**Adult Social Care**

**Practice and Quality Assurance Panel Application Form**

**When Submitting this form for a panel slot, please adhere to the below:**

1. **If you require an URGENT slot this needs to go to the panel chair to arrange and NOT the ASCH Inbox**
2. **Please always use a new form for each submission, do not use an old form and change the date**
3. **Please put at the start of the email subject line Older People or Disability to help us allocate**
4. **Please provide 2 weeks of availability so we do not book a slot that clashes with a prior booking**
5. **Please only send a submission once, or this could cause duplicate bookings and waste a slot**
6. **Please ensure all mandatory fields are completed below, forms will be returned if not done**
7. **The Managers section must be complete, every form must be pre-approved for presentation**
8. **Reminder: Challenge Panel is not an advice surgery, please have your proposals ready for approval**
9. **The Outcome records the basic details, but are not minutes, ensure you capture details on LAS**
10. **Submissions will be returned and not allocated a slot until the requirements are met**

**\* Indicates a Mandatory Field that must be completed**

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| **\*** | **Client LAS Number** |  |
| **\*** | **Cost Code** |  |
| **\*** | **Client Surname** |  |
| **\*** | **Client Forename** |  |
| **\*** | **Social Worker** |  |
| **\*** | **Team** |  |
| **\*** | **Manager** |  |
|  | **NHS number (if known)** |  |
|  | **Have the persons needs been before this panel previously, if so when (what date)?** |  |

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| **\*** | **S117 Eligibility Status Yes/No** |  |
| **\*** | **If Yes, what date were they detained under the Mental Health Act 1983?** |  |

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| \* | **Out of the options below, what type of care is the funding request for?** **Please place an ‘X’ next to what is required** |
|  | New Home Care Package |  |
|  | Increased Home Care Package |  |
|  | New Permanent Placement – Residential  |  |
|  | New Permanent Placement – Nursing |  |
|  | New Permanent Placement – Other |  |
|  | Change of Placement |  |
|  | Respite Residential  |  |
|  | Temporary Residential |  |
|  | Temporary Nursing |  |
|  | Extra Care |  |
|  | Supported Living |  |
|  | Shared Lives |  |
|  | Advocacy  |  |
|  | Legal Costs |  |
|  | Other – Please provide details |  |

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| \* | **What is the current situation?**  |  |

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| \* | **What has been done to ensure that only the minimum of statutory care is provided?** * **Strength based?**
* **Asset based**
* **Community based**

**Resource Wheel Considered?****A picture containing cartoon, circle, art  Description automatically generated** |  |

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| \* | **What is the proposed Solution and what other options were considered?** |  |

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| **\*** | **What are the risks of not providing this care and which of the S114 criteria has been applied?** Only spending allowed under the new emergency measures are:* on goods and services which have already been received
* expenditure required to deliver the council’s provision of essential statutory services at a minimum possible level
* urgent expenditure required to safeguard the vulnerable citizens
* expenditure required through existing legal agreements and contracts
* expenditure funded through ring-fenced grants
* expenditure necessary to achieve value for money and/or mitigate additional in-year costs
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| **\*Current Costs Per Week** if applicable (do not use £ sign) |  |
| **\* New/Increase in Costs Per Week**. If unsure of costs have you used the RAS? (do not use £ sign) |  |
| **\*Total of Package (do not use £ sign)** |  |
| Are there any **One-off** payments? If so – how much? (do not use £ sign) |  |
| **Existing hours** of care per week if applicable |  |
| **Proposed hours** of care per week |  |
| **Total hours of care (existing and new)** |  |
| **\***What is the status of the **financial assessment**? |  |
| **\*Client Contribution** – if FA completed, what is the weekly contribution? (do not use £ sign) |  |
| Does the client have a **Direct Payment** and if so the value? |  |
| Has a **CHC checklist** been completed? If not, why? |  |
| Any other comments |  |

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| **\*Managers Authorisation – Mandatory Field \***This is mandatory and any submission without managers sign off and comments will be returned |
| **Managers Name** | **\*** |  |
| **Comments and Approval for submission** | **\*** |  |
| **Date** | **\*** |  |

Adult Social Care

Practice and Quality Assurance Panel Outcome Form

**(to be completed by the panel facilitator and returned to the relevant social worker and team manager)**

**Panel Present**:

* **Azuka Agbai**
* **Eunice Awosika**
* **Permjit Basi**
* **Caroline Baxter**
* **Kaye Carter**
* **Tim Gray**
* **Alison Heathcote**
* **Stephen Hopkins**
* **Deborah Howard**
* **Phil Howell**
* **Felicity Nii Bortey**
* **Valentine Nweze**
* **Sean Olivier**
* **Mirella Peters**
* **Carl Richards**
* **Nick Sherlock**
* **Simon Wadsworth**
* **Lorraine Wallace**

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| **Date** | **Time** | **Manager** | **Social Worker and team** | **Resident** | **Document** |
|  |   |  |  |  |  |
| Decision: Start Date: Cost PW: Comments:  |