Carers' Resource Independent Support Planning (CRISP)

Report on progress, February 2013

In the beginning

Once we heard that Carers' Resource Independent Support Planning (CRISP) had been selected as one of the Social Work Practice Pioneer Projects (SWPPPs), a steering group was formed. This then took the lead on the project until a member of staff was recruited to lead it. The steering group:

- developed a planning tool
- sought sources of referrals
- recruited a lead person for the project
- developed marketing material for the project.

Angela George was recruited to the project and the social work leads were Kathryn Teasdale and Carolyn Eastwood.

What we did and with whom

As an organisation we receive a large number of referrals from health and social care and our clients span carers and those in need of care and support. We felt we would pilot our paperwork with some of the referrals for those in need of care and support and check whether this worked for them, and then look at introducing the notion of the charge.

Developing the plans

Kathryn developed the initial plans and Angela attended a newly formed support planning training session in Bradford to develop her skills and work alongside an experienced group of support planners. We trialled the plans on a number of vulnerable older people who had been referred to our Good Neighbours Scheme. The support plans were well received by the clients, and 75% of the plans were developed further. At this stage there was no charge associated with the service, although the services supporting the clients were chargeable.

Our team around vulnerable older people (those in need of care and support)

CRISP made us as an organisation think about our work with those clients in need of care and support. Our main client group is carers, and we have had some additional funding for vulnerable older people from Partnerships for Older People Projects (POPPS) nationally and older people's funding streams locally. We felt that there could be ways that the team working with those in need of care and support could work together more in the future. As a result of this project we have created a team around those in need of care and support, and ensured that this spans the organisation.

Support planning in the locality

Angela has attended the support planning workshops led by Bradford Metropolitan District Council, which focus in the main on planning for those with a learning disability. Angela has completed the training and been linked with one client, and the relationship has worked well. The coordinators of the training are keen to use CRISP more, and for Angela to become the key worker for not just one client but for all the residents living in one unit. Angela's support planning relationship was a case study for a recent study day (February 2013). We continue to be in discussion with Bradford about the future of their work and our involvement – they are looking to move support planning to volunteers and while valuing our work, do not have the funding going forward.

Promoting the service

We have promoted the service in a range of different ways, but mainly through our existing services. Due to demand for the service we have not needed to promote it more widely than to a small group of health and social care professionals as our own triage service has been the source of most referrals. One presentation to a group of financial planners met with a great reception and we have now begun to scope a new service based on CRISP called the Professional Advisory Service.

The difference it has made for people who use services

Our work with clients has grown and there have been a number of successes. Angela has worked with 19 clients in total and all have benefited from the service. This has ranged from:

- The daughter of Mrs A was very concerned about her mother who lived 20 miles away. Mrs A was 92 years old and had led a very sheltered life and had refused any kind of help in the past. She had dementia, arthritis and poor mobility and was housebound. Her daughter was her only child and was feeling the weight of her caring role. Mrs A had been forgetting to take her medication and there were also doubts about her personal care and hygiene. Her daughter would like her to have some support at home as this would give her peace of mind and reassurance that her mother was being looked after, and take some of the burden from her. Angela arranged a visit with Mrs A and her daughter and gently broached the subject of her having some help at home. The response received was positive and Angela then organised for the help at home which they had agreed. The difference it made was two-fold – Mrs A was able to remain independent of her daughter and her daughter felt some of the weight being lifted off her shoulders just knowing that there was someone else there to support not only herself, but also her mother. What had felt stressful and insurmountable was made possible by a gentle and supportive intervention. The daughter was overjoyed at this result and felt supported as a carer. *This was a charged service*.

- Mrs B was 79 years old and lived on her own. She had recently been in hospital for five months after a fall and had an operation on her leg. A metal plate was fitted from her hip down to her knee. She also had very bad arthritis in her hands. While Mrs B was in hospital her husband, whom she cared for, died. On discharge Mrs B returned home to an empty house. She was not only trying to recover from a huge operation, but also had to cope with the grief of losing her husband to whom she had been married for 50 years. Obviously this caused Mrs B to be depressed and very lonely. On her discharge from hospital the START (short-term reablement) team was put in three times a day to help her with personal care and hygiene and meals. This was a temporary free service to help Mrs B get her independence back. Also, Mrs B was overwhelmed by the letters awaiting her on her return from hospital. Angela visited Mrs B and helped her to get her paperwork in order and also made a few telephone calls for her regarding her financial situation and informing some companies of the death of her husband. Angela made a number of referrals for other services including CRUSE, the bereavement counselling service, and given the developed relationship, Angela helped Mrs B think about the future following the withdrawal of the START team. *This was a charged service*.
- Mrs C had recently been discharged from hospital and arrived home a little confused. Her neighbour was worried about her – the initial referral came to us via the Home from Hospital Scheme. Much needed to be done to support Mrs C on her return home, including dealing with a range of contractors – the police were aware that Mrs C had been a target for rogue traders. The most immediate concern was to get help into Mrs C's home to support her and Angela, working with and through the neighbour, organised for regular help at home, which has helped her remain at home longer. *This was not a charged service* but many of the services supporting Mrs C at home are charged.
- R was 18 and had a learning disability. Angela worked with R planning his move to independent living. The independence of this relationship proved beneficial to R and his family and the move was successful. R is now living with a group of young people in supported accommodation; he is starting to focus on his next plans. *This was not a charged service* as it was delivered as part of accredited training with Bradford Metropolitan District Council.

The difference it has made for social work and social workers

We are very aware of the demands on social workers in the locality and feel, due to the small scale of this project, that it may not have had a huge impact on their work. For R's social worker it made a huge difference as she was able to feel confident that R had someone he trusted to talk to – from her perspective she has described us as a "trusted partner". I think that this sentiment is reflected by others' comments:

- “having time for …”
- “working at a pace that suits …”
- “listening to their issues and responding appropriately …”
- “it’s not something I could have achieved …”

As social workers focus on the most vulnerable, the people we have developed the service around may end up being overlooked. Our work on this project has been about planning interventions to prevent clients becoming more at risk, socially isolated or unable to cope at home alone. We remain committed to this preventative work but understand that in a world where resources are tight, this could be viewed as wasteful or too expensive. The demographic change will have an impact on all those working in a care environment, and the whole focus on the cost of care has begun to look at preventative interventions. I feel that projects such as this will be viewed positively in retrospect.

Our learning

Developing the service takes time

We expected that the service would develop much quicker than it has, but on reflection, this was unrealistic; it has taken years for the carers’ service to get the regular referrals it now has, and the reputation grows with our practice and feedback to the referrers.

The holistic nature of the service

Understanding the needs of the clients and their families is important and takes time. Actioning the plan also takes time and needs to be done at a pace that the clients dictate and by working through others who are trusted.

Charging

This is the first time that we have charged for our core service and there was much learning for us, both in terms of charging and helping others within the service understand this. The reaction we received from the financial planners made us realise that we need to broaden to whom we are talking. Health and social care may not be the only source of referrals for this project – solicitors and financial planners do not have our skills or understand the care sector as well as we do, and so in terms of charging for our services, this may be a better source of referrals.

Developing a team around those in need of care and support

We appointed an independence and breaks service manager (funded through North Yorkshire monies) to be located in the Skipton office, with a view of having a Common Assessment Framework and to make our offer more seamless. It was previously complicated for referrers to understand the discreet nature of individual projects focused on those living alone.

Professional Advisory Services

We believe that this model will be the basis for other charged services in the future, and have begun to scope this service and to develop a team that can deliver this.

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