half of the front page of the Review tool is the same information as on the UY (please see section on what to record on the UY).

Please record any changes to personal details here	Record any changes since the UY assessment to the person's details.
Any change in how you prefer to communicate?	Record any changes since the UY assessment to the person's preferred communication.
Reviewer's name	Record the name of the person reviewing the individual's progress towards their 'outcomes'.
Guardian/Power of Attorney	Record the details of any person's present that are legally representing the person.
Advocate required?	Offer the individual the opportunity to have an advocate present. Record whether an advocate is required.
Your GP/Practice	Record the registered GP details.
Who is at your review & what relationship are they to you	Please list all those in attendance at the review meeting and their relationship to the individual.
Apologies	Please note any apologies from those who were not able to make the review meeting. It is important however, if there are people who can't make the meeting that information on progress towards outcomes is sought verbally or in writing and that this information is included in the negotiated measure of progress towards outcomes.
Your Current Support Plan	This plan is taken from the most recent UY assessment and forms the basis of the review.

As described earlier the aim of the review is to monitor progress against each of the individuals agreed outcomes.

Agreed Outcomes	Under each '**Overall Aim**' section please transfer the agreed negotiated outcome from the support plan as described by the person.
Has this outcome been achieved?	It is important to both ask the person about their progress towards their outcomes, but also continuing to use the 'exchange model' by asking the opinions of others involved. The progress is recorded by taking into account all of the information from those involved, i.e. a negotiated measure of progress. Record the agreed progress in the box. **Achieved** – This means that the outcome is fully met. **Mostly achieved** – This means the outcome is almost met with a little way to go (at least 50% met or more). **Somewhat achieved** – This means that progress has been made but there is still some way to go to meeting the outcome (less than 50%). **No change** – This means that circumstances are still the same and no progress has been made towards the outcome. **Some Deterioration** – This means that no progress has been made and that the person is further away from meeting the agreed outcome.
If the outcome was achieved, was this due to planned support?	If progress towards the outcome has been made, state if that was due to the planned support. Yes or No.
Is the person satisfied with the support they received in relation to their outcomes being achieved?	Is the person happy with the way in which they receive the support, the people and services involved?
If the outcome was achieved but not through planned support, what was the reason for this? i.e. lack of resource or better alternative	Record here anything else that has contributed to progress towards an outcome. i.e. a neighbour has helped out, the person had successful enablement and is doing it for themselves, their condition improved, they used a private domestic service to clean up, the person chose an alternative to day-care to socialise etc. As well as what else contributed please record the reasons for the alternative support, i.e. no provision available etc.

If the outcome was not achieved, what was the reason for this and what are the impacts?	If there has been no progress or deterioration in meeting an outcome, record here the reasons for this, i.e. the person's condition has deteriorated, services weren't available etc. It is important to include a brief description of what the impact or consequences of not having an outcome met has had on the person.
What next?	In this box record the agreed actions for this outcome, ensuring it is clear what the individual's role will be i.e. continue with current support, individual will contact friends for transport, a change in day care is needed, referral to physiotherapy etc
Is there anything else you would like others to know as part of your review?	Record here anything else that the person feels they would like known about their progress towards their outcomes. This may include information on 'change outcomes' i.e. the person has learnt new skills, their confidence has increased, they have reduced symptoms or improved mobility. You may also record the person's feedback of how they have experienced services and the process of review i.e. they felt listened to, respected, felt that individuals were reliable etc.
Is there anything your carer would like to add to your review?	Record here anything else that the carer's feels they would like known about the individual's progress towards outcomes. This may include information on 'change outcomes' i.e. the person has learnt new skills, their confidence has increased, they have reduced symptoms or improved mobility. You may also record the carer's feedback of how they have experienced the process of the review i.e. they felt listened to, respected, felt that individuals were reliable etc.
Is there anything your reviewer would like to add to your review?	This is an opportunity for the reviewer to express their views on the progress the individual has made towards their outcomes. This may include something the reviewer has observed that the individual has not recognised for themselves. The review is a learning opportunity for the individual.

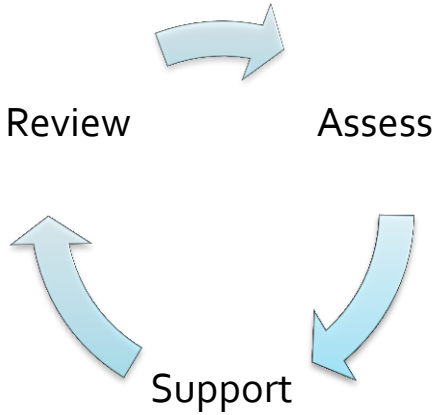
Other information relevant to my review	Please record here any other reports, assessments or documents that have been considered at the review.
Assessment to be updated	Consider if there have been any negotiated changes to the assessment. Are there new identified outcomes?
Change current package of care	Consider what changes are needed to ensure that the person's outcomes are met.
Revised Plan Completed	If changes are required update the Care Plan.
Does a contingency plan need to be done	Again consider if a contingency plan is required for temporary changes to circumstances (see notes on completing UY).
Change of Care Manager / Care Coordinator	Has there been or is it necessary to change the person responsible for assessing, monitoring and reviewing the individual's progress towards outcomes.
Closure	Does the person no longer require support to meet their outcomes?
Date of next review	This date should be in 6 – 12 months time depending on the level of support required to meet outcomes.
Signatures	Please ensure that the review document is signed by the Reviewer, the individual and/or a carer who has POA/Guardianship.
Your revised Support Plan	Record any changes to the support plan here.

Appendix A: With You For You (WYFY) Pathway

Pre-WYFY Involvement:

(Straightforward Single service involvement)

Using own referral form; assessment tools which are appropriate and proportionate to need, services will:



Referral

If an outcome is identified that cannot be met through own service provision or by one other relevant provider refer to duty social work

Statutory Involvement:

STAGE 1 Referral and Screening

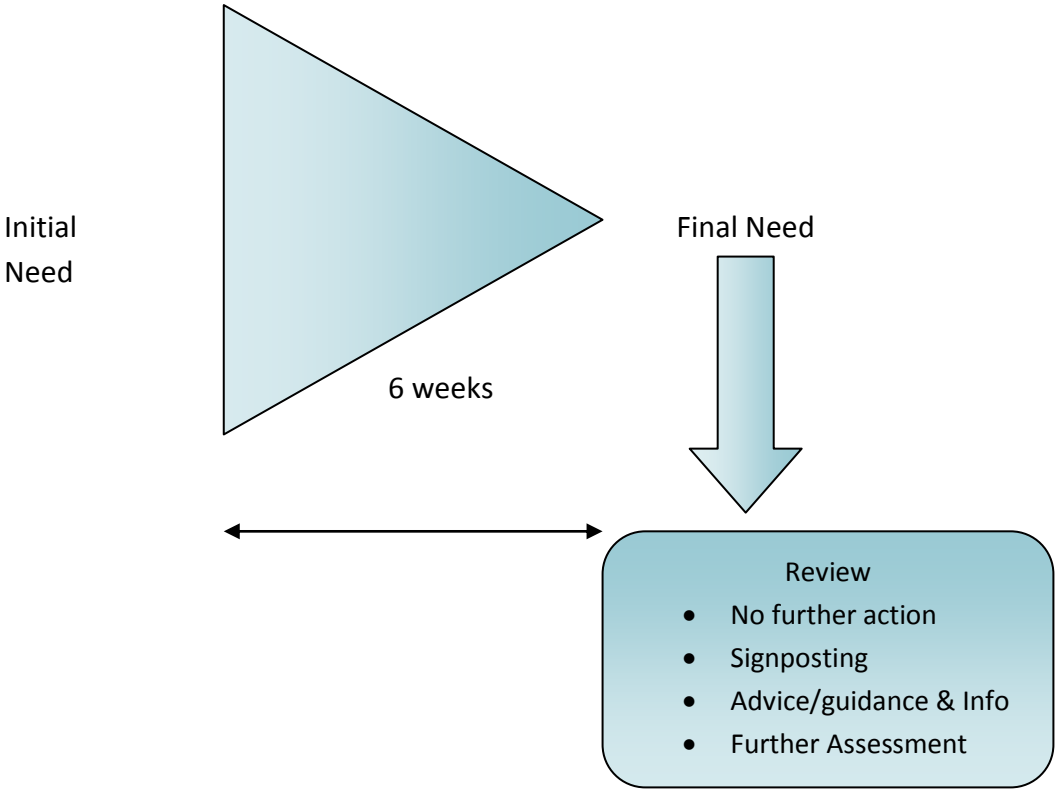
The role of duty social work is to screen referrals. The outcomes of this stage are:

- No Further action
- Signposting
- Advice/guidance & info
- Initial Assessment
- ASP

Stage 2

Enablement/Getting to know you

To ensure individuals needing to learn or re-learn skills for everyday living have access to 6 weeks free Enablement; the purpose of this is to promote independence and reduce the initial need for immediate intervention to none or longer term stable needs.



Stage 3

Assessment & Planning

The Understanding You (UY) is used as a Single Shared Assessment this is to identify individuals:

- Strengths /Assets/Resilience
- Personal Outcomes
- Needs
- Risks
- Capacity

This is done by pulling together appropriate and proportional information from the individual and all involved including 3rd Sector, NHS, Family and Carers. Following analysis of this information a support plan is put in place, based on personal outcomes.

Stage 4

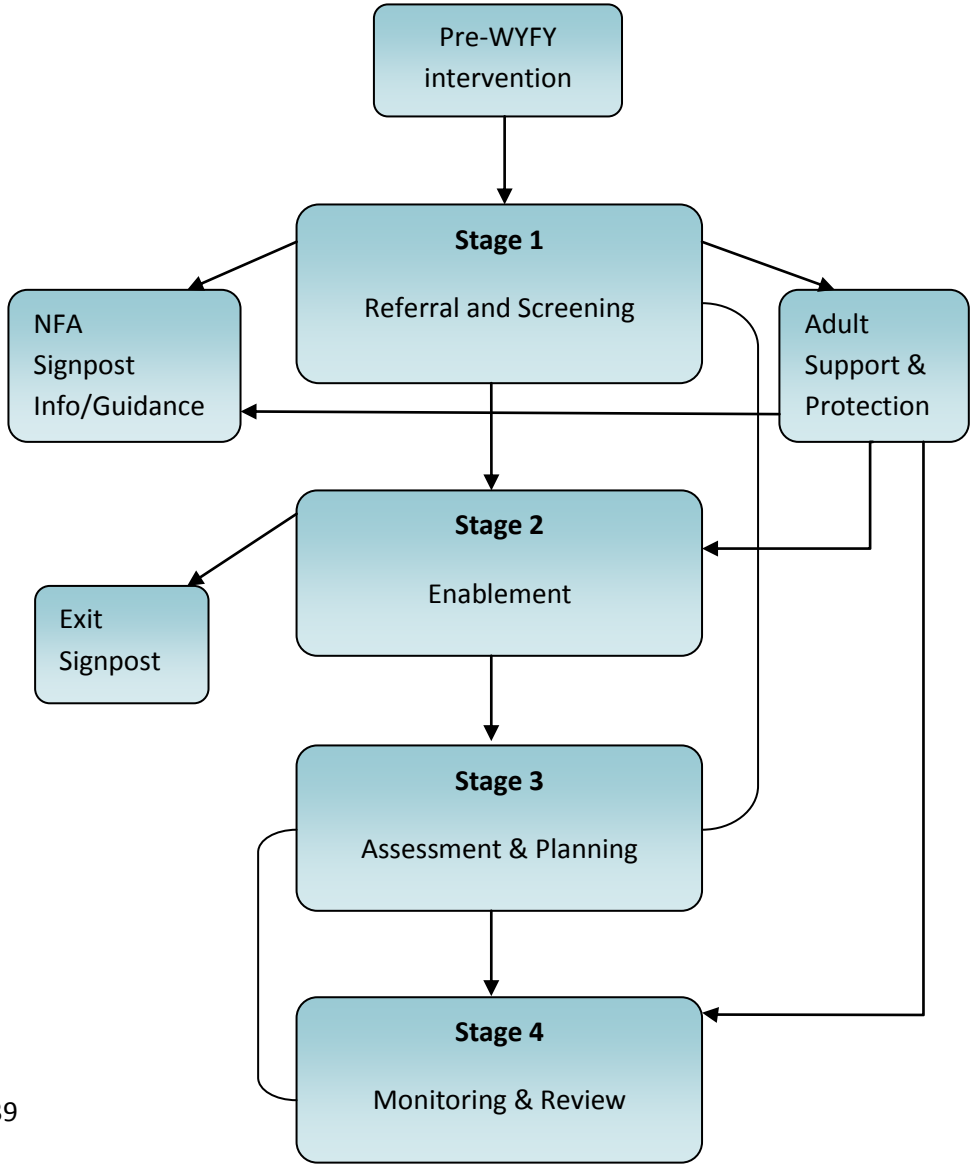
Monitoring & Review

Monitoring is essential in ensuring support is working to meet personal outcomes. The level of monitoring will depend on the complexity of the individual case. Monitoring will inform the review. 6 monthly reviews are held locally and will include:

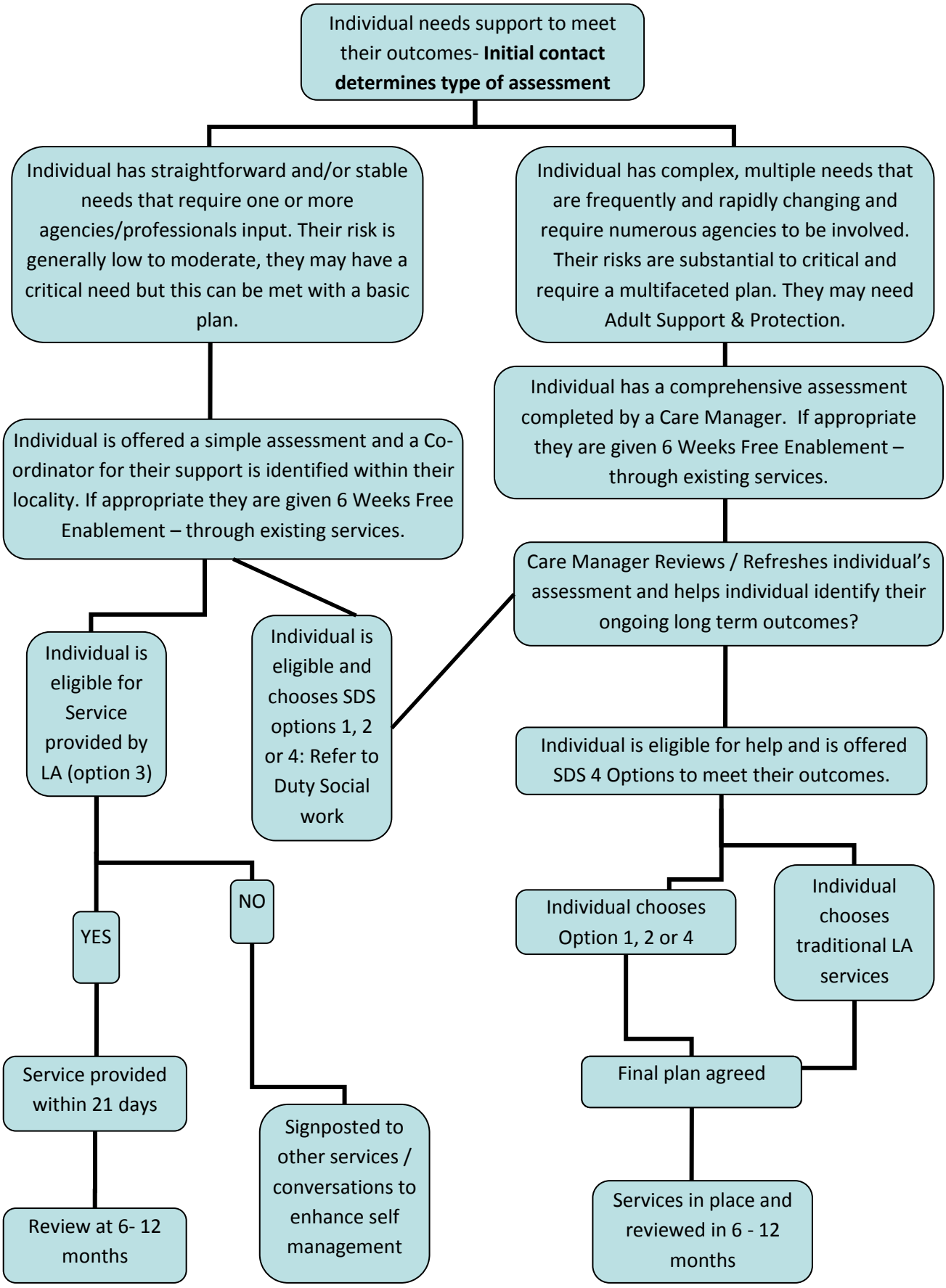
- Personal Outcomes
- Satisfaction and experience of services
- Other changes as a result of support, i.e. confidence, skills gained

The views of others involved will also be taken into consideration, including family and Carers.

Overview of Pathway



Appendix B: Screening & determining type of assessment required:



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