Additional information regarding savings proposal A14

Managing the demand for formal social care and achieving best value in the provision of care packages

September 2015

Background

The Care Act 2014 requires local authorities to *'consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help*' in considering *'what else other or alongside the provision of care and support might assist the person in meeting the outcomes they want to achieve'*. In order to do this the assessor '*should look at the person's life holistically, considering their needs and agreed outcomes in the context of their skills, ambitions and priorities*'.

The Care Act also states that "*Any suggestion that support could be available from family and friends should be considered in the light of their appropriateness, willingness and ability to provide any additional support and the impact on them of doing so".*

Taking a person's own strengths and capabilities, alongside their wider support, into account is referred to as using "asset-based approach".

The objective of using an asset-based approach is to protect the individual's independence and resilience and their ability to make choices and maintain their wellbeing. Supporting the person's strengths can help address needs (whether or not they are eligible) for support in a way that allows the person to lead, and be in control of, an ordinary and independent day-to-day life as much as possible. It may also help delay the development of further needs.

How we are approaching the Savings

For 15/16, the identified savings are being achieved primarily through ensuring that an "asset based approach" is being taken in relation to packages of care, including residential and nursing home placements. These assessments are being undertaken within a clear framework and resource allocation system that enables the service to manage demands within a reduced budget.

Multi-disciplinary teams – which bring together social workers, district nurses and other therapies - have been formed and now work more closely together to problem

solve and reduce duplication in any care package being delivered. Newly trained support planners, now work with the service user and their families/carers to create support plans that maximize resources available within their family network and in the community before calling upon resources available through Adult Social Care. The support planners also assist in market development.

Specialist Occupational Therapy (OT) resources are working with service users who have high cost double handed packages of care. These service users are often discharged from hospital with complex health conditions. Within 6 weeks of discharge OT's work with the service user, families and care workers to reduce double handed visits by using specialist equipment and by providing training to care workers on moving and handling techniques. This more personalised support plan puts the service user back in control of their daily living and effectively reduces the care cost.

By working closer with specialist health services we are also delivering care in a different way. For example the Medicine Management Service reviews medication requirements and where possible prescribe medication that only needs to be administered once a day, and therefore reduces the number of care calls a person receives during the day.

We are re-tendering our Domiciliary Care Framework, so that providers will deliver assessed needs and agreed outcomes within the service user's personal budget in line with co-produced support plan.

Identifying and mitigating risk

Adult Social Care takes a structured approach to the identification, assessment and management of risk. In additional regular reviews of incidents take place as the total elimination of risk is unrealistic.

To ensure we identify and mitigate risk associated with providing the right levels of care, the following has been put in place:

- All staff continuously receive training in identifying and mitigating risk.
- Assessment and Support Planning tools identifying risks and mitigating actions are agreed and signed off with service users, families and carers.
- Neighbourhood co-ordinators work with GP's and multi- disciplinary staff to deal with urgent cases where care packages are no longer meeting needs due to declining health and wellbeing.
- All service users have a named Key Worker to contact should an emergency arise or care is no long sufficient.

- Dedicated duty desk take calls from service users, their families/friends or care providers and undertake emergency re-assessments should a need or risk be identified.

- Regular monitoring of pre-paid card accounts for those service users managing their personal budget via direct payments. This ensures expenditure within the accounts is aligned with the Service user's identified care needs.

- The vulnerable adults (VA) panel considers all applications for care packages to ensure the package meets client's needs, delivers agreed outcomes and deals with associated risks.

- Specialised risk assessments are carried out on manual handling and enablement care.

- Adult Safeguarding process and procedures have been put in place.

- Quality monitoring of Care providers is carried out in line with safeguarding and risk management procedures.

Work underway in 2015/16

We are currently undertaking a programme of service user reviews:

- Re-assessment of all care packages using the RAS (resource allocation system)
- Reviewing Independent Living Fund (ILF) cases as result of its discontinuation
- Reviewing all double-handed care packages
- Reviewing high cost residential packages
- Reviewing high cost nursing packages
- Review of CAT 1 funded care packages
- Review of the Laundry service
- Review of Meals on Wheels service

In any one year, there are approximately 4600 Lewisham adults receiving Adult Social Care.

From the reviewing programme above, in the first 4 months of 15/16 (April to July) we have competed 728 reviews achieving a £722k reduction in packages of care. The amount of savings relating to reviews that have taken place in August and the first half of September will be available shortly.

By 31st March 2016 we will have completed approximately 3000 reviews and anticipate achieving total full year savings of £2m.

In 2016/17 and 17/18 we will continue with the current reviewing regime, ensuring that any current service user and all new service users receive an “asset based” assessment approach as detailed above.

We therefore forecast that a further 600k saving can be achieved in 2016/17 and a further 500k in 2017/18.

Case Studies

Case Study One (Re-assessment of Independent Living Fund (ILF)

Mr J is a 61 year old Black Afro-Caribbean man, who resides with his father in a two storey maisonette which is on the 3rd floor of a council building.

Mr J has been left with Brain injury as a result of having meningitis, followed by several strokes in 2001. He presents with difficulty in speech, understanding and communication, His mobility is affected with inability to balance, high risk of falls and difficulty negotiating stairs and needs assistance at all times for personal care.

Mr J currently receives a care package of £495 weekly from the independent living fund to meet his night time care needs, and £235.71 weekly from the local authority to meet his day-time care needs.

Analysis of the care package demonstrated that the Local Authority and ILF had been double funding part of the previous package for this Service user. Discussions with Mr J’s sister resulted in her offering to order food on line for both Mr J and his Father; she also agreed to provide some support with some domestic tasks. Mr J’s church through their volunteering scheme will now provide 2 weekly visits to church meetings and social events.

Mr J’s package of care was re-assessed using the newly introduced assessment tool, which resulted in a reduced care by £213.78 weekly. This represented an accurate reflection of his care needs.

Case Study Two (Continuing Health Care)

Mr G was born in Scotland in 1966, he was involved in a Road Traffic Accident aged 27, when he was the passenger in a car hit by a drunk driver. The accident left him Paralysed from the neck down.

Mr G has been known to Lewisham Adult Social Care for nearly 20 years. He has complex health needs relating to the spinal injury which took place in the 90's.

He currently receives a care package of £507.59 weekly from the independent living fund to meet his night time care needs, and £923.59 weekly from the local authority to meet his day-time care needs.

A thorough examination and review of his existing care package clearly indicated that the service user may be eligible for Continuing Health Care funding as he would likely score high in Mobility, Continence and Breathing domains. A joint reassessment took place with District Nurse, and it was determined that Mr G has met the eligibility criteria for CAT1 funding due to the complex nature of his health needs. Funding responsibility has now moved from Adult Social Care budgets to NHS funding.

Case Study Three (Occupational Therapist Re-assessment of care package)

Mr X is a 107 year old gentleman that had been experiencing some decline in his abilities to mobilise and carry out activities independently. He requires a lot of prompting and encouragement to carry out his personal care and support with transfers and mobility.

He was admitted to hospital on in July 15 following a fall due to left leg weakness and confusion.

His previous care package before been admitted into hospital as a result of his fall was1.5 hour care calls daily.

On discharge from hospital his care package was increased to two hours daily (double-handed) One hour in the morning, half an hour in the afternoon, and half an hour late evening to support Service user on discharge.

A re-assessment of his care package was carried out three weeks after discharge by an occupational therapist.

Despite his advanced age, Mr X showed a significant improvement and his care package was reduced to one hour daily.

Case Study Four (Re-assessment Adult with Learning Disability)

Mr Y is an adult with learning disabilities, who currently lives in a registered residential care home in Kent. Mr Y has no health problem although he is found to have a borderline level of cholesterol**.** He has been advised `by his GP to manage his cholesterol with healthy diet and exercise; and to quit smoking.

Mr Y can independently manage his personal care needs including shaving he also independently manages his dressing and undressing needs.

Mr Y reported that he is able to manage some aspects of day to day living activities such as prepare his choice of cold breakfast, sandwich, and hot drinks He also reported that he is able to manage shopping for basic everyday items but needs support to manage large household shopping. He has no mobility issue and travels independently on local buses.

Mr Y participates in many community based activities and spends alternative weekends away from his residential home with his parents at their home.

Mr Y currently receives a residential care package at a cost of £1,309 weekly.

A re-assessment of his care needs was undertaken recently and it was identified that his care needs are best met within a supported accommodation environment rather than a residential placement. This was discussed and embraced by Mr Y and his care team, to enable him to live more independently. We are now working to find Mr Y a suitable Supported Living tenancy. His new care costs will be in the region of £470 per week.

Case Study Five (Re-assessment due to MDT request)

Community Nurse (CN) telephoned Neighbourhood Co-ordinator (NC) as she had visited service user and reported that service user had a blocked catheter and was being conveyed to hospital. Concerns were also raised that service user was unable to cope at home, home was in disrepair and service user was eating takeaway food which was not good for his diabetes. The service user attended A&E and discharged home

The service user is housebound due to mobility issues, has a long term catheter and heart condition and is also a diabetic. He also has a visual impairment but this has been undiagnosed as yet. He is also has low mood and socially isolated.

The service user had Enablement input after a lengthy hospital admission at UHL and Enablement had recently ended their involvement. The service user seemed very upbeat and well when he was receiving input and support from the Enablement Team and therefore deemed to be able to cope without support but when the support was withdrawn Service user was unable to cope.

CN noticed on another visit that service user had a necrotic toe, the Nurse was concerned as it was so bad that she thought that the toe may need amputating, an ambulance was called and he was conveyed to St Thomas's Hospital.

Whilst the service user was in hospital, NC discussed the case with the Senior Social Worker and also with the Visual impairment team lead to discuss the best way forward for this Service user. As the case hadn't come over to the Community team at this stage so the Senior Social Worker discussed the case with the Enablement Support Planner and they put in an on-going package of care consisting of 1 x call a week to assist the service user with some light shopping and housework.

NC also discussed with the support planner some of the difficulties that the CN were facing and their concerns about the welfare of the service user, which were as follows:

- service user was having difficulty in reading letters due to his visual impairment and some hospital appointments had been missed, there were issues in regards to booking of transport to take him to medical appointments this was highlighted by the CN who managed to book the transport for some of his appointments when the service user asked her to read his letters but there were other times when it was too late to book transport and so appointments were not attended because of this, thus being detrimental to the health of the service user. NC contacted GP to see if there was a way that the surgery could notify the NC of any hospital appointments for the service user so that the NC could convey the information to the relevant people, but the GP stated that they were only information of non-attendance of appointments or information after the appointments.

  NC contacted various departments within the hospitals that the service user had appointments with as it was deemed that the service user can read but can only read large, bold font. He requested that any appointment letters be sent out to service user in the appropriate font to allow him to read the letters and also requested that transport be booked at the time of sending the appointments where possible as service user was not able to book his own transport unaided.

- Concerns were raised by the CN in regards to the bedding and clothing of the service user was dirty and he seemed to be wearing the same clothes for most of the time, it came to light that service user was unable to operate his washer/drying machine. Support Planner set up temporary additional support via the Enablement Team to work with the Service user to enable him to complete his own washing tasks.

- Service user was unable to complete any shopping tasks due to his poor mobility. Service user had been given Wiltshire Farm Foods information but was unable to complete orders unaided; A regular order was placed on his behalf so that he could access nutritional food and heat the food himself.

- Staff referred service user to the Podiatrist who visited the service user at home and suggested some more suitable shoes/slippers be purchase to aid the healing process of the service user's toe. Support Planner liaised with the service user around the purchase of the items required and has arranged to purchase the items for him on his behalf.

- One Support have been assisting the service user with his housing and assisting him with his benefits, completing a benefits check to ensure service user is claiming all that they are entitled to. It came to light that the service user was in rent arrears as he had mislaid his rent card. Service user was supported to the post office via taxi to withdraw money and paid his rent and clear his arrears and also to put money on his gas and electric key and to have some money for shopping which was required. Due to his mobility issues service user is reluctant to venture out on his own at this current time. One Support have also been supporting the service user to open a bank account and join a credit union to enable the service user to pay his bills via direct debits.

- Service user also raised concerns in regards to his sash windows and felt that the window would fall on him and the windows do not stay open independently. The Support planner contacted his housing association and arranged for a site visit. It came to light that the property of the service user is in disrepair and seems to have missed the decent homes initiative, but they also found a substantial leak underneath the property which has occurred over a period of time which has contributed to the damp and overall condition of the property.

  Service user has now been registered on the housing register and a possible property has been identified for him which is in an elderly block on the ground floor, also nearer to the shops. We are awaiting the outcome from Phoenix Housing.

- Visual Impairment Worker has been to visit the service user, service user has been referred to the hospital for a diabetes eye check and we are awaiting the outcome of his appointment.

This case study has not concluded as yet but to date the service user has benefited from MDT working as service user was socially isolated, has no family in this country or friends, and with input from the Community Nursing Team, Enablement Team and his regular Agency Worker, One Support, Visual Impairment Team, Pheonix

Housing, GP and the NC we have worked together to achieve the following outcomes for the Service user.

- The Service user is now able to read his letters independently due to the larger and bold font.

- We have put in mechanisms for the hospital to arrange transport to permit him to attend appointments therefore saving the NHS money in missed appointments and unnecessary hospital admissions due to appointments being missed.

- Service user was ordering takeaways and pizzas to be delivered which was having an impact on his health as he is a diabetic and is now having a volunteer buy his shopping and also being supported to order Wiltshire Farm Foods therefore eating a proper balanced diet. Service user can also prepare light snacks and hot drinks independently.

- Service user is able to complete the following household chores independently after Enablement input – operate his washing machine and complete washing of clothes and bedding

- Service user to be more in control in regards to his finances and having bills paid via Direct Debits.

- Brought to the attention of the Housing Association problems with his accommodation, which highlighted the main leak under the property and that the house had been missed on the Decent Homes Initiative.

- Supported service user in a possible house move to more suitable accommodation so that Service user is not socially isolated.

The Service user is no longer in receipt of a care package from Adult Social Care, but is receiving support from other agencies.