ITEM 7a

Adult Social Services

Financial report and analysis 07/08

Purpose of the report

1. To outline the financial pressures currently facing adult social services
2. To explain how and why these pressures have arisen
3. To provide comparison information in terms of budget and performance
4. To outline the actions currently being taken to control the pressures
5. To outline the projected outturn and likely impact in 08/09 and 09/10
6. To outline other measures which could be taken to bring the budget into line

1. The financial pressures currently facing adult social services

The adult social services gross budget is 68.65 million. The current projected overspend is £3.2 million (period 5 to end August 2007).

In 2006/07 the adult social services overspent by £1,700,000. In 07/08 adult social services were required to make a further £1,500,000 in efficiency savings (which were taken off budgets at source). In addition the full year effect of significant increases in home care hours in the first three quarters of 06/07 has impacted on the 07/08 position.

There are 3 key pressure areas:

1. Home care Services

At the beginning of the year we were providing 22,107 homecare hours per week. We are now providing 19,700 hours per week (as at end September 07). The budget available allows for only 16,500 hours per week. The resulting overspend in 07/08 is projected at £2.254 million.

2. Residential care – adults with mental health needs

This budget is projected to overspend by £647,000. More placements have been made than in previous years. This budget overspent in 06/07 by £228,000, and was further reduced by £150,000 for 07/08 as part of the efficiency programme.

3. Staffing

Assessment and care management staffing budgets are projected to overspend by 563,000. This is not due to any increase in staffing but to the way the budgets have been set up.

Staffing budgets in Social Services have historically been funded at mid point of salary scales. We have low turnover in many areas, particularly in assessment and care management teams, with most staff at or near top of their pay scale. This, together with an unrealistic increased turnover factor, has resulted in the problem.

These overspend areas total £3,464,000, balanced by small under spends in other areas leaving a residual projected overspend of £3,200,000.

2. The reasons for the pressures

2.1 Home care - hours provided

Home care includes hours provided by the in-house home care service, hours provided by independent domiciliary providers, and hours provided via direct payments.

In March 2005 we were providing 14225 home care hours per week. The hours provided started to rise from this point until they reached a peak of 22,423 hours by January 2007. They have decreased since January 2007 to the current level of 19,700 with the full implementation of the changes to eligibility criteria.

In order to fully understand the detail behind the reasons for the growth in we have mapped it against changes in services and performance over this period. We have also compared our level of provision and rate of growth to that of other authorities. A detailed report is attached as Appendix 1.

It has been suggested that some of this growth is as a result of lack of managerial control. Up until September 2005 new assessments for care services were carried out either by in-house home care managers (more straightforward needs) or by care managers (more complex needs). This changed from September 2005 with care managers carrying out all new assessments, but this was six months after the growth started. This change may have contributed to the growth but the change itself was in line with CSCI requirements and led to significantly improved performance in relation to reduction in care home placements and increased intensive support, key adult social care performance requirements. It is however true to say that the financial impact of these improvements to services were not fully appreciated until mid/late 2006.

The table below shows that the vast majority of the growth in home care hours can be clearly attributed to the following factors and is mirrored nationally.

Factors affecting growth in home care hours	Growth in home care hours per week attributable (March 2005-January 2007)
Demographic changes, especially the growth in population of older people over 80 years; and the growth in numbers of young people moving into adulthood with high level complex needs (learning disability and physical disability, often combined)	700
The level of disability and health difficulties people live with, not only are there more older people requiring services, but they are likely to have more needs for longer periods of time	500

The council's improved performance on increasing intensive home care and reducing the number of people entering care homes. This is a national performance priority (a key indicator for adult social care. Our performance has significantly improved over the past 2 years, although it is still not yet top band performance. The calculation of 3600 additional home care hours is based on an assumption of a 20 hour per week care package for each person who in previous years would have been admitted to a care home.	3600
The continued growth in the use of direct payments, which means that some people are accessing services which they would not have done in the past (where traditional methods of provision did not meet their needs). The number of direct payments service users grew from 128 to 280 over this period, with an increase of 2200 hours per week.	2200
There have been significant changes to specific performance requirements for adult social care over the past two years : Assessments must be started within 48 hours of referral and completed within 28 days. Minimum acceptable standard rose from 65% in 2004/5 to 80% in 2006/7. Care packages must be started within 28 days of assessment. Minimum acceptable standard has been raised from 65% in 2004/5 to 80% in 2006/7. Hospital discharges must be completed with 24 hours of section 5 notice from the Ward, otherwise Derby City Hospitals Foundation Trust is at liberty to charge the Council for reimbursable days. The information cited above is for minimum acceptable standards. In order to be considered a "good" authority, performance levels required are significantly higher. It is no longer possible to employ waiting lists as pressure relief valves on the system	1000
TOTAL	8000

In addition to the above the growth is further explained by the changes in NHS provision, for example the reduction in delayed transfer of care, reduced number of hospital beds, and shorter lengths of stay in acute hospital care all have significant impact of adult social services. If older people are discharged earlier from hospital they are likely to need more care at home support than if they had remained in hospital for

example for another 3 days. Similarly if a person is offered more intensive healthcare to prevent an admission to hospital their social care needs still need to be met whilst at home. NHS care and Adult Social Care are interdependent; a change in one part of the system very often affects other parts of the system

2. Mental Health Services residential care

The spend on placements has increased over the past 2 years

	05/06	06/07	Overspend 06/07	Projected placements 07/08
Number of placements – adults mental health	23	35	£ 228,000	

The number of placements made has risen, hence the projected overspend. The financial impact is not necessarily restricted to the year in which the placement is made, depending on the length of the placement.

The commission will be aware that adult mental health services are managed through a partnership with Derbyshire Community Mental Health Trust. The Trust re- organised their management structure in 05/06 into divisions based on functions rather than local authority areas. At this point Derby City no longer had a lead manager and budget control/accountability may have been affected. There is no formal agreement with the Trust relating to the management arrangements, and at the present time we are working with the Trust to understand the reason for the growth in spend and to discuss future management and accountability arrangements. Adrian Perry, our strategic commissioning manager for mental health services has also assumed responsibility for chairing the Community Care Panel which agrees all placements, in order to better understand demand and control expenditure as far as possible for the remainder of this financial year.

It should be noted that the spend on adult mental health services is below average for our comparator group (as at 05/06)

3. Staffing Budgets

This is a long term issue. Adult Social services staffing budgets have historically been funded at mid point in salary scales whereas, with low turnover, the majority of our staff are at top point on scales. This problem was masked with underspends in other parts of the budget in past years. At the current time however, with the whole of the adult services budget under pressure, the problem is exposed and considerable.

3. Comparison with our comparator authorities

Derby is the second lowest spending council on adult social services in our comparator group. The table below shows the latest available comparison information for adult social services, and the real difference between the annual spend in Derby as compared to other authorities.

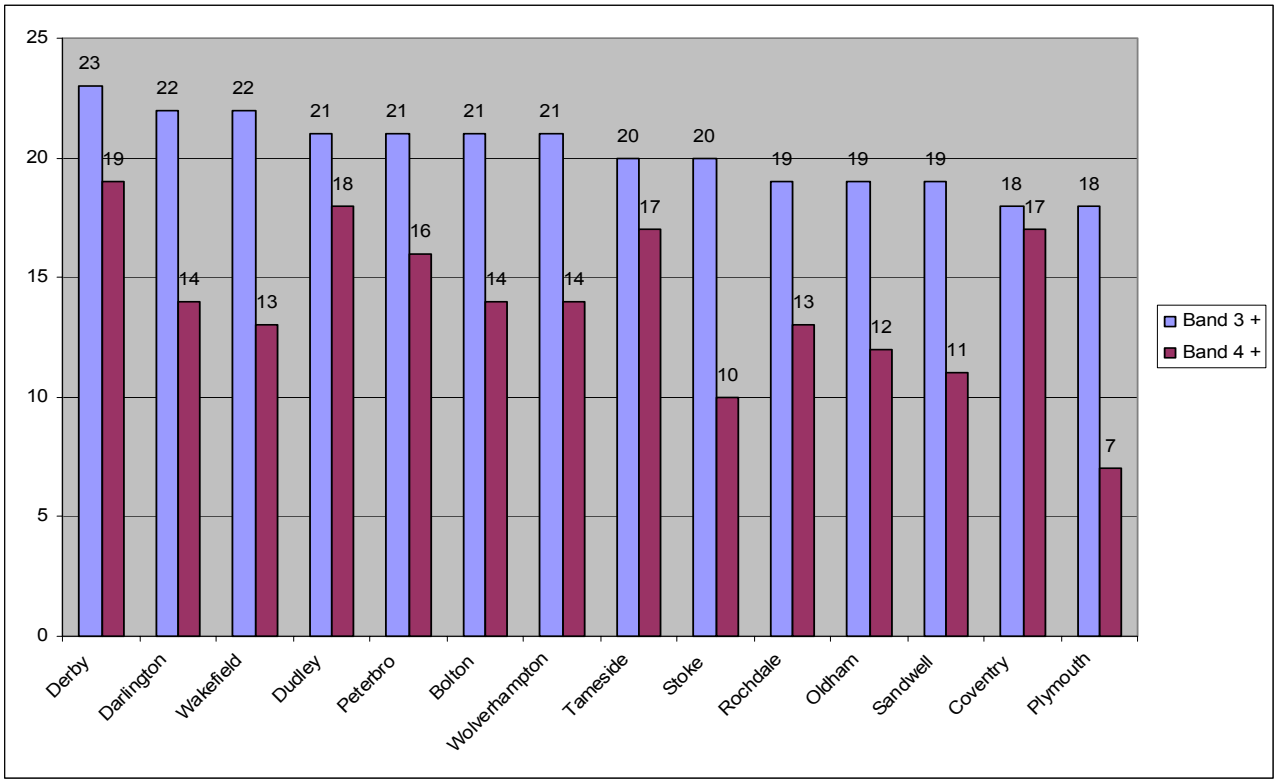
	2005/06			Spend Per Head			
Council	Gross £'000	**Total Income**	**Net £'000**	**18+ Pop**	**Gross Per Head**	**Net Per Head**	**Gross Budget Differential £m**
Walsall	97932	28,127	69,805	192867	507.77	361.93	27.43
Oldham	78,353	26,703	51,650	163747	478.5	315.43	22.15
Wolverhampton	86486	15,703	70,783	185503	466.22	381.57	19.93
Sandwell	96,390	20,058	76,332	218222	441.71	349.79	15.50
Tameside	71464	23,960	47,504	164841	433.53	288.18	14.03
Rochdale	66,470	16,485	49,985	155636	427.09	321.17	12.86
Stoke	79280	21,083	58,197	186002	426.23	312.88	12.71
Wakefield	105201	24,516	80,685	250057	420.71	322.67	11.71
Darlington	32,403	8,005	24,398	77080	420.38	316.53	11.65
Bolton	81814	18,494	63,320	202543	403.93	312.62	8.68
Plymouth	77427	16,368	61,059	194863	397.34	313.34	7.49
Coventry	93445	18,718	74,727	235688	396.48	317.06	7.33
Peterborough	46,389	13,546	32,843	121360	382.24	270.62	4.76
Dudley	85,026	14,652	70,374	238517	356.48	295.05	0.11
Derby	64,271	**11,590**	**52,681**	**180603**	**355.87**	**291.7**	
Stockton	50,846	10,870	39,976	143831	353.51	277.94	-0.43
IPF average					396.68		

If we breakdown spend into user groups, we are low spenders on older people and learning Disability services, below average for mental health services and near the top of our comparator group for Physical Disability. (This is influenced by the high number of deaf people in Derby and the high people supported to live at home through direct payments as outlined earlier).

If we spent the average per head of our comparator group on adult social services it would require an additional £7.37 million pa.

Despite having one of the lowest levels of funding we are one of the best performers in terms of the performance indicators for adult social services. Of the 24 indicators, we are at average or good for all but one indicator (cost of intensive care). We are lower in this indicator as we have more in house services than other authorities, with an increased cost. This does compound the difficulty in managing our budget.

Performance Overview



4. The actions taken to control the pressures and the end of year projected outturn

This is an extremely challenging year for adult services. A range of actions are being taken to achieve savings and contribute to limiting the overspend. These are outlined in the table and detailed below. Despite these actions the resulting position is a projected overspend of £3.2million.

Action taken to deliver efficiencies and minimise overspend	Saving projected achieved in 07/08	Full year expected effect of saving
Implementation of the change in the council's eligibility criteria to cease providing services where there is a low risk to independence	1,345,000	1,793,000
Freeze on external recruitment, and reductions in cost through non filling of posts (assessment, care management and support services)	330,000	330,000
Reduction in Direct payments rate paid	80,000	160,000
Shift in the balance of homecare provided from in house to independent sector	100,000	200,000

Changes to Section 117 arrangements	30,000	45,000
Review of high cost residential placements	150,000	150,000
Consultation on the possible closure of a residential care home	20,000	100,000
TOTAL	2,055,000	2,778,000

Implementation of the change in the council's eligibility criteria to cease providing services where there is a low risk to independence.

The decision to cease providing low level services was taken in April 2006. There was no comprehensive implementation plan, and as a result the hours continued to rise until December 2006.

In order to fully implement this change staff required increased support, practice guidance, managerial direction and cultural change. Reviews of all users needs against the new eligibility criteria and practice guidance have been completed, resulting in a reduction of 2700 hours in care delivered. This action has saved around £1.3 million this financial year, £1.7 million full year effect.

The impact has been the withdrawal of services for some individuals, and a reduction in services for others. This, in the main, has been domestic support, particularly shopping (where there is an alternative), cleaning (except for maintenance of essential hygiene), laundry and meal preparation (where necessary now provided in a more cost effective way through meals on wheels). In all cases we have ensured that people are claiming all non-means tested disability related benefits to which they may be entitled, to enable people to purchase additional support and services needed which are no longer eligible to be funded by social services. In most situations people have understood and accepted the change, although it is unrealistic to expect anyone to be happy at the withdrawal of a previously provided free service.

The reduction in the number of people receiving a service has adversely affected the performance indicator which measures the number of people helped to live at home through care managed support. We remain in the second highest band.

We also anticipate it will adversely affect the number of people receiving intensive care packages, as services to meet low level needs have been comprehensively reviewed out, to achieve a fair and consistent approach.

Vacancy Management and freeze on external recruitment

Since the beginning of this financial year there has been little or no external recruitment to posts in adult social services. Instead posts have either been held empty, or offered to staff that are redeployed as services are modernised. This has an impact on the workload of teams, as not only are vacant posts unfilled but nor are we able to cover for maternity or long term sick leave.

Reduction in Direct payments rate paid

As noted earlier our spend on people with a physical disability is the second highest of our comparator group. This is influenced both by the high number of deaf people and the high number of people receiving direct payments (7th highest in the country) and the relatively high rate of payment per hour (one of highest in East Midlands region in 06/07). In order to achieve financial efficiencies the rate was reduced for people employing their own PA from July for new users and from October for existing users, with transitional arrangements to ensure that no one is forced to end a carer's contract.

There has been a reduction in the number of people receiving Direct Payments as some individuals are no longer eligible for service, there has been no reduction as a result of the change in the Direct Payment rate.

Shift in the balance of homecare provided from in house to independent sector

In-house home care costs approximately £4.50 per hour more than independent sector care. We have therefore pursued a strategy of offering work to the independent sector in the first instance, and working with the independent sector to build capacity. The % of hours has changed as follows:

Date	Independent sector hours	% independent sector	In-house hours	% in-house
March 2006	5124	39.2	7943	60.8
March 2007	8756	52.9	7780	47.1
September 2007	9181	63.1	5382	36.9

In order to realise the full efficiency we need to reduce in house management costs, this is incremental due to our need to avoid redundancy.

The above excludes learning disability services which are wholly provided in-house and direct payments.

We still provide more in house home care than the average for our comparator group and for all England, the average for our comparator group was 30% in house in September 06 (the latest published comparable information).

Figure 1.3 Percentage of total hours of home care provided in house

	Derby	IPF	Unitaries	England
September 2003	65.5%	41.2%	31.5%	33.5%
September 2004	53.6%	38.4%	28.1%	30.7%
September 2005	47.3%	32.9%	25.5%	26.6%
September 2006	40.6%	30.0%	21.0%	24.6%

Changes to Section 117 arrangements

This relates to people with mental health need who have a protected status (where their care costs are fully met by the local authority with no cost to the individual) as a result of previous hospital admission for acute mental health needs. Previously we included costs of accommodation in this, although other local authorities do not do so. This was identified and action taken to change the arrangements in July 07. This saves around £40,000 pa full year effect.

Review of high cost residential placements

Some placements for people with complex needs, especially for people with both learning and physical disability, are very expensive and agreed on an individual basis (unlike placements for older people where the council has an agreed fee level). Review of the particular arrangements for individual placements has resulted in a saving of £150,000 pa full year effect.

Consultation on the possible closure of a residential care home

Consultation is currently underway regarding the possible closure of one residential care home. This was included as part of the efficiency savings plan for 06/07. If realised, subject to cabinet approval this will release between 100,000 and 233,000 in revenue savings (the exact saving depends on the alternative placements for individuals) and also capital for investment in future alternatives to residential care and/or the development of specialist dementia care services.

5. Projection for 07/08, 08/09, and 09/10

The table in Appendix 2a projects the current year position forward into 08/09 and 09/10. This is based on the service remaining as it is now, with no additional income for adult social services, and 1.5 million efficiency savings per year as included as part of the councils financial strategy.

This shows a deteriorating position, with a projected overspend in 08/09 and 09/10 of £4.9m, and £6.3 million respectively. This assumes efficiency savings of £1.5 million are required in 08/09 and a further £1.5 million in 09/10.

The overspend without these efficiency savings are projected at £3.4 million in 08/09, and £4.8 million in 09/10.

There is no growth and no service development in this projected budget, a position which would significantly adversely affect social services performance. The following section outlines the changing nature of adult social services and particular service developments and improvement issues.

5. The changing nature of adult social services, investment needed

The performance requirements and national strategy for adult social services require that people with increasingly higher levels needs should be supported to live at home, and placements in care homes minimised. Care plans are expected to be comprehensive and address the seven social care outcomes. A significant amount of our overspend is attributable to pursuing this strategy, which is a key performance measure for adult social services, based on what the vast majority of people say that they want. CSCI have clearly indicated that they expect the progress made in the last 2 years to continue and for fewer people to be supported in residential care, particularly requiring the council to increase our level of intermediate care services. The development of extra care housing and the extended use of Telecare technology is also required. The local authority has received a Telecare grant which comes to an end in March 08 and authorities are expected to continue the use of this technology within mainstream budgets

This national direction is set to continue, and the requirements likely to become even more challenging as social services are tasked with increasing the alternative options for people (for example extra care), and the cost of some specialist services increase (for example dementia support and care). The needs of older people with dementia and their carers are particularly relevant. With the increasing age profile in Derby the number of people living with dementia is a major challenge. We have few specialist services in the city, and need to expand both the range and level of services. Dementia services, both home based and in care homes require high staffing levels and cost more than general services.

Adult Social services is increasingly focussed on people with higher level needs, it cannot justify an open door lower level support service as in previous years. This is the case across the country with two thirds of local authorities' only providing services to meet critical and substantial needs. Most councils are moving eligibility criteria further up the risk scale. Our services now support people who, without them, would face at least a moderate level risk to their independence. Some case examples are attached as Appendix 3; these examples are typical of the everyday work of adult social services.

The advent of Individualised budgets which allow people to be more in control of how their care entitlement is spent, but without some of the employer responsibilities associated with direct payments, is being strongly developed and promoted nationally. It is one of the new social care indicators in the LAA. This will bring new people into the system and again is likely to bring increased financial pressure (as was the case with direct payments).

In addition to all of the above adult social services is responsible for ensuring that services commissioned from the independent sector meet the changing needs of people and are of an agreed quality. This involves working with all our providers through the commissioning and contracting processes to improve both availability and quality. There are potentially fee level implications, and many authorities are now providing above inflation rises linked to quality initiatives.

Appendix 2b shows the budget position if we are able to invest in the above improvements.

6. Summary and Future Options

The key messages

- We cannot afford to continue to provide services at our current level of funding
- We either have to further reduce services or increase the funding available to adult social services
- We are the second lowest spending authority for adult social services, with a very high level of performance, we are under-funded not inefficient
- Performance has suffered this year and will continue to suffer if we reduce levels of service further
- We currently have gaps/weaknesses in our service in which we should be investing, for example, extra care, dementia support, carer services, intermediate care, and assistive technology; at the present time we have no capacity to invest in any of these services.

Public expectations and the reality of what is affordable

We need to have a wide debate internally and externally with the public and partners, about what the council can and cannot afford to provide through adult social services.

The reality is that we cannot afford to provide low level support (as stated above this is often domestic type support), and we cannot afford our current level of services.

We either have to reduce service or increase the budget available to adult social services, or both. Whatever we do, we must be prepared to be absolutely honest about the implications for individuals, as there will be a significant impact on the level of service provided.

At present we are considering the full range of possible options for cost reductions, assuming there is no additional budget made available for adult social services in 08/09, and that efficiency savings previously indicated continue to be required.

We are considering all possibilities, but given the scale of the problem it is inevitable that there will be a significant impact on the level of service provided to the public. As we have already removed all low risk to independence services the impact on the public of further reductions would be high, and would affect people's ability to live at home, with a reasonable quality of life. Any further reductions would affect services such as homecare (including personal care), day service provision, and support for carers including care at home and short breaks. This would be contentious and likely to generate much criticism of the council.

The budget preparation process has now commenced, so the need to establish the funding available to adult social services and, if necessary, the programme of service reductions required, is imminent .

Appendix 1 – Home care growth detailed analysis
Appendix 2 – 3 year projections
Appendix 3 - Examples of current care and support packages

APPENDIX 1

Home care hours 2005/6 – 2006/7

1. Purpose

There has been a rise from 14,000 to 22,000 hours of home care provided per week by Derby City social care over the previous two financial years. There are a number of reasons why this has occurred. This paper examines the factors with reference to home care activity elsewhere in the country.

2. Analysis

There are several factors leading to changes that have taken place which have directly or indirectly impacted upon the home care service over the last two financial years. This has given rise to the increased activity in the home care service quantified above. Detailed below are most of the variables that have led to the current status i.e. an increase of 8,000 hours over the two year period. These variables are interconnected and merit careful consideration collectively and individually.

2.1 Elderly population

Over the two years in question the over 85's population has increased by 8.9%. A significant proportion of home care demand is generated by the elderly population. There are now 400 more people over the age of 85 living in Derby than there were two years ago. Based upon the volume of home care services delivered to the over 85's population one would estimate that this would increase demand for home care services by a minimum of 700 hours per week.

2.2 Health Improvement

In addition to the increase in the ageing population, as health treatments are improving people are living longer with long term conditions. There is some anecdotal evidence individuals already in the service are staying longer, whilst it is not possible to isolate all leavers and examine reasons in detail within the timeframe of this report, one conservative estimate is that there has been a reduction in exit turnover of 3% across the service over the two years in question. This would cause an increase in hours over the period by approximately 500.

2.3 National / Regional Growth

This growth in demand for homecare is mirrored nationally. Based upon the survey weeks that all local authorities participate in, during 2005/6 and 2006/7 the returns from all authorities depict an increase of 11% nationally in home care hours. Furthermore the East Midlands authorities have experienced increases in contact hours above this level as detailed in the table below. The table contains information on the number of contact hours provided by local authorities per 10,000 households. As can be

seen from the table there is significant growth in contact hours across all three major cities in the East Midlands. It is notable but not comforting from a resource perspective, the proportional range of growth is very tightly distributed for the large cities

Contact hours of home care per 10,000 households, 2004 – 2006.

Authority	2004/5	2006/7	% Change	Current FACS Eligibility Band
Derby	*1964*	*2483*	*26.4%*	*Moderate +*
Leicester	1447	1865	28.9%	Substantial +
Nottingham	1404	1797	28.0%	High Moderate +
Derbyshire	2262	2604	15.1%	Moderate +
Nottinghamshire	941	1435	52.5%	Substantial +
Leicestershire	1318	1515	14.9%	Moderate +

The Shire Counties in the East Midlands have also experienced significant growth. Derbyshire provides more care per household than Derby but has not experienced as much growth, coming from a higher base. Nottinghamshire's 52% growth is noteworthy over the two year period.

The growth in home care hours is a national phenomenon and councils are constantly considering their eligibility criteria levels in order to contain demand within available resources.

NB Direct Payment Hours are not included in the survey or the data on home care detailed in the above table and below.

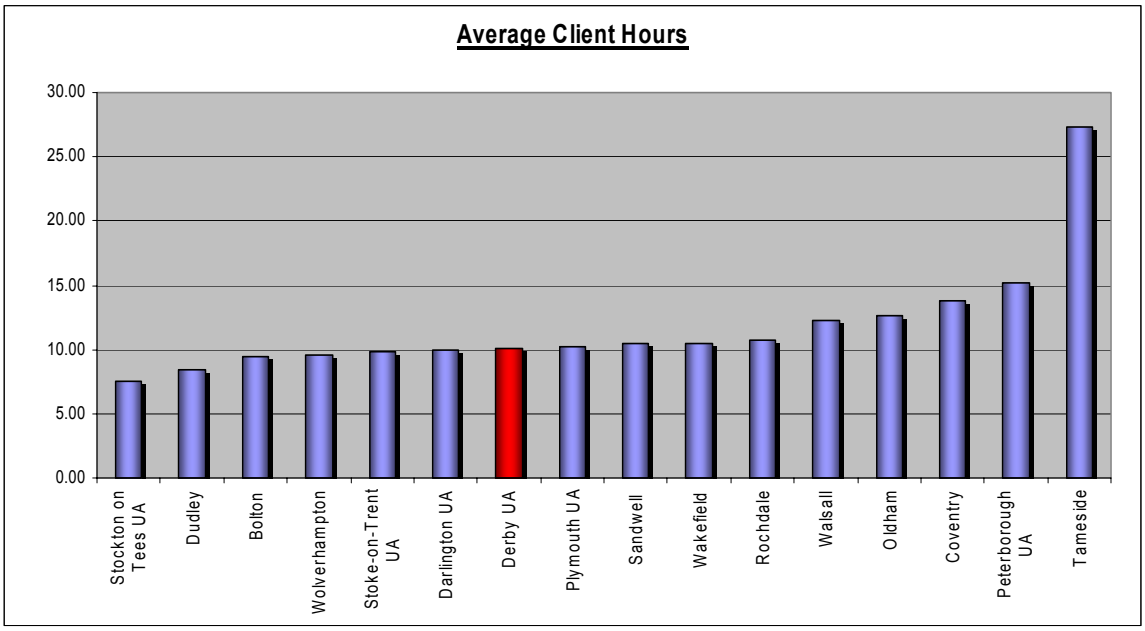
Contact hours of home care per 10,000 households, 2004 – 2006.

Authority	2004/5	2006/7	% Change
Tameside	5,050	4,867	-3.6%
Oldham	3,571	3,210	-10.1%
Coventry	2,469	2,758	11.7%
Walsall	2,135	2,573	20.5%
Derby UA	*1,964*	*2,483*	26.4%
Peterborough UA	1,955	2,288	17.0%
Bolton	2,619	2,275	-13.1%
Wolverhampton	1,728	2,071	19.8%
Rochdale	1,315	2,052	56.0%
Darlington UA	1,450	2,005	38.3%
Stoke-on-Trent UA	1,864	1,970	5.7%
Sandwell	1,812	1,967	8.6%
Wakefield	1,557	1,760	13.0%
Dudley	1,699	1,630	-4.1%
Plymouth UA	925	1,405	51.9%
Stockton on Tees UA	996	1,263	26.8%

The comparison with the IPF group shows a general upward trend in home care hours. There are a few exceptions to this for example Tameside, Oldham and Bolton. The former two authorities have a very high provision and can be discounted and Bolton has a high volume of extra care as an alternative to home care provision. Derby's growth is certainly not the highest in the group it is in fact just above the average growth, 22% (excluding authorities experiencing a cut in home care hours).

Average Contact Hours per Client Comparator Authorities

Authorities	Contact hours (all sections - all ages)	Clients (all ages)	Average client hours
Stockton on Tees UA	9,215	1220	7.55
Dudley	20,375	2,415	8.44
Bolton	24,585	2,585	9.51
Wolverhampton	20,120	2,110	9.54
Stoke-on-Trent UA	20,330	2,080	9.77
Darlington UA	8,480	855	9.92
Derby UA	*22,945*	*2,280*	*10.06*
Plymouth UA	14,410	1415	10.18
Sandwell	22,705	2,180	10.42
Wakefield	23,275	2,210	10.53
Rochdale	17,125	1,595	10.74
Walsall	26,075	2,125	12.27
Oldham	28,190	2,225	12.67
Coventry	33,740	2,450	13.77
Peterborough UA	14,965	985	15.19
Tameside	43,795	1,605	27.29



The average contact hours table illustrates Derby provide an average of 10 hours per package which is somewhere below the middle of the average package size for our comparator authorities, the range being from 7.5 hours per package to 15 hours per package excluding Tameside, as it is an outlier. From the national home care survey report the average package size for England is 10.8 hours.

2.4 Direct Payment Service

There has been a national drive to provide Direct Payments (DP) to people in lieu of services to meet eligible needs. This delivery mechanism is believed to offer greatest choice, control and flexibility to service users. The authority retains the duty to assess needs, and in the case of a DP it has the duty to assess the person's ability to manage a DP albeit with some support and assistance.

Here at Derby we have trained several staff to promote DP as a mechanism for services. We also grant fund Disability Direct to provide support services for individuals who are in receipt of DP. The growth in DP hours over the two years in question amounts to 2219 hours per week reflecting a 79% growth factor. We have been extremely successful at promoting DP and are one of the top performing authorities in the country on use of DP.

Clearly the success of the DP service does have a budgetary impact as it is a strongly held view that there are some people within the service who are receiving an enhanced service i.e. individuals may have received less hours or even no provision at all had we commissioned or provided the service directly. There is a review exercise organised around all DP recipients to ensure consistency of FACS criteria application and appropriate scale of hours, to meet eligible need.

Direct Payments Service Users per 100,000 of Adult Population

Geographical Neighbours

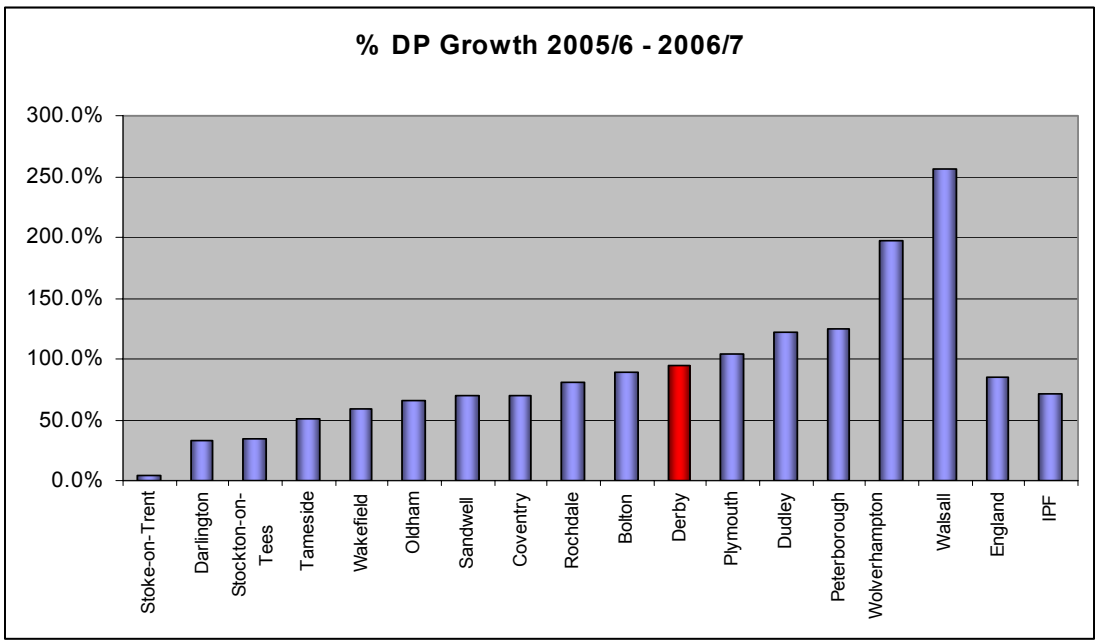
PAF C51 Direct Payments users Per 100k of Adult Population	2002-03	2003-04	2004-05	2005-06	2006-07 Forecast	% Growth 2005-06 to 2006-7
Nottinghamshire	27.2	55.0	57.4	69.0	71.0	23.6%
Nottingham	23.5	33.3	49.4	67.0	75.0	51.8%
Derbyshire	22.8	33.8	52.2	71.0	80.0	53.4%
Derby	*34.3*	*64.7*	*87.1*	*125.0*	*170**	*95.1%*
Leicester	27.9	35.3	45.4	66.0	90.0	98.3%
Leicestershire	16.3	23.6	38.7	57.0	85.0	119.6%
Northamptonshire	12.8	14.8	31.8	61.0	90.0	182.8%
England	21.7	34.8	58.0	86.1	107.0	84.4%
East Midlands	22.1	35.7	49.0	65.9	78.4	60.2%

Institute of Public Finance (IPF) Comparator Group

PAF C51 Direct Payments users Per 100k of Adult Population	2002-03	2003-04	2004-05	2005-06	2006-07 Forecast	% Growth 2005-06 to 2006-7
Stoke-on-Trent	53.8	81.4	95.2	95.0	99.0	4.0%
Darlington	30.5	55.7	86.6	109.0	115.0	32.8%
Stockton-on-Tees	17.3	36.1	74.6	91.0	100.0	34.0%
Tameside	20.3	34.2	45.0	62.0	68.0	51.0%
Wakefield	8.3	22.2	53.7	75.0	85.0	58.4%
Oldham	20.8	39.3	90.6	137.0	150.0	65.6%
Sandwell	13.4	55.1	58.8	84.0	100.0	70.2%
Coventry	74.9	81.7	84.5	163.0	144.0	70.4%
Rochdale	11.5	27.2	36.0	57.0	65.0	80.3%
Bolton	18.6	38.9	65.0	99.0	123.0	89.2%
Derby	*34.3*	*64.7*	*87.1*	*125.0*	*170**	*95.1%*
Plymouth	4.2	11.1	34.3	58.0	70.0	104.2%
Dudley	4.6	22.2	40.6	56.0	90.0	121.9%
Peterborough	14.4	15.0	41.8	59.0	94.0	124.7%
Wolverhampton	7.2	11.8	33.6	66.0	100.0	197.2%
Walsall	8.5	16.2	29.2	82.0	104.0	256.0%
England	21.7	34.8	58.0	86.1	107.0	84.4%
IPF	21.4	38.3	59.8	88.6	102.3	71.1%

*Please note Derby figure for 2006/7 is actual not forecast. Comparator actual data unavailable at time of press for 2006/7.

From the above data it is absolutely clear the vast majority of local authorities are seeking to increase their volume of direct payment users significantly. Derby's growth over the period in question ranks somewhere in the middle of neighbouring authorities and in the 2nd quartile of statistical comparator authorities. Certainly, Derby's growth is not at the very top end of the scale.



The England average confirms the desire to increase direct payment numbers and hours significantly across the country.

The Derby average package size for a DP recipient is consistent with that of Derbyshire, 18 hours and 18.5 hours respectively. Leicestershire's average package size is also 18 hours per week per service user and Nottinghamshire is higher at 25 hours per week, bearing in mind Nottinghamshire provide for substantial and critical risk only.

2.5 Residential Care[1] Substitution

Home care is one substitute service for residential care. The national drive is for people to be able to live and be supported in communities; the residential care option is not the option of choice. To this end, local authorities are performance managed on new admissions to residential care year on year. Depending on level of eligible need, cost factors, age of client etc a decision is made about our ability to keep the client in the community.

During the two years under review we placed 180 less people into residential care than previous years. Residential admissions prior to this period were at a much higher level. This deliberate policy to reduce residential admissions in line with DH policy guidance has fuelled a significant increase in homecare hours.

People who would otherwise be admitted into residential care would require something in the order of 18 - 25 hours of homecare depending on prevailing circumstances. One estimate therefore, and direct consequence of keeping people out of residential care over the last two years has been to increase homecare hours by 3600 hours if we take an average of say 20 hours.

[1] Residential care terminology in this context includes nursing care admissions

The tables below illustrate that the majority of authorities are reducing their admissions into residential care, in line with policy direction from DH via the National Service Framework guidance for older people.

Geographical Neighbours

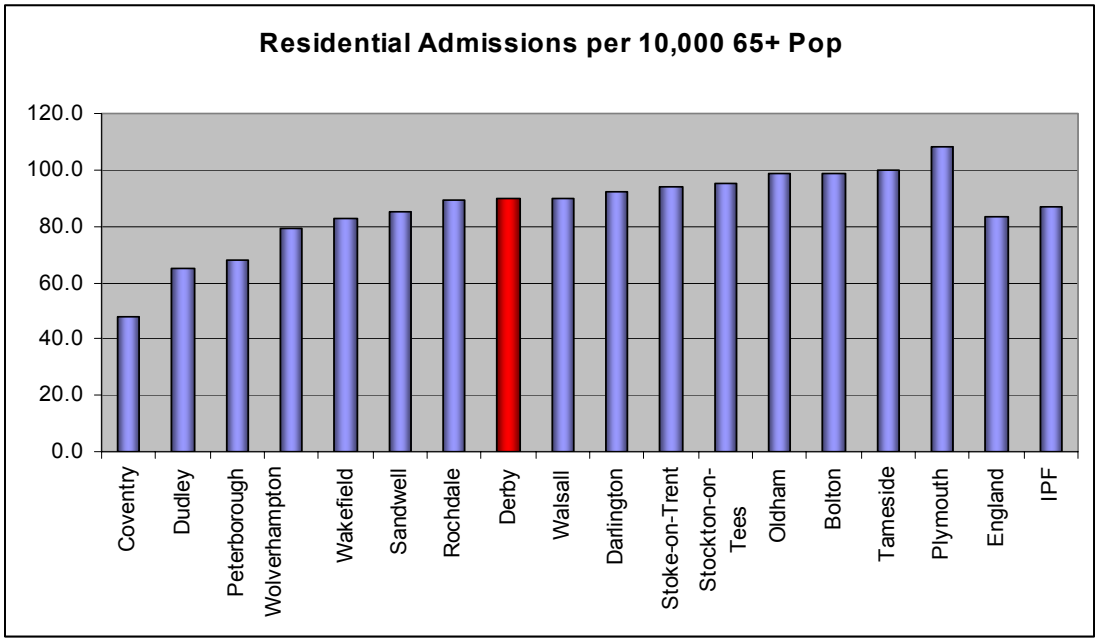
PAF C26/C72 Admissions to Residential Care per 10k of 65+ Population	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07 Forecast	% Reduction 2004-05 to 2006-07
Lincolnshire	87.8	51.6	54.8	76.7	90.0	79.0	-3.1%
Nottinghamshire	126.9	122.6	106.0	102.9	98.0	94.0	8.7%
Derbyshire	104.8	98.3	92.6	88.3	86.0	80.0	9.4%
Nottingham	96.5	102.8	86.3	101.1	105.0	90.0	11.0%
Leicester	106.8	84.3	79.0	88.8	85.0	79.0	11.0%
Leicestershire	120.5	111.4	101.8	95.3	86.0	80.0	16.1%
Northamptonshire	117.2	112.3	102.7	100.5	79.0	78.0	22.4%
Derby	*132.6*	*134.0*	*124.2*	*118.6*	*99.0*	*89.9**	*24.2%*
England	110.7	103.0	97.5	91.2	87.4	83.3	8.7%
East Midlands	111.1	100.5	92.8	94.5	89.8	83.8	11.4%

IPF Comparator Group

PAF C26/C72 Admissions to Residential Care per 10k of 65+ Population	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07 Forecast	% Reduction 2004-05 to 2006-07
Oldham	147.3	133.4	75.9	70.2	102.0	99.0	-41.1%
Bolton	136.6	113.2	103.3	91.4	98.0	99.0	-8.3%
Plymouth	146.5	117.0	112.0	114.9	119.0	108.0	6.0%
Dudley	91.6	87.0	79.1	72.6	65.0	65.0	10.4%
Stockton-on-Tees	124.5	125.8	113.6	111.0	109.0	95.0	14.4%
Sandwell	137.9	141.6	113.7	102.1	89.0	85.0	16.8%
Peterborough	107.9	106.0	115.1	81.7	68.0	68.0	16.8%
Coventry	107.9	93.6	73.2	58.4	48.0	48.0	17.7%
Darlington	119.3	115.9	118.0	113.1	87.0	92.0	18.7%
Stoke-on-Trent	140.1	141.5	125.0	115.7	94.0	94.0	18.8%
Tameside	101.7	120.4	134.9	123.9	103.0	100.0	19.3%
Wolverhampton	112.9	114.8	105.8	98.6	85.0	79.0	19.8%
Wakefield	99.3	105.8	110.7	106.2	87.0	83.0	21.8%
Derby	*132.6*	*134.0*	*124.2*	*118.6*	*99.0*	*89.9**	24.2%
Rochdale	108.7	116.6	128.2	123.0	104.0	89.0	27.7%
Walsall	161.1	127.1	149.3	140.8	97.0	90.0	36.1%
England	110.7	103.0	97.5	91.2	87.4	83.3	8.7%
IPF Cluster for Derby	123.5	118.3	111.4	102.6	90.9	86.8	15.5%

*Please note Derby figure for 2006/7 is actual not forecast. Comparator actual data unavailable at time of press for 2006/7.

Admission levels to residential care have been reducing significantly over the period but particularly over the preceding two years. This does not imply there is a reduction in needs but rather that individuals are being placed in the community.



The geographical neighbours table shows that Derby's position is still higher than the average of authorities in the region and the all England admissions figure. This would imply that more people should be kept out of residential care than we have managed to do over the previous two years.

The IPF comparator table and graph of admissions into residential care also shows that Derby is not an outlier on admissions at approx 90 per 10k of the over 65 population. Whilst we have reduced residential admissions significantly over the past two years we are not at the extreme end of performance, to imply we are doing anything radically different here in Derby.

The issue within Derby is that whilst other authorities particularly those seeking to reduce admissions to unprecedented levels such as Coventry, have developed significant capacity in alternative housing solutions for older people i.e. extra care, Derby has not had the capital investment to achieve this. However, we are at the early stages of developing some capacity in this vacant service space. This lack of alternatives creates pressure on the home care service as the alternative option to residential care.

2.6 Performance Management Regime

There have been significant changes to the performance management regime for social care over the past five years. Over the past two years we have experienced step changes in performance requirements;

a) Assessments must be started within 48 hours of Referral and completed within 28days. Minimum acceptable standard raised from 65% in 2004/5 to 80% in 2006/7.

b) Care packages must be started within 28 days of Assessment. Minimum acceptable standard has been raised from 65% in 2004/5 to 80% in 2006/7.

c) Hospital discharges must be completed with 24 hours of section 5 notice from the Ward. Otherwise the Derby City Hospitals Foundation Trust is at liberty to charge the Council for reimbursable days.

d) The minimum acceptable standard for Direct Payments recipients has been raised from 30 per 100k of the adult population to 90 in 2007/8.

The information cited above is for minimum acceptable standards. In order to be considered a "good" authority, performance levels required are significantly higher. It is no longer possible to employ waiting lists as pressure relief valves on the system, and maintain good performance in the current performance regime. In addition, the public are better informed and more robust processes are in place for individuals to complain to the ombudsman, and seek judicial review for decisions made by local authorities.

3.0 Conclusion

From the above analysis it is clear that over the past two years Derby's social care function is not experiencing an increase in demand for home care services that is in any way being driven by local practice. The evidence clearly suggests there has been a national surge in demand for home care and Derby is no exception. The main contributory factors are

- Growth in population and health improvements
- Transfer from residential care
- Promotion of Direct Payments

One estimate of how much of the eight thousand hour change in volume of home care in Derby is attributable to each factor is detailed in the table below.

Factor	Hours
Population & Health	1200
Transfer from Residential	3600
Direct Payments	2219
FACS change to Moderate	(158)
Other	1139
Total	8000

Appendix 2

Derby City Council **Adult Social Services** **2007/08 - 2009/10**	**2007/08** **£000's**	**2008/09** **£000's**	**2009/10** **£000's**
Proposed Budget (April 07)	45638	45667	45745
Efficiencies Included in above			
Increase care management staffing vacancy factor by 1% to 5%	(67)	0	0
Reduction in RAS costs arising from Council 24-hour contact centre	0	(73)	0
Change skill mix of Care Managers & Community Care Workers	(62)	(26)	0
Increase residential care staffing vacancy factor by 1% to 5%	(7)	0	0
Recharge for cost of hospital-based services	(200)	0	0
Hire out vehicles in evenings and at weekends	0	(117)	0
Introduce home care package cost-sharing with service users	(180)	0	0
Increase in day centre charges	(45)	(45)	(35)
Increase in meals on wheels charges	(40)	0	0
Increase non-residential care staffing vacancy factor by 1% to 5%	(12)	0	0
Increase in funding from Supporting People	(250)	0	0
Reduce high cost placements	(300)	0	0
3.5% reduction in support services budgets	(145)	(145)	(125)
Outsource home care	(200)	(400)	(400)
Transfer of long-term OP residential & nursing budgets	(581)	(81)	0
Eligibility criteria	0	(500)	(1,000)
Voluntary sector inflation	(38)	0	0
Outsource shopping	0	(100)	0
Less savings to fund additional pressures below	627	(13)	60
Total savings target proposals	**(1,500)**	**(1,500)**	**(1,500)**

Forecast Position			
Failure to achieve 2007/08 efficiencies	-888	-805	-805
Failure to achieve 2008/09 efficiencies	0	-1310	-1310
Failure to achieve 2009/10 efficiencies	0	0	-1400
Home Care 19,700 hours per week v budget for approx 16,500	-2161	-2118	-2118
Mental Health Residential Services	-647	-647	-647
Underspends	442	0	0
Total Overspend	-3254	-4880	-6280

Overall Summary			
Required Budget	48892	50547	52025
Indicative Budget	45638	45667	45745
Budget Gap	**-3254**	**-4880**	**-6280**

Derby City Council Adult Social Services 2007/08 - 2009/10	2007/08 £000's	2008/09 £000's	2009/10 £000's
Proposed Budget (April 07)	45638	45667	45745
Efficiencies Included in above			
Increase care management staffing vacancy factor by 1% to 5%	(67)	0	0
Reduction in RAS costs arising from Council 24-hour contact centre	0	(73)	0
Change skill mix of Care Managers & Community Care Workers	(62)	(26)	0
Increase residential care staffing vacancy factor by 1% to 5%	(7)	0	0
Recharge for cost of hospital-based services	(200)	0	0
Hire out vehicles in evenings and at weekends	0	(117)	0
Introduce home care package cost-sharing with service users	(180)	0	0
Increase in day centre charges	(45)	(45)	(35)
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Increase non-residential care staffing vacancy factor by 1% to 5%	(12)	0	0
Increase in funding from Supporting People	(250)	0	0
Reduce high cost placements	(300)	0	0
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Eligibility criteria	0	(500)	(1,000)
Voluntary sector inflation	(38)	0	0
Outsource shopping	0	(100)	0
Less savings to fund additional pressures below	627	(13)	60
Total savings target proposals	**(1,500)**	**(1,500)**	**(1,500)**

Forecast Position			
Failure to achieve 2007/08 efficiencies	-888	-805	-805
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Home Care 19,700 hours per week v budget for approx 16,500	-2161	-2118	-2118
Mental Health Residential Services	-647	-647	-647
Underspends	442	0	0
Total Overspend	-3254	-4880	-6280

Growth			
Home Care Growth (6% of Activity - expected growth in older population)		-391	-1196
Day Services Growth (6% of Activity - expected growth in older population)		-162	-496
1% Above Inflation increases to Long Term Care Providers - Quality.		-200	-200
Dementia Care Services		-250	-500
Intermediate Care / Rehabilitation		-150	-300

End of Preventative Technology grant		-150	-150
Total Growth	0	-1303	-2842

Overall Summary			
Required Budget	48892	51850	54867
Indicative Budget	45638	45667	45745
Budget Gap	**-3254**	**-6183**	**-9122**

Appendix 3

Case Example: Mr B, Age 73 years, Alvaston

Home and family circumstances

Mr B lives at home with his wife, in a privately owned property.

Personal care needs

He has dementia linked to previous strokes. His dementia is advanced and he is unable to understand simple instructions and unable to describe what he wants or how he feels. He gets very frustrated. He can be very resistant to any intervention, is sometimes aggressive, kicks, bites, fights with carers and tries to prevent carers from assisting him.

He is able to use the toilet but has periods of incontinence.

He has good mobility, but likely to get disorientated and wander out of the house.

He takes multiple medications, and can be reluctant to take his medication.

Care/Support package provided

Mrs B wishes to continue to care for her husband at home, and she is his main carer. She has a supportive local family but almost all of the day to day responsibility falls on her. She has been caring for her husband for 5 years and he needs constant attention. She is also 70+ years. She has given up almost all her other interests/commitments to look after her husband, she is also awaiting further healthcare tests herself.

He was discharged form the DRI with a substantial 7 day per week support package, with 1.5 hours each morning (2 carers), 5 hours care during the day and 1 hour each evening (also 2 carers). He is also supported by visits from a CPN who provides advice and support re medication and managing his behaviour. The package is jointly funded, as level 2 continuing care. The cost to Social Services is £400.00 per week.

The impact of Adult Social Care not providing a service

Despite the pressure all round this arrangement works well for Mr B and his wife. Mr B's needs are critical. Without this care package he would undoubtedly be in a specialist nursing care home placement.

FACS eligibility: Critical

Case Example Mr M, Age 33 years

Home and family circumstances

Mr M lives with his partner in a two bed-roomed bungalow rented from a housing association.

He is in receipt of full rate DLA Care and Mobility and Incapacity Benefit.

Personal Care needs

He has Multiple Sclerosis, diagnosed in 2002 – he was registered partially sighted in 2003 and blind in 2006.

He has some cognitive impairment but retains insight into his condition resulting in him being low in mood at times. He can no longer walk and uses a wheelchair both indoors and out. He has involuntary and unprovoked body spasms in his limbs. He is unable to transfer independently.

The combination of the above factors and his sight loss have resulted in him being dependent for all his needs – with regard to domestic, meals, personal care, communication, transport, social and emotional support.

Care /Support package provided

He has received counselling in the past – but he found this not particularly helpful and while being encouraged to attend day activities - he has declined due to the fact that he does not like to travel because of vertigo, he feels anxious and his lack of sight and spasms affect his ability to participate.

Equipment such as a talking watch and signature guide has been provided to aid independence.

We are providing home care services for 12 hours per week, Monday to Friday (independent sector provider) to assist with personal care, meal preparation, ensuring that kitchen and bathroom areas are clean and no obstacles in the way. Factored into this, is time to enable carers to assist with social activities – sometimes activities in the home i.e.: to assists in using computer – other times going out - to avoid social isolation.

(Direct Payments have been used in the past but was not successful as it placed additional tasks on his partner)

The desired outcomes are to enable Mr M to remain independent at home – while enabling his partner who provides all care at all other times to remain in full time employment. We also provide extra care as and when required – recently we provided early evening calls for a week – because his partner was attending a training course and was returning home later than usual.

The impact of Adult Social Care not providing a service

Mr M is able to remain safely in his own home – due to significant input from his partner. However, without our input, she would have to give up her job and become a full-time carer. Her career is important to her, and if she was put in a position whereby she had to give up work, it is extremely unlikely the relationship would survive. If this should happen Mr M's quality of life would be greatly reduced and we would have to provide a massive package to meet his needs.

FACS eligibility: Critical.

Case example: Mr X, Age 63 years

Home and Family circumstances

Mr X, a white male of British origin, lives alone independently in his own flat. He has minimal contact with family members.

Health issues / Personal care needs

Mr X was admitted into the DRI after collapsing at home. On admission he was found to have had a severe left sided stroke and was admitted to the stroke rehab unit.

After 10 weeks of rehab the Multi disciplinary team decided that he had reached his potential and discharge planning commenced. He was referred to the social work team with a view to being discharged home with a care package.

Even after this period Mr X had considerable personal care needs. He is non weight bearing and visually impaired and reliant on carers and a hoist for all hygiene and personal care needs, meal provision and medication.

He also had a range of other social care needs, further assessment revealed that Mr X had been a habitual drinker and lived in accommodation that required de-cluttering, cleansing, redecorating and furnishing prior to his return. Mr X was also in debt with utilities and credit cards as he had not been able to access his finances whilst in hospital.

Care/Support package provided

Mr X had a period of short term care in a nursing home whist his property could be made suitable and a care package arranged.

He was then discharged home to his flat with a care package of 39.5hrs a week (4 calls per day but he requires 2 carers) for personal care. He supplements the package by paying for a laundry and shopping service from his DLA. The stroke co-ordinator and community Physio are also involved in his aftercare.

The impact of adult social care not providing a service

Mr X could not live alone as he would be unable to get out of bed or manage any activities of daily living. If we were not providing services he would have to move to a residential care home

FACS eligibility: critical

Case example Mr X, 49 years

Home and family circumstances

Mr X lives with his wife (who is his main carer) and his daughter who works full-time. He has multiple sclerosis and uses a wheelchair.

Health/personal care needs:

Mr X has MS and has recently been hospitalised following a deterioration of his condition. Mr X's condition is unpredictable.

Mr X requires support with all personal care tasks: washing, showering, dressing, toileting, bowel management, skin care, shaving and cutting up food. He requires hoisting for all transfers. He had been housebound for a long time, and had been isolated to an upstairs bedroom due to access difficulties.

He is very anxious and low in mood which is causing stress within the family.

Mrs X requires regular respite from her caring role.

Care/Support package provided:

Mr X currently has 10.5 hours per week homecare support. This is 2 calls per day, seven days per week. (One hour personal care in the morning and 30 minutes in the evening). Mrs X participates in all her husband's personal care alongside homecare staff as two people are needed for two carers are required for transfers/personal care tasks/moving and handling

Mr X also has 5 hours respite care per week to allow Mrs X to have a break.

A downstairs extension has been built, to include: clos-o-mat toilet, level access shower, bedroom with ceiling track hoist. He has been provided with a specialist shower chair. We supported the family to secure charity funding for a ¾ size profiling bed (to meet their personal preference as opposed to standard single profiling bed).

The extension was required as previously Mr X was isolated upstairs and was becoming increasingly anxious and depressed at being on his own. There was no room for a through floor lift, and he could not use a stair lift. The profile bed enabled Mrs X to sleep in the same room/bed as her husband as she had been sleeping on the floor before this. The clos-o-mat improved Mr X's independence and dignity with his personal care.

The desired outcomes of our support are

- That Mr X is provided with all support he needs to remain living with his family in the community and increase social integration, dignity and independence.

- To provide Mrs X with the support she needs to continue in her caring role for her husband.

- Prevent breakdown within the home situation and marital relationship

The impact of adult social care not providing a service

There would be a high risk of family breakdown, with Mr X then requiring placement in specialist care home.

Mr X's depression and anxiety would increase creating significant risk to marital relationship, home situation and emotional and physical well-being of carer.

FACs criteria: Critical

He is unable to carry out vital personal care or domestic routines and he has little or no choice or control over vital aspects of his immediate environment.

Case Study Mrs C Age 77 years, Alvaston

Home and family circumstances

Mrs. C lives in her own 2-bedroom bungalow with her daughter, which has been her home for the last 25 years. Mrs. C was referred to us directly by her family, as they have been struggling to cope with her at home.

Mrs C's daughter is her main carer. Her son and daughter in law, who also live in Derby, are also very committed to caring for their mother in the home environment and also provide regular care and support.

Health/personal care issues

Mrs. C was diagnosed with Alzheimer's in 2002. Mrs C is disorientated in time, place and person and has no insight into her illness and circumstances, which can lead to frustration and distress. Mrs. C has a disruptive sleeping pattern and gets up constantly each night and is usually incontinent of urine. She becomes very agitated and restless and requires constant supervision.

Mrs C's needs have increased over the last few months, as her sleeping pattern has become much disrupted which is affecting her daughter who lives with her. During the night, Mrs. A can have periods of shouting out and on occasions is difficult to settle. This in turn presents difficulty in the house as it disturbs Mrs. A's daughter, who has disturbed sleep as she has to attend to her mother and also has work the next morning.

Care /Support services provided

Mrs C is totally dependent for all her personal care tasks and requires assistance of one carer to attend to her needs. Mrs. A currently receives 7 hours 30 minutes homecare as follows:

3 times a week	1 hour call which includes a shower call & personal care tasks.
4 times a week	45 minutes call for personal care tasks.
4 times a week	15 minutes evening call to make a sandwich, tea and administer medication.
Once a week	30 minutes lunch time call.

In addition to the above Mrs. A receives day care services 6 times a week, which is attending both Marlstone road day centre and Coleridge House. Her family provided much to the transport required (Mrs C is reluctant to use it on occasions)

Two wake-in nights per week are funded by PCT to further support Mrs. C and her daughter (carer), who works as a home help for Derby City Council and her working pattern is mainly mornings and afternoons. As Mrs. C is awake several times during the night her daughter is constantly experiencing difficulty in getting uninterrupted sleep. Other family members provide a further 2 wake-in nights per week.

The total cost of the package to adult social services is in the region of £400.00 per week.

What would be likely outcome if we were not providing these services?

Mrs C would be most likely to require a specialist residential EMI placement.

However, the family are committed in supporting Mrs. A in the home environment and would like to keep her at home, with additional support from social services and health staff.

FACS eligibility: substantial

Case example: Mrs Y, age 95 years

Home and family circumstances

Mrs. Y lives alone in a privately owned semi-detached property. She has a star lift to access the upstairs of her home and various pieces f equipment within the home (grab rails in the downstairs toilet, toilet frame, commode in the bedroom for night time use, a perching stool, wheeled trolley, wheeled Zimmer) .she has an extra loud phone and door-bell.

Mrs. Y has a supportive niece, who lives nearby. Mrs Y is in receipt of low rate Attendance Allowance and high rate had been applied for.

Health/personal care needs

Mrs Y is very frail and weak; she weighs less than 5 stones.

She is at risk of falls has had 3 falls since last November 2006. She has broken both her hips on separate occasions through falls.

She has limited mobility, limited dexterity and strength due to her general frailty brought on by her age and shortness of breath. She normally uses a wheeled zimmer or trolley around the house, and a wheelchair for any further distance.

She suffers from shortness of breath and has an irregular heartbeat. She has as ongoing thyroid problems and takes heart medication. She uses an oxygen machine, approximately 3-4 times a day.

She does not leave her property without assistance because of the risk of falls and shortness of breath. She has a key safe in place.

She is unsteady on her feet and physically too weak due to shortness of breath to safely prepare her own meals. She can make a hot drink using the kettle cradle situated in the kitchen, when she is feeling well enough to do so. Some day's this is not possible. She requires assistance with washing and dressing/undressing to minimise the risk of falls due to her general physical weakness and also shortness of breath. She is unable to reach her lower half due to her poor balance, weakness and shortness of breath. She can be occasionally incontinent as she cannot reach the commode from her bed in time.

Care/Support package provided

Mrs Y has a care link pendant.

Adult Social services provides 8 hours 45 minutes per week homecare services (2 calls per day, morning and evening (45 minutes in the morning, 30 minutes in the evening). This is to assist with washing, dressing/undressing, emptying and cleaning her commode, preparing breakfast and prepare snack for tea-time.

We also provided a hot meal delivery every day and a fortnightly shopping call.

Mrs Y pays privately for a weekly cleaner and has a private gardener. Her laundry is carried out by her private domestic assistant and also her niece, with additional help from a neighbour. Carers have been assisting in this area.

Mrs Y administers her own medication with assistance from her niece. Her nieces supports her with her financial affairs,

Mrs Y also has periods of short term care while her niece is on holiday.

The impact of adult social care not providing a service

Mrs Y would be unlikely to be able to live in her own home, which she very much want s to do. Whilst this might not be entirely impossible she would be very anxious and vulnerable.

FACS eligibility: substantial

Case Example Mr S Age 63 years

Home and family Circumstances

Mr S lived with his mother until she died recently, he now lives alone. His mother was his main carer.

Health Issues / Social care needs

Mr S has Spina Bifida. Mr S has limited mobility and is unable to shower without assistance. He is risk of falls when not wearing a calliper. He is also under investigation for incontinence problems, GP/DN involved.

Care/support service provided

Mr S has 2 hours per week homecare, (one hour twice weekly) to enable him to shower, to maintain personal hygiene, prevent sores, skin deterioration and to monitor vulnerability following concerns.

Mr S also attends enabled art day service provision on a weekly basis to prevent social isolation.

Mr S also has a shopping call.

Implications of not providing a service

This gentleman would be unable to maintain his personal hygiene without the shower call, he would be at risk of sores and the risk of falls would increase.

He would become socially isolated without the day service provision as he relies on this to maintain contact with others. He previously relied heavily on his mother in many areas of his life, and is now at particular risk because of his bereavement.

FACS Eligibility: Moderate

We are working towards the shopping service from Disability Direct when it extends to his area, involvement of an advocate and provision of clos-o-mat which will reduce services provided by this Department in the long term. Therefore, by identifying these needs at a Moderate Level we are able to prevent crisis intervention at a later date and promote independence to enable this gentleman to remain in his own home within the Community and with low level risk to independence.

Case example Mr T Age 74 years

Home/Family circumstances

Mr T lives alone in a ground floor flat. He has no relatives apart from an elderly sister who lives in Devon.

Health issues /social care needs

Mt T has poor mobility as a result of a spinal injury in the past, and is unable to go out. He has cellulitis in both legs which are infected at present - the district nurse visits him twice a week to dress his legs. Mr T can manage his own personal care but he does struggle with this. He does like to manage himself and declined assistance with personal care. Mr T is socially isolated as he is unable to go out and does not have regular close family or friends who visit.

Mr T has little motivation to look after himself. His house is very cluttered and there are concerns about a health risk to him and also a fire risk. The fire service has visited him recently to advise him of this.

Care/Support services provided

Mr T currently has 2.75 hours per week of homecare services, providing assistance with cleaning, shopping and pension collection. These services are provided to minimise the risk to Mr T.

Mr T is in receipt of Attendance Allowance but would be unlikely to use this to purchase services to support him as he does not see this as important, and lacks motivation to do so.

The implications of not providing the service

Mr T is unlikely to change his behaviour. If these services were not being provided for him he would not arrange them for himself and would be at risk of his home becoming very dirty/unhygienic/ not shopping or eating properly and generally neglecting himself. His health and overall well being would be likely to suffer.

FACS Eligibility: Moderate

Case Example Mrs D Age 80 years, Allestree

Home and family circumstances

Mrs D lives alone in her own privately owned home. She has a downstairs toilet and upstairs bathroom and only goes upstairs / downstairs morning and evening.

She has very supportive daughters who live locally.

Health issues /Social care needs

Mrs D has been diagnosed with vascular dementia; she also suffers with raised blood pressure. She is suffering with depression associated with the dementia and is very demotivated. She had an adverse reaction to antidepressant medication and takes no medication for this.. She has recently had an episode where she lost her mobility completely; she is disorientated in space and time. Mrs D is socially isolated as she finds meeting and talking to people very difficult and has stopped going to her previous social groups.

A referral was made to a Domiciliary Services Organiser just before Christmas 2006; suggesting Mrs D needed admission to permanent care. She had suffered deterioration in her mental health and become unable to manage her own care in any way. Her daughter had taken her to stay with her as she was unable to walk independently, was confused and her daughter feared she would need permanent care. Mrs D stayed with her daughter for 2 weeks, her physical condition improved and she regained some mobility. She remained confused and forgetful. She did not know where she was and could not remember it had just been Christmas. She was however clear that she did not want to enter residential care and wanted to return home.

Social care support package provided

Mrs D did return home and now lives at home alone with the support of her daughters and 7 hours per week home care each week (2 x 30 mins calls, 7 days per week), hot meals on wheels twice per week plus day services once per week.

The home carers help Mrs D get up, washed dressed in the morning and help her to go to bed at night. Mrs D is unable to do this for herself. The carers also supervise her eating, drinking and taking her medication as she would not be able to do so alone.

Mrs D recognises her own home and her own belongings and feels safe there. The package is working very well for her.

Her daughters supplement the care provided by social services, ensuring Mrs D eats a hot meal 5 days per week, and undertaking all her shopping, cleaning, laundry and household tasks.

The impact if social services were not providing this care

Mrs D is clear that living in her own home is what she wants and the current arrangements are working well. If we were not providing this support she would be likely to deteriorate quickly (as she did before the package was put in place). Ultimately this may lead to hospitalisation or a care home admission. It would also put a much greater responsibility on her daughters, who already provide a significant level of support.

FACS Eligibility: Moderate

Case Example Mrs L Age 85 years

Home and family circumstances

Mrs L lives with her son, who is her main carer.

Health issues /Social Care needs

She suffers severe arthritis resulting swollen joints, ankles and knees. She experiences severe mobility problems, is able to walk only short distances and is very unsteady when doing so. Mrs L needs assistance with all aspects of personal care including washing, dressing, bathing and incontinence management for instance regular assistance to change her pads. This is largely provided by her son.

Mr L (son) experiences a high level of stress as a result of caring full time for his mother. His sister is supportive but she has her own family and work commitments. Mr L's role as main carer has significantly impacted on his own life, resulting in him being at risk of carer breakdown and probable admission into residential care for his mother. Mr L is dedicated to his caring role and committed to supporting his mother at home.

Social care/support services provided

Homecare services are provided every morning, 7 days per week, to support Mr L in caring for his mother. Carers help her transfer safely as she is particularly stiff in the mornings. A sitting service is also provided for 3 hours per week to allow her son to have a break each Saturday.

All offers of further services have been adamantly refused by Mrs L.

The Care Manager keeps in close contact with Mrs L and her son, as this is a situation at risk of breakdown.

The impact of Social services were not provided

Mr L is very committed to caring for his mother and would try to continue to do so, but there would be a heightened risk of carer breakdown. . The relatively small amount of support we do provide is probably the difference between him being able to cope and not.

FACS Eligibility; Moderate