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PERSONALISATION, PERSONAL BUDGETS AND SERVICE USER INVOLVEMENT IN ENGLAND: AN OPPORTUNITY TO BUILD COMMUNITY CAPACITY AND SOCIAL ENTERPRISE?

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1. INTRODUCTION

Over the past twenty years, English adult social care policy has gradually determined that service users and carers should have greater influence in both strategic and frontline decisions about care and support. This culminated in the 2007 *Putting People First* English government adult social care policy directive (HM Government 2007) which outlined the personalisation agenda and implementation plans, such as self directed support, personal budgets and an increase in user-led organisations as part of the adult social care support infrastructure (Carr 2010a). As outlined in policy and in practice models, 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 received the right help. New 'personalised' approaches like 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 also requires provider market development, building community capacity and local strategic commissioning so that people have a good choice of local support, including that provided by user-led organisations, the local community and voluntary sector and new types social enterprises and mutuals in line with wider public sector delivery business reform in England (Maude 2010; Blond 2009) .

As a consequence of these changes, administrative processes, organisational culture and power dynamics in adult social care are being challenged by the extension of greater influence, choice and control to users of adult social care and support. Service user participation in strategic decision making and service design and delivery along with the personalisation agenda (particularly the promotion of choice and control, self directed support and personal budgets) is allowing people to challenge professional organisational cultures and administrative approaches to care and support delivery. Local authorities and established provider organisations in adult social care have traditionally often prioritised administrative processes rather over the needs of individuals and change as a result personalisation or service user participation (including self directed support and personal budgets) may be resisted. As personalisation is being implemented it is becoming increasingly apparent that people who use services want person-centred, relationship focused working and to determine their own support and outcomes. The emerging evidence base on what works for self directed support and personal budgets shows the central importance of the quality of frontline relationships, communication and a focus on user-determined outcomes. However, traditional welfare structures, organisational behaviours and provider markets are not yet facilitating this. This paper will explore some of the key issues with the implementation of personalisation in England, particularly personal budgets, in relation to increasing choice and control and improving outcomes for people who use adult social care and support. It will also examine some of the service design, commissioning and market reforms needed for the personalisation of the English adult social care system. Finally it will cover some of the current issues with continuing to implement personalisation in the context of severe public sector funding cuts and the effect of some council funding decisions on personal budget recipients.

2. PERSONALISATION: A 21ST CENTURY ENGLISH ADULT SOCIAL CARE POLICY REFORM

As part of their overall public service modernisation programme, the New Labour government personalisation reform agenda in adult social care was formally introduced in December 2007, with the publication of the cross-sector concordat *Putting People First: A shared vision and commitment to the transformation of adult social care* (HM Government 2007) and the subsequent *Local Authority Circular (DH) (2008)1: Transforming Social Care* which detailed the plan for transformation in order to develop "a personalised approach to the delivery of adult social care" and introduced a ring-fenced Social Care Reform Grant of £520m (DH 2008 p1). These reforms were strongly influenced by the policy direction set out in *Improving the life chances of disabled people* (Prime Minister's Strategy Unit 2005) and the local government White Paper *Strong and prosperous communities* (Department for Communities and Local Government 2006). The 2008 Local Authority Circular (LAC) set out some of the defining principles and approaches for personalisation, which were ambitious in scope: "Personalisation is about whole system change, not just change at the margins...[it] reaches beyond the confines of adult social care. It is essentially about a significant cultural shift and management of change for the wider social care and local government sectors" (DH 2008 p5-6). The UK Coalition government, elected in May 2010, has also stated its commitment to adult social care personalisation and personal budgets in the *Vision for Adult Social Care: Capable Communities, Active Citizens* (DH 2010a) which sets out seven key principles for a modern system of social care: prevention; personalisation; partnership; plurality; protection; productivity and people. The vision document states:

"Personalisation: 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 own care" (ibid p8).

3. CONSUMERS AND CITIZENS: PERSONALISATION AND PERSONAL BUDGETS IN ENGLAND

Personalisation can be seen in the overall context of the (former UK) New Labour government public sector modernisation programme, which had three underpinning and, some would argue sometimes ideologically or practically conflicting drivers. The first was to increase the participation and influence of users to shape services from below: "modernisation has...required that the relationship between state and citizen be reconstructed" (Scourfield 2007 p107) and for adult social care, "participation or...user involvement, has come to be seen as a cornerstone of social care and social work policy and philosophy...arrangements for participation now permeate public policy" (Beresford & Croft 2001 p295-296). However, Beresford and Croft observe that "the welfare system has shown remarkable capacity to resist the demands of its users as expressed through consultation and conventional schemes for involvement" (ibid p297). The second was an increase market mechanisms and the involvement of business in the belief that this would not only boost consumer choice but also improve quality and efficiency; however some policy analysts noted that business had greater degrees of influence and involvement in social policy than other stakeholders, such as the consumers or service users (Farnsworth 2006). Some have argued that the combination of user empowerment, citizenship and consumerism does not result in a fundamental shift in power or rights, but the reconstruction of the "role" of the service user as a particular sort of citizen to operate in the adult social care

system: "This transformation is not simply about the reconstruction of citizens as consumers but the transformation of citizens into both managers and entrepreneurs. New Labour's perspective on citizenship appears to focus less on what the citizen should expect from the state in terms of social rights, and more on how the citizen *should be* – in this case, active, responsible and enterprising" (ibid p112). The third element of public sector modernisation was to establish a system of "top down" performance management mechanisms such as performance targets and regulation. One way the government appeared to try and address this issue in adult social care was to launch an ambitious reform programme to give eligible service users the freedom to buy their own support services, with the intention of empowering them as citizens. However, for some there is an inherent incompatibility between the service user understanding of empowerment and that of the state and service system: "for service user movements, getting involved has meant the redistribution of power, democratization and achieving change in line with their rights and needs. For the state and service system there has more often been a managerialist/consumerist model, framed in market terms" (Beresford, 2009 p4). So, one of the tensions within personalisation for adult social care is the construction of the service user as a consumer citizen, or is even resulting, as some have argued, in the demand for the service user as well as the services to be flexible, with the former being expected to a new approach to the design and purchase of their care and support (Farnsworth 2006; Scourfield 2007).

Understanding the history of the disability movement and its influence on personalisation is important for understanding this tension. Since 1996 people eligible for social care support have had the option to take a cash payment to purchase the support they choose in negotiation with their care manager, this is known as a "direct payment" (SCIE 2005). Direct payments were the result of years of campaigning by disabled people who wanted to live independently, take part in community life, have a meaningful occupation and to purchase their own support in order to do so. Disabled people themselves also set up a new type of independent support organisation called a "Centre for Independent Living" which was run by and for disabled people who used direct payments, and could now be understood as a type of social enterprise. This type of enterprise, renamed the "user-led organisation" or ULO in policy documents, became the standard model for the support infrastructure envisaged for personal budgets (DH 2008). The difficulties with local authorities giving people the option to have a direct payment and the resulting problems with uptake led to the experimental design of an alternative "operating system" called self-directed support and personal budgets (which do not have to be taken as cash) so that more people could exercise choice and control over their support packages (Poll & Duffy 2006). The *Putting People First* concordat said that, as part of the social care transformation process, local authorities should offer "personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision" (HM Government 2007). Much of the conversation about personalising adult social care services has focused on personal budgets, particularly as these were referred to in *Improving the Life Chances of Disabled People* (Prime Minister's Strategy Unit 2005) and were the key proposal in *Our Health Our Care Our Say* (DH 2006) The idea of personal health budgets for people with long-term conditions has been introduced and these are now being piloted in 20 in-depth study sites across England (DH 2009a). Initial findings from the personal health budget research show similar cultural, systemic and organisational barriers and facilitators as personal budgets in adult social care (Jones *et al* 2010). Importantly, personal budgets in both health and social care "should be seen in the context of the wider movement to empower people to have more say and control in all aspects of public life" (DH 2009b). For social care this means recognising personal budgets and choice and control as part of the wider personalisation agenda which includes ensuring universal access to public and community services, prevention and early intervention, promoting co-production of services and the growth of social capital in communities and the social care sector, improving access to information and advice for all social care service users

regardless of how they are funded. For service users, having a direct payment or personal budget means being able to choose and control their care and support so that they can be active citizens, which for many is recognised as a human right.

Shortly after the launch of the *Putting People First* concordat, the centre-left social policy think tank Demos directly influenced the interpretation of personalisation for adult social care, by publishing *Making it Personal* (Leadbeater *et al* 2008), a rhetorical and largely theoretical outline for radical reform. This report focused on self-directed support and personal budgets and influenced the direction of much of the early discussion about the implications of personalisation for adult social care in England. Demos positioned the 'new operating system' (as mentioned above) of the 'In Control' programme (a Government sponsored social enterprise programme for improving the uptake of direct payments for people with learning disabilities) as the model for social care reform for all adults, using evidence from the evaluation of the first pilot phase in seven local authorities and highlighting particular individual stories to illustrate the positive impact of the new approach (Poll & Duffy 2006). The report claimed that self directed support and personal budgets could result in cost savings for local authorities, based on evaluations of very small samples of personal budget users, the majority whom were people with learning disabilities who often had higher value support packages than, say, older people. The report cover featured the following quote, indicating the magnitude of the reform ambition: "Personal budgets and self-directed services mobilize the intelligence of thousands of people to get better outcomes for themselves and more value for public money' (Leadbeater *et al* 2008, front cover).

However, references to the origins of direct payments, the role of the disability movement, the social model of disability, the goal of independent living, the service user/survivor perspective, the effects of social and economic deprivation and the role of social work do not feature in the highly influential Demos report. This has lead some social work academics to be very critical of the policy think-tank theoretical analysis of the welfare problems and market-oriented conceptualisation of personalisation early on. One social work academic argued that for reasons of inequality and deprivation, many people who use social care services will not fit the model of active citizenship required to benefit from Demos's conception of personal budgets (Ferguson 2007). Critics of personalisation point to the lack of service user involvement and evidence in the construction of policy, its internal ideological conflicts, the claims about cost savings and the speed of its implementation (Beresford 2009; Cutler *et al* 2007). The public sector union, UNISON, later voiced workforce concerns about social care funding, pay and conditions and the increased marketisation associated with the implementation of the reforms (Land & Himmelweit 2010).

In terms of operation, the unique characteristic of the personal budget approach is giving clear understanding of the amount available to the individual (this can be taken as cash or as a managed option), so that they can influence or control the spend, in a way which helps them best meet their needs. They must be implemented within the framework of self-directed support which involves self-directed assessment, 'up-front', transparent allocation of funds and support planning to promote maximum choice and control. As part of self-directed support, the personal budget holder is encouraged to devise a support plan to help them meet their personal outcomes. Assistance in developing this plan can come from social workers, user-led organisation and other support organisations, 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 or third sector, user-led organisations, community groups, and neighbours, family and friends. People can use their budgets to access a wide range of services, including traditional social care, as long as it is legal and meets agreed outcomes. Support plans should be periodically reviewed with the person to make sure agreed outcomes are being met

and to respond to any changes (Bennett *et al* 2009). Evidence from piloting and early adoption shows that some people will use the new flexibilities to design very different services, while others (most notably older people) value the ability to adjust more conventional packages to deliver a service more responsive to their own needs (Bartlett 2009).

4. PERSONAL BUDGET SCHEMES: INTERNATIONAL EVIDENCE AND PERSPECTIVES¹

Within the European and wider international context, England is undergoing welfare reforms similar to those of its fellow welfare states, but approaches to new types of social care funding distribution, provision and practice may remain peculiar to the particular national context. In Western Europe and other developed welfare states "a new type of government regulation designed to restructure rather than reduce welfare programmes" (Pavolini & Ranci 2008) has emerged, although very recent economic events and severe cuts to public funding means that welfare programmes may also be reduced as well as restructured. Importantly, a comparative investigation into the operation of personal budget or "cash-for-care" schemes in the UK, Austria, France, Italy, and the Netherlands concluded that:

there is considerable variation in the way cash for care schemes have developed, but [there] is no single blueprint that can be advocated as without disadvantages, or indeed as the best scheme so far available...we can only stress that these schemes will not, and cannot, offer governments a panacea for the difficult problems they face in developing good quality social care. (Ungerson & Yeandle 2007)

Over the past decade many developed welfare states in Europe, the USA, Canada, Australia, and New Zealand have started to implement social care reforms which allow greater choice and control for the person using care and support services. Motivations for this overall trend towards offering service users options like personal budgets, direct payments (or cash for care), and voucher systems appear to be broadly similar across nations and states. Schemes have been piloted and introduced for various service users with differing patterns of restriction on spend and levels of regulation.

When considering the development of personal budget and self-directed care schemes internationally, it is crucial to understand the public policy framework and socio-political cultural context in which they are being conceived, the models of citizenship in which they have a value-base and the people who are eligible for the particular programmes (Cloutier *et al* 2006; Phillips & Schneider 2007; Newman *et al* 2008; Glendinning & Bell 2008). European research has indicated that "the precise architecture of each cash-for-care scheme as it emerges in its national context is highly variable" (Ungerson & Yeandle 2007). Some schemes are primarily aimed at promoting independent living, while others are designed to improve the family's capacity to take on caring responsibilities, and most share the goal of cost reduction (Timonen *et al* 2006; Da Roit *et al* 2007; Ungerson & Yeandle 2007). Eligible groups differ between national systems and fewer schemes to date have been available for people with mental health problems (Roehrer Institute 2000; Waterplas & Samoy 2005; Arksey & Kemp 2008) Although personal budget systems have been found to have a variety of aims, with some designed to the use of expensive residential care (Waterplas & Samoy 2005) and others partly aiming at solving the problems resulting from a shortage of long-term care staff (Tilly *et al* 2005) in Europe their

¹ For a full account see: Carr S & Robbins D (2009) *SCIE Research Briefing 20: The implementation of individual budget schemes in adult social care* London: SCIE

introduction has been linked to certain overarching EU objectives, including market development (Glendinning 2009). A relative perspective allows an assessment of the extent to which implementation lessons can be learned, sustainability assessed, and approaches replicated for UK policy and practice. Based on direct payment uptake data, even within the UK some authors have noted differences in the policies and operation of social care systems between the four administrations that could influence the implementation of personal budgets (Pearson 2006; James 2008). For example, eligibility for access to social care services can vary between UK countries and the local authorities within them, depending on local resources and interpretation of social care funding eligibility criteria. (Glendinning & Bell 2008; Glendinning 2007).

Policy analysis shows that one of the main drivers for welfare reform and the introduction of cash allowance schemes across countries is to address the increasing need for long-term care and support by an ageing population (Timonen *et al* 2006; Wanless 2006; Da Roit *et al* 2007; Pavolini & Ranci 2008;). The EU has a policy strategy aimed at developing markets within social and long-term care services (Glendinning 2009), although research also indicates that allowing people more control over their care and support does not inherently imply further marketisation (Ottmann *et al* 2009). Comparative investigations between European countries operating "cash benefit" schemes for adults have shown that the majority is only needs tested (Cloutier *et al* 2006; Glendinning 2009). It has been noted that England is unusual in Western Europe for having assessment that relies on both a needs and a means (or assets) test and employs restrictive eligibility criteria,(Glendinning & Bell 2008; Glendinning 2009) which has had a particular impact for older people seeking social care support (Henwood & Hudson 2008; Wanless 2006) and many older people are funding their own social care (Newman *et al* 2008).

Research suggests that "one important aspect of choice and control is what may be purchased with cash-for-care payments" (Arksey & Kemp 2008). Some countries allow recipients to spend their allowance how they wish while others have more restrictive conditions and heavier regulation (Timonen *et al* 2006; Da Roit *et al* 2007; Ungerson & Yeandle 2007). For example, the established German, Dutch, French, and Swedish systems are "closely related to a case management system and with strong accountability controls" (Pavolini & Ranci 2008), but Italy and Austria have systems which are largely unregulated (Arksey & Kemp 2008). Some systems allow people to purchase practical and personal care from friends and relatives while more restrictive voucher systems militate against this option and only enable people to purchase care from traditional support agencies (Glendinning 2009). The Dutch system introduced vouchers to enable choice in labour market reintegration services as well as personal care (*ibid*). The US Cash and Counseling personal budgets are "offered in lieu of traditional Medicaid-covered services" (Doty *et al* 2007) and are only allowed to meet "health and disability related [social care] needs, not to cover general expenses or luxury items" (*ibid*). This means that budget holders can only spend their allowance on personal care and home support, although this can be purchased from relatives or neighbours in some cases (Phillips & Schneider 2007). The six-year, three-state Cash and Counseling Program study research indicates specific defining elements, particularly in relation to spending restrictions and risk management (Robert Johnson Wood Foundation 2007). Cash and Counseling has defined limits and restrictions on how people can spend their personal budgets and the personal budget option is seen as supplementary to existing state directed services (Robert Johnson Wood Foundation 2007; Schore *et al* 2007; Hall & Jennings 2008).

Despite the structural and systemic differences between countries operating adult social care personal budget schemes, commonalities have been identified for the establishment of this approach in developed welfare states:

- consumerism and empowerment;
- cost containment;
- the use of cash-for-care schemes to shift the locus of care to home and community and from state to individual;
- the power of the disability lobbies to link the notion of independence and direct employment of personal assistance through the use of cash for care. (Ungerson & Yeandle 2007)

Similarly, research into adult long-term care reforms focusing on cash allowances in France, Germany, Italy, the Netherlands, Sweden, and the UK has shown that "although embedded within peculiar national traditions, [the] new policies share some characteristics:

- a tendency to combine monetary transfers to families with the provision of in-kind services;
- the establishment of a new social care market based on competition;
- the empowerment of users through their increased purchasing power;
- the introduction of funding measures intended to foster care-giving through family networks" (Pavolini & Ranci 2008)

A comparison between schemes operating in England, Finland, Ireland, and the Netherlands indicated the following as similar goals:

- increasing freedom of choice, independence, and autonomy for care recipients;
- compensation for gaps in existing services;
- the creation of jobs in personal-care services;
- efficiency gains or cost savings through reduced overheads and increased competition between providers;
- the shift of care preferences and use from institutional to domiciliary care. (Timonen *et al* 2006)

Although no universally successful and applicable scheme has been demonstrated by international research studies from the UK, Europe, and the USA have found that central government has a vital role to play in providing the optimum conditions in which cash for care schemes can work (Ungerson & Yeandle 2007; Glendinning 2009). Although much long-term care reform centres on devolved power and decision making, research suggests that central government has a strategic role to play in ensuring policy coherence and in addressing funding stream alignment across departments, particularly between health and social care. Central government should also provide leadership and guidance to ensure quality, equity, and equality of opportunity for all potential users of direct payment schemes (Ungerson & Yeandle 2007; James 2008; Netten *et al* 2008; Glendinning 2009; Ottmann, *et al* 2009).

5. BUILDING COMMUNITY CAPACITY, BLURRING BOUNDARIES: COMMISSIONING FOR INNOVATION AND EFFICIENCY

One of the barriers to achieving choice and control for service users through personal budgets and direct payments has been the lack of diversity in the social care market, with large providers still dominating and smaller innovative local and "civil society" providers such as social enterprises and micro providers being less prevalent (Singh 2010). This has partially been due to commissioning practice and the slow process of decommissioning the older large block

contracted services (IPC 2010). Policy makers had also initially assumed that once people were given a budget to spend then the market would somehow flourish without further reform or development (Leadbeater *et al* 2008) (critics of this position argued that this had not happened with people funding their own care so why should it with state funded people?). However, this has not yet been the case and both central and local government are considering ways to develop local adult social care and public sector provider markets and something which the UK Coalition Government is seeking to address in its Modernising Commissioning programme, designed to improve the conditions for charities, mutuals, social enterprises and co-operatives to deliver public services (Cabinet Office 2010). The English National Market Development Forum recently identified some defining characteristics of an "ideal" social care market, one of which was a new form of local strategic commissioning practice which involves people who use services and invests in social capital of individuals and communities:

"Mechanisms will be in place that enable people with care and support needs, their carers and families, to contribute to the direction for local commissioning and service development and communicate their aspirations and priorities to the market... Both the way that services are commissioned and delivered will take account of people's social capital and will seek to build these reserves where they are not available... Simpler tendering and contracting arrangements will actively engage people with care and support needs throughout and increasingly view providers as partners." (NMDF 2010 p9-10)

Similar recommendations on adult social care commissioning reform and market development were made by the UK Association of Directors of Voluntary Organisations (ACEVO), who account for the severe cuts to public sector resourcing in their thinking and are radical in their suggestions for new forms of collaboration and a "new mutuality": "the Government should tilt its funding and reforms towards the promotion of mutual aid" (ACEVO 2010 p4). Further, as will be discussed further below, they recommend "supporting prevention and the development of social capital, including through the greater use of social investment, extension of co-funding, 'mutual budgets' allocated to individuals who band together to form mutual support networks, and linking the Government's initiatives on neighbourhood budgeting and community organisers" (ibid p5). With regard to investing in mutual support networks, funders and commissioner need to understand the type of social enterprise or charity that constitutes a user-led organisation, which research shows are a vital part of the support infrastructure for people using personal budgets (Carr & Robbins 2009, Davey *et al* 2007). A regional evaluation of the relationship of commissioners to user-led organisations in England showed mismatches in understanding of business models and tendering processes (SES 2010).

So, service users' ability to use their personal budgets to purchase better value care and support can be limited by their local social care and support market as well as their personal budget amount. The Office for Public Management's (OPM) survey of personal budget users in Essex in South East England showed that "service users and their relatives tended to feel they had limited purchasing power within the market for social care services because the rates being charged by many companies were higher than their personal budget enabled them to spend" (OPM 2010 p 5). There have been similar findings for direct payments (Audit Commission 2006; Davey *et al* 2007). Coupled with this, there is also increasing evidence from the independent provider sector and from local micro providers (of 5 people or less) that local authority commissioning practice is not yet facilitating the type of market development and diversification needed for personal budgets to be used effectively and efficiently (NAAPS 2009; Dayson 2010; IPC 2010; Macmillan 2010; VODG & IPC 2010). The voluntary sector is providing some evidence on providing efficient and cost effective services for people using a personal budget,

but there can regulatory and commissioning issues and behaviour which make it difficult for local voluntary or community services to enter or maintain their place in the market (NAAPS 2009; Dayson 2010; DH 2010c; VODG & IPC 2010). Therefore the potential for efficiencies and improved outcomes as a result of personalisation may not yet be realised because of current commissioning practice (DH 2009c). The Confederation of British Industry (CBI) and the LGA have reported that outcome based, user-directed, flexible approaches to commissioning services, rather than rigid "time and task" service models, can result in greater efficiency and better outcomes (CBI & LGA 2009).

Personalisation and self-directed support was designed to recognise and support a person's informal support networks such as family and friends, neighbours and volunteers and to increase links with and activity within the local community (DH 2010a; 2010b). Early indications have been that people who hold personal budgets have used them to increase participation and activity in their communities, reducing social isolation through building links with local people, organisations, universal services, education, training and employment, to promote independent living (Bartlett 2009; Audit Commission 2010; Newbronner *et al* 2010; OPM 2010; Wood 2010). A UK Audit Commission survey on personal budgets found that "research participants used personal budgets to improve housing, stimulate the local economy, strengthen the role of voluntary organisations and help people into employment" (Audit Commission 2010 p 17). Greater involvement with and access to community networks and support is being shown as having a preventative effect (Raynes *et al* 2006; VODG & IPC 2010), and the idea of pooling personal budgets to fund community-based support enterprise is being explored (DH 2009d; Fox 2010).

Clearer evidence is appearing about the economic benefits of certain approaches to building community capacity (DH 2010d). A recent study "calculated the costs of three particular community initiatives – time banks, befriending and community navigators for people with debt or benefits problems – and found that each generated net economic benefits in quite a short time period" (Knapp *et al* 2010, p 7). More broadly, the use of personalised and "low level" community-based approaches to integrated health and social care can result in crisis prevention and avoiding admission to hospital or residential care, particularly for older people (Raynes *et al* 2006; PSSRU 2008; DH, 2009c). The way people use personal budgets can be preventative, particularly in mental health (Spandler & Vick, 2006; Glendinning *et al* 2008), thereby reducing health crises or hospital admissions that can result in savings to health. However, in some local authorities funding for personal budgets is being reduced to only cover basic personal care (Dunning 2011) or still pays for pre-existing care packages over which people have no choice or control (Newbronner *et al* 2010), rather than offering broader opportunities for social inclusion, community activity, prevention and personal productivity, it remains to be seen whether these wider, longer-term community and cost benefits will be realised.

6. WHITHER NEXT FOR PERSONALISATION IN ENGLAND? APPREHENSIONS AND POSSIBLE CHANGE IN A CONTEXT OF REDUCED PUBLIC FUNDING

The reality of public funding cuts in the UK has been well publicised since the Coalition government took office in May 2009 and is now beginning to have a demonstrable effect on adult social care "choice and control" personalisation reforms, particularly personal budgets, community capacity and the diversification of local provider markets . The perception of the Coalition after a year is that generally the Conservation "partner" is dominating the agenda. At

an event held at the Constitution Unit in London it was suggested that the Conservative partner had managed to get the better of the deal.²

The Coalition Government programme published on 11 May 2010 stated the clear intention to seek cuts in public sector spending, with decisions on how to make those cuts passed on to local councils as part of the "localism" agenda and the devolution of certain aspects of power in the public sector down to local level.

The parties agree that modest cuts of £6 billion to non-front line services can be made within the financial year 2010-11³

A key question is whether such cuts will indeed be contained to "non-front line" services and savings sought from streamlining administrative processes and rationalizing "back-office" functions (something for which there is emerging evidence on increased cost efficiency see: Carr, 2010b), given the speed and scale of the cuts being demanded by the Coalition Government. The agenda of a number of key stakeholders (especially public sector trade unions such as UNISON) is around the implications for public sector workers and, increasingly the users of public sector services. The numbers of jobs losses posited were influenced by an inadvertent disclosure by a Government minister:

"The coalition expects 490,000 public sector jobs to be lost by 2014-15 as a direct result of its drastic spending cuts, Danny Alexander, the chief secretary to the Treasury, has accidentally disclosed. Alexander inadvertently allowed two pages of tomorrow's spending review to be photographed as he left the Treasury building".⁴

However the key implication is in the actual reductions for local council funding. Such funding cuts would have implications for all council activities, including personal budgets and for the wider aims of personalisation such as building community capacity and improving access to universal services and civic amenities. The Coalition Government indicated that councils across England would have their funding cut by 28% over four years. Associated with this cut George Osborne, the Chancellor of the Exchequer, announced a 7.1% reduction in local government funding each year until 2014.

It can be argued that there is an inherent tension between the "choice" envisaged by personalisation and personal budgets and the (understandable) desire of key public sector stakeholders to minimise the adverse consequences of budget cuts for their staff as well as for the service users and carers. The usual strategies employed in the public sector (and indeed in other large organisations) in such a case is to freeze recruitment and to encourage staff to take advantage of early retirement. Redeployment is also a common strategy in order to cover shortfalls in staffing as a result of "unplanned" departures. In the case of personal budgets and personalised services this might well lead to a situation where staff find themselves working in settings for which they were not trained and where they located as an alternative to redundancy.

There are also legal implications for some local council decisions on cutting adult social care budgets. Attempts by Birmingham, a major English local authority, to cut care budgets were only staved off by some of those affected going to court. In an account of the judicial hearings a comment was made that:

² 11th March 2011 The Black Widow Effect? A Pessimist's take on the Consequences of the Coalition for Clegg & Co. Tim Bale (University of Sussex) held at Constitution Unit, University of London

³ Coalition Programme 11 May 2010

⁴ The Guardian 19 Oct 2010

^{5a} Polly Curtis Guardian Whitehall Correspondent 19th October 2010

"It was thought that up to 5,000 disabled people in Birmingham would have been denied all or parts of their front line social care packages currently provided by the Council under the plans"⁵

What is perhaps significant is that the argument made against the cuts was primarily procedural in that the local authority had not adequately consulted or taken account of equality law. The judgement made stated:

"Mr Justice Walker declared that both Birmingham City Council's budget setting and decision to change its eligibility policy, were unlawful on the grounds that they did not promote equality under Section 49A of the Disability Discrimination Act 1995 and their attempts at consultation were flawed."⁶

There is little doubt that other local authorities will be taking legal advice in order that similar exercises in cutting budgets or reducing eligibility will be immune for similar challenge. In the case of Birmingham the likely effect will not be to prevent the overall cut in the municipal budget but rather to either delay it or to move it to another area of provision. On a national level, the English parliament's Joint Committee on Human Rights is holding an inquiry into implications of Article 19 of the UN Convention on the Rights of Persons with Disabilities for adult social care provision⁷. Article 19 recognises the equal right of disabled people to live in the community with choices equal to others.

An inherent risk associated with personalisation is that because personal budgets are held on a individual basis, a reduction or a tightening of criteria may not be picked up in the way that a similar action would be noticed in the case, for example, of a unionized workforce reduction or of a cutting of a large grant or contract with a third sector organization. In the early days of mining a canary was carried down the mine because, being more sensitive than a human being, it gave early warning of the presence of dangerous gases. How can the effects of the case such reductions or restrictions on the individual personal budget recipient be highlighted and challenged? Through collective action, online campaigning and networking and civil activism? Critics have pointed out that the ways councils administer personal budgets does not always encourage collective approaches or peer support (for example, that which could be facilitated by independent user-led organisations): "...current discourse around direct payments stresses independence, individual choice and responsibility. The desirability of funded, collective and mutually supportive networks to make them work more effectively is seldom articulated as strongly" (Scourfield 2007 p117).

A perceived crisis in the costs of social and residential care has been developing for some time. In a hard hitting report focused on the elderly one of the main voluntary organizations in the UK drew attention to the funding and resource implications (Age UK 2011). One of the main private sector providers of residential care in the UK (Southern Cross) is, at the time of writing of this paper, seen as on the verge of collapse. This collapse was, by account, significantly brought about by a combination of the impact of reduced funding for residential care places for a lease structure based on annual rent increase miscalculations; increased competition through people choosing to stay in their own homes for longer; poorer rated performance by the private sector

⁵ <http://www.bbc.co.uk/news/uk-england-birmingham-13147675>
Accessed 30 May 2011

⁶ <http://www.bbc.co.uk/news/uk-england-birmingham-13147675>
Accessed 30 May 2011

⁷ See: <http://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/news/independent-living-inquiry-launch/> Accessed 30 May 2011

and the mismatch with the business investment model of the main shareholder – a private equity firm – and a fatal misunderstanding by the corporate investors about the nature of residential care homes being about property letting rather than the provision of sub-acute health care (O'Connor 2011a). This has led to the most one of the most influential international business newspapers – the Financial Times – to condemn Southern Cross for running on a "failed business model" (O'Connor 2011b).

Whilst supportive of Personal Budgets Age UK (the largest, most influential older people's charity in the UK) stated their concerns in the following way:

"More recently, growing emphasis has been placed on more personalised services, including increased uptake of Direct Payments, preventative support and improved information and advice. This reform agenda is laudable, and in a different financial climate could be delivering significant improvements in care. But with insufficient funding, the results have been patchy, with many authorities simply lacking sufficient funds to provide adequate personal budgets or invest in prevention at the same time as they withdraw existing services." (Age UK 2011:3)

Age UK demonstrate this through identifying the trend of reduced expenditure before the current signaled reductions in public funding. (Figure 1.)

Figure 1 Net Spending on older peoples social care in England⁸

Year	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Net spending	£6,850,000	£7,438,000	£7,683,000	£7,680,000	£7,421,000	£7,384,000
Real increase	6%	9%	3%	0%	-3%	0%
	outturn	outturn	outturn	outturn	outturn	outturn
Year	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Net spending	£7,633,000	£7,482,000	£7,407,000	£7,333,000	£7,260,000	£7,187,000
Real increase	3%	-2%	-1%	-1%	-1%	-1%
	outturn	budget	projection	projection	projection	projection

NOTES

2010 prices; Outturn: Personal social care expenditure and unit costs 2009/10, NHS Information Centre
 Budget: Revenue Account Budget (revised) 2010/11, Department for Communities and Local Government; Projection: -1% real terms assumes government projections for local government spending and £2 billion top-up for social care passed on in full. Early indications suggest these are optimistic; Inflation index: RPI

The report draws attention to three concerns about reduced financial provision in this area of need:

- Tougher eligibility rules
- Variations across the country
- Inadequate services

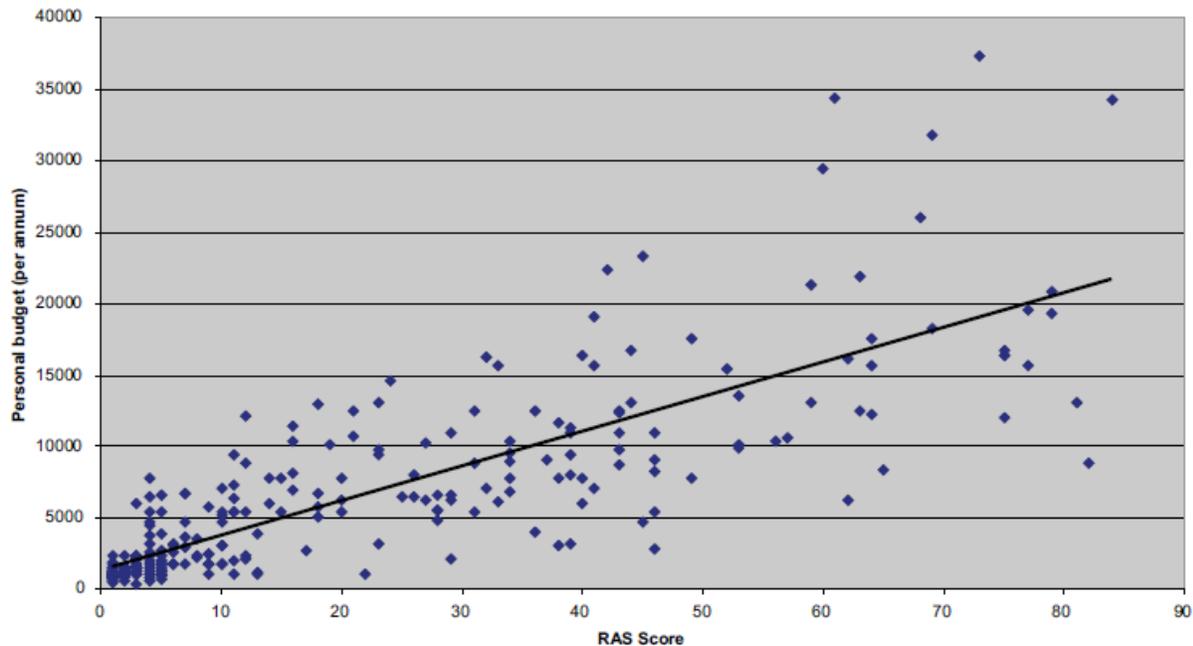
There are implications for personal budgets and choice in respect of all these concerns. Provisions made under personalisation are described as "often paid at such low levels that older people have little room for manoeuvre in buying their own services" (Age UK 2010 p.7).

⁸ Source : Age UK 2011:6

There are implications of a tighter analysis of the allocation or funding against outcomes which may bring about some possibly unintended consequences. Ayling and Cattermole examined performance factors and in Figure 2 below provide an example which identifies the points allocated under the personal budget Resource Allocation system (RAS) against the amount of the cost of provision (Ayling & Cattermole 2010). They note that, given the complexity of current provision, personal budgets may offer a means to enable more accurate assessment of actual costs. However they also caution that "self-directed support, per se, may be unlikely to deliver cost reductions unless accompanied by measures to deliver wider strategic change" (Ayling & Cattermole 2010 p.24).

The implication of greater sophistication in measuring cost of provision against assessed need has the clear implication of potential reductions in budgets where the provision is seen as out of step with the RAS. It is questionable whether the reverse calculation (increasing provision which appears under-resourced) will apply in a context of straightened resources.

Figure 2 Older People: RAS score mapped to budget



9

One key organisation in the personalisation arena in the UK is Carers UK. They represent the huge cohort of people (often family, friends or neighbours) who give time, often unpaid and unrewarded, to look after people who need care and support. They are supportive of personalisation but are also critical of the slow progress and also over a perceived narrowness of focus. In the comment below from a recent report they draw attention to differences between the UK and Europe in the nature of the care market. The implicit implication of the latter part of the quote is that personalisation should be extended and seen as a general right for all those involved in the care setting.

"The drive toward personalisation of services through direct payments and individual budgets is creating change, but has a long way to go to fulfil its potential. There are no clear drivers or incentives for shaping and stimulating the care market. Elsewhere in Europe the care market is seen as a dynamic mixed economy growth sector, which is improving the quality, quantity and affordability of a wide range of care services. Critically, these are seen not as services to 'needy' individuals, but services to families that enable their family and working lives." (Carers UK 2010 p.5)

It could be that this view of Carers UK will be seen as purely aspirational in a context of reduced budgets and a perceived need to tighten eligibility criteria, but it serves to contrast the English "individualised" needs- and means-based understanding of adult social care and the limited provider choice with the European situation which appears to be more holistic and dynamic in approach.

⁹ Source Ayling and Cattermole (2010) p.10

CONCLUSIONS

The English Coalition Government document which makes a continued ideological commitment to personalisation is called *Vision for Adult Social Care: Capable Communities, Active Citizens*. This title implies that personalised adult social care should be about more than basic personal care, but about people being able to choose and control their support to enable them to be active members of society, rather than having their lives restricted by inappropriate, inflexible or inadequate services. It also implies the need for community development and capacity building, local commissioning which encourages social enterprise and small voluntary or community providers and ensuring that everyone has equal access to the same opportunities for civic and social life, regardless of disability, mental health status or age. Evidence is beginning to show that such approaches have the potential to make adult social care more productive, preventative and efficient in the medium and longer term. However, at present the Coalition Government appears to be undermining its own vision and ambition for adult social care.

As the international research evidence on personal budget schemes has shown central government cannot divest itself of its strategic role in ensuring policy coherence and in addressing adult social care funding issues. Central government should also provide leadership and guidance to ensure quality, equity, and equality of opportunity for all current and potential users of personal budgets. However, the unprecedented degree and speed of public sector funding cuts and the decentralisation agenda mean that local councils are left to make their own rapid decisions about where and what to cut. Increasingly some of these decisions appear to be having a direct negative effect on people providing, working in and using adult social care services, and this may have serious financial, business and legal implications. At the time of writing, the English Care Services Minister, the Liberal Democrat MP Paul Burstow, has strongly criticised some of the decisions made by certain councils to cut or restrict the spend of people's personal budgets. Burstow is clear that this undermines choice and control and, ultimately, goes against "the spirit of personalisation" (Pitt 2011). But how to keep that spirit alive in the current social, economic and political climate in England remains to be seen.

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