For general release

REPORT TO:	**Adult Social Services Review Panel 24 April 2013**
AGENDA ITEM NO:	**6**
SUBJECT:	**PERSONALISATION & REABLEMENT**
LEAD OFFICER:	**Edwina Morris, Interim Director of Personal Support**
CABINET MEMBER:	**Councillor Margaret Mead, Cabinet Member for Adult Services and Health**
WARDS:	**ALL**

CORPORATE PRIORITY/POLICY CONTEXT:

Implementation of personalisation and reablement across adult social services contributes to the Council's objectives of reforming public services, transforming the council and empowering communities by enabling Croydon citizens, who may be in need of social care support, to access timely information, advice, assessment and support to enable them to make choices about how they will use the support available to them to continue to live in their local communities.

FINANCIAL IMPACT:

The transformation of the existing day centres and introduction of the reablement service has been achieved with a reduction in ongoing revenue expenditure of £1,020K, comprised of £300K from the day service redesign and £720K from ongoing reductions in support costs for individuals following reablement.

FORWARD PLAN KEY DECISION REFERENCE NO: N/A

1. RECOMMENDATIONS

1.1 This report is for information and should be noted.

2. EXECUTIVE SUMMARY

2.1 Personalisation (incorporating a strategic shift towards early intervention, prevention, and reablement) is now the cornerstone of social care services. It means that every person who receives support, whether provided by statutory services or funded by themselves, can now have choice and control over the shape of that support in all care and support settings.

2.2 This concept and ideological intent is enshrined in *Think Local, Act Personal* - the sector-wide statement of intent that makes the link between the government's new vision for social care and *Putting People First*.

2.3 The restructure of DASHH in 2011 gave formal recognition to the fact that personalisation had moved from programme status into “business as usual”. It is now the departmental default position for the social work assessment & case management service which is responsible for delivering personal sustainable outcomes that maximise independence and choice for Croydon residents.

2.4 Over the past year, Council officers, local health agencies, and service providers have been working collaboratively to personalise and integrate service delivery across health and adult social care and make vital public funding go further. Increasingly we are recognising the contribution that individuals, families, carers and communities make in providing care and support - both to those who are publicly funded and those who either pay for themselves or rely on family carers. DASHH services work in partnership with clients to design independence plans that address their Fair Access to Care Services (FACS) eligible need following assessment. The plans focus on the outcome that the client hopes to achieve in terms of meeting their identified need. The plans draw on the concept of social capital, and aim to maximise an individual's potential and independence. Particular emphasis is placed on enabling clients to access universal services within their community.

2.5 Personalisation as “business as usual” means that we consistently encourage people to plan for a fulfilling life in accordance with their individual aspirations and goals to achieve health and wellbeing from engagement with the wider community in a variety of ways. We are building on existing links with local partner agencies that deliver universal education, training, employment, and housing services so that we can enable service users to move on from intensive therapeutic support and access mainstream services. Our desired outcome for service users is an increase in their experience of social inclusion and their sense of themselves as stakeholders in their communities. In all aspects of our work we reinforce the individual’s personal responsibility for creating the life they want for themselves, and we work to enable and support them to achieve this.

2.6 The focus upon what will make the most difference to an individual and their lives has led to the outcomes that are shown in the case studies attached to this paper in Appendix 1. It has also highlighted the need to focus upon prevention and the importance of reablement and recovery services, more therapeutic interventions including rehabilitation and convalescence supporting people who have physical and / or mental health difficulties

3. DETAIL

3.1 Each client group supported by Adult Social Care is engaged in promoting personalisation and we are continuing our work with health partners to develop personal health budgets. Our service users have told us that they have found our process complex and we have taken the opportunity through the restructuring of the Department and the introduction of a new IT system to review our processes and streamline our assessment. We now have a workflow system which speeds our back office function and we have slimmed down our assessment documentation. Our new IT system will in the near future enable more regular and transparent information for individuals about their personal budget allocation and spend where they have asked the Council to administer the budgets on their behalf.

3.2 Mental Health Services. These are delivered in partnership with South London and Maudsley NHS Trust (SLaM) and there is clear evidence that adopting a more person centred approach has helped mental health staff to support more people at home.

3.3 Changing the culture of the large work force in the SLaM services has proved to be challenging in mental health as in many other client groups. However, there is clear evidence that personalisation has become increasingly more embedded in the thinking of front line metal health staff when they are carrying out assessments and reviewing care plans. It is also evident that personal budgets for specific interventions, often on a time limited rather than long-term basis, are delivering successful outcomes.

3.4 The majority of front line staff in community mental health services have now been trained in enabling users to develop their own self directed support plan. This gives the people who use services greater control in their own care plans and has resulted in a much greater range of solutions to tackle their problems, including some very creative plans not based on conventional services. Front line staff are becoming more accustomed to taking managed risks in order to support these new choices. Case examples of the outcomes achieved through this way of working are included at Appendix 1.

3.5 Croydon substance misuse services led a successful community based pilot which began in 2010. In addition the service is a national leader for the delivery of personal health budgets for people with drug and alcohol needs. Croydon is the only site in England to have been awarded the legal power to offer direct payments for health care to people with substance misuse problems, although this power has not yet been exercised. Our first pilot (in which we offered small personal budgets of up to £1k to help people with their recovery journeys) proved very successful, with 55% of participants reporting improvements in psychological health, 40% reporting improvements in physical health, and 65% reporting improvements in overall quality of life. Where people were abstinent from substances throughout or by the end of the pilot, findings were even more positive (e.g. 83% reporting improvements in overall quality of life).

3.6 We are not yet able to report on the findings of our personal health budgets pilot, but we know there have been some significant individual "successes", with several individuals with deeply-entrenched drug and/or alcohol problems managing to turn their lives around in very positive ways by using personal health budgets to achieve personal recovery and community integration outcomes. A case example is included in the Appendix. Evidence of the success of the pilot in this area is captured in comments from people who have been involved in the scheme, e.g.

> "I feel fantastic whenever I look at my daughter's bedroom, and we often spend time in her room lying on her bed watching TV together. When I was in addiction, I did not spend quality time like this with her. Since I re-decorated my daughter's bedroom and completed it with items from the pilot scheme, she no longer feels ashamed, and has friends to sleep over. I feel I have achieved so much by making amends to my daughter."

4 REABLEMENT AND RECOVERY

4.1 Good progress has been made in relation to the implementation of a reablement and recovery service aimed at preventing the need for long term support for individuals. This work is being developed in partnership with Health colleagues and our private provider contractor in Homes for the Future.

4.2 The outsourced Addington Heights Resource Centre is managed by Care UK via a contractual arrangement with DASHH/LBC, with the Reablement Centre on the same site being managed by DASHH.

The Addington Heights Resource Centre, i.e the care home, currently comprises 50 beds covering both long term residential and nursing placements, and short term respite and reablement beds.

4.3 At the Reablement Centre on the same site as the above service, the following reablement and recovery facilities are also available.

- Reablement centre
- Gym / activity suite in the centre
- Day activity centre staff to also be utilised as a resource when needed with reablement clients temporarily placed in the reablement beds at Addington Heights
- Sensory Impairment Team activities
- Community Access Team activities

The latter two services listed above facilitate various community based activities taking place in the centre for people with sensory and/or physical impairments and are led by the Sensory Impairment Team and Community Access team.

4.4 As can be seen from above there is a growing range of complementary reablement and recovery services and specialist beds contracted to and managed by CareUK and also by DASHH & Croydon Health Services (CHS). Whilst there have been successes, it has to be said that with the full range of reablement, residential, respite and nursing beds now on stream, this has proved something of a challenge to Care UK together with the high turnover of their nursing staff in the unit.

Discussions are being undertaken by the DASHH Commissioning Contracts Team, in liaison with Occupational Therapy and Personal Support colleagues, to resolve these issues.

4.5 Within DASHH and following liaison with the Occupational Therapy service and care management, arrangements have also been put in place for a Discharge Co-ordinator post in DASHH to facilitate placements and follow up actions with clients, care managers and health colleagues. We have recognised the importance of continuity and a single point of contact for people as they pass through this service.

4.6 To further facilitate the reablement and recovery programme two reablement flats at the Council's Southsea Court special sheltered housing scheme have been refurbished and refreshed by DASHH and came back into use in March 2013 in order to offer a further range and choice of reablement facilities for clients.

4.7 A Pathway to Reablement workshop was also held in September hosted by DASHH with excellent representation and participation from CHS and DASHH, and with valuable support from the Council's Business Change Section. The key themes of the Workshop being:

What is working well in respect of:

- Patient / Client / Carer
- Capacity and resourcing
- Multidisciplinary and multiagency working
- Access to and pathways for reablement services

Such themes are also being considered in the context of what is not working so well and then identifying the way forward to resolve such issues. As part of this work a multi agency team has been working on finalising the pathways into accessing the services. This will provide clarity to staff teams and clients alike regarding pathways into the different elements of the service. A joint DASHH/CHS implementation group is being established to oversee the development and delivery of these important reablement and recovery services.

4.8 Close liaison and planning has also taken place and is ongoing between senior management at CHS and DASHH regarding the CHS restructuring of the joint Adult Integrated Therapy Services, and in the context of considering its impact on the OT and associated therapies provision of reablement services in the borough.

4.9 Turning to the DASHH transformation of the Council's Day Activity Centres, an integral part of the move to the reablement service, this work has also progressed well since the Cabinet decision in April 2012.

4.10 The transformation of the day activity centres has involved a full consultation programme with approximately 110 clients and their carers and care managers across the three day centres for older people ie. Bensham, Addington & Coleby. DASHH staff have worked closely with day centre clients and their carers to achieve the transformation to more universal services and the implementation of reablement in the centres via a detailed process / work plan. The programme has been completed for Addington Heights and Coleby with clients assessed and successfully transitioned into their new services together with ongoing support and advice in place.

4.11 Arrangements have also been completed to transform and relocate Bensham day centre in December 2012 following the South London and Maudsley decision to change the use of it's Queens Road site service, where Bensham Day Centre was located. A similar programme of assessment, consultation and liaison with clients and carers has therefore been undertaken with all Bensham clients, and who have now moved to the day services at Heavers and Langley, together with appropriate Borough services and with the Bensham staff team members being transferred with them.

Such a service relocation for the former Bensham clients has:

- Enabled a redesign of the Mental Health Day Services for clients with Functional Mental Health Needs;

- Supports an increase in the numbers of clients using the service at a time of greatest need;

- Provides services which are located at the centres nearer the clients' local community;

- Reduces transport journey times for clients;

- Assists client independence and facilitates use of wider community services.

The relocated service has therefore been offered in centres with facilities and services fit for purpose.

4.12 As well as the reablement services described above, there has recently been investment made by the Croydon CCG of £200,000 to pilot reablement for mental health service users which will focus on social care support and interventions. This project will be starting soon and it has been agreed recently with the Croydon CCG that this project will be subject to formal academic evaluation by the University of York. It is recognised that there are few reablement services in the country which have looked primarily at supporting mental health clients. Therefore, the findings from this pilot will be of interest both locally and across the wider health and social care community in England.

5 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 Great care and attention to detail has been taken in creating a financial model to support personalisation, a RAS, resource allocation system, to ensure that adequate resources are allocated to meet need and that individuals are neither over or under resourced. The financial model is used to generate indicative funding, a rigorous process is in place to verify the allocation. This has protected the individuals assessed to be in need of support and also the overall Council budget ensuring that it is allocated to best effect. We regularly review the algorithm we use to calculate indicative personal budgets to ensure it continues to add value to the overall process of resource allocation.

5.2 The original government target to have 100% of people assessed to be in need of support to be in receipt of a personal budget has been revised down and now is at 70%. The reduction in the target figure from 100% to 70% is a national change. It has been introduced by the Department of Health as, following review, it was recognised that some authorities were "defining" Personal budgets in different ways with some including one-off pieces of equipment or short-term support which was not required on an on-going long-term basis, in their reported figures. The Department of Health have concluded that by defining types of service and needs that qualify as Personal Budgets more specifically, there will be greater consistency across authorities, and an opportunity to understand progress better on a national basis.

5.3 Croydon's performance for the department in relation to personal budgets at the end of 2011/12 was 47.58%, it has continued to climb and at November 2012 was 51.52%. At the time of writing this report, the end of year performance on this indicator is not yet available, however early indications are that the target of 70% will be achieved.

5.4 The plan to transform the existing day centres and introduce the reablement service has significant in year efficiencies attached.

- Older persons service redesign in day care to a Reablement model, saving £300K pa.

- Older persons' Reablement, anticipated reduction in support costs for individuals of £720K pa.

Both of these efficiencies have been achieved**.**

6 NEXT STEPS

6.1 In common with other local authorities, there have been problems for Mental Health commissioners in releasing enough flexible funds to support the growing number of individual/personal budgets. Funds are committed to a range of block contracts and additional pressures are experienced due to the need to reduce costs and budgets. A pricing scheme for self-directed support has been agreed and is being implemented in order to facilitate a move from block contracts to individual purchasing.

6.2 Although some users of mental health services have embraced the idea of self-directed support and personal budgets, there is still some way to go to ensure a good level of understanding among people with mental health problems, some of whom have been service users for many years, of the benefits that personal budgets can offer people. A multi-agency communications group has been re-convened to help develop more effective means of personal budgets including publicity to explain issues in plain language.

6.3 In substance misuse as we come to the end of the personal (health) budgets pilot, commissioners now need to decide whether and in what form personal (health) budgets may be rolled out in the local substance misuse treatment and support system in the future. The major challenge is how to shift monies towards recovery in a sustainable way, whilst ensuring the continued availability of key medical interventions such as stabilisation and detoxification, and opiate substitute prescribing, all within a diminishing financial envelope.

Some local stakeholders feel personal health budgets should include funding for medical interventions (as in our personal health budgets pilot), whilst others feel it would be best to exclude funding for medical interventions, so that personal (health) budgets are offered only when people are ready to move beyond treatment into recovery and community integration.

6.4 The challenge of encouraging more older people and people with a learning disability to take their personal budget as a direct payment remains. Work is at an early stage to investigate the potential use of accounts at the Credit Union which may be able to support more independence and peace of mind for individuals. The commissioners continue to stimulate the market to try to ensure local choice for individuals and also deliver safeguarding for these most vulnerable of people. Increased use of telecare and Carelineplus is providing opportunities for a less intrusive way of monitoring support.

Commissioning for people with a learning disability is also undertaking work with the provider market to develop outcome driven placements, with value to the individual and Council being key features for developments. Significant work is also taking place to ensure the promotion of positive risk management to deliver independence rather than stifling the individuals' development.

6.5 In addition commissioners are looking to further boost the role of the voluntary sector in prevention and early intervention. The current voluntary sector funding agreements end in March 2014 and the recommissioning of these services is being re-cast to meet the changing needs of the wider adult population. A key element will be to provide another access route for information, advice and support for adults that will enable people to choose not to come directly to the council.

6.6 In conclusion good progress is being made overall in relation to personalisation and reablement in the borough. Officers are not complacent and continue to work to make improvements in the system.

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BACKGROUND DOCUMENTS: **None**

Appendix 1 - Case Studies

Case Study - Older People

AB lives on her own in her own home. She is 80 years of age. Husband died in 2011. AB was receiving AM and PM domiciliary care calls of 30 mins each plus Meals on Wheels.

Review carried out following concerns raised by AB's family, about two recent incidents where she had been wandering outside in the locality and was found by neighbours in a confused state and returned home. AB's two sons who live in Hertfordshire and daughter who lives in Israel thought that AB needed a 24 hour care.

AB has poor memory but no formal diagnosis of a dementia type illness. She had refused input from the Community Mental Health Team.

Initially care package kept to 2 calls per day and Mow's. AB and her family agreed a referral to be made to telecare for assessment for this.

17th July 2012: Police responded to a telephone call from AB asking for someone to come to her home as she was alone in the house and was frightened. Police arrived and found AB in a very confused state.

20th July 2012: MOW rang an ambulance as they had found AB in an extremely confused state. She was taken to Croydon University Hospital. Tests were completed but there was found to be no physical cause to her confusion and she was discharged home on 21/7/12.

27th July 2012: AB was again taken to Croydon University Hospital after being found in the community by a member of the public in a distressed and confused state. Although there was no physical reason for her confusion, the A and E Discharge Coordinator thought that AB should not return home and that a temporary emergency placement was required. AB was placed as a short – term emergency into residential placement.

It was reported from the residential care home that AB becomes more confused in the afternoon.

17th August 2012: a mental capacity test was completed by care management with regard to whether AB had the capacity to decide where she wanted to live. AB requested that she would like to return home. She was told about the episodes of wandering but couldn't recall doing this although she believed that this may have happened. She felt the idea of telecare would be good. She was able to weigh up the risks and therefore deemed to have capacity to return home. Initially AB's daughter was reluctant for her mother to return home and wanted her to stay in 24 hr care but eventually conceded that this was AB's decision.

AB's daughter agreed to organise shopping and have this delivered by Sainsbury's.

17th August 2012: confirmation was received by CMHT (OA) that AB had a cognitive impairment but no formal diagnosis. A new referral had been received by the GP and they were due to visit her in early September 2012.

29th August 2012: Telecare assessment completed.

4th September 2012: GP made referral to Memory Service.

12th September 2012: assisted technology was put in place at AB's home. The services in place are:

- 1 x heat extreme (temperature sensor in kitchen to detect high levels of heat e.g. burnt pan);
- 2 x smoke alarms;
- Wandering client alarm on front door – reminder not go out and sends alarm to Careline;
- Pendant alarm.

Just checking has been put in place to monitor movements (this will clarify AB's movements, whether she will try to leave her premises and at what times).

Cost of Telecare package £23.40 per week

Care Package to be re-started 2 calls per day to assist with meal prep, personal care and prompt meds. Mow's to be re-started.

Attends lunch club once a week and has support by local voluntary group once a week.

Cost of care package £90.16 per week.

Overall cost £113.56 per week.

AB returned home on 15th September 2012. We have contacted her family and carers on a regular basis and she is responding well to this care package. This care package will be reviewed and possible further assisted technology put in situ e.g. an electronic monitoring and tracking system to monitor any incidences of "wandering" depending on feedback from Just Checking, carers and family.

12th December 2012: AB remains at home – assisted technology and care package appear to be working well.

Case Study – Young Person with Physical Disabilities

M is 19-year old man with cerebral palsy, which affects all 4 limbs. M has no independent sitting ability and uses his power wheelchair for all his mobility needs. He has very restricted upper limb function and displays raised tone in both arms with restricted shoulder, elbow and wristmovement. M uses a hoist for all his transfers. He has a bespoke seating system in his wheelchair to accommodate his spinal position.

M spent the last 3 years at college in a residential unit attending a course in Travel and Tourism (BTEC Level 2). He achieved exceptional results, he also completed an independence programme when he stayed at the college during which time he arranged his care services, organised his menu and worked to a specific budget. He is able to use technology to a very high level and manages many things in his life through the internet (shopping, banking accessing service and social networking).

M has been through a very difficult year with the loss of his mother and the possibility of further surgery. His relationship with his father is not ideal and he would rather not live with him any longer as he finds it very restricted and disabling.

Following an assessment it was clear that M had substantial needs he requires assistance with toileting, washing, showering, dressing, nutrition and other aspects of his daily life. It was also clear he wants to pursue his educational goals and wants to do a degree in business and administration in the near future. His goal is to run his own business within travel and tourism. He has researched this and has enrolled at college. With the support of the social worker M has sourced his own supported living accommodation. He will have a large and very spacious apartment on the ground floor with a door to a wheelchair accessible large communal garden, bathroom and an open plan kitchen and lounge. The property has been designed and planned to support young adults with physical disabilities using wheelchairs. The accommodation is also close to accessible transport links which will enable him to access college and the community.

The apartment required some adaptations so that M needs can be fully met. This included changing the bathroom into a wet room, installing a hoist and other minor adaptations not affecting practical use of this apartment.

Following a full assessment of need and putting in place an agreed independence plan a personal budget has been allocated to M. He has opted for a direct payment to employ his own personnel assistance and put some essential equipment that he will manage. This will give him the independence and control over his life. Living in his new accommodation has enable M to go to college, has allowed him to pursue his educational needs and also build his relationship with his father.

He will be positively encouraged and supported by the social worker to live more independently in the community, through regular review and contact.

Case Study – Mental Health

Middle aged man of Pakistani origin living with his wife and children at home. He was admitted to hospital following a severe depressive episode and ended up needing an extensive stay in inpatient rehabilitation unit. Self Directed Support was used to enable him to return home to live with his family rather than moving him into residential care. He has been able to employ a male Urdu speaking personal assistant to visit him every day at home who assists him with his personal care. The personal assistant also takes him to the mosque and to a day centre (also funded via SDS) where his cultural needs and occupational needs are also met. Recently, his SDS support plan funding has been increased to enable an increase in personal assistant time at home to enable his wife (his main carer) to go on holiday and have a well deserved respite break- this has avoided a period in residential care and meant that he can stay within familiar surroundings which has also aided his mental well being.

Case Study – Substance Misuse

Male, aged 50, with a long history of alcohol and cocaine use, and mental health problems. Previous episodes of treatment had been unsuccessful, and his cocaine use escalated to crisis point, adversely affecting his work as a self-employed tradesman (electrician), and resulting in marital breakdown, with the risk of estrangement from his children.

Shortly after being offered a personal health budget, he achieved abstinence from alcohol and cocaine (in early 2011), and has remained abstinent since that time. He spent part of his budget on relapse prevention, and on counselling to resolve deep-rooted issues underlying his substance misuse. He also used his budget to update his professional trade certification, and purchased a laptop and relevant software to facilitate his period of study. Over the course of the pilot, his relationship with his wife (from whom he was now separated) improved enormously, and he began to see his children once again. He used part of his budget to take his children on a very modest caravan holiday, enabling them to spend quality time together, and reducing the risk of estrangement. He also purchased a father and child football season ticket, enabling him and his son to spend time regular together on a weekly basis, sharing their passion for football. He is now looking for better accommodation, so he can have his children to stay at weekends.

Case Study – Reablement following stroke

Client initially admitted to Intensive Care Unit in Hospital following a stroke in April 2012. She had been living independently with her husband with no care needs prior to this.

Moved to the Wolfson Neuro-rehabilitation centre in July 2012, following her stroke she was experiencing left sided weakness, reduced mobility and cognitive difficulties.

Wolfson requested that a needs assessment take place for ongoing support at home following discharge from the rehab centre in October 12.

An independence plan was initiated following this assessment, this was for 3 x calls per day to assist with personal care, assist with dressing and toileting.
Community OT's were also involved to provide equipment and advice to make activities of daily living as independent as possible.

At client's 6 weeks review husband felt able to take on his wife's care and the independence plan was ended. He was advised of the option of a carer's assessment but declined this. The planned multi agency discharge and the initial support was enough to support client and carer to remain independent