



social care
institute for excellence

ADULTS' SERVICES SCIE GUIDE 47

Personalisation: a rough guide



The Social Care Institute for Excellence (SCIE) was established by government in 2001 to improve social care services for adults and children in the United Kingdom.

We achieve this by identifying good practice and helping to embed it in everyday social care provision.

SCIE works to:

- disseminate knowledge-based good practice guidance
- involve people who use services, carers, practitioners, providers and policy makers in advancing and promoting good practice in social care
- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.

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Foreword



Personalisation has been a policy ‘buzz word’ some time now, and SCIE has been at the forefront of supporting the policy to become a reality. Our latest offer is SCIE’s new digital guide to personalisation, an enhanced online resource that follows on from the success of our *Personalisation; a rough guide*. We have continued to identify the knowledge on personalisation, explore the principles and explain what the main policy and practice implications are for social care and health. You can still print the guide off but the digital version gives access to multimedia supporting materials, different options for navigation and the ability to bookmark and personalise the guide. So you can have a personalised guide to personalisation.

Of course, discussions about implementing personalisation are currently happening in a difficult economic climate. But it is too easy to fall into the counsel of despair and not to make any changes. There are many things, both big and small, that we can all do to keep improving services and people’s lives. This guide shows how such changes are being made across the country to enable people to have more choice and control over their care and support and to become more active participants in their communities. It is good news that politicians from across the divide now understand and are delivering on promises about personalisation and are extending the principles to health, something that would have been unthinkable even ten years ago.

Enjoy the guide. Use it often and here’s to even more personalisation in care and support.

A handwritten signature in black ink, appearing to read 'Andrea Sutcliffe'. The signature is fluid and cursive, with a large initial 'A'.

Andrea Sutcliffe
Chief Executive

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Introduction

I just want to control my own life ... I like to socialise with other people and meet new friends. I just want to enjoy my freedom. I don't want people to control my life for me. I want to control it myself. That's what my Mum brought me up for, to control my own life.

(‘Maria’ in Taylor et al. 2007: 92)

Personalisation means, for me, that I want to be able to stay living in my own home. I want to be able to access every kind of public transport. I guess it's really about the ordinary, to be honest.

(Ann Macfarlane in Social Care TV, *Personalisation for older people living at home*).

Public service reform has proceeded far more successfully where government has successfully articulated a story about reform ... that has engaged the workforce.

(Brooks 2007: 3)

This publication aims to tell the story so far about the personalisation of adult social care services. It is intended to be a ‘rough guide’, exploring what personalisation is, where the idea came from and placing the transformation of adult social care in the wider public service reform agenda. It explains some of the basics and examines what personalisation means for different social care stakeholders and for the sector as a whole.

Who is the guide for?

This guide is aimed at all those concerned with implementing personalisation in adult social care and health.

How SCIE is trying to help

By identifying and transferring knowledge about good practice, the Social Care Institute for Excellence (SCIE) has a special role to play in the transformation of social care services for adults. One of the organisation's main priorities is to support the personalisation of adult social care and health services.

SCIE was a signatory to the Putting People First (HM Government 2007) concordat, which set out the shared commitment to the transformation of adult social care in England. It is a member of the Think Local Act Personal (TLAP) sector-led transformation partnership.

SCIE recognises that the concept of personalisation continues to evolve in terms of both policy and practice. It has produced further materials that reflect the evidence and experience arising from implementation and further developments. This guide is not an effort to capture everything that is happening in personalisation, but rather offers a brief, accessible overview of some of the evidence, ideas, issues and implications in England.

The basics

What is personalisation?

Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. The traditional service-led approach has often meant that people have not been able to shape the kind of support they need, or receive the right kind of help. Personalised approaches such as self-directed support and personal budgets involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives. People need access to information, advocacy and advice so they can make informed decisions.

Personalisation is also about making sure there is an integrated, community-based approach for everyone. This involves building community capacity and local strategic commissioning so that people have a good choice of support regardless of age or disability, including support provided by user-led organisations (ULOs). It means ensuring that people can access universal services such as transport, leisure, education, housing and health, as well as employment opportunities. All systems, processes, staff and services need to put people at the centre.

Personalisation means:

- tailoring support to people's individual needs whatever the care and support setting
- ensuring that people have access to information, advocacy and advice, including peer support and mentoring, to make informed decisions about their care and support, or personal budget management
- finding new collaborative ways of working (sometimes known as 'co-production') that support people to actively engage in the design, delivery and evaluation of services
- developing local partnerships to co-produce a range of services for people to choose from and opportunities for social inclusion and community development
- developing the right leadership and management, supportive learning environments and organisational systems to enable staff to work in emotionally intelligent, creative, person-centred ways
- embedding early intervention, reablement and prevention so that people are supported early on and in a way that's right for them
- recognising and supporting carers in their role, while enabling them to maintain a life beyond their caring responsibilities
- ensuring all citizens have access to universal community services and resources – a 'total system response'.

The Department of Health (DH) makes it clear that:

Importantly, the ability to make choices about how people live their lives should not be restricted to those who live in their own homes. It is about better support, more tailored to individual choices and preferences in all care settings.

(DH 2008a: 5)

This has equal, if not more, resonance for those living in residential care homes and other institutions, where personalised approaches may be less developed. Here, the independent sector has a crucial role to play in delivering personalised solutions for people no longer living in their own homes.

Personalisation is a relatively new term and there are different ideas about what it could mean and how it will work in practice. There are several terms used in association with personalisation, or to describe services or activities that reflect the agenda. Some terms are used interchangeably and others are used in relation to particular policies, processes or people who use services. Based on our current understanding, the list below aims to clarify some of the different examples of personalised approaches.

- **Person-centred planning** was an approach formally introduced in the 2001 Valuing People strategy for people with learning disabilities (DH 2001). The person-centred planning approach has similar aims and elements to personalisation, with a focus on supporting individuals to live as independently as possible, to have choice and control over the services they use and to access both wider public and community services, employment and education. Rather than fitting the person to services, services should fit the person.
- **Person-centred care** has the same meaning as person-centred planning, but is more commonly used in the field of dementia care and services for older people.
- **Person-centred support** is a term being used by some service user groups to describe personalisation.
- **Independent living** is one of the goals of personalisation. It does not mean living on your own, doing things alone or everything by yourself, but rather means 'having choice and control over the assistance and/or equipment needed to go about your daily life; having equal access to housing, transport and mobility, health, employment and education and training opportunities' (ODI 2008: 11). Using direct payments, individuals can recruit their own personal assistants (PAs) to support them with living independently.
- **Self-directed support** is a term that originated with the In Control project and organisation and relates to a variety of approaches to creating personalised social care. In Control sees self-directed support as the route to achieving independent living. It says that the defining characteristics of self-directed support are:
 - the support is controlled by the individual
 - the level of support is agreed in a fair, open and flexible way
 - any additional help needed to plan, specify and find support should be provided by people who are as close to the individual as possible
 - the individual should control the financial resources for their support in a way they choose
 - all of the practices should be carried out in accordance with an agreed set of ethical principles.

(Adapted from Duffy 2008)

The **recovery approach** in mental health has significant parallels with personalisation. Both are about the individual determining their own life and being supported to be an active member of their community (Carr 2010). A central concept is:

about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems

[and] self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all'.

(Shepherd et al. 2008: i)

Mental health recovery can be defined in this way:

1. **Agency** – gaining a sense of control over one's life and one's illness. Finding personal meaning – an identity which incorporates illness, but retains a positive sense of self.
2. **Opportunity** – building a life beyond illness. Using non-mental health agencies, informal support and natural social networks to achieve integration and social inclusion.
3. **Hope** – believing that one can still pursue one's own hopes and dreams, even with the continuing presence of illness. Not settling for less (i.e. the reduced expectations of others).

More about self-directed support

Self-directed support is the person-centred framework through which personalisation can be delivered. It involves finding out what is important to people with social care needs and their families and friends, and helping them to plan how to use the available money to achieve these aims. It is about focusing on outcomes and ensuring that people have choice and control over their support arrangements. Self-directed support should be available wherever people live, including in residential and nursing homes.

People can work with peers, practitioners and others to design their self-directed support plan. In practice, implementing self-directed support in social care means ensuring the following elements are in place.

- **Self-directed assessment** – simplified assessment that is led as far as possible by the person, in partnership with the professional, and which focuses on the outcomes they want to achieve in meeting their eligible needs. Assessment looks at the individual's circumstances and whole situation, and takes account of the situation and needs of carers, family members and others who provide informal support. The local authority's duty to assess needs can be met through proportionate self-directed assessment and support planning processes, and the local authority is legally responsible for signing off the assessment and support plan. Carers are entitled to their own separate assessment.
- **Up-front (indicative) allocation** – the person has a clear indication at an early stage of the amount of public funding (if any) that is likely to be available to achieve these outcomes before support planning takes place. This amount may be adjusted following the development of the support plan.
- **Support planning** – there is advice and support available to help people (no matter where their money comes from) to develop plans that will achieve a desired set of outcomes. Putting People First stated that the plan should be 'proportionate and non-prescriptive' – it need not be expressed in units of provision (like hours of care) and can include broader needs and desired outcomes beyond those that made the

person eligible for support (Putting People First Consortium 2010a). Arrangements should make the most use of any existing social support networks and mainstream services. For those people who will be receiving ongoing public funding (i.e. with a personal budget) to meet their care and support costs, the local authority must sign off support plans to ensure that eligible needs will be met and any risks managed.

- **Choice and control** – the person should (as far as capacity allows) decide how any funding should be managed and how best to spend it to meet their needs and achieve their agreed outcomes. Decisions should not be constrained by the choice of services currently offered.
- **Review** – the local authority should have a process for checking whether the outcomes agreed in the support plan are being achieved.

(Adapted from ADASS 2009a: 3–4).

In addition:

The move towards self-directed support and personal budgets involves comprehensive change – the policy makes it clear [that] self-directed support needs to become the core way of doing business. It is not an ‘option’. Implementing self-directed support is as much about changing culture as about changing systems.

(ADASS 2009a: 5)

What is a personal budget?

In December 2007, *Putting people first* (HM Government 2007) proposed that all people who are eligible for social care and support should have access to a personal budget, including the direct payment option, with the intention that they could use it to exercise choice and control in meeting their agreed social care outcomes. Personal health budgets are also being developed for people with continuing care needs. In March 2012 the Association of Directors of Adult Social Services (ADASS) Personal Budgets Survey showed that the total number of personal budgets delivered by local authorities across England is estimated to be 432,349, an increase of 38 per cent since 2010–2011. The amount spent on personal budgets in 2011–2012 was nearly £2.6 billion – some 15 per cent of all direct spend on adult care and support services. However, the number of direct payments had remained stable overall since 2010–2011 (ADASS 2012).

Personal budgets have been informed both by the experience of direct payments and also by the piloting of individual budgets in 13 English local authorities in 2007–2008. Individual budgets attempted to combine the following funding streams:

- local authority adult social care
- integrated community equipment services
- disabled facilities grants
- Supporting People for housing-related support
- Access to Work
- Independent Living Fund.

Research into the effectiveness of the pilot schemes was conducted by the Individual Budgets Evaluation Network (IBSEN) (Glendinning et al. 2008). The evaluation was promising and showed that people can benefit from having more choice and control over their social care and support services, as well as indicating that this could cost no more than traditional services. However, the research also showed that integrating these funding

streams could not happen without central government changes to some of the legislation and administration rules relating to the different funds (Moran et al. 2011). The government is currently focusing on using only social care money in the immediate future. The DH has stated that the term 'individual budget' is no longer in use and that the correct term for allocation of social care funding to an eligible adult through self-directed support is 'personal budget' (ADASS 2009a).

Key to the personal budget approach is giving clear, early understanding of the amount available to the individual, so that they can influence or control how it is spent, in a way which helps them best meet their needs. A personal budget should focus on providing for ongoing support and care needs, and should normally be considered only after examination of relevant preventative and reablement options (ADASS 2009a). Personal budgets must be implemented within the framework of self-directed support, which involves self-directed assessment, 'up-front' allocation of funds and support planning to promote maximum choice and control. This should include sufficient funding to cover any additional costs involved in employing personal assistants directly, as well as contingency funding for emergency cover. Personal budgets are not a crisis intervention option.

ADASS, together with the DH, has issued some useful information about how personalisation, including personal budgets, can be implemented within the current social care legal framework, including the duty of the local authority to assess people in need of social care and support, and the right to a direct payment for eligible individuals (ADASS 2009b).

Several forms of resource allocation system (RAS) are in use around the country to determine the size of a personal budget. The majority of these systems are points-based, offering transparency, so that the individual knows at an early stage what resources are available to them (ADASS 2009c). In this way, outcomes defined by the person using the service drive the spending. This allocation can be either a full or partial contribution to social care costs. The person may also choose to pay for additional support on top of the budget. A personal budget may be taken by an eligible person:

- In the form of a direct (cash) payment, held by the service user or, where there is a lack of capacity, by a 'suitable person'.
- By way of an 'account' held and managed by the local authority in line with the person's wishes, to pay for community care services which are commissioned by the local authority, or an account placed with a third party (provider) and 'spent' by the user in direct negotiation with the provider. This 'managed option' includes individual service funds (ISFs) and can be the means by which someone who does not opt for a direct payment can draw on existing or new contracts to suit their needs without taking on direct budget management responsibilities.
- A mixture of the above.

(Adapted from ADASS 2009a: 5)

What is a direct payment?

A direct payment is one way of taking a personal budget. It is a means-tested cash payment made in the place of regular social service provision to an individual who has been assessed as needing support. Following a financial assessment, those eligible can choose to take a direct payment and arrange for their own support instead. The money

included in a direct payment only applies to social services. As part of self-directed support, the personal budget holder is encouraged to devise a support plan to help them meet their personal needs. Assistance in developing this plan can come from care managers, social workers, independent brokerage agencies and family and friends. Once a plan has been devised, support can be purchased from:

- statutory social services
- the private sector
- the voluntary sector
- ULOs
- community groups
- neighbours, family and friends.

Practice example: direct payments for lesbian and gay people

The former Commission for Social Care Inspection (CSCI) (now part of the Care Quality Commissioning – CQC) issued a series of equality and diversity bulletins designed to support providers in addressing personalisation in social care. The first bulletin looked at providing appropriate services for lesbian, gay, bisexual and transgender (LGBT) people and found that many valued the choice and control direct payments gave them:

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.

Staff treated me with respect because I was in control of who was employed and what they did to assist me, both in my home and the wider community. I would not employ someone who decided they would take over my life and decide what was best for me. And I certainly would not employ any person who did not feel comfortable around my lifestyle.

People can use their budgets to access a wide range of support, as long as it is legal and meets agreed outcomes. Personal budgets are a conscious attempt to shift control to people who use services. Rather than receiving a fixed range of services with little choice, individuals are better able to design the services (frequently non-traditional) which best meet their agreed outcomes and care plan. This support plan is periodically reviewed with the person to make sure agreed outcomes are being met and to respond to any changes (Bennett et al. 2009).

Evidence shows that some people will use this new flexibility to design very different types of support and activity, while others value the ability to adjust more conventional packages to deliver a service more responsive to their own needs (Bartlett 2009; Wood 2010a; TLAP 2011a). Personal budgets, including direct payments, are a means to facilitate independent living and must be underpinned by a commitment to citizenship, independence and a social model of disability (Beresford 2009; Glasby and Littlechild 2009). The adult social care White Paper, *Caring for our future* (HM Government 2012) proposes piloting direct payments for residential care.

More about ‘managed’ personal budgets

Material from the DH, ADASS, and the Local Government Association (LGA) (DH 2010a; Putting People First Consortium 2010a, 2010b) clarifies how local authorities should be implementing the personal budget option for people who do not want a direct payment and would prefer their personal budget to be managed for them. A managed personal budget means either:

- the local authority places an individual’s personal budget with a third party so that day-to-day business arrangements are between the service user and the third party provider (purchasing or commissioning) OR
- the local authority itself holds the personal budget and manages/arranges the services on behalf of the service user (providing in-house owned or managed services).

The managed option should not mean less opportunity for the person to exercise choice and control than if they chose to have a direct payment. Whatever the personal budget option, people must be aware of what sum of money is available to them and be offered genuine choice and control over the services provided (TLAP 2011a).

A person who decides to keep existing service arrangements should be making a positive choice, having been provided with all the support and information they require to make the decision. Having made an informed choice about their care and support, service users should:

- receive a regular statement showing how their personal budget has been spent and the remaining balance
- have easy access to support services that encourage them to think about new ways they can use their personal budget flexibly to obtain the care and support most suitable for their needs.

The provision of personal budgets needs to be consistent with the principles and values of personalisation – they should maximise choice and control for people using services, their carers and families wherever possible. The DH is clear that local authorities should avoid strategies to:

bolster personal budget numbers at the expense of the wider Putting People First agenda ... Without changing internal processes and culture, establishing support services, developing markets and altering commissioning contracts it is highly unlikely that real choice and control will be provided.

(Putting People First Consortium 2010b: 8).

Individual service funds

Individual service funds (ISFs) are a means to achieving greater choice and control within a managed personal budget, where providers hold the budget but the services are controlled by the budget holder. The DH has described ISFs as being

where all or part of the person's budget is held by a provider of their choice under the terms of a contract held between the local authority and the provider – this can be a framework contract, a spot purchase or a cost and volume contract. ISFs have so far been developed in supported living and shared services as well as for domiciliary care.

(DH 2010b)

Five key features of ISFs have been identified (Sanderson et al. 2012: 7):

1. All or part of a personal budget is held by a provider on an individual's behalf where the money is restricted for use on that person's support and accounted for accordingly.
2. No specific tasks are predetermined so that the personal budget holder is empowered to plan with the provider the who, how, where, when and what of any support provided.
3. There is flexibility to roll money/support over future weeks or months and to bank support for particular purposes.
4. The ISF is accompanied by written information that clearly explains the arrangement and confirms any management costs to come from the personal budget.
5. There is portability, so the personal budget holder can choose to use the money in a different way or with a different provider.

Further developments with choice and control

Personal health budgets

In order to extend the principles of personalisation, choice and control into health, and following positive initial outcomes for personal budgets in social care, the National Health Service (NHS) is exploring how personal health budgets (PHBs) could work for people with long-term conditions, including mental health problems (NHS Confederation 2009b).

According to the DH (2009b: 4):

A personal health budget makes it clear to someone getting support from the NHS and the people who support them how much money is available for their care and lets them agree the best way to spend it.

PHBs are being introduced for people with continuing health care needs in 2012. The DH has explained that PHBs can be managed in three ways, with clear parallels to personal budgets in social care:

- a notional budget
- a third-party arrangement: an organisation legally independent of both the individual and the NHS (e.g. an independent user trust or a voluntary organisation) holds the money on the individual's behalf, and buys or provides the goods and services the person has chosen

- a direct payment for health care: the money is transferred to the individual, and the individual buys the goods and services.

The DH is clear that PHBs will not be the right approach for every person or situation, particularly surgery or emergency care:

they are generally more suitable for people with long term conditions who are higher users of NHS services or those people with complex health needs.

(HM Government 2012: 5)

The Royal College of Nursing (RCN) (2011) believes that to uphold patient choice, PHBs should remain optional, while the Royal College of General Practitioners (RCGPs) believes that:

patients should be asked to agree the outcomes of their care plan and the way in which their budget will be utilised to support these, with key carers also being kept informed, subject to normal procedures for patient consent.

(RCGPs 2012: 6)

PHBs will be offered to people eligible for NHS Continuing Healthcare, which is an NHS-funded package of care that can include health, personal care and accommodation costs. Carer support and contributions will need to be considered. About 53,000 people in England are currently receiving Continuing Healthcare from the NHS.

The personal budget approach has the potential to improve the integration of health and social care funding and self-directed support planning at the level of the individual. This is being explored with some people with long-term conditions who are testing integrated assessment and planning processes as well as integrated budgets.

Research by the NHS Confederation has highlighted the management challenges of implementing PHBs and has shown that:

leaders, clinicians and service users have different understandings of what personalisation means, and to what extent it is currently a reality.

(NHS Confederation 2011: 1)

According to the NHS Confederation, clinicians have reported concerns about choice and the use of personal budgets for non-evidence based treatment, and are also concerned about balancing freedom of patient choice with the professional duty of care. Social workers and occupational therapists working in multi-disciplinary teams are concerned about the potential for increased bureaucracy. Service users and carers believe that PHBs may not be right for everyone and want:

assurance that personal health budgets would not lead to the local services they valued closing down and leaving them with less choice.

(NHS Confederation 2011: 4)

The NHS Confederation (2011: 5) proposes five tests to apply to strategies to extend PHBs beyond the pilot stage:

1. Has the national evaluation generated evidence that PHBs improve outcomes, experience or cost?
2. Does the roll-out establish guidance for a significant expansion of the brokerage and advocacy systems?
3. Has a viable solution been found for how to release funds to finance PHBs at scale?
4. Have sufficient preparations been made to integrate PHBs in the NHS with personal budgets for social care?
5. Does the plan to roll out PHBs contain sufficient levers to drive take-up?

Interim findings (Davidson et al. 2012) on experiences and outcomes for budget holders are showing that:

- using a PHB could improve health outcomes beyond the particular long-term condition, including improvements in mental health for people with physical health problems and a reduction in relapse and crisis service use for people with mental health problems
- people access support not usually available through the NHS such as PAs, home care workers, physical exercise and complementary therapies
- people can experience increased self-confidence, greater social activity and reduced use of general practitioner (GP) services
- there can be wider benefits for families and/or informal carers, with reductions in stress and a rebalancing of family life.

Some of the emerging implementation challenges are similar to those for personal budgets in social care (Davidson et al. 2012):

- need for information and transparency to enable choice and control
- delays in approving care and support plans and getting services in place
- managing the personal budget
- reviewing care and support plans
- integrating PHBs and social care.

Right to Control Trailblazers

The Office for Disability Issues (ODI) has a goal of achieving equality for disabled people by 2025 and is working with disabled people to explore different ways to achieve this. The New Labour government's White Paper *Raising expectations and increasing support: reforming welfare for the future* (DWP 2008) set out proposals for the 'Right to Control', which means empowering disabled people by giving them greater choice and control over public money currently spent on their behalf. The ODI tested how the Right to Control could work for disabled adults in seven 'Trailblazer' areas in England, and is now considering further testing and evaluation to inform any decisions on wider roll-out.

People were consulted on what support should be in the Trailblazers, how disabled people and their organisations could work to develop the Trailblazers, what support disabled people would need to exercise the Right, what Right to Control means for service providers and support services, and their views on cost and viability (ODI 2009a). A feasibility study was also carried out (Purdon et al. 2009) and a Right to Control prospectus for potential Trailblazers was published outlining more about the initiative (ODI 2009b).

Trailblazers explored how disabled people can exercise greater choice and control over the following funding streams (which will still be governed by the existing criteria):

- adult social care
- Supporting People
- Work Choice
- Access to Work
- Independent Living Fund
- Disabled Facilities Grant.

Disabled people taking part in the Trailblazers had a legal right to:

- be told how much money they were eligible to receive
- have choice and control over the support they received
- be able to choose how they received the support
- decide and agree the outcomes they wanted to achieve based on the objectives of the funding stream with the relevant public body.

Disabled people in Trailblazer sites continued to receive existing services if they were happy with them. They also had the option to take a cash payment to buy equipment and support services themselves, or they could have a combination of arranged support and equipment and a cash payment (ODI 2009b).

The first wave of the Right to Control Trailblazers evaluation has some important messages about how to ensure disabled people have greater choice and control over support funding not included in the remit of a personal budget or direct payment (in health or social care). The Trailblazers involved ULOs in developing more streamlined, co-productive and efficient processes and services for shaping and delivering Right to Control at strategic and delivery levels.

Initial service user experience of Right to Control was similar to that of people receiving a personal budget in social care, with 'customers' and staff not always understanding Right to Control (particularly those in JobCentre Plus) and with patchy implementation. People were often unable to recall going through self-directed support planning. Challenges with having insufficient choice of support provider were apparent as well as difficulties with different rules for some funding streams. Technical and data-sharing challenges were also identified. However:

customers who did follow the intended journey were usually very satisfied, they found the process quick, and received tailored and flexible services that met their needs.

(Tu et al. 2012: 4)

Key successes and observations in the first-wave evaluation included:

- staff reporting the benefits of Right to Control, particularly where it triggered culture change and joined-up, person-centred approaches
- the benefits of strategic and delivery co-production with ULOs, with disabled people becoming involved in the design and delivery of support services

- closer partnership working between different agencies which could have a lasting impact; communications worked well in Trailblazer sites that had formal joint-working meetings for staff
- Trailblazer initiatives can build on personalisation
- the majority of Trailblazers had delivery models that did not need additional funding beyond set-up costs, which is positive for sustainability.

Community Fund Holding

As part of the Open Public Services agenda, the coalition government's *Community budgets prospectus* (HM Government 2011a) introduces the ideas of local authorities pooling budgets and communities designing solutions, determining outcomes and having greater control over spending.

Community Fund Holding is a related approach which is being explored as a way to increase local choice and control, and draws on the experience of personal budget implementation. The idea is that:

decisions may be devolved to local communities in ways that bring them real choice and control, while delivering the strategic and preventative outcomes commissioners require.

(Waters 2011: 1)

The aim of Community Fund Holding is to move beyond service- or budget-based working to a more place-based approach:

so rather than thinking of a community as an administrative unit such as a local ward or even just as a neighbourhood, communities in this context should be thought of as people and places with strong common experiences, a shared interest and connections.

(Waters 2011: 8)

In Control has proposed a six-step approach to Community Fund Holding (Waters 2011: 11):

1. Creating the community fund: allocating resources, defining outcomes, setting limits.
2. Creating a lead group: selection of a fit and proper group to hold funds and act as a hub.
3. Developing a community plan: a vision based on the skills and resources of community members.
4. Agreeing the plan: checking the criteria and constraints.
5. Implementation: following the plan.
6. Review and learning.

Where has personalisation come from?

Service user movement

In practical terms, a major impetus behind the development of individual or personal budgets has been the experience of direct payments which became available, initially to disabled adults of working age in England, as a result of the Community Care (Direct Payments) Act 1996, and have since been extended to other groups. The popularity and

success of direct payments has stimulated much of the thinking around individual and personal budgets (Glasby and Littlechild 2009). Significantly, direct payments were championed by disabled people themselves. The service user movement, independent living and the social model of disability have been powerful driving forces (Beresford 2009).

Personalisation has many of its roots in the disability, mental health survivor and service user movements which emerged in the 1970s, when individuals and groups undertook direct action and lobbied for change (Campbell and Oliver 1996). Associated ideas about independent living, participation, control, choice and empowerment are key concepts for personalisation. The current personalisation policy has been influenced by the practical work of In Control, which was established as a social enterprise in 2003 and has pioneered the use of self-directed support and personal budgets as a way to reform the current social care system, particularly for people with learning disabilities (Poll et al. 2006).

Social work values

Although the term 'personalisation' is relatively recent, it has grown from a number of different ideas and influences. Personalisation originates at least in part from social work values. Good social work practice has always involved putting the individual first; values such as respect for the individual and self-determination have long been at the heart of the social work ethos.

In this sense the underlying philosophy of personalisation is familiar. The British Association of Social Workers (BASW) states that social work is committed to the five basic values of human dignity and worth, social justice, service to humanity, integrity, and competence (BASW 2002).

Public policy

In terms of public policy, personalisation is not just about social care but is a central feature of an ongoing agenda for public sector reform which began with the New Labour government and has continued into the coalition government (Needham 2011). New Labour described public sector personalisation as:

the process by which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive.

(Prime Minister's Strategy Unit 2007: 33)

Personalisation has become a key concept for the future of the NHS, with PHBs being introduced and personalisation forming key approaches in mental health and dementia. It was linked to wider cross-government strategy including the notion of local authority 'place-shaping' (Lyons 2007) and the New Labour local government White Paper *Strong and prosperous communities* (DCLG 2006). This policy has continued with coalition agendas on localism, public services and social value, and building community capacity and volunteering.

The 2008 New Labour Carers' Strategy had integrated and personalised services at its heart (HM Government 2008). The next steps for the Strategy under the coalition administration prioritise:

personalised support both for carers and those they support, enabling them to have a family and community life.

(HM Government 2010: 19)

The DH has issued practice guidance on improving outcomes for carers through personalisation which recognises carer expertise, whole family approaches, prevention, self-directed support, information and provider choice (DH 2010c).

Personalisation's application to adult social care was first announced in *Putting people first: a shared vision and commitment to the transformation of adult social care* (HM Government 2007) – a document resulting from a groundbreaking concordat between central government, local government, the NHS and the social care sector. This officially introduced the idea of a personalised adult social care system, where people have maximum choice and control over the services they receive. Since then, personalisation has become core to adult social care reform for the coalition.

In November 2010 *A vision for adult social care: capable communities and active citizens* (DH 2010d) was published, with personalisation and personal budgets, prevention, health and social care integration and the development of a plural social care market to enable choice forming central aspects of continuing social care reform:

Individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their care.

(DH 2010d: 15)

However, the document is clear that personalisation is not just about personal budgets:

A personal budget alone does not in itself mean that services are automatically personalised. This requires wholesale change – a change of attitude by councils and staff, reform of financial and management and information systems, and reduction of inflexible block contracts. People should get personal choice and control over their services – from supported housing to personal care. Even those with the most complex needs can benefit from personalised services.

(DH 2010d: 15)

In July 2012 the *Vision for adult social care* was followed by the White Paper *Caring for our future: reforming care and support*. This outlines a commitment to give people greater control over their budgets, care and support plans:

They will be empowered to choose the care and support that best enables them to meet their goals and aspirations. We will put people not institutions in control.

(HM Government 2012: 9)

The White Paper also proposes combining social care and health personal budgets so that people can make the most of the support to which they are entitled.

Staying with public policy, personalisation can be seen as echoing many of the themes of the community care reforms that followed the National Health Service and Community Care Act 1990. The aim of these changes was to develop a needs-led approach, in which new arrangements for assessment and care management would lead to individuals receiving tailored packages of care instead of standard, block-contracted services.

Practice example: delivering personalisation to black and minority ethnic communities – Oldham Link Team and Language Shop

So that all citizens benefit from personalised care and support, those responsible for planning and providing services need to take steps to ensure that they are accessible and appropriate for people from a range of diverse backgrounds.

The Oldham Link Team and Language Shop is situated within the local authority and works to promote equal access to social care and support via language and community liaison work with black and minority ethnic (BME) people, focusing particularly on assessment and support planning. The team works at strategic and operational as well as front-line delivery levels across adult social care.

The aim is to empower individuals, families and communities by providing relevant accessible information and ongoing support to help people get the most from the personal budget option. The team also has a role in developing and strengthening services which take holistic, flexible approaches to support provision that accounts for the family context and cultural needs. This has allowed a wider and more appropriate choice for people from local BME communities and has improved the uptake of personal budgets. For instance, one provider can guarantee gender-specific support and is able to provide significant flexibility, choice and control to the users of the service, who are able to cancel and rearrange scheduled sessions at minimal notice.

The team also works at a strategic level with commissioners and service planners within the local authority. As part of their community liaison role, the team can provide intelligence for the strategic commissioning and development of care and support services which are appropriate for the local population. For example, they have recently identified a need for a suitable brokerage service. By offering an analysis of social care assessments which were not successful, the team can potentially identify any patterns and barriers in assessment practice or service provision which may need to be addressed at a strategic level. They have recommended that the assessment process be enhanced by the use of knowledgeable language support workers rather than generic interpreters.

Policy ideas

Finally, personalisation has been shaped by the policy ideas of researchers, policy analysts and think-tanks. One of the most significant contributors is Charles Leadbeater, whose influential Demos report *Personalisation through participation* (2004b) outlined a potential 'new script' for public services.

Drawing heavily on some of the influences highlighted above, he emphasises the direct participation of service users:

By putting users at the heart of services, by enabling them to become participants in ... design and delivery, services will be more effective by mobilising millions of people as co-producers of the public goods they value.

(Leadbeater 2004b: 19)

Leadbeater argues that personalised public services can have at least five different meanings (2004a: 1):

- providing people with customer-friendly versions of existing services
- giving people who use services more say in how they are run, once they have access to them
- giving people who use services a more direct say in how money is spent on services
- turning people who use services into co-designers and co-producers of services
- enabling self-organisation by society.

The last two are defined as 'deep personalisation', with service users working in equal partnership with providers. This is the type of personalisation that underpins social care transformation. It is not about modifying existing services, but changing whole systems and the way people work together.

Wider views of personalisation

Co-production

Another fairly recent term being used in discussions about personalisation is 'co-production'. Co-production relates to direct participation, community involvement and power- and expertise-sharing in social care and health services. It is also referred to as 'co-creation' and 'co-design', and can be seen as a way of building social capital by recognising that service users and carers have assets and valuable experience. Governance International has explored ways of approaching co-production in health and social care and has developed a model which includes the elements of co-commissioning, co-designing, co-delivering and co-assessing (Governance International 2012).

The Putting People First agenda asserts that the transformation of adult social care:

seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage.

(HM Government 2007: 1)

Co-production is being recognised as a core approach to implementing personalisation for everyone, including carers and those often described as 'seldom heard' (Ramsden 2010; TLAP 2011b). In proposals for new ways of organising and delivering social care services, people who use services have suggested that:

service user-controlled organisations can be a site where social workers are employed working alongside service users in a hands-on way.

(Shaping Our Lives et al. 2007: 13)

This would seem to encapsulate the essence of co-production in adult social care.

Research on co-production has shown that front-line workers should focus on people's abilities rather than seeing them as problems (Boyle et al. 2006) and should have the right skills to do this. Developing staff confidence and improving how they feel about themselves and their jobs is also very important. Co-production should mean more power and resources being shared with people on the front line – people who use services, carers and front-line workers – so they are empowered to co-produce their own solutions to the difficulties they are best placed to know about (Boyle and Harris 2009; HSA/NDTi 2009; Needham and Carr 2009):

Service users should be regarded as an asset, encouraged to work alongside professionals as partners in the delivery of services.

(Boyle and Harris 2009: 15)

Having examined some of the literature on the progress of personalisation and the potential of co-production for changing social care and support, the New Economics Foundation (NEF) and SCIE concluded that co-production could be applied to personalisation in four main ways (Slay 2011: 5):

- reconsidering the approaches to creating personalised services and moving beyond delivery mechanisms such as personal budgets to consider how the relationship between people using services and staff might be more equal and reciprocal
- rethinking the capacity and assets that social and health care services can utilise to support personalised services, including people's time, knowledge, skills and experience
- shifting the emphasis of personalisation from treating people who are supported as passive consumers, to treating them as citizens with an active role to play in designing and delivering public services
- considering new models and structures that might help to develop more mutual and collaborative approaches to personalisation.

Active and supportive communities

The TLAP partnership's 'Making it Real' Markers of Progress (TLAP 2011b) emphasises that as well as people being given choice and control over their care and support through personal budgets, self-directed or person-centred support, it is important to build active and supportive communities for people to be part of. The partnership makes the following key points:

- people are supported to access a range of networks, relationships and activities to maximise independence, health and wellbeing and community connections (including public health)
- there is investment in community activity and community-based care and support which involves and is contributed to by people who use services, their families and carers
- effective programmes are available that maximise people's health and wellbeing and enable them to recover and stay well
- longer-term community support and not just immediate crisis is considered and planned for; a shift in resources towards supportive community activity is apparent
- systems and organisational culture support both people and carers to achieve and sustain employment if they are able to work.

(Adapted from TLAP 2011b)

The DH has issued a guide outlining some practical approaches to improving the lives of disabled and older people by building stronger communities (Wilton and Routledge 2010). Drawing on the learning from the Putting People First 'Building Community Capacity' project, the guide gives an overview of some developing approaches, characterised by:

- **Building on people's existing capabilities** – altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively supports them to put these to use at an individual and community level.
- **Reciprocity and mutuality** – offering people a range of incentives to engage, which enable them to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.
- **Building support networks** – engaging peer and personal networks alongside professionals as the best way of transferring knowledge and supporting change.
- **Blurring distinctions** – removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.
- **Facilitating rather than delivering** – enabling public service agencies to become catalysts and facilitators, rather than central providers themselves.
- **Recognising people as assets** – transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal and essential partners in designing and delivering services.

(Adapted from Wilton and Routledge 2010: 12)

A consortium of organisations and individuals concerned with community development in the context of personalisation and funding cuts has outlined seven principles for 'empowerment and inclusion in an age of austerity'. They recognise that personalisation is both about better provision of care and support and about people making connections and contributions to their community, and that the two are interrelated:

- community development needs to start from how people themselves define their situation, the challenges they face and their aspirations and assets
- communities are stronger where people who use services are helped to find good ways of making a valued local contribution, not just seen as in need of care
- most support is delivered by families and social networks; it is critical that services support and work in partnership with people who make unpaid contributions
- the personalisation of public services marks a genuine change when it represents a change in culture, aspirations and the availability of a wider choice of support providers, not just a change in funding mechanisms
- to live fully, we all need to be able to make informed choices, to take risks and to experience the consequences of our choices
- public sector contributions are more cost-effective when they look across the pattern of local assets and needs, not just at those assessed as 'most needy'
- micro-providers (very small social care and support services of five staff or less) and interventions can be a powerful vehicle for mobilising new contributions and enabling people to co-design and share ownership in services which are personalised to their needs.

(CSV et al. 2012: 1)

Finally, TLAP has produced a report on the benefits of volunteering in relation to personalisation, inclusive citizenship and building community capacity. Social care commissioners and providers are asked to think about the benefits of investing in building community connections, the voluntary sector infrastructure and user and carer participation. Of particular importance is action on building social networks, encouraging membership of groups, nurturing an inclusive community and enabling everyone to make a contribution (Wilton 2012).

Housing

Housing and accommodation have a central role to play in a more integrated understanding of personalisation and providing preventative support which fits with individuals in their communities. Personalisation is also emerging as a way to design support with homeless people. The ADASS Housing Network has produced a helpful model to understand how personalisation might work for housing at different levels:

- **Individual level** – choice-based lettings and self-directed support.
- **Collective level (interest groups)** – co-housing where a group of older people buy or rent a home together.
- **Collective level (geographical)** – community governance models that drive community safety or regeneration programmes.
- **Universal level** – safeguarding lifetime homes and neighbourhoods, housing options and advice service.

(Adapted from ADASS 2010: 5)

The Network has also defined the following four different service areas where personalisation should work:

1. 'Housing, health, care, support including prevention
2. Communities, place-shaping and safeguarding
3. Housing options and development
4. Service choices for residents' (ADASS 2010: 6).

ADASS also suggests that while personalisation principles are not yet embedded in housing policy practice, there are developments which are increasingly allowing people more choice and control over their living circumstances. For example:

- choice-based lettings
- the new focus on outcomes for tenants and tenant scrutiny
- a range of financing options from full rent to full purchase
- accessible information and advice on housing options to support greater choice
- tenant management organisations, commonhold and community land trusts – collective choice for ownership and management
- flexible, person-centred housing-related support for people regardless of where they live.

Along with ADASS, Sitra's work with the Yorkshire and Humber Housing Related Support Group shows how housing can support personalisation and prevention, drawing on the increased potential for choice and control resulting from the Right to Control initiative and ensuring service user participation at all levels (Sitra 2009; Saunders 2010). Similarly, the

Housing Learning and Improvement Network (Housing LIN) has argued that housing support and personalisation have an important preventative aspect (Simpson and McAllister 2011) and that co-production, personalisation and housing could improve outcomes for individuals and communities (Simpson 2010).

A Housing LIN report on personal budgets and extra care housing suggests different options for providing choice, control and independent living opportunities, including a co-productive collective purchase approach and several 'core and add-on' models with various purchasing choices (Skidmore 2010). Personalising block contracts in support housing for people with mental health problems has been successfully piloted in one local authority, with the following success criteria identified:

- customers have control over purchasing a proportion of their support externally, using the cash allocation
- customers have choices of support worker, and can choose different workers for different things
- customers have choice over how, when and where support is delivered
- customer-personalised plans are underpinned by person-centred planning
- the model needs to be simple: there are robust sign-off and accountability procedures, but bureaucracy and rules are kept to a minimum.

(Look Ahead 2010: 11)

A small London-based study on providing personalised support to rough sleepers showed positive findings, particularly where people could choose a worker and build up trust with them:

Long-term personalised support after resettlement, provided by one dedicated worker, was seen as essential to maintaining tenancies.

(Hough and Rice 2010: 1)

Carers

Research is showing that carers are crucial for making personalisation work and can experience positive outcomes, but they need access to appropriate support and advice (Larkin and Dickinson 2011). In 2010 the government published *Recognised, valued and supported: next steps for the carers strategy* (HM Government 2010). This drew on carer responses to a consultation on priorities for the next four years, and the views of the Standing Commission on Carers, the government's expert advisory group. In response to this consultation and advice, the government identified four priority areas, including two focusing on personalisation:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution, involving them in designing local care provision and in planning individual care packages
- personalised support both for carers and those they support, enabling them to have a family and community life.

Alongside these proposals, the government published *Carers and personalisation: improving outcomes* (DH 2010c). This document recognises that one of the challenges is to enable commissioners, providers, carers and those they support to co-produce care and support that is at once responsive, creative and sustainable. Such systems-wide

transformation, which enables person-centred and self-directed care and support arrangements, requires carers to be regarded as experts and care partners. The agenda applies equally to carers and those they support and reflects the interdependence that exists between them. To achieve this, there is a need to:

- recognise the expertise of, and work in genuine partnership with, carers at all levels of service design and delivery
- enable carers to design and direct their own support, have access to direct payments and be engaged in the support plan of the person they care for and the assessment where appropriate
- establish, wherever possible, whole family approaches that ensure there is integrated support planning that benefits everyone involved
- fully recognise the differing social and emotional impacts of providing support to another person and that these do not necessarily correlate to the number of hours spent, or the tasks undertaken, in providing care
- develop a range of support options and opportunities to match the diverse needs of carers (including those who do not choose to identify themselves as carers) and the outcomes they wish to achieve in their lives.

The government summarised the implications of personalisation for carers in the White Paper *Caring for our future* (HM Government 2012). These changes are set out in the draft Care and Support Bill, so they will come into effect when this Bill becomes law.

- Carers will no longer be treated as an extension of the person they are caring for and will have a right to an assessment even if they are not providing a substantial amount of care regularly.
- If they are eligible for support, carers will have a legal right to receive state funding in the same way as the people they care for. This will give carers much better access to support to help them balance their caring roles and responsibilities.
- Carers who are eligible for support will be legally entitled to a personal budget in the same way as the people they care for. This means they will get a specific amount of money to spend on care and support and will be able to choose how they spend it. By 2013, everyone needing state-funded care should be offered a personal budget as part of their care and support plan, preferably as a direct payment.
- Carers should have much better, clearer information to help them make more informed, appropriate choices about care for themselves and the people they care for. From 2013 there will be one website bringing together information on the NHS, social care and public health in one place for the first time.
- There will be a requirement for local authorities to provide a universal information and advice service on care and support, focusing on helping people to understand how the system works, what services are available locally, and how to access services now and in the future.

Children and families

Personalisation is also being introduced as a way of transforming services and support for children, young people and families (Crosby 2010). Increasing the personalisation and integration of support and service arrangements for this group can address some of the dissatisfaction with current fragmented arrangements between social care, health and education (LGID 2011).

The Department for Education (DfE) commissioned a pilot evaluation of personal budgets for families with disabled children which found that they had improved access to social care services and had started to use different support options such as PAs. Many reported greater satisfaction with services, however, although the support planning process had the potential to increase efficiency and effectiveness, the delivery process was in need of refinement. The main lessons for implementation were:

- the requirement of dedicated resources to drive activity and engage wider professionals and families in the process
- the willingness of a range of families to engage with IBs [individual budgets], where considerable effort at the level of the individual family is required to draw out this demand
- the challenges of resource allocation, where the technical aspects are not yet fully resolved
- the importance of support planning in delivering the benefits of the IB approach
- the challenge of engaging health and education services as part of the process
- while much progress has been made in engaging parents in the process, practice is less developed.

(Thom and Prabhakar 2011: iii–iv)

Parents are now able to control the personal budget of children with special educational needs, rather than the local authority being the sole provider. There is a policy proposal that from 2014 special educational needs statements and separate learning disability assessments for older children will be replaced with a single, birth to 25 years, assessment process and education, health and care plan. A personal budget can be used to buy the services and support outlined in the plan.

Social care and health integration

Social care and health integration has an important role to play in achieving personalisation and an evidence base is emerging on how different types of integration can make a difference to people's experience of services. Social care and health divisions rarely make sense to service users and carers:

divisions between health and social care make little sense to people using services. They expect joined-up services that give them choice and control.

(SCIE/King's Fund 2011: 1)

Research is showing that:

people who use services and carers value services that are appropriate to their needs – they are less concerned with how these are organised ... [they] value timely assessment and services; partnership and the development of trusting

relationships with named key workers and improved communication between the agencies.

(SCIE 2012: 12)

Overall, evidence on integration and personalisation is indicating that:

Although most service users and carers report high levels of satisfaction, more can be done to involve them in care planning and influencing future care options. Integrated services work best when they promote increased user involvement, choice and control.

(Cameron et al. 2012: 1)

The Office for Public Management (OPM) has suggested that the future of health and social care integration will be driven in part by:

the need to make services personal for each individual, to deliver effective services that people understand, trust and control.

(OPM 2011: 1)

The King's Fund suggests that a person-centred perspective 'aspires to people experiencing one system of care and treatment, not several disconnected ones, and encompasses:

- how people access services through information, advice and referral
- their journey through the health and social care system and the pathways they use in navigating across a variety of organisational and professional boundaries
- their overall experience and outcomes
- the extent to which they can help shape their own experience of the system, (e.g. through self-care, PHBs and social care budgets).'

(Humphries and Curry 2011: 6–7)

The government wants to promote more integrated or joint commissioning between the NHS and local authorities responsible for adult social care. The Health and Social Care Act 2012 sets out clear obligations for the health system and its relationship with care and support, which will improve the quality of services and people's experience of them. Integration across the NHS, public health and social care is a key means to achieving this. The government expects integrated services to be person-centred, to improve outcomes and to reduce health inequalities. The adult social care White Paper, *Caring for our future* (HM Government 2012) has a focus on addressing barriers to achieving integrated care and support. One approach will be through personal budgets:

As personal health budgets are extended beyond the pilot sites, subject to the current evaluation, Government will make it straightforward for people to combine them with personal social care budgets so that they can make the most of the support to which they are entitled.

(HM Government 2012: 58)

What does personalisation mean for adult social care services?

Personalisation is not a mechanism for public service reform. Rather, personalised services that meet the needs of the individual service user are one of the key objectives of such reforms.

(Brooks 2007: 10)

This section discusses some of the emerging implications for:

- the social care workforce
- voluntary and community organisations
- private sector providers
- user-led organisations
- commissioning
- regulation.

The social care workforce

The social care workforce is not in a state of crisis or failure, but on the cusp of radical and comprehensive change at all levels.

(Hudson and Henwood 2009: iv)

The role of social workers

Social work is seen as having a central role in developing and delivering personalised social care and support services (DH 2009b; Hudson and Henwood 2009). The authors of *Making it personal* suggest that in a context of increasing self-directed support, social work roles will adapt accordingly and social workers could enjoy more creative, person-centred roles (Leadbeater et al. 2008). A statement affirming the role of social work for the delivery of Putting People First in England has been issued by ADASS, the DH, Skills for Care, the BASW and the Social Care Association (SCA). The statement sets out the purpose of social work and its distinct contributions, particularly those relating to better outcomes and increased control and independence for people who use services, their carers, families and the wider community. Evidence shows that many still want the support of experienced social workers:

when they feel most vulnerable, to manage risks and benefits, and to build their self-esteem and aspirations so that they can take control or make difficult decisions.
(Putting People First Consortium 2010c: 2).

The key social work organisations involved make it clear that social work's distinct contribution is to make sure that services are personalised and that people's human rights are safeguarded through:

- building professional relationships and empowering people as individuals in their families and in communities, working through conflict and supporting people to manage their own risks

- understanding and applying legislation
- accessing practical support and services
- working with other professionals to achieve best outcomes for people.

Social workers bring together knowledge, skills and values and put these into practice, according to the experiences, relationships and social circumstances of the people they work with. They therefore have a crucial role to play in multi-disciplinary teams because they can bring a perspective on the whole person, rather than focusing only on their symptoms, disability or circumstances:

seeing the individual in the context of family, friends and community, and reflecting their hopes and fears for their own future is where social work can bring an important contribution to the work of the team.

(Putting People First Consortium 2010c: 2)

Social work is a regulated, graduate profession with a code of practice and a dynamic and evolving knowledge base. As personalisation develops, existing social work skills can be strengthened and new ones developed to:

- support people with the assessment of their needs, circumstances and options
- work with families to improve wellbeing and safeguard family members who may be in circumstances which make them vulnerable
- contribute to early intervention and preventative services, reablement, social inclusion, and helping to build capacity, social enterprise and social cohesion.

Social work and its values can potentially shape the responses to personalisation of the entire health and social care workforce. Listening, empowering individuals, recognising and addressing potential conflict, safeguarding needs and the capacity of individuals, being sensitive to diversity and putting people in control should be central to the way staff and services treat people from the first point of contact. The acceptance by the government of The College of Social Work's (TCSW) recommendation that designated principal social workers should exist within adult social work has emphasised the important role that social workers have in the leadership of a more personalised approach to working with people across the sector.

The key social work bodies involved in drawing up the statement affirming the role of social work in personalisation conclude that these are some of the areas that social work might develop into as personalisation progresses:

- **Social work and interpersonal support** – with the development of information, advice and advocacy services, support planning and brokerage, there may be new roles for social workers alongside provision led by service users and their families. This includes services for people who fund their own social care.
- **Social work and safeguarding rights** – social work could have an important role in community development work and promoting social cohesion, for example where disabled, mentally ill or substance misusing people are victims of hate crime.
- **Social work with families** – social workers already help to break the cycle of families where generations of individuals are trapped in abusive relationships, crime, substance misuse, poor health, unemployment and other factors. Their role in this

work could be strengthened to support the current priorities for local authorities to create safe, healthy and prosperous communities.

(Adapted from Putting People First Consortium 2010c: 3)

The complexity of interrelated skills, knowledge and values needed to undertake these roles and tasks is represented in the Professional Capabilities Framework (TCSW 2012a) which was developed by the Social Work Reform Board and has been completed by the College of Social Work.

People who use social work and care services and their carers consistently say that:

People value a social work approach based on challenging the broader barriers they face. They place a particular value on a social approach, the social work relationship, and the positive personal qualities they associate with their social worker. These include warmth, respect, being non-judgmental, listening, treating people with equality, being trustworthy, open, honest and reliable and communicating well. People value the support that social workers offer as well as their ability to help them access and deal with other services and agencies.

(Shaping Our Lives 2008)

Consistency and reliability have also been cited as especially important, along with the capacity for workers to keep their promises and go out of their way to help (Hopkins 2007). The social work skills described here are those expected of social care practitioners in *Independence, well-being and choice*, which recognises that

people who use social care services say that the service is only as good as the person delivering it. They value social care practitioners who have a combination of the right human qualities as well as the necessary knowledge and skills. If we are to deliver our vision this means workers who are open, honest, warm, empathetic and respectful, who treat people using services with equity, are non-judgemental and challenge unfair discrimination. The workforce is therefore critical to delivery.

(DH 2005: 14)

In statutory settings, some social work roles have become restricted by their 'gate-keeping' function and some social workers see personalisation as an opportunity to 'do real social work' with people, rather than be constrained by bureaucratic processes. Research by The College of Social Work suggests that social workers are concerned that personalisation means an increase in bureaucracy and 'care management' but, if managed properly it

offers opportunities to move ... back to 'old fashioned' social work tasks such as assessment, intervention and community based work.

(Dunn 2012: 10)

Social workers will need to be empowered by their organisations in order to empower service users in turn. Therefore, organisational issues need to be considered and changes implemented which enhance relationship-based front-line working. People who use social care and support services have recognised the limitations social workers can face when working within the constrained rules and resources of organisations (Beresford 2007, Beresford et al. 2011). One of the current roles for social workers is to ration resources and identify priorities. While people who use services are clear that

having a different relationship with social care staff is an important part of what they are seeking

(Blewett et al. 2007: 28)

they have been equally clear that the

process of getting a service and the way in which it is delivered can have a major impact on users' experience of a service ... users did not perceive process as detached from outcome ...

(Shaping Our Lives National User Network et al. 2003: 2)

People have indicated that although having greater choice of services may be a good thing, there also needs to be an improvement in how current services and support are provided, including addressing issues concerning budgets, rationing and personal budget management, along with the impact this has on the quality of social work. The National Consumer Council (NCC) recommends that:

where greater choice cannot create new efficiencies of scale or cost reduction, policy makers should be open and transparent about rationing decisions.

(NCC 2004: 11)

Research is showing that frontline staff and managerial training and supervision is vital for the implementation of personalisation. It is needed in areas such as personal budgets (particularly where people receive a direct payment), managing change, improving knowledge, assessment, the promotion of equality and diversity awareness, and challenging perceptions about risk and capacity for certain groups (particularly older people and people with mental health problems or severe learning disabilities) who could benefit from the personal budget option (Carr and Robbins 2009; Carr 2010). One international research review on different personal budget schemes states that:

social services practitioners who are not only well-informed, but also communicate that information to potential recipients and share their aspirations for independent living are important in helping people to maximize their opportunities for choice through cash-for-care schemes.

(Arksey and Kemp 2008: 12)

It is particularly important to target training at front-line staff who will be working directly with service users and involved in the assessment and decision-making processes, along with the person's carers (Ellis 2007; Manthorpe et al. 2010). Successful personal budget schemes are emphasising and facilitating frontline working, with the same practitioner, which is person-centred and relationship based, rather than focusing on processes and technical aspects in an environment with a high staff turnover (Arksey and Kemp 2008; Bartlett 2009; Carr and Robbins 2009; Glendinning 2009; NHS Confederation 2009a; Ottmann et al. 2009; TLAP 2011a).

Social workers can also draw on their skills in counselling and community development to take forward personalisation. Here it is important to remember that personalisation is not only about personal budgets and self-directed support:

There ... is a danger that assisting people with self-directed support could become the only and overriding definition of the social work role. Social work also has a contribution to make through its counselling competencies ... and has a tradition and track-record of community development, stimulating and supporting local community resources for disabled and older people.

(Jones 2008: 46)

The final report of the Social Work Task Force, *Building a safe, confident future*, considers the context of personalisation in its recommendations for reform and recognises the need for the following.

- **Better training** – with employers, educators and the profession all taking their full share of responsibility for investing in the next generation and in enabling social workers already in practice to develop their skills continuously.
- **Improved working conditions** – with employers signing up to new standards for the support and supervision of their front-line workforce that make good practice possible.
- **Stronger leadership and independence** – with the profession taking more control over its own standards, how it is understood and valued by the public, and the contribution it makes to changes in policy and practice.
- **Confident, high quality, adaptable professionals** – who can build long-term careers on the front line.
- **Greater understanding** – among the general public, service users, other professionals and the media of the role and purpose of social work, the demands of the job and the contribution social workers make.
- **More use of research and continuing professional development** – to inform front-line practice.

(Adapted from Social Work Task Force 2009: 2)

Commentators have remarked that:

recruiting and retaining ... are important to the personalisation agenda because progress will be limited if there are insufficient workers with the right commitment, training and support to meet the unique needs of people who use social care services.

(Hudson and Henwood 2009: ii)

In order to address the need for the reaffirmation of some social work roles and change in others, the DH has produced an adult social care workforce strategy which, as the local authority circular states:

recognises that in developing a more personalised approach, it is essential that frontline staff, managers and other members of the workforce recognise the value of these changes, are actively engaged in designing and developing how it happens, and have the skills to deliver it.

(DH 2008a: 8)

The workforce strategy document, *Working to put people first* (DH 2009b) was produced in consultation with stakeholders and maps out six key priorities for the workforce to deliver personalised services in the future:

- the leadership of local employers in workforce planning whether in the public, private or third sectors and of directors of adult social services in their strategic commissioning role
- ensuring the right steps are taken to promote recruitment, retention and career pathways to provide many of the workforce's needs
- workforce remodelling and commissioning to achieve service transformation
- workforce development to produce the right people with the right skills
- more joint and integrated working between social, health care and other sectors
- regulation for quality in services as well as public assurance.

The document also emphasises the need for social work to support the major cultural changes implied by the principles and values of personalisation, such as choice and control, independent living, dignity and respect, equal citizenship, good health and quality of life. This means supporting the shift from:

- clients to citizens
- welfare to wellbeing
- expert to enabling
- transactional change to transformational change
- 'freedom from' to 'freedom to'
- safety net to springboard.

The College of Social Work has affirmed the importance of social work for achieving personalisation in adult social care, saying that it brings a holistic understanding allied to an ability to pose constructive challenge' (TCSW 2012b: 3).

The role of social care staff

Making the social care personalisation agenda a reality has implications not just for social workers but for all social care staff:

Increasingly the workforce cannot be described simply in terms of local authority or independent sector, but must also include personal assistants, carers, volunteers, advocates and brokers.

(Hudson and Henwood 2009: iv)

The personalisation agenda influences the way health and other professionals (such as occupational therapists and nurses) work in multi-disciplinary teams (e.g. community mental health teams). Increasingly people will make arrangements with private individuals to provide the support they need, and this will raise a range of issues about employment rights, pay, health and safety, and safeguarding. These issues already apply to people who make their own private arrangements for care in their own homes without recourse to public funding.

The Skills for Care New Types of Worker programme was set up in response to some of the key issues in order to explore what a new personalisation workforce would look like. The programme supported pilot sites in England and in 2007 over 300 organisations took part in a mapping exercise which, among other things, identified personalisation as a key

theme for workforce development. The result was the identification of a number of new types of role and organisational change.

- **Hybrid roles** – for example, social care workers or social workers doing tasks that have traditionally been carried out by other professionals in areas such as health, housing, justice, leisure and employment.
- **Person-centred working** – working in such a way that people who use services have as much control of their own lives as other people.
- **Experts by experience** – people who have experience of using social care services or caring for people and who contribute to the ‘business’ of social care.
- **Prevention and early intervention** – workers supporting people early enough or in the right way, so that they don’t require more intensive services, including adult safeguarding or hospitalisation.
- **Changes to organisations** – to make them more effective, efficient and productive – for example, enabling workers to get their qualifications more quickly, working in partnership with other organisations and professions, integrating internally or externally or commissioning differently.
- **Community support** – supporting community networks so that people can be independent from services.

(Adapted from Skills for Care 2007: 1–2)

The majority of those working in the sector are female, there are an increasing number of migrant workers in the field and staff turnover can be high (Experian 2007; Eborall and Griffiths 2008). Private sector employers argue that the pay and conditions of service they can offer their staff are constrained by what is affordable within the contract price set by public commissioners, and that policy expectations will not be delivered unless providers are funded realistically (ECCA 2008). Those planning, purchasing and providing personalised social care services need to be aware of the potential wider impact of certain associated workforce developments (Leece 2007).

UNISON, the union which represents staff in the social care sector, from PAs to social workers, has recommended that a strategy for sustaining the social care workforce needs to account for issues with migrant workers, pay and conditions and equal opportunities. UNISON also emphasises the need to make social care a desirable career choice, with apprenticeships and a training and career structure (Land and Himmelweit 2010). Research shows that initial and ongoing training for staff is vital for implementing personal budgets and personalisation:

training will remain a central issue when implementing personalised social care services and ... models of training for such changes should be shared and evaluated over the long term.

(Manthorpe et al. 2010: 319)

A report published by the Commission for Rural Communities states that:

the personalisation of social care will also have an effect on the social care workforce ... Some [participants] were optimistic that new employment opportunities would emerge and saw this as a way to sustain local economies and communities. Others foresaw greater instability and disadvantages for care workers. Local authorities need to manage these risks with partner organisations and local needs assessments.

(Manthorpe and Stephens 2008: 37)

Workers with experience of working with older people in some rural budget pilot sites say they are concerned about travelling to remote areas, and the often isolated nature of their work.

Practice example: independent living –Sense East’s supported living project, Norfolk

A young woman who is deaf-blind and has a complex syndrome with a deteriorating effect on both her mobility and intellect was identified as needing support by the outreach team. Her home life was becoming isolated and her ageing parents were struggling to cope.

A supported living project was set up to enable the young woman to live independently in the community. The complex care team consulted her and her parents about what sort of housing would best suit her needs and preferences. The young woman decided on a town location and wanted a one-bedroom ground-floor flat with no garden. The young woman, her parents and Sense then explored what level of support she needed and how this would take place, and a funding package was set with the local authority. The package was awarded to Sense with the full support of the young woman and her family.

The young woman then participated in the selection of her team and they supported her in equipping the flat, with parental input as she directed. She has a personal finance plan and is involved in planning her daytime activities. Her evening funding is such that she has a staff team to take her anywhere she chooses.

For home care workers, personalisation means rethinking some of their traditional task-centred personal care roles. This could include a wider range of support such as domestic help, household management and correspondence, home maintenance and gardening, or even being taken out. Care workers could be trained by agencies to widen their support skills (Sawyer 2008). The Social Policy Research Unit (SPRU) found that personalisation, particularly personal budgets, offers:

new opportunities for [home care] agencies, including opening up new markets and demands for new types of support, such as help with shopping and social activities.
(Baxter et al. 2008: 1)

Skills for Health has looked at new professional career development and progression opportunities for independent care home staff to provide new levels of personalised care. This is being designed to enhance staff flexibility and aims to reduce staff turnover and

improve continuity of care and relationships with people living in care homes as well as their families and carers (Skills for Health 2008).

At a strategic level, the DH has stated that:

the personalisation agenda will entail more sophisticated workforce planning which makes explicit links with other sectors. Such workforce planning must maximise opportunities for strategic market development, bring together skills across different professional groups, identify different ways of working and spell out the changing requirements within professional roles.

(DH 2008b: 18)

Capable, confident, skilled (Skills for Care 2011a) is the Skills for Care workforce development strategy for adult social care, designed to support sustainable personalisation and community development in an environment with increasingly diverse providers. The document details the following range of skills needed by the adult social care workforce for implementing personalisation:

- supporting self-assessment and person-centred planning with an emphasis on self-directed care, health promotion, and growing and sustaining circles of support
- supporting risk-taking, and helping to manage and minimise harm that may prevent people directing their own lives
- outcomes-based and outcomes-driven practice
- protecting, where service users are deemed not to have the capacity themselves
- providing information, advice, advocacy, brokerage and guidance
- providing personalised social care services, in people's own homes and in residential and other settings, that respect people's dignity, choice and self-direction
- providing care and support with flexibility and understanding in ways that reflect the circumstances, religion, cultural background and lifestyle of the service user
- enabling employment, education, training and other valued activities
- supporting service users who are or who wish to become employers to acquire the organisational capabilities to manage their own care and support, including providing reliable information and advice about employment law and practice
- recognising the value of the expertise and contributions of service users, and involving them from the outset in designing local care provision, influencing commissioning and planning their own care
- creating capacity and confidence among service users to lead, manage and work in social care and other organisations
- community capacity-building
- engaging service users in developing strong local communities, enabling them to have a family and community life
- facilitating people's participation in governance, commissioning, training and quality assurance of social care services.

(Adapted from Skills for Care 2011a: 14)

The Skills for *Care Common Induction Standards* for social care workers include some important outcomes relevant to personalisation as part of workplace-specific requirements such as person-centred support and equality and inclusion (Skills for Care 2010). This means that personalisation, person-centred working and supporting participation and self-

determination should be embedded in staff training. Standard 7 outlines the main areas and outcomes for person-centred support, with the key areas being:

1. Promoting person-centred values in everyday work.
2. Working in a person-centred way.
3. Recognising possible signs of dementia.
4. Supporting active participation.
5. Supporting an individual's rights to make choices.
6. Promoting spiritual and emotional wellbeing.

(Adapted from Skills for Care 2010: 11–13)

To support personalisation and address the need for improved local workforce strategies, Skills for Care and ADASS have developed Integrated Local Area Workforce Strategies (InLAWS) to help with detailed local labour market assessment and appraisal. The idea is to develop local strategies that ensure:

the right workforce doing the right things at an achievable cost [with a] set of processes that assist [directors of adult social services] and satisfy the needs of citizens.

(Skills for Care/ADASS 2010: 2)

Although Scotland is developing personalisation in adult social care in a distinct way, the principles of person-centred working remain the same. Research from there on the workforce implications of personalisation for social care workers in the voluntary sector has found that:

frontline voluntary sector workers face ... demands on their time through calls for enhanced decision making, dealing with taking on the tasks of other professionals, community building and risk enablement skills.

(Cunningham et al. 2010: 21)

The research highlights the following key areas of development activity:

- increasing involvement of service users in recruitment to match new employees with their interests
- sensitising training programmes to the principles of personalisation
- developing performance management systems focused on notions of customer satisfaction
- adopting a risk enablement approach to health and safety.

(Adapted from Cunningham et al. 2010: 21)

The Association of Chief Executives of Voluntary Organisations (ACEVO) has emphasised the importance of developing a person-centred workforce, and has said that:

Organisations must ensure they have a set of core competencies, skills and behaviours that all staff must adopt and adhere to. These should be flexible and readily adaptable to the needs of service-users. These may include:

- an understanding of 'person-centred', informed risk

- an ability to be aspirational for service-users
- proactiveness
- a basic level of IT, numeracy, literacy and communication skills
- commitment to flexible working.

(ACEVO 2010a: 13)

The role of personal assistants

For people using personal budgets, particularly taken as a direct payment and potentially using their own private funds to buy their support, PAs have become an increasingly important choice. A study commissioned by Skills for Care found that 79 per cent of direct payment users were very satisfied with the support they received from their directly employed PA, compared with 26 per cent who had been very satisfied with services supplied directly by the local authority. The study also showed that 95 per cent of PAs 'love their work', 64 per cent were happy in their current role and many valued the flexible hours of the job (IFF Research 2008). While this suggests that the direct payments system is working well for direct payment employers and PAs on an individual basis, the study also raises wider questions about the workforce such as pay, terms and conditions, training, registration and market capacity. These questions should be addressed ahead of the planned increase in personal budgets.

It has been argued that people employing workers using direct payments (or personal budgets):

need to be able to offer reasonable terms and conditions of employment to attract employees, and these workers deserve to be paid a fair wage ... [so that] user-controlled support does not founder on the inability of users to recruit and retain their personal assistants.

(Leece 2007: 194–195)

The DH and Skills for Care have focused on supporting the development of the PA workforce. The DH has issued a framework for supporting PAs working in adult social care with the following three broad aims:

- to support future growth of the PA workforce and their employers
- to address challenges to the development of PA working
- to share best practice examples of personalised care provision by PAs and of support for employers.

(DH 2011a: 8)

The framework brings together a sector-led action plan for PA workforce development with the following points:

- better understanding of PA working
- recruitment and retention
- learning and development
- supporting PAs and employers
- enabling risk management.

(DH 2011a: 6–7)

As part of the New Types of Worker programme, Skills for Care has identified some of the factors disabled people feel are important in their relationships with PAs and support workers:

- flexibility
- boundaries
- adaptability
- motivation and self-esteem
- gender and sexuality
- culture
- trust
- privacy
- values and attitudes
- enabling people to have control
- active listening
- using personal mobile phones
- being friends.

(Skills for Care 2011b: 4)

Skills for Care also identifies the following issues as being important for commissioners, providers, workforce leaders and direct employers.

- Often the focus of commissioners and providers is on supporting employers to work within the legal framework. However, the management skills required by direct employers are overlooked, causing stress to the individual employers and their PAs.
- Providing the right support to direct employers to establish effective relationships from the start and quickly address problems can be cost-effective, since the costs of a breakdown include health and wellbeing as well as financial and employment difficulties for both the employer and the employee.
- Regular peer support enables direct employers to discuss options when issues arise with their PAs.
- New employers need to be enabled to think clearly about what they are looking for from a PA before they interview.
- Potential PAs need to have a better understanding of what qualities may be required of themselves.
- Any training for PA employers (e.g. direct payment users) must be developed in partnership with disabled people living in the area in order to ensure that there is empathy and understanding of the importance of maintaining good working relationships.
- Short joint courses that benefit both the employer and the PA are a useful way of enabling shared learning.

(Adapted from Skills for Care 2011b: 1–2)

Other research on developing PAs in the adult social care workforce from the North East Regional Efficiency and Improvement Partnership has highlighted the role of ULOs in supporting direct employers and PAs, and revealed some models of the type of relationship that may exist:

- the employer might employ a PA direct – in this case they would be taking on all the responsibilities of being an employer
- someone else (e.g. a partner or sibling) might employ a PA on behalf of an employer – in this case there might be third-party issues and liabilities
- the employer might contract with an agency which employs PAs – in this case they would have minimal responsibility as an employer, but the service would need to conform to the underlying principles of personalisation (i.e. giving the employer a choice of PA and service)
- the local authority might contract with a private company or social enterprise to provide the service, following an individual assessment of needs and an agreed package of care; the service would need to conform to the underlying principles of personalisation.

(Adapted from Fletcher et al. 2011: 57)

Skills for Care has also identified the important role that ULOs play in supporting individual employers when employing their PAs, and has developed a range of resources to support ULOs in achieving this (Skills for Care/Coalition for Independent Living 2011).

UNISON (2011: 4) has expressed concern about a lack of training in employment and safety law among PA employers and has focused on organising support for PAs. They suggest that ULOs could have a role to play in developing a PA network, 'along the lines of Unison's partnership working with the Scottish Personal Assistance Employers Network (SPAEN) (Land and Himmelweit 2010: 54).

Skills for Care and Skills for Health have indicated some of the different ways of working for PAs in their seven Common Core Principles, which were developed in partnership with service users and carers (Skills for Care/Skills for Health 2008). These can be used to help people develop practical solutions to working as a PA. The Principles are as follows.

1. Ensure individuals are able to make informed choices to manage their self-care needs.
2. Communicate effectively to enable individuals to assess their needs, and develop and gain confidence to self-care.
3. Support and enable individuals to access appropriate information to manage their self-care needs.
4. Support and enable individuals to develop skills in self-care.
5. Support and enable individuals to use technology to support self-care.
6. Advise individuals how to access support networks and participate in the planning, development and evaluation of services
7. Support and enable risk management and risk-taking to maximise independence and choice.

The principles were developed in partnership with people who use services and carers. PAs can use the principles to work with the person they are supporting, develop job descriptions and to agree individual learning plans.

The role of leaders and managers

It has been noted that:

the transformation agenda has direct implications for leadership and management. The new vision demands additional skills and competencies from commissioners, managers and senior leaders. Transforming leaders will be expected to create the conditions for others to transform realities, to galvanise innovators and to inspire, communicate and operationalise the new vision.

(Hudson and Henwood 2009: ii)

The Adult Social Care Workforce Strategy is very clear about the need for good leadership, effective management and commissioning skills, so that change is well facilitated and services can be transformed:

New cadres of leadership talent need to be planned and fostered in both the independent and public sectors. User-led organisations and networks will grow and provide strong voices ... Directors of Adult Social Services [have] a pivotal role in leading workforce change locally through their responsibility for strategic workforce commissioning, working with local employers.

(DH 2009b: 5)

The Strategy outlines the need for new types of leadership at all levels, including the front line, and suggests (p 22) that leaders need to:

- look to people who use services and their communities
- be skilled at collaboration across systems and boundaries
- work well within complex systems
- be developed at all levels of the organisation
- keep in direct contact with frontline services as their careers develop.

Evidence is beginning to show that transformation of adult social care and social work for personalisation requires leadership for managing and delivering change:

effective leadership should be able to take traditional organisational forms and transform them to meet new and emerging requirements such as personalisation and spending pressures.

(Hawkins 2011: 55)

The Strategy is clear that:

leadership is not exclusive to top managers, but is required, and needs to be promoted, at all levels in organisations and communities.

(Skills for Care 2011a: 29)

In order to assess the implications of personalisation for the NHS, the NHS Confederation surveyed the opinions of social care and health leaders who had experience of implementing it, in particular personal budgets. Five main lessons emerged from the research.

1. Creating the supporting culture is a far bigger challenge than developing the mechanism.
2. Collecting stories of how personal budgets have impacted people's lives is an important tool in building momentum.
3. Voluntary organisations are as vital as providers, trainers and advocates.
4. A coordinated local approach to personalisation, with agreement both across and beyond health and social care, is important.
5. The risks of such a new system can never be completely eliminated; at some point local leaders will have to display courage.

(NHS Confederation 2009a: 2)

In a report on leadership for personalisation and social inclusion in mental health, the authors state that:

leadership challenges include driving a values-led service and systems transformation, whole-system workforce reform and a need for sustained and cultural change within and across organisations.

(Allen et al. 2009: vi)

The sort of leadership needed to bring about the type of transformation required for personalisation is seen as being very different from the managerial, 'command and control' model, focused on one person at the top. The National Skills Academy for Social Care, which supports training, development and career support in adult social care in England, is developing a leadership and management programme to strengthen the workforce in this area (National Skills Academy for Social Care 2009), and Skills for Care has produced some principles of workforce redesign for leaders and managers. After research and consultation, Skills for Care distilled seven principles to address the challenges of personalisation.

1. Take a whole systems view of organisational change.
2. Recognise how people, organisations and partnerships respond differently to change.
3. Nurture champions, innovators and leaders.
4. Engage people in the process – acknowledge and value their experience.
5. Be aware of the ways adults learn.
6. Change minds and change systems.
7. Develop workforce strategies that support transformation and recognise the shape of resources available in the local community.

(Thomas and Balman 2008)

Skills for Care launched its Manager Induction Standards in 2008 to reflect the new skills and professional environment needed for personalisation and social care transformation. The Standards are based on management practice with person-centred planning at its core, and are as follows.

1. **Understanding the importance of promoting social care principles and values** – these underpin good leadership.
2. **Providing direction and facilitating change** – including understanding role, responsibility, accountability and the social and environmental contexts in which the organisation operates.

3. **Working with people** – developing team and individual performance through good supervision, recruitment and induction, training and communication.
4. **Using resources** – understanding responsibilities for finance, contracts, buildings and technology.
5. **Achieving outcomes** – delivering a quality, person-centred service and understanding responsibility for partnership working, information sharing and change management.
6. **Managing self and personal skills** – taking responsibility for continuing professional development, leadership and management skills.

(Skills for Care 2008)

The Standards have been refreshed to account for further changes under personalisation and emphasise relationship-centred care and support as the main approach. The responsibilities of managers are outlined:

Managers must develop and maintain services which are person-centred, seamless and proactive. They should support independence, not dependence and allow everyone to enjoy a good quality of life, including the ability to contribute fully to their whole communities and neighbourhoods. They should treat people with respect and dignity and support them in overcoming barriers to inclusion.

(Skills for Care 2012: 2)

These responsibilities are built into 'Manager Induction Standard 4', and three key areas are:

1. Understand the principles that underpin outcomes-based and person-centred practice.
2. Understand how to lead outcomes-based and person-centred practice.
3. Understand positive risk-taking in the context of person-centred and outcomes-based practice.

The importance of leadership for change management in the voluntary sector has been emphasised by ACEVO and a number of provisional practical measures to support change towards personalised services are outlined:

- being clear about what personalisation means, so that everyone involved has a shared understanding of its values and implications
- developing an explicit 'personalisation vision statement' with service users, carers, families, staff and advocates to outline what a personalised service would look like and how it would work
- encouraging staff to review their roles and approach to service delivery in the light of the agreed vision statement, identifying what areas need to change
- reviewing how service users and their supporters are involved in staff recruitment, deployment and wider decision-making about service operation
- ensuring all staff development is underpinned by the principles of personalisation
- ensuring management systems and financial processes reinforce personalisation through person-centred planning, quality monitoring and back office functions
- developing outcome-driven service improvement plans based on user feedback with clear targets.

(ACEVO 2010a: 24–25)

Voluntary and community organisations

Voluntary and community providers include organisations that:

- are independent of the government
- work to achieve social, environmental and cultural aims
- mainly reinvest any profits they make to achieve those social, environmental or cultural aims.

The sector includes community groups, co-operatives and mutuals, ULOs, voluntary groups, charities and social enterprises (HM Treasury 2007: 1). The New Labour government stated that:

the government should support the development of the many new and innovative services that provide tailored advice to specific community interest groups.
(Prime Minister's Strategy Unit 2007: 42)

While Putting People First made it clear that a crucial part of developing personalised services is supporting voluntary and community sector innovation, including social enterprise, New Labour's *Independence, well-being and choice* said that:

local partners will need to recognise the diversity of their local population and ensure that there is a range of services, which meet the needs of all members of the local community.
(DH 2005: 12)

In 2007, the Treasury issued its plans for the future role of the community and voluntary sector in social and economic regeneration. It stressed the need for capacity-building and investment in the sector, which is seen as vital in transforming public services. The subsequent coalition government's Open Public Services agenda is informed by personalisation and is based on the following five principles:

- choice and control – wherever possible we will increase choice
- decentralisation – power should be decentralised to the lowest appropriate level
- diversity – public services should be open to a range of providers
- fairness – we will ensure fair access to public services
- accountability – public services should be accountable to users and taxpayers.

(HM Government 2011c)

The development of 'micro-markets' of very small providers and ULOs, which offer peer support, information, advocacy and advice as well as sometimes providing services, is important for making choice and control a reality in adult social care (NAAPS/DH 2009a; DH 2010b). A 'social enterprise' is defined as:

a business that reinvests its surplus primarily back into the business for the interest of the community rather than working to make a profit for the benefit of shareholders alone.

(Lorimer 2008: 12)

Such social enterprises are emerging as business models for smaller, local not-for-profit social care and support providers. The Institute of Public Care (IPC) has identified some of the distinctive contributions of the not-for-profit sector in social care, such as innovation and value, including social value and community development (IPC 2012). It has been argued that people with support needs should be enabled to set up social enterprises, such as micro-providers, which increase social value and promote choice (Community Catalysts 2011), and local authority commissioners are being encouraged to understand social value in the commissioning cycle, with particular reference to social return on investment (LGA/SROI Network 2012).

Practice example: personalisation in a residential setting – Anchor Homes’ food ordering system

Anchor Homes is the largest not-for-profit provider of residential and nursing care for older people in England. In 2006 it began piloting a new meal ordering system in its care homes. Previously residents had to order their food a day or more in advance, as was the case in most care homes. However, under the new system residents are able to choose what they want as they sit down to eat – they can choose based on seeing and smelling the food.

This more personalised approach to mealtimes means that staff don’t have to spend hours collecting food orders in advance and are freer to provide care and support. Residents are now making decisions based on what they like the look and smell of, they are eating more, they are more adventurous in their food choices and less is wasted. Any savings go back into buying even better food. The chefs regularly hold meetings and obtain feedback from residents on meal choices and are guided by residents’ requests and favourite recipes. If what’s on offer doesn’t appeal to someone, chef managers can still make a simple alternative if that’s what the individual would prefer.

Clearly the voluntary and community sector has a key part to play in the personalisation of social care services, having the potential to offer a wider choice of specific or specialist services, particularly for people from minority groups who have been historically under-served by generic statutory agencies. The National Council for Voluntary Organisations (NCVO) has been very clear about the important role the voluntary and community sector has to play, not only in providing unique, personalised services for individuals, but in building local and community resources for the benefit and wellbeing of all. It asserts that:

operating at the frontline, VCOs [voluntary and community organisations] are often highly aware of local need and can identify gaps in provision and meet the shortfalls.

(Harlock 2009: 7)

Strategic engagement with this sector may help to address some of the issues with service provision and local diversity in certain areas (Harlock 2009).

The ACEVO Commission on Personalisation is looking at how to radically shape new social markets across all the main public service areas, including social care:

We propose social markets that exist within a new legal framework of roles, rights and responsibilities – a new social contract.

(ACEVO 2009: 5).

The Commission has outlined four key building blocks for the future.

- **Devolving financial control** – control over how money is spent on services should be devolved down to a level as close as possible to the service user.
- **Self-help and mutual aid (co-production)** – the ‘service-centric’ model of ‘public services’ should be turned inside-out, with self-help and mutual aid (in other words, community) placed firmly at its heart. People should be seen not as ‘service users’ but as ‘service helpers’ and agents for change.
- **Building ‘can do’ assets** – personalisation should inspire a revolution on the supply side of public services that sees far-reaching culture change throughout the system, frees up public service professionals and creates an environment in which innovation flourishes.
- **Social markets** – a new generation of genuine social markets should be created, in which power shifts from commissioners and providers to service users, and in which good performance is rewarded and invested in, and poor performance is driven out.

(Adapted from ACEVO 2009: 5)

A Demos report has suggested positive impacts for the voluntary and community sector from the increased use of personal budgets in social care, particularly as much of the innovation, advocacy and campaigning which resulted in the current wider social care reform had its roots in the work of social enterprise and voluntary organisations (Bartlett and Leadbeater 2008). However, the authors warn that as the social care market develops, traditional voluntary and community sector organisations will need to be mindful of the need to adapt and compete:

Although the third sector has the right value base to thrive in a world of personal budgets, they might not always be as good at competing in the market – which may require branding, marketing and customer relationship management – as private sector providers.

(Bartlett and Leadbeater 2008: 5)

As personalisation has progressed, the implications for and role of the voluntary and community sector has become clearer:

- supporting choice so that service users understand their own particular needs and the options available to them
- providing different services that respond to the needs of individual purchasers rather than generic frameworks specified by local authorities
- providing services differently so that users become ‘consumers’ whose ‘business’ must be won in an increasingly competitive market.

(Harlock 2010 in Dayson 2011: 99)

The NCVO has outlined some of the key roles for voluntary and community sector organisations in taking personalisation forward (Harlock 2009: 9):

- building user-focused and responsive services that reflect the needs and wishes of local people
- developing a skilled and person-centred workforce able to respond flexibly to user needs and preferences
- adapting systems and processes to meet the requirements of micro-commissioning and purchasing through self-directed funding mechanisms
- helping users to understand and access information on services available and plan for their support
- working with commissioners to give a voice to service users' needs and shape the provision of personalised services.

The challenge of personalisation for the voluntary sector has been described as:

more than just a change in the way services are *funded* but a step-change in the way they are *designed and delivered*.

(Dayson 2010: 8)

Research into the implications of the personalisation agenda for the voluntary sector has identified a number of key practice issues, where providers need to:

- have a good understanding of the groups they are aiming to deliver services for and their associated wants and needs
- have a good understanding of their individual services
- understand the mechanisms to bring about personalisation and their potential impact on the financing of public services
- understand that reduction in block contracting will mean voluntary sector providers will need to market their services in a different way to a different audience
- think carefully about how they might effectively secure the 'user voice' in their organisations
- forge close relationships with a range of public and other voluntary sector partners.

(Adapted from Dickinson and Glasby 2010: 22)

Although they may be at different stages of preparedness, many providers in the voluntary and community sector see the personalisation agenda as being consistent with their aims and values (Dayson 2010; Dickinson and Glasby 2010). Research shows that they see the potential of personalisation for delivering better quality services and for more collaborative approaches with other voluntary sector providers (Dayson 2010). The Yorkshire and Humber Joint Improvement Partnership (JIP) has informed thinking about the implications of personalisation for the voluntary sector's contribution to adult social care.

- **Personal budgets and direct payments** – voluntary sector organisations have a role to play in expanding the market and providing support brokerage and planning services.
- **A change in local authority role** – from purchaser and commissioner to facilitator of the market, guaranteeing availability of choice.

- **Adding value** – voluntary organisations can offer reduced delivery costs and overheads and can be more efficient and flexible in their responses.
- **Galvanising volunteers** – particularly the voluntary activity of older and disabled people.
- **Galvanising communities** – changing attitudes in communities where people feel responsible for their neighbourhoods and the people who live there.

(Adapted from IPC 2011a: 5)

The progress of personalisation in adult social care has meant that a large number of voluntary sector providers and ‘non-traditional approaches and enterprises’ (Fox 2012: 20) have entered the market. In terms of provider self-definition, some organisations may not regard themselves as being social care organisations, and yet still deliver services that offer social care benefit (IPC 2011a: 3). This highlights the voluntary and community sector’s pivotal role in personalisation’s wider aim to build community capacity as well as create more personalised care and support services. However, there is also concern about the effects of public sector funding cuts on the sector which may compromise people’s ability to choose from a diverse range of providers and the wider local capacity-building agenda to support personalisation (Patterson 2010; VODG/IPC 2010; Wood et al. 2011; Fox 2012). As the Voluntary Organisations Disability Group (VODG) has argued: ‘squeezing price or sudden cuts are not always compatible with quality and choice’ (VODG/IPC 2010: 3).

Commissioners are being urged to understand more clearly the wider value for money that voluntary and community sector providers can bring:

what is important is that additional value is quantifiable and framed in terms of what benefits or outcomes can be delivered at the given price.

(IPC 2011: 4)

Evidence suggests that the voluntary sector can help deliver both personalisation and efficiencies, provided the following factors are attended to.

- **Improving knowledge** – voluntary groups may have links to the community that cast light on how best to meet the needs of particular user groups.
- **Changing commissioner–provider relationships** – successful service transformation and efficiency savings depend on commissioners and providers working together.
- **Getting personalisation right** – personal budgets are only the start. The culture of social services has to change too, providing an infrastructure of support, market development and new styles of commissioning. Some of the more innovative providers may need additional support.
- **Demonstrating efficiencies** – the most cost-effective models of service delivery are often found when commissioners, service users and providers work together to share their expertise. Some cost efficiencies require time, and occasionally investment, to materialise but are the more sustainable in consequence.

(Adapted from VODG/IPC 2010: 3–4)

The Yorkshire and Humber JIP shows the value of outcome-based commissioning for voluntary sector organisations. It recommends using an investment funding model based on improving prevention (IPC 2011). Research shows that despite the capacity of the

voluntary sector to deliver cost-effective services, the commissioning and procurement process can make it difficult for organisations to tender and can compromise their responsiveness to local needs (Macmillan 2010). Smaller local voluntary and community sector organisations, along with micro-providers and ULOs, need access to business advice and support (NAAPS/DH 2009a; Patterson 2010; Bennett and Stockton 2012).

One particular area of provision that has the potential to be delivered through social enterprise is brokerage, information and advocacy services for people using personal budgets or direct payments:

Personalisation support services facilitated by social enterprise are a valuable area for consideration, while commissioners may take longer to establish agreed strategic needs that will drive the shape of a wider, mixed economy of care.

(Lorimer 2008: 16)

The DH and key partners in the social care transformation agenda have stated that access to information, advice and advocacy is essential for all adults who need social care and support (together with their carers, families and friends). The DH recognises the role of the voluntary and community sector in providing this essential service infrastructure, particularly ULOs (IDeA 2009).

There is an emerging role for 'local infrastructure organisations' which act as a mediating link between voluntary and public sector organisations. This is particularly important for building capacity and improving the engagement of smaller local community organisations serving marginalised people, such as those from BME communities (Dayson 2010). Research suggests that local organisations could play the following roles in implementing personalisation:

- facilitating improvement in the external environment in which personalisation is being developed
- building the capacity of frontline voluntary organisations to respond to personalisation
- developing a more strategic approach to local infrastructure organisation activity in support of both of the above.

(Dayson 2011: 103)

Private sector providers

Many adult social care staff are employed by the private and owners, managers and staff in the private sector have a crucial role to play in developing personalised solutions to people who use their services. Commissioners will be looking to procure different types of service from different sorts of provider. The aim is to foster greater choice and more flexible, responsive services in order to provide a more personalised service in both community and residential settings.

For people in need of care and support, choice is only possible if the services (including residential and nursing care homes) they want to purchase are readily available, of good quality and have spare capacity to respond to choice. Local markets in many locations, particularly rural areas, still provide only limited choice. Thus local authorities have been asked to develop and shape the market to ensure sufficient provision for enabling choice.

This means reforming how services are commissioned and procured (Bennett 2008). There is also the question of:

how to ensure that greater choice for users stimulates innovation and quality in what providers deliver, rather than increasing financial risk to a level where they cease to be viable, potentially leading to the contraction of the market (and therefore of choice).

(Sitra 2009: 8)

To develop services that are focused on the person, and are competitive within a social care market geared towards personalisation, private sector providers can learn from what their customers (including older people living in residential care or nursing home settings) are saying and what the personalisation policy seeks to achieve. As Bartlett and Leadbeater (2008: 18) note:

While the private sector care services offer more flexible hours, its services can also be too impersonal. Care depends on intimacy and relationships – it is not just a transaction, but a relationship of trust between carer and cared for. The contracted out care services market often fails to deliver such relationships, for example it has a very high staff turnover, which it consistently complains about.

So private providers need to ask whether they are able to respond to the demand for individually tailored services based on good, stable relationships between staff and service users. Equally, local authorities should work with providers to help in predicting how the market might change and to encourage innovation (Manthorpe and Stephens 2008). A new, more trusting relationship is required between commissioner and provider. This should be based on achieving the right outcomes for the individual, their carers and community, rather than financial concerns:

at present service providers are kept at arm's length from the detailed planning process, because they are perceived as tending to drive up costs in order to meet their own needs.

(Bartlett and Leadbeater 2008: 28)

However, it has been recommended that:

dialogue between providers and commissioners must always reflect and be driven by what is best in the interests of people and communities.

(Harlock 2009: 12)

The emerging evidence on the implementation of personalisation for private sector providers suggests that:

Many providers may continue to provide the same services, but delivered within the cultural framework of person-centred care. Staff training and a re-evaluation of organisational values may be crucial in order to work for outcomes ... Many providers have reported that they see personalisation as an opportunity to increase and encourage quality services, engage staff, work collaboratively and provide new and more flexible services.

(Patterson 2010: 218–219)

Research into the workforce implications of personal budgets for social care providers has shown that providers are concerned about:

potential loss of financial stability and subsequent opportunities to plan staff recruitment, training and capacity to provide a range of support for personal budget users.

(Baxter et al. 2011a: 62)

A particular concern of many home care agencies was that they believed that they and the holders of personal budgets were 'competing for care workers under different rules' (Baxter et al. 2011a: 63), with the training and regulatory framework for agencies being seen as a barrier to recruiting workers who did not wish to be formally trained in a similar way to PAs employed directly by individual budget holders. The United Kingdom Homecare Association (UKHCA) has also expressed concern over the 'increasing regulation of the homecare worker' while directly employed PAs remain unregulated (Angel 2010: 232).

Some of the challenges for private sector providers are becoming clearer, with commissioning practice being one of the biggest:

care providers cannot deliver on the personalisation agenda in isolation. Commissioners need to understand and act on their duty to work in partnership with the care sector, and the Care Quality Commission needs to centre its new regulatory regime on the outcomes of service users.

(Patterson 2010: 220)

Private sector providers are calling for an increase in engagement with local authorities because:

insufficient access to local authority market intelligence creates uncertainty among providers about where to concentrate resources.

(Patterson 2010: 220)

They want commissioners to 'include providers as much as possible in their personalisation planning meetings and recognise that work with providers is vital to shaping and building the social care market (Patterson 2010: 221–222). UKHCA has identified some of the following issues about commissioning practice as personalisation is being implemented in a time of greatly reduced spending:

- tenders for new and established business being awarded between substantially fewer providers
- a tendency to award high-volume contracts to large corporate providers, rather than small and medium sized enterprises
- local authorities requiring providers to commit to a maximum charge to self directing users, often capped at the price currently received for high-volume contracts.

(Angel 2010: 231)

Such commissioning practice has implications for market development and diversification, particularly if small and medium sized providers are unable to compete and personal

budget rates may in some cases be too low to purchase support from a regulated agency, thereby potentially restricting choice (Angel 2010; Baxter et al. 2011a).

It has been recommended that private providers see individuals as well as local authorities as the main purchasers of social care (Baxter et al. 2011a, 2011b). It is becoming clearer that providers can benefit from dealing more directly with service users because this can allow for more flexibility than a local authority service-level agreement and because:

the best way to know what services people want is by asking them, because they have the solutions. Sometimes providers may be surprised that small changes to services make the biggest difference to people's lives and sometimes service users' requests will be challenging, requiring very creative and flexible responses.

(Patterson 2010: 224).

Flexible, self-directed or person-centred support is important for residential care home providers (Wood 2010b). The National Care Forum (NCF) has stated that:

In care home settings person-centred and relationship-centred care should be at the heart of the service offered ... Capturing the person's view of their experience, and using that information to continually improve is an integral part of how a care home should operate. It was described ... as a 'concentration on the small things of everyday life'. This requires attention to detail on the part of staff, including understanding each person's life history.

(Kelly 2011: 300–301)

The English Community Care Association (ECCA) has been clear that

knowing service users makes it a lot easier to understand their needs and behaviour, particularly for those service users with communication difficulties and complex conditions such as dementia.

(Patterson 2010: 225)

It also recommends that care home providers consider how their organisation can 'become part of the wider community, rather than operating in isolation' (Patterson 2010: 225), while the NCF believes that 'care homes have the potential to be used as community resources', with residents who still have things to offer to their local community (Kelly 2011: 301).

The My Home Life (MHL) movement offers a framework for improving personalisation and quality of life for older people in residential care homes using the following themes (Owen and NCHRDF 2006):

- managing transitions
- maintaining identity
- creating community
- shared decision-making
- improving health and health care
- supporting good end of life care
- keeping the workforce fit for purpose
- promoting a positive culture.

The work of the MHL programme in developing resources and a practice network to support care homes has its focus on the quality of life of residents. The personalised care and support necessary to put this into routine practice means seeing the 'community' of a care home as consisting of those visiting and working there as well as those living there. The ECCA has produced a case-study based 'route map' to the delivery of personalised care for independent sector providers of both residential and community based care as well as support services for all people who use social care (ECCA 2010).

User-led organisations

Collective approaches

Service users consistently emphasise the need for collective user-led and peer support organisations based on the fundamental principles of:

the social model of disability and the philosophy of independent living developed by service users themselves.

(Beresford and Hasler 2009: 56)

It is important to recognise that personalisation is not about individual solutions per se but represents a broader, more varied approach. The potential for personalisation to encompass collective ways of working has been articulated by Iain Ferguson, who suggests that personalisation requires:

the development and strengthening of *collective* organisation both amongst those who use services and amongst those who provide them. One of the most exciting and challenging developments in social work and social care over the past 20 years – Independent Living Centres advocacy schemes, new models of crisis services and, above all, social models of disability and mental health – have emerged out of the collective experience and organisation of service users.

(Ferguson 2007: 401)

In relation to discussion about personalisation, individualism and community, it has been noted that:

it must be recognised that service users are not isolated individuals but are part of a larger community or public. This collectivism is crucial to the concept and nature of public services, which must meet and balance both the collective needs of the community and those of individuals.

(Harlock 2009: 6)

Practice example: a user-led organisation – Essex Coalition of Disabled People

The Essex Coalition of Disabled People (ECDP) is an organisation run by and for disabled people, including people with mental health problems. Established in 1995, its origins are firmly rooted in a belief that the voice of disabled people, both as individuals and collectively, is vital. ECDP's vision is to enhance the everyday lives of disabled people in Essex and beyond. It does this in a variety of ways. For example, it provides a wide range of support, information, advice and guidance services – providing direct payment and personal budget support services to just over 3,500 people. A new independent support planning service run by ECDP enables people to have choice and control over their care

and support, with everyone who uses this service taking some form of cash payment. ECDP also provides a range of disability equality-based training for individuals and organisations in the public, private and voluntary sectors, alongside a CRB administrative service that processed over 500 CRBs from February 2009 to February 2010.

In total, ECDP has over 1,500 members and just under 70 volunteers, all of whom are closely engaged with ECDP to ensure its work, and so the work of public bodies, is based on the lived experience and voice of disabled people. More details about ECDP can be found on their website: <http://www.ecdp.org.uk>.

Some have argued that highly individualised approaches may undermine collective social care initiatives and opportunities for developing co-operative organisations led by those using services, or peer advocacy (Scourfield 2007). One report concerning the implementation of self-directed support and personal budgets identified the loss of collectivism as an ideological obstacle to reform. The Institute for Public Policy Research (IPPR) has stated that individual choice is best supported by:

having forms of collective voice and influence, peer support and accountability of providers to users ... [but] routes for collective influence are currently lacking, as are spaces in which to engage with and support each other.

(IPPR 2008: 5)

However, the NEF argues that:

personal budgets without mutual support misunderstand the nature of public services.

(NEF 2008: 15)

Similarly, the NCVO has asserted that:

user-led initiatives and mutual organisations can offer users more market power by jointly commissioning and managing services. They can also ... promote networks of support which are essential to wellbeing.

(Harlock 2009: 6)

The IPPR has recommended that:

mechanisms for exercising collective voice should be focused on larger and more significant decisions and priority-setting exercises, and be better resourced.

(Brooks 2007: 9)

Putting People First has made it clear that as part of system-wide transformation there should be:

support for at least one local user led organisation and mainstream mechanisms to develop networks which ensure people using services and their families have a collective voice, influencing policy and provision.

(HM Government 2007: 4)

As part of this commitment the New Labour government published an advisory document, *Putting people first: working together with user-led organisations* (HM Government 2009). Developed in partnership with people who use services and others, it outlines the benefits that local authorities and their residents enjoy when they work with ULOs. These benefits range from helping local authorities deliver greater personalisation to improved engagement with seldom-heard population groups.

The New Labour Improving the Life Chances of Disabled People strategy of 2005 (Prime Minister's Strategy Unit 2005) included the expansion of centres for independent living to support, advise and advocate for disabled people. The direct involvement of disabled people through such centres was seen as one of the key ingredients to the Life Chances programme and is now understood as a vital component of wider social care transformation. The National Centre for Independent Living (NCIL) (now part of Disability Rights UK), and ADASS have developed a joint protocol for the provision of centres for independent living and user-led support services (NCIL/ADASS 2006). There is an expectation that local authorities will talk directly to disabled people and their organisations in order to implement system change, but this assumes that those ULOs exist and have the capacity to undertake their new and expanded roles.

Some key principles have been learned from activity around developing individual and community capacity to support people to self-direct:

- 'grow your own' co-production networks by building a local community of interest with people using services, carers and their organisations
- local authorities, user- and carer-led organisations need to be proactive in building partnerships around personalisation
- co-production doesn't just happen and needs leadership and investment
- small steps can make big changes and investing in user and carer support groups can build trust
- people feel empowered to learn and use support planning skills themselves.

(Adapted from DH 2010b: 4–5)

The cross-government Independent Living Strategy (ODI 2008) included an investment in the development of 25 ULOs as action and learning sites to promote service improvement, mentoring between organisations, the sharing of learning and the fostering of ULOs in general. However, it will be up to local authorities to support ULOs as partners because:

the success of [the] whole system change is predicated on engagement with communities and their ownership of the agenda at local level.

(DH 2008a: 9)

A critical success factor for ULO development:

appeared to be how user-led organisations are perceived and supported within the local authority environment; such as where they fit in to local spending priorities; whether the idea of nurturing a strong user voice is seen as important or 'difficult'; or whether it is down to one or two individuals who have reason to champion the cause.

(Maynard Campbell 2007: 8)

As part of their personalisation strategies, local authorities will need to commit to resourcing ULOs and to recognise them as equal partners rather than optional extras or tokenistic consultants (Bennett 2008):

The value of services provided by service user organisations needs to be written into service level agreements. If services are run by service user organisations they could bring health and social care together.

(Shaping Our Lives et al. 2007: 13)

Support infrastructure for personalisation

Nearly all the evidence on how people successfully use personal budgets, particularly the direct payment option, shows the important role ULOs have to play as part of the local support infrastructure and their unique contribution as providers of peer support (Newbronner et al. 2011; OPM/ECDP 2011; TLAP 2011a; Williams and Porter 2011; Bennett and Stockton 2012). ULOs can contribute to making the personal budget and direct payment processes easier for people, particularly as the present complexity and levels of information and communication are having a negative impact on people's experiences and outcomes, as well as wider efficiencies (Hatton and Waters 2011; Bennett and Stockton 2012). The Equality and Human Rights Commission (EHRC) has identified ULOs as being important for engaging with marginalised groups for a better understanding of needs and assets. Its project on making personalisation work for all communities in England:

demonstrated the potential effectiveness of user-led services as a means of helping disabled people exercise their rights

(EHRC 2011a: 27)

and recommends that ULOs should provide information and support to marginalised people who want to access personal budgets, particularly direct payments.

As part of the Independent Living Strategy, from 2006 until 2010 the DH ran a ULO development project with action learning sites. Learning from those sites is grouped into five categories and various elements of learning, including specific toolkits, are now available for ULOs to access:

- management and governance
- models of ULOs
- finance and quality
- service delivery
- equality, diversity and human rights.

An ODI ULO support planning and brokerage demonstration project across three local authorities highlights some key messages about ULOs delivering support to disabled people using personal budgets, especially direct payments:

- support planning was experienced by service users as more 'human' when delivered by a ULO than by a local authority, with less bureaucracy involved

- people whose support plan was facilitated by a ULO were more likely to take their personal budget as a direct payment than those whose support plan was delivered by the local authority
- the peer support element of ULO-led support planning and brokerage was important to service users whose plan was ULO-led.

(ODI 2011: 6)

The importance of ULOs has been re-emphasised through a dedicated programme launched by the ODI in July 2010. The Strengthening User-led Organisations programme aims to build the strength and sustainability of ULOs through both non-financial support (in the form of local ULO ‘ambassadors’) and a dedicated £3 million facilitation fund, which was co-produced with ULOs themselves.

An investigation by Age Concern into peer support and peer brokerage for self-funders showed that older people who fund their own care would benefit from the type of support offered by a ULO (Clark and Hornby 2011). Other research on peer support and peer brokerage showed the broader effectiveness of people directing their own support, including increased self-esteem, self-confidence, a greater sense of belonging and improved motivation (Fulton and Winfield 2011). There is scope for direct payments support organisations such as ULOs to assist people to access work, start micro-providers or pool budgets to buy support collectively (Bennett and Stockton 2012). If they have the capacity, ULOs also have the potential to be local support vehicles for direct payment users and PAs, with research from the North East Regional Improvement and Efficiency Partnership recommending the development of an agreed set of operating standards and a shared database of resources, which would enable ULOs to offer a more consistent approach.

(SES 2011: 62)

Over the past few years, ULOs have been working more closely with local authorities as part of the personal budget and direct payment support infrastructure. As a result, some tensions have arisen over certain types of ULO activity and what the local authority perceives the role of a ULO to be. In some cases this was a tension between the ULO’s support provider and advocacy roles (JRF 2010; EHRC 2011a). This tension has been further explored in a commissioning guide to best practice in direct payments support, which states that:

ULO’s need freedom to maintain their independence and being tied to large volume contracts for service delivery can conflict with their role in representing the interests of [service users, carers and] local communities.

(Bennett and Stockton 2012: 31)

Similarly, research on capacity-building in voluntary sector organisations, of which ULOs are a part, concluded that:

local infrastructure has an important and multifaceted role to play: it must be lobbyist, broker and advocate for the sector with public officials, but it must also be a source of independent capacity building advice and support.

(Dayson 2011: 104)

The National Skills Academy for Social Care is encouraging leaders and commissioners to

recognise the value of ULOs in service delivery – see them as a critical friend who:

- understands the constraints under which you are working – they too have often found themselves being called to do more with less
 - wants to achieve the same goals as you
 - is well positioned to review existing and new provision
 - can become both a strategic partner and an organisation able to deliver services.
- (Adapted from National Skills Academy for Social Care 2011: 3)

Commissioning

Commissioning was defined by the former CSCI (now part of the Care Quality Commission – CQC) as:

the process of translating aspirations into timely and quality services for users which meet their needs; promote their independence; provide choice; are cost effective; and support the whole community.

(CSCI 2006: 5)

Under the Health and Social Care Act 2012, clinical commissioning groups (CCGs) are made responsible for commissioning the majority of health care provision at local level. CCGs are dependent on the unique role of general practice in connecting with and acting as the liaison for all the care patients receive but they will need the full range of skills and clinical advice from many different professional groups. The government proposes establishing an NHS commissioning board whose role will include supporting, developing and holding to account an effective and comprehensive system of CCGs. The board will support CCGs while ensuring they have the freedom to deliver improvements in outcomes for their local populations in a clinically-led and bottom-up way.

The Act also establishes Health and Wellbeing Boards as a forum where key leaders from the health and care systems work together to improve the health and wellbeing of their local population and reduce health inequalities. The boards will have the following tasks and functions.

- Strategic influence over commissioning decisions across health, public health and social care.
- Strengthening democratic legitimacy by involving elected and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards will also provide a forum for challenge, discussion and the involvement of local people.
- Bringing together clinical commissioning groups and local authorities to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.
- Through undertaking the JSNA, the boards will drive local commissioning of health care, social care and public health and create a more effective and responsive local

health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

(Adapted from HM Government 2012)

The boards will have the following people as members:

- one local elected representative
- a representative of the local HealthWatch organisation
- a representative of each local clinical commissioning group
- the local authority director for adult social services
- the local authority director for children's services
- the director of public health for the local authority.

(Adapted from HM Government 2012)

Practice example: strategic commissioning – sustainable commissioning in Camden

The Camden commissioning project, which has been funded through the Treasury Invest to Save budget, aims to improve the way public services are commissioned so that the wider social, economic and environmental impacts of services are taken into account. The project is piloting the NEF's sustainable commissioning model to look again at the provision of day services for people with mental health problems. The winner of the tender to provide new day services in mental health was a consortium of local organisations including MIND in Camden, the Holy Cross Centre Trust and Camden Volunteer Bureau. The consortium was not the cheapest tender on a unit cost basis, but commissioners felt that the focus on wider social and economic impacts would create the most positive outcome for the whole community. The sustainable commissioning model contains two key elements.

1. An **outcomes framework** to ensure social, economic and environmental impacts are accounted for in the tendering process and delivery. The framework encourages innovation by allowing providers to explain how their activities and outputs will achieve certain service levels and wider outcomes, as identified by the local authority.
2. A **valuing model** which tracks social, environmental and economic outcomes and includes a financial savings component (see www.procurementcupboard.org).

The notion that commissioning needs to change if personalisation is to become a reality has been strongly stressed (CSCI 2006; Bennett 2008; ACEVO 2009; Bartlett 2009; Harlock 2009) and directions on how this might be achieved are gradually emerging. There needs to be a balance between a focus on market shaping and other commissioning issues relating to personal budgets, and building on the broader agenda of commissioning for the health and wellbeing of all citizens:

All people are dependent on social networks, universal services and the resources of communities in which they live to become active citizens. This logically leads to the consideration of an inclusive approach to commissioning – that is about shaping the places in which we live and supporting everyone to live better lives.

(Bennett 2008: 13)

To enable successful commissioning for personalisation:

the traditional split of interests between providers and commissioners must end. Information about market trends, gaps and difficulties must be shared ... this means sharing information about ... strategy and direction, spending decisions, commissioning vision and market intelligence.

(Bartlett 2009: 35)

In order to gather and use the type of person-centred information needed to inform and drive commissioning, the DH has outlined a simple six-stage process, based on the principles of co-production, which should be carried out at least every year (Bennett and Sanderson 2009).

1. Gathering the person-centred information (e.g. from individual outcome-focused reviews).
2. Transferring the information into a usable format – capturing the top three things that are working and not working in people's lives and the three things they feel are most important for the future.
3. Clustering the information into three themes.
4. Analysing the information.
5. Action planning.
6. Sharing the information.

The IPC has explored the shift commissioning practices need to make from a focus on outputs to a focus on outcomes for personalisation:

the need is to shift the debate about outcomes from a method of defining strategic goals to one where it defines the practical relationships between service users, commissioners and providers.

(IPC 2009: 9)

Although policy emphasis and terminology may have changed, the evidence shows that commissioning for personalisation and building community capacity remains largely the same. ACEVO's Commission on Personalisation suggests that a revolutionary change is needed (ACEVO 2010b), and often there has been a focus on technical changes to funding mechanisms rather than transformation and culture changes (Fox 2012). In order to respond to the challenge of personalisation, local authority commissioners need to:

- nurture and diversify the social care and support provider market
- invest in and build community capacity, particularly for prevention, independent living and social inclusion
- ensure value for money, sustainability and quality
- achieve efficiencies, productivity and social value
- work in strategic partnership on place-based approaches which reflect people's lives, in order to encourage innovation and integration
- decommission and reconfigure services
- understand local need and make strategic decisions informed by local data, demographics and market intelligence
- communicate with providers and build up partnerships focused on achieving positive outcomes for service users, carers and local communities

- involve service users, carers, providers and local communities in the commissioning process (co-production in decision-making).

New approaches to commissioning

There seems to be a broad consensus about how commissioning for personalisation should work. Research by the New Local Government Network (NLGN) (2011: 6) argues that three broad shifts are needed:

- commissioning for outcomes
- developing a mixed market accountable to service users
- becoming 'place shapers'.

Further research by the Institute of Government on new public sector commissioning models concluded that:

implementing choice ... requires market makers to make a mental shift from being in control of a policy to stewarding markets and enabling them to function.

(Blatchford and Gash 2012: 7)

In the context of promoting choice for personal budget users and self-funders, the National Audit Office (NAO) suggests that:

the local authority role moves from one delivering services directly or commissioning them to one of overseeing local care markets to ensure they are delivering the required outcomes.

(NAO 2011: 6)

The Yorkshire and Humber JIP also recognises that personalisation means a change in the local authority role as commissioner. There will be reduction in the role of the:

local authority as a purchaser and [traditional] commissioner of services. Instead the partnership statement sees the local authority as a facilitator of the market, guaranteeing the availability of a choice of services.

(IPC 2011a: 4)

In order to support commissioners in their transformation and major 'culture shift', Skills for Care has worked with the North West JIP to define some key elements in this changed role:

- supporting choice
- purchasing and managing services
- devolved funding
- marketing and service development
- framework contracting
- personalising services not funded by personal budgets
- building social capital
- new commissioner-provider relationship.

(Skills for Care 2010: 6)

When examining how value for money in adult social care could be achieved at a time of austerity, the Audit Commission recommends that local authorities still need to:

develop and implement strategies for delivering sustainable, modern, good-quality services, involving large-scale, transformational change. Prevention, personalisation, building community capacity and a shift to independent living in the community ... change on this scale will require good data, leadership and strong partnerships with housing, transport and leisure services as well as the NHS.

(Audit Commission 2011: 4)

The Audit Commission's emphasis on commissioning partnerships with housing, transport, leisure and health is important for developing universal services and is crucial for extending choice for personal budget holders (NAO 2011; OPM/ECDP 2011). Research shows that in line with independent living, many people want to use their budgets to access leisure services (Wood 2010a; OPM/ECDP 2011), with Demos predicting that the demand for leisure services could rise as a result of personal budget use, particularly for younger disabled people.

Elsewhere, local authority commissioners have been urged to think about the broader cost effectiveness potentially offered by ULOs as providers of direct payment support services, as part of a 'mixed economy of options':

it will be important to understand the broader social returns that ULOs and other external bodies can offer and to ensure these are given appropriate consideration alongside comparisons of costs when commissioning support.

(Bennett and Stockton 2012: 25)

The NLGN identifies the potential of 'outcome based commissioning' for cost effectiveness:

by identifying and managing the contribution a service makes to an individual's wellbeing and providing transparent costing for those services, an outcome-based system will help commissioners identify the services that provide best value for money' .

(NLGN 2011: 13)

The NLGN refers to the DH's Adult Social Care Outcomes Framework as supportive of outcome-based commissioning.

The Centre for Policy on Ageing has looked at how local authorities with reduced funds can support better outcomes for older people. The research, conducted with older people and innovative providers, shows the benefits of investing in 'that bit of help' in the local community. This can provide:

older people with the assistance they need to sustain the health, activities and relationships that are important to them. This may include collective solutions, small grants or seed-funding for self-help groups, and developing local markets to provide support people want and value.

(JRF 2011: 1)

This is part of building community capacity. Research on micro-providers shows the importance of commissioners creating the conditions for such small-scale providers to develop (Bull and Ashton 2011). Similarly, co-operatives providing person-centred support have reported that traditional commissioning and its processes can make it difficult for newer types of provider to enter the market:

longstanding commissioning processes (e.g. preferred provider lists) are a significant barrier for new co-operatives entering the market under personalisation.
(Fisher et al. 2011: 1)

The same challenge has been identified for home care agencies (Baxter et al. 2011a). Existing procurement systems have presented a barrier for ULOs entering the adult social care market, and a three-year study on personal budget implementation in Essex showed the importance of commissioners supporting new entrants (OPM/ECDP 2011). The National Skills Academy for Social Care has recommended that commissioners:

create a 'level playing field' for tendering opportunities to enable ULOs to compete for contracts in an increasingly commercial environment.
(National Skills Academy for Social Care 2011: 3)

Commissioning in partnership

Health and social care partners are not always aware of the joint financing options available as part of joint commissioning. The Audit Commission has provided guidance to local authorities and the NHS to support the move away from concentrating on the mechanics of joint financing and the processes of partnership, and instead looking at how joint funding and closer integration can improve people's lives. Agreed outcomes should be the focus of joint working in order to help older people and those who need mental health and learning disability services. Pooling funds can improve services, but often the actual financial arrangements can become the focus of attention:

Organisations can usually describe how they now work better together but often not how they have jointly improved user experience.
(Audit Commission 2009: 4)

The Audit Commission emphasises that:

NHS and social care organisations increasingly need to work together in partnership to get better value from available resources and improve services and outcomes for users. There are many different approaches and mechanisms available for joint financing, but the focus should always be on value for money and improving the user experience.
(Audit Commission 2009: 5)

However, in the context of personalisation in social care, the Audit Commission notes that because NHS services are free at the point of use and social care is subject to means as well as needs testing, it may be necessary to separate pooled funds 'in order to allow personal budgets for social care' (Audit Commission 2009: 34). It is likely that this issue will be explored in the personal health budget pilots.

A common feature underpinning the changes in each local authority has been a shift from traditional and often adversarial relationships towards collaborative and constructive partnerships between commissioners and providers (Bennett and Miller 2009: 4).

It is clear that local authorities have been tasked with 'shaping and building the market' to make sure people have a choice of services. Local authorities are now being encouraged to change from thinking about service commissioning to thinking about strategic investment:

Directors of adult social services will need to consider making some long term investments in innovative services that users are starting to request ... Commissioners need to become what some have termed 'strategic bridge builders', meaning they look for gaps in the market for services people seem to be demanding and use strategic investments to encourage this market to develop.
(Bartlett and Leadbeater 2008: 29)

One important area is to sustain and stimulate local micro-markets and remove barriers which make it hard for innovative and highly personalised enterprises to develop (NAAPS/DH 2009a). As part of a drive towards better use of adult social care resources, local authorities have been encouraged to invest in preventative and reablement services as part of the personalisation and transformation agenda (Bolton 2009).

Improving partnerships and information sharing between commissioners and providers is important for personalisation. The National Market Development Forum (NMDF) has identified some key elements for effective procurement which focus on collaboration and partnership between commissioners and providers:

- engagement between stakeholders at the earliest opportunity
- building the right alliance for the job
- building and sustaining high quality relationships
- innovation
- flexibility
- willingness and ability to share risks
- cost effectiveness
- support for capacity-building
- a focus on outcomes – and clarity of what's to be achieved
- clarity about added social value
- paying attention to strategic vision.

(IPC/NMDF 2011: 26)

Skills for Care has emphasised the importance of commissioner–provider collaboration to develop personalisation, outlining the need for:

- continuous training and staff development for both commissioners and providers as personalisation progresses
- risk management that enables supported positive risk-taking
- provider–provider collaboration for efficiency and cost-sharing
- local authority to local authority collaboration to share intelligence and develop a diverse provider market

- small business support for micro-providers, mutuals and small voluntary and community organisations
- regulation informed by a shared view between service users, providers and commissioners
- change management support for managers.

(Adapted from Skills for Care 2010: 11)

One of the key tasks for commissioners implementing personalisation is decommissioning and reconfiguring services. ADASS, the Yorkshire and Humber JIP and the IPC have defined these general principles for decommissioning:

- transparency in decision-making process and fairness to all stakeholders
- ensuring the welfare of service users
- staff consultation and transition
- value for money and quality
- clarity about risks and risk management
- partnership with all stakeholders
- communications strategy and engagement with all stakeholders including staff, service users and carers.

(Adapted from IPC 2010: 4)

The IPC emphasises that:

in all cases, addressing the immediate and long-term needs of service users should be paramount in any decision to decommission a service.

(IPC 2010: 4)

The EHRC states that for decommissioning and commissioning, commissioners, local public bodies and regulators should:

use monitoring and user involvement to inform needs analysis and to assess the quality of services and to identify any inequality that is being caused by the implementation of personalisation locally.

(EHRC 2011a: 26)

The participation of service users and carers as pivotal stakeholders in commissioning is emphasised in the evidence (DCLG 2011). Research undertaken by Age Concern and the Joseph Rowntree Foundation highlighted the following factors important for user and carer participation in commissioning work:

- acknowledging the realities of involvement – resourcing, human contact, power sharing, learning from mistakes, honesty and involving users and carers at the start
- the need for honesty and feedback – what happened, what didn't and why
- different stages and different contexts of commissioning from buying services to longer-term planning
- involving others, including front-line staff, providers and social care workers, acknowledging all expertise
- shared strategic ownership of user and carer participation.

(Adapted from JRF 2010: 4)

Stakeholder involvement is an essential part of local strategic commissioning. Evidence from the JIPs on Joint Strategic Needs Assessments (JSNAs) and from the Department for Communities and Local Government (DCLG) long-term evaluation of local area agreements and local strategic partnerships can further inform 'whole system' or place shaping commissioning for personalisation. The DCLG defines strategic commissioning as:

making the best use of all available resources to produce the best outcomes for our locality.

(DCLG 2011: 7)

This reflects ACEVO's Commission on Personalisation recommendation to take:

stock of all the resources available to us in tackling social ills ... public, private and voluntary sector sources, and involving assets as well as revenues.

(ACEVO 2010b: 4)

In order to clarify the change needed, the DCLG has outlined the following strategic commissioning principles, with further details and examples given in their practitioner report:

- involving stakeholders
- relationships
- understanding needs
- wider outcomes
- agreeing priorities
- commissioning together
- sharing resources
- managing markets
- innovation
- transforming services
- managing performance
- evaluation.

(DCLG 2011: 24)

The North West JIP examined the relationship between commissioning and JSNAs. The original DH definition of a JSNA, which is a statutory responsibility of local authorities and health directors, shows its central importance for strategic commissioning:

a process that identifies current and future health and wellbeing needs in light of existing services, and informs future planning, taking into account evidence of effectiveness. JSNA identifies 'the big picture' in terms of health and wellbeing needs and inequalities of a local population.

(DH 2007b: 7)

The JIP identified certain issues with JSNAs and outlined the following challenges which need to be addressed:

- identify the key drivers behind demand and what contribution the JSNA can make to preventative strategies across health and social care
- help strategic commissioners review the current market and the approaches that might be used to lessen demand
- develop the capacity to target the right populations at times when people are most amenable to change
- establish the cost benefit of such interventions.

(NWJIP 2010: 19)

The NMDF and the IPC, drawing on evidence from the South West Regional Improvement and Efficiency Partnership (RIEP) believes that JSNAs should form part of a local authority 'market position statement' (IPC/NMDF 2011). This is an approach to improving the use of market intelligence in order to improve commissioning for personalisation. A 'market position statement' is:

an analytical document that brings together material from the JSNA and commissioning strategies into a document which presents the data that the market needs to know if they are to plan their future role and function. It identifies the needs of different service user groups ... and covers local authority and privately funded users of care. It indicates how the local authority will support and intervene in local markets

(IPC/NMDF 2011: 15)

Market development for personalisation

The adult social care market is worth approximately £17 billion, but is currently configured and operating in a different way to conventional 'free' markets based on the supply and demand of goods (Baxter et al. 2011a; IPC/NMDF 2011). For example, one of the preconditions for a market is to have information for buyers and sellers to make informed judgements, but this type information is not readily available in the adult social care market and this is affecting people's ability to use personal budgets and direct payments (Baxter et al. 2011a; NAO 2011; OPM/ECDP 2011). The NMDF has examined the development of the adult social care market for personalisation and concludes that it has the following distinct features:

- a wide range of purchase arrangements from large block contracts to individual personal budgets
- a considerable degree of government control where relationships between the provider and service user are filtered through the local authority
- a range of providers operating under different rules of engagement
- comparative isolation from other market sectors – the market may not make full use of wider market stimulation activities such as business support or regeneration initiatives
- a distance between the local authority as a purchaser and the providers, which does not help with collaborative long-term market development decisions.

(Adapted from IPC/NMDF 2011: 4)

In order to address this situation, along with the challenges of public funding cuts and strategic commissioning with health and other partners, the NMDF has characterised an 'ideal' adult social care market, some of the features of which are:

- local authorities, with GP and NHS partners, to have a wider view of the care market other than just the services they fund
- service users and carers to contribute to local commissioning and market development
- all services to be person-centred, offering choice and control in all settings
- each area to have a market position statement covering current supply, areas of need and future predictions
- service users and carers to have access to good, independent information on service cost and quality
- less use of 'traditional' residential care; remaining provision should be personalised with better trained and better paid staff
- an expansion in the use of PAs
- a focus on payment for care and support by the outcomes it delivers rather than the cost and volume
- fewer local authority commissioned block contracts for most services
- more diverse property market of accommodation suitable for older and disabled people
- emphasis on combined preventative health and social care with more holistic, flexible provision delivered by multi-disciplinary organisations
- less fragmentation into professional 'disciplines', with an emphasis on a 'do what it takes' approach to person-centred care and support.

(Adapted from IPC/NMDF 2011: 8–9)

The DH and the TLAP partnership have provided practical tools and approaches to support commissioners in their market and provider development role (DH 2010e; TLAP 2011c). Reflecting the evidence, the DH presents a framework consisting of four components: strong engagement, market intelligence, provider development and flexible arrangements and TLAP's diagnostic and action planning tool for shaping the market for personalisation emphasises that commissioning means:

Working together with citizens and providers to support individuals to translate their aspirations into timely and quality services, which meet their needs; enable choice and control; are cost effective; and support the whole community.

(TLAP 2011c: 2)

TLAP has also produced a protocol for market relations based on the market facilitation work carried out by NMDF. Four key principles of engagement to strengthen partnerships are identified (Bennett 2012: 5):

1. Sharing risks.
2. Reducing bureaucracy.
3. Increasing capacity.
4. Measuring success.

Regulation

The shift towards person-centred services raises questions about the role and functions of regulatory bodies and systems. Social care has inherited a regulation and inspection system which is focused more on the services rather than the people using them, their

carers and families. A regulation and inspection system needs to ensure that policies and procedures provide assurance about quality and safety, as well as a focus on better outcomes for people (Fraser 2008). Much regulation has relied on compliance, but it has been noted that:

regulatory compliance does not equate with good personal outcomes ... quality is a synthesis of personalisation, clinical and personal care standards and risk management.

(Bowman 2010: 303–304)

Personalisation requires new, more flexible approaches to regulation, able to adapt to innovative support from new types of providers offering broader opportunities, including scope for people to take appropriate risks. It is important to establish close working links between the regulator and the director of adult social services (given the latter's remit for commissioning, market development and quality assurance), as well as local adult protection services. It has been noted that, in the context of personalisation and the transformation of adult social care:

modern regulation must find an approach which is consistent with promoting choice and control while also offering appropriate safeguards.

(Hudson and Henwood 2009: iii)

Research on micro-providers (very small social care and support services of five staff or less) has shown that applying disproportionate regulation and legislation designed for large-scale providers is a barrier to developing and sustaining small initiatives which are often flexible and innovative, based on models of co-production and rooted in the local community (NAAPS/DH 2009a).

Care Quality Commission and the Health Professions Council

The CQC is responsible for regulating health and adult social care. It is implementing person-centred regulatory approaches, intended to empower people who use services, their carers and families. Its guidance on direct payment support schemes outlines which services will need to be registered, and this clarifies some of the confusion about this aspect of personalisation, including support brokerage schemes requiring registration status as domiciliary care agencies (CQC 2008). The CQC regulatory approach includes standards on levels of choice and control, in order to strengthen personalisation and person-centred care and support. The CQC *Essential standards of quality and safety* (CQC 2010) has personalised care, treatment and support as one of the six key areas of regulation.

The CQC applies a framework of compliance standards to all types of health and social care provision (CQC 2010). Some standards are common to many or all types of service. Others are specific to particular forms of service, such as residential care. The primary focus is on standards and safety. The compliance framework is based on 28 standards, with the first 11 focusing on individuals using services and the rest on staffing, management and administration. Of relevance to personalisation, the following three standards are aimed at ensuring services are person-centred and promote choice and control.

Involvement and information

- Service users, or those acting on their behalf, are involved in making decisions about their care, treatment and support.
- The views and experiences of service users are taken into account when making decisions about how services are delivered and improved.
- Providers should give people the information necessary to make informed choices, including information about any charges they are expected to pay for their care, treatment and support.

Personalised care, treatment and support

- What providers should do to ensure service users receive effective, safe and appropriate care, treatment and support that meets their individual needs.

Safeguarding and safety

- Service users, staff and visitors are as safe as they can be and risks are managed.
- The human rights and dignity of service users are respected, and staff identify and respond properly when people are in vulnerable situations.
- The premises and equipment staff use to provide care, treatment and support are safe and suitable.

The new regulatory system and standards aim to put the service user or patient at the centre of decision-making, with the inclusion of an explicit requirement to respect and involve service users. The CQC describes a new system that is consistent with the personalisation agenda:

The new registration system for health and adult social care will make sure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. The new system is focused on outcomes rather than systems and processes, and places the views and experiences of people who use services at its centre.

(CQC 2009: 6)

The new regulations are clear that:

agencies that directly provide personal care (for example domiciliary care agencies), or those that have a continuing role in the personal care of an individual (for example, introduction agencies who might monitor carers' performance, respond to complaints, or develop care plans) will need to register with the Care Quality Commission.

(DH 2009d: 12)

However, if someone chooses to be supported by family or friends then:

where such care was wholly under the control of the person receiving it, this would not require registration.

(DH 2009d: 22)

The details of the draft regulations have been set out in The Health and Social Care Act 2008.

Social workers now register with the Health Professions Council (HPC) which has taken over the duties of the General Social Care Council (GSCC). The standard on acting in the best interests of service users relates directly to personalisation and person-centred support:

You are personally responsible for making sure that you promote and protect the best interests of your service users ... You must not allow your views about a service user's sex, age, colour, race, disability, sexuality, social or economic status, lifestyle, culture, religion or beliefs to affect the way you treat them or the professional advice you give ... If you are providing care, you must work in partnership with your service users and involve them in their care as appropriate.
(HCPC 2012: 8)

Enabling excellence (HM Government 2011c) sets out proposals for health and social care regulation and recognises personalisation, increased choice and control, and local accountability. It states that:

the health and social care systems ... need a new approach to risk that is more effective and more responsive to local and individual needs.
(HM Government 2011c: 8)

In relation to the regulation of social workers, the paper introduces the distinct roles of the HPC and the CSW, the latter being a self-funding body for statutory professional regulation. For the wider social care workforce, there is a proposal to establish a system of assured voluntary registration (HM Government 2011c: 23).

HealthWatch and Monitor

The NHS and Social Care Act 2012 established HealthWatch to represent the views of the public, patients and people using social care services at local and national levels. HealthWatch England will operate as a new, statutory committee of the CQC, formed to act as the national consumer champion. The aim is to include the voices of those who have struggled in the past to get their views heard – for example, people with mental health problems, disabled people, and children and young people. This will involve ensuring that HealthWatch England builds strong relationships with local HealthWatch organisations, local authorities and other local agencies.

HealthWatch will have a role in gathering adults' views and experiences of health and social care, feeding these back and presenting this local intelligence to the statutory Health and Wellbeing Board. To do this it will work with individuals, community and user groups and organisations representing adults (including adults whose circumstances make them vulnerable) to inform its feedback. Building on the work the CQC has done with Local Involvement Networks (LINKs), HealthWatch will need to work collaboratively with the CQC to share information and any plans to visit services, to avoid duplication.

The NHS and Social Care Act also defines the role of Monitor as a specialist sector regulator for health care. It will work with the Office of Fair Trading to apply competition law to providers in the health care sector. This law exists to protect the interests of patients

(and consumers more generally) but the Act does not extend the scope of its application to the NHS. Monitor's responsibility for applying competition law will help to ensure that the law is only applied in the interests of patients.

The Act addresses the need for more integrated services, as reported by patients and service users, by providing the basis for better collaboration, partnership working and integration across local government and the NHS at all levels. It establishes Monitor as a sector-specific regulator with a core duty to focus on what benefits patients, and with duties and powers to enable integrated care. Monitor has recently published a report which explores how its powers and functions may be used to improve services in this way (Monitor 2012). In due course, Monitor and the CQC will operate a joint licensing regime, and work is underway to develop a mechanism whereby providers seeking both CQC registration and a Monitor licence can secure both via a single application process.

Practice example: information and advice – Brighton and Hove Access Point

The Access Point is the adult social care contact centre for Brighton and Hove. It provides a point of access for adults wishing to access social care services or who require advice and information in order to access services independently.

The Access Point brings together the older people's community assessment team, the physical disability (under 65) assessment team, the sensory team, occupational therapy and the learning disability team. By contacting the Access Point by phone, minicom, email or fax, service users can access information on or assessment for any one or more of these services. Traditionally each service had its own contact number and would complete its own initial assessment, meaning that people who required more than one service or advice and information from a variety of services would need to call more than one number and potentially undergo more than one assessment. The Access Point ensures more accessible services, and needs-led, as opposed to service-led, assessment.

What are the key issues for the social care sector as a whole?

Overall personalisation progress

This section is a brief overview of some of the broader themes and issues appearing in the literature since 2010. It is not exhaustive – the intention is to give an idea of some of the general challenges and lessons and how these relate to implementing personalisation in social care and health, in the context of significant reductions in public sector funding.

Progress and challenges

Reports from several national public sector and social policy organisations assess some of the key points of progress and barriers to personalisation in general. This section outlines some of their key findings, many of which are consistent with each other.

The Royal Society for the Encouragement of Arts, Manufactures and Commerce RSA has produced a report outlining the lessons from social care on personalisation. It concludes that the progress so far has resulted in some of the following gains:

- the principles of choice, control and independence for all service users being firmly embedded in the sector
- community-based living seen as the norm for most people with long-term conditions
- the rise of ULOs, with service users and carers routinely involved in local decision-making
- the increasing satisfaction of the majority of service users and carers with services and with holding a personal budget
- 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 commissioning
- little evidence of increasing fraud, abuse or inappropriate use of personal budgets.

(Adapted from Fox 2012: 20)

The report goes on to outline the risks and challenges of personalisation, some of which could hamper the gains:

- misunderstandings of the values and ultimate aim of personalisation among service users and professionals, partly due to a lack of co-ordination between reforms of practice, training, regulation and legislation
- converting entitlements into cash can entrench a culture preoccupied with levels of entitlement and lead to perverse or bureaucratic local implementation of new resource allocation systems
- low uptake of personal budgets and direct payments among 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 among 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 on paid family carers leading to poor health and unemployment
- challenges in integrating reform with other sectors, to produce whole-system changes.

(Adapted from Fox 2012: 20–21)

The NEF, along with SCIE and the TLAP, has produced an overview of the literature on how personalisation is progressing in the context of restricted funding. The report is part of a wider project to investigate how different approaches to personalisation, such as those based on co-production, could change the way social care and health support is designed and configured. Some of the main findings of the report are:

- as a term, 'personalisation' is still somewhat amorphous and can mean many different things when applied in practice
- despite targets to move people onto budgets, personalisation is still new and under-developed in the social care sector and only at an early pilot stage in the health sector
- there is an overwhelming lack of long-term, reflective or qualitative evaluations of economic analyses
- the vision and values of personalisation are often conflated with the preferred delivery mechanism – personal budgets
- building community capacity and co-production have often been marginalised at the local level in favour of a focus on personal budgets
- the focus on personal budgets as the key indicator of success may have detracted attention from personalising residential and agency home care.

(Adapted from Slay 2011: 3)

Demos has identified the following barriers to personalisation:

- a lack of funding
- poor integration between health and social care
- the limitations of the health, care and wider service markets
- the lack of integration of health and care with housing
- the constraints of communal living for those in residential care
- the challenges of palliative care (e.g. the low take-up of advance care plans)
- service user resistance to personalisation
- staff cultures and leadership.

(Wood et al. 2011: 14–15)

Finally, the TLAP research (2011a: 1) round-up report on personal budgets identified these main areas for action:

- access to direct payments
- ensuring authenticity in local authority managed personal budgets
- better information and advice

- improving equality of access
- reducing unnecessary process and increasing flexibility.

Service user and carer perspectives

In November 2011 the Joseph Rowntree Foundation and SCIE held two service user and carer seminars to discuss the future of personalisation and independent living. The participants affirmed that the core aim of personalisation is independent living, with the following key messages coming from the seminar discussions:

- it is important to define personalisation in terms based on the principles of independent living
- this should include service users and carers having choice and control and the freedom to live their lives in the way they want to
- many users and carers have positive experiences of personalisation and there are examples of good practice
- however, the number of people receiving truly personalised services remains very low and cuts to services may make this situation worse
- more needs to be done to ensure that everyone involved in service provision understands personalisation
- there needs to be better co-ordination of resources and services
- there needs to be more co-production with service user and carer organisations
- a stronger vision based on a return to the principles of independent living is needed to ensure that personalisation delivers better outcomes for service users and carers at the same time as ensuring resources are used as effectively as possible.

(Turner 2012: 3)

These findings are very similar to the responses from people who use social and health care, and lend support to government proposals for the future of adult social care:

Service users raised concerns about personalisation and personal budgets. They felt these were being derailed by public spending cuts, poor preparation and inadequate support infrastructure. Some described a mismatch between the current social care market and person-centred support. They recommend effective user involvement and more support for user-led organisations.

(Beresford and Andrews 2012: 4)

Service users highlighted the importance of a skilled workforce, prevention and early intervention, and integration in achieving personalised support and services to enable independent living. They recommended:

- better training, support and supervision; better terms, conditions and career progression; more support for the role of PAs; effective user involvement; social work based on a social model of disability
- 'that little bit of help' as a cost-effective and rights-based way to meet people's needs
- seeing integration as a wider issue, including housing, education, equipment services, transport and leisure (as well as social care and health).

(Adapted from Beresford and Andrews 2012: 3-4)

Finally, as part of the Joseph Rowntree Foundation's Standards We Expect project, service users gave their recommendations for sustaining personalisation and person-centred support. This report outlines the following as an effective approach to change:

- will be rights-based and needs-led, in line with an independent living philosophy
- can make some progress through bottom-up approaches, without broader reform, but this is likely to be limited, insecure and constrained
- needs a stable context; the constant churn of organisational and external change makes it difficult to sustain bottom-up developments
- needs commitment at every level
- requires the development of forums for collective involvement and opportunities for capacity-building for all key stakeholders – these are key for participatory change to be possible
- takes a long time, longer than might be expected.

(Adapted from Beresford et al. 2011: 4)

Risk enablement and safeguarding

Safeguarding is an aspect of personalisation that is of concern to social care stakeholders implementing approaches to service delivery that increase choice and control. The initial findings from the individual budget pilot site evaluation concluded that local authority adult protection leads can have unique insights from working at the intersection between the demand for safety for the individual, assurances about spending public money and the increased demand for choice and control in social care. The researchers recommend that their expertise is used consistently with individual budget implementation, with safeguarding issues being addressed at an early stage (Manthorpe et al. 2009).

The DH's *Independence, choice and risk: a guide to best practice in supported decision-making* recognises the complexities involved in managing risk in relation to choice. However, the guide is clear that:

ultimately, the local authority has a statutory duty of care and a responsibility not to agree to support a care plan if there are serious concerns that it will not meet an individual's needs or if it places an individual in a dangerous situation.

(DH 2007a: 2)

SCIE has conducted an in-depth exploration of how risk can be managed and enabled for people using self-directed support, particularly those who may be regarded as being in vulnerable situations. The key messages from international research and emerging practice were as follows.

- Providing real choice and control for people who use social care means enabling them to take the risks they choose, particularly in the use of self-directed support and personal budgets.
- With the support of frontline staff, service users should be enabled to define their own risks and to recognise, identify and report abuse, neglect and safeguarding issues. Informed choice is vital.
- Practitioners may be concerned with balancing risk enablement with their professional duty of care to keep people safe.
- Practitioners need to be supported by local authorities/trusts to incorporate safeguarding and risk enablement into relationship-based, person-centred

working. Good quality, consistent and trusted relationships and good communication are particularly important.

- Risk enablement can transform care, not just prevent abuse. Risk enablement and safeguarding training for staff, service users, carers and families is important in achieving this.
- Risk enablement should become a core part of placing people at the centre of their own care and support. It cannot be a 'bolt-on' solution to traditional adult social care systems which are not person-centred.

(Adapted from Carr 2011a: 1)

It is also important that practitioners use the Mental Capacity Act (2005) to support people by empowering people to make their own decisions. Where a person lacks the capacity to make a particular decision, their views must still be sought.

Public sector funding cuts and productivity

A range of organisations have examined the impact of public sector and local authority funding cuts on adult social care and personalisation.

Demos and Scope have looked at how funding cuts are affecting the front line, particularly the lives of disabled people. They conclude that the cuts have had a 'cumulative and disproportionate impact' but that local authorities do not always monitor this and so do not necessarily know how disabled people are being affected by budget reductions. The report identifies some elements common to local authorities that were mitigating the impact of cuts at the front line, many of which are consistent with personalisation:

- co-production: involving service users in designing and planning their services, and in some cases delivering them
- a capabilities approach to disability: looking at people's strengths and promoting what they can do, rather than a deficit model, which focuses on what people can't do for themselves
- a strategy of progression or 'just enough support': where people gradually rely on less formal services and more community-based support
- a move towards more integrated services: bringing in care, health and often housing and leisure
- a commitment to personalisation: not as a cost-cutting measure, but as a foundation on which these other strategies can be built.

(Adapted from Wood et al. 2011: 13–14)

DIAL, the disability advice network, and Scope have produced a guidance note on personalisation at a time of cuts, particularly concerning the way personal budgets are calculated (DIALUK/Scope 2011). Similarly a report by a consortium of large disability charities has mapped some of challenges for the equitable implementation of personalisation, particularly the personal budget option, and offers an RAS self-assessment checklist (Sense et al. 2011).

Using the information available at the time, in 2010 SCIE produced an evidence overview report focusing on personalisation, efficiency and productivity. The evidence suggested the following.

- It is too early to make conclusive decisions on whether or how personalisation has delivered efficiency savings, but there is emerging evidence of factors which may increase productivity and efficiency.
- In measuring efficiency, it is important to evaluate the impact on outcomes for people who use services and their carers, as well as the cost.
- The personalisation agenda is already stimulating changes in business processes which are resulting in efficiencies. For example, managing access to services, auditing and information technology (IT) systems.
- Potential efficiencies such as waste and overhead cost reduction, improved value for money and better outcomes require outcome-based, user-directed, flexible approaches to commissioning services.
- It may be more efficient to have specially trained staff managing the administrative aspects of care and support planning to free up front-line practitioners.
- Integrated working, early intervention and prevention services can result in cost savings. Co-productive approaches also have the potential to be cost effective and release community resources.
- Despite variations in the cost of implementing direct payments, there is evidence that they have the potential to achieve greater efficiency, while giving people who use services greater control over their care and support.

(Adapted from Carr 2011b: 1)

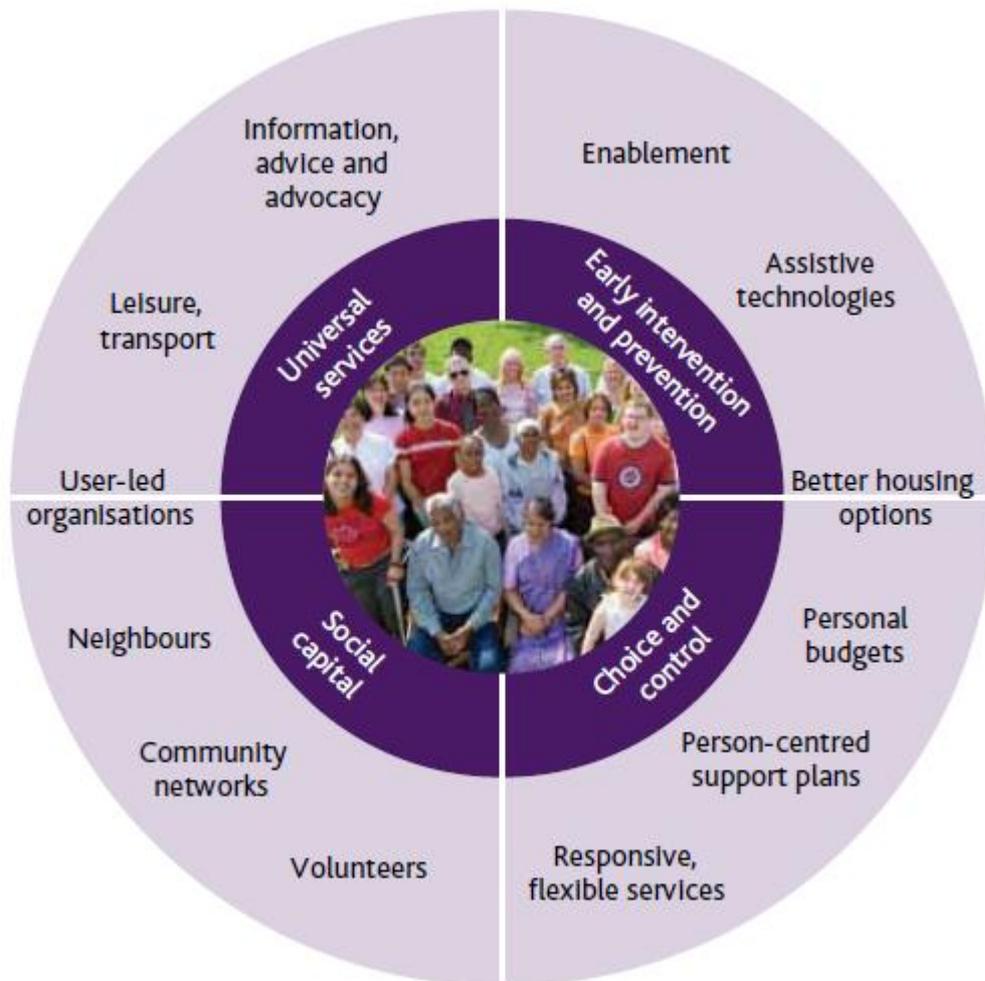
To complement this evidence overview, ADASS has published a guide entitled *Practical approaches to improving productivity through personalisation in adult social care*. The key messages are:

- understand the cost-effectiveness of personal budgets
- understand costs at individual and strategic levels
- simplify business processes
- build community capacity
- achieve better value for money for people who require ongoing support through self-directed support and review
- shape markets to offer personalised services at a fair price
- personalisation can be the key driver of strategic change.

(Ayling and Cattermole 2010)

Supporting frameworks and approaches

The personalisation vision first set out in *Putting people first* (HM Government 2007) was underpinned by four key themes, as illustrated in the figure below. These themes were discussed further in the document *Putting people first: the whole story*, which came with the 2009 local authority circular on transforming adult social care (DH 2009c).



Since 2011 the sector-led TLAP partnership has committed to supporting the implementation of personalisation in England, and its focus is still on these four key areas. In November 2010, TLAP set out the next steps for transforming adult social care and a framework for delivering a personalised, community-based approach for everyone using adult social care and support. Their continued implementation plan draws on learning from implementing Putting People First across England and focuses on areas where more development and action is required. The agreement:

- underlines the necessary connection between preventative, community-based approaches and personalised care and support
- provides a general framework for action supported by examples to assist partners in benchmarking progress and by co-designed tools to aid delivery.

(TLAP 2010: 1)

The framework for action outlines two core sets of activities that local leaders need to ensure are present in their area:

1. Universal approaches designed for all, including:
 - promotion of health and wellbeing
 - hospital admission avoidance
 - public information including assured financial advice

- assessment of social care needs on request
- advice and support to choose and arrange suitable services
- the availability of an adequate range and quality of provision in the market-place
- robust local community capacity
- quality assurance and consumer feedback on care and support services

2. Targeted support for particular groups including:

- crisis support
- reablement and intermediate care
- personal budget entitlement
- care management and safeguarding
- carer support.

(TLAP 2010: 2)

Assessing personalisation progress

In order to support local authorities in their progress towards personalised, community-based support, TLAP has produced the citizen-led 'Making it Real' progress markers. These criteria reflect what citizens want and are presented as 'I' and 'my' statements:

1. Information and advice: having the information I need, when I need it.
2. Active and supportive communities: keeping friends, family and place.
3. Flexible integrated care and support: my support, my own way.
4. Workforce: my support staff.
5. Risk enablement: feeling in control and safe.
6. Personal budgets and self-funding: my money.

(TLAP 2011b)

The Making it Real markers of progress are being mapped with the CQC standards and the DH Adult Social Care Outcomes Framework (ASCOF). The ASCOF is extremely relevant to implementing personalisation, particularly when developing and measuring an outcomes-based approach to commissioning and assessing quality (DH 2011b). The NLGN recommends using ASCOF for commissioning and measuring outcomes-based personalised care and support services (NLGN 2011). *Transparency in outcomes: a framework for quality in adult social care* (DH 2011b) outlines the main four domains of the framework:

1. Enhancing quality of life for people with care and support needs.
2. Ensuring that people have a positive experience of care and support.
3. Delaying and reducing the need for care and support.
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

The PSSRU's Adult Social Care Outcome Tool (ASCOT) can be used by commissioners and providers to measure the relative value of services to an individual based on quality of life – the 'social care related quality of life'. The ASCOT measure was developed with the general public and service users. The quality of life domains and their rankings were

therefore determined by people rather than by services. The quality of life measures cover eight domains, all of which are consistent with the outcomes of personalisation, and are applicable across as wide a range of user groups and care and support settings.

1. **Control over daily life** – the service user can choose what to do and when to do it, having control over their daily life and activities.
2. **Personal cleanliness and comfort** – the service user feels they are personally clean and comfortable and look presentable or, at best, are dressed and groomed in a way that reflects their personal preferences.
3. **Food and drink** – the service user feels they have a nutritious, varied and culturally appropriate diet with enough food and drink at regular and timely intervals.
4. **Personal safety** – the service user feels safe and secure. This means being free from fear of abuse, falling or other physical harm and fear of being attacked or robbed.
5. **Social participation and involvement** – the service user is content with their social situation, where ‘social situation’ is taken to mean the sustenance of meaningful relationships with friends and family, and feeling involved in or part of a community, should this be important.
6. **Occupation** – the service user is sufficiently occupied in a range of meaningful activities whether they be formal employment, unpaid work, caring for others or leisure activities.
7. **Accommodation, cleanliness and comfort** – the service user feels their home environment (meaning all the rooms), is clean and comfortable.
8. **Dignity** – the negative and positive psychological impact of support and care on the service user's personal sense of significance.

(Adapted from PSSRU 2011)

Equality, diversity and human rights

Personalisation should be delivered within the framework of the Equality Act 2010. The EHRC emphasises that:

the new Public Sector Equality Duty is an opportunity to direct public bodies to do more to take account of the needs of a wider range of groups.

(EHRC 2011a: 23)

In its report *From safety net to springboard*, the EHRC produced a series of seven broad principles to guide social care transformation:

1. Care and support based on clear outcomes and founded on human rights and equality.
2. Access to publicly funded care and support based on clear, fair and consistent criteria.
3. Individuals and their families in control of their care and support.
4. The right balance between safety and risk to promote choice and independence.
5. Local strategic partnerships that play a central role in developing and maintaining local care and support.
6. Funding that balances affordability and sustainability with fairness.
7. Equality and human rights law and practice re-calibrated to respond to our ageing society.

(EHRC 2009: 6–7)

The EHRC has conducted work on equality and personalisation in adult social care and concludes that more needs to be done to improve equality of access to personalised services and options such as personal budgets. Among other things the EHRC identifies the following two main challenges:

Many services and the assumptions that drive their commissioning and delivery appeared to be predicated on narrow perceptions of key characteristics of age, disability or long-term conditions. It was not easy to test how some services reach those whose other characteristics such as sexual orientation, their youth, faith or ethnicity might be invisible ... Personalised services do not yet adequately reach diverse communities, despite the fact that those groups are the ones that could arguably benefit most from them. There needs to be a major effort to make independent advocacy more available and accessible. This will be essential for many citizens to become more competent consumers of increasingly personalised modes of care.

(EHRC 2011b: 4)

In its detailed report on *Making the personalisation of care and support work for all communities in the English regions*, the EHRC identifies specific barriers to personalisation or particular unintended but disproportionate impacts on equality of access to personalised care and support. Summing up, it concludes that personalisation can work for all communities, provided there is an understanding of, and a response to, the various impacts on equality:

Personalisation must also take account of how culture and identity impact on an individual's needs. The challenge to the public sector and to provider organisations is not simply how they might better service marginalised groups, but the extent to which they can provide leadership to challenge the stigma, discrimination and low esteem experienced by some groups. This will require fundamental shifts in the ways in which organisations and services engage with groups who face discrimination and disadvantage.

(EHRC 2011a: 32)

Personalisation is underpinned by a human rights framework, particularly the UN Convention on the Rights of Persons with Disabilities. Article 19 of the Convention focuses on personal assistance and independent living and states that disabled people:

should live where they wish and with whom they wish ... they should enjoy a range of community support services including personal assistance ... they should enjoy community life and its opportunities on an equal basis.

(Jolly 2010: 1)

Conclusion

Person-centred support is not another thing services have to do; it's what they must do. It's not another job – it's *the* job.

(Glynn et al. 2008: 11)

Personalisation means thinking about public services and social care in an entirely different way – starting with the person rather than the service. Although this shift will take time, it will ultimately mean change at every level throughout the whole local authority system to ensure that universal services such as transport, housing and education are accessible to all citizens. This means that commissioning must change to be more strategic and open, with a focus on the local community, its resources and the people who use services. Approaches to early intervention and prevention need to develop further so that people are encouraged to stay healthy and independent. The future of health and social care integration should be driven by a need to provide person-centred care and support which is timely and allows people to stay in control.

In social care, system-wide organisational, structural and cultural change will need to take place so that people, rather than systems and procedures, come first. This will include fostering innovative and collaborative ways of working, and giving universal access to information and advice to everyone in need of support regardless of where their funding comes from. It will also require supporting social care practitioners to work in new ways alongside service users, their carers, families and communities. New models of leadership will need to develop to drive and respond to the fundamental changes in power sharing and the renewed focus on front-line relationships.

This guide is intended to sketch out our current understanding of personalisation. SCIE is supporting the sector by rapidly absorbing lessons from innovations and pilots, drawing on the experiences of creative implementers and emerging research findings, and making these accessible through further products and initiatives.

Further information

SCIE personalisation resources

The Social Care Institute for Excellence www.scie.org.uk

Personalisation At a glance briefings

SCIE has co-produced a series of personalisation At a glance briefings looking more closely at implications for different social care stakeholders:

- At a glance 06: Personalisation briefing: Implications for commissioners
- At a glance 07: Personalisation briefing: Implications for home care providers
- At a glance 08: Personalisation briefing: Implications for housing providers
- At a glance 10: Personalisation briefing: Implications for carers
- At a glance 12: Personalisation briefing: Implications for advocacy workers
- At a glance 13: Personalisation briefing: Implications for voluntary sector service providers
- At a glance 14: Personalisation briefing: Implications for personal assistants (PAs)
- At a glance 15: Personalisation briefing: Implications for user-led organisations (ULOs)
- At a glance 17: Personalisation briefing: Implications for residential care homes
- At a glance 18: Personalisation briefing: Implications for community mental health services
- At a glance 20: Personalisation briefing: Implications for nursing homes
- At a glance 21: Personalisation briefing: Implications for people with autistic spectrum conditions and their family carers
- At a glance 22: Personalisation briefing: Implications for community learning disability staff
- At a glance 27: Personalisation briefing: Implications for occupational therapists in social care
- At a glance 29: Personalisation briefing: Implications for social workers in adults' services
- At a glance 30: Personalisation briefing: Implications for NHS staff
- At a glance 33: Personalisation briefing: Implications for NHS staff
- At a glance 35: Personalisation briefing: Personalisation, productivity and efficiency
- At a glance 41: Personalisation briefing: Implications of the Equality Act 2010
- At a glance 42: Personalisation briefing: Implications for lesbian, gay, bisexual and transgendered (LGBT) people

Social Care TV films on personalisation

Social Care TV www.scie.org.uk/socialcaretv with films and related interactive resources. Film titles include:

What is personalisation?

Personalisation for older people: living at home

Personalisation for older people: supported housing

Personalisation for older people: residential care

Personalisation for someone with a learning disability

Personalisation for someone with a physical disability

Personalisation and mental health

Personalisation – making it happen: user-led organisations

Personalisation – making it happen: the social worker's perspective

Personalisation – making it happen: black and minority ethnic (BME) communities

Commissioning for personalisation – London

Commissioning for personalisation – Dorset

Other SCIE resources relating to personalisation

Report 27: Leadership for personalisation and social inclusion in mental health

Report 36: Enabling risk, ensuring safety: Self-directed support and personal budgets

Report 37: Personalisation, productivity and efficiency

Report 40: Keeping personal budgets personal: learning from the experiences of older people, people with mental health problems and their carers

Report 55: People not processes: the future of personalisation and independent living

At a glance 31: Enabling risk, ensuring safety: Self-directed support and personal budgets

At a glance 36: Personal budgets briefing: Learning from the experiences of people with mental health problems and their carers

Social Care TV films – Personal budgets

Health and social care integration

Micro-enterprises

Risk enablement and mental health

Personalisation elearning resources: www.scie.org.uk/publications/elearning

For more information on how direct payments work please see SCIE's *Resource Guide 5: Direct payments: answering Frequently Asked Questions*, which was produced with the National Centre for Independent Living (NCIL).

For more information on how direct payments are working for black and minority ethnic people please see SCIE's *Race equality Position Paper 1: Will community-based support services make direct payments a viable option for black and minority ethnic service users and carers?*

For more about the role of people who use services in culture change see *SCIE People management Knowledge Review 17: Developing social care: service users driving culture change*, produced by Shaping Our Lives, National Centre for Independent Living and University of Leeds Centre for Disability Studies, and *SCIE At a glance 4: Changing social care*.

Social Care Online www.scie-socialcareonline.org.uk

General information on social care and health transformation

Association of Directors of Adult Social Services (ADASS)

www.adass.org.uk

Association of Directors of Voluntary Organisations (ACEVO)

www.acevo.org.uk

British Association of Social Workers (BASW)

www.basw.co.uk

Care Quality Commission (CQC)

www.cqc.org.uk

The College for Social Work

www.collegeofsocialwork.org

Demos

www.demos.co.uk

Department of Health personalisation web pages

www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm

DH Personal Health Budgets information

www.dh.gov.uk/health/category/policy-areas/nhs/personal-budgets/

DH Personal Health Budgets Learning Network

www.personalhealthbudgets.dh.gov.uk

Disability Rights UK

www.disabilityrightsuk.org

English Community Care Association (ECCA)

www.ecca.org.uk

Health and Care Professions Council

www.hpc-uk.org/

The IBSEN project – National Evaluation of the Individual Budgets Pilot Projects

<http://php.york.ac.uk/inst/spru/research/summs/ibsen.php>

in Control

www.in-control.org.uk

Local Government Association

www.lga.gov.uk

My Home Life

www.myhomelife.org.uk/

National Care Association (NCA)
www.nationalcareassociation.org.uk

National Council for Voluntary Organisations (NCVO)
www.ncvo-vol.org.uk

National Skills Academy for Social Care
www.nsocialcare.co.uk

National Survivor and User Network
www.nsun.org.uk

NHS Confederation
www.nhsconfed.org

Office for Disability Issues
www.officefordisability.gov.uk

Shaping Our Lives National User Network
www.shapingourlives.org.uk

Skills for Care
www.skillsforcare.org.uk

Skills for Health
www.skillsforhealth.org.uk

Think Local Act Personal (TLAP)
www.thinklocalactpersonal.org.uk/

About the development of this product

Background

This guide is the third version produced to support the personalisation agenda, with the first version published in October 2008, and updated in April 2010. Personalisation is a challenging field because it has continuously developed through research and practice experience since policy inception. It is therefore entitled a 'rough guide', since the evidence base for particular models is not yet sufficiently strong to support strong recommendations for particular practice models. The first and second editions were extremely well received by the sector, and this version has been fully revised to reflect new research findings, practice and policy developments.

Scoping and searching

Original scopes for the first edition were carried out in January and September 2008; the second edition was based on scoping and searching in January 2010. This third revised version is based on social and searching in February 2012 which was subsequently supplemented by project advisory group members and other field experts.

Stakeholder involvement

SCIE has an in-house specialist in personalisation (senior research analyst) who identified additional material (including what were then brand-new policy documents), carried out the synthesis, and worked with experts. The Partners' Council consultation informed the work. For the first version, external peer review was undertaken by a senior fellow of the King's Fund, and the DH lead for personalisation was consulted, as were the Putting People First Delivery Coordination Group (PPFDCG), and the Transforming Adult Social Care Board. The second version was informed by customer feedback, changing policy and new research, with consultation from PPFDCG.

This third edition required some major revisions and involved the input of a project advisory group (PAG) which included users, carers, practitioners, providers and academics from adult social care and health. The PAG gave initial advice on changes and new material to supplement that identified in the scoping and searching. The PAG members peer reviewed the final draft of the guide. PAG members are listed in the Acknowledgements section.

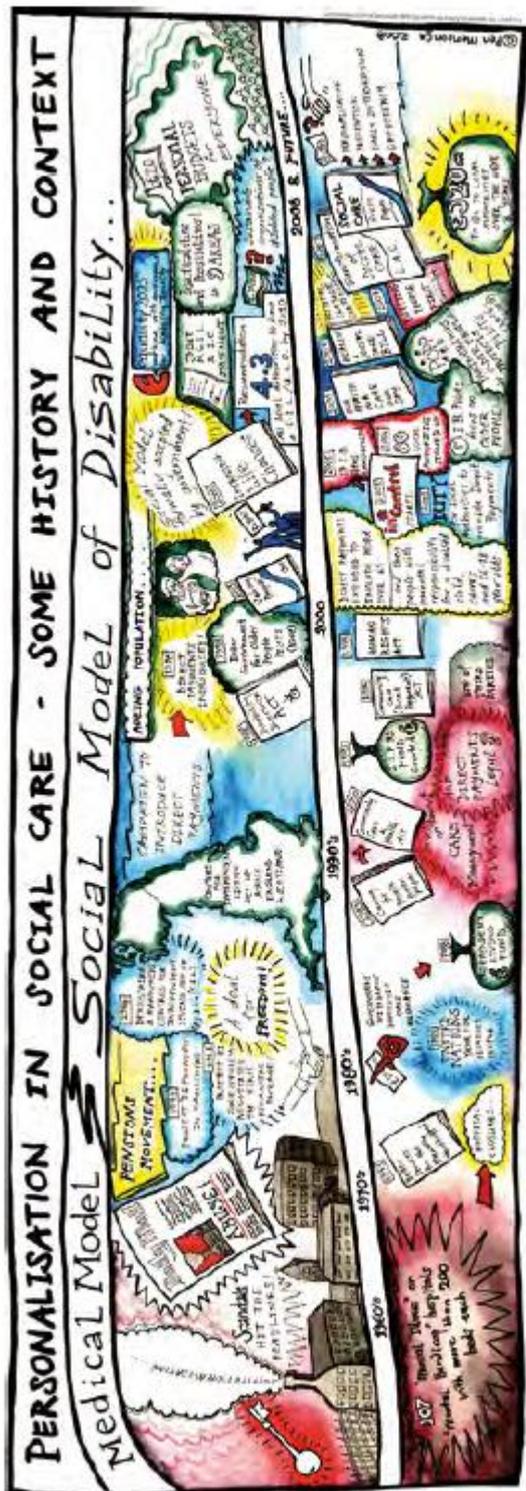


Image: 'Personalisation in social care - some history and context' by Pen Mendonca penmendonca@btinternet.com

Personalisation: a rough guide

Personalisation has been a policy 'buzz word' some time now, and SCIE has been at the forefront of supporting the policy to become a reality. Our latest offer is SCIE's new digital guide to personalisation, an enhanced online resource that follows on from the success of *Personalisation; a rough guide*. We have continued to identify the knowledge on personalisation, explore the principles and explain what the main policy and practice implications are for social care and health. You can still print the guide off but the digital version gives access to multimedia supporting materials, different options for navigation and the ability to bookmark and personalise the guide. So you can have a personalised guide to personalisation.

To view, go to [Personalisation: a rough guide](#)

NHS Evidence accreditation

NHS Evidence has accredited the process used by SCIE to produce guidelines. Accreditation is valid for three years from July 2011 and is applicable to guidance produced using the processes described in the SCIE Guide Production Toolkit. More information on accreditation can be viewed at [NICE Accreditation](#)

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