Agenda Item 6

Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**6 March 2014**
By:	**Director of Adult Social Care and Health**
Title of report:	**The East Sussex Social Care Pathway**
Purpose of report:	**To provide an overview of the social care pathway from assessment to outcome, including the self directed support pathway.**

RECOMMENDATION: The committee is recommended to use this opportunity to develop a deeper understanding of the East Sussex social care pathway and to consider whether to include any elements in its future scrutiny work programme.

---

1. Financial Appraisal

1.1 There are no specific financial implications associated with this report.

2. Background

2.1 At the Committee's Reconciling Policy, Performance and Resources Board held on 20 December 2013, Members identified ***access to care and support*** as an important potential topic to include in the committee's scrutiny work programme. As a first step, they requested the opportunity to develop a deeper understanding of the following elements of the East Sussex social care pathway:

- an overview of the whole process from assessment to outcome
- the way personal budgets are calculated
- the impact of 30% average reduction in personal budgets
- lessons from complaints information
- how we can help 'self-funders' to get the best deal
- whether the eligibility criteria (to access social care services) are sufficiently responsive to any sudden, marked changes in demography.

3. The self-directed support (SDS) social care Pathway

3.1 This report outlines the key stages in the whole social care pathway and is divided into sections as follows:

Appendix 1: An overview (comprising information slides to be presented at the meeting)

Appendix 2: Fact sheets and leaflets on: (a) Eligibility; (b) Calculating Personal Budgets – the Resource Allocation System or 'RAS'; (c) Self Directed Support – SDS; and (d) the appeals process.

Appendix 3: A briefing on the Self Funders Project. See also http://www.mycaremyhome.co.uk/

Appendix 4: Case studies

3.2 Present at the meeting to take part in the discussion will be:

- Keith Hinkley, Director of Adult Social Care and Health
- Jane Goldingham, Head of Self Directed Support
- Beja Morrison, Service Development Manager (Older People)

4. Conclusion and Reason for Recommendation

4.1 The committee is recommended to use this opportunity to develop a deeper understanding of the East Sussex social care pathway and to consider whether to include any elements in its future scrutiny work programme.

KEITH HINKLEY
Director of Adult Social Care and Health

Contact Officer: Samantha Williams Tel No. 01273 482115
Local Members: All

Background Documents None

An update on the Social Care pathway

by Jane Goldingham

Head of Self Directed Support

East Sussex County Council

Social Care Pathway

- National Context
- The self directed support pathway
- Some key facts and figures
- Impact of the current financial climate
- Learning from complaints
- Options for self funders
- Local priorities

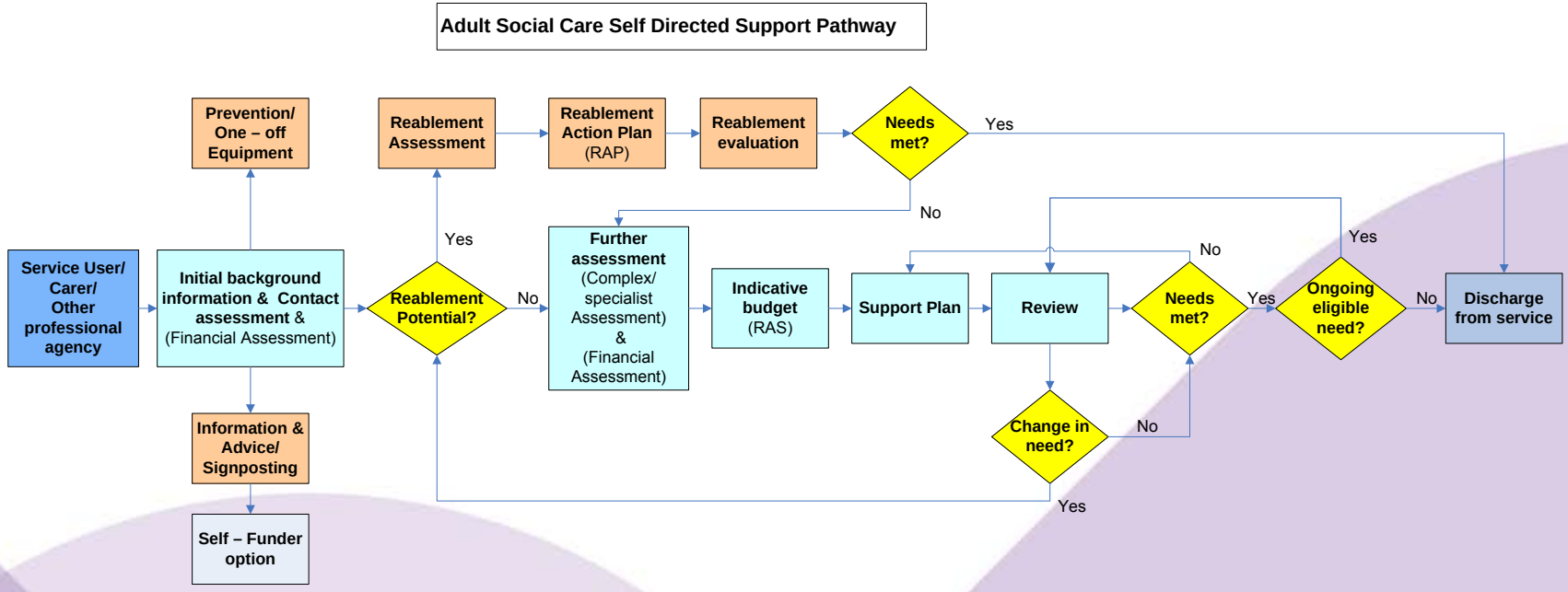
National Context

- Time of dynamic changes on all fronts – exciting and challenging
- Unprecedented financial constraints
- Care Bill – to streamline ad hoc legislation – promote well being/promote strengths rather than deficits/prevent crises and focus on prevention and reablement
- SW role seen as crucial in Adult and Children's Services
- Focus on personalisation/independence/cost based social work/importance of choice and control
- Focus on prevention/reablement/well being/advice and info/supporting people to support themselves/building communities

Eligibility

- National eligibility criteria – Fair Access to Care Services
- Four levels of need – critical, substantial, moderate and low
- ASC supports people with eligible critical or substantial needs
- Provide advice, guidance and singposting for people with low or moderate needs

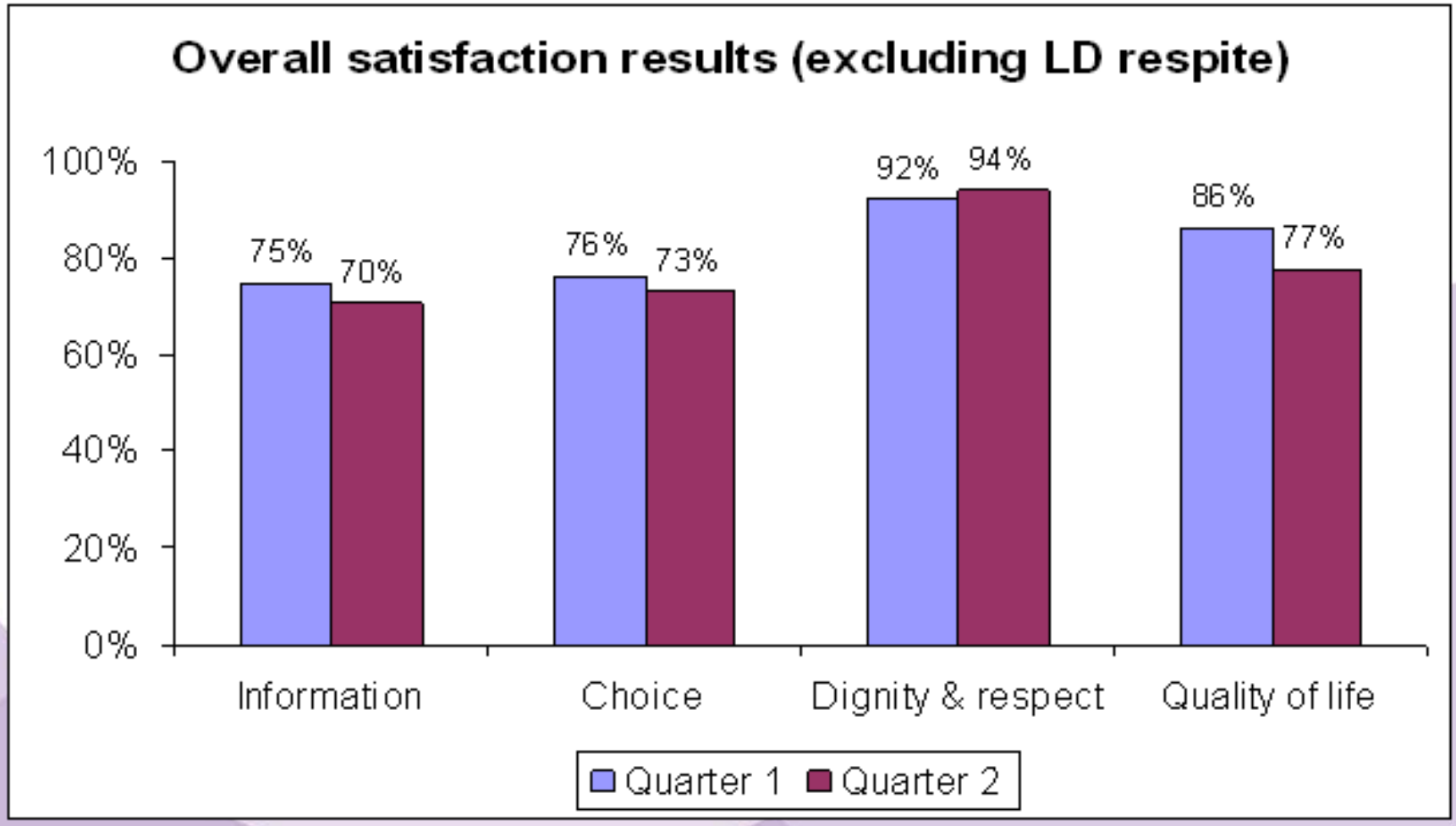
Self Directed Support (SDS) pathway



Impact of the current financial climate

- Average 30% reduction in personal budget
- Clients and carers reported to be understanding of financial climate, but many clients “resigned”
- Usually, existing clients have had their services reduced rather than changed to alternative providers
- 24 Appeals, mainly from existing clients and many from specialist teams (LD and MH)
- 1 appeal upheld, indicating revised offer being applied fairly and appropriately

“Listening To You” Survey



Learning from Complaints

- 100 complaints (20% decrease from Q2)
- 35% about assessment; 14% about provision of service; 12% about staff actions/behaviour
- 52% of complaints upheld or partially upheld
- As a result of complaints, changes made include speeding up processes for Financial Assessments and Lifeline orders, improving timeliness and continuity of homecare and revising guidance for Blue Badges.

Options for self funders

- Arranging support independently – East Sussex 1 Space and Support with Confidence
- Referral to Service Placement Team
- Referral to My Care My Home
  - New option of independent help and advice
  - One year pilot: Jan – Dec 2014
  - Referral from ASC or direct self referral
  - Free and chargeable services
  - Home visits/consistent support

Local priorities

- Partnership with health – links with Hospitals
- Safeguarding
- Work with local communities/Third sector to enable people to help themselves
- Good information and advice
- Focus on reablement
- Streamlining the pathway – timely response
- Increase in Direct Payments for maximum choice and control

Adult Social Care
Fact Sheet 1

January 2014

Who qualifies for our services?

Eligibility criteria explained

Introduction
This factsheet explains how we assess your needs for social-care support, how we decide if you qualify for Adult Social Care to help provide that support, and what kind of support you might get.

Many of our responsibilities as an adult social care department are set out by the government in law. Using the government's guidelines we have to make sure that services are available that will benefit the local community, whether we provide them directly or commission them from another organisation. Decisions about new or existing services that we provide are made by elected councillors to ensure value for money and a fair approach to services across the county.

The county councillors agree the policies that set out how we carry out our responsibilities in East Sussex and how we spend our money. You can look at reports of their meetings in public libraries or on the County Council's website www.eastsussex.gov.uk.

How do I know if I qualify for a service?
We use 'eligibility criteria' to find out the best way we can help. Eligibility criteria are the rules we apply to work out who qualifies for help from us.

We use the eligibility criteria as guidelines when we assess your individual circumstances to see what kind of social-care support you might need. We call this a social care assessment.

The assessment shows what needs you have that could be met through social-care support. The eligibility criteria apply to all adults who receive a social-care assessment in East Sussex.

When we carry out a social-care assessment we have to take into account your level of need (we explain below what we mean by level of need), the risks to your independence and how urgent it is that you get some support.

However, if you have a permanent and substantial disability (including sight or hearing difficulties, or both) we will also assess you with regard to the Chronically Sick and Disabled Persons Act 1970.

Why do you use eligibility criteria?
The Department of Health provides a national set of eligibility criteria, called Fair Access to Care Services, which provides the guidance that we have to follow. In deciding what services and support to provide, all councils take into account the demand for services and what they are already providing, as well as available resources.

The aim of these national criteria is to work out where there is the greatest risk to someone's independence. These criteria also make sure that the limited budget local authorities have is spent on the people who most need support. This then makes sure that adults across the country have equal access to services.

East Sussex County Council

The criteria outline four levels of need:

Critical needs
'Critical' is defined as a situation where the need is, or will be, apparent 'now or within seven days'.

We will consider you have a critical need if, for example, you are disabled and need 24-hour personal care and support. If you didn't have this care, you would be at serious risk of harm, or need hospital treatment.

We will use the following standards to assess whether your needs fall within the critical band. Your needs are critical if:

- there is immediate risk of serious harm to yourself or another person;
- you have suffered, or are at immediate risk of, physical, sexual or emotional abuse or neglect;
- you cannot manage on your own, or there is a serious risk to your safety,; you would very soon need to go into a care home or a hospital if you do not get any support;
- you have an ongoing health condition which needs especially high levels of personal hygiene, and you need help with this;
- your carer is in severe or immediate danger of injury, or there is a severe or immediate risk of care not being provided properly;
- you need physical help to be able to get in and out of a chair or bed, or on and off the toilet, or you are completely unable to do this; or
- you have a health problem that is likely to have a poor outcome or is rapidly deteriorating.

Substantial needs
'Substantial' is defined as a situation where the need is, or will be, apparent 'now or within six weeks'.

We will consider you have a substantial need if, for example, you are disabled, have some mobility problems and cannot carry out personal care tasks, like washing, on your own. You may also need help with essential household tasks, managing your money, bills and other paperwork. Without this support you would steadily deteriorate and might eventually need residential care.

We will use the following standards to assess whether your needs fall within the substantial band. Your needs are substantial if:

- your physical or mental health and safety is at risk without care or support;
- you are at some risk of abuse or neglect without help;
- without support you will not be able to be involved in work, education or learning activities, and your physical or mental health is at risk because of this;
- you cannot do most personal or domestic daily living activities on your own, and your physical or mental health would be at risk without help;
- you have limited control over your physical environment and cannot move around independently in your home or local area;
- you are becoming more isolated, have little contact with other people, or are finding it difficult to keep in touch with your family;
- you cannot access social support, and without it your physical or mental health would be at risk; or
- your carer is at risk of injury, or there is a risk of care not being provided properly.

Moderate needs
We consider you to have a 'moderate' need if, for example, you have a chronic illness which is likely to get worse, and your carer lives with you while working full time.

You may need help with some personal care tasks, such as dressing and undressing or bathing. You also need help with shopping and cleaning. Your carer wants and needs to keep working.

Low needs
We consider you to have a 'low' need if, for example, you are living at home, alone or with your carer, and can walk around the home but have limited mobility when walking outdoors. You may also need help to get in and out of the bath.

What Level of need (eligibility criteria) does ESCC support?
ESCC currently supports people who have eligible **critical or substantial needs**. ESCC has a duty to provide an assessment to anyone who appears to be 'in need of a social care services'. Following an assessment, if you have eligible social care needs or risks to safety that are considered to be **critical, or substantial** you will be offered support in finding ways of meeting these needs. This support may include help with funding (subject to a financial assessment.)

When you first contact Adult Social Care we will ask you about your situation, to determine your level of need and risk.

If it is clear that your needs are 'low' or 'moderate' we can support you by offering advice, guidance and sign posting to other organisations that may be able to assist.

What can I do if I don't agree?
In the first instance, it's always best to talk to your social-care worker, and you can ask them to reconsider the decision. You can do this in writing, or by talking to them, and provide supporting information where you can.

Your social-care worker will consider your appeal, and will work with you to try to reach agreement with you. If their decision does not change, your worker will refer the appeal to their Manager for consideration and they will let you know the outcome. If they stick with the original decision, and you are still unhappy or don't agree, then you can make a complaint and you will be given information about how you can do this.

If you feel you may need someone to help you speak up, you can ask your social-care worker about how to get in touch with an independent advocate.

Adult Social Care
Fact Sheet 6

January 2014

How we work out your personal budget

Your personal budget
We work out your budget in two stages. First we work out your estimated budget (called your 'indicative budget') which is based on the information you gave us in your assessment about your social-care needs and your personal situation. Then we help you to put together a plan for the support you need. We only know how much money we can offer you when we have finally agreed your support plan with you.

This factsheet explains the first stage, that is, how we work out your estimated budget.

How is my budget estimated?
Your budget is estimated using an online system called the Resource Allocation System (or RAS). We enter the information you gave us during your assessment with your social worker. This includes information about:

- your physical health, well-being, and any disabilities you have;
- your need for support with personal care and day-to-day activities;
- your mobility (getting around indoors or outside);
- your relationships with family and friends;
- your involvement in work, education or learning;
- your involvement in the community;
- your safety;
- the support you get from friends, family, and other local people or services.

We give each of these areas a score to reflect your current situation. We then enter your scores into the Resource Allocation System which uses a formula to estimate the amount of money required to meet your needs.

How does this formula work?
The Resource Allocation System formula uses data collected about thousands of people across the country - their scores and the cost of their support - to estimate how much money is estimated to meet your particular needs.

The system takes into account things like:

- help you receive from friends or family;
- whether different care needs can be met by the same service; and
- local differences in the cost of care and support.

The formula gives a different weighting to each score so that your indicative (estimated) budget is as close as possible to the amount you actually need.

East Sussex County Council

An example:
Suppose, for example, that you scored 12 on the assessment questions about your need for support with your personal care, and 6 on the questions about support you need with daily activities in the home, such as cooking and tidying.

Based on the data from around the country it might turn out that the best way to calculate the cost of meeting your needs is to multiply your personal care score by 10 and to multiply your daily activities score by 8.5.

If this is the case then the budget you might be allocated by the formula would be:

(12 x 10 = 120) + (6 x 8.5 = 51) = £171 a week.

However, you may receive some support from your family or friends, so you may not need as much money as this. Supposing that about half the support you need is being provided by family and friends. This is also recorded on your assessment and so you will be offered half of £171, that is, £85.50 a week.

The actual formula is rather more complicated than this example. This is because your needs in one area of your life often affect your needs in another area. For example, you might need someone to drop by twice a day to make sure you are safe. If you also need help with dressing and preparing meals, then the person who comes in to help with these can check that you are alright at the same time. In this situation you will not need additional money in your budget to make sure that your safety is checked.

Alternatively, if you need someone to drop by, but don't need any help with personal care or daily activities, then you *will* need something in your budget for this. So the formula cannot give the same weighting to 'safety' in both situations – otherwise people who don't need extra money could be given it, or people who do need extra won't get enough.

To avoid such 'double counting' the formula has to be a bit more complicated than simply adding up a few numbers. However, we hope this fact sheet explains why the formula is necessary to make sure you get the right amount of money.

The Resource Allocation System was developed by many local authorities working together, and it was thoroughly tested in East Sussex before being used.

The system is continually checked and updated to see that it remains accurate. So we are confident that in most cases it provides a reasonable estimate of the money that may be needed for your support.

If you feel that your estimated budget is too high or too low, please tell your social worker and we'll see if we can look at it again. Remember though that this isn't the final budget figure.

Also, we are happy to give you a full copy of your assessment so you can check the information on that form is accurate.

Agreeing your final personal budget
This is based on the actual cost of support that we have agreed agreed with you and that will meet your identified eligible social-care needs and outcomes as outlined in your support plan.

What can I do if I don't agree?
In the first instance, it's always best to talk to your social-care worker, and you can ask them to reconsider the decision. You can do this in writing, or by talking to them, and provide supporting information where you can.

Your social-care worker will consider your appeal, and will work with you to try to reach agreement with you. If their decision does not change, your worker will refer the appeal to their Practice Manager for consideration and they will let you know the outcome. If they stick with the original decision, and you are still unhappy or don't agree, then you can make a complaint and you will be given information about how you can do this.

If you feel you may need someone to help you speak up, you can ask your social-care worker about how to get in touch with an independent advocate.

Adult Social Care
Fact Sheet 12

July 2012

Self-directed support: 7 easy stages

What is self-directed support?

Self-directed support is the way that we (that is, East Sussex County Council) provide you with social care. It means you can plan how you want your social-care needs met, and have far more choice and control over the support you receive.

If you qualify for ongoing social-care, we will help you through the self-directed support process. Whether you qualify depends on your level of need – we must provide social-care and support to those who need it most. We use a set of rules called 'eligibility criteria' to help us decide who can receive support from Adult Social Care.

Stage 1: Getting in touch

When you contact us, we will ask for information about you and your needs. If it looks like you don't qualify for our support we can still give you information and put you in touch with other local services that might be able to help you. If it looks like you do qualify for our support, we will complete an initial assessment with you over the phone. In some situations, we may be able to provide you with some support, based on this phone call.

We may also need to complete a more detailed assessment with you. It is likely that your social-care worker will complete this with you, face-to-face. If you would like to complete this on your own first, we can send it to you before you meet with your social-care worker.

Stage 2: Finding out more about you

We use the assessment to gather more information about your daily life and your care and support needs. We will support you to do the assessment, and you will have the opportunity to say what your needs are and to tell us about the support you need. If you have a carer (that is, someone who supports you but isn't paid for doing so) we will also take their views into account.
We will ask you questions about your income and savings at this stage, as it will help you to know in advance if you will need to pay a contribution towards the cost of your support. We call this a financial assessment.

East Sussex County Council

Reablement

Following your assessment we may agree with you that your social-care needs can best be met through reablement.

Reablement is about maximising your independence by dealing with anything in your home environment that may be making it difficult for you to live independently, and helping you regain practical skills and confidence in aspects of your life that are important to you. Reablement is provided by a number of different services, so if it looks like you may benefit from a period of reablement your social care worker will discuss the options with you. That could include items of equipment, adaptations to your home, or getting practice with specific skills for everyday activities that you find difficult. Any reablement service will be tailored to meet your individual needs.

By working with you in this way we aim to support you to be as independent as possible in your daily life. Reablement may mean you won't need other care and support services, or will need less.

If all your needs can be met in this way you may not need to continue to Stage 3.

Stage 3: Estimating your personal budget

All the information you give us at the assessment stage will be put into our Resource Allocation System (RAS). Using this computerised system, we will work out how much we think it will cost to meet your needs, and we'll tell you the amount. We call this amount your indicative (estimated) personal budget.

You can use this indicative budget to help you to complete your support plan.

Stage 4: Developing your support plan

Now you have an indicative personal budget, you can start developing your support plan. You can complete your support plan with help from us, a family member, friend, or an independent support-planner (a person or organisation that specialises in preparing support plans). We can provide more information about this. There are many ways you can use your personal budget. You can:

- buy services yourself by having a Direct Payment (when we give you the agreed amount of money to arrange your own support);
- ask us, or a provider, to buy services on your behalf; or
- you can have a mixture of the two.

You can be as creative as you like when developing your support plan, as long as it meets your agreed social-care needs.

Stage 5: Agreeing your support plan

Once you have completed your support plan, we will confirm your final personal budget. We will also look carefully at your support plan to make sure it is (**ALE**) –

- **A**ffordable (within budget)
- **L**awful (using our money sensibly and within the law)
- **E**ffective (effective to meet your outcomes)

– and of course it must meet the social-care needs identified in your assessment.

Stage 6: Setting up your support

Once we have agreed your support plan, and your personal budget has been confirmed, you can start organising your support and make your plan work for you. You don't have to do this on your own – we can help you if you need us.

Stage 7: Checking how things are going

Once your support plan is up and running, we will set a date with you to see how things are going. This is called a review, and will usually be within six weeks. After your first review, we will make sure that we review your progress at least once a year, or more often if necessary. At that point, if your needs have changed, or you want to adjust your support plan, we can help you with this.

Support and advice

If you want advice or support to understand how we work out your personal budget, you can contact your social-care worker or Social Care Direct. Their contact details are at the end of this factsheet.

Alternatively, you can ask for an independent advocate to support you if, for example, you want support to challenge a decision made at any point along the self-directed support pathway. An advocate is an independent person who can speak up for you. In East Sussex this service is provided by an organisation called POhWER. We can put you in touch with them, or you can ask Social Care Direct or your social-care worker. Or, you can contact POhWER direct on 0300 456 2370, or email pohwer@pohwer.net.

For more in-depth information on each stage of self-directed support, and how it can help you make the most of your personal budget, read our other fact sheets on self-directed support.

You might also find useful:

- FS1 - Who qualifies for our services? Eligibility criteria explained'
- FS2 - Independent advocacy – Someone to speak up for you
- FS7 - Financial assessment for support at home
- FS10 - Direct Payments
- FS11 - Help with housework or shopping services – a practical guide
- FS13 - A practical guide to travel and transport
- IL01 (leaflet) The cost of your social-care support – how we work out what you have to pay

Help and advice

If you need any further information about any stage of self-directed support you can contact your social-care worker at any time.

Social Care Direct

- Phone: 0345 60 80 191
- Minicom: 01323 4666 30
- Fax: 01323 466567
- E-mail: socialcaredirect@eastsussex.gov.uk
- You can contact us by text message from your mobile phone. Send your text to 07797 878111.

Calls are charged at your phone company's local rate.

You will be sent a letter outlining their decision and an explanation as to how it was reached within 10 working days.

If you're still unhappy with the outcome then you can make a complaint.

Support with making your appeal

If you would like support with making your appeal your social care practitioner can help you contact an advocate who will support you through the process.

Please ask for the factsheet "Independent Advocacy" for further information.

Making a complaint

If your appeal is not upheld then you can contact the Complaints Unit at

East Sussex County Council
County Hall
St Anne's Crescent
Lewes BN7 1UE

Phone: 01273 481242

Email:
asccommentscomplaints@eastsussex.gov.uk

You can approach the Local Government Ombudsman if you are unhappy with the outcome or our handling of your complaint.

PO Box 4771
Coventry CV4 OEH

Phone 0300 061 0614/ 0845 602 1983
Text message: 07682 480 3014
Website: www.lgo.org.uk

Appendix 3

East Sussex County Council

Self-directed support appeals process:

What to do if you would like a decision reviewed

If you feel that your assessment or review hasn't addressed all your eligible needs, or that your Personal Budget is not enough to meet your eligible needs, we want to work with you to resolve things.

What is an appeal?

An appeal is a request for us to revisit our assessment / review or a proposed package of support.

We want to work with you to look at how best your eligible needs can be met within available resources. An appeal is a way for you to highlight areas that you feel may leave some of your eligible needs unmet or might put you at risk.

Who can appeal?

You can make an appeal if:

- ✓ You're a client
- ✓ You are a carer for a client
- ✓ You are someone who is involved in the client's life - family member, friend or neighbour
- ✓ An advocate
- ✓ Anyone else that the client has agreed can appeal on their behalf such as GPs or other professionals

What can I appeal about?

You can appeal if:

- ✓ you feel your assessment or review does not reflect your eligible needs
- ✓ you feel your personal budget is not enough to meet your eligible needs
- ✓ you feel the proposed support package might place you or your carers under unreasonable pressure

How do I appeal?

There are three stages to our appeal process.

1. The first thing to do is to let your social care worker know that you would like the decision reviewed. Tell them what you feel needs to be changed, and why.

Sometimes negotiation can be the simplest way to reach an agreement so it's important that you are open about how you feel.

2. If you can't reach a mutual agreement, you'll be asked to provide information to support your appeal within 10 working days. However, this timescale is flexible depending on individual circumstances.

The information could be letters or reports from those involved in your life including your GP or consultant.

Your social care worker will then look again at the information you've provided and review their decision.

3. If you're still not in agreement with your social care worker's decision, tell them and they will pass the matter on to their Practice Manager for consideration. They will review all the paperwork relating to your case, including any additional information provided by you, and make a decision as to whether your appeal is upheld or not.

Briefing on the Self Funder pilot for Scrutiny Committee March 2014

ASC are carrying out a 12 month pilot to improve the current pathway for self funders by adding in an option of independent help and advice.

This service, run in partnership with an organisation called My Care My Home, will be for self-funders who are already in contact with Adult Social Care, as well as those who have not had any contact with us. Self-funding clients will be referred to My Care My Home (MCMH) by Adult Social Care teams or may contact them directly. MCMH staff offer face to face advice through home visits. Initial advice and assessment will be free, with a scale of charges applying to further assistance such as arranging support.

Self funders can still choose to come through Adult Social Care for the assessment and support we provide, with referral on to My Care My Home, where appropriate.

Benefits – these include:

i) Holistic, comprehensive service offer of information and advice dedicated to self funders, without the need to involve ASC, at no direct cost to ASC
ii) Free initial information and advice for all self funders, regardless of contact with ASC
iii) Ability to work closely with My Care My Home as the key delivery partner on intelligence and information about self funders. This will support future strategy and commissioning.
iv) Ability to manage demand for social care assessment and care management and focus this activity on those that need it most – resulting in more efficient use of resources
v) Learning from this project will contribute to planning for meeting 'Dillnot requirements', the new National Eligibility Criteria and the new Care Bill.

How My Care My Home will work with providers in East Sussex

- MCMH will help their customers to find the right care provider. To help people find a PA, they will use Support With Confidence, work closely with voluntary agencies or advertise.
- MCMH will obtain a list of the homes ESCC use and give information to customers to enable them to make informed choices about residential care.
- MCMH will link in with East Sussex 1 Space. On their website MCMH have 50,000+ organisations which can be searched by distance and care type – domiciliary care, residential or extra care. See link below:
  http://www.mycaremyhome.co.uk/search/

Stakeholder Engagement

My Care My Home will meet with various different stakeholder groups, including GPs, to promote the service they offer and get views on how the service might develop. Engagement from January to March includes with the Independent Care Group (care home owners), East Sussex Seniors Association Health and Social Care Group, Carers Services Network and with the three East Sussex volunteer centres.

Monitoring and Evaluation

The service will be monitored throughout the year and an evaluation will take place at the end of the year, which will include user and carer feedback. We have developed a Self Funder Reference Group, which includes self funders and carers, to provide advice and guidance throughout the pilot.

My Care My Home is a company that provides advice, assessment and support to self-funders on all aspects of care and support. This includes helping to find the right local support, providing financial advice, managing any changes needed in the home and, if necessary, helping people to sell their homes so they can move to alternative accommodation. More information can be found at http://www.mycaremyhome.co.uk/

eastsussex.gov.uk

East Sussex
County Council

Adult Social Care

Case studies

March 2014

Meeting needs through Reablement

Case Study 1 - Demonstrating Telecare

A referral to the Duty Team was made following the client's sister contacting SCD for a Review. The client, JW, was not coping well with managing her medication and had recently had a hyperglycaemic attack caused by forgetting to take her medication. JW is a 58 year old woman with medication controlled diabetes and a history of mental health problems, including a diagnosis of psychotic depression for which she was also taking medication. Additionally JW was struggling to manage her diet and ensure that she was eating appropriate foods to help manage her diabetes. JW's sister was finding her role as main Carer very stressful and was impacting on her job and relationships with other family members as she was constantly anxious and dealing with numerous phone-calls from her sister daily concerning various aspects of daily living, including meals.

Following a Review and discussion of what JW felt her needs were, identified outcomes included; safe and correct management of medication, maintaining a healthy diet, effective management of correspondence and finances and reducing social isolation.

JW was keen to remain as independent as possible so rather than meet these with homecare, we discussed how Telecare may help meet her need to be prompted to administer medication throughout the day. JW was unsure about whether she wanted Telecare as she was unfamiliar with the equipment and wasn't convinced it would work. A referral was made to Living Well Enhanced who demonstrated the equipment and focused on building her confidence around using a med prompt. The medication prompt was installed soon after and has been enabling Julie to manage her medication independently through prompting her to take it three times per day at the programmed times.

Consequently, the GP informed the social worker that JW's diabetes and mental health had become much more stable and this has had a positive impact on the relationship between JW and her sister, who is feeling much less anxious and stressed knowing the equipment is working effectively and her sister is calling her much less now her condition is more stable.

Living Well fed back that the medication prompts via the lifeline base unit are proving a great success and had raised an alarm when the client had not taken her medication and subsequent action on Julie's behalf of contacting her sister who was able to call the client to remind her to take it and avoid another hyperglycaemic event.

Additionally, following the referral to Living Well Enhanced, they were able to source a suitable Personal Assistant through the Support with Confidence Website and negotiated a lower rate per hour. The PA provides the appropriate continued support for JW whilst working to reable her around shopping and meal planning which has also helped to stabilise her diabetes. Living Well sourced a local support group which has reduced her social isolation. The PA assigned had an excellent background reflecting all the skills required to support the client.

Case Study 2 - Demonstrating Telecare

MY is a physically fit, fiercely independent 90 yr old lady who lives alone in her privately rented cottage. MY has a formal diagnosis of Vascular Dementia and her short term memory is affected, she also has Asthma which is managed through medication/inhalers, high cholesterol, heart condition, high blood pressure and depression for which medication is prescribed. Her brother Derek who is the main carer for his wife lives in the cottage next door but he is a frail 87 yr old with limited ability to support MY. MY has a history of self neglecting her medication, personal appearance and home environment and has an open fire in her property that she likes to use and also a gas fire that she occasionally leaves on. MY often goes out and uses public transport to go into town or sometimes further afield but she occasionally gets off at the wrong stop or gets on the wrong bus.

MY had a fall when she tripped over in her front garden and was admitted to hospital having fractured her right arm. Being right handed impacted on her ability to carry out activities of daily living and following discharge from the acute hospital setting she was re-admitted to the local hospital for a period of rehab prior to discharge. At the point of review professionals at the hospital were requesting a substantial package of homecare for MY to meet her needs and manage the risk of her living at home to enable discharge.

To enable MY to maintain independent access to the community and manage this as a positive risk, a referral for a Romad alarm was made as part of the assessment. MY carries the Romad device in her handbag enabling MY's niece to monitor and be aware of MY's movements via a website in the event MY does not return home within a reasonable time frame. Additionally, a property exit alarm was also installed, linked to a Carer Assist so that her brother who lives next door would be alerted when MY leaves her home. Managing this risk through the use of telecare also enables MY to attend Church on a Sunday which is very important to her due to her strong Catholic faith. An assessment for multiple identified risks was completed following the referral for telecare.

To reduce the risks of falls, an OT assessment was also requested to see what Daily Living Equipment (DLE) could help manage this risk and ensure MY's independence as much as possible with several pieces of equipment being prescribed.

Following the installation of the telecare and DLE equipment, only a minimal package of homecare was needed to be provided to assist with MY's personal care, leading to a more cost effective package of care but also one that maintained MY's independence and enabled her to take positive risks.

Case study 3 - Demonstrating collaborative working between Neighbourhood Support Team (NST) and Occupational Therapy Reablement Team (OTRT)

Mrs X, who has dementia, lives with her husband and had a number of needs identified in her social care assessment: To be able to maintain personal care, support to eat and drink at lunch time, assistance late afternoon to be moved to and from the toilet again and in the early evening to get ready for bed and be made comfortable for the night. Mrs X required the assistance of 2 carers on each occasion she was moved using a hoist.

Mrs X required 2 carers 3 times daily and 1 carer once daily which amounted to 4.5 hours of support per day and use of a fixed hoist for all transfers.

Following an OT assessment the following was prescribed:

- Voyager hoist in lounge for use with 1 carer
- Moving and handling equipment that could be used with 1 carer
- Tilt in space shower chair and armchair (*supply awaited*)

Mrs X also changed from a having a care agency to a Personal Assistant; A PA already known to Mrs X and who was very experienced. She was able to complete care on her own. When this PA was on holiday or day off a care agency were to provide care but they were still to use 2 carers. The OT anticipates once all equipment is in situ the care agency will also agree only one carer is required per visit.

Previous history of care package costs had always been above the RAS figure. Most recently prior to the OT assessment and supply of equipment the support costs had been £507.26. After these changes were made the weekly commitment reduced to just £349.74. This enabled Mrs X to remain at home instead of needing to go into nursing care.

Meeting longer term support needs

Case Study 4 - Younger adult with physical impairment

Mrs Q has Multuiple Sclerosis and is reliant on others for all her daily living needs. She is wheelchair dependent and needs to be hoisted for all transfers. Her husband is her carer and has been providing all her support, he now has curvature of the spine and suffers back pain. He is no longer able to support in the morning with her personal care.

The client attends respite for one week of the year, which is able to cater for her specialist needs due to symptoms of her condition.

The pressure of caring impacts on the couple's relationship and a break is needed by them both to maintain and enhance their relationship and enable Mr Q to continue in his caring role.

The couple want to remain together but need support to relieve the situation and reduce stress levels, the support will also enable them to follow their own interests and come back home refreshed with new topics etc to talk about.

Issues/risks: Mrs Q has very complex needs around her condition and mobility.

Mr Q used to provide all of the support but due to a curvature in his spine, he is no longer able to continue with the personal care and manual handling/hoisting etc. If the expectation is for him to continue to support his wife, he could potentially end up hospitalised and eventually needing ASC support himself, therefore increasing the dependency on services for both.

Mrs Q is totally reliant on 2 carers to provide support around transfers and personal care, without this support she would be unable to continue to live independently.

The Senior Practitioner OT who knows the client well acknowledges the services she is accessing are costly because of the need for specialist support, due to her complex needs around her MS and the need for two people to aid with transfers and personal care.

At present Mrs Q uses her budget as a direct payment and therefore has chosen the type of support she currently receives.

	Previously	**Revised offer**
RAS	£335.00	£235.00
Actual PB value	£391.00	£221.89

Support package		Single Direct Payment for repair of ceiling track hoist = £114 - £2.19pw pro-rata
	Homecare 14 hrs per week = £204.40	Homecare reduced from 14 hours = £204.40 to 7 hours = £98.98 at a rate of £14.14 per hour, for carers for 1 hour in the morning but with support from informal carer.
	Day care 2 days ARCC = £123.44	Day-care reduced from 2 days = £123.44 to 1 day = £61.72
	Respite 1 week = £1222.70 Carers Home based respite 3 hrs pw = £39.33	Respite 1 week & Carers Home based respite to remain the same

This option is for 1 carer only in the morning, supported by Mr Q as the second carer but only with the lighter aspects of the personal care support and not to be involved in heavy lifting, or twisting.

The day care has reduced to 1 session per week and the home based respite and residential respite will remain the same to provide the carer and client with a break.

Independent Support Planning & Brokerage (ISPB)

Case Study 5 - Younger male adult with mental health need

Mr T, aged 52, referred himself to ASC as he felt "unable to cope with my job due to severe anxiety and depression". Following an assessment of his social care needs the Resource Allocation System (RAS) identified his needs to warrant an indicative personal budget of £101.00 per week.

Mr T opted to work with an independent support planner to assist in how best to meet his eligible needs within the personal budget identified. As a result a number of no-cost opportunities were identified to meet his preferred outcomes and interests as well as a need for a one-off Direct Payment and recruitment of a Personal Assistant (PA). Agreed support included free day-time activities such as a healthy eating cookery course, joining a healthy walks group and attending a local coffee morning. In order to identify a suitable PA a trip was arranged to the local library to access the free internet to explore PAs approved through the Support with Confidence scheme.

His Personal Budget would be £95.65 per week to cover Personal assistant and Peer Support specialist time plus a one-off payment of £90.00 to supply resources to improve self-organisation to aid improved sense of well being and positive mental health.

Appeals

Case Study 6 - Older couple with physical impairments

Mr J (82) is sole carer for his wife who is 84 years old and has limited mobility due to an unsuccessful hip replacement in 2009. She is also occasionally incontinent. Mr J suffers from back pain and is unable to do any lifting. Mrs J has three personal care visits per day in the morning, lunchtime and evening to change her incontinence pad and attend to her personal hygiene.

Mrs J's current support package costs £411 per week and a recent review indicated that her personal budget should now be (up to) £287. Mrs J's social worker has discussed the implication of this with Mr and Mrs J and suggested her lunchtime homecare visit could be cancelled as she is very rarely incontinent during the morning.

Mr and Mrs J appealed against the reduction in Mrs J's personal budget, stating that she relies on the lunchtime visit as the carers put their lunch in the microwave and provide them with essential social contact without which they would have no visitors during the day. They concede that Mrs J does not usually need her pad changing at lunch time.

The **appeal** was **not upheld** as the social worker and practice manager felt that Meals on Wheels could provide the couple with a hot lunch-time meal, and that the social element to the visits did not constitute a critical or substantial need. Mr and Mrs J expressed their disappointment with the outcome but were reassured that their social worker would be looking into alternative sources of social contact via local voluntary groups.

Case Study 7 - **Younger male adult with a learning disability**

Paul has a moderate learning disability and autism. He lives with his mother who is his sole carer, and his 2 siblings. Paul has a support package which consists of 5 days a week at an autism-specific day centre and 5 hours support from a personal assistant at weekends.

Paul's support package currently costs £489 per week. Following a recent review his new personal budget should now be (up to) £342 per week. His social worker has discussed changes to the support package with Paul and his mother, and has suggested ceasing the 5 hours P.A support at weekends and reducing his day service to 4 days per week, which would bring the package within the new budget. In-house day services were considered (which would be a more cost-effective option) but declined as they felt Paul would struggle in the busy and noisy environment due to his autism.

Paul's mother has appealed against this proposal, stating that reducing his attendance at the day service was impossible as she works full-time and is therefore not at home to care for him. She states that, without her full-time income she would need to sell the family home which Paul shares with his two younger siblings (one of whom has severe asthma). She does agree that they could probably manage without the personal assistant at weekends.

In considering the appeal the social worker and team manager conceded that to prevent Paul's mother from working to support their family would be unreasonable in the circumstances. Ending the personal assistant support at weekends would save £85 per week.

The **appeal** was therefore **upheld** and the department agreed not to reduce funding for Paul's day service but to end the weekend support, meaning that the indicative budget would be "topped up" by the department by a further £62 per week. Paul and his mother were very happy with this outcome, and stated that they understood the council's need to make savings wherever possible.