

## Personalisation – what is it all about?

Valuing People Now Transition Events

**PURPOSE**

To introduce participants to the personalisation agenda and what it means for young people in transition

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**AGENDA**

Participants will:

- Be introduced to the personalisation agenda and have an opportunity to explore what is happening in their area.
- Explore how personalisation fits into the transition pathway
- Be introduced to support planning
- Undertake some local action planning

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**ROLES**

- Facilitator
- Timekeeper
- Recorder/reporter

**RULES**

- Misery is optional
- No such thing as a silly question
- Have fun
- Mobles off or silent
- Give and Get
- No observing 5 min rule
- Listen with "30/20"

### Did you know there are five government agendas working on personalisation?

- Putting People First
- Personal health budgets
- Right to Control
- Children's Individual Budget Pilot Project
- Valuing Employment Now – Getting a Life and Jobs First

### How did we get here?

- Disabled people's movement, Independent Living Movement and the Woodlands Group (1976)
- In Control Phase 1 2003-2005, Taking Control and Staying in Control
- D of H Adult Individual Budget Pilot Project 2006-2008 – IBSEN report
- Putting People First 2007
- Lord Darzi – NHS review – recommended Personal Health Budget Pilot. Pilot started March 2009
- Children's IB Pilot




### The commitment

**10 December 2007**

### What will change?

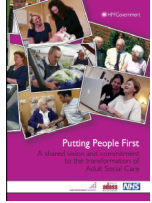
DH Department of Health



- Information, advice and advocacy for all
- Early intervention
- Low level services
- Volunteers
- Neighbours
- Self-assessment
- Self-directed support
- Personal budgets

**Putting People First**  
Transforming Adult Social Care


### Supporting Choice and Control



- Self Determination.
- Person centred thinking, working, planning and reviewing.
- Outcomes focussed.
- System to be responsible not risk averse.

### PPF Milestones.


By April 2010...



- The transformation agenda is well understood by all key local stakeholders and users and carers are involved in planning for change.
- 10% of people accessing adult social care are doing so via a personal budget.
- A clear strategy, jointly agreed with health partners, for Prevention and Reablement is in place.
- A strategy to develop universal advice and information services is in place.
- Commissioning strategies for the council and health partners clearly address the transformation required.

### PPF Milestones.


By October 2010...



- Local practice development with local service users and carers fully engaged and involved.
- All new service users are offered a personal budget.
- All existing service users are offered a personal budget at review.
- Early evidence of the shift in investment to Prevention and Reablement is visible.
- Arrangements are in place for universal access to advice and information.
- Providers and third sector organisations are changing their working practices and evidence of increased choice is clear.

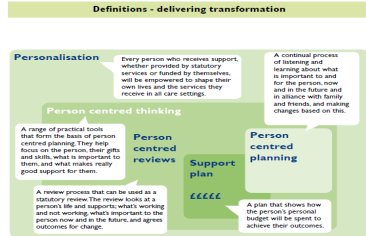
### PPF Milestones.

By April 2011...



- At least one ULO is in place and is actively contributing to the transformation locally.
- At least 30% of service users / carers have a personal budget.
- Whole system benefits of the shift to Prevention and Reablement have delivered a minimum of 3% efficiency saving.
- Local people know where to go for advice and information.
- Council and Health procurement decisions clearly reflect the choices and preferences of local people, both publicly and privately funding their care and support needs.

### Definitions - delivering transformation



**Personalisation**  
Every person who receives support, whether provided by statutory services or funded by themselves, will be empowered to shape their own lives and the services they receive in all care settings.

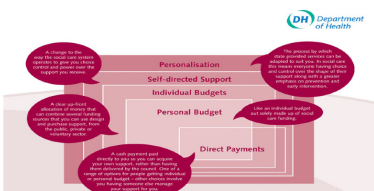
**Person centred thinking**  
A change of practical tools that form the basis of person centred planning. They help focus on the person, their gifts and skills, what is important to them, and what makes really good support for them.

**Person centred reviews**  
A review process that can be used as a statutory review. The review looks at a person's life and supports, what's working and not working, what is important to the person now and in the future, and agrees outcomes for change.

**Support plan**  
A plan that shows how the person's personal budget will be spent to achieve their outcomes.

**Person centred planning**  
A continual process of listening and learning about what is important to and for the person, now and in the future, and in alliance with family and friends, and making changes based on this.

### More definitions



**Personalisation**  
A change in the way that services are provided to ensure that they are tailored to the individual needs of each person.

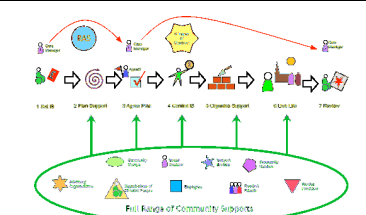
**Self-directed Support**  
The person has control over their own care and support, and can choose how they want to receive it.

**Individual Budgets**  
A budget that is set for an individual to fund their care and support needs.

**Personal Budget**  
A budget that is set for an individual to fund their care and support needs, but only a portion of it is paid directly to the individual.

**Direct Payments**  
A sum of money paid to an individual to fund their care and support needs, which they can use to pay for services or employ staff.

### The process.



- Local IB
- Plan Support
- Apply Plan
- Common IB
- 22 Month Support
- Local IB
- Personal

Full Range of Community Supports

### Children's IB Pilot

- Part of the Aiming High for Disabled Children programme
- Six pilot sites – Gloucestershire, Essex, Derbyshire, Newcastle, Gateshead and Coventry
- Supported by separate evaluation and support teams.
- Structured around a Common Delivery Model developed as part of a previous scoping study.

### Children's IB Pilot – Progress so far

**What has gone well**

- Sites have progressed broadly in line with the speed and scale envisaged
- There are a range of families involved
- Families include those who were both satisfied and dissatisfied with their current support packages
- Early feedback shows that some families have taken the opportunity to significantly change their support package – even with less resources

### Children's IB Pilot – Progress so far

**What hasn't gone well**

- Recognition that some of the processes put in place having been tested may need substantial refinement and adaptation
- Some discomfort around the robustness of the resource allocation systems and also their fit with support planning
- Linking within local authorities
- Attracting other funding streams

### Learning and Living Now Project

- Small project working with the Learning Skills Council in the Eastern Region and Yorkshire & Humber Region.
- Sort to combine social care and LSC funding into one individual budget for young people at risk of going to residential college because their learning needs could not be met locally.
- Developed a resource allocation system and a set of planning criteria and tools
- A number of young people also combined health money in their budget

### Group work

**What have you heard and what is happening in your local area?**

In your groups discuss what you have heard and then record what you know is happening in your local area in relation to personalisation. We will use this work later in the day

**So, what needs to be in a Support Plan?**



**There are 7 essential components of a support plan.**



The social worker must be satisfied that all 7 are met before the plan can be signed off and the individual budget released.

**1. What is important to you?**

Your Social Worker or Care Manager will look for information about what is *important to you*, and what is *important for you*, including people, places and routines as well as support needs.



The plan will not be agreed if the information treats you like a stereotype, does not express your individuality or is written in very general terms.

**2. What do you want to change or achieve?**

The plan should say what you want to change in your life and what needs to stay the same. Any changes must be realistic and achievable and can include long term changes you'd like to make.



The plan will not be agreed if it does not clearly show what you want to change, if the changes appear to be imposed by others or if the actions would make your situation worse.

**3. How will you be supported?**

The plan should say exactly what support you want to achieve these outcomes, when you need it, how you want it provided and by whom and how you will positively manage any risks.



The plan will not be agreed if you have no idea how you will get the support, or if you or others are at risk of harm and have not addressed this.

**4. How will you use your Individual Budget?**

The plan should state clearly how you plan to take your Individual Budget and what your support will cost for the year.



The plan will not be agreed if it does not say how your money will be used, if it does not show how much the service will cost, if the service will cost more than the amount that has been agreed or if the money is to be used illegally!

**Six ways of spending the money.**

- As a direct payment
- As an indirect payment to a third party
- As an indirect payment to a Trust
- As a care managed package – a “virtual budget”
- As an individual service fund, or ISF
- As a broker managed fund.



**5. How will your support be managed?**

The plan must explain how your support is going to be organised on a day to day basis, and who is going to manage things. If you are going to employ people directly, it must explain how this will be managed.



The plan will not be agreed if it is unclear who is responsible for what, or if you don't intend to do everything that you must by law (taking into account employment and discrimination laws).

**6. How will you stay in control of your life?**

This means thinking about how you will self-direct your support. Where other people make decisions for you, it has to be clear how they involve you and get your agreement. The plan should say how often reviews are needed and if there are specific changes of circumstances which should trigger a review.



The plan will not be agreed if it looks like others are making decisions for you, which you could reasonably make yourself.


### Remember, the Mental Capacity Act says...

Every adult has the right to make their own decisions if they have the capacity to do so, and you must start from an assumption of capacity in ALL cases.

All possible steps should be taken to try to help people to reach a decision for themselves.

People have the right to make decisions that others might think are unwise.


Any decisions made on behalf of an individual must be made in their **best interests**: representing the least restrictive course of action which the person could reasonably be expected to choose for themselves.



### 7. What are you going to do to make this plan happen?


The plan should set out real and measurable things that will happen in the future. These outcomes will relate clearly to the needs identified in your original assessment and will form the basis of reviews. It should say what actions need to be taken, by whom and when.

**The plan will not be agreed if you just said some general things that need to happen – they need to be clear actions that will make sure your plan will happen.**



### In summary, Support Plans must be:

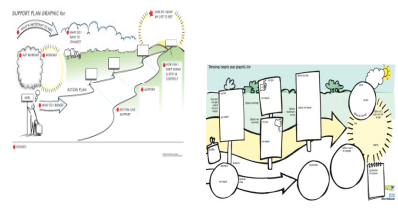
1. Person centred
1. Outcome focussed
2. Clear and specific
3. Linked to the assessed need



### How are support plans developed?

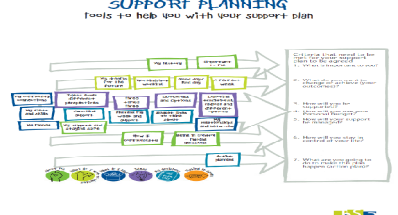


### How are support plans developed?



### How are support plans developed?

**SUPPORT PLANNING**  
Tools to help you with your support plan



### Additional information:

[www.helensandersonassociates.co.uk](http://www.helensandersonassociates.co.uk)  
[www.in-control.org.uk](http://www.in-control.org.uk)  
[www.shop4support.co.uk](http://www.shop4support.co.uk)  
[www.supportplanning.org](http://www.supportplanning.org)

