Agenda Item 7

Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**14 June 2012**
By:	**Director of Adult Social Care**
Title of report:	**Implementation of Self Directed Support within Adult Social Care**
Purpose of report:	**To provide a progress report on the implementation of Self Directed Support**

RECOMMENDATION: to Consider and comment on the contents of this report and agree to receive an update on Self Directed Support and 'Access' to Adult Social Care in a year's time in order to review progress.

1. Financial Appraisal

1.1 The implementation of Self Directed Support was developed and supported through the Putting People First (PPF) programme which was funded through the government's Social Care Reform Grant (£5.3 million for East Sussex over three years). Funding for the development costs of the programme has been carried forward year on year and has been sufficient to cover the costs of the programme.

2. Background and Supporting Information

2.1 Self Directed Support (SDS) is the internal Adult Social Care pathway which enables the delivery of part of the 'Putting People First' agenda by enabling those people with continuing support needs to have as much choice and control as possible over designing the support needed to go about their daily lives. Under the PPF vision those people who would benefit from a short term intervention through a 'reablement' package to support and promote their independence are offered this at the first point of delivery, as a result of which many people either no longer require ongoing support or need much reduced support.

2.2 By March 2011 all local authorities were required by central government to have 30% of all people eligible for a Community Care service receiving a personal budget. To respond to this, East Sussex introduced SDS to all adult teams from April 2010. By March 2011 40.6% of ESCC people in receipt of support were receiving a personal budget, thus exceeding the 30% target. Progress has continued over the past year and at the end of March 2012 this figure had reached 59.4%, thus exceeding the locally set 50% target. For a breakdown of how people have chosen to take their personal budgets see appendix 1. There continues to be a drive to promote the increase in direct payments as the preferred way of taking a personal budget but this continues to increase at a slower pace than desired. This is a national issue being promoted by central government and, to address this locally, several initiatives are being developed within ESCC to further promote the take up of direct payments (see 2.5).

2.3 The first year of the PPF programme saw significant developments within systems, processes and tools as the Adult Social Care pathway was redesigned, tested and amended to support the new ways of working. This first year was challenging because of the amount of change involved in different ways of working for both staff and service users and carers. Improvements to the SDS pathway and the tool set have continued over the past year with the introduction of 'Lean' thinking which has resulted in a more streamlined, user friendly pathway. In addition to the changes to the pathway and tool set, the past year has also seen a much needed greater emphasis being placed on changing the underpinning practice required to support new ways of working. The aim is to shift the emphasis away from a service led approach to one which focuses on needs assessment and meeting needs and outcomes. This requires a significant culture shift which will take time to fully embed. Changing practice has been supported by new ways of delivering staff training. This is increasingly provided through 'topic based workshops' which enable teams to identify their own training needs within an overarching framework and

have bespoke training sessions arranged for them to benefit from a more participative and self directed style of learning. This approach has been very successful in engaging with staff and in changing practice.

2.4 Substantial progress has been made in developing the SDS tool set over the past year and ESCC has now fully adopted the FACE national assessment documentation, along with the FACE Resource Allocation System which has seen significant improvements in terms of accuracy and sensitivity to user need. In addition, much work has been done with users, carers and staff to improve the support plan to make this more user friendly and needs and outcome focussed, whilst at the same time containing sufficient financial information to be understood by service users and carers as well as meeting ESCC requirements. Staff, both operational and back office, and service users and carers have an ongoing role in supporting and advising on the development of the SDS tool set through appropriate forums including the Personalisation Advisory Group and the SDS Tools Group. The tool set is now stable but will be regularly reviewed to incorporate any required changes.

2.5 Alongside the above developments has been the parallel work taking place through the market development workstream to enable people to have more choice over what and how to meet needs through less traditional service provision. This workstream has been proactive in supporting the development of a number of different projects such as the promotion of small micro providers able to support needs in different ways through more bespoke provision (Appendix 2). In addition, a pilot Personal Assistant service development project has been launched in the Hastings and Rother area to support people to take a direct payment, enabling them to choose both how and who provides their support without having to employ people directly (Appendix 3). Work is also ongoing regarding the development of an online resource directory (East Sussex 1 Space) which will enable people and their supporters to have access to up to date information about what is available, both locally and nationally, in the market place to meet their support needs. These developments are ongoing and are starting to have a real impact in offering people more and different choices over how to meet their needs.

3. Conclusion and Reasons for Recommendation

3.1 Overall, the past year has seen some really positive developments within SDS with substantial shifts being made in relation to changes in practice and an overall leaner, more streamlined, user friendly pathway. This, combined with the various market development initiatives, is leading to different ways of meeting needs and outcomes. While these changes are slow and incremental they are nevertheless very significant in enabling ESCC to move towards much more personalised support for all. These changes will be taken forward and further developed through the new service delivery model which will be introduced as a result of Project Pathway in autumn 2012. This will be continuously improved and developed over time.

3.2 It is recommended that the committee continues to review the ongoing development of the SDS pathway by receiving an update on ‘access’ to Adult Social Care in a year’s time.

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Appendix 1

Service users receiving Self Directed Support in a 12 month period, by age group and primary client type

Self Directed Support process				
	Direct payment only	**Services arranged or paid for by Adult Social Care only**	**Both direct payments and services arranged**	**TOTAL**
Aged 18-64				
Physical Disability	121	990	401	**1,512**
Mental Health	40	292	106	**438**
Learning Disability	9	385	106	**500**
Substance Misuse	0	17	0	**17**
Other vulnerable person	6	38	14	**58**
Unknown Client Type	24	41	4	**69**
Total 18 – 64	**200**	**1,763**	**631**	**2,594**
Aged 65 and over				
65 – 74	45	1,020	131	**1,196**
75 – 84	63	2,042	200	**2,305**
85 and over	75	2,682	331	**3,088**
Total 65 and over	**183**	**5,744**	**662**	**6,589**
Unknown age	2	0	1	**3**
TOTAL 18 AND OVER	**385 (4%)**	**7,507 (82%)**	**1,294 (14%)**	**9,186**

As shown above the most popular deployment method was services arranged or paid for by Adult Social Care, which equated to 7,507 people (82%), 1,294 people (14%) received both direct payments and services arranged, and 385 people (4%) received direct payments only.

Carers receiving Self Directed Support in a 12 month period, by age

The table below shows the 2,124 carers who received self directed support between April 2011 and March 2012 , broken down by age group of carer.

Under 18	1
18 - 64	1,129
65 - 74	476
75 - 84	378
85+	117
Unknown	22

53.2% of carers were aged between 18 and 64
22.4% of carers were aged between 65 and 74
17.8% of carers were aged between 75 and 84
5.5% of carers were aged 85 and over
1.0% of carers were of unknown age
0.1% of carers were aged under 18

Appendix 2

Lewes and North Wealden Pilot Report

1. Background

A pilot project which aims to explore and facilitate the use of Support with Confidence and micro provider services to deliver creative solutions to meeting service users' identified needs and outcomes has begun. The pilot is being run with representatives from the Lewes and North Wealden Assessment and Care Management Team and the Countywide Reviewing Team for three months starting from May 2012.

2. Support and engagement of pilot staff

There has been a strong focus at the start of the project on facilitating high levels of engagement with staff taking part in the pilot. Other managers and staff are also engaged, with thorough briefings about national developments being cascaded to staff to promote the importance of pilot as a learning experience. Independent support planning is also being promoted as a way of collaborating with other providers to fully explore options as part of the support planning process.

3. Be Creative; Be Involved Showcase

This event was held on Wednesday 2nd May in Lewes and was advertised to staff as an opportunity to become more familiar with micro providers and Support with Confidence scheme members who are operating in the Lewes and North Wealden locality. The event included presentations from some of the micro providers as well as a market place so that staff could have one-to-one conversations with service providers.

There were presentations from:

- Creative Dementia Support – Community Interest Company
- People Inspiring People
- TEAM
- Lawrence Gelid
- Vandu – Community Support Services
- Caring 4 All Ltd
- Irene Mynott and Gilly Webber – Personal Assistants

The event attracted 57 people: 17 Provider representatives and 40 ESCC staff including 25 ASC care managers.

Following the event a number of support plans have included elements of the services showcased, as well as other micro provider provision not previously utilised. As a result a number of real case studies have been/are being developed which will be shared widely to further promote and consolidate operating a more creative approach to support planning. ASC staff are also being encouraged to identify market gaps and help to direct the range of provision available through Support with Confidence.

This project is also promoting uptake of direct payments, although a Letter of Agreement has been finalised to support a lean approach to contracting with Support with Confidence approved providers where a direct payment is not suitable/required.

Micro Provider Case Study

Mrs G is an 89 year old lady who has a diagnosis of moderate dementia due to Alzheimer's disease. Mrs G presented as experiencing self neglect of her nutritional and personal care needs. A small traditional care package was put in place and she was coping quite well at home, although she was socially isolated.

Unfortunately Mrs G contracted a chest infection for which she was hospitalised. While in hospital she experienced a small stroke. Mrs G recovered her physical health quite well but her cognitive abilities had declined. Mrs G's care package was increased to ensure a safe discharge from hospital, but she was even more isolated so at review the package was revised.

The morning calls were reduced by 15 minutes a day, as Mrs G was able to make her own breakfast as long as someone reminded her to eat it. Her meals in the community were reduced to 5 days a week and her evening calls were reduced by 15 minutes each day. This enabled Mrs G to take a direct payment to employ a PA through a micro provider for 4 hours a week to take her out for lunch twice a week.

Mrs G mostly chooses to go to garden centres. Mrs G was a keen gardener; she enjoys walking round looking at plants, often remembering not only the common names but the Latin names as well and so the micro provider helped her find a PA with similar interests.

Mrs G is now back in the wider community, she is taking her an interest in life, she is having healthy exercise and is socialising with a person she now considers a friend. This was achieved with no increase in costs on the traditional care package. Mrs G can also use her PA for medical or other appointments if required as they are more flexible than the traditional care package. This also frees Mrs G's family to enjoy their visits with Mum as they are not always just to offer support and assistance.

Appendix 3

Case Studies

1. Mrs C

1.1 Mrs C is 98 years old, widowed and lives with her son, his wife and their 12 year old twin boys.

Mrs C has a history of:

- bowel cancer and subsequent surgery
- general arthritis.
- falls and general frailty
- incontinence
- recurrent urine infections

1.2 Son has given up his job to care for his mother on a full time basis a couple of years ago. At the beginning of my involvement there was clear tension between the family members, as 'normal family life' had become impossible, due to the needs of Mrs C who could not be left alone due to her complex needs and risks of falling. Reablement services had not been able to make any significant improvement in Mrs C's level of independence.

1.3 Mrs C was resistant to respite care in residential setting or day care facility, which would have given much needed break for son and his family, as Mrs C is unable to travel due to severe reactions to motion/travelling.

1.4 It was imperative to have a flexible approach to delivery of Mrs C's care. The need was going to be variable and was primarily to support the family as a whole. Direct payments were discussed and implemented through the Prime Care Agency PA Pilot.

1.5 It was agreed that the son would continue to meet the majority of his mother's day to day care needs and that a Personal Assistant would provide additional hours to release him to meet the needs of his family in his role as a husband and a father.

1.6 Prime Care identified a PA, who has fitted in perfectly with Mrs C herself and the family as a whole. Son states that the PA working with his mother 'is an ambassador for Prime Care'. Mrs C had been resistant to the idea of any support other than son and family, but is really pleased with the PA support and the diversity that it has offered in her life. Son said they went back home recently and found their mother with the PA in the kitchen baking cakes together ~ which delighted them all that Mrs C was getting more out of life now.

1.7 Son states that all their lives have altered unbelievably and cannot thank those within the process enough.

2. R

2.1 R is a 65 year old male who lives alone. His housing provider made a referral to Adult Social Care in January 2012 requesting support for R who was struggling with personal care and domestic duties.

2.2 R has very limited mobility due to chronic sciatica and has other health problems which are currently being investigated. R reported that he had an accident over 10 years ago resulting in sciatica in his back and has been unable to work for 10 years due to the pain. R also has psoriasis. R mobilises inside and outside the home with a stick and is currently having difficulties with transfers and being able to manage the stairs leading to his flat.

2.3 At our meeting it was evident that R is struggling to come to terms with his poor physical health and the impact this has had on his independence. He reported drinking half a bottle of vodka every night to help with the pain and with getting to sleep. R is a keen Spurs supporter and wanted to watch the football in the pub on a big screen. He used to enjoy gardening and requested support to do this again during the spring/summer. R also enjoys going to the seafront and eating out. He particularly likes jellied eels or pie and mash.

2.4 R's personal appearance was unkempt, he had not shaved or washed, he was very thin and his clothes were dirty. His home environment was also unkempt i.e. laundry strewn across the floor, unwashed dishes, bags of rubbish and lots of empty takeaway boxes. R was very tearful during our meeting and he spoke of his isolation.

2.5 The PA Pilot service was explained to R and he agreed to meeting with the agency to discuss how his needs could be met. R required support with all daily living activities and with accessing the community. R specifically requested male carers.

2.6 R was eligible for 20 hrs direct payments to employ male PAs via the Prime Care PA Pilot. meals-on-wheels were also commissioned and an OT assessment was requested.

2.7 6 Week Review (02/04/12)

R has two regular PAs who provide the support he requires and who he has already begun to build a trusting relationship with. R reports that he is drinking less alcohol and is now able to go out of his home to enjoy social activities with the PA's support. R has been able to get to the pub to watch football and has eaten jellied eels on the seafront. His personal appearance and home environment had noticeably improved i.e. clean shaven, hair cut, wearing clean clothes and he appeared to have put on weight. R's emotional well-being seemed to have improved as he was less tearful and spoke animatedly. His home appeared clean and tidy and he was enjoying a freshly cooked breakfast made by his PA.

2.8 At the review R requested some changes to how his needs could be met. It was explained that R was in control of how he used his time and could make changes as long as there was not undue risk, he used his budget effectively and his PAs were able to work when wanted. R's PAs were willing and able to alter their working hours as per R's requests and will move to managing the rota directly rather than done by Prime Care.

2.9 R spoke positively about how the PAs have helped him to get his home clean and tidy and with getting out into the community. R stated that he respects the PAs and is happy with their support.

3. Mr T

3.1 Mr T elected to trial 8 potential PAs over a 3 week period (to enable staff to be scheduled effectively). At the end of this period Mr T chose two PAs – both of whom had been recruited specifically to work as PAs.

4. Ms C

4.1 Ms C is an older woman with relatively high support needs. Ms C had been reluctant to use care services but was struggling to manage at home without support. Ms C worked with Prime Care to identify a PA who had similar interests – in this case knitting. Consistency of worker and a shared interest has meant that Ms C has moved from a position of accepting a less than adequate amount of support (c. 2 hours per week) to a position where she is happy to use her full allocation of 21 hours per week for the care she needs.

4.2 Using direct payments, through an A4e Agency Only Managed Account, Ms C is also able to use her time flexibly and to 'bank' hours so that she can use the time to access the community.

5. Mr A

5.1 Again, PAs recruited who had a shared interest with the service users and this has been a key factor in developing the package. As well as help with personal care and some domestic tasks the service user manages their budget so that they can have time out at a local steam engine club. This arrangement has also evolved so that hours worked are negotiated and arranged directly between the service user and PA rather than Prime Care managing their rota.