HEALTH & WELL-BEING SCRUTINY COMMITTEE

9th February 2011

PERSONALISATION AND REABLEMENT IN SUNDERLAND – PROGRESS REPORT

REPORT OF THE EXECUTIVE DIRECTOR OF HEALTH, HOUSING AND ADULT SERVICES

1. Purpose of Report

1.1 At the Health and Wellbeing Committee's request, this report provides an update on how Sunderland is implementing the personalisation and reablement agendas, ensuring they complement one another and details how hospital discharges are supported through these agendas (in particular reablement approaches).

2. Background

2.1 **Putting People First: A shared vision and commitment to the transformation of Adult Social Care** (December 2007) set out a "shared vision and commitment to the transformation of Adult Social Care". It stated that, "People who use social care services and their families will increasingly shape and commission their own services''. Personalisation is the process by which state provided services can be adapted to suit the individual receiving them. In social care this means everyone having choice and control over the shape of their support. Personalisation means thinking about public services and social care in an entirely different way – starting with the person rather than the service. It required the transformation of adult social care.

2.2 The personalisation agenda has been further emphasized by the Coalition Government through the publication of **The Vision for Adult Social Care,** in November 2010. This further highlighted the importance of putting people, personalised services and outcomes centre stage of social care. It sets a challenge for councils to provide a personal budget, preferably as a direct payment, for everyone who is eligible by April 2013.

2.3 A consequence of personalisation is that people will increasingly take their own decisions about how to balance their new freedoms with a sensible approach to risk, accessing solutions to meet their eligible needs, which are very different from the services that social care has historically provided.

2.4 The Department of Health, through their revision of the NHS Operating Framework set out the **NHS commitment to reablement**. They describe reablement as….'the use of timely and focused intensive therapy and care in a

person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on reabling people within their homes … so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care'.

2.5 Reablement is not the same as intermediate care. Intermediate care patients have a defined clinical need, and intermediate care services are clinician-led. In contrast, reablement service users have a social care need (which may result from a clinical need) and reablement services are not clinician-led, and tend to adopt a social model of support.

2.6 The overall aim of reablement is to help people regain the ability to live as independently as possible. Everyone involved in reablement services needs to be supporting and motivating users to achieve these changes, every time they work with them.

3. Current position – Personalisation and Reablement in Sunderland

3.1 Over the last 18 months, Health, Housing and Adult Services Directorate have been working on their 3 Year Delivery Plan through a range of projects which were focussed on implementing the policy agendas detailed in the background section. The key projects were 'Reviewing Care Management and Assessment Processes' and 'Development of Reablement at Home Services'.

3.2 A starting point for the directorate has been to review its current arrangements and practices against the philosophy of personalisation in social care, which means everyone having choice and control over the shape of their support and against national best practice which was evidencing how adult social care systems should be set up to enable personalisation to become a reality (See Appendix 1 – ADASS Systems Map)

3.3 As part of the 'Reviewing Care Management and Assessment Processes', a number of developments have been progressed, which continue to see the implementation of personalisation within Sunderland:

3.3.1 Branding of the Directorate – feedback from people who use social care services and members of the public suggested that it was difficult to understand what 'Health, Housing and Adult Services' did or could do for someone. Work is progressing on marketing information that clearly demonstrates how social care can enable and support people to access care and support that meets their needs.

3.3.2 Self Directed Support – a fundamental aspect of personalisation is for people to have the opportunity to identify their needs and have control over how these needs are met. To facilitate this, access to a **self assessment** is now available via the Council's website, where people

can either complete by themselves or with support from a family member/friend, providing information about what their problems are and how they would like their problems to be solved. Another important element is the development of the **personal plan**, which sets outs how a person will spend their personal budget (see 3.3.4)

3.3.3 Right Level of Assessment –ensuring that the right level of social care assessment was applied to individual people was a priority in implementing personalisation, avoiding over complicated processes. To support this, it was decided that the Care Management and Assessment Teams needed to be restructured to reflect different processes that can be used to assess people and their needs. We now have an **Initial Advice and Assessment Service**, which is broken down to 5 geographically linked teams and a **Long Term Complex Service,** with teams focussed on the key client groups (older people, physical disabilities, learning disabilities, mental health and drug and alcohol). Both these services have social workers and care managers within the teams.

3.3.4 Personal Budgets – over the last few years, people have been able to access direct payments, which is a funding mechanism whereby the person themselves employs people to provide the care and support they need. Now, if a person is eligible for social care support they will receive a **personal budget,** which is calculated using the Resource Allocation System (RAS), based on information obtained from their assessment. A personal plan is drawn up with the individual detailing how they will spend their personal budget to meet their support needs and achieve their outcomes. The person has a choice as to how their personal budget is accessed. The person can:

- Take it all as a direct payment; or
- Ask Health, Housing and Adult Services to arrange and pay for their support needs from their Personal Budget; or
- A combination of the above two choices.

People are already using their personal budgets in innovative ways, tailoring services to meet their needs, rather than using traditional provision e.g. going for a weekend away to Amsterdam with their personal assistant rather than a week's stay in respite care.

3.3.5 Reablement – it is important that reablement is not seen as being separate from personalisation; rather reablement is an integral part of implementing the personalisation agenda. Reablement is an approach that focuses on supporting people to do things for themselves, learning or relearning skills necessary for daily living. A pilot Intermediate Care at Home Service was established 12 months ago, which focussed on supporting hospital discharges following a social care assessment for older people by providing therapeutic interventions to people in their own homes.

During this pilot, there was a 37% reduction in the need for ongoing packages of care, demonstrating the importance of providing intensive support following a hospital stay to enable people to do things for themselves and remain independent.

Work has been progressing to further develop this pilot into the ongoing **Reablement at Home service,** which will be available for adults of all ages, capturing customers living in their own homes as well as those leaving or potentially entering hospital. From January 2011, referral pathways into this service have been extended to community therapists and therapists within City Hospitals, therefore reducing the need for a social care assessment – this is particularly important to improve hospital discharges.

People can receive reablement at home services for up to 6 weeks (free of charge) and an assessment of their ongoing care and support needs will not take place until the necessary reablement interventions are completed.

4. Conclusion

4.1 The implementation of personalisation and the integral role reablement plays in the overall agenda continue to be taken forward to ensure that people are at the heart of their decision making in relation to meeting their care and support needs through tailored and personalised services.

4.2 Reablement provides an opportunity for people to learn or relearn skills that support daily living, benefitting people and their carers by improving independence and choice, partner organisations by supporting hospital discharges or stopping unnecessary admissions to hospital and the council by reducing need for ongoing care packages, which are costly with a view to spending this money on more preventative services.

5 Recommendation

5.1 Members are requested to receive this report as an update on progress to date and agree to receive a further update in 6-9 months.

6. Background Papers

6.1 Putting People First, 2007
Vision for Adult Social Care, 2010

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