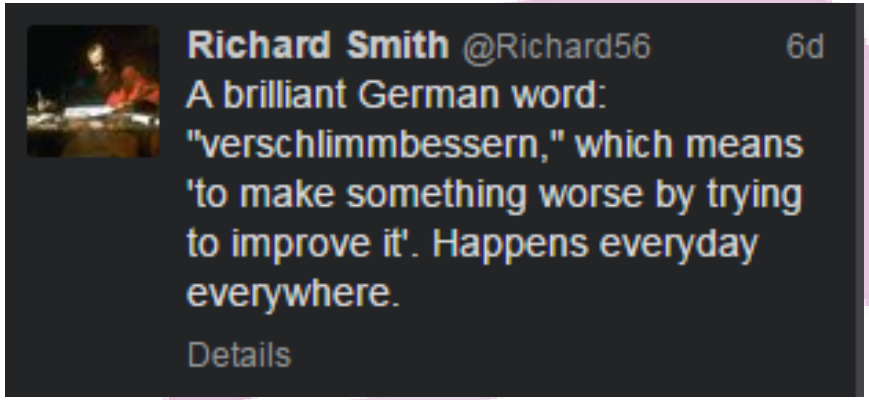
think local act personal

Personalised care and support planning: The Care Act and beyond

Community Care Live
4 November 2014

Two tweets


Richard Smith @Richard56 6d
A brilliant German word: "verschlimmbessern," which means 'to make something worse by trying to improve it'. Happens everyday everywhere.
Details


Dr Peter Fuda @PeterFuda 1d
Anyone seeking to make change or create transformation should prepare to be metaphorically 'punched in the face' at regular intervals
Details

Overview

- Sharing a personal story
- Where are we?
  - The difference personalisation (=> Personal Budgets?) is making
- Highlight the factors that enable and get in the way of good planning
- The Care Act (and beyond)
- Share practical tools
- Integrated Personal Commissioning programme and other initiatives

Colin Royle

- Sharing a personal story of the difference good care and support planning made

What is Think Local Act Personal?

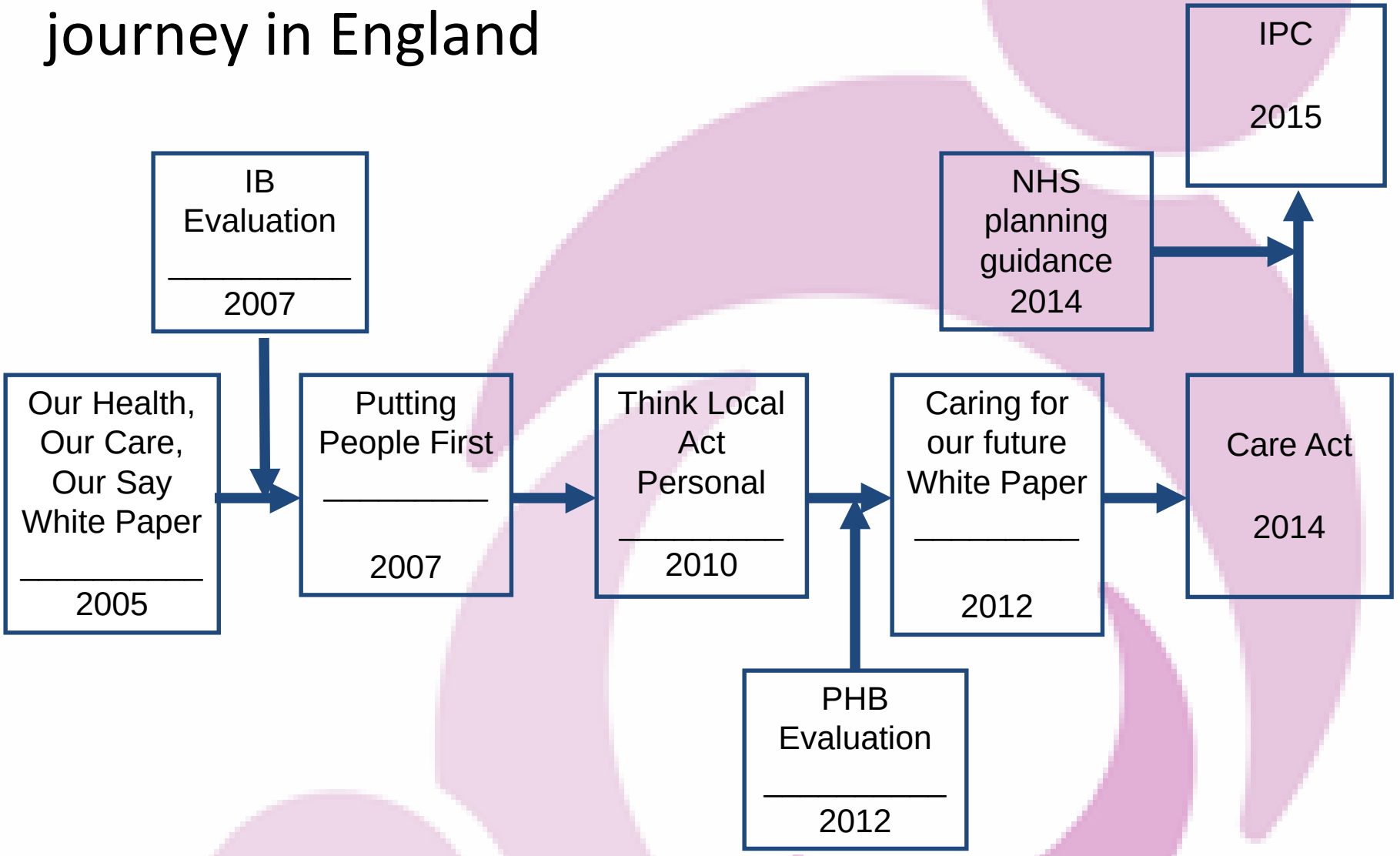
Established in 2010 as a cross-sector partnership of more than 50 organisations or associations committed to advancing self-direction and integrated care for people with care and support needs in England.

Works in a number ways:

- Shaping and influencing policy
- Informing and improving practice
- A catalyst for social change
- A model of “coproduction”


adass
ADCS
age UK
ARC
base
CareQuality Commission
carers trust
carers UK
ceretas
csv
make a difference
DH
Department of Health
Housing LIN
H&SA
In Control
Local Government
MENTAL HEALTH PROVIDERS FORUM
NCF
NCAG
NDTi
NATIONAL HOUSING FEDERATION
NICE
NHS England
Public Health England
SCIE
SharedLivesPlus
skills for care
THE COLLEGE OF SOCIAL WORK
Voluntary Organisations Disability Group

Self-directed care timeline: 10 year journey in England



ASCOF (Adult Social Care Outcomes Framework)

To be counted as receiving self-directed support, the person (adult, older person or carer) must either: be in receipt of a direct payment; or have in place a personal budget which meets all the following criteria: 1. The person (or their representative) has been informed about a clear, upfront allocation of funding, enabling them to plan their support arrangements; and 2. There is an agreed support plan making clear what outcomes are to be achieved with the funding; and 3. The person (or their representative) can use the funding in ways and at times of their choosing.

Care Act 2014 Statutory Guidance 11.2

The personal budget is the mechanism in conjunction with the care and support plan that enables the person…to exercise greater choice and take control over how their care and support needs are met. It means:

- being able to choose from a range of options for how the money is managed, including direct payments, the local authority managing the budget and a provider or third party managing the budget on the individual's behalf (an individual service fund), or a combination of these approaches.
- having a choice of over who is involved in developing the care and support plan for how the personal budget will be spent, including from family or friends.
- having greater choice and control over the way the personal budget is used to purchase care and support, and from whom.

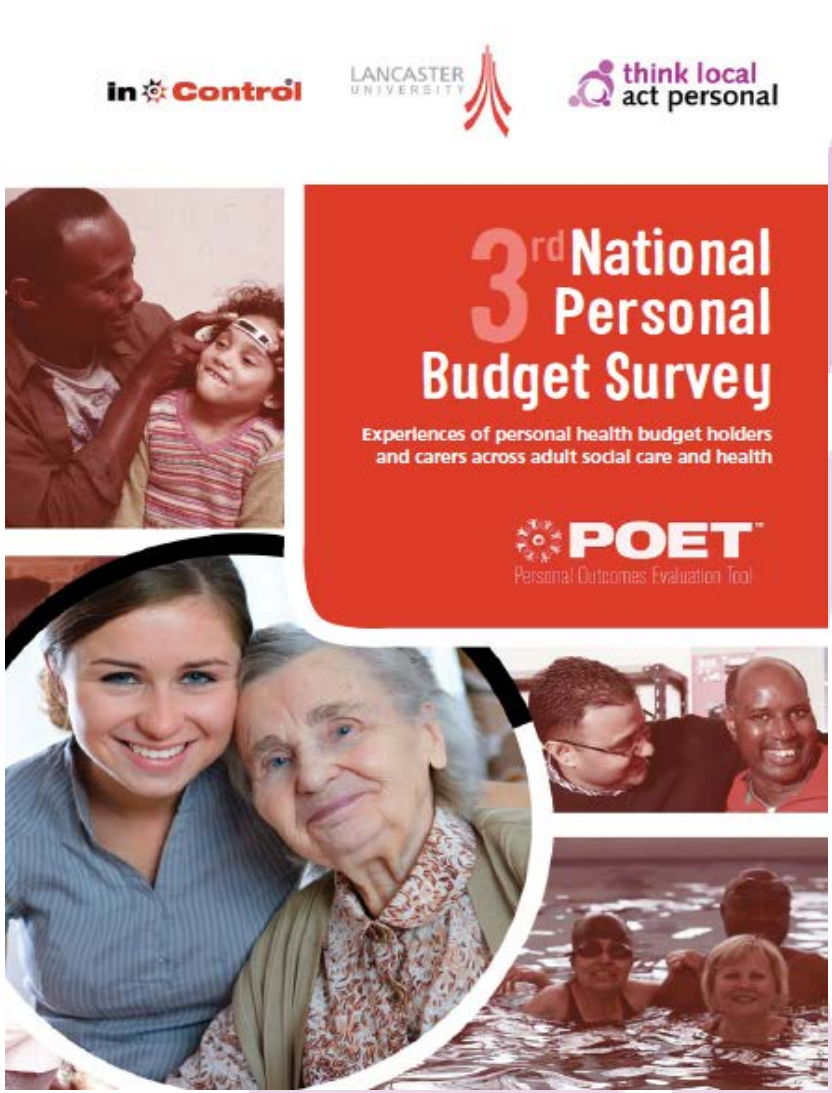
Individualised funding and self-direction: Progress to date

- More than 648,000 people now self-direct their support through a personal budget, over 62% of those eligible
- The total expenditure through self-direction in 2013-2014 was almost £4.2 billion
- 23% have a direct payment
- Pilots are underway to extend the use of direct payments to residential care settings for the elderly
- Personal health budgets were piloted in England from 2009-12, with a “major expansion” is planned in 2015/16 for people, where evidence indicates they could benefit

Proportions of people using self-directed support and personal budgets by group

Who?	Self-directed support / personal budgets		Direct payments	
Adults 18-64 with a physical disability	91,615	64.1%	42,755	29.9%
Adults 18-64 with a learning disability	88,445	82.7%	34,045	31.8%
Adults 18-64 with a mental health problem	33,725	28.5%	12,685	10.7%
Adults aged 65 or over	430,595	64.2%	62,420	9.3%
Carers (all ages)	110,915	64.1%	80,455	46.5%

Is it making a difference?



National report includes data from more than 4,000 people

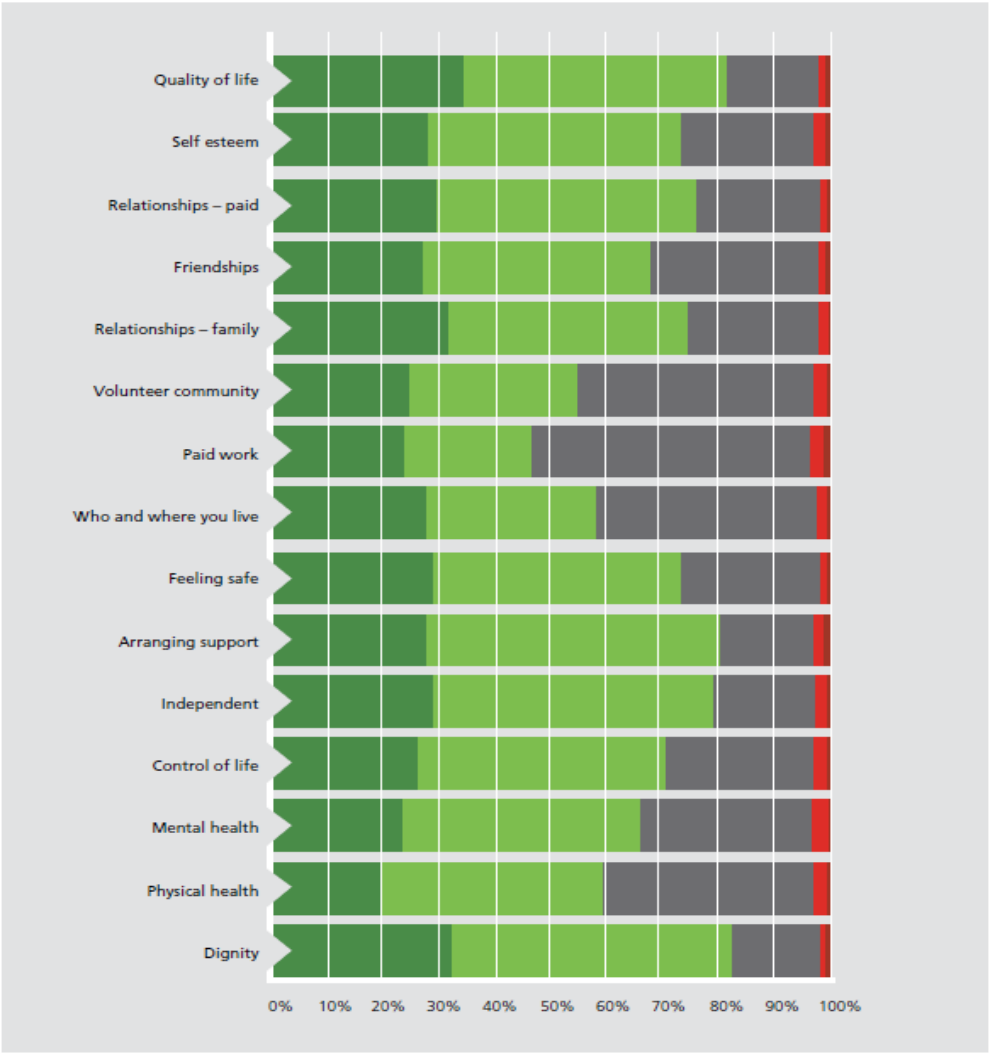
- 2,679 personal budget holders
- 1,328 carers of people in receipt of a personal budget.

Personal Outcomes Evaluation Tool survey collects info on:

- Who budget holders are
- The choices they make (how to self-manage / who plans?)
- How people experience different aspects of the process
- Impact on wellbeing

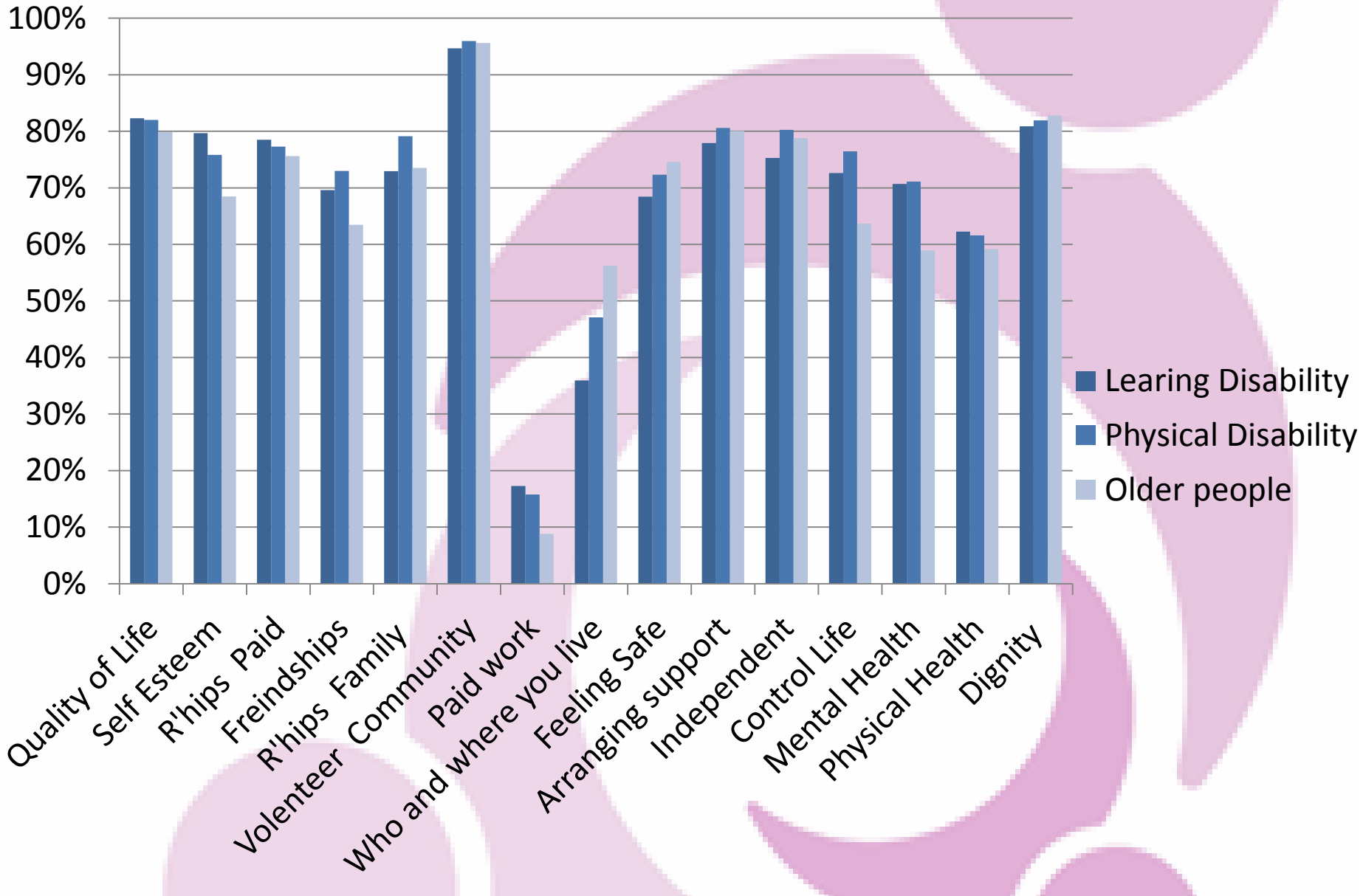
Outcomes for people

FIGURE 11: Difference personal budgets have made to lives of personal budget holders

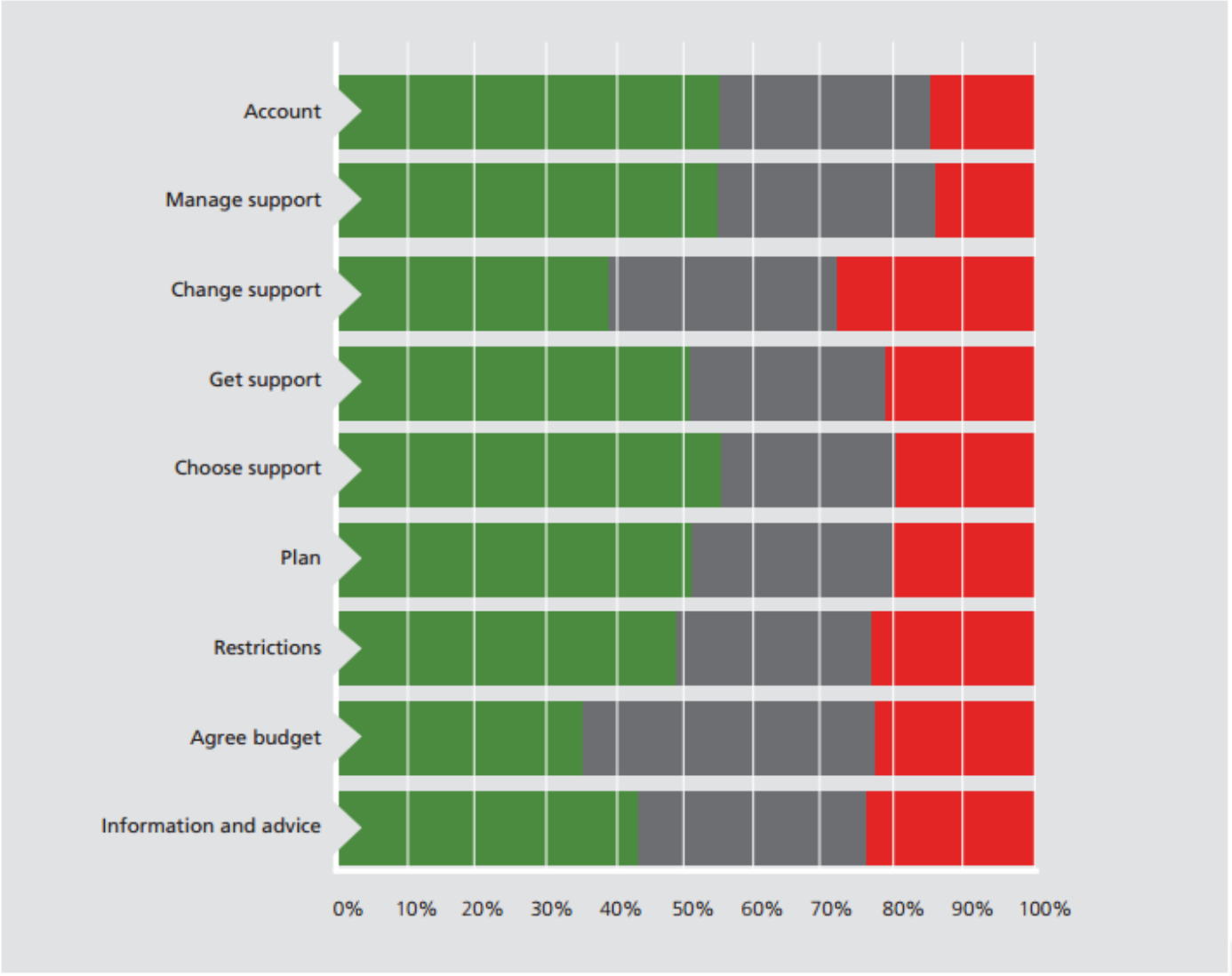


- Dignity in support (82%)
- Independence (78.9%)
- Arranging support (79.9%)
- Relationships with people paid to support them (75.9%)
- Quality of life (81.4%)
- Mental health (66%)
- Control over life (70.6%)
- Feeling safe (72.8%)
- Family relationships (74.6%)
- Paid relationships (67.8%)
- Self-esteem (73.2%)

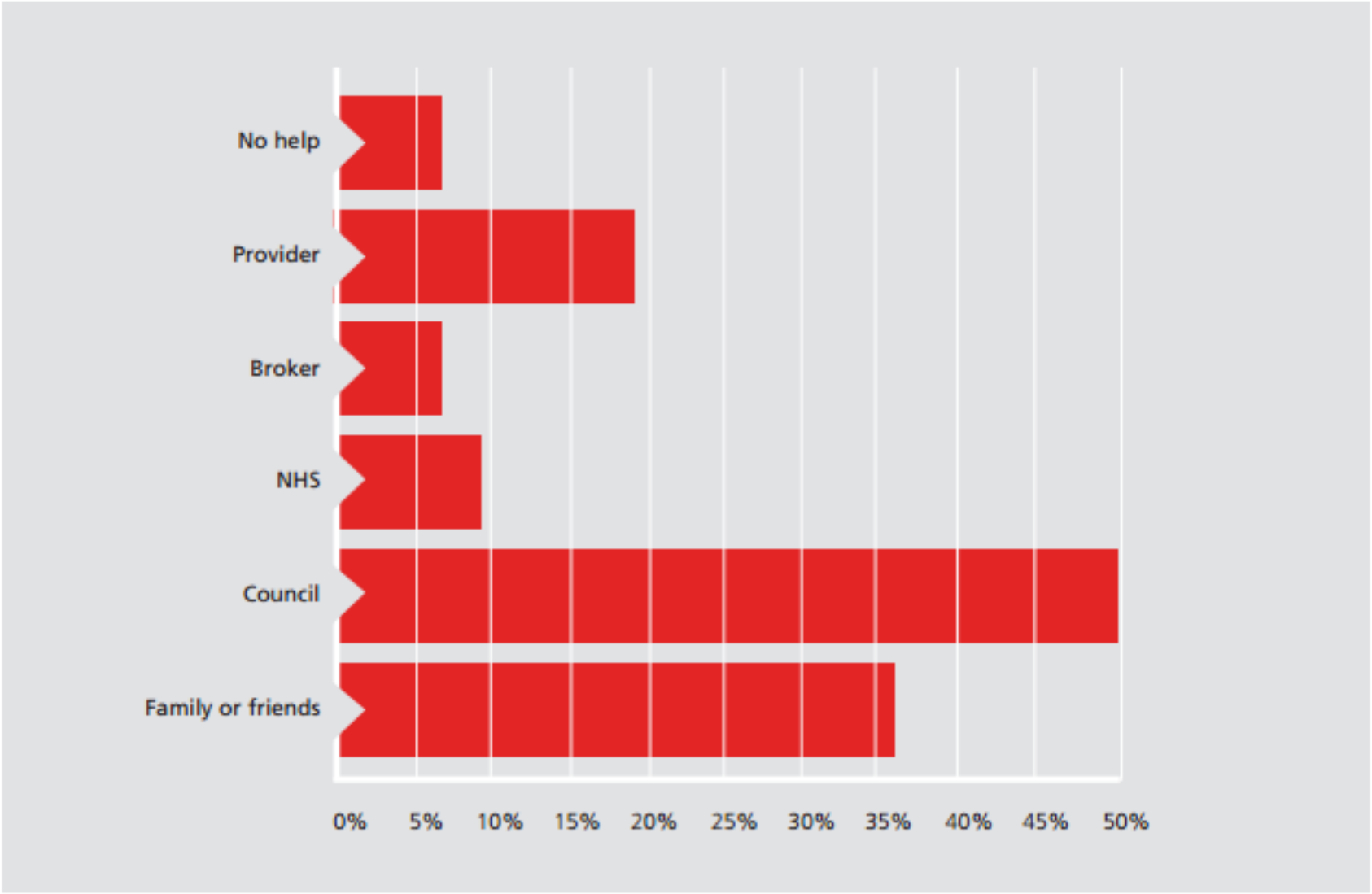
Variations by group



How easy was the process?



Who did the planning?



How does who helps planning affect outcomes?

Outcome	Factors potentially associated with outcomes: Support in the personal budget planning process					
	Family/ friends help me to plan	Council helps me to plan	NHS helps me to plan	Independent person helps me to plan	Provider helps me to plan	Plan without help
Quality of life	1.15	1.04	1.06	1.28	1.25	0.57*
Self-esteem	0.99	1.07	1.18	1.15	1.28	0.64*
Relationships-paid	0.77*	1.13	1.03	1.53	1.16	0.64*
Friends	1.01	1.00	0.91	1.50*	1.41*	0.49*
Relationships-family	0.80*	1.12	0.96	1.57	1.23	0.52*
Volunteer-community	0.91	0.92	1.06	1.36	0.70	1.08
Paid work	0.89	1.02	0.98	1.28	1.05	0.71
Where & who you live with	0.90	0.85	0.64*	1.00	1.47*	0.61*
Feeling safe	0.85	1.00	1.26	1.61*	1.34*	0.54*
Arranging support	0.78*	1.20	1.25	1.44	1.06	0.66*
Independence	1.17	0.90	1.37	1.29	1.28	0.53*
Control over life	0.88	0.90	1.26	1.26	1.55*	0.63*
Mental health	0.69*	1.04	1.16	1.81*	1.34*	0.59*
Physical health	0.65*	1.04	1.05	1.32	1.30*	0.56*
Dignity	0.82	1.15	1.08	1.47	1.10	0.54*

Being involved in planning affects outcomes?

Outcome	Factors potentially associated with outcomes: The personal budget process			
	Views included when needs assessed	Views included when budget amount was set	Views included when support plan written	Council/NHS made the personal budget process easy
Quality of life	2.88*	2.40*	2.57*	2.57*
Self-esteem	2.11*	2.19*	2.10*	2.32*
Relationships-paid	1.41*	1.72*	1.54*	2.35*
Friends	1.54*	1.66*	1.58*	2.00*
Relationships-family	1.41*	1.75*	1.47*	2.12*
Volunteer-community	1.70*	2.06*	1.76*	2.08*
Paid work	1.54	2.35*	1.68*	3.39*
Where & who you live with	1.37*	1.68*	1.80*	2.52*
Feeling safe	1.83*	2.02*	1.86*	2.39*
Arranging support	2.26*	2.29*	2.59*	2.79*
Independence	2.41*	1.61*	2.13*	2.07*
Control over life	2.28*	2.31*	2.46*	2.29*
Mental health	1.54*	1.74*	1.79*	2.15*
Physical health	1.60*	1.87*	1.89*	1.90*
Dignity	2.06*	1.79*	2.23*	2.43*

Factors closely associated with good outcomes

- **People being able to lead** the planning process and have choices over who to involve
- **People's views included** in other aspects of the process (e.g. in assessment and budget setting)
- The overall process feeling "easy" to understand and navigate
- A focus on **whole life outcomes** – in particular people being supported to access community and leisure
- Support to understand and access the **range of support options** available
- The availability of personal assistants
- The availability of a diverse range of care and support options

What the Care Act requires

Other key principles which underpin the Act that councils must have regard to are:

- The importance of beginning with the assumption that the individual is best-placed to judge their own wellbeing.
- The individual's views, wishes, feelings and beliefs.
- The importance of preventing or delaying the development of needs for care, or needs for support, and the importance of reducing needs of either kind that already exist.
- The need to ensure that decisions about the individual are made having regard to all the individual's circumstances. It is important that these decisions are not based only on the individual's age, or appearance or any condition of the individual's or aspect of the individual's behaviour which might lead others to make unjustified assumptions about the individual's wellbeing.
- The importance of the individual participating as fully as possible in decisions relating to the exercise of the function concerned, and being provided with the information and support necessary to enable the individual to participate.
- The importance of achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual.
- The need to protect people from abuse and neglect.
- The need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of a function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

The Care Act section 1 (3)

The Care Act 2014 on planning:

*"The person must be **actively involved and influential throughout the planning process**, and should be **free to take ownership** of the development of the plan if they wish. There should be **a default assumption that the person, with support if necessary, will play a strong leadership role in planning**. Indeed, it should be made clear that the plan 'belongs' to the person it is intended for." (10.2)*

*"Ultimately, the **guiding principle in the development of the plan is that this process should be person-centred and person-led**, in order to meet the needs and outcomes of the person intended in ways that work best for them as an individual or family. Both the process and the outcome should be **built holistically around people's wishes and feelings**, their needs, values and aspirations, irrespective of the extent to which they choose or are able to actively direct the process." (10.3)*

The Care Act 2014 on planning:

"The plan must detail the needs to be met and how the needs will be met, and ***will link back to the outcomes that the adult wishes to achieve in day-to-day life****... This should reflect the* ***individual's wishes, their needs and aspirations, and what is important to and for them****, where this is reasonable. This process is central to the provision of person-centred care and support that provides people with choice and control over how to meet their needs. The* ***local authority should encourage creativity*** *in planning how to meet needs, and refrain from judging unusual decisions as long as these are determined to meet needs in a reasonable way" (10.31)*

The Care Act 2014 on planning:

"The guiding principle therefore is that the person be actively involved and is given every opportunity to influence the planning and subsequent content of the plan in conjunction with the local authority, with support if needed. Joint planning does not mean a 50:50 split; ***the person can take a bigger share of the planning where this is appropriate and the person wishes to do so****. A further principle is that planning should be* ***proportionate****. The person should not be required to go through lengthy processes which limit their ability to be actively involved, unless there are very strong reasons to add in elements of process and decision making. Wherever possible the person should be able to be fully involved in the development of their plan, and any revision if circumstances change, with minimum process. " (10.32)*


1) THE PROCESS FROM ASSESSMENT THROUGH TO REVIEW IS TRANSPARENT AND CLEAR; I KNOW WHAT TO EXPECT AND WHEN TO EXPECT IT, AND PEOPLE DO WHAT THEY SAY THEY WILL DO.
2) IF I NEED HELP TO PLAN, I CAN CHOOSE WHO SUPPORTS ME TO PLAN AND PUT THE PLAN INTO PRACTICE.
3) PEOPLE WHO SUPPORT ME TO PLAN HAVE A FLEXIBLE, OPEN, HONEST, POSITIVE, SOLUTION-FOCUSSED ATTITUDE.
4) I AM TRUSTED TO WRITE MY OWN CARE AND SUPPORT PLAN WITH WHATEVER HELP I NEED.
5) I CAN INVOLVE FRIENDS AND FAMILY IF I CHOOSE.
6) I HAVE ALL THE INFORMATION I NEED TO PLAN; WHEN I NEED IT, IN AN ACCESSIBLE WAY, INCLUDING SIGNPOSTING TO WHAT IS AVAILABLE LOCALLY.
7) I AM SUPPORTED TO TAKE RISKS, AND KNOW IT IS OK TO MAKE MISTAKES AND CHANGE MY MIND.
8) MY CARE AND SUPPORT PLAN IS ABOUT THE WHOLE OF MY LIFE, NOT JUST ABOUT ASSESSED NEEDS OR MONEY.
9) I AM ENCOURAGED AND SUPPORTED TO THINK CREATIVELY ABOUT WAYS TO ACHIEVE MY OUTCOMES.
10) MY REVIEW IS PERSON-CENTRED, FOCUSED ON ME AND MY LIFE, MY OUTCOMES AND WHAT IS WORKING AND NOT WORKING, NOT JUST THE MONEY. THROUGH MY REVIEW I CAN ALSO CONTRIBUTE MY VIEWS TO IMPROVING THE SYSTEM.

What we know about good planning

Key elements to get right:

1) Moving from assessment to planning
2) Choice of who supports the process and how
3) What goes in the plan and how it is recorded
4) How the plan is agreed and signed off
5) How the plan is reviewed

For each of these elements

1) What good looks like
2) What the Care Act requires
3) What works in practice
4) What doesn't work
5) Examples throughout
6) Summary
7) Recommendations

For example…

Lancashire Council has outsourced care and support planning and brokerage functions, and in doing so has embraced the concept of choice and control. People can choose who helps them to plan via the council's online information and advice/ portal. Once selected, this person can help the individual download their outcomes from the completed assessment as the basis for care and support planning, and if wanted, the same person can 'stick around' to help put that plan into action and review progress.

Hertfordshire Council uses a variety of ways to engage and support people in the planning process – including high quality, accessible web pages, a wide array of facilities and venues that provide information (e.g. libraries, community centres, leisure centres), a call centre/first point of contact, a focus for every team on giving out information, modern leaflets, trained staff and an e-market place for support that doesn't need to be commissioned.

Where the plan is supported by someone familiar with or close to the community where the person lives, and/or is from a non-professional background, there appears to be greater creativity and use of natural supports. There is some evidence

People2People CIC and Shropshire County Council have worked together to design a system that provides support to plan and implement plans in neighbourhoods across the county. People2People employs social workers, social care staff and local people as volunteers who meet with people in "Let's Talk Local Hubs" where conversations during support planning focus on opportunities to access natural resources and supports rather than service based solutions.

They aim to support people to plan for their own support and/or have help to develop their care and support plan in a quick and timely fashion – in line with the emphasis in the Act on early intervention and prevention which also helps to manage or reduce demand for more intensive and expensive support.

Derby City and Derbyshire County Councils have developed Local Area Coordination (LAC) in some of their neighbourhoods. The principles of this asset based approach are felt to be embedded in their arrangements for care and support planning, where the closer those tasked with the responsibility of helping people to plan (and then realise that plan) are to local communities

Some key findings:

*"The most creative and person-centred planning processes and plans occur when **care and support planning is one step removed from the assessment of need**, whilst ensuring a seamless and invisible transition from one step to the next."*

*"Where the plan is **supported by someone familiar with or close to the community where the person lives**, and/or **is from a non-professional background**, there appears to be greater creativity and use of natural supports. There is some evidence that this reduces demand for more formal support."*

*"**Time pressures lead to less good plans and less good outcomes**, in comparison to those who are supported to plan over a longer timeframe – i.e. quick planning driven by resource constraints and short term horizons is a false economy"*

Disabled people involved in planning

- Disabled people and their organisations in England successfully deliver support planning and brokerage to a wide range of people and have adopted different approaches for people with different impairments and circumstances.
- Support planning was experienced as more ‘human’ when delivered by disabled people
- People whose plan was facilitated by disabled people were more likely to self-manage and to take a direct payment (DP) than those whose support plan was delivered by local government staff.
- The peer support element of planning was highly valued.
- Disabled people’s organisations (DPULO’s) need investment in capacity building and involvement in strategic partnerships to optimise their contribution.

Final report, Support Advocacy and Brokerage Demonstrator Programme, Office for Disability Issues 2011

Information about different models…

Type/model of support planning	Local Authority (LA)	Number of hours of staff time	Cost per hour	Estimated cost per care and support plan
Whole process of assessment, care and support planning and money management outsourced	LA D			£116 average cost per support plan (includes some done in group planning workshops as well as individual 1:1 sessions)
Care and support planning outsourced as discrete function	LA E	3 to 4 hours for basic level of support, up to 6 to 7 hours for more complex support	£18 per hour	Between £54 and £126 (excludes separate service level agreement for management, admin, support plan allocation etc.)
	LA F			£450 for care and support plan (includes help to implement it), £200 for review (includes help to implement it)
	LA G	Use three organisations, average hours not provided (though one capped at 10 hours)	Two out of the three organisations have hourly charge of £10 per hour	One organisation provides free support planning if no support plan previously been produced and decision not made re which support/ service/activity wanted, one charges £100 for support planning
	LA F	Takes average 3 to 6 hours but not paid by hour, paid based on set tariff for support plan	Support planners paid £11.80 per hour (excludes on costs and travel)	£75-£100 per plan – agreed set tariff

Event!
26 Nov, York

Questions/reflections

The Care Act 2014 on planning:

Combining plans

10.73. Local authorities should not develop plans in isolation from other plans (such as plans of carers or family members, or Education, Health and Care plans) and should have regard to all of the person's needs and outcomes when developing a plan, rather than just their care and support needs.

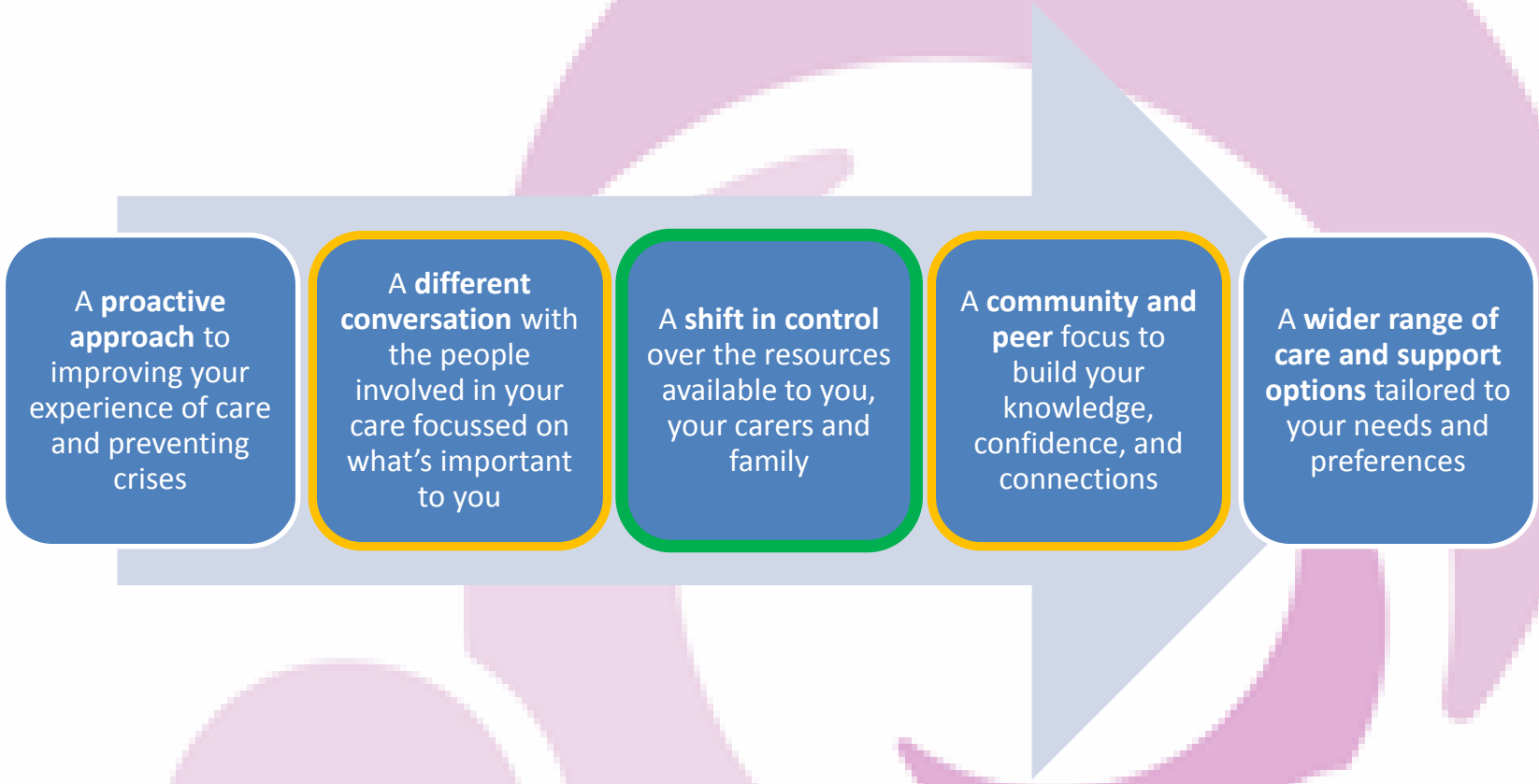
10.74. The local authority should attempt to establish where other plans are present, or are being conducted and seek to combine plans, if appropriate. This should be considered early on in the planning process (at the same time as considering the person's needs and how they can be met in a holistic way) to ensure that the package of care and support is developed in a way that fits with what support is already being received or developed. For example, this may be where the plan can be combined with a plan being developed to meet other needs, or where a plan might usefully be combined with that of a carer, or family member. In all circumstances, the plan should only be combined if all parties to whom it is relevant agree and understand the implications of sharing data and information. It is the responsibility of the local authority to obtain consent from all parties involved, and the combination of plans should aim to maximize outcomes for all involved.

10.75. Where one of the plans to be combined is for a child (below 18 years old), the child must have capacity to agree to the combination, or if lacking capacity, the local authority must be satisfied that the combination of plans would be in the child's best interests. Often it will be; but where there is a conflict of interest (for example a parent does not wish to support their 17 year old daughter's wish for greater independence) it may not be (see chapter 16 on transition to adult care and support).

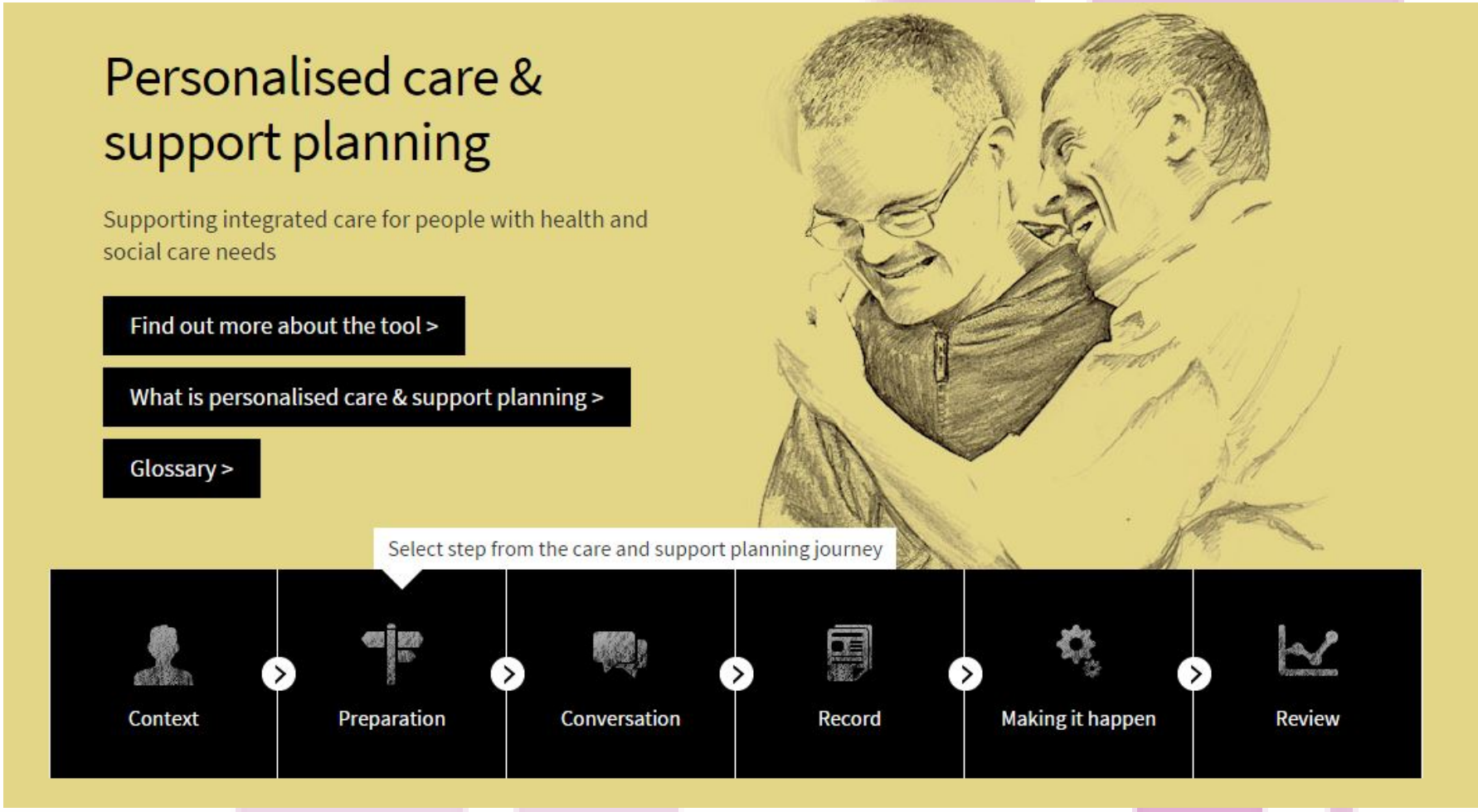
10.76. The local authority may be undertaking care and or support planning for two people in the same household who require independent advocacy to facilitate their involvement. If both people have the capacity to consent to having the same advocate, and the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent the two people. If either person lacks the capacity to consent to having the same advocate, the advocate and local authority must both consider that using the same advocate would not raise a conflict of interest and would be in the best interests of both

Integration

- Five Year Forward View, NHSOF (Domain 2)
- Better Care Fund, Integration Pioneers, Integrated Personal Commissioning



Personalised care and support planning tool



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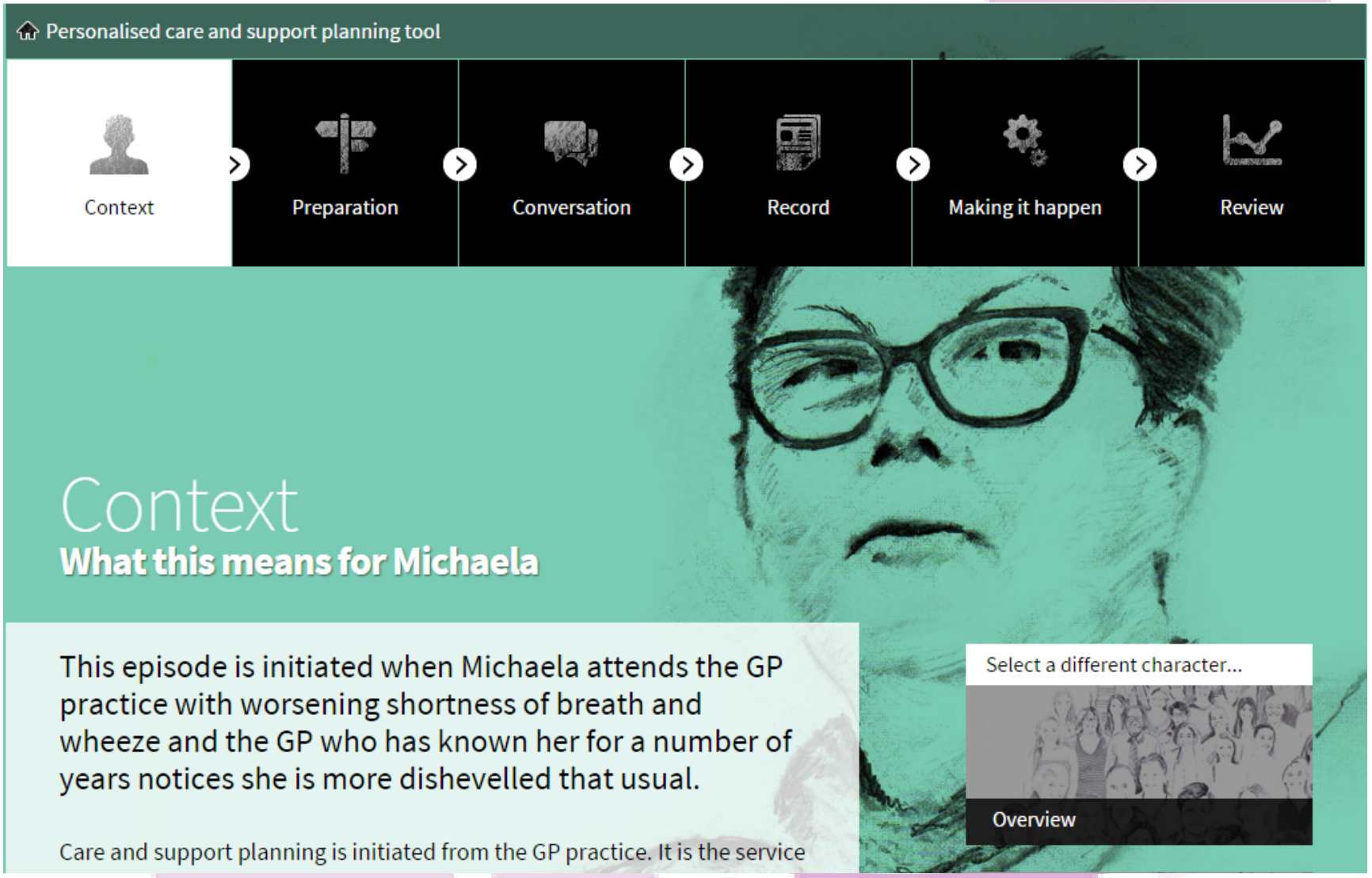

Personalised care and support planning tool

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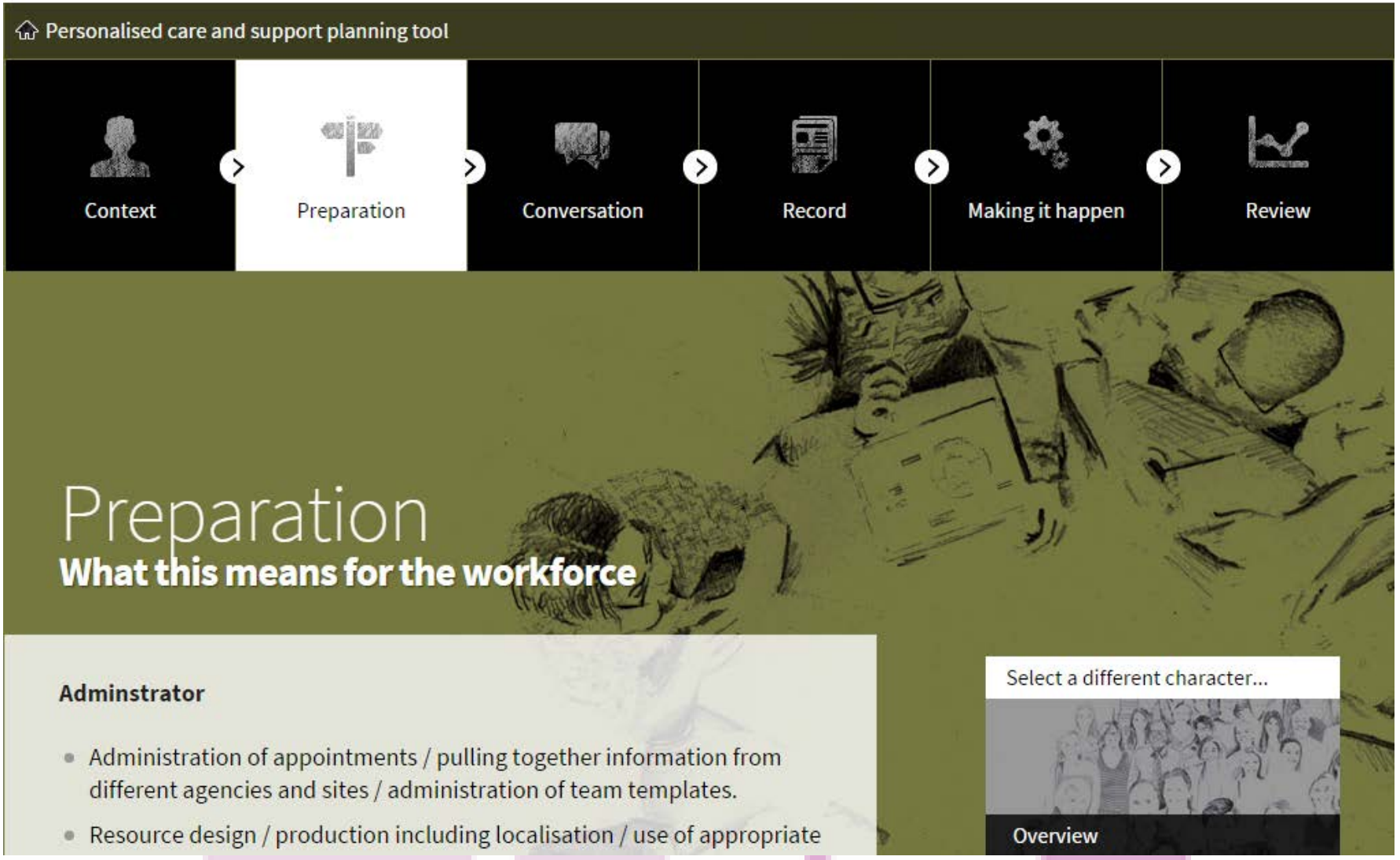
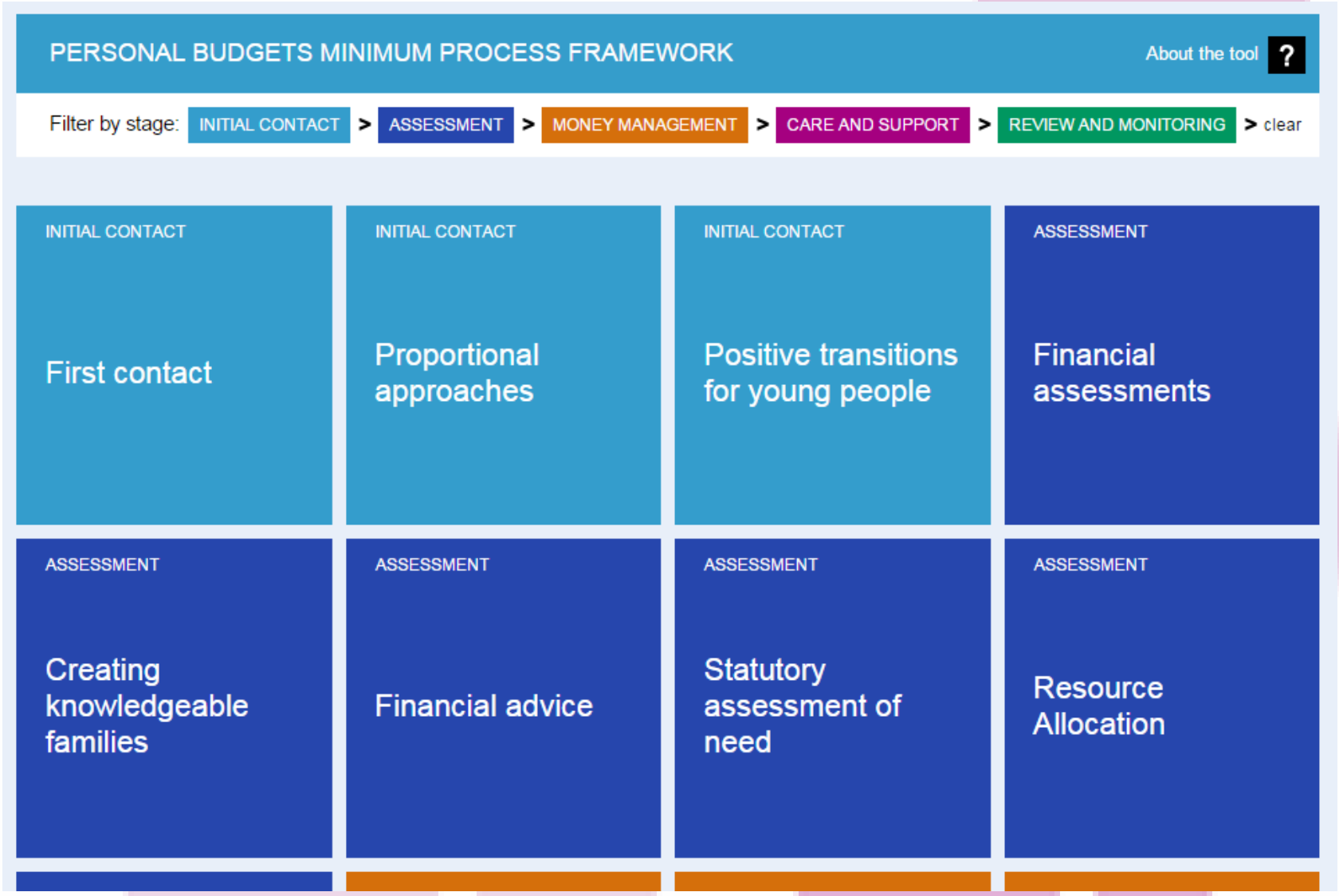


Person-centred care and support planning tool

- Beta version
- Seeking feedback now, with a plan to…
  - Update existing resource
  - Add practical, bridging resources
- Open question about what next
  - Events?
  - Training?
  - Promotion?
  - Etc.

Other tools


PERSONAL BUDGETS MINIMUM PROCESS FRAMEWORK
About the tool
?
Filter by stage:
INITIAL CONTACT
>
ASSESSMENT
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MONEY MANAGEMENT
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CARE AND SUPPORT
>
REVIEW AND MONITORING
> clear
INITIAL CONTACT
First contact
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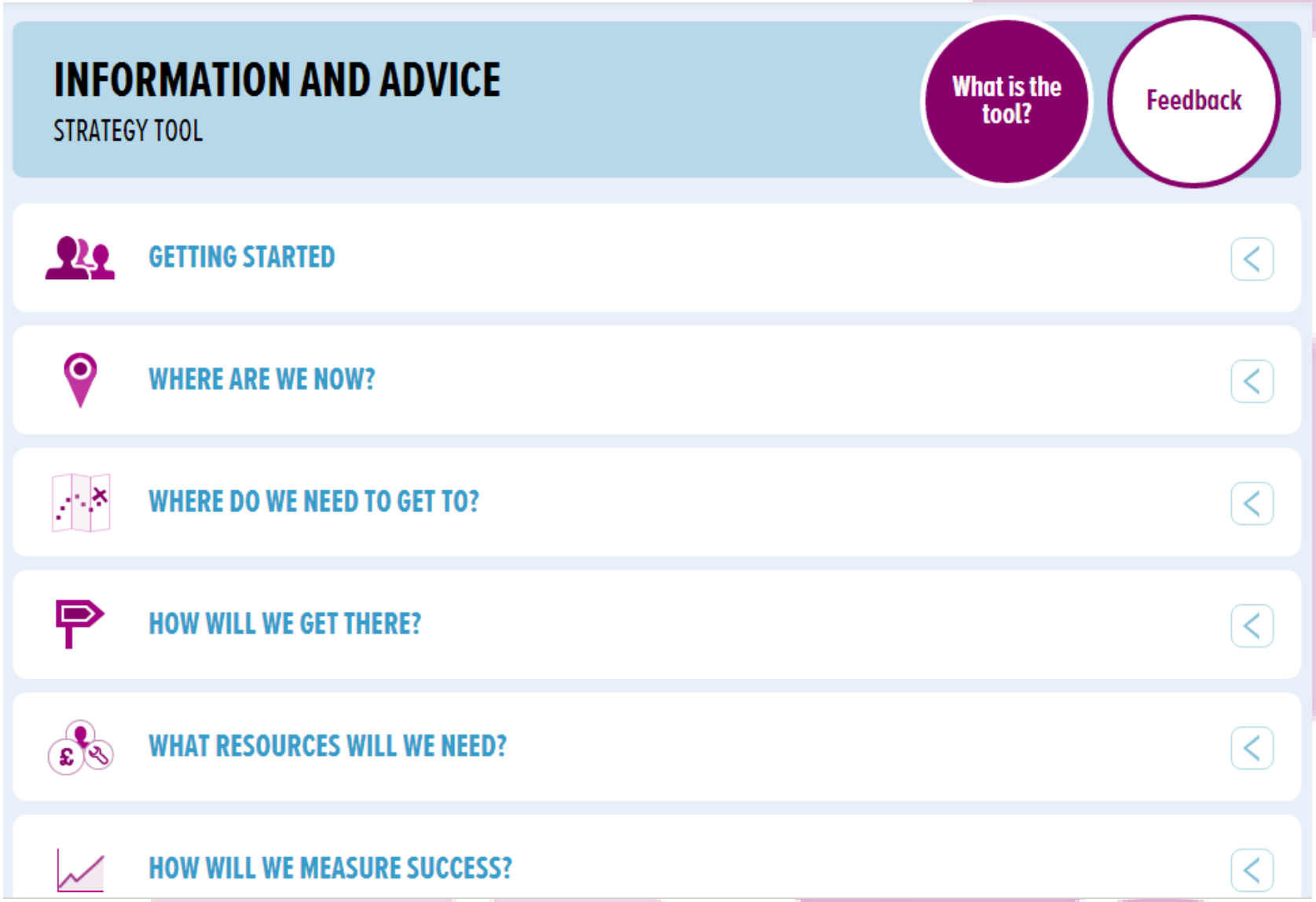
Proportional approaches
INITIAL CONTACT
Positive transitions for young people
ASSESSMENT
Financial assessments
ASSESSMENT
Creating knowledgeable families
ASSESSMENT
Financial advice
ASSESSMENT
Statutory assessment of need
ASSESSMENT
Resource Allocation

Other tools


INFORMATION AND ADVICE
STRATEGY TOOL
What is the tool?
Feedback
GETTING STARTED
WHERE ARE WE NOW?
WHERE DO WE NEED TO GET TO?
HOW WILL WE GET THERE?
WHAT RESOURCES WILL WE NEED?
HOW WILL WE MEASURE SUCCESS?

C4CC work: developing the workforce

This discussion paper looks at a key element in achieving our vision: the people who are part of the health and social care workforce. Planning, developing and supporting an integrated workforce that routinely works in a person-centred, community-centred way is a complex and multi-faceted challenge. To make it easier to understand and respond to, we've broken it down into four areas:

- **Mind-set** challenges for person and community-centred care;
- The specific **knowledge and skills** that are needed;
- The importance of supportive **working environments**; and
- **Capacity and roles**: workforce planning.

This paper is intended to stimulate discussion. It briefly sets out some ideas on:

1. The context: what do we mean by person-centred, community-centred care?
2. The workforce challenge
3. What is needed to create change at the local and national levels?
4. What action might the C4CC partnership take?

We would welcome feedback and ideas in response: contact details are at the end of the paper.

C4CC work: improving system levers

This briefing looks at the decisions made at a *national* level, which have an impact on the ability of people *locally* to work in a person-centred way. These national decisions are often referred to as "system levers". The purpose of this briefing is to:

- focus thinking on key levers
- promote consideration of opportunities for action and influence
- stimulate consideration of potential C4CC partner roles and activity

Discussion of system levers can quickly become technical and complex. The NHS alone is an enormous and complex system – and things get even more complex when we try to think about the NHS, social care and the community at the same time.

This briefing therefore attempts to simplify somewhat, to promote a focus on what is important, so that we can plan and take specific action. It will not go into detail, but rather give examples and attempt to set out the key issues. It asks:

- What do we mean by system levers?
- What does this mean for person-centred care for people living with long-term conditions?
- What needs to be done, and how might C4CC help?

Summary of resources

- Delivering Care Act care and support planning
- Person-centred care and support planning tool
- IAG strategy toolkit
- Minimum process framework
- Making it Real
- All available from www.thinklocalactpersonal.org.uk
- C4CC workforce planning discussion paper

One question

- What one, small thing can you do?

Stay in touch with TLAP

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