22 REVIEWING CARE AND SUPPORT

22.1 The purpose of a review

This section describes guidelines for an assessor carrying out a review of care and support.

The purpose of a review is to look back at the effectiveness of a care or support plan over a period of time, to gauge the extent to which it has met the needs of the service user and achieved their desired outcomes, and to identify changes in need and to adapt the care or support plan accordingly. For those service users with direct payments, it is also to ensure that the money is being used appropriately.

We are required to carry out face-to-face reviews of service users at least annually. Reviews will always concern themselves with the needs, views and preferences of service users and their carers and the effectiveness of services in meeting those needs.

The individual responsible for reviewing the care plan will ensure that all those involved in the care plan are consulted, where relevant, including main contacts, and service providers.

Ordinarily you always visit the service user at the point of review in order to assess adequately whether their needs have changed. If this has not been done you must record the reason and ensure it is approved by your manager.

The review may take the form of a network meeting, or, an informal series of meetings or telephone calls over a short period of time. Choose the method appropriate to the particular case. Inform the service user / carer of the timing and arrangements of the review.

22.2 Timing of reviews

If the service user has chosen (or, if they lack capacity to make this choice, where it is in their best interests – see Sn 25) to have their support arranged by the Council and has a care plan, then a first review of the care plan takes place within six weeks of the care package being put in place or of the person being admitted to a residential or nursing home. The second review must be held for each individual at a point determined by the complexity and risk of the case, but certainly within 12 months.

If the person has chosen to manage their personal budget themselves or has a suitable person managing it for them, then the care manager checks with the service user after six weeks that the direct payment arrangements are working properly, and makes any necessary adjustments.

The first review of direct payments takes place after six months.
Thereafter they must be reviewed at least once a year.

**The aim is to synchronise reviews of direct payments and care and support plans.**

Reviews should be brought forward as part of the overall work in a case when:

- there is evidence of significant change in need of the service user;
- requested by a service user or carer;
- there is a change in circumstances of service user or carer.

Service users should be re-assessed as a matter of course every three years to maintain a comprehensive record of their needs.

**22.3 Components of a review**

During a review, work with the service user (and carer where appropriate) to:

- evaluate the extent to which desired outcomes have been achieved, and identify reasons for success or failure;
- examine how the service user is managing their personal budget, where they have chosen to do so, and ensure that any direct payments are being used appropriately;
- evaluate the quality and cost of the services provided, including whether the service user is satisfied with them.

For those services users who have direct payments, go to Sn 22.4.

Determine whether the service user’s needs have changed significantly. If they have, run the new needs through the RAS to determine a new indicative personal budget, discuss the individual’s personal aspirations, set new desired outcomes, and adjust the care or support plan accordingly. Incorporate the current needs and the new care arrangements into a revised care plan and give it to the service user/carer with the review report. State what the Personal Budget is for the next year, whether or not it has changed. Set the date of the next planned review.

Record the review on ASCC and create/complete an updated care plan.

For details of the steps on ASCC, see ASCC Guidance Sheet 9.

**22.4 Review of Direct Payments**

As noted previously, check by telephone with the service user after six weeks to make sure that the arrangements for direct payments are working properly, and make any necessary adjustments. This check does not constitute a review.

The review of direct payments is to ensure the payments are being used appropriately. As noted above, the first review of direct payments takes place after six months. Thereafter they must be reviewed at least once a year.

Examine the service user’s or suitable person’s expenditure form to check that services purchased are in line with the support plan. The expenditure form is a list of all the money that is paid out of the direct payment bank account, Visa card or
managed account. This will include any money paid out to employees or agencies, and any Inland Revenue payments.

Check bank statements, invoices, receipts and timesheets to make sure they are consistent with the expenditure sheets.

Check whether the service user is making any contributions towards their personal budget if they have been assessed to do so.

*If the service user uses a company to provide care to them*

Check that:
- the care agency is invoicing at regular intervals, usually on a monthly basis;
- the hours they are charging for match what has been planned in the support plan. There may be some variation as the service user is entitled to use their budget in a flexible way that best suits their needs. However, it is expected the monthly hours would remain fairly consistent unless stated otherwise in the support plan;
- the hourly rate is the same as agreed in a care contract between the service user and the agency and is reflected in the support plan.

*If the service user directly employs a care worker*

Check that:
- the service user is paying the care worker regularly, either by making payments into their bank account or giving them a cheque and keeping cheque receipts. The support plan should indicate the weekly hours agreed and the rate of pay. Account statements should show regular and consistent payments being made.
- whether the service user is using a payroll service or taking on the responsibility of setting aside appropriate Income Tax and National Insurance Contributions (NIC) money that is required of them as an employer.

This is a complex area but you are only looking to see that regular payments are being made using the appropriate payment method as stated above. Check at the review that the service user is aware of their responsibilities as an employer.

Things to check:
- Does the service user have a copy of the employee contract – does it include terms and conditions on pay, holidays, notice and disciplinary procedures?
- Does the contract honour the employee’s statutory rights such as sick pay and maternity leave?
- Does the service user have clear records on paying tax and national insurance contributions on behalf of their employee?
- Does the service user have a copy of their public liability insurance?
• Has the service user given due consideration to their employee’s health and safety while at work?

Record the service user’s responses to the above questions as it is important that they maintain a full understanding of their responsibilities as an employer. Record if there are particular reasons why these questions are not appropriate. This will mean that everyone is comfortable about their role as an employer.

If the service user makes cash payments

On occasions the service user may spend their direct payment money on cash purchases, for instance for travel, public admittance fees, or one-off gratuities (a thank you payment). These should be made and reviewed in line with the support plan. The service user may have designed their care to pay for day-time, personal activities that require cash payment; as long as these have been agreed on the support plan allow some flexibility in how the service user pays for them, but check that there are receipts.

Occasionally the service user might feel they would like to give money as a gratuity. They should check with us about the circumstances and amount of the payment. Although one-off exceptions can in principle be accepted, ongoing payments should not occur. If this is happening discuss alternative arrangements with the service user, agree them if appropriate and add them to the support plan.

If these checks raise any concerns for you, then discuss with your manager, and if necessary, ask the Finance Team to arrange to carry out an audit.

22.5 If needs have changed significantly

If the service user’s needs have changed significantly, reassess the service user’s needs and appraise the service user’s eligibility for assistance under FACS (see Sn 6.10). In all reviews consider the continuing needs of the service user in relation to their eligibility for services. Where the service user has been receiving services for some time but does not have needs which fall within the eligibility criteria, arrange a reduction or ending of service provision as sensitively as possibly. Such a reduction or removal of services for service users should only arise where the review identifies that their needs no longer call for the provision of those services. A review will not result in an ending or reduction of a service, which a service user still needs. During a review you may also identify needs which require increased service provision by either health or social care.

Where there are significant changes in needs, then you should undertake a Re-assessment.

Create a Review document stating the need for a Re-Assessment, before creating a new FACE Assessment on ASCC.

Essentially, the process is now the same as that described in the preceding sections. So go to Sn 6.8.

Record the review on ASCC.
22.6 OT Reviews

The OT Service monitor service users who:

- have complex items of equipment which require servicing six monthly or yearly (e.g. electrically operated load bearing equipment e.g. hoists, mattress elevators, bath lifts, riser recliner chairs);
- have Community Alarm Service provided via Preventative Technology Grant (PTG) or via a direct referral from the OT Service;
- have complex or progressive disabilities.

Complete the Monitoring review either over the phone for low level risk cases or via a home visit with a member of the MDT such as Physio or District Nurse as appropriate.

Use the Proforma available for bath lift monitoring and for completing Monitoring reviews.

22.7 Reviews of care home or nursing home placements

Hold a formal review at about four to six weeks into the placement, with the home manager/care staff, member of the Financial Assessment Team, service user, their family/friends and any others involved in their care. At the review, confirm the placement as permanent if appropriate. If the resident is having difficulty coping with the transition, or is unhappy in the home, you may need to negotiate an extended trial period or seek an alternative placement. If the resident lacks capacity to decide whether to stay at the placement and is unsettled, consider the use of guardianship or the Deprivation of Liberty Safeguards (see Sn 27).

When the placement has been confirmed as permanent, ensure arrangements are in place for terminating the previous community tenancy, finalising utilities etc. Record the review on the Residential Care Plan Review in ASCC. If necessary, amend the Residential Care Plan.

For details of the steps on ASCC, see ASCC Guidance Sheet RC4.

Transfer the responsibility for ongoing monitoring and review to the Residential Placement Team once all major outstanding issues have been resolved.

For details of the steps on ASCC, see ASCC Guidance Sheet RC5.

22.8 Review of placements under Deprivation of Liberty Safeguards (DoLS)

See Sn 27.11 and Sn 27.12.

22.9 Substance Use Reviews

Review regularly all care plans throughout the care management process. Review purchased services twice in a 12-week contract and carry out at least one further review if a placement is extended. An aftercare review is essential near placement completion. Complete a review TOPS and BCP if due.
Put all reviews in writing and send copies to the service user and key worker/counsellor of the provider agency. Encourage the Provider agency to produce progress reports and updated care plans. Send TOPS/BCP to Team Support Officer for monitoring and inputting on NDTMS

Manager

The Team Manager approves all reviews via the ASCC system.