Brighton & Hove City Council

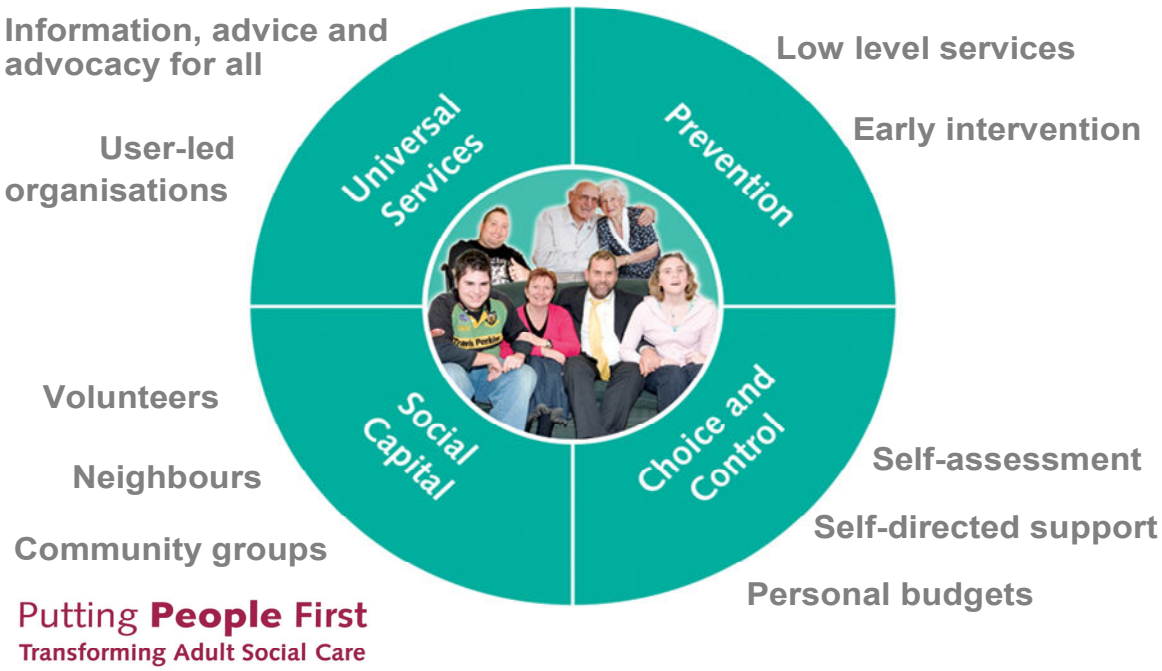
PERSONALISATION STRATEGY 2010-11

(V3.8)

'THE CITY CONVERSATION'

'Enabling access to a range and choice of services which support people to maximise their independence and quality of life'

DH Department of Health



FOREWORD

Our direction is clear; we need to make Personalisation including intervention and prevention, the cornerstone of all our services.

In Brighton & Hove this means every person in the city who has an identified social care need having choice and control over the shape of his or her life and where possible enabling that person to live independently in their own home.

For some, exercising choice and control will require significant levels of assistance either through professionals or independent care and support. Our challenge is to make sure this choice is possible for all our residents including the most vulnerable while keeping them safe.

Personalisation means improving health and preventing long-term conditions through an emphasis on self help and support that is continuous, integrated and individualised. It means building stronger communities in which disabled and older people can participate.

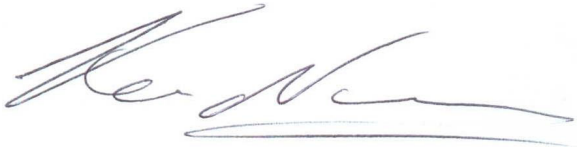
Nationally there is all party support for this vision and council Members in Brighton & Hove are committed to developing Personalisation from Ward level upwards by promoting opportunities for volunteering and involvement across the city.

In 2010 will be starting a 'City Conversation' with all our residents and partners to help deliver the strategic priorities contained within this strategy. It is a strategy that will improve the lives of all our older and disabled people in the city by enabling them to do the things they want to do in the way that they choose.

Our work has just begun and it is the biggest change to Social Care since the Community Care Act of 1990. Personalisation is a huge and exciting agenda that cannot be achieved by Adult Social Care alone. To achieve these changes will mean working jointly with Housing, Health and other directorates in the Council. It will also mean working across the sector with partners from independent, voluntary and community organisations to ensure that services in the city are able to meet the requirements of Putting People First.

Our commitment will ensure that the residents of Brighton & Hove can be confident that they will be able to make choices about how they live and be supported to do so, if necessary, for as long as they need.

Councillor Ken Norman



Cabinet Member for Adult Social Care & Health

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1) BACKGROUND AND CONTEXT

The White Paper, "*Our health, our care, our say" (Department of Health 2006)* set out the following outcomes:

- Improved health and emotional well being,
- Improved quality of life, making a positive contribution,
- Increased choice and control,
- Freedom from discrimination and harassment,
- Economic well-being & maintaining dignity and respect.

The paper underlined that people want support when they need it, and they expect it quickly, easily and in a way that fits into their lives. They want Adult Social Care services to consider their needs with a greater focus on preventing problems from happening and promoting independence and wellbeing.

This means that every person who receives support from the Council, Health services or funded by themselves, will be able to shape their own lives and the services they receive no matter what those services are. This will lead to Social Care working more effectively, providing better value for money for everyone.

The changes we expect are:

- Integrated working with the NHS
- Commissioning Strategies that maximise choice and control whilst balancing investment in prevention and early intervention
- Universal information and advice services for all citizens
- Proportionate social care assessment processes
- Person centred planning and self-directed support to become mainstream activities with personal budgets which maximise choice and control

- Mechanisms to involve family members and other carers
- A framework that ensures people can exercise choice and control with advocacy and brokerage linked to the building of user-led organisations
- Appropriate safeguarding arrangements
- Dignity in Care across all our working practice
- Effective quality assurance and benchmarking arrangements

The Government expects that by 2010-2011, Councils will have made significant steps towards redesigning their Adult Social Care services, with the majority having most of the personalised system in place. We will have to show how we are working more effectively by focusing on supporting people to remain independent.

This means not only must our current systems and services change but also those of our partners and providers. We must empower people by giving them more choice and control over their lives and the support services they receive – a right previously available only to self-funders. Statutory agencies, including ourselves will have a different not lesser role. We will need to take a proactive and enabling approach and be prepared to be less controlling. It will put the principles of independent living into practice and enable people to be active citizens of the city. It is about flexibility and choice and having a decent quality of life. It is part of creating a healthier city with stronger and safer communities.

PUTTING PEOPLE FIRST

The Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) joined with a range of other agencies and six Government Ministers to sign the vision for Adult Social Care laid out in Putting People First. Putting People First sets out a shared ambition for the transformation of public services, promoting personalised support through the ability to exercise choice and control against a backdrop of strong and supportive local communities. The

Putting People First agenda encourages us to broaden our focus beyond those with the highest needs. We will have to ensure that the application of the eligibility criteria is firmly situated within this wider context of Personalisation, including a strong emphasis on prevention and early intervention. This means we will need to make adjustments where necessary to ensure a seamless approach between Personalisation and the determination of eligibility for social care.

The Putting People First Concordat explains how an increasing number of people are living longer, but with more complex conditions such as dementia and chronic illnesses. By 2022 we expect that 14% (38,800) of our residents will be over 65 (Source Office of National Statistics). To ensure this demand for social care services is met the Concordat identified four cornerstones of Personalisation:

- Social Capital
- Prevention
- Universal Services
- Choice and Control

SOCIAL CAPITAL

Social capital theory describes how an individual's health and well-being can be affected by the way that they relate to social networks and communities. Individual benefits include increased positive mental well-being, confidence, self-esteem and a sense of belonging. High levels of social capital may act as a buffer in a deprived community by shielding individuals from the worst affects of deprivation, therefore building strong communities and neighbourhoods is extremely important in terms of improving health.

Social Capital means ensuring that people feel included and if necessary supported to be able to participate in their local community. It might include activities to address social inclusion such as volunteering activities, luncheon clubs or befriending; healthy living advice and support; employment advice and support; physical recreation and leisure pursuits; community safety; housing support and transport.

The vast majority of people will want to live in their own homes for as long as possible. At Brighton & Hove we want to support people to achieve this. In some cases this can be achieved through maximising social capital i.e. using the support of family members, work colleagues, friends and social networks.

Only a minority of these universal services will be funded through social care and many will be reliant on community-based provision.

Although the duty placed on councils to meet social care needs only applies to people who have been assessed as having eligible needs, we will also need to consider the significant benefits of addressing the needs of their local community more generally. There is a growing evidence base around interventions that can prevent or delay older people in particular from needing social care, although much work still needs to be done in this area.

In Brighton & Hove by 2011 we will ensure that we improve links with our public health and other corporate colleagues to develop existing good practice in community development.

Our Progress to Date - (Volunteers, Neighbours and Community Groups)

Joint work has taken place with health colleagues to support two neighbourhood volunteer schemes in Hangelton and Knoll and Queens Park & Craven Vale. Over the last 12 months Community Developments Workers, (commissioned from the third sector) working in communities across Brighton and Hove, have reported an increase in the number of residents actively involved in community activities. Particular focus has been given to engaging with seldom heard and isolated residents.

Across the city there are approximately 1855 people involved in community groups with 180 local community groups supported by workers.

Examples of the work being carried out include the Vallance Community Centre and Hangleton and Knoll 50+ Community Development Work.

There has also been input from other statutory services such as the Department of Work and Pensions (DWP), voluntary sector providers and the Neighbourhood Care Scheme. Nearly 500 people have been

supported through this scheme with further plans to extend this scheme through the development of a co-ordinating body.

Our Lifelines scheme also enables older people to be supported by other older people through an agreement with the voluntary sector.

Access Point

Our officers in the Access Point have gathered an extensive range of information regarding community resources that can support independent living, promote wellbeing and provide opportunities for participation and inclusion. Good links have been established with organisations like Age Concern Crisis Service, Federation of Disabled People, Carers Centre and Community Meals.

Over time we have built up our knowledge of community and neighbourhood based social and cultural activities ranging from the University of the Third Age through to small community based clubs and activities. Experience has shown that our current data collection systems do not properly capture the rich variety of support and opportunity that we know we provide to large numbers of people. Work is currently taking place to systematically capture and record the outcomes achieved for users of the service.

Discussions have started with the Life Lines project (Age Concern) and the East Brighton Healthy Living Centre to explore ways in which we can use these organisations as a source of support to maintain independent living but also to reconnect isolated and vulnerable people to activity and support networks in their local neighbourhoods.

We are already in discussion with a number of community organisations with the view to trialling a number of neighbourhood based Access Surgeries. These surgeries will deliver information to people where they live and provide us with opportunities to further develop our knowledge of local resources and networks.

Daily Living Centre

The Daily Living Centre (DLC) is now managed alongside the Access Point and is delivering rapid access to assessment for daily living aids achieving maximum independence with the minimum of timely intervention. Enhanced Assessor Training is delivered from the DLC to a range of Health and third sector organisations, enabling them to support people to achieve independent daily living.

Community Solutions

Community Solutions has proved its ability to provide a re-abling service to a broad cross section of people. As it begins the transition from a pilot to an established part of our services it is now picking up all referrals coming through from the Access Point. The Community Solutions team work closely with colleagues in the Access Point Team to ensure that their service users benefit from their extensive knowledge of community support and networks.

Day Options

The Day Options Team will offer advice, guidance, signposting and act as 'brokers' to maximise and develop sustainable support and a broad range of activities and opportunities for older people in the city.

Staff will work with individuals or small groups of people to look at what local activities are available to them. This includes a variety of activities, ranging from attending the cinema, visiting friends, how to utilize local transport, and possibly setting up clubs, e.g. a small gardening co-op, book club, cookery sessions etc. Staff can also investigate training opportunities (e.g. University of the Third Age) if individuals so wish. Activities also focus on physical well being, and healthy eating. These may include working in partnership with other agencies including the voluntary sector.

Example Case Study – Success in Brokerage

Joyce is an active 78 year old woman, who fractured her hip after getting hit by a passing car. Prior to this, Joyce used to attend a day service several miles from her home address.

After spending several weeks in hospital Joyce regained her mobility, but lost her confidence in going out on her own.

The Day Options Team worked with Joyce to help her regain her confidence and reach desired goals in her life following her fall.

The member of staff has a directory of activities, in Joyce's local community, and shares these with her during her first home visit.

Joyce decided that as part of her rehabilitation, she would like to visit her sister who lives in the next county.

The member of staff worked with Joyce to find out information on local transport. A trip was organised, for a staff member to accompany Joyce to visit her sister (who she hasn't seen for eight years).

The visit went better than expected and Joyce now visits her sister every month through the use of a Direct Payment, which she uses to get a taxi to the local train station, a taxi to her sister's house and back again.

Joyce is now more independent, and enjoys socialising and going out again. She also decided that she no longer requires the 'traditional' day service, and instead attends a small local lunch club (with the help of the day options team) near to where she lives.

PREVENTION

Preventative services impact directly on the well-being of the city. Brighton & Hove already contribute to the work of the World Health Organisation
' Healthy Cities' agenda and have aided the development of 'Healthy Ageing' in the city since 2004. This and the work of the Health City Partnership contributes significantly to prevention and early intervention services. In 2010 Adult Social Care, as a member of the Healthy City Partnership, will develop the following three key areas:

- Healthy Workforce/Place
- Healthy Living (Physical activity, mental health and well-being)
- Healthy Urban Design and Environment

In addition to this all individuals, whether or not they are funding their own care, can benefit from effective information, signposting and support planning. Early intervention, well-being and prevention through information provision means that we will be able to help people live at home independently, preventing them from needing social care support for as long as possible and potentially creating future cost efficiencies.

Individual financial means should have no bearing on this offer. We must consider how we can work to support high quality outcomes for all people in the city including those funding their own care and support.

Aside from the potential cost savings to be made through preventative strategies, it would appear that simple, low cost interventions may have a considerable impact on day-to-day quality of life.

The Commission for Social Care Inspection (CSCI) have already identified evidence that raising eligibility thresholds without putting in place adequate preventative strategies often leads to a short term dip in the number of people eligible for social care followed soon after by a longer-term rise. Therefore, rather than using eligibility criteria as a way of restricting the number of people receiving any form of support to only those with the very highest needs it will be preferable to adopt

a strong preventative approach to help avoid rising levels of need and costs at a later stage. Early interventions can also improve general community well-being and wider social inclusion.

Our Progress to Date- (Low level Services and Early Intervention)

Access Point

The Access Point works with people to prevent ongoing or delayed need for services through the use of timely information and advice. Access Point can also offer equipment to service users requiring sensory or Occupational Therapy (OT) services across all needs groups including low to medium need service users.

Case Study – Success in Prevention

The Access Point was contacted via a local housing officer regarding a man whose first language is Arabic. He had been discharged from hospital following a knee operation and was struggling to move around his property, prepare meals and perform personal care. Using the 'Big Word' interpreting service, options were discussed with him and it was established that he was keen to remain independently at home without the use of a carer. The Access Officer arranged a referral to the WRVS Meals Service and ensured the special dietary requirements of Halal meat or vegetarian meals were met, and a perching stool was issued to enable bathing. These two simple services ensured that this man is still living independently at home in line with his wishes.

Community Solutions (Reablement)

The introduction of the Community Solutions Team has provided a streamlined approach that puts the service user at the centre of the process and prevents over assessment and duplication. The results so far have shown that many people who might traditionally have been

provided with a home care package can maintain their independence with equipment, supportive technology and links into the local community. For those people who require more in depth intervention to meet their needs the Independence at Home team provides re-abling home care to support people to regain skills that they may have lost, to increase their motivation, build confidence and gradually reduce the amount of support that the person relies upon.

Home Care Support Workers have been trained to provide a more hands-off approach to care, encouraging people to do more for themselves and showing them how to use equipment effectively to maintain their independence. On average, care hours have been reduced by 69% for those people who have received both equipment and re-abling home care. 46% of people who completed their reabling care needed no ongoing services.

UNIVERSAL SERVICES

Universal Services means that we must ensure that support is available to everyone within their community. This remit is wider than social care and must include access and information regarding issues such as transport, leisure, education, employment, health, housing, community safety and information and advice.

The development of accessible and universal services will be vital for those individuals whose needs do not meet the council's eligibility criteria but who still need a certain level of support in order to maintain their independence and well-being. In particular, everyone should be able to access high-quality information and advice to point them in the right direction for help.

Our Progress to Date (Information, Advice and Advocacy for all & User Led Organisations)

Access Point

Our Access Point Officers are providing a cost effective service to the majority of people who contact the department for support, advice and information. This ensures that the maximum number of people

achieve the maximum independence with the minimum of intervention. Community resources and networks are fully utilised to promote independence and enhance wellbeing. This is achieved by providing high quality information, advice and simple assessment. A rapid assessment service for daily living equipment is now available via the Daily Living Centre.
The success of the Access Point allows us to focus our more experienced and professionally trained staff on those users with more complex needs whilst developing outcome based planning, self directed support and brokerage.

Hospital Social Work Service

Many people experience an episode of hospital admission and are discharged home without ever having contact with Adult Social Care yet, benefit from information about services available in the community. Others are referred through to the hospital social care service but do not have a level of need that warrants our intervention. To ensure that a larger number of people do have access to information about the support available to them in the community we are working closely with hospital staff to ensure that they have access to the information that they need to achieve more effective hospital discharge. This includes scrutinising the referrals we receive from hospital staff and sending back those which could be dealt with by ward staff. This scrutiny is running alongside an initiative to support hospital staff with the information they need to achieve a greater number of appropriate 'ward led discharges' with confidence.

Information Prescriptions

The Council has been working collaboratively with partners in the Primary Care Trust (PCT) to develop Information Prescriptions. (Appendix Two) This is a project that brings together information from a range of providers across the city. A website has been developed that links information from these providers both locally and nationally. There are a number of pilot sites across the city which can provide people with an Information Prescription which identifies areas of information that could assist in maintaining independence for that person. Alternatively, there is a helpline number where an adviser can obtain the relevant information for the caller.

CHOICE AND CONTROL

Choice and control means giving people a clear understanding of how much is to be spent on their care and support and allows them to choose how they would like this funding to be used to suit their needs and preferences.

Our Progress to Date (Self Assessment, Self Directed Support, Personal Budgets)

Self Directed Support (SDS) is central to our overarching commitment to ensure greater choice and control for service users within Brighton & Hove. This shift in emphasis ensures that social care users have the same choices and opportunities as those who fund their own support.

Self Directed Support builds on previous moves towards personalisation, such as Direct Payments, care management and person-centered planning by providing purchasing power to enable formerly passive recipients of services to become consumers and resource managers.

We are redesigning our ASC systems to ensure we embrace the principles and values of self-directed support. In order to manage these changes three work-streams have been established which are managed by the Self Directed Support Executive Group. These work-streams are:

- Systems, which includes development of Resource Allocation System
- Information & Support
- Contract and Commissioning

Self Directed Support - Personal Budgets

In 2008 the Community Team for People with Learning Disabilities carried out a Personal Budgets Pilot. Following the success of this pilot more than 100 people have been offered the opportunity of Self Directed Support.

CASE STUDY – Success in Self Directed Support

Annie lived at home with her parents but wanted to go to college. The services offered for people with learning disabilities and supported living environments were not flexible enough to meet her needs. Annie wanted an opportunity to live, like other young people of her age, with her friends that she had grown up with. This would give her the opportunity to develop her independent living skills and be supported by staff that she and her house mates had chosen to support them. Annie pooled her Personal Budget with her friends to obtain accommodation they could all live in. Six months after the service was implemented Annie had developed a more mature identity, was happy and healthy and had started to 'come out of her shell'. She and her house mates now take turns in cooking the meals and doing the shopping. Annie now has her own bank account which she is able to manage with support and is able to treat herself now and again to clothes and CD's- without having to ask mum and dad!

Self-Directed Support - Outcome Based Support Planning

A small pilot of 30 service users was carried out to test an outcome based approach to support planning. The pilot is a flexible approach to home care which aims to respond to a person's changing preferences and choices and to actively encourage a participative approach and personal independence.

This comprises of a support planning process with the identification of objectives or 'outcomes' to be achieved with the person receiving care. The actual activities to be undertaken to meet the required outcomes (the support plan) are the subject of discussion and agreement between the person receiving the care and the care provider. The only criterion being that the agreed activities should directly contribute to the achievement of the required outcomes.

The pilot is being undertaken with an independent home care provider and if successful will be rolled out to all Approved Home Care Providers during 2010-11.

Case Study – Success in Outcome Focused Home Care

Mrs B. is 78 years with deteriorating mobility and had been experiencing falls with increasing frequency. Mrs B. had lost her confidence and had not been out of her house for a long time. The outcome based Support Planning process was carried out with Mrs B and a Care Manager from OPCAT. They identified outcomes to improve her quality of life and confidence. The outcomes were:

- To be able to go out either for a short walk with a Care Worker or to go out for lunch.
- To review medication and have it blister packed to enable Mrs B. to be in control of this aspect of her life.
- To have a different Zimmer frame as her current one was not the correct size.
- To be able to go to a lunch Club.

Mrs B. and her Care Worker looked at the hours allotted to her and decided to "bank" some of the time over a three week period so she could go to a supermarket and have lunch out with the assistance of the Care Worker. This was the first time Mrs B. had been out of her house for many months. Mrs B. has been out with the support of her Care Worker at least once a month. The next goal will be to build on these experiences to work toward Mrs B. attending a local Lunch Club so she can make contacts within her community. By using the hours in a more flexible way Mrs B is now working toward becoming more confident and independent. When asked how this

had improved her quality of life she said that "before I used to just stare at the four walls, but now I can get out and have a laugh".

OUR VISION & STRATEGIC PRINCIPLES

Adult Social Care is changing. The Personalisation Strategy outlines the vision and plans that Brighton & Hove City Council has in place to fundamentally change the way social care services are commissioned and delivered within the city. Our vision sets out the way in which we will work across the council and with our partners and stakeholders to offer flexible, personalised services to all residents in the city. These changes will require working closely with local communities and service users to ensure that we offer safe but responsive services which meet social care needs.

"Our vision is to create an integrated range of effective services and opportunities that deliver timely and appropriate responses to individuals' needs and aspirations and support them in leading fulfilled and healthy lives. Our commitment is to empower people to make informed choices about the sort of support that suits them and to achieve the outcomes they want to maximise their independence and quality of life. This includes safeguarding those people whose independence and well being are at risk of abuse and neglect."

In delivering the strategy we will apply a number of key principles to all the work we carry out. These principles are:

- Listen to people's views and be open to change
- Enable people to make decisions and choices wherever possible
- Ensure appropriate balance between risk and choice
- Facilitate independence whereby people can access the appropriate resource at the right time and move on
- Offer or enable services that are flexible and designed to meet changing needs
- Be fair to all parts of the community and not discriminate on the basis of income or background
- Offer good value for money for the community and the person using the service

- Uphold the ten Dignity Challenges

OUR STRATEGIC PRIORITIES

The priorities contained within the Brighton & Hove Personalisation strategy align with the 5 key priorities indentified by the Association of Directors of Adult Social Services (ADASS) vision for adult social care laid out in Putting People First. Our priorities are:

- Delivery of High Quality Personalised Services
- Delivering Value For Money
- Working in Partnership
- Developing our Workforce
- Excellent Customer Services
- Reducing Inequality

OUR STRATEGIC GOALS

The challenges set down by Our Health, Our Care, Our Say and Putting People First are not insignificant but by March 2011 we expect people in Brighton & Hove who use our services and their carers, as well as front line staff and providers, to experience significant changes in the way we and our partner organisations work. We have seven strategic priorities. Each priority has a number of strategic goals that will be delivered throughout the lifetime of this strategy.

Strategic Priority 1: The Delivery of High Quality Personalised Services

Goal 1: Commissioning and Market Place Development
Goal 2: Self Directed Support Development (Business Processes)

Strategic Priority 2: Delivering Value For Money

Goal 1: Financial Remodelling
Goal 2: Managing Total Performance (Personalisation)

Strategic Priority 3: Working in Partnership

Goal 1: Establish Corporate Links
Goal 2: Stakeholder and Partner Engagement

Strategic Priority 4: Developing Our Workforce

Goal 1: Workforce Development

Goal 2: Raising Staff Awareness

Strategic Priority 5: Delivering Excellent Customer Services

Goal 1: Development of Operational Services

Goal 2: ICT and Systems to Support Personalisation.

Strategic Priority 6: Reducing Inequality

Goal 1: Safeguarding, Dignity and Well Being

Goal 2: Equalities Impact Assessment

Strategic Priority 7: Choice in Housing

Goal 1: Health Homes, Healthy Lives, Healthy City
Goal 2: Improving Housing Supply
Goal 3: Improving Housing Quality
Goal 4: Improving Housing Support

Strategic Priority One - Delivery of High Quality Personalised Services

Goal 1: Commissioning and Market Place Development

Our commissioning service needs to undergo a planned programme of redesign so that resources and support can be allocated on a truly individual basis. In the future, our commissioning must incentivise and stimulate quality provision offering high standards of care, dignity and maximum choice and control for all our service users.

We must also develop our local market to meet the rigours of Personalisation. If we are to offer residents increased choice and control we must have a market place that can deliver this. Our market strategy outlines the ways in which we will do this.

We need to capture information on 'gaps' in services and we will do this in a variety ways, such as recording 'gaps' identified by assessment teams, the Access Point, and through contract management meetings. We are working towards a real understanding of what will be needed. These could be services that are currently not provided or available in ways that are flexible enough to meet requirements.

We need to ensure that this information is made available to providers and potential providers. We will do this through the regular provider forum, through newsletters and other briefings and specialist events. We also will facilitate 'market development' meetings where providers

and potential providers can learn of new initiatives and discuss future plans as a group or individually. Information on how markets are being developed will be shared with commissioners across services e.g. Learning Disabilities and in Health.

We will communicate the social care and health message to all current and potential providers and stakeholders to ensure consistency of understanding. Existing providers will be supported to meet new market need and develop initiatives. Where appropriate, this may include some decommissioning of services and realigning of monies.

There are a number of risks in the market strategy and we must take care to grow the market without destabilising what is already in place. Accreditation, 'kite marking' will be considered. Local commissioners will work with regional commissioning and contracting groups where risk and regulation will be discussed and regional approaches considered.

Key Action Points:

- Implement Market Place Strategy
- Carry out market place gap analysis with providers, voluntary organisations and the Third Sector
- Use data from Access Point, frontline teams, providers and users to establish market demand for services/providers
- Establish and develop appropriate Provider links/offer support re Personalisation agenda
- Develop electronic access to provider information which includes consideration of an accreditated list of services
- Develop a business/retail model for Community Equipment
- Review Personalisation links to main Commissioning Strategies
- Provide a Telecare open-day
- Develop opportunities for 'Support with Confidence' in personalised services
- Agree Contract ´´flexibilities´´ which allow measurement of personalised services

1a: Brokerage

There are a number of commonly identified brokerage models:

- In-house
- Independent
- Community Organisations (Peer Support)
- Individual, family and friends
- Support Providers

In Brighton & Hove we believe we already have a range of services which could be developed to meet the needs of the city. Our intention is to scope these services with a view to identify gaps and overlaps and redesign services where necessary to provide support to people who need extra support to manage and arrange their support package.

Key Action Points:

- Carry out a scoping exercise to determine levels of Brokerage in Brighton & Hove
- Redesign/readjust services and teams to meet the needs of the city.

Goal 2: Self Directed Support Development (Business Processes)

To develop and build upon previous successes with self-directed support for service users a Self Direct Support Executive Team has been set up to develop and promote choice and control for our service users. The Executive group oversees three sub-work-streams

2a: SDS Systems Sub Group

A key area of work in relation to personalisation is the development of a resource allocation system (RAS), with the aim of having a clear and rational way of calculating how much money a person is likely to need to arrange support. The primary role of this group has therefore been to support our participation in the FACE RAS development programme as well as sharing good practice with other local authorities. FACE is

the leading supplier of assessment tools nationally and their RAS programme aims to deliver a scientific, evidence based model to support local decisions concerning resource allocation, built on their proven assessment tools.

The SDS Systems sub group is also the forum for identifying internal system requirements, particularly in relation to finance and income arrangements in order to deliver self directed care and personal budgets.

Key Action Points:

- Test prototype RAS
- Establish the level of consistency in assessments and budgets allocation.
- Identify and provide any training needs for assessment staff
- Roll out RAS across services
- Support the build of RAS & Assessment tools in Care Assess
- Participate in FACE RAS phase 2 work programme (Mental Health, enhancing the accuracy of RAS when applied to people with low levels of need etc.)
- Support development of integrated system for financial, commissioning and income arrangements

2b: SDS Information and Support Group.

Putting People First identifies the need for a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding. This approach is endorsed in the Care and Support Green Paper.

The Information and Support sub group is developing information and support options to enable individuals to make informed choices

regarding their self directed support. The group is made up of 16 representatives from voluntary organisations and staff from Adult Social Care. In the future the group will also include further representation from stakeholders. An important role of the group is to consult with service users.

Key Action Points:

- Develop a range of leaflets, fact sheets, DVD´s and posters promoting SDS
- Encourage, consult and raise awareness with service users and carers regarding SDS
- Develop support mechanisms for service users and carers to become employers and manage the associated financial responsibilities
- Development of council web pages on self directed support including links to web services (Big Bridge) for people with learning disabilities
- Develop peer support for service users and carers in conjunction with the Federation of Disabled People
- Develop Staff Practice Forums
- Develop guidance for staff on the processes of Self Directed Support
- Provide regular articles for publication in '*Person to Person*' voluntary sector newsletters and other relevant publications regarding SDS

2c: SDS Contract & Commissioning Group

The SDS Contract and Commissioning Sub Group provide advice and support regarding contractual arrangements related to self-directed support with the overall purpose of identifying gaps in service and providing market stimulation.

Key Action Points:

- Develop partnerships and improve personalised services with external providers
- Identify and develop SDS related commissioning plans
- Scope impact of Personalisation on Contract and Commissioning arrangements
- Identify gaps in service for market stimulation related to SDS
- Support commissioning models and future contracting arrangements for brokerage

2d: Delivering Self Directed Support

Self Directed Support builds on previous moves towards Personalisation (e.g. Direct Payments, care management, person centred planning) and takes them much further. What the self directed support model adds to these techniques is the budget and the purchasing power to enable passive recipients of services to become consumers and resource managers.

Key Action Points:

- Refresh SDS Implementation plan to align with Personalisation agenda
- All Service Users to be offered the opportunity for SDS (including Personal Budgets)
- Implement an assessment process which links to the Resource Allocation System
- Develop and agree an approach to Outcome Based Support Planning
- Develop potential opportunities for Independent Living Trusts
- Develop potential opportunities for Individual Service Funds
- Work in partnership with the local market to stimulate SDS opportunities with providers
- Meet the requirements of the NI130 Performance Indicator (Social care clients receiving Self Directed Support)

Strategic Priority Two - Delivering Value For Money

Goal 1: Financial Remodelling

Personalisation will align with our overall business plan that aims to provide more efficient services that are value for money. To achieve this we need to consider how the re-organisation of our services will impact across the whole of our services and the business of our providers. Our intention is to take a whole systems approach to change to ensure that services to users remain of the highest quality while maintaining value for money. Already we have seen improvements to our assessment processes that offer better value for money whilst maintaining a responsive and quality service for our service users. We now need to quantify the costs of Personalisation across the entire operational and commissioning functions to ensure that we manage those services within budget.

We intend to identify how changes to our services and ways of working will also have a potential impact on the work and services of our providers by clarifying the business models that will need to be adapted in response to Personalisation in the independent sector. This means that we will need to ensure that partnership working is optimised to improve outcomes for users and value for money.

Key Action Points:

- Develop model to test affordability, influence budget and Medium Term Financial Strategy
- Estimate costs of all council services under Personalisation (Access Point, Community Solutions, Brokerage, Reviews etc)
- Develop finance systems to support all aspects of Personalisation (RAS)
- Maximise income opportunities aligned with Personalisation
- Estimate expected unit costs and develop monitoring mechanisms
- Capture 'savings' from personalisation
- Measure impact of financial change on existing providers and our future commissioning requirements

Goal 2: Managing Total Performance (Personalisation)

Our current performance framework has been reviewed within the context of Putting People First. We have in place a framework which captures:

- The National Indicators Set relevant to Adult Social Care and within this the indicators that form part of our Local Area Agreement
- Feedback from people who use our services, co-ordinated through the Consultation and Information Group (CIG)
- Performance in relation to our contracted services
- Performance in relation to the seven national outcomes for Adult Social Care which is provided annually for the Self Assessment Survey.

We have also developed specific performance measures for each new service implemented, the Access Point measures are in place and the Community Solutions measures are in development. We have also reviewed the recent national 'tools' that have been developed specifically to support the performance management of PPF. It is proposed to make use of the five Key Milestones suggested by the regional ADASS group to provide a benchmark that we can measure progress against in relation to key PPF milestones. The SDS 'Dashboard' of indicators will be adopted to monitor progress across the 'end to end' process.

Key Action Points:

- To review the proposed framework in the light of the national 'tools' and confirm the framework to be used
- Review the work of the CIG group to strengthen the impact of user and carer feedback

- Develop contracts that are outcome focused and can respond to the personalisation of services
- To complete the development of measures for each service
- Establish Baseline Performance Indicators for long-term comparison
- Identify impacts of Personalisation on relevant performance indicators
- Measure performance through use of the five ADASS key milestone
- Maintain an SDS 'Dash-Board' of Performance

Strategic Priority 3: Working in Partnership

Goal 1: Establish Corporate Links

Personalisation crosses the breadth of the council's services and therefore must include participation from all directorates from the very highest level. This strategy initiates work to link to all the council's directorates.

This cross service engagement is vital to ensure that we develop Universal Services to all residents in Brighton & Hove. We can achieve this by involving:

- Corporate Communications
- Leadership Group
- Directors
- TMT
- DMT's
- Communities
- Ward Councillors

Key Action Points –

- Establish & Develop a 'Grid' of Partnership Opportunities related to Personalisation
- Carry out Corporate Consultation and Engagement regarding Personalisation
- Carry out a Staff Event for Personalisation
- Carry out a Members 'Personalisation' Event
- Carry out two city wide events 'The City Conversation' to develop and promote Personalisation
- Enable Member led community events to develop and promote Personalisation

Goal 2: Stakeholder and Partner Engagement

If we are to succeed in personalising services it is essential that citizens, stakeholders and partners are active participants in our change programme from the design stage onwards. Their involvement will help shape and refine our Personalisation Programme. We have already created the Partnership Board which includes Member and voluntary sector representation links and other strategic partners as well staff across Adult Social Care. The next step is involve other directorates across the council including Members, the private and voluntary sectors, the local community, stakeholders, partners, and the third sector to develop services.

Key Action Points:

- Develop a Carer, User and Stakeholder Engagement Plan
- Inform staff, service users and key stakeholders about changes in ASC (City Conversation)

- Publicise how staff, service users and key stakeholders can give their views and shape change

2a: Working with Providers

Our providers are vital in helping us deliver the services that will be required to meet the demands of Personalisation. It is essential therefore that we engage providers at an early stage. We will do this via various forums and as part of 'The City Conversation' planned for 2010.

Key Action Points:

- Inform providers about the Government's agenda to transform adult social care
- Support providers to adapt their organisation to provide flexible, person-centred support
- Inform providers and partners (including Health) of new services and referral pathways
- Ensure links to Primary and Community Strategy

2b: Working with Service Users

We need to ensure that service users and their families have a collective voice, influencing policy and provision. This can be achieved through the provision of a range of implementation groups to inform users and carers about our commissioning plans in relation to Personalisation.

Key Action Points:

- Obtain people's views to shape service developments
- Communicate the benefits of service re-developments
- Inform people about new services, support options and referral pathways
- Advise people about how we will respond to what people have told us they want

2c: Working with Community & Voluntary groups

Key Action Points:

- Obtain views from representative groups to help shape service developments, create fit-for purpose tools, and guide the development of accessible information for people and carers who use services
- Inform community groups about new services and referral pathways

- Support community groups to develop new ways of working to contribute to delivering on the Putting People First agenda.
- Ensure that there is support for at least one local user led organisation

2d: Working with the NHS

Address the 4 key PPF themes through collaborative and joint commissioning. Ensure that joint arrangements lead to effective and efficient services across the city. There is an opportunity to contribute to the development of Personal Health Budgets in Brighton & Hove, as learning from national pilot activity begins to build. Brighton and Hove NHS will be considering how to take forward and implement Personal Health Budgets locally.

Key Action Points:

- Link to developmental activity on the Primary and Community Care Strategy within the PCT to ensure that opportunities for Personalisation are capitalised on e.g. A&E services
- Develop opportunities for Personalisation within Expert patient/Peer Support Networks
- Assist with developing opportunities for Personalisation and information provision in GP services/practice based commissioning.
- Support any proposed Personal Health Budgets pilot activity locally
- Link to workforce development strategies and use staff awareness/ training and development opportunities to promote Personalisation where relevant.

Strategic Priority 4: Developing Our Workforce

Goal 1: Workforce Development

A workforce strategy that supports the transformation has been developed that has been significantly shaped by the principles of PPF. The workforce strategy is relevant to all staff in ASC as well as those working with us such as the independent and voluntary sector, unpaid carers, personal assistants and their employers. Whilst the primary focus of this strategy is on Adult Social Care there are links, overlaps and areas of common interest with partner stakeholders supporting vulnerable adults (such as health professionals, the police, housing etc). The detail of this work is contained within 6 strategic priorities within the workforce strategy. These priorities ensure that we will invest in our current and future leaders and empower them to identify solutions and take decisions that enable the workforce to own and deliver the vision for Personalisation. This will also mean supporting and developing our workforce to meet regulatory requirements, vocational training and meet the changing needs of people accessing social care, including personal assistants, their employers and unpaid carers.

To achieve this we will work in partnership with statutory, voluntary and independent sector partners to move towards a set of achievable targets, and to develop synergies between our workforce strategies.

Key Action Points:

- Carry out staff and Trade Union communication
- Carry out Workforce re-modelling
- Carry out Workforce budget planning
- Develop a comprehensive training and development programme that equips staff with new skills to develop new service models
- Create a leadership and development programme for Social Care Managers

Goal 2: Raising Staff Awareness

We need to attract and retain a workforce that reflects both the communities and individuals it delivers services to and to ddevelop skills and equip people to work confidently to meet new challenges and changes in the adult social care system.

Key Action Points:

- Identify and mobilise Personalisation 'enthusiasts'/develop Staff Practice Forums
- Offer Personalisation motivational and awareness raising sessions to all staff
- Identify key competencies/skill sets required by staff to deliver self-directed support/Personalisation

Strategic Priority 5: Delivering Excellent Customer Services

Goal 1: Development of Operational Services

Our Operational Services continue to improve and will be reviewed to achieve delivery within the framework "Putting People First". This means all that we do will offer Choice and Control & Universal Services while ensuring excellent Prevention services and opportunities to build Social Capital.

Our Access Point is well regarded and already offers timely, quality advice, information and signposting to universal services. Where service users have needs that can not be met at Access Point they are able to access Community Solutions. This means our skilled staff work with people and their carers for up to six weeks to enable them to determine their own outcomes for the future and to live as independently as possible. Those leaving hospital following a crisis or accident and need support will receive reablement provided either by our Independence at Home Team or our independent providers. This support will be offered either within their own home or by moving into our short term bed-based services to help people maximise their independence by learning or re-learning skills necessary for daily living. Following a period of reablement people who still have an assessed need for support will be offered the opportunity of a Personal Budget and proportional support to enable them to decide how best to use their budget to meet their on-going social care needs. People who are at particular risk or subject to abuse will receive social care support as part of an intervention plan which will look at how the risks that they face can be best managed.

Key Action Points:

- Take a whole systems approach to a review of Operational Services (The 'End to End' process) to ensure alignment with Putting People First.
- Develop Personalisation within Hospital and Transition Services to enable more people to remain at home rather than be admitted to hospital

- Arrange for people leaving hospital, with needs that make them eligible for social care support, opportunities for reablement (residential or domiciliary) that promote or restore their independence.
- Develop a partnership approach to working with Health colleagues for people with Long Term Conditions to enable them to live independently in the community
- Work with commissioners to support reablement and self-directed support with Independent Home Care providers
- Review the role of the Day Options Service and the Physical Disability outreach role.
- Improve prevention and learning from Safeguarding Adults work and provide leadership for Safeguarding Adults across the city
- All service users to be offered the opportunity of self-directed support including Personal Budgets by March 2010

1a: Development of Carers Services

Ensuring that carers are an integral part of the Adult Social Care vision for Personalisation will go a long way to meeting the key priorities in the national strategy and the local priorities for carers in Brighton & Hove. Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.

Key Action Points:

- Provide and further develop appropriate, good quality information for carers
- Implement an Information Sharing Policy
- Develop equality of access to services for all carers through targeted information and outreach work across all communities underrepresented in statutory and provider services
- Offer good quality, timely and proportionate outcome focused carers' needs assessments and reviews to meet National Indicator 135
- Ensure Self Directed Support options are available to carers
- Ensure provision of information to carers supporting cared for at end of life
- Ensure carer involvement in the development and provision of services
- Ensure carers' needs and views are taken into account on admission to, discharge from and during stays in hospital as well as in discussion and decisions about diagnosis, ongoing treatments, therapies and services
- To extend the choice and accessibility of quality break opportunities for carers

- To work with partners and local employers to help carers take up and/or remain in employment
- Ensure partnership working with JobCentre Plus
- Ensure access to support in NHS services
- Ensure access to advice and training
- Ensure access to emotional support
- Implement joint working between services for adults and services for children and whole family work

1b: Learning Disabilities

We have a model developed and hosted our first Choices Day for services users, family carers, partner organisations and prospective future '. We have convened our 'Personal Budgets in Day Services' Project Team and are completing financial modelling with a view to all service users having an up front allocation in our in house services next year. We are also piloting a similar approach with our voluntary/independent sector day services. We continue to work with our colleagues in the Children's and Young People's Trust (CYPT) to improve the transitions experience for young people and their families. Personalisation will be the default option for all young people who will require support as adults and need to start while they are children. Further work will also be carried out to raise awareness firstly amongst professionals in CYPT and then with families and young people.

Key Action Points:

- Develop and implement day options in learning disability services
- Develop and implement personalisation for younger people in transition to adult services across client groups.

Goal 2: ICT and Systems to Support Personalisation.

We have produced an Information Strategy to ensure that the Personalisation Programme is supported by developments in information and technology. This work is overseen by the Information Strategy Board.

All assessment staff now use CareFirst 6 and our Access Point team are using CareFirst 6 and Care Assess. We need to develop CareFirst and Care Assess to reflect and support our new ways of working e.g. Self Directed Support. We need to embed our RAS and all our performance data in the system and give staff an intuitive and simplified method of imputing which minimises error and maximises use of technology e.g. pre-population, duplication, mandatory fields, triggers etc. This will have the dual benefit of making imputing easier for staff and improving the integrity of our performance data.

CareFirst 6 has a range of benefits, but primarily it is web based and can interface with other web based systems and can communicate

with citizen facing portals should we choose to implement this in the future. Care Assess will hold a whole range of assessment, care planning, resource allocation system, safeguarding and self directed support documentation. The Care Assess development will ensure that all performance data is included in the documentation build. New performance reports will need to be written as we change our structure and functions in order to gauge the effectiveness of new ways of working. Our current service agreements and financial modules will require modification to facilitate self-directed support. OLM, the suppliers of Care First have this area of work in development.

Goal 2: ICT and Systems to Support Personalisation.

Key Action Points:

1. Roll out Care Assess to all ASC Assessment teams (core documentation with performance indicators embedded) by April 2010.
2. Build RAS into Care Assess (ensuring practitioners can submit assessment and receive an indicative budget amount) by April 2010
3. Recruit to Information Governance post
4. Review and develop Information Governance arrangements
5. Implement e-monitoring within Home Care
6. Implement web based policy and procedures
7. Develop & implement web portal/access linking to CF6 & Personalisation systems
8. Implement effective data transfer with SPFT (data matching all Social Care performance information required) by March 2010

Strategic Priority 6: Reducing Inequality

Goal 1: Safeguarding, Dignity and Well Being

We need to ensure that there is a balance between risk and choice when implementing changes to the way that social care is delivered through the Personalisation agenda. There are risks in delivering support in new ways, just as there are risks inherent in traditional community care services. But with comprehensive risk management systems in

place, and a strengthening of citizenship and communities, people can have control over their own lives and be safe from abuse.

We need to ensure there are systems in place which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of "champions", including volunteers and professionals promoting dignity in local care services.

We also need to ensure that policies and procedures currently in place for safeguarding adults continue to be relevant and workable as the changes to how people are supported develop, and that people have access to clear guidance for their own decision making on things such as employment checks and money management.

The Brighton and Hove Safeguarding Adults Board has a business Plan for 2009-11 which links closely with this Personalisation Strategy, identifying actions to ensure that the Personalisation agenda can achieve more effective safeguarding of vulnerable people.

Adult Social Care will also take responsibility for championing the rights and needs of older people, disabled people, people with mental health needs and carers within the local authority, across public services and in the wider community.

Early priorities will be intergenerational programmes involving older people as active citizens, integrated policy development which supports independent living (housing, access to work, education/training and leisure) including transition planning for young disabled people and local action to tackle the stigma faced by people with mental health problems.

Key Action Points:

- Develop Risk Enablement Panel
- Develop risk enablement processes/policy to support people to determine their own lives (co-produced)

- Contribute to SDS & Safeguarding training/awareness raising sessions
- Ensure robust links to Carer's Strategy
- Improve quality of safety networks and support through provision of Friendship Policy
- Establish Circles of Support via community engagement. Develop links with GP's, dentists, pharmacy, financial services
- Ensure Service User/Carer representation on Safeguarding Adults Board
- Work with Providers/Community to spread risk management
- Multi-Agency Safeguarding procedures to be reviewed (Pan Sussex)
- Safeguarding Training Strategy and Competency framework to reflect Personalisation programme
- Safeguarding to be included on staff training for Support Planning
- Ensure Recruitment and Selection arrangements in line with requirements from Independent Safeguarding Authority and vetting and barring scheme
- Provide training programme for Personal Assistants
- Develop Safeguarding Investigation audit process and feedback mechanism from service users
- Develop Safeguarding Adults Abuse Prevention Strategy
- Develop links with Safe in the City partnership
- Model Safeguarding protocols for voluntary sector organisations
- Agree Safeguarding monitoring data to be collected from CF6
- Ensure Safeguarding included in all commissioning arrangements

Dignity in Care

Upholding standards of dignity will be prioritised in everything we do. People have the right to expect to be treated with dignity and respect throughout our services. Continuous feedback from people who use services will continue to be collected so that we can further improve our services. We aim to work together with service users and partners to achieve Dignity in Care. (See Appendix One)

Key Action Points:

- Establish 'Dignity' as a corporate priority
- Deliver a local campaign to promote Dignity in Care
- Ensure Service User representatives represented at Dignity Board
- Ensure Dignity is prioritised in our policies, procedures and information services
- Identify and recruit further Independent Provider Dignity Champions
- Promote Well Being through service provision (Patching Lodge)
- Provide Dignity and Empowerment training to 50% of our independent providers
- Ensure Services who we contract/commission with meet the 10 Dignity Challenges
- Provide opportunities for feedback via our website
- Ensure 'Dignity' is a mandatory feature of all staff training in ASC

Goal 2: Equalities Impact Assessment

As part of the development of this strategy, we will carry out an Equalities Impact Assessment (EIA). The results of this assessment are helping us to ensure that our strategy and action plans contribute to improving access to personalised services to local people.

An Equality Impact Assessment is used to identify what effect, or likely effect, the Strategy will have on different groups within our communities. EIA's help to anticipate and identify equality consequences of policies, strategies and service delivery. EIA's should be used, as far as possible to ensure any negative impacts for a particular group or sector of the community are eliminated or counterbalanced by other measures.

The very inherent ideals of Personalisation allow all members of the community to access appropriate and proportionate support when they need it. Services will change and develop to meet the needs of our diverse community and it is anticipated that there will be increased access and participation from all user groups and services. With the shift towards community based provision it is anticipated that individual need will be met in a way that will be much more relevant to individual choice and lifestyle. We will also need to ensure that our staff group is reflective of our diverse community and trained to sensitively deliver services catered to meet individual need.

Key Action Points:

- Carry out an EIA for Personalisation that will assess the potential impact on the 6 strands of Diversity: Race, Religion/Belief, Sexual Orientation, Gender, Age, Disability
- Produce an EIA Action Plan that will monitor the positive impacts and eliminate, or counterbalance by other measures, any negative impacts on the 6 strands of diversity.
- Develop effective monitoring and feedback mechanisms

Health Equalities

Partnership working with Health colleagues has shown that preventative services
can help to reduce inequality and make significant contributions to the reduction of deprivation. A joint steering group is already in place

which reviews current health inequalities with a view to providing effective, preventative interventions which will reduce ongoing need for services.

Strategic Priority 7: Choice in Housing

Goal 1: Healthy Homes, Healthy Lives, Healthy City

The Housing Strategy sits at the heart of the city's Community Strategy and shows how the Council and its partners are working together to address the regions housing pressures and also the needs and aspirations of the city. We have 3 overall housing priorities that reflect the basic housing needs of local people:

- Improving housing supply
- Improving housing quality
- Improving housing support

Action to address these priorities will ensure we have the right type of high quality housing in the city to meet the needs of local people and that those in need are provided with appropriate support to enable them to maintain their independence.

Key Action Points:

- An increase in the amount of housing available for low cost home ownership and affordable rent
- An increase the number of affordable family homes
- Essential repairs, improvements and energy efficiency measures to around 1,000 homes in the private sector every year
- An Accessible Housing Register of adapted and wheelchair homes
- A Local Delivery Vehicle that will raise funding to help improve the quality of council housing up to the Decent Homes Standard and regenerate deprived areas
- Excellence in our housing management services
- Support being provided to around 5,000 people every year to help them maintain their independence
- The first Extra Care housing scheme for people with disabilities

Goal 2: Improving Housing Supply

We need to make sure that the city has the right type of housing to meets the needs of current and future residents.

Key Action Points:

- We will support households become homeowners
- Provide opportunities for households to move to larger homes or downsize as their needs change
- Identify opportunities to improve and develop deprived neighbourhoods
- Make best use of the housing stock
- Increase the supply of affordable rented housing

Goal 3: Improving Housing Quality

We want to make sure that residents are able to live in decent quality homes suitable for their needs.

Key Action Points:

- Work with home owners and landlords to maintain and improve the quality of their housing
- Reduce fuel poverty and minimise CO_2 emissions
- Develop the Brighton & Hove Standard for high quality and well maintained council housing and improve tenants' homes to ensure that they meet the standard
- Work with owners to bring more of the city's long term empty homes back into use
- Ensure new housing is developed to the latest standards

Goal 4: Improving Housing Support

Households have many different levels of need and there is no one solution that fits all housing need and so we seek to take advantage of every opportunity and provide a range of services to support households back to independence.

Key Action Points:

- Support households to make informed choices about their housing options
- Provide adaptations and support to households and their carers
- Work to prevent homelessness and rough sleeping

- Contribute to the wider city agendas of reducing worklessness, improving community cohesion, reducing anti-social behaviour and reducing inequality
- Work to ensure student housing provides a positive contribution to students' lives and the city

Housing Management

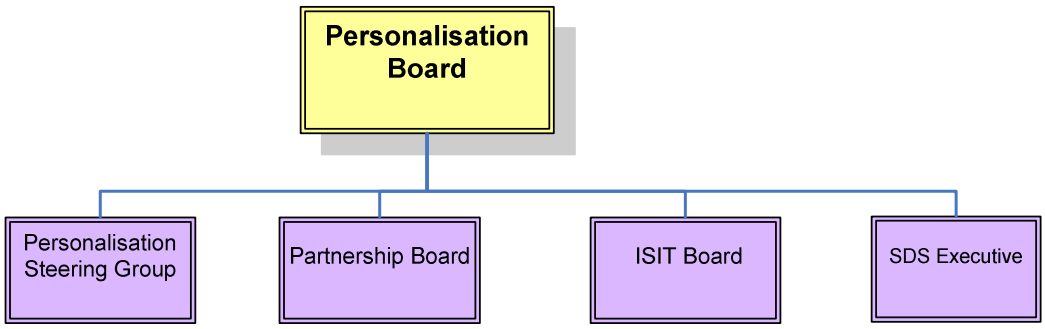
One of the biggest changes in Housing Management is the offer of personalised support plans within our 23 shelterd housing schemes within the city.

Personalised support plans which historically focused on health and social care are now seen as holistic, co-produced documents that incorporate the aspirations of the residents. Residents are no longer passive about the services that they receive and scheme managers now see their role to support the resident to achieve things for themselves.

The 850 residents of sheltered housing in Brighton and Hove are encouraged to be active partners in the projects that are undertaken and elect representatives to ensure that the opinions of the residents are heard and acted upon.

GOVERNANCE ARRANGEMENTS FOR PERSONALISATION

The Personalisation Programme which will deliver this strategy is overseen by the Personalisation Board. The Board consist of senior managers including the Director of Adult Social Care and Housing as well as Members of the Council. The board provides strategic direction for the programme and makes key decisions regarding the projects overseen in each of the work-streams.



MEASURING PROGRESS

In order to support the process of change ADASS and Local Government Association have worked in partnership with the Department of Health and other key stakeholders (including the Care Quality Commission (CQC) to establish a set of milestones against which we can judge our progress.

	April 2010	October 2010	April 2011
Effective partnerships with People using services, carers and other local citizens	That a communication has been made to the public including all current service users and to all local stakeholders about the transformation agenda and its benefits for them. That the move to personal budgets is well understood and that local service users are contributing to the development of local practice. [***By Dec 2009]*** That users and carers are involved with and regularly consulted about the councils plans for transformation of adult social care.	That local service users understand the changes to personal budgets and that many are contributing to the development of local practice.	That every council area has at least one user-led organisation who are directly contributing to the transformation to personal budgets. ***(By December 2010)***
Self-directed support and personal budgets	That every council has introduced personal budgets, which are being used by existing or new service users/ carers.	That all **new** service users / carers (with assessed need for ongoing support) are offered a personal budget. That all service users whose care plans are subject to review are offered a personal	That at least 30% of eligible service users/carers have a personal budget.

		budget.	
Prevention and cost effective services	That every council has a clear strategy, jointly with health, for how it will shift some investment from reactive provision towards preventative and enabling/ rehabilitative interventions for 2010/11. Agreements should be in place with health to share the risks and benefits to the 'whole system'.	That processes are in place to monitor across the whole system the impact of this shift in investment towards preventative and enabling services. This will enable efficiency gains to be captured and factored into joint investment planning, especially with health.	That there is evidence that cashable savings have been released as a result of the preventative strategies and that overall social care has delivered a minimum of 3% cashable savings. There should also be evidence that joint planning has been able to apportion costs and benefits across the 'whole system'.
Information and advice	That every council has a strategy in place to create universal information and advice services.	That the council has put in place arrangements for universal access to information and advice.	That the public are informed about where they can go to get the best information and advice about their care and support needs.
Local commissioning	That councils and PCTs have commissioning strategies that address the future needs of their local population and have been subject to development with all stakeholders especially service users and carers; providers and third sector	That providers and third sector organisations are clear on how they can respond to the needs of people using personal budgets. An increase in the range of service choice is evident. That councils have clear plans	That stakeholders are clear on the impact that purchasing by individuals, both publicly (personal budgets) and privately funded, will have on the procurement of councils and PCTs in such a way that will guarantee the right kind of supply of services to meet

	organisations in their areas. These commissioning strategies take account of the priorities identified through their JSNAs.	regarding the required balance of investment to deliver the transformation agenda.	local care and support needs.

CONSULTATION & ENGAGEMENT – The City Conversation

During the life of this strategy there will be a number of engagement and consultation events with our staff, partners & stakeholders and service users that will shape and inform how personalised services develop in Brighton & Hove. These events will be called 'The City Conversation' and will also draw in previous work carried out by staff focus and 'ambassador' groups as well as more formal groups such as the Partnership Board.

The Partnership Board currently provides a forum which aims to influence issues in related to Personalisation in Adult Social Care. This group will influence council wide commissioning to empower adults in Brighton & Hove to have full and active participation in decision-making processes. This is achieved by ensuring that members of the board represent people in the local community, providers, stakeholders and local organisations.

Priority groups to engage in consultation

1. People who use services – adults receiving social care which is provided or arranged by ASC. This includes the families and carers of people who use services;

2. All Directorates within the council;

3. Service providers, particularly those with a direct service delivery role;

4. Statutory partners including the B&H PCT;

5. All staff working to support the delivery of care, which includes people working in the provider services and third sector organisations.

6. Elected Members of the Council

7. Local voluntary groups;

8. Local media.

9. Primary Care Trusts and the wider health community.

10. Regional and national development groups.

APPENDIX ONE

Dignity in Care

The 10 'Dignity Challenges' which meet the requirements of Dignity in Care are:

1. Have zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

APPENDIX TWO

Information Prescriptions

APPENDIX THREE

Strategic Links

The Personalisation Strategy links to a number of key strategic documents these include:

- Housing Strategy
- Carers Strategy
- Our Health Our Care Our Say
- Brighton and Hove Supporting People Strategy
- Market Strategy
- Workforce Development Strategy
- Physical Disability Strategy
- 'Turning the Tide'

APPENDIX FOUR

Glossary

Brokerage & Brokers

There are many organisations including Brighton & Hove City Council who have been providing brokerage services albeit by other names for many years (care matching, signposting, support planning, information and advice etc). However, more recently it has been quoted in the context of self-directed support and the ability to help people with a personal budget to make decisions about the way their care and support is delivered.

Carer

A friend or family member who supports a person with social care needs either full time or part time.

Community Solutions

An Adult Social Care multi-disciplinary assessment team working together with clients to bring about individual solutions with the aim of maximising independence in the community

Direct Payments

This is the mechanism by which money is paid to an individual to purchase their own care. (It only applies to those with identified need and who are eligible for public funding under the conditions set out in '*Fairer Access to Care Services – FACS*; see below')

Direct Payments are offered as an alternative to the traditional delivery of prescribed services – directly from, or commissioned by, ASC. It is the key mechanism for providing a *Personal Budget*, or part of a *Personal Budget* to the individual.

Eligibility criteria and Fair Access to Care Services (FACS)

We have a limited amount of money to spend. The eligibility criteria help us to make sure that money and services go to the people who need them most.

The Department of Health provides a national set of eligibility criteria, known as Fair Access to Care Services (FACS). FACS is the guide that all Adult Social Care departments in England use to help them decide who they can give services to and what those services will be.

When we say someone is 'eligible' for a service, it means they qualify for support services. However, the criteria are only a guide. We look at each person and their individual needs when we make our decisions.

The services an individual gets depends on their level of need. There are four classes of need: Critical, Substantial, Moderate & Low. FACS criteria will still need to be applied when the Self Directed Support (SDS) process is introduced.

Independence at Home

Independence at Home is an intensive reabling service provided by trained Home Care workers to support people to regain the skills that they may have lost and to increase motivation and confidence with the aim of reducing the number of hours of support a person needs and for them to remain in their own homes.

Home Care support workers are encouraged to take a more hands-off approach and to encourage Service Users to do more for themselves, whilst demonstrating how specialist equipment can be used to increase independence.

Outcome based planning

An 'outcome' is the objective or goal that someone wishes to achieve.

Outcome based planning plays a vital role in self directed support. It is a way to help service users work out what they need. For example, one outcome could be "to socialise more with other people outside my own home". A *support plan* can then be developed that will achieve this desired outcome.

Personalisation

The personalisation agenda aims to support people to make choices and to be included. It goes under many different names, including 'independent living', 'person-centred support' and 'self-directed support'. They are all based on the same principle: if people are to participate and contribute as equal citizens they must have choice and control over the support they need to go about their daily lives.

Personal Budgets

A Personal Budget is the social care funding allocated to the individual upfront, enabling them to understand how much financial support they

may receive to enable them to make informed choices about the design and purchase of support. NB This is still based on eligibility to receive funding.

A Personal Budget may be constructed of:

- An amount of value in money passed to Service User – via a *Direct Payment*
- An in house service provided at a notional cost
- A commissioned service, via Adult Social Care
- Or any combination of the above.

Personal Assistants (PAs)

A Personal Assistant is a person employed to help someone witht heir daily social care. Using their Personal Budget, a person can employ a Personal Assistant to provide support like: cooking; cleaning; help with personal care like washing and using the toilet; driving or help with getting around; medical tasks; shopping; banking or paying bills.

Putting People First (PPF)

This is a Government agreement to transform public services. The aim of this agreement is to enable people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being and dignity.

Reablement

Reablement is short-term intensive support to promote independence following an illness, hospitalisation or an accident. It is time limited (generally 6 weeks in Brighton & Hove) and aims to reduce the need for services, help people to live independently at home and remain at home for longer.

Resource Allocation System (RAS)

A resource allocation system is a way of deciding how much money a person should get in a *Personal Budget*. The calculation is based on early assessment work from the *self assessment questionnaire*. If people know at an early stage roughly what their budget will be, they can start thinking about their own *support plan* and what they want to achieve. Any budget allocation is subject to eligibility criteria.

Self Assessment Questionnaire (SAQ)

The answers to this set of questions helps decide what level of support a person needs. It can be filled out by an individual on their own, or with

assistance from a care professional or any member of the individual's own support network.

The SAQ gives an early indication, through the *resource allocation system*, of the amount of money allocated to the individual in a *Personal Budget*. This helps service users to look at how they plan to achieve the support they need at an early stage. The SAQ may identify the requirement for a more detailed or specialist assessment.

Self Directed Support (SDS)

This is about individuals being at the centre of the planning process, putting them in control of decisions about their support. It is about enabling each individual to decide what they want to achieve and how to do this.

This may mean that they self manage the support, but they might also choose to have somebody else manage it for them – this is still Self Directed Support.

It starts from how we provide information to enable individuals to make initial decisions about their care, covers the initial contact with an individual in need of assistance, and goes through to the review and monitoring of each person in receipt of some form of support.

Self Funders

If an individual is not eligible to receive funding from social care, a *personal budget* will not be offered. However "self-funders" can still be advised on their options, taking into account their support needs, and what outcomes they want to achieve.

Support Planning

A support plan says what type of help the service user needs to achieve identified *outcomes*. An individual can develop this plan a) on their own, b) with the help of their own support network, c) with an assessor or d) a combination of all three.

An outcome might be "to socialise more with other people outside my own home". The support plan may include something like "attend a weekly class at the local college" in order to achieve the outcome.

The plan will also show:

- What the money will be spent on
- Plans to promote health, safety, wellbeing and independence
- How the support will be organised and the help needed to do that.

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