ADULT SOCIAL CARE PEER CHALLENGE
DEVON COUNTY COUNCIL
MAY/JUNE 2015

CASE AUDIT REPORT

Conducted at Devon County Council, County Hall, Exeter on 14/15 May 2015

Prepared by David Vitty
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Head of Adult Social Care – Services
Borough of Poole

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1. METHODOLOGY

1.1 The case audit of Devon County Council Adult Social Care was based on a brief to consider four particular areas of focus:

- Whether social care reablement is reaching the right people and maximising their independence;
- Whether community enablement is reaching the right people and maximising their independence;
- Whether phone based assessments and Care Direct Plus are identifying peoples' strengths and looking for solutions in the person's family, social network and local community;
- Whether opportunities were missed to delay or reduce needs by other means earlier in the case history.

1.2 These themes were addressed through the audit of twelve cases, which were distributed amongst the following service areas:

- Three social care reablement cases with an outcome of no further involvement;
- Three social care reablement cases with an outcome of ongoing needs and services;
- Two community enablement cases with any outcome;
- Four cases that have received an assessment from Care Direct Plus with an outcome of ongoing needs and services.

1.3 All of the above cases were active within the six months prior to audit and most of the activity took place prior to the Care Act implementation on 01 April 2015. To avoid confusion, this report uses terminology that was applicable at the time the casework took place.

1.4 The LGA ‘case record audit proforma’ was used for each case audited and these can be found in the Annexe to this report. The Annexe of this report also contains a commentary on each case to expand upon the case audit proformas.

1.5 In order to address the themes identified for this case file audit, it has been necessary to consider cases in more detail than the standard fifteen minute review recommended by the LGA guidance and, consequently, it has only been possible to consider twelve cases over two days. The community enablement cases proved to be extremely complex and, whilst this gave a very rich picture of the practice within that service, it precluded the review of more than two cases.

1.6 The audit undertaken as part of the Peer Challenge was paralleled on the 14/15 May 2015 by an in-house audit conducted by officers from Devon County Council. This proved to be an extremely helpful arrangement which allowed for discussion about individual cases and the opportunity to explore the operational models of practice behind the cases being audited. Sarah Mackereth (Professional Lead for Social Work) and Sarah Cambridge (Professional Lead for Occupational Therapy) were particularly helpful in this respect.

1.7 This report does not contain people's names, addresses or dates of birth, but does include possible identifying information such as CareFirst numbers and personal circumstances.

2. EXECUTIVE SUMMARY

2.1 The twelve cases audited all pointed to services which are safe, of high quality and which resulted in good outcomes for people.

2.2 The operational pathway from the point of first contact in Care Direct through to reablement or community enablement appears to work very efficiently. There is very little evidence of delay and exchange of key information was effectively handled at the point of hand off. There was evidence too of the right level of involvement by different professionals in each case and of appropriate communication and information sharing between those professionals. From the perspective of the person using services, most case records indicated a person-centred approach with a strong focus on addressing the needs and wishes of people using the services.

2.3 The audit did identify shortfalls in process - in particular incomplete recording of assessment information and the use of two entirely separate record management processes for Care Direct and the social care reablement service. Although these process issues did not appear to diminish the effectiveness of service delivery or outcomes for people, there is inevitably a risk that important information may either go unrecorded or unseen.

2.4 There were three examples of appropriate safeguarding referrals being made, although none of these resulted in action being taken by the safeguarding service. Three out of twelve cases with a safeguarding element does suggest that safeguarding has a sufficiently high profile in Community Enablement, Reablement and Care Direct Plus.

2.5 **Lines of Enquiry:**

- *Is social care reablement reaching the right people and maximising their independence?*

  The cases explored suggested that the reablement team practice is particularly effective, person-centred and with a focus on sound reablement outcome goals. The involvement of occupational therapy appears helpful and good leadership and management oversight ensures day-to-day progress towards the agreed goals. The reablement team also refer and signpost to other services, which raises a question about whether they could be empowered to provide further simple services allowing them to become even more effective. Reablement does appear to be reaching the right people and achieving very impressive outcomes, including maximising independence. One or two cases may not have been appropriate for reablement, although this related to medical deterioration as much as an inappropriate referral in one of those cases, but there may be some value in reviewing the screening and referral process into reablement from Care Direct Plus to ensure that cases are fully appropriate for reablement.

- *Is community enablement reaching the right people and maximising their independence?*

  It would seem to be the case that the Community Enablement Team is targeted at people who are not otherwise being supported by other teams and, without that support, may require more intensive case management and services. There was evidence from case notes that the people supported by the Community Enablement Team were being enabled to manage independently and, in particular, there was a focus on personal finances, housing and relationships.

- *Are phone based assessments and Care Direct Plus identifying peoples' strengths and looking for solutions in the person's family, social network and local community?*

  Case notes were mixed in this respect. Very often, the person's own strengths, needs and wishes were recorded, but an exploration of family, social and community based opportunities for help and support did not appear to have taken place. In many cases, this type of support may have been exactly what was needed to address risk factors which were not otherwise followed up (see below).

- *Are opportunities missed to delay or reduce needs by other means earlier in the case history?*

  Case notes suggested that there were opportunities missed to intervene earlier and address risk factors such as falls, nutrition or self-neglect. A pattern has emerged of known risks, most commonly falls, which were not acted upon in a targeted way.

3. THEMES AND OBSERVATIONS

3.1 Areas Of Strength:

3.1.1 Almost all cases audited from Care Direct Plus, Reablement and Community Engagement demonstrated a safe service with good outcomes. There is an evident "golden thread" through Care Direct, Care Direct Plus, My Assessment, My Plan and on to casework and review/reassessment.

3.1.2 Intervention was noted as almost always timely and responsive, with no substantial delays identified.

3.1.3 In the cases audited there is a clear process for referrals from acute and community hospitals into Care Direct Plus to request support with hospital discharge. These referrals were all of an appropriate level of complexity for the team, suggesting that NHS hospital partners know when to refer for specialist hospital social work and when Care Direct Plus are better placed to support a discharge. In one case, the hospital had been particularly prescriptive about the nature of reablement required which seemed to inhibit independent assessment and planning by Care Direct Plus and the reablement service who simply followed the prescription from the hospital based referrer.

3.1.4 The assessments recorded in CareFirst are mostly framed using plain English and very personalised language. The prompts within forms lead practitioners to think about the persons own view of their needs and encourage consistent outcome planning. The voice of the people receiving services, although not always heard in the case notes, was often present and in most cases the services provided did respond to those things which the person felt were most important to them. There are well set out risk fields on CareFirst, and there may be some value in using these more consistently.

3.1.5 Overall, case notes are clear, succinct, purposeful, use plain English and at their best evidently demonstrate a personalised, caring and respectful approach to people.

3.1.6 The Social Care Reablement paper-based records are often outstanding. In most cases there is an evident pathway from assessment, reablement planning and daily intervention through to review and closure. These records are usually written in plain English, regularly updated, purposeful and structured to be held in the persons own home. Comments are made elsewhere in this report about the lack of connection between these paper-

based records and CareFirst, but as a discrete set of documents, they seem to be supporting very effective reablement practice.

3.1.7 The records suggest a very effective reablement service, with a culture at leadership, management and front line levels of person-centred and purposeful work to help people regain independence. The practice within the reablement service of assessment, goal-setting, daily progress tracking and review indicate well understood processes and a common approach to good practice. Involvement of service users is evident in most cases, and it is not unreasonable to assume that without reablement intervention, even when a person did go on to need some form of long-term service, outcomes would not have been as positive and the cost to Devon County Council may well have been higher. The reablement service seems to benefit from occupational therapy involvement, which is present in most cases, and there is evidence that the reablement teams refer people to community services and on occasion can arrange for simple services such as the repair of a key safe. There may be some benefit in considering whether further empowerment of the reablement service to provide services such as assistive technology would allow the promotion of even greater independence and more comprehensive management of risks.

3.1.8 The Community Enabling Team records are comprehensive, written in a plain English style and mostly use personalised language. Although only a limited number of records for this team were examined, it does seem as though this team deal with complex, challenging and sometimes chaotic people. The team employ a person-centred and responsive approach which relies on drawing in support from the person's network of family and friends as well as partner organisations, including the voluntary sector. This approach, in the cases audited, clearly maintained some degree of stability for the person, minimised risk and supported the person towards achieving their goals. In viewing the records, it did seem as though without the intervention of the Community Enabling Team, the people supported may have either come to harm or required more extensive long-term care or support.

3.1.9 All cases reviews had CareFirst evidence of consent by the person to share their personal data.

3.2 **Opportunities for Development:**

3.2.1 The audit identified consistent instances of risk (particularly from falls, self neglect and poor nutrition) being identified at the point of initial assessment or from a previous episode of care. These known risks were, however, not followed through into the risk assessment, outcomes setting, planning and subsequent delivery of services in some of the cases audited. There does not appear to be a consistent approach to identifying key risks and ensuring that they are central to goal planning and subsequent intervention. There is an opportunity to promote safe and independent living that will reduce or delay the demand for further services if these known risk factors are targeted and acted upon.

3.2.2 The CareFirst system is entirely separate from CM2000 and the paper based reablement records. Although information from the initial assessment is passed through to the reablement service, CareFirst has no access to reablement records. The reablement team gather substantial quantities of rich information relating to needs, risks and progress against outcomes, but which is never seen outside of the reablement service. There is evidence from case notes that information held by the reablement service is not reflected in subsequent assessment and planning by Care Direct Plus, which may diminish the quality and effectiveness of intervention and perhaps miss the opportunity to address known risks.

3.2.3 Several cases audited suggested that Care Direct Plus is not reviewing previous episodes of care as part of the initial assessment. As a result, important information that would inform the most current intervention is missed. In particular risks such as falls, nutrition or self-neglect are not always picked up from past involvement, and consequently opportunities for targeted prevention and risk management are lost.

3.2.4 There is no evidence that assistive technology has been considered in any of the cases audited. Three cases were noted to have pendent alarms in-situ, but otherwise there was no record of telecare evident. Given the risks identified in a number of cases and the opportunity to manage demand through application of assistive technology as an early stage, this is perhaps a missed opportunity.

3.2.5 One reablement case audited was declined by the reablement service because of lack of capacity. The value of the reablement service is very evident from case notes and it is suggested that the Care Direct Plus methodology for deciding which cases are passed to reablement is reviewed to ensure that, given limited capacity, those cases which are most likely to benefit from this service are prioritised. There were instances too where reablement was not effective (mostly for reasons beyond the control of the service such as medical deterioration) and in these cases the reablement service provided domiciliary care support until such time as a long-term package could be put in place. Although a pragmatic and often necessary use of resources in the absence of alternative care, this type of practice is also limiting the capacity of the service to target reablement activity at those people who would most benefit.

3.2.6 In one Community Enabling Team case, the case of a young person was handed over from Children and Young People Services without any transition planning, the Community Employment Team managed this handover well, but lifestyle and risk factors came to light later in the assessment and case management process which probably would have been known to Children and Young People Services and could have been shared with the Community Employment Service at an earlier stage if there had been a longer transition period.

3.3 **General Observations:**

3.3.1 In every case there was a good (and sometimes excellent) pen picture within the initial assessment. The pen picture is recorded in the "Background, living situation and main concerns" field. In most cases, this pen picture included needs, risks, limited family/carer information and what outcome the person was looking for. As a result of this practice, accompanying fields are not completed. It would seem that Care Direct Plus staff have not entirely changed their practice following changes to CareFirst and continue to use a pen picture methodology to recording information, risks and outcomes rather than distribute this information across a range of assessment fields. The pen pictures are well written and proportionate. In light of this, the absence of information distributed across other fields in the initial assessment is not necessarily detrimental to the management of the case, but as things stand, the assessment methodology required by CareFirst is not consistent with practice within Care Direct Plus, and it may be helpful to be clear with practitioners about what information must be collected as part of an initial assessment and where it is to be recorded.

3.3.2 Allied to the comments above, there are two further assessment tabs, one with the primary purpose of calculating the RAS and a second functional tab for use by occupational therapists. The fields with these two tabs can contain helpful and detailed information about people, but are not in most cases completed by Care Direct Plus. It may be impractical for these fields to be completed as part of the initial assessment, but CareFirst does offer an opportunity for a richer, fuller assessment at the point of first contact which is not being exploited by Care Direct Plus.

3.3.3 The Community Enabling Team hold some relatively complex cases, and in doing so avoid demand for more intensive services. There was evidence, however, that they were left holding the case without the support they may require from other services such as Learning Disability or Safeguarding. Certainly, in the cases explored, referrals and requests were made to the LD team and Safeguarding team, but without any further intervention from these teams evident, leaving the Community Engagement Team to continue addressing the needs and risks associated with the case without specialist support.

3.3.4 In at least one case, there was evidence that the reablement assessment by a team leader took place several days after the reablement episode had started. Until that assessment takes place, reablement staff undertake activity based on their own observation of the person and any records they have access to. It is possible that these first few days of reablement are less effective than they would be if a team leader has assessed and set a reablement plan at the outset of the intervention.

3.3.5 Carer’s assessments were not evident in large number, and where they had taken place, were joint assessments with the person they care for. Opportunities to better support carers may have been missed, but it is understood that practice relating to carers has changed since these cases

were active.

3.3.6 Management oversight is evident in the case record within the reablement service, but not in Care Direct Plus.

3.3.7 There were case examples of appropriate safeguarding alerts being raised, however none of those examined resulted in action by the safeguarding team. This may have been appropriate, however there was very limited evidence of the decision-making process at the point of safeguarding triage and it appears that the main reasons for taking no further action were because people had mental capacity to make choices about risk or because people were not felt to be sufficiently vulnerable.