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Personalisation: lessons from social care

2020
Public Services Hub
at the RSA

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8 John Adam Street, London WC2N 6EZ
+44 (0)20 7451 6962

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Author

Alex Fox is CEO of Shared Lives Plus, the UK network for small community services for older and disabled people. Shared Lives Plus represents Shared Lives carers and schemes and works with Community Catalysts (www.communitycatalysts.co.uk) to support social care micro-enterprises. It is also the network for Homeshare schemes. Alex sits on the National Programme Board for *Think Local, Act Personal*, the sector-led programme for transforming care and support. He co-led on prevention for the social care White Paper engagement process (http://caringforourfuture.dh.gov.uk).

Alex was Director of Policy and Communications for The Princess Royal Trust for Carers and he still sits on the Standing Commission on Carers. Alex is a visiting lecturer at Nottingham University and a Fellow of the Royal Society of Arts. He blogs at www.alexfoxblog.wordpress.com, @AlexatNAAPS and www.socialcareworker.co.

Foreword

The twin challenges of quality and funding loom large over the adult social care sector. Age UK has argued that the future sustainability of long term care will require a rise in public spending from 0.5% to 0.9% of GDP: an extra £2–3 billion a year from 2015.* Andrew Dilnot, chair of a recent commission into the future funding of social care, called the system 'confusing, unfair and unsustainable'. Health Select Committee chair, Stephen Dorrell, has lamented damaging fragmentation between health and care settings. And as our society ages and our care needs get more complex, the quality of support in a diverse and sometimes struggling market is under increasing scrutiny.

There is consensus about the need for change in the way we fund, manage and deliver social care. But we do not yet agree about what kind of change is needed, nor what should be the balance of responsibility between individuals, families, communities, providers and the state. The agenda is being led by events. Reform agendas in the NHS, local government and beyond are ensuring that the social care policy horizon keeps shifting. Health and social care reform is becoming re-politicised as the Coalition's promised budget ring-fencing and hands-off approach has evolved into a controversial set of structural reforms. And at a local level, many social care commissioners and providers are struggling to cope with the impact of austerity. Meanwhile, there is a desire for approaches to creating disability- and age-inclusive communities to move far beyond the traditional confines of the social care and health sectors, into housing, employment, education and beyond.

Amidst this shifting set of policies and realities, there has been remarkable consistency around the need for greater personalisation of public services and a bottom-up, integrated approach. Today's focus on direct payments and personal budgets is part of a long-term transition from institutional to community-based care, and towards the co-design and co-production of services. Now is the right time to ask where this transition takes us next and whether it stops with social care and health.

* www.ageuk.org.uk/get-involved/campaign/poor-quality-care-services-big-q/care-in-crisis-key-issues/

As Alex Fox shows in this thoughtful paper, the personalisation agenda encourages innovation, offering the potential to create new markets around localised and individual needs, to focus fiscal resources directly and discretely, and to enable small groups of individuals to 'positively disrupt' a complex and opaque system. These are all developments to be welcomed. Yet the success of the personalisation agenda in future will depend upon answering some even more fundamental questions about the nature of future supply and demand for public services.

Most crucially, these questions go beyond the capabilities of the individual, and beyond the mechanics of how health and care services are funded. As the following pages suggest, this means exploring what the role of families, communities and collaborative groups could be in designing and providing support and creating inclusive communities. It means defining what is needed to catalyse and sustain a much broader market of services that would take personalisation to the next level. It means asking what government, citizens and the market can do to scale pilots and piecemeal change into long term transformational change for the sector.

We believe that the 2020 Hub's social productivity approach – which focuses on the strength and quality of relationships between citizens and public services – can help policymakers and practitioners address these issues. We are delighted to be working with Shared Lives Plus and others within the sector to take this agenda forward.

Henry Kippin, 2020 Public Services Hub, April 2012

1 Personalisation as a route to social productivity

In their 2011 paper, *From Big Society to Social Productivity*, Henry Kippin and Ben Lucas of RSA's 2020 Public Services Hub set out a vision for 'social productivity' which focuses on the social value which is created through the interaction between public services and civil society.

Many sectors recognise creating social value as something of a holy grail, bringing together social goods such as responsible citizenship and stronger, more connected communities, with economic benefits as a result of individuals, families and communities doing more for themselves and asking less of government and services. 'Co-production', 'social capital' and 'community capital' have been an increasingly strong element of the personalisation of social care. However, personalisation is still widely, if unfairly, understood to be based on seeing people as individuals with support needs, rather than as part of families, relationships and communities. Thus the changes associated with personalisation have successfully transformed many people's relationships with their services, but less so their relationships with their communities

There has been recent interest from the health, criminal justice and other sectors in emulating the personalisation reforms of social care and this is at least partially motivated by a belief that personalisation can lead to greater social productivity. It seems helpful therefore to set out a 'warts and all' picture of the personalisation journey within the social care sector and to consider the lessons on which other sectors might draw as they embark upon their own journeys. To attempt this, this paper begins with a potted history of personalisation, and ends with five recommendations for the implementation of personalisation, whatever the sector, in a way that increases the availability and use of new, community-based approaches to support and inclusion.

2 The personalisation journey in social care

Beginnings

The starting point for transforming social care was a sector characterised by:

- Disabled people warehoused in long-stay institutions;
- A medical model of disability and low expectations of people with long term conditions;
- 'One size fits all' state social care services, centrally planned and organised.

Alongside this dominant narrative, community social work took a more holistic view of support, particularly for older people and families under pressure. Unpaid family care was and remains a much bigger source of care and support than state services, although family carers were poorly recognised and valued by the state.

Community care reforms following the Griffiths Report (1988) and others, led eventually to the closure of nearly all long-stay institutions for people with disabilities and a significant shift of care for people with long term conditions, including mental health problems, into community-based settings. Expectations of unpaid family carers increased as did the use of voluntary and private sector care and support providers.

In 1983, John Evans became the first person whose move out of a care home was funded with local authority money.[1] At the time, this was technically unlawfully. Direct Payments – the right to take the cash equivalent of a social care service offered to you – were enshrined in law in 1996,[2] but awareness and take-up remained very low, due to barriers including:

- Lack of local authority enthusiasm to cede control of budgets to individuals, partly expressed in terms of fears of inappropriate use of money (in fact, there has been limited evidence of fraud,[3] or reckless use of resources in evaluations);

- The state's reluctance to cede control has been evident in local systems which in some cases make it very hard for people to purchase anything other than traditional services from established providers, making the gains from taking a Direct Payment unclear to individuals;
- A lack of understanding of the mechanisms for taking control and lack of confidence in taking on responsibilities such becoming an employer;
- People lacking capacity initially excluded from holding a Direct Payment;
- Lack of availability of alternatives to traditional services for Direct Payment holders to purchase.

Putting People First

Putting People First (2007) set out a comprehensive vision for personalising social care, including:

- A universal offer of advice and information to help people make informed choices;
- A focus on developing inclusive and supportive communities ('social capital');
- A focus on investing in prevention;
- Introducing choice and control through the introduction of personal budgets.

It is important to note that these four "quadrants" of personalisation were considered of equal importance. It was intended that not only should the location of support move to the community, but that community development approaches would prepare the community for this. People who are not informed or in crisis are not in control, so the focus on information for all (including 'self-funders' not entitled to state funded social care) and on prevention were part of the empowerment agenda. Those three quadrants remain unfinished business, as highlighted by many policy documents and reports including the Centre for Social Justice's *Unfinished Revolution* critique of the lack of community development work to accompany moves towards 'community based' mental health services (Centre for Social Justice 2011).

Whilst there is limited and patchy evidence of the impact of the first three aspects of the Putting People First vision, repeated reinforcement of the fourth aspiration has now resulted in 340,000 personal budget holders, up 100% on the previous year, amounting to £1.57bn of public money. 25% of these are Direct Payments (44% of the money).[4] Direct Payments remain seen as more transformative than personal budgets.[5] As explored below, introducing personal budgets influences demand, but does not by itself shape supply.

Case study: social care micro-enterprises

Michael, who has a learning disability and uses a wheelchair, pays for *Funky Fitness and Fun* using his personal budget. Carita launched the micro-enterprise after seeing that the closure of day services had resulted in a lack of activity for some people. The programme of activities is co-designed by the 15 people who use the service and takes place in a community centre. Michael found traditional services too rigid and didn't like the constant changes of staff. He feels Carita's service is cheaper and better than employing a personal assistant, and he likes the social aspect. Carita was supported by Community Catalysts (www.CommunityCatalysts.co.uk) a social enterprise specialising in helping people set up and sustain micro-enterprises.

Personal budget allocation mechanisms

In a personal budget based system,[6] people who have been assessed (or in some cases, have self-assessed) as eligible for a service are told how much money is available to fund their service and are given the option of taking control of that money, either through taking a cash Direct Payment, or through co-producing a spending plan with the council (a managed personal budget), an independent brokerage organisation, or a service provider (an Individual Service Fund). Councils have developed risk assessment tools for workers and individuals to use to decide the most appropriate way to take a personal budget, and processes such as loading Direct Payments onto a pre-pay bank card to monitor or limit spending choices.[7] From 2010, family carers and other 'Suitable Persons' could take

on the legal responsibilities of managing and spending a Direct Payment on behalf of an individual who lacks capacity to do so.

In order to help people plan realistically, most areas have developed a Resource Allocation System (RAS),[8] an algorithm designed to translate assessed eligible needs into a proportionate, 'fair' share of limited state budgets. This figure is intended to be an indicative 'ball park' figure to aid planning, with the final figure arrived at through user-led, 'co-produced' individual planning.

The introduction of Direct Payments and personal budgets was accompanied by concerns about escalating costs to councils and conversely, claims that, through tailored support being more cost-effective, councils would make savings. There is little national evidence of either impact.[9]

3 The benefits and limitations of personal budgets in driving change

Personal budgets and Direct Payments have been transformative for a significant proportion of people using care and support services, including thousands of people with physical impairments who have been able to employ a personal assistant (PA) to provide support tailored to their own needs, thus allowing them to gain employment themselves. There are numerous examples of disabled people who would in previous decades have spent their lives in institutional care, now living independently, such as the young woman with Down's Syndrome who employed a PA to help her set up her own dance activities enterprise, of which she is the Director.

> 'I am a direct payments user. Yes, it has been a much better option for me as a gay person, no question. I would have been imprisoned with a care agency. Can't stress that too strongly. I live at home supported by people I recruit who I am very clear with who I am. They don't change every week and they are not all straight or gay ... life has been a thousand times better on direct payments, even with its challenges.'[10]

Most service users and their carers report that taking a personal budget has had a positive impact upon their lives,[11] but evaluations and surveys have also suggested that:

- Some groups, including older people and people with mental health problems, have a much more mixed experience of personal budgets with uptake low (sometimes due to poor marketing or low expectations on the part of professionals),[12] and outcomes varying widely;
- People reported as having a personal budget by their council have not always experienced a new choice of services or greater control,[13] and in some cases are not even aware of their supposed uptake;[14]

- Whilst personal budgets are not always preceded by the self-directed support processes needed to make them worthwhile,[15] long, bureaucratic allocation and sign-off processes remain a problem;[16]
- The money made available through a personal budget can be less than that needed to sustain the previous level of support, particularly when moving to a personal budget based system has coincided with a programme of budget cuts.[17] This can increase demands upon family carers.[18]

Focusing on the money at the expense of changing the culture

The personalisation transformation continues to face significant structural and cultural barriers. Some areas have focused entirely on changing funding mechanisms and developing a RAS, with less evidence of a culture change towards ensuring a wide choice of personalised services over which people have real control. A RAS should generate an indicative figure to aid individual planning, but in some areas, deviating from that figure involves an appeals process. In another, service users are only given a choice of care providers who can give quotes which fall below the supposedly indicative RAS-generated figure. In response to an FOI request to councils about the mechanism used for their RAS, one council refused to give the information on the basis of commercial confidentiality and because they feared individuals would use that information to 'game' the system:[19] an attitude some distance from the aspiration for a culture of transparency, trust and empowerment.

A RAS does not replace people's statutory right to a Community Care assessment of their needs, so resource allocation can be experienced as an extra stage of an already bureaucratic system. Support to arrive at a costed care plan requires new resources, such as the input of a brokerage organisation, which can be a cost top-sliced from a personal budget allocation.

A conundrum inherent in a personal budget based system is the difficulty in helping people to plan based upon an indicative budget, without the process of arriving at that indicative figure itself limiting choice. In many areas, Direct Payment allocations are expressed in terms of hours per week of PA assistant at market rates, whereas some of the most imaginative uses of Direct Payments have been to purchase services from niche and 'micro'

enterprises, with very different cost structures. In a time of scarce resources, discussions based upon an indicative amount can become very focused on a monetary 'entitlement' and upon purchased services, at the expense of a more holistic approach to life planning which includes exploring unpaid family and community contributions. However, 20% of personal budgets are less than £20 per week,[20] suggesting that people may be finding ways to combine small amounts of money with other kinds of assets.

The difficulties the sector has had in developing a balanced, proportional and trusting approach to resource allocation is a reflection of the poor fit between personalisation (an 'assets-based' system) and our current system for establishing eligibility for state support through an assessment of people's needs and vulnerabilities. Life and support planning conversations typically take place in the context of high levels of need, and very often, outright crisis. The co-leads of the government's recent engagement process, who were asked to submit recommendations for reform ahead of the social care White Paper due in the Spring of 2012, suggested developing a system in which planning and navigation conversations were held with a much wider group of adults, at a much earlier stage in the development of support needs, in order that those conversations could look at a wider range of non-service solutions, rather than being restricted to being about entitlements to services and budget allocations.[21]

Promoting new, niche and innovative suppliers

In its 2012 social care Framework, the Welsh Government states that "We believe that the label 'personalisation' has become too closely associated with a market-led model of consumer choice", which they do not necessarily equate with "stronger citizen control".[22]

Small and niche providers can often struggle to survive the transition from grant-funding to the 'free market' of personal budget funding. Start-ups face commissioning and regulatory challenges,[23] whilst large, generic providers have the resources to market their services and to participate in complex framework agreement commissioning processes. Matching the transformation of provision with gradual and uneven take up of personal budgets creates the challenge of running two kinds of provision, or conversely battles over closures of 'outdated' building-based services still

valued by their long-established users.[24] To replace a council's market-shaping role, individuals need support to coordinate their purchasing or to pool budgets. Meanwhile, universal and preventative services, aimed at people without established eligibility to support, still need funding through traditional mechanisms.

The current legislative framework also presents challenges to new and small providers. Entrance into social care individual planning processes is largely reserved for those who can establish a significant existing need, often amounting to a crisis, which is incompatible with the aspiration to help people to remain in control and to make considered choices considering a wide range of formal and informal sources of support. Despite this, some areas have retained or developed roles and services which open up planning and navigation to people without statutory entitlements. For instance, Leeds council funds 39 'neighbourhood networks', three of which now work with a seconded social worker. Their role is to offer community-based and informal interventions to people at risk of needing formal support.

An early aim of introducing personal budgets was to allow for budget pooling across sectors, in order that people might purchase integrated packages of care. However, where social care and health care intersect, there are challenges in integrating differing approaches and cultures. People with similar needs can find themselves in receipt of rationed and means-tested, but personalised, social care, or conversely in receipt of free, but clinician-controlled NHS Continuing Care. Similarly, the lack of integration of social care with the education, training and employment sectors is evident in the continuing low levels of employment of disabled people.[25]

The regulatory framework

Regulation of social care is designed with traditional services in mind, whilst support managed directly by Direct Payment holders is exempt. Similarly there is a tension between the aspiration to professionalise social work and the freedom of Direct Payment holders and their families to seek care from unqualified workers. This has created cliff edges in the regulatory framework which are not obviously grounded in evidence of differing risks present in situations subject to very differing levels of regulation. Despite these challenges, there is no current evidence that Direct

Payment holders are experiencing greater abuse, in contrast to recent abuse scandals in traditional settings. Empowering people can in fact reduce their vulnerability to abuse.

Case study: regulatory hurdles for social care innovation

Companions is a micro-domiciliary care service established to provide consistent and flexible care for a small group of older people, who pay for the service from personal budgets or their own money. The providers consulted with potential customers before setting up the service. Older people said they couldn't use public transport and were essentially confined to their homes, isolated and lonely. Top of their 'wish list' was help to get out into the community and to meet friends. Companions designed a service which included using their own cars to take people out but were told that they would have to be licensed as private hire vehicles. The costs and complexity of obtaining a licence were insurmountable, so they were not able to provide the service most desired by their customers, until Department of Transport regulations were clarified in 2011, as part of a programme of cutting red tape for micro-enterprises.[26]

Regulation is not an activity commonly associated with innovation and proactivity. The more creative providers are in helping people to achieve outcomes which do not fit neatly into sector 'boxes', the more likely they are to encounter regulation never intended to affect them. For innovation in supply to keep up with the creativity of service users and support planners, there is a need for regulators and their sponsors within government to maintain a constant dialogue with provider representatives. Ideally, regulation anticipates innovation in supply, rather than innovators having to fight protracted battles in order to make their approach lawful. Similarly, innovation in the insurance industry can aid the development of novel approaches which involve new risks, or conversely innovators can find themselves uninsurable. In the case of transport regulation issue above, the Department of Business, Innovation and Skills, the Department of Health, the Department of Transport and Shared Lives Plus representing micro-enterprises, collaborated successfully to clarify the regulations and remove the barriers.[27]

4 From individual to community?

Personalisation is, arguably, individualistic in its focus upon individual need, choice and individually tailored services. This was entirely appropriate in transforming the culture of a sector which had often failed to recognise the individuality of people with long term conditions, but recent critiques of personalisation[28] have focused on its lack of focus upon relationships, community life and responsibilities.

The coalition government has reaffirmed its commitment to transformation in 2010's Vision for social care, which includes an increased focus on the role of inclusive and involved communities and a new focus on building a diverse market place of providers. There is promising evidence of improved outcomes and savings from approaches which combine personal choice and control with a focus on social productivity:

- Shared Lives, in which adults are matched with registered Shared Lives carers and their families, with participants sharing family and community life in relationships which can be lifelong, consistently outperformed other forms of regulated care[29] and realised significant savings.[30]
- KeyRing Living Support Networks (used mainly with people with learning disabilities) have been evidenced as being very cost-effective by Care Services Efficiency Delivery (CSED).[31]
- Local Area Coordination approaches, used in Australia to increase independence and self-sufficiency through developing and maintaining formal and informal community networks, have consistently been evaluated in Australia and also in Scotland as showing value for money as well as high levels of satisfaction from the people who use services.[32, 33]
- In the Stamford Forum approach, piloted in Leeds, individuals are invited to pool budgets with the resources held by some of Leeds' 39 Neighbourhood Networks (one for each ward). Each Network is led by older people and receives council support as well as drawing upon volunteering and time banking. Some have established social enterprises which deliver services to older people as alternatives to traditional care.

If the Networks and personal budget holders can find more effective and cheaper ways of including and supporting budget holders (through greater use of volunteers and other community resources for instance), the partners will be able to keep some of the savings to reinvest in the community.

Whilst the desire to give individuals control of their budgets is arguably in conflict with a council Finance Director's duty to balance budgets, enabling groups and communities to budget collectively and to co-produce plans with the council has the potential to bridge this divide. Such approaches also address the issue of risk-sharing, addressing the gap between councils' focus on safeguarding and tendency to be risk-averse, and the desire to empower individuals to make decisions which inevitably carry new risks,[34] such as the risk of an individual support relationship breaking down. In *A Glass Half Full*,[35] the Improvement and Development Agency sets out approaches to planning which do not just assess an area's *needs* (the nominal focus of the Joint Strategic Needs Assessment) but also map an area's *assets*, including those not normally considered by the state, such as grassroots community groups.

Approaches with a greater focus on inclusion and supportive networks may enable more effective responses to complex issues, such as support for disabled parents in their parenting roles[36] and support for people with learning disabilities to gain and keep employment. (Personal budgets currently make no impact upon employment or volunteering for most people).[37]

In Australia, Local Area Coordinators (LACs) support 50–65 individuals and their families and are based in their local communities as a local, accessible, single point of contact for people of all ages who may be vulnerable due to age, disability or mental health needs. They take time to build positive, trusting relationships with individuals, families and local communities, including a wide range of vulnerable people. LAC combines a range of existing, often disconnected roles in a single, local point of contact supporting children and adults within their local community. LACs have a remit to support people to identify their vision for a good life and their plans for getting there, utilising personal, family and community

gifts, strengths and interests, not just services. Where solutions to problems such as isolation do not already exist, LACs use community development approaches to help local people, groups, businesses and services to create them.

5 The progress so far

The brief history above attempts to outline some of the gains and challenges of the social care transformation process. The gains are unarguable and very significant:

- The near eradication of long term, institutional care for people with learning disabilities;
- The principles of choice, control and independence for all service users being firmly embedded in the ethos of the sector;
- Community based living seen as the norm for most people with long-term conditions;
- The rise of user-led or user-owned organisations, with people who use services and carers routinely involved in local and national decision-making;
- The increasing satisfaction of the majority of service users and carers with services and with holding a personal budget;[38]
- Some examples of a more plural and creative market including a large number of voluntary sector providers and a growing number of non-traditional approaches and enterprises;
- Some examples of community development and asset-based approaches in planning and 'asset-based' commissioning;
- There is little evidence of increasing fraud, abuse or inappropriate use of personal budgets.

The risks and challenges include:

- Misunderstandings of the values and ultimate aim of personalisation amongst service users and professionals; partly due to a lack of coordination between reforms of practice, training, regulation and legislation. Converting entitlements into cash amounts can entrench a culture preoccupied with levels of entitlement and lead to perverse or bureaucratic local implementation of new resource allocation mechanisms.

- Low uptake of personal budgets and Direct Payments amongst some groups and difficulties in translating budget holding into changes in services or daily living;
- Destabilising the provider market can lead to reduced provider diversity as well as increased diversity, particularly amongst the smallest providers;
- Risks of service failure can be shunted onto individuals and families;
- Increasing isolation for some people living 'independently'; (rare) instances of hate crime.
- Increased pressure upon unpaid family carers leading to poor health and unemployment;
- Challenges in integrating reform with other sectors, to produce whole systems changes.

6 Implementing personalisation successfully

Many of the hard-won lessons of transforming social care could be of value to other sectors as they consider the application of personalisation in their efforts to transform expectations, outcomes and costs. The account above attempts to illustrate the complexity of achieving the culture change towards individuals not only having choice and control, but also having the opportunity to form positive relationships and networks and to live as full citizens. From the experiences above, some key lessons for the successful implementation of personalisation can be derived which are relevant to all sectors:

1 Introducing personal budgets can positively disrupt monolithic systems

Personal budgets, especially those taken as cash Direct Payments, can be used with greater imagination and freedom by well-informed and confident individuals and families.

However, institutions and state bodies will inevitably attempt, if in some cases unwittingly, to assimilate changes into their existing world-view. For instance, generating a budget by estimating the costs of traditional services will be, to some extent, self-defeating if the goal is to help service users and professionals to think creatively. If it is felt necessary to generate an up-front ball-park estimate of someone's budget in order to aid their planning, creating an arcane and opaque set of algorithms to do so will not help to create a trusting relationship between the state and individual.

Any system will begin to do what it is measured upon, and it has been apparent that targets for funding arrangements which can be labelled 'personal budgets' have had perverse consequences within social care. The *Think Local, Act Personal* sector-led partnership has published a set of markers of progress, developed by service users and carers themselves, called *Making it real* as a response to this challenge.[39]

2 Develop new kinds of provision as well as new ways of purchasing

Personal budgets are only one part of giving individuals greater choice and control. Widening choice requires an equal focus upon demand (i.e. moving from procurement to personal budgets) and supply (i.e. commissioning and provider market development).

Commissioning approaches which are inimical to innovative organisations and start-ups (e.g. Framework Agreements, Preferred Provider lists) should be questioned. Commissioners may need assistance to manage the transition from block contracts, some of which may tie up existing resources for some years to come, to smaller scale purchasing. Transforming existing provision requires strategic planning which takes account of the wishes and needs of existing as well as new and future service users.

Individuals with personal budgets on their own can only ever be well-informed consumers, not commissioners. A more radical change can be achieved through supporting personal budget holders to pool budgets (including pooling resources with community groups) and to develop user-led commissioning, mutuals and cooperatives.

Changes from state-owned, building-based 'one size fits all' services to more individually tailored solutions have often been acrimonious in social care. Involving existing and potential users and their families and communities is vital in reviewing building-based services. Discussions should recognise that building-based services are comprised of a building which could be used in many ways, a set of services which may need transforming or relocating, and many close relationships which existing service users may well wish to maintain.

3 Opportunities to take real responsibility can be more empowering than entitlements

Even the most individually tailored service solution may fail to help ensure that someone can be a full citizen. Full citizens can contribute to their family and other relationships and have responsibilities as well as rights. Most people want to contribute as well to receive but so far, the introduction of personalisation in social care has had the least impact upon outcomes associated with people's desire to contribute, such as

employment and the ability of parents with learning disabilities to retain custody of their children as 'good enough' parents.

Advice, assessments and planning should be able to consider people as part of families and communities, not only as individuals. Interventions in community settings must be co-produced with those communities in order to increase inclusion and to harness latent social capital. At the area level, asset-based approaches to assessment and planning are needed.

It is important that new expectations placed upon people to take responsibilities for contributing to their own solutions are clear, fair and reciprocal. Valuing positive risk-taking can help to empower people and can result in more creativity, but those risks must be shared between state, individual, family and community. For instance, moving towards self-managed and community-based support will place new risks and demands upon family carers, who may need to develop new expertise or be able to access new kinds of support or involvement to do so. Kippin and Lucas argue that the big society narrative has given "inconsistent attention…to identifying and managing the downside risks" and argue that their social productivity approach involves greater attention upon the inevitable unevenness of the impact of such policies, so that more thought can be given to "how the playing field can be levelled".[40]

4 Communication is central to bringing whole-system change

Large amounts of money are spent on services which could be labelled as information, advice or advocacy. These include Dementia Advisers, Carers' Centres, brokerage and advocacy organisations, websites such as First Stop and Carers Direct, and councils' own call centres. But this spending is rarely coordinated and strategic and many information and advice services have a strong focus on service solutions, which in some cases are being cut rapidly, resulting in the danger of people finding a plethora of signposts with no destination to which to point. Making creative and cost-effective decisions about support and the spending of resources such as personal budgets, relies upon the availability of navigators and advisors who can help people understand and consider a wide range of solutions, not just those traditionally associated with their particular presenting need or health condition. It is worth noting that whilst today's challenge may be

too little information, the exponential increase of the reach and power of the internet suggests that tomorrow's challenge is much more likely to be *too much*.

At policy level, personalisation reforms have at times become a battleground between competing narratives about improved outcomes, rights, savings and stealth cuts. So communication of both the new mechanisms and of the expected culture change is needed. In social care, the highest impact messages have generally been anecdotes illustrating previously unachievable changes in people's lives. Certainly, effective messages will be those generated from the grassroots which are borne out of genuinely co-developed initiatives.

5 Pilots are not enough for whole-area and whole-system change

It has been noted above that adversarial and service-focused thinking has remained embedded in the 'transformed' social care system. Arguably, this will remain the case whilst entry to that system is based upon an assessment of current need and 'vulnerability'. A gate-keeping approach to expensive services may always be required. But a gate-keeping approach to support with creative planning is not. Interventions aimed at reducing dependency and increasing an individual or family's desire and ability to be more self-sustaining must be opened up as widely as possible in order to create a truly asset-based and socially productive culture.

When Local Area Coordination (see above) was introduced into Western Australia in the 1980s by Eddie Bartnik and his colleagues in government, it was not as a set of new practices, but as a coordinated attempt to transform the entire system. Even after the UK cuts, social care in Australia remains less well-funded but thought by many to achieve better outcomes than UK social care.

The transformation of one sector will affect and be affected by developments in other sectors. It is striking that a disabled person may well now be in receipt of two payments from the state – a personal budget and a welfare benefit – both intended to improve their well-being, but both delivered through entirely separate systems of assessment, eligibility and support. Cross-sector work is required to remodel transition points

between sectors, particularly where someone may find themselves simultaneously being encouraged by different agencies to think like a empowered commissioner, an informed consumer and a grateful recipient.

Endnotes

1 *Tireless champion of autonomy*, The Guardian, 2008. http://bit.ly/udXBDE

2 The Community Care (Direct Payments) Act (1996) came into force in 1997.

3 *Protecting the Public Purse*, Audit Commission November 2011. This report notes that £2.2m of personal budget fraud was reported in 2011, against social care spend of £16bn (compared to public procurement fraud of £855m). It notes that the risk of fraud is "significant" but that where councils have focused on fraud reduction they have good evidence of success.

4 *Personal Budgets Survey March 2011*, ADASS, 2011.

5 *The national personal budget survey*, Think Local, Act Personal, 2011.

6 The Department of Health (DH) funded 13 'Individual Budget' pilot areas in 2005–7, which attempted to give people control not only of social care allocations, but also to pool those allocations with other sources of funding. The budget pooling aspect of these pilots was not successful, due to incompatible cultures and systems.

7 *Use of Social Care Budgets,* National Audit Office and Ipsos Mori, 2011.

8 See the tools developed by pioneer user-led organisation, In Control: www.in-control.org.uk

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13 *Use of Social Care Budgets,* National Audit Office and Ipsos Mori, 2011. *Personal Social Services Adult Social Care Survey*, England 2010–11, The NHS Information Centre found that personal budget and particularly Direct Payment holders were slightly more satisfied with their support than other service users, but that situation was reversed when people were asked about their control over daily life, social contact and spending time doing things that you want. This may reflect differing expectations of people who have chosen and not chosen to take a personal budget.

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20 *Personal Budgets Survey March 2011*, ADASS, 2011.

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25 6.1% of adults with learning disabilities are in some form of paid employment (at least one hour per week); the majority of those worked part-time. *Improving Health & Lives: Learning Disabilities. Observatory, People with Learning Disabilities in England*, 2010.

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at the **RSA**

2020 Public Services Hub at the RSA
8 John Adam Street
London WC2N 6EZ
+44 (0)20 7451 6962

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