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Reforming Care and Support in the Home - The Implications of Personal Budgets on Providing Care for Older People Using the Example of the London Borough of Barking and Dagenham

eingereicht bei

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1. Introduction

1.1 Abstract

In July 2012 the Conservative-Liberal Democrat coalition government published the white paper "Caring for our future: reforming care and support". At the same time the London Borough of Barking and Dagenham embarked on the journey of reforming care and support in the home by replacing care agencies with personal assistant support for older people. This thesis will show that both those events are linked and embedded within a journey, starting with the rise of the New Public Management which resulted in the development of the Care Management approach in the 1980's. These policies were supported by the Independent Living Movement and the 1996 Direct Payment act and then exasperated by the push to personalising public services. For adult social care this was outlined in the 2006 White Paper "Our Health Our Care Our Say" and then subsequently put into action by the "Putting People First" concordat in 2009.

The journey described above and within this thesis is also the story of how personalisation was established in England. In order to understand why Barking and Dagenham is trying to replace care agencies with personal assistant support for older people we must understand the recent history of public welfare, social work and politics in England. We will see that the journey is not a straight forward one. There are detours which some describe as distractions or even unnecessary while others deem them necessary to get to where we are now. This thesis will try to show both perspectives.

After having set the scene with a brief history of policies and politics in adult social care the reader will learn about the "Choice and Control Project" in Barking and Dagenham. This project was established not only to follow the recommendations of the before mentioned 2012 white paper "Caring for our future: reforming care and support", but crucially in an endeavour to try and fix the problems currently experienced with care agency support. Ultimately Barking and Dagenham wants the initiative to enable services for older people to be truly personalised.

The "Choice and Control Project" is only one of many initiatives to implement personalised services which are happening all over England. To put this into perspective the last chapter will relay the findings of two studies and a review around personalisation and/or the older people homecare market. This will show that even though personalisation is commonly rated as having a positive impact it does come with its own problems of implementation which need to be recognised in order to be overcome.

Having been an active part of the personalisation agenda in England since 2004, but with a social care background in Germany, the journey of this thesis was one of discovery. Discovering the history of the social care system in England and tying it to the current developments has helped to create a clearer picture as to why things are unfolding the way they are presently. It is quite interesting to note that, even though the overarching paradigms of adult social care between England and Germany are generally following the same ethos, the implementation follows a different pace and has different results. This thesis could have been a comparison between England and Germany to emphasise these differences and make even more sense of them, as there is much to be explored in this respect. But it was decided against this as this would have meant to uncover the journey of two countries which would have taken space away from telling one narrative properly. Hopefully the reader will be able to relate from the way the story is told how each country in this context England has its own journey which will shape and influence the present of a certain topic in this context personalisation.

1.2 Definition of Terms

Before getting into the story of personalising services for older people this chapter will endeavour to define some of the terms which are the key to understanding this journey. The terms Personalisation, Self Directed Support and Direct Payments mean different things by definition; however in practice are often used synonymously or even mixed up. Section 1.2.1 and 1.2.2 of this chapter will attempt to clarify the meaning, while alleviating confusion and explaining how these terms will be used in the remainder of this discussion.

As this thesis focuses on older people point 1.2.3 will clarify which group of people are defined within this term while also explaining why no other term is used to describe this customer group. As there are some other connotations when the term older people is used in the context of social and health care this chapter will also give a brief summary of the challenges social care is about to face in the near future.

1.2.1 Personalisation

When typing the term personalisation into the UK google the first 9 entries refer to adult social care. When entering the same term into the US google the first entries the search engine comes up with are mostly technology or social media related articles. Even though the term personalisation is also used in the social care context in the US. This hints to the fact that currently in the UK there is a big interest in personalisation in adult social care. Interesting to note is that the term personalisation is not currently featured in the Oxford or Cambridge dictionaries.

In line with the assumption that personalisation is a so called "buzz word" in adult social care, the Department of Health (DH) makes it clear that it is central to the current developments in social care and how it links with other terms like self directed support and personal budgets:

> *"Central to the transformation of social care .... is the concept of personalisation as an approach to the delivery of public services, self-directed support as a manifestation of this concept in health and social care and personal budgets as the operating system that will deliver choice and control to citizens requiring social care support." (DH, 2008 p 9)*

A dictionary of social work defines personalisation as follows:

> *"**Personalization** the strategic reorientation for health and adult social care based on the twin principles of early intervention and user choice and control over the service they receive." (Pierson; Thomas 2010 p 394)*

Needham (2011), who analysed literature and conducted interviews with professionals and service users to establish the personalisation narrative in public services, finds that definitions offered in government documents are vague, and that very often they fit as well into the developments of the welfare state at any period since the Second World War. Her own "emphasis ...[is] on how services will be tailored to the person, with the individual as the unit of analysis. This does not preclude individuals working with others to commission and share group services, but it does assume that services cannot be personalised to a community" (Needham 2011 p 30). Her own analysis and the interview data collected for her project, showed that it is not possible to identify a simple or one-dimensional definition of personalisation, but a set of related stories about public service reform. These stories are based on common sense diagnoses about what is wrong with existing policy and a set of self-evident assumptions about how service can be improved. In her own words these "feature a cast of professionals (usually bad) and service users (often heroic), and a simplified set of assumptions about how complex policy tools can achieve desired results" (Needham 2011 p 48).

Even though definitions can often be a bit woolly this clearly shows that personalisation is to be seen as a description of what is happening in adult social care (and in other public services) on a strategic meta level Point 1.2.2 will separate the term personalisation from self directed support and direct payments which in comparison are terms describing the practical implementation of personalisation.

1.2.1 Self Directed Support, Personal Budgets & Direct Payments

Whereas personalisation is a term being used outside social care, self directed support, personal budgets and direct payments are terms unique to the area of adult social care. As defined above in the DH definition the term personalisation can be seen as the umbrella to the terms that will be defined below.

By definition self directed support, personal budgets and direct payments describe different and distinct things, but at the same time they are so interconnected that they could often seem to mean the same thing. In order to clarify these differences as well as, how they are linked and used, each will be defined individually, and their relationships will be illustrated.

Direct Payments

A social work dictionary defines direct payments as "local authorities transferring funding directly to service users who could then purchase their own services" (Pierson, Thomas

2010, p 167). This has been legally possible only since the introduction of the groundbreaking Community Care (Direct Payments) Act 1996. Glasby and Littlechild (2009) go on to say that, "this is available for social care only, and can be used to contract with a private/voluntary sector agency or to become an employer by hiring one's own staff - it cannot be used to purchase public sector services" (Glasby, Littlechild, 2009, p xi). Before the personalisation agenda was introduced, direct payments, even though a major step forward, were established in a restrictive care management system and were not able to unfold to their full potential (Duffy 2005, p 8). In easy terms, direct payments are cash payments directly to a service user.

Personal Budgets

Broadly speaking personal budgets are "...funding allocated to an individual on the basis of need which can be spent as directed by the service user in order to achieve agreed outcomes" (Pierson, Thomas 2010, p 268) but to describe the ethos one would have to add that "..., it involves being clear with the person from the outset how much money is available to meet their needs, then allowing them maximum choice over how the money is spend/how much control they want over the money" (Glasby, Littlechild 2009, p xi). In order to define personal budgets in the way this term is used in adult social care in England today it is important to understand that it was developed to distinguish personal budgets from individual budgets. Individual budgets described budgets that integrated multiple budget sources like Access to Work (AtW), Supporting People (SP) and Independent Living Funds (ILF) which are all funds allocated through different means to disabled citizens from different government agencies. However, attempts to integrate multiple budget sources, derived from different government agencies, were recognised to be problematic, and implementation shifted back to a focus on budgets for social care.

To summarise, personal budgets is the term for a personalised service funded by the local authority alone. It follows a distinct process which allows the service user to exercise maximum control. Whereas direct payments only describe the way the money goes directly to the service user, personal budgets include different delivery mechanisms and can be administered as a direct payment or with different methods. Those methods include indirect payments, where a payment is made to a third party which supports the individual to administer the money. The third party could be a professional body like a payroll agency, or a family, perhaps even a friend of the individual. They also include individual service funds (ISF), which is also known as managed personal budget. in this case either a service provider or the local authority manages the funds on behalf of the service user.

Self directed support

To define self directed support one needs to look at the commonly asked question how direct payments differ from personal budgets. The answer is that personal budgets are only one part of a broader approach, commonly referred to as self directed support which itself is only one part of the personalisation agenda. Direct payments fit into this approach but as described above are only one of the delivery mechanism for personal budgets. A social work dictionary brings it together by saying that "Individual budgets, personal budgets and direct payments are tools for achieving self-directed support" (Pierson, Thomas 2010, p 268). So in summary self directed support is the term used to describe the overall approach and process to introduce maximum choice and control for the service user and personal budgets and direct payments are the tools to achieve this.

1.2.3 Older People

Not so long ago older people were commonly described as the elderly or old people but as you can see The Telegraph (2009) article entitled " 'Elderly' no longer acceptable term for older people", clearly indicates a societal change in what we call more mature individuals.

A social work dictionary defines the term older people and goes on to describe why it has replaced the term elderly:

> *"**Older people** the term now widely used in practice in preference to 'elderly' or 'old people', to refer to those who may have age-related health needs. The phrase 'older people' is commonplace in social work, social care and health care for the good reason that it is less stigmatizing than the alternatives. It is difficult to say at what age a person becomes 'older' ..." (Pierson, Thomas 2010, p 370).*

Research conducted by McDonald and Taylor (2006) explains why deciding on an age when people should be considered 'older' is so difficult. They assert that older people are not a homogeneous group and their needs are diverse. Services for older people may be offered to those aged 50 plus like some leisure services, or retirement age when talking about financial services, or for over 75s like specific types health checks. Even Local authorities use the age of 65 as a cut of point from younger to older person. This shows that when we talk about older people, within different contexts, this may mean very different things. In the context of this thesis the term older people defines anybody over 65 who because of health or disability related reasons may be eligible for care and support service from a social care department.

The above defines the term older people and explains why this is used instead of elderly or old people, but when using this term in social care there are always some other facts that need to be taken into consideration. The Audit Commission (2004) determined that we live in an ageing society where people are living longer. For the first time there are more people aged 60 and over than children under 16 in the UK. Most older people can now look forward to many more healthy years of life after retirement than ever before. As a result more is expected from public services. The make up of the older age group is beginning to reflect the first generation immigrants of the 1950s, and the post-war baby boomers, who during the 1960s, redefined what it meant to be young. This has had profound implications for public services and local authorities will be required to come up with imaginative solutions to meet these challenges in the future:

> *"Either our countries will make decisions about adapting to our ageing societies, or these decisions will be made for us by the sheer force of demographics and economics. It becomes a question of whether we will manage change, or whether change will manage us." (Audit Commission 2004 p2)*

2. Political and Policy Background

In chapter one it was described how in order to understand the present we must understand the past. This chapter will try to summarise the key milestones of the social welfare system in England on its way to the introduction of a personalised adult social care. The narrative is being highlighted by first looking at the political movements followed by a brief policy and legislative outline, after which it will look at the developments in the social care market and the changes within the social work profession.

2.1 Political movements

Any developments in the society are formed and influenced by politics. This chapter will look at the two movements which have influenced the development of the personalisation agenda.

> *"While direct payments were a victory for disabled campaigners, they were also championed by a Conservative government committed to neo-liberal social policies aimed at rolling back the frontiers of the welfare state and promoting greater consumer choice through the creation of markets in social care." (Glasby, Littlechild 2006, p 27-28)*

As the quote above outlines there are two key movements, which could not be any more different in source, that lay the cornerstone for the implementation of direct payments and later personalisation. This chapter will introduce both, explain their origin and how they influenced the way adult social care is changing at the moment.

2.1.1 New Public Management

Within the research collected in relation to new public management, there were two reoccurring themes, the 1980s, and Margaret Thatcher. In the 1980s the UKs public services experienced a top-down pressure of change. This top down pressure stood in stark contrast to the pre-1979 period which was driven by a bottom-up mode of service development (Ferlie et al. 1996, p 3). Margaret Thatcher believed that the public was no longer content with the public services delivered through the welfare state. Her perception was that public servants were inefficient, ineffective, and more concerned with their own welfare than that of the public they were meant to be serving (Osborne, McLaughlin 2001, p 8). These perceptions triggered a series of reforms and changes in the public sector.

Ferlie *et al.* (1996, p. 5-6) mention the following features of change:

A large scale privatisation programme in the sphere of economic activity.

- Those functions that remained in the public sector experienced a large scale managerialization and saw the development of quasi markets with previously line managed organisations developing into purchasing and providing departments.
- Doing more with less by focusing on value for money and developing audit and performance systems.
- Move to management of change and individualistic forms of leadership under the banner of 'organizational learning'.

Adult Social Care and herewith, the care for Older People experienced these changes in a drive from what was community care to market care. The development of the care management profession which was created to replace social worker and was meant to organise the care for older people by managing so called quasi-markets (Means et. al 2002, p 129 - 131) This topic will be explored further in section 2.3.2.

2.1.2 Independent Living and other disability rights movements

The independent living movement was started in the US in 1973 by three disabled students who attended University with the support of personal assistants (PAs). In order to give other disabled people the same opportunities these students later developed a network of user-led centres for independent living (CIL) to support people to take greater control of their lives (Glasby, Littlechild 2009, p 12). One key aspect of CILs is that they are led by disabled people for disabled people. The philosophy of the Independent Living Movement is based on four assumptions:

- All human life is valuable.
- Anyone is capable of exercising choices.
- People who are disabled by society have the right to assert control over their lives.
- Disabled people have the right to participate fully in society. (Morris, 1993, p 21)

Cash payments also known as Direct Payments were seen as a means to achieving independent living (Glasby, Littlechild 2009, p 12). Even though the independent living movement was mainly driven by physically disabled people in their 30s and 40s the movement was clear that their aims and aspirations are equally relevant to people with learning disabilities, older people and individuals with mental ill health (Morris 1993, p 22).

Morris (1993) and Barnes, Mercer (2006) describe that in Britain the movement was initiated by people living in residential homes in the 1980s who wished to live in the community and take more control over their lives. Several organisations were founded to support the campaign and soon the first British CIL was established in Derbyshire. The movement, and individuals within it, started to put pressure onto Local Authorities to give them a Direct Payment because, like the members of the US movement, they saw this as the only way to achieve real independent living. This proved to be a big challenge because until the 1993 Direct Payment Act was put into place cash payments in lieu of services were prohibited by the 1948 National Assistance Act (Morris 1993, p 26).

During the same time campaigns for more inclusive approaches for people with learning disabilities were becoming influential in Britain. The aim was to move people with learning disabilities out of long stay hospitals and into the community. This also meant a move from professionally led individual programme planning, to person centred approaches and person centred planning (Needham 2011, pp 66 - 68). Person centred planning (as opposed to service led planning) involved several features that would later be seen as key to the broader personalisation reforms. These included: recognition of the 'authority of the service user's voice'; a focus on 'aspirations and capacities' of the service user rather than 'needs and deficiencies'; and 'attempts to include and mobilise the individual's family and wider social network; as well as to use resources from the system of statutory services' (Needham 2011, pp 66 - 68).

The 2005, "Improving the Life Chances of Disabled People", strategy paper can be seen as the coming together of the two movements: independent living for people with physical disabilities and inclusion for people with learning disabilities. The key topics of this paper not only combine the two movements and pick up on their demands, but also hint on the topics that will later become key in the personalisation agenda, and the Putting People First concordat. The key topics include the idea that DPs are seen as the key tool for encouraging independent living, as well as that every local authority should have at least one User Led Organisation (ULO) by 2010.

2.2 Policy overview

After having looked at the political developments this chapter will explore the policy and legislation that followed from the idea of a more personalised and customer driven public service within adult social care as described in chapter three. Section 2.2.1 will be looking into the national developments, white papers and legislation that finally led to the developments English local authorities find themselves in today. Section 2.2.2 will describe the developments on a more local level to explore how the London Borough of Barking and Dagenham made its way from community care to a fully integrated service working under the ethos of personalisation, including the preparation to deliver a service to older people which is provided by personal assistants through a direct payment.

2.2.1 National Context: From "Our health our life our Care" over "Putting People First" and "Think Local Act Personal" to "Caring for our Future"

Chapter 2.1.1 looked at the developments in the era of New Public Management (NPM) which has also triggered immense changes in the world of Adult Social Care. Means et.al (2002) describe in their book with the telling title: "From community care to market care" the journey Adult Social Care has made since the introduction of NPM. The DoH White Paper "Caring for People: Community Care in the next decade and beyond" aptly describes how Social Service provisions make the journey, from monopolistic providers to purchasers of care (DoH 1989, p 14).

In order to put these developments into context with previous legislation and policy the figure overleaf gives a quick overview of the period between 1948-1995 as can be found in Ray and Phillips (2012):

"The Beveridge Report, 1942 - Counselled against being 'lavish in old age' and recommended that pensions should be set below the subsistence level to promote thrift.

National Assistance Act, 1948 - Local authorities are enabled under section 29(1) to promote the welfare of older people. Section 21 of the NAA 1948 places a duty on local authorities to 'provide residential accommodation for persons who, by reasons of age, illness, disability or any other circumstances, are in need of attention which are not otherwise available to them'. Section 47 contains the power to remove a person from their own home in specific circumstances.

Royal Commission on Population, 1949 - Noted the increasing population of older people and saw this as a threat to the nations prosperity.

Phillips Report, 1953 - Looked at the economic and financial problems involved in providing for old age **.**

Mental Health Act, 1959 - Recommended care in the community; closure of Victorian asylums.

Health Services and Public Health Act, 1968 - Made arrangement for the provision of meals and recreation, visiting and social work services, adaptations, warden services and boarding out, as well as assistance in transport to services.

Chronically Sick and Disabled Persons Act, 1970 - Local Authorities required under section 2 to assess individual need and provide services to meet the needs of disabled people.

A Happier Old Age, DHSS, 1979 - A discussion document about whether community care could keep people out of residential, warning that 'The rise in the elderly population puts a great strain on all our pockets.'

Care in the Community Green Paper, 1981 - Considered joint financing to promote moves out of (long term) hospital(s).

Growing Older White Paper, 1981 - A discussion document produced by the Conservative Government, reinforcing the idea that care in the community must increasingly mean care by the community; that is 'informal' care.

Care in Action White Paper, 1981 - Recommended strengthening neighbourhood and community support.

DHSS Supplementary Benefit rules change 1981 - providing public support to residents of private and voluntary homes. This had major repercussions for the growth of private residential care.

Mental Health Act, 1983 - Obliged authorities within the resources available to promote community care for mentally ill people.

Social Services Provision of Care to the Elderly, 1983 - DoE Audit Inspectorate found patchy and inefficient distribution of resources across the country, recommended home-care organisers as coordinators of community care.

Making a Reality of Community Care, Audit Commission, 1986 - Audit Commission again reinforced Ineffective service delivery and geographical inequality.

Firth Report, 1987 - Against concerns that older people were entering private residential care unnecessarily, focused on assessment of need and concluded that public support for residential care was justified.

From Home Help to Home Care, 1987 - Social Services Inspectorate Report identified deficiencies in the technical efficiency of home-care services.

Griffiths Report, 1988 - Recommended social services to be 'enablers' rather than 'providers'.

Caring for People: Community Care in the Next Decade and Beyond, 1989 - White Paper advocating a wide spectrum of services to people in their own homes, to be provided by the independent and public sectors, but acknowledging that the bulk of care is provided by family and friends.

NHS and Community Care Act, 1990 - Major legislation telling social services they would be the lead agency in community care; introducing the purchaser-provider split and a mixed economy of social care.

Community Care (Direct Payments Act), 1995

Figure 1 legislation and policy documents relating to the care of older people (Ray, Phillips 2012, pp 56-58)

Following the 1989 White Paper the 1990 Community Care Act set the scene for the profession of Care Manager, who on quasi markets bought in and managed people's care on their behalf. In 1995 the Direct Payment Act marked a further step in this journey as

this act for the first time made it possible for Local Authorities to give money directly to the customer enabling them to purchase their own care.

Although all those steps got social care on its way to better customer care, it was still miles away from offering a health and social care system that enables the customer to commission services which fit with their chosen lifestyle (DoH White Paper 2006, p.3). This is why the afore mentioned 2006 White Paper, was drafted to accelerate the move into a new era (Tony Blair 2006). This white paper introduced and funded 13 Local Authorities across England to pilot the concept of Individual Budgets. The 13 chosen pilot sides were asked to determine a way to give service users more control over their services, allowing them to spend the money on obtaining services of their choosing. The concept and how it differs to what was done before is illustrated in figure 2 underneath.

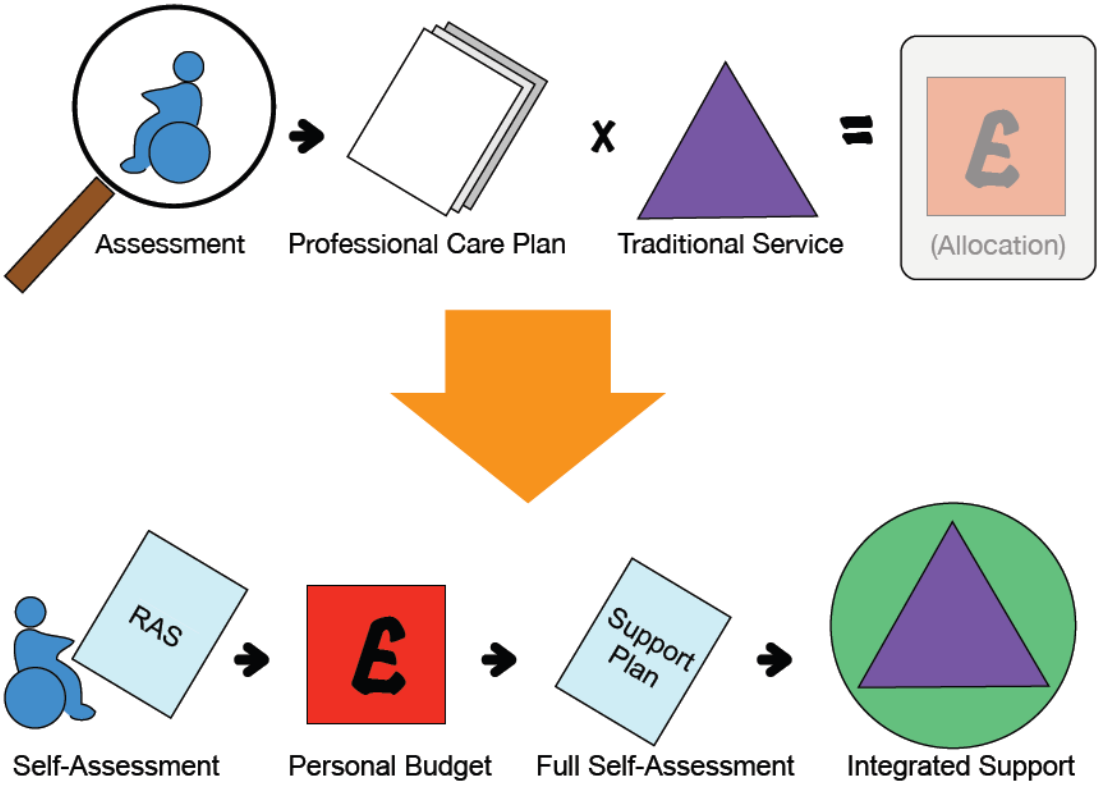


Figure 2: How personal budgets change the way the current allocation system works (In Control 2011)

The "Putting People First" concordat published as a result of the individual budget pilot by the Department of Health in December 2007, then asked all Local Authorities in England to transform their Adult Social Services with a focus on:

- Prevention
- Early intervention and Reablement
- Personalisation
- Information, Advice and Advocacy (DoH 2007)

"Putting People First" has triggered a major reorganisation in most local authorities in England which was sponsored by a grant each local authority received from the DoH.

As an ongoing signpost and statement in favour of continuing the work on personalised services following the Putting People First programme Think Local Act Personal (TLAP) was published in January 2011. TLAP is a national, cross sector, leadership, partnership agreement which focuses on driving forward work set forth in the personalisation agenda in community-based social care. The priority areas for work under TLAP are personalisation and personal budgets. They are looking into developing more cost effective and efficient solutions by building community capacity and developing the provider market. Another focus is on improving information provided to the public and the importance of co-production. (TLAP 2011)

It must be stressed that not only the recent past, but also the future of adult social care will be personalised. The new coalition government has already outlined its support and vision for the future of personalised care and support, with service user in control, in the more recent White Paper entitled "Caring for our future. Reforming care and support" published in July 2012. This report focuses on people's wellbeing and the support they need to stay independent for as long as possible. Its vision is to introduce greater national consistency in the overall access to care and support. Local authorities are asked to provide better information to help people make choices about their care which will give them more control. Apart from this the paper emphasises that the support for informal carers needs to improve and so must the quality of care and support and the integration of different services especially between health and social care (DoH 2012). "The landscape of change is further reinforced by a Law Commission review of current legislation for adult social care" (Ray; Phillips 2012 p 55).

2.2.2 Local context: From the "Individual Budget Pilot" over the "Personalisation/Transformation Programme" to the "Choice and Control Project"

After exploring the national policies and legislation that lead to where we are today this section will now tell the story from a local level, and will illustrate what was happening in LBBD, and how developments led to the implementation of the choice and control project. In order to provide the context behind the developments in LBBD it is important to note that this local authority is, and has always been, a labour governed authority.

As described in section 2.2.1 with the introduction of the 2006 White Paper : "Our health, our care, our say: A new direction for community services, "the department of health sponsored 13 Local Authorities in different parts of the country to run Individual Budget Pilots. LBBD was one of those 13 Local Authorities, which also included the following Local Authorities: Barnsley, Bath & North East Somerset, Coventry, Essex, Gateshead, Kensington & Chelsea, Leicester City, Lincolnshire, Manchester, Norfolk, Oldham and Sussex. The pilots were supported and evaluated by the Individual Budgets Evaluation Network (IBSEN) at the University of York. The pilot sites were given a number of clear principles that were required to underpin the pilot.

Sites were asked to develop ways of enabling service users to play a greater role in the assessment of their needs. Individuals should know the level of resources available to them before starting to plan how they wish their support needs to be met. Here the sites were asked to develop a Resource Allocation System (RAS). The RAS is an iterative process where an individual's level of need across a series of domains is scored to give a total number of points. The individual scores of, say, 100 people are aggregated; and the global social care budget is divided by the total number of points to obtain a cash value for each point. An individual's IB is therefore a product of the total number of points and the price per point which is determined beforehand. Allocation of sufficient resources for people with particularly high or low level needs, and the overarching requirement to remain within existing budgets were also consiered. IB levels calculated through these processes may subsequently be adjusted following discussions between care managers and potential IB users, to ensure their needs are met.

Furthermore sites were to test out opportunities for integrating resources from several different funding streams into a single IB. In addition to adult social care, the resources to be included in IBs were: Access to Work; the Independent Living Fund (both the responsibility of the Department for Work and Pensions); Supporting People and the Disabled Facilities Grant (both the responsibility of the Department for Communities and

Local Government); and local Integrated Community Equipment Services (which were funded from pooled social care and NHS resources). Pilot sites were to experiment with aligning eligibility criteria and aligning or integrating assessments. This was done with the aim of reducing the number of assessments an individual had to undergo.

In planning how to use their IB, individuals were to be encouraged to identify the outcomes they wished to achieve and the ways in which they wished to achieve them. Whereas direct payments are generally used to employ a personal assistant, IBs could be spent on a wide range of existing services; to purchase ordinary community or commercial services (for example, lunch in a pub rather than meals-on-wheels); or to pay relatives and friends for the help they give.

Sites were encouraged to experiment with a range of options for paying IBs. As well as offering direct cash payments, other possible options included: local authority managed accounts; provider-managed accounts; and payments to third party individuals and Trusts. (IBSEN 2008 pp.5-6)

The pilot sites were given free reign in choosing which client groups they were going to target for IBs. LBBD chose to test this pilot on these four client groups:

- People with physical and sensory Impairments
- Older people
- People with learning disabilities
- People with Mental Ill Health

In the course of the pilot LBBD was able to develop a RAS that allocated resources reliably to people with physical and sensory impairments and older people. The RAS was integrated into an assessment tool which could be used as a self directed assessment, meaning that even though the professional was involved in carrying out the assessment the assessment was led and directed by the service user. Altogether IBs were delivered to 130 service users from each of the four client groups. Other than all of the other pilot sides LBBD was able to integrate Supporting People monies into the RAS allocation and the IB. Barking and Dagenham was also to first Local Authority to trial and Implement Individual Service Funds (ISFs). This meant that LBBD was able to pay monies upfront to a support provider who then, led by the service user, determined how the funds would be spent in order to achieve the outcomes determined by the service user. This was seen as a good alternative to direct payments for service user who did not want the responsibility of managing funds or employing their own staff. Finally the opportunities of a new profession called Support Planner, as an alternative to Care Managers, was explored.

IBSEN was to determine whether IBs would deliver better outcomes than conventional packages of care and at what cost (IBSEN 2008, p 6).

> *"Given the complexity of the evaluation task, a multi-method evaluation was designed. A randomised controlled trial examined the costs, outcomes and cost-effectiveness of IBs, compared to conventional methods of service delivery. [...]The trial was complemented by in-depth interviews with subsamples of people from the across the range of user groups who had been offered IBs." (IBSEN 2008, p 231)*

In addition to interviews with service users, interviews with senior managers, individuals involved in conducting the pilot, and front line staff, were also carried out. The evaluation found that:

- In the majority of cases the service user bought personal care, assistance with domestic chores, social and leisure activities with their IBs.
- Overall service user with IBs felt more in control of their lives.
- The average cost of an IB is equivalent to the cost of a traditional package of care.
- The integration of other funding streams encountered many barriers. (IBSEN 2008)

Interestingly the Department of Health did not wait for the outcomes of this major evaluation which was supposed to influence the future roll out of Individual Budgets. Instead a decision was made to introduce a major transformation agenda towards personalisation which included the introduction of IBs or rather Personal Budgets (PBs) in every Local Authority in England. This occured 10 months prior to the publication of the IBSEN evaluation report.

As detailed in section 2.2.1 in December 2007 the Putting People First concordat was published and with it came a commitment to transform adult social care in all Local Authorities. In order to get this major programme on the way each LA was given a generous grant to achieve the goals set out in a Local Authority circular. Figure 3 overleaf outlines the key expectations tied to the grant which ultimately is supposed to result in better care and support.

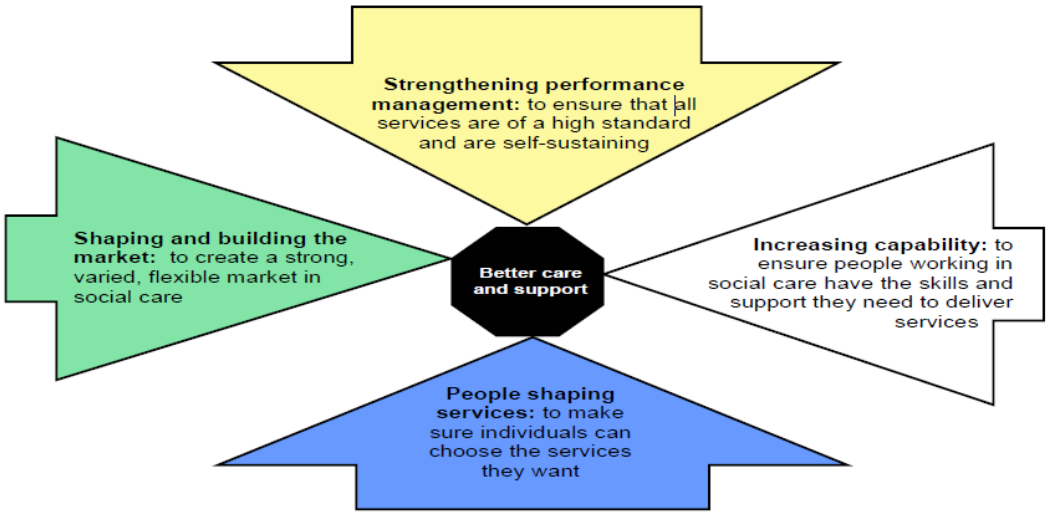


Figure 3: Better Care and Support. (Local Authority Circular 2008)

LBBD was given a total grant of £1,995,000.00 over a three year period apportioned as follows: 2008/09: £327,000.00, 2009/10: £752,000.00, 2010/11: £916,00.00 (DH LAC 2008). As detailed in figure 3 this money was granted so that local authorities could make changes in four key areas, including the market, performance, capability of staff (i.e. training) and people shaping services. In LBBD part of this grant was used to appoint a programme manager and a programme team who were employed to drive progress towards achieving the programme vision to provide a personalised system of care which offers people the highest standards of professional expertise, care, dignity and a maximum of control and self determination. Figure 4 below illustrates how the programme organisation will achieve the targets set by the DoH:

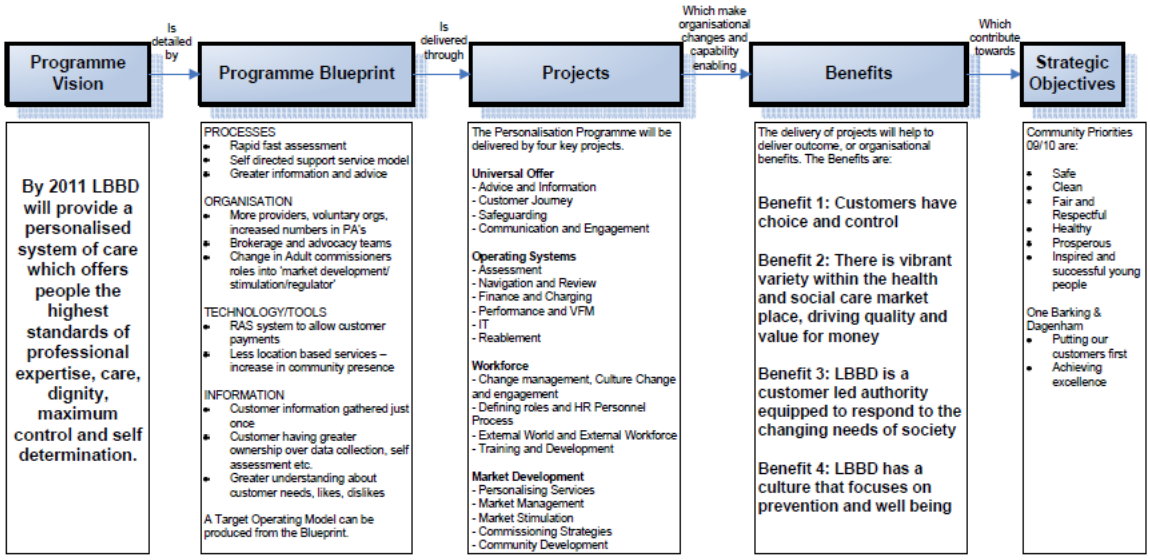


Figure 4: Programme vision and overview LBBD 2009

As part of the transformation LBBD underwent a major restructure of its adult social care department. The biggest change in regards of services for older people was to go from two so called long term condition teams to six fully integrated clusters. The long term condition team served all physically disabled and older people starting from the age of 18 years in two location related teams which followed the care management process detailed in section 2.3.2. The six clusters are part of the assessment and support planning section (detailed in green in the figure underneath). They are fully integrated with health which means that they are each aligned to 3 GP (family doctor) practices and a corresponding community matron as well as a health coordinator part of each cluster. From the social care side two social worker, and two support planner, (called SDS facilitators in figure underneath) were included. Each of the cluster follow the same process for delivering self directed support as detailed in the target operating model depicted in figure 5 underneath.

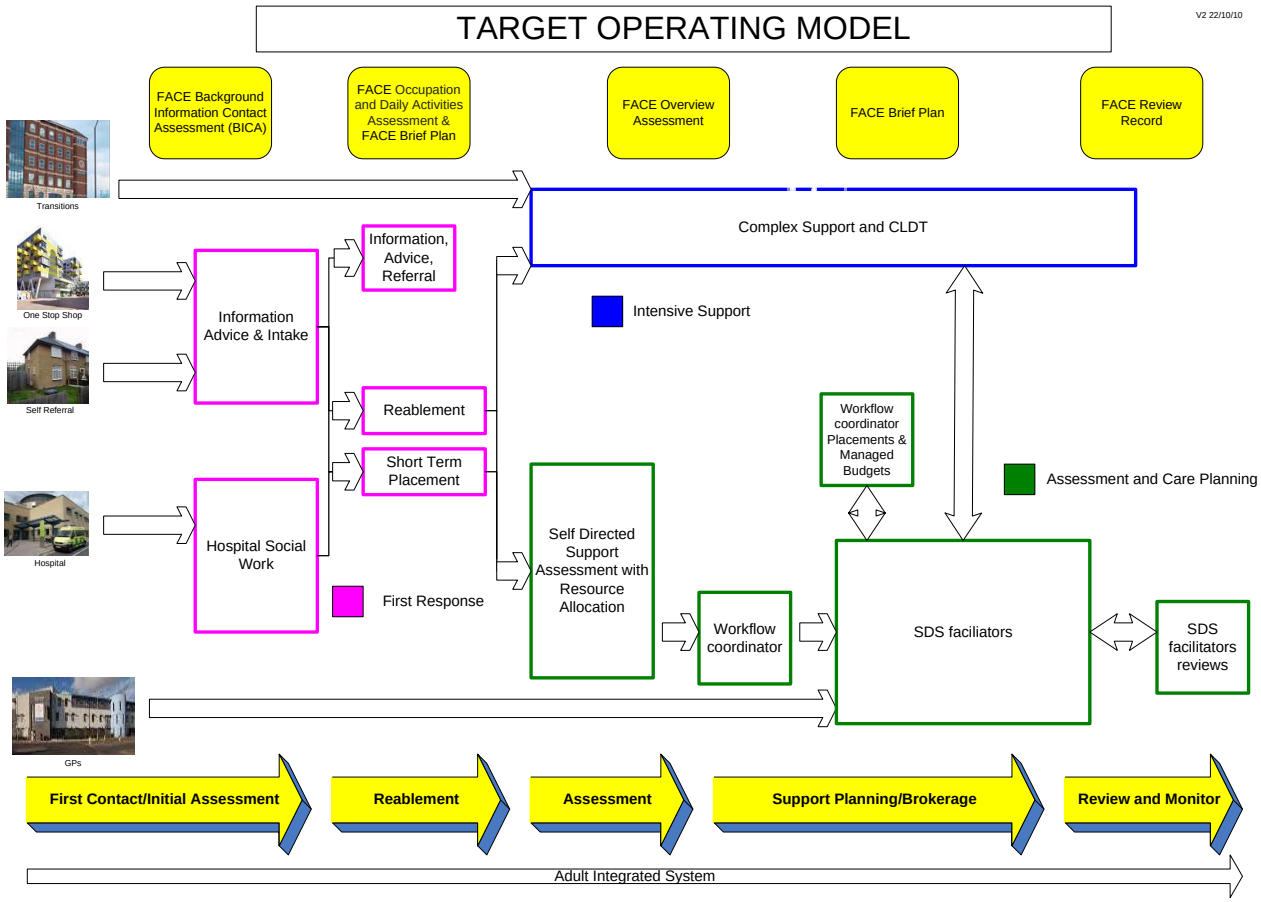


Figure 5: Target Operating Model for delivering self directed support in LBBD (LBBD 2010)

Prior to anybody going through the assessment and support planning section (green) each person would go through a phase of reablement to ensure everybody is on the highest ability of their functioning before being assessed for an ongoing personal budget. Individuals who require ongoing intensive support due to complex needs, commonly associated with difficult social/family interactions, and/or drug and alcohol abuse, is dealt

with in the blue section. The blue section is also home to a specialist team for individuals with learning disability, which also has been fully integrated with health.

This process model and way of working was fully introduced in April 2011, after a difficult start with high staff dissatisfaction and resistance to change (as can be expected in such a major change programme). Successful change management was implemented and the department has settled down and has since come to terms with the changes. As of late 2012 staff working within the new process, experience only the normal problems and challenges a social care department would expect to deal with.

Proof that the change prescribed by the DoH and senior management had actually established itself on the ground was found in April 2012 when it was noticed that one cluster produced a higher number of personal budgets, delivered via a direct payment than the departmental average. When establishing what was happening it was found that the two support planner allocated to this cluster had taken the ethos of personalisation one step further and got to know their community very well. As a result they found that living in the community where many parents of school aged children and particularly the mothers were keen to take up work that would fit with their parental lifestyle. Some of them had started work with care agencies but found that they were underpaid and undervalued, always chasing behind time and never able to dedicate enough time to individuals. The two support planners saw an opportunity and introduced those people to the job of personal assistants explaining to them how this may be a good job opportunity. They asked those interested to put their details down and began a campaign for direct payments, and personal assistants to the service users they worked with on a daily basis. They soon had established a well oiled matching service between potential PAs and service users.

When senior management discovered this outcome their reactions ranged from well done to, but what about all the risks involved. In order to understand what was really happening, and to determine the potential risks, a workshop was set up. Representatives of each management level were invited to attend. Everyone from the councils chief executive, who was the director of Adult Social Care at the time, to cluster managers, were included. During this workshop the two support planners, some of the service users and some of the PAs were invited to tell their stories. It is impossible to capture what happened at this workshop on paper, but the outcome speaks for itself. It was decided there and then that the model run by the two support planners would be adopted and rolled out as the future of care and support model in LBBD. In order to ensure that all obstacles and risks of making this reality would be well managed, the Choice and Control Project group was founded. More about the project and outcomes will be covered in chapter 3.

2.3 Market Development and the rise and demise of the Care Management approach

So far, it has been explored how adult social care evolved into what it is today, by firstly looking at the two different movements that set the scene. This was followed by a summary of developments in national policy and legislation and concluded with local developments that directed the way the London Borough of Barking & Dagenham is heading. Before moving on to the practice part of this thesis, this chapter will look at two other levels of the story. Put together this should depict an overall viewpoint of the developments that ultimately led to the way care and support is delivered in Barking and Dagenham today. The missing pieces in the puzzle are the developments of the social care market and the paradigm shift of the social work profession. Both follow the same storyline as political and policy changes but examine the topic from a different perspective. This perspective is important to understand the problems faced in implementing and establishing the changes proposed by the 2012 White Paper.

2.3.1 From in house services over quasi Markets to an open Market

This section will introduce the developments in the social care market since 1970. Since 1970 the market changed from being an internal market, delivered solely by Local Authorities, to a quasi market commissioned by Local Authorities. The next step is the open market, which is intended as one of the result of the personalisation agenda.

The first time in history that local authorities became responsible for the delivery of services to older and disabled people was a result of the Seebohm report (1968) and the subsequent 1970 Local Authority Social Services Act in April 1971 when social services departments (SSDs) came into being. "... their responsibility in regard to older people included local authority residential homes, the home help service, meals and lunch club provisions, laundry facilities, aids and adaptations and social work/counselling services" (Means et. al. 2002, p 10). All those services described were delivered directly by local authorities and were commonly described as in-house services. They employed staff to deliver home help services and opened residential homes to accommodate those older people who could no longer care for themselves at home. A side effect of these newly established departments was a 10% increase in the social care budget (Ivory 2005). This combined with the 1973 world economic crisis, and in particular the economic problems Britain was facing, lead to the rise of the New Right which saw the welfare state and social care as part of the problem. Chapter 2.1.1 looks at the introduction of new public management which in this connection and due to other more pressing issues with a ten

year delay lead to the 1989 White Paper and a manageralisation of social care (Rogowski 2010, pp 55-56).

The 1989 White Paper: "Caring for people: Community care in the next decade and beyond" defined the roles of LA as follows:

- carrying out assessments (in collaboration with medical, nursing or other caring agencies if indicated) to establish an individual's needs for social care
- appointment of case/care managers to design packages of care to meet the individuals needs
- ensuring the delivery of services not by acting as provider of care but by taking on a purchasing and contracting role (see Means et al 2002 pp 4-5)

The 1990 NHS and Community Care Act then introduced the purchaser-provider split as a legal obligation. As of April 1993, 85% of Local Authority monies had to go towards funding services in the independent sector (Local Authority Social Services letter 92/12) (Means et al 2002, p 112). At the same time, with the changes requested in the 1989 White Paper and the 1990 NHS and Community Care Act introducing a contract culture in community care, many LA began to consider '"more formal partnership arrangements between the statutory and voluntary sectors', with a much increased emphasis on the service provision role of the voluntary sector" (Means et al 2002, p 117).

All these changes led to a phenomenon which Le Grand et al (1993) referred to as "quasi markets". Quasi markets as defined by Propper et al are:

> *"In contrast to standard markets, [...] free at the point of delivery: no money changes hands between the final user (eg pupils, patients) and the provider of services (eg schools, hospitals). Thus the state has retained its role as a funder of services within the welfare state, but the task of providing has been transferred from an integrated set of state owned and managed enterprises to a variety of independent provider organisations including not for profit organisations, private companies and state owned units under devolved management." (Propper et al 1994, pp 1-2)*

According to Proper et al. quasi markets had a number of common features:

- separation of purchaser and provider of services
- devolving managerial responsibility to individual provider units,
- funding is based on either formula funding or contracting between purchaser and provider.

It was anticipated that this development would stimulate a thriving marked and drive up quality of provision through competition, while keeping prices low, and choice high for service users. In reality this proved to be illusory as service users very often did not have a choice of providers due to LAs being locked into block contracts (Ray, Phillips, 2012).

As described in chapter 3.2 the pressure from users was high to enable them to break away from those quasi markets and enter the market themselves. The 1995 Direct Payment Act was a first step in this direction. Ultimately the introduction of personal budgets was seen as a chance to free the market from the Local Authoritie's input and open the way for the market to be controlled by the people who actually have to live their daily lives with the services provided. As free enterprise says: "Competition and choice in an effective market improve quality whilst driving down costs,..." (Skidmore 2012, p 3). So far no evidence can be found to support or oppose this claim.

The first developments that can be evidenced in the social care market since introducing personalisation can be seen as local authorities move away from block, or cost and volume contracts, to framework agreements. A framework agreement is a contract that sets out the terms and conditions (including the price) on which the local authority will purchase services from providers. Providers tender to be on the framework. Local authorities purchase care only from framework providers, but do not guarantee business to any provider. When packages of care are needed, all providers on the framework have an opportunity to express an interest in delivering the package. If more than one provider offers to deliver the package, the one preferred by the service user is chosen. The IPC concluded that:

> *"The move by many local authorities from block contracts to framework agreements potentially introduces greater flexibility and choice into the market. However, for providers, a framework agreement may also introduce greater uncertainty about cash flow and volumes of activity. It also requires a considerable investment of time and energy into a bidding process, but with no guaranteed work at the end of it." (IPC 2012, p 20)*

2.3.2 From Social Work to Care Management

We have now seen how the different legislation and policies changed the market of adult social care. This chapter will have a look at the impact this had on the social work profession. In order to put this all into perspective this will include a very short summary of the history of social work in England.

"Social work as a profession, has its origins in 19th-century philanthropy ..." (Glasby, Littlechild 2009, p 5). In the early 1940s local authorities employed social workers for the first time. This was triggered to a degree by social problems caused by the Second World War. These developments peaked in the 1942 Beveridge Report, which established the welfare state and confirmed the view that the government needed to take action in order to address social problems (Rogowski 2010, pp 40-41). In 1948 (National Assistance Act) a separation, of social work which was provided by Local Authorities and dealt with the non-financial welfare of disabled or older people and social security which was dealt with by the National Assistance Board, took place (Glasby, Littlechild 2009, p 7).

As Rogowski (2010) points out: "Social work has been around for a long time but as an occupation certainly reached a high point in the 1970s when it was the raising star of the human service professions" (Rogowski 2010 p20). This involved the move from charity to social work. The Seebohm Report (1968), mentioned in section 2.3.1 had, according to Rogowski (2010), a positive effect on Social Work which was invigorated and underpinned with training opportunities, increasing influence and professionalization. The 1970 Chronically sick and Disabled Persons Act which placed the onus on local authorities to establish the needs of sick and disabled people opened new opportunities for the professional competence for social work particularly with older people. The newly established SSDs were staffed with newly qualified social workers who were encouraged to act autonomously in their practice. According to Ivory in his article “Knock it down and start again” social work was filled with youthful idealism which seemed unstoppable (Ivory 2005, pp 32-34).

The above mentioned 1990 NHS and Community Care Act introduces care management which for social worker meant a move from a therapeutic relationship to one of assessment and care planning (Rogowski 2010 p76). The drawing below describes the care management process which illustrates the shift from autonomous working to proceduralised work:

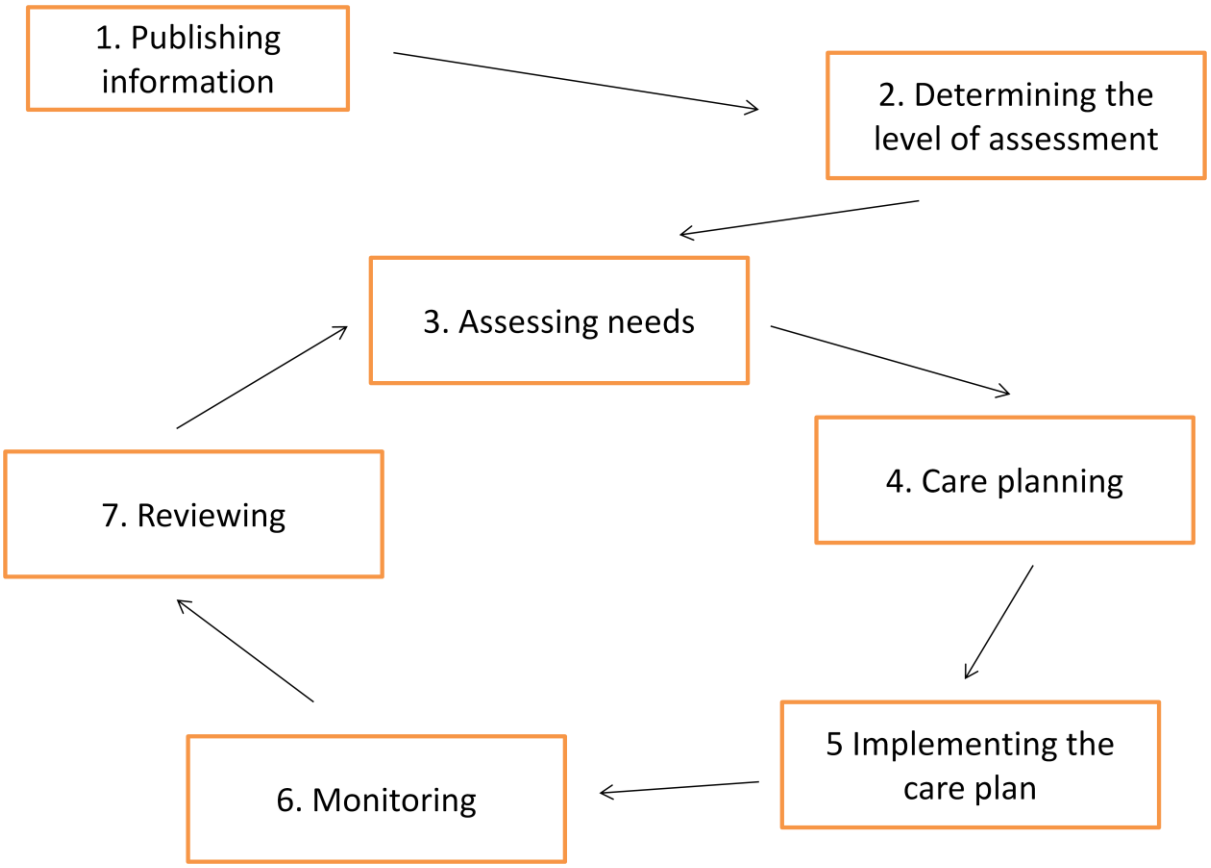


Figure 6: Care Management process (DoH/SSI 1991, p 12)

The above figure illustrates the care management process which can be described as: First, information must be made available to the public for them to understand how to access support with their social care needs. As soon as an individual contacts the social services department screening takes place to identify the eligibility for an assessment. Should eligibility for an assessment be identified, it is then decided whether a simple or comprehensive assessment should be carried out. At the same time an assessment is offered to informal carers (i.e. caring relatives). The assessment identifies needs and establishes the eligibility of the need to warrant a service. All established needs will then be prioritised and a care plan is drafted which outlines how those needs will be met. A financial assessment is carried out to determine the service users financial contribution towards the service to be put in place, if any. The care manager then sets up the service and resources and signposts to other services (i.e. voluntary organisations) for further support. The care plan is reviewed on at least a yearly basis (Ray Phillips 2012, pp 54-55).

The fundamental background to the community care developments is that the Social Services Department must assess people's need, not what services they could have. The care manager was then to spot purchase services that would meet the eligible needs of

the service user. However a policy framework for this needs level approach set out the needs that will be assessed (the 'eligible needs') and the priority order of these eligible needs, and the criteria for gaining access to resources (Means et al 2002, pp 155-156). This policy framework was published in 1993 and called "Fair Access to Care Services".

In recent literature it is argued that these reforms have not always been able to result in positive change and it is seen that they "may have contributed to a limited and proceduralised approach to practice with older people" (Ray, Phillips 2012, p 49). Bowers et al. (2009) and Blood (2010) talk of evidence that suggests that solutions to support needs especially for those with the highest level of needs, have often been found in traditional services with assessments being focused on confirming eligibility. Rogowski (2010) argues that the introduction of care management led to the beginning of the deprofessionalisation of social work.

Ray and Phillips (2012) argue that now is the time that social workers need to go on a journey to rediscover their professional confidence. Rogowski however comes up with the counter argument, "that social work is now operating in a quasi-business regime that subordinates the public's needs and the skills of social workers to the demands of competition within the social care market" (Rogowski 2010, p 24). Which of the two is true remains to be seen.

3. Choice and Control a Project to reform care and support in the home in Barking & Dagenham

Chapter 2 described the national developments that have set the scene for the choice and control project in Barking & Dagenham. We have heard how the independent living movement and new public management have involuntarily worked together to set the scene for the change of adult social care. We have also seen what impact policies and legislation have had on adult social care, its market and its professionals. Chapter 3 will give an overview of the project itself and the impact it has on the reality of adult social care, its market and professionals in Barking & Dagenham.

> *"One of the storylines of personalisation is that in order for support to be tailored more closely to the users, there will need to be a radical redevelopment of the local service interface. Users will take on new roles in commissioning their own services and front-line staff and local authority commissioners will play a facilitating role in connecting users to markets." (Needham 2011, p 87)*

The above quote sums up what needs to happen in order to implement personalisation. Even though this is a logical conclusion from the changes requested and sounds straight forward on paper, it will become clear from this chapter, as well as chapter four, that a lot of effort, planning and culture change has been, and will have to be applied to really achieve the changes associated with personalisation. Chapter 3 will illustrate this by first introducing some numbers that will explain the make up of the homecare market in LBBD. In the next step the project will be introduced by illustrating the project background, the project outcomes and deliverables and the project team. As we will see the project's aim and outcomes had been changed a few weeks into the project so in section two of this chapter we will see how redefining a project fits in with project management. Section three will then look at the revised project plan and its deliverables and finally the achievements of the project will be illustrated. It has to be considered that this thesis is being written at the same time as the project is being conducted and the project lifespan will finish after the thesis is completed. This means that any final outcomes will not be featuring in this documentation.

3.1 The adult social care market in LBBD in 2011/12

When the choice and control project was initiated in May 2012 care and support in the home was provided through the following means: One, as part of a six week reablement service via the in-house reablement service. There is an overspill into external service providers when the in-house service is unable to cope with the number of service user. Once the first six weeks are over care and support in the home will be provided in one of the following four different ways, described as follows. The first option involves a council managed personal budget provided by the in-house dementia team who provides a tailored service to service user with dementia who lack capacity to organise their own support. Only 30 service users are able to receive this service due to the capacity of this very small team. The second option involves a provider managed personal budget provided by one of eight contracted homecare agencies. The council has a service level agreement with those agencies which defines the quality standards that is expected of their provision. The service user and the agency will be told the value of the allocated personal budget. Together they draft a support plan on how this money will be used. The agencies are paid and monitored by the council but day to day business happens between the agency and the service user. The third option comes into place, if a service user has capacity and the willingness to manage their own money and support and will be provided as a direct payment paid directly to the service user into an account they have opened for the sole purpose of managing their direct payment. The service user may employ their own personal assistant with the money or pay a provider of their choice to support them. The business takes place directly between the service user and the chosen provider. The council monitors the expenditures once every 3 months by checking bank statements, which the service user provides to the direct payment monitoring officer. In the fourth option the payment is administered as a so called brokered direct payment. This means the council pays the money into an account opened by a so called "payroll agency", who either pays a personal assistant or a care provider chosen by the service user. The service user is responsible for the day to day management of their care and support, the "payroll agency" deals with the money side of the transaction. As with a direct payment to the service user the council only gets involved to monitor that the money is spend as agreed.

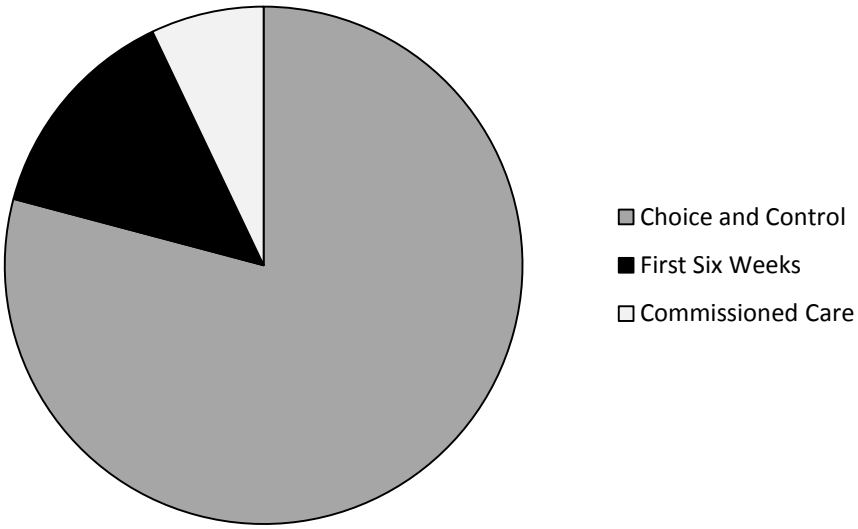
We will now see how these break down into volume and expenditure to form the market for care and support in the home in LBBD. It has to be noted that the figures presented here include disabled service user under the age of 65 as well as older people. In summary it is suggested that the current care and support in the home market could be broken down into three areas:

The First Six Weeks – This is the targeted support a service user receives as they enter social care and/or after leaving hospital, which is often called reablement.

Choice and Control – This is comprised of Direct Payments and Managed Personal Budgets where the service user is making decisions about his/her care.

Commissioned Care – This area covers people who lack capacity to make decisions or do not want to make decisions about their care and support.

The annual expenditure in 2011/12 in each area is shown underneath:



Area	Annual Expenditure 2011/12
First Six Weeks	£1,715,375
Choice and Control	£9,834,814
Commissioned Care	£878,353

Figure 7: Annual Expenditure 2011/12. LBBD 2012

The next three sections detail further information on the expenditure and number of service users in each of the three areas in 2011/12.

3.1.1 The first six weeks

	No. of Service Users 2011/12	Average weekly snapshot 2011/12	Annual Expenditure	Hourly Rate	Requiring No Further Home Care
Council's Reablement Service	496	44	£1,074,975	£51.08	37.77%
External Providers	431	75	£640,000	£17.00	13%
TOTAL	**927**	**119**	**£1,715,375**		

Figure 8 – The First Six Weeks Clients and Costs 2011/12. LBBD 2012

Council's Reablement Service – This is the Council team consisting of 28 carers. Annual expenditure includes support costs at 10% of salary and oncosts as well as an outsourced out of hours management support. Not included in the calculation is a full time PO2 Occupational Therapist (£42,580pa) also aligned to the service.

External Providers – An average weekly snapshot is 75 individuals a week. The hourly rate is calculated using the real cost of the packages, with half hour calls at 60% of the hourly rate. The 60% are applied as homecare agencies charge a higher amount than 50% of the hourly cost when delivering 1/2 h visits due to higher travel costs.

3.1.2 Choice and Control

	No. of Service Users (March 2012)		Annual Expenditure	
Direct Payment (Cash)	138		£1,074,275	
Brokered Direct Payment	419		£3,727,250	
	314 (Payroll)	105 (Invoice Agency)	£3,593,756 (Care)	£133,494 (Broker costs)
Managed Personal Budget	493		£5,033,288	
TOTAL	**1053**		**£9,834,814**	

Figure 9 – Choice and Control Clients and Costs 2011/12. LBBD 2012

Direct Payment (Cash) – This is a payment received directly into the service user's bank account. The average direct payment per person is £7,784.60 per annum. The number of people on direct payments is increasing.

Brokered Direct Payment – This is where the direct payment is brokered by a so called "payroll agency" either through paying the personal assistant (payroll) or an agency providing the service (invoice agency). 'Payroll' is the service provided when the service user has at least one private personal assistant paid for by their personal budget. 'Invoice agency' is where the payroll agency pays the home care agency invoices on behalf of the service user.

Managed Personal Budget – This is where a service user uses their personal budget to buy support from a single provider. While 547 service users in total have managed personal budgets, a proportion of budget holders do not have capacity to make decisions and do not have family or friends to support them with decision making. This is currently estimated at being 10% (54) of the 547 service users.

3.1.3 Commissioned Care

	No. of Service Users	Expenditure	Hourly Rate
Dementia Care Service	30	£351,685	£45.62
Managed Personal Budget	54	£526,668	£14.00
TOTAL	**84**	**£878,353**	

Figure 10 – Commissioned Care 2011/12. LBBD 2012

Dementia Care Service – Council team consisting of 11 carers. Costs were arrived at using the same method as the reablement team.

Managed Personal Budget – This is the anticipated number of people who do not have capacity to make decisions about the care and support they receive, as discussed above.

3.2 The project introduced

3.2.1 Background

The choice and control project was initiated in May 2012. One year after the closing of the personalisation programme which as detailed above, implemented the recommendations of putting people first and entailed a major restructure of the adult social care department in LBBD. The reason for initiating this project so soon after a major restructure and transformation programme were threefold:

Due to a tendering exercise, predating the start of the personalisation programme, LBBD was still locked in to a block contract with 8 homecare agencies who were expected to provide all home care for service users in LBBD, apart from those receiving a direct payment. During the transformation programme the terms and conditions of the contract were amended to include managed personal budgets. This meant instead of a social worker presenting the agencies with a care plan which they were supposed to follow the service user and the agency were given a budget, and the agency was then expected to sit with the service user to develop a support plan within the allocated budget. Even though this meant a step in the personalised direction due to being locked in a contract with only 8 providers the choice for the service user was limited. In reality this meant that in most cases the department would chose the provider on behalf of the service user. This contract is due to run out in April 2013, and the choice and control project was meant to

find an alternative solution to a block contract for those people who would not like, or are not able to receive their personal budget as a direct payment.

Another argument in favour of the project is "Close to Home" which was an inquiry into older people and human rights in home care that was published by the equality and human rights commission and highlighted major breaches in human rights of older people receiving care at home by homecare agencies, due to the way home care is commissioned (Equalities and Human Rights Commission 2012, p 95).

Thirdly on 14 December 2011 the Council agreed a large number of savings proposals at Cabinet. The savings required for home care were as follows: 2013/14 £100.000 and 2014/15 £100.000. The choice and control project is supposed to find those savings proactively to ensure that no last minute decisions are needed. As last minute actions to achieve saving targets very often result in hourly rates being cut, which can lead to poorer service for older people.

3.2.2 Project objectives and deliverables (products)

The project initiation document set the objectives for the project as follows:

- To develop a clear view of the current services available and what people want and need
- To develop a model of service delivery which supports people to maintain independence
- To increase capacity of the market to meet increased demand
- To support local businesses and voluntary sector organisations
- To provide employment opportunities for local people
- Improved outcomes for individuals
- To communicate throughout the life of the project and engage with stakeholders to obtain the best outcomes
- To ensure that change in structure, roles and responsibilities are managed through the appropriate HR processes
- To deliver savings of £100,000 in 2013/14 and additional saving of £100,000 in 2014/15

The deliverables (products) were defined as:

- Profiling of people currently using services in the borough
- Analysis of need from those currently using services
- Forecast of future demand and future need
- Analysis of what people would like in the future
- Analysis of how people are spending their personal budgets
- Test market for providers able to offer services required
- A new internal staffing structure with a reduced number of job roles
- A vibrant market of care and support options

3.2.3 Project Organisation Structure

Figure 11 underneath depicts the organisational structure of the choice and control project:

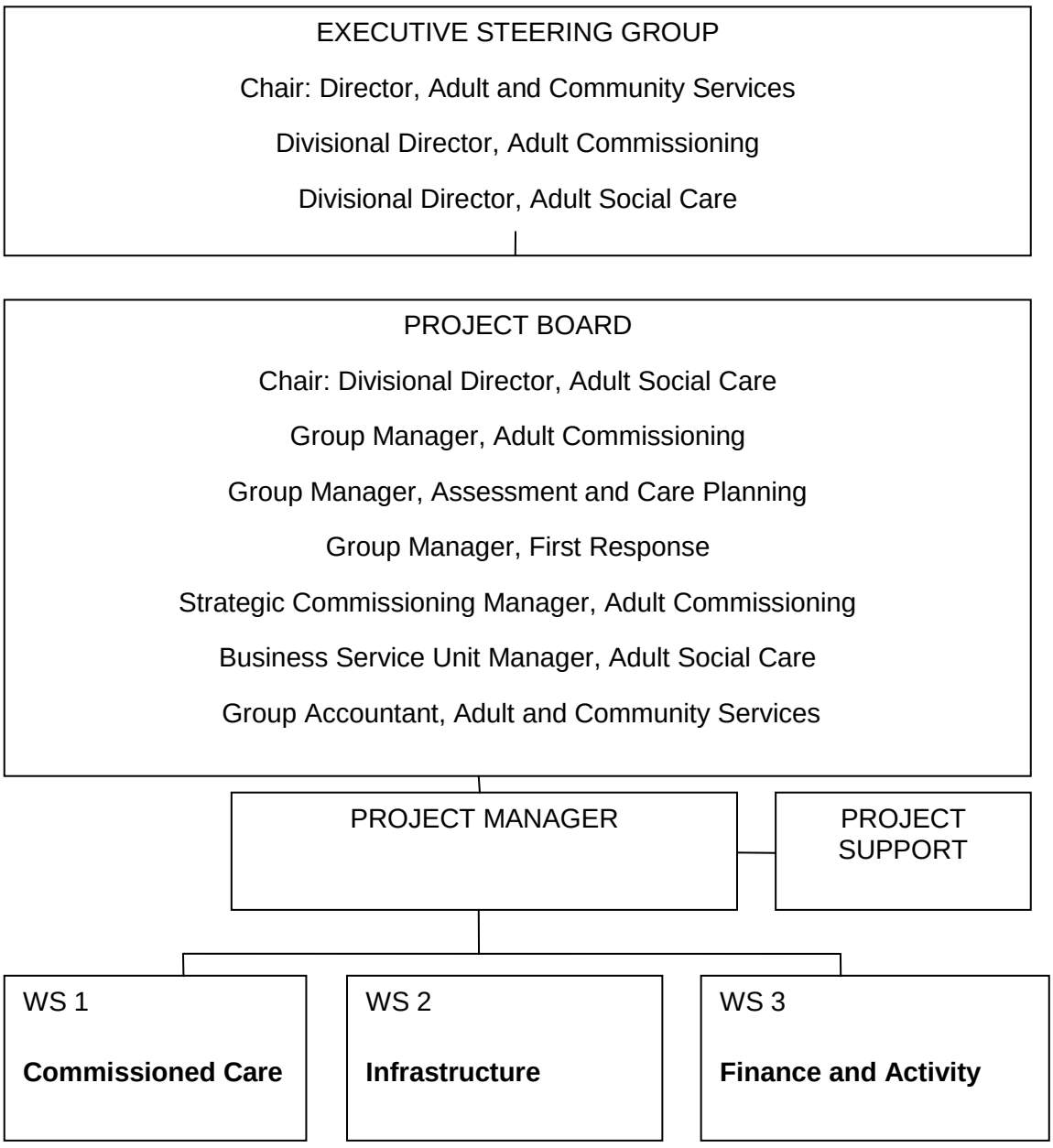


Figure 11: Project Organisation structure. LBBD 2012

The duties and responsibilities of each part of the project can be described as follows:

Executive Steering Group: The Executive Steering Group is appointed to provide overall direction to, and management of the project. The Executive Steering Group is accountable for the success of the project and has responsibility and authority for the project.

Project Board: The Project Board is ultimately responsible for the project, and is supported by the Executive Steering Group. The Project Board (Officers Group) consists of senior stakeholders from the service areas involved in the remodel. The Project Board will oversee the delivery of the various workstreams to be explained below. The Project Board must have the authority to commit or acquire necessary resources required to deliver the products.

Workstream 1 Commissioned Care: The workstream called Commissioned Care is responsible for delivering all products associated with commissioned care. This includes communication with current block providers and exploring new ways of commissioning care and support in the home.

Workstream 2 Infrastructure: The workstream called Infrastructure is responsible to deliver all products associated with infrastructure. This includes all infrastructure needed in order to support choice and control in the market. Details of which will be given further down the line. This does not exclude any internal infrastructure.

Workstream 3 Finance and Activity: The workstream called Finance and Activity is responsible for the delivery all products associated with finance and activity. This includes delivering the data needed to establish number of throughput in certain areas. For example this could include the number of service user on a direct payment. This workstream is responsible for delivering financial information to ensure the project is delivered within the budgetary constraints and delivers the required savings.

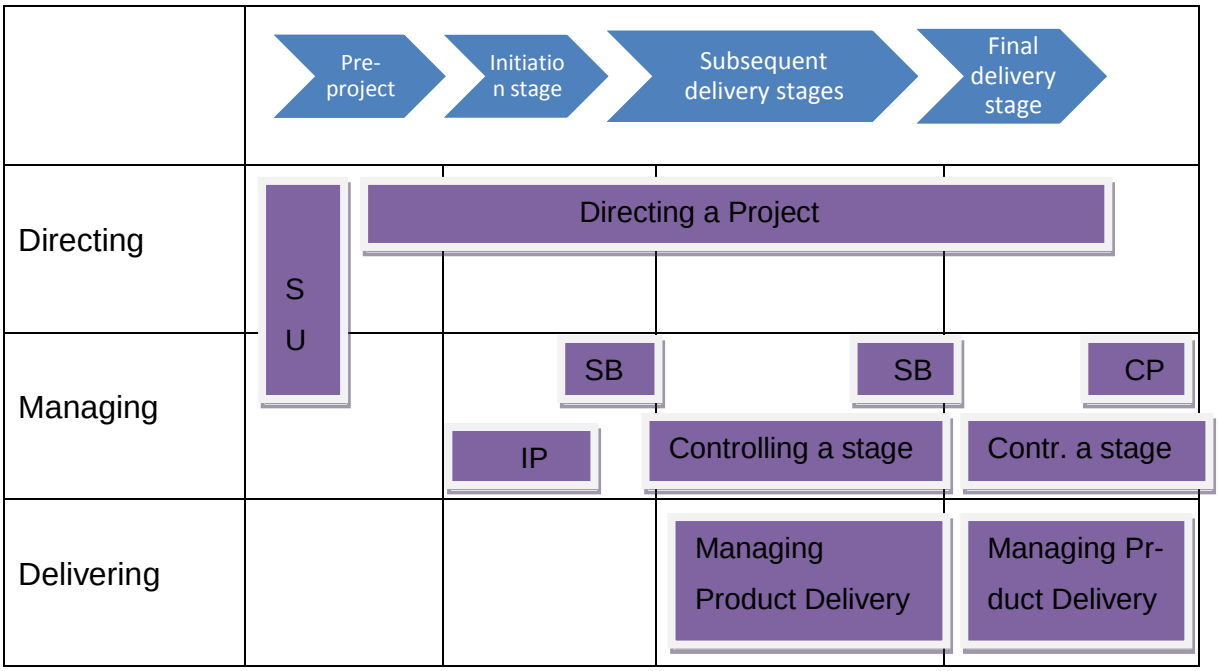
3.3 Project management and redefining deliverables

As hinted previously the project experienced a drastic reformation just a few weeks after commencing. This section will bring into context what happened and how a drastic change like this fits into the flow of managing a project. In order to illustrate the consequences of an unplanned change like this figure 12 explains how project stages would normally be managed compared to the project management concept used to manage this project.

3.3.1 Project management and the project U-turn explained

Like all projects in local government this project was managed following a protocol entitled Projects in Controlled Environments 2 (PRINCE2). PRINCE2 is a project management method developed by the Office of Government Commerce (OGC) and is the official method for projects in the UK Government but is also widely used in the private sector. In order to be a PRINCE2 practitioner one has to gain a qualification which can only be obtained through accredited organisations.

"PRINCE2 is a process-based approach to project management. A process is a structured set of activities designed to accomplish a specific objective. It takes one or more defined inputs and turns them into specific outputs" (OCG 2009, p. 113). The below figure shows the processes every project has to go through and how they are directed, managed and delivered.



SU = Starting up a Project; IP = Initiating a Project; SB = Managing a Stage Boundary; CP =Closing a Project

Figure 12: The PRINCE2 processes (OGC 2009)

In the Initiation stage a Project Initiation Document (PID) is drafted which defines the objectives and deliverables (products) the project has to deliver to. In an ideal scenario the products are checked at the boundaries of each stage and signed off by the project sponsor. In this case the project made a u-turn and the deliverables had to be re-defined. Chapter 2.2.2 told the story how a workshop was set up to analyse what people would like in the future, which set the scene for this u-turn. The powerful anecdotal evidence provided by the users themselves convinced the executive steering group that the direct payment and personal assistant approach was the way forward on a large scale. After the workshop, the project was refocused, enabling other clusters and the overall infrastructure to deliver personal assistants and direct payments to everybody who, with the right support would be able to manage it. A quick recap was held after the workshop and within a week the project status was set back to initiation stage. The project initiation document was rewritten with a new vision and deliverables.

The new vision for the future of care and support in the home is set out in figure 13 below:

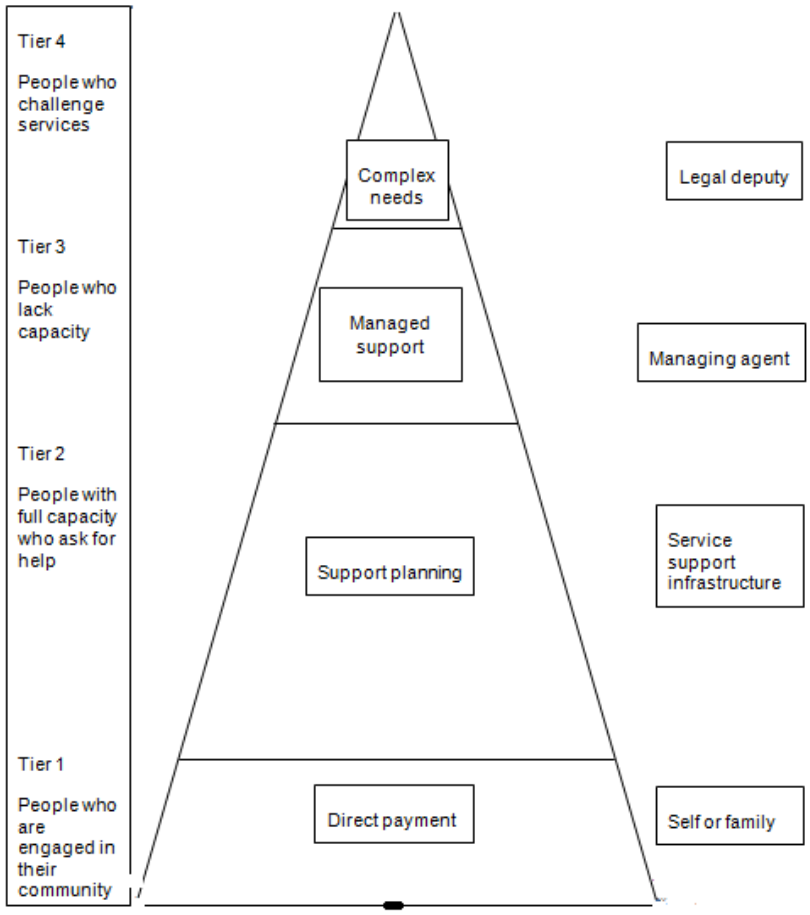


Figure 13: Hierarchy of support to assist people to manage their own care LBBD 2012

Figure 13 illustrates the set up of those older people LBBD supports with care and support in the home. In order to be able to deliver direct payments and personal assistants to the majority of this clientele it is important to understand the support they would need to achieve this. Therefore the target group has been divided into 4 tiers which outline the hierarchy of support that needs to be in place to assist people in managing their own care. The size of each tier is illustrative and cannot be directly linked to the number of people receiving that level of support. It is also anticipated that numbers in each tier will shift with the project taking effect and as infrastructure improves.

Tier 1 represents those people who are able to manage their direct payment without any kind of formal support. They manage their own payment, recruit their own personal assistants. Any help or support is provided within their own community by friends and family. In March 2012 this group of people makes up 10% of all personal budget users.

Tier 2 represent the part of the population who have the capacity to be part of tier one but have a lesser degree of community connectivity. This means they ask for formal support in order to be able to receive support from personal assistants via a direct payment. They require assistance from a support planner to plan their support and recruit their personal assistant. For the ongoing management of their direct payment they will employ the help of a payroll agency and employment advice. In March 2012 this group makes up 40% of all personal budget users.

Tier 3 represent the group of people who have so far declined any form of direct payment and receive their personal budget as a managed personal budget via a care agency. In March 2012 50% of all personal budget users received their budget in this way. There is no specific requirement for this and reflects the experience that once a service has commenced people are reluctant to change to something new unless there is a problem with what they have. A review of current assessments indicates that about 15% of people require a managed personal budget because of their vulnerability. This is predominantly because they have a long-term conditions that restrict their intellectual capacity, such as dementia. From a professional perspective this is a group of people who would benefit from the strong consistency of support offered by a personal assistant. The implication is that if arrangements were in place to support those who had limited capacity (as defined in legal terms) then there would only be a small role for managed personal budgets in the future.

Tier 4 represents the group of people who consistently challenge services. This may be due to their own chaotic lifestyle, alcohol or substance misuse or very complex family dynamics. This group often requires constant social work input. At this moment in time there is no information about the exact number of individuals in this group as they are currently not being treated separately. As part of this project it will have to be established what shape their services will take in the future. In discussion at the moment are either a contract with an external provider for a specialist service or the restructure of the current in-house specialist dementia team.

The revised deliverables were defined as follows:

- Officer and member engagement with the developing vision of personalised care.
- Increased number of personal assistants in service delivery.
- Offer consolidated information for prospective employers on how to set up and manage a personal assistant.
- Re-focus of reablement to manage demand and support the introduction of personal assistants.

- Strengthen demand management and the best use of available resources.
- Reduce the number of managed personal budgets.
- Manage the reduction in the current value of commissioned home care.
- Develop public information on home care providers that supports individuals commissioning their own care.

3.3.2 The new Project Plan and its delivery

In order to be able to manage a project successfully it has to be ensured that it is delivered on time. The project manager has to divide each deliverable into individual tasks and define each by when they will have to be completed. The project plan is the visual representation of this exercise. The project plan for the choice and control project can be seen underneath in figure 14. The yellow line represents the timeframe in which the task are being dealt with and completed. Each of the tasks is aligned to one of the three workstreams, and its completion is monitored by the work stream lead who would feed back to the project manager should there be any slippage from the assigned time frame. The project manager has been given tolerances by the executive steering group, but should the delivery slip outside the tolerances the steering group has to be informed.

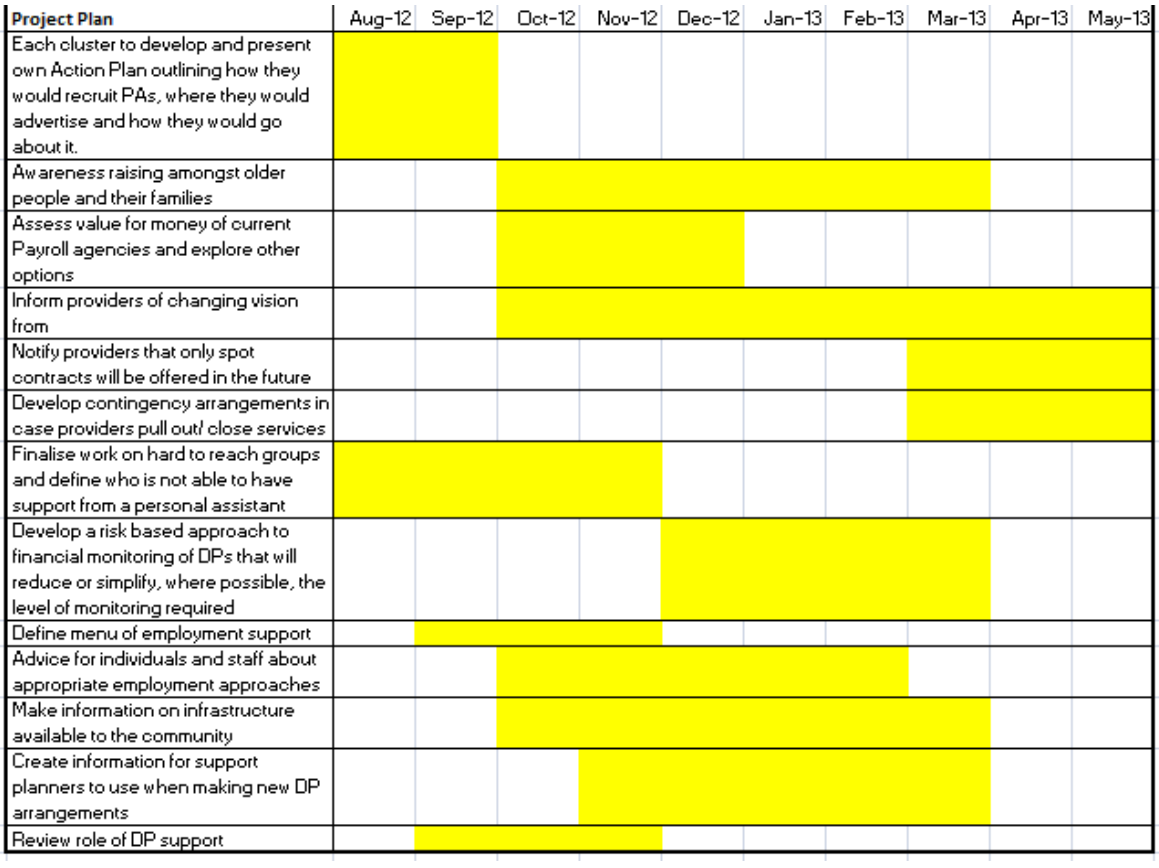


Figure 14: Project plan for choice and control project after redefinition. LBBD 2012

The following will explore each of the tasks, what they mean in practice and how they have developed at time of writing.

Task 1

Each cluster was to develop and present its own Action Plan outlining how they would recruit PAs, where they would advertise and how they would go about it: The manager and the two support planners in each of the 6 clusters had to prepare a presentation for the project board in which they outlined their ideas on how they would achieve an increase in personal assistant provided care and support. The idea of this was that the project board would get a better idea of the different clusters and personalities, and their idea of the project and their role within it. At the same time it was an opportunity for the front line staff to be part of the development of the final concept and to voice their concerns about the project. At first each of the staff members who had to present felt that this was a daunting task, particularly as the divisional director and two group managers where part of the board. In the end, each presentation proved to be an interesting exchange of information and ideas. Each of the sessions started out with a fair amount of negativity, particularly from the support planners who were asked to step out of their comfort zone and set up an elaborate network of personal assistants. Interestingly in the weeks immediately after the presentations took place an increase of direct payments could be monitored in each of the clusters. In the project boards opinion this phenomenon could be explained by two things. Firstly, the discussion with the divisional director gave an opportunity for front line staff to explain their concerns and what they thought the risks of such a development would be. During the presentation senior management made sure that they showed staff they understood their concerns including the surrounding risks. This shifted the responsibility from front line staff to management which made it easier for support planners to deal with. Secondly having to present to senior management reinforced that the department was determined to push this agenda forward and that there was little choice in this matter.

Task 2

Awareness raising amongst older people and their families: The second task was achieved by adding a kiosk to the older peoples day. Each year in Barking and Dagenham older people are celebrated with a big event that includes stalls, events and workshops. The kiosk was staffed with front line workers who explained direct payments and how it can make a difference in receiving care and support in the home. Apart from this more in depth information about direct payments and personal assistants provided during this event this information was also added to the adult social care section on the LBBD

website. They also made it so the information can be printed off as a fact sheet and distributed by anybody who visits an older person. This information is also added to the adult social care welcome pack, which gets sent out to anybody who gets in touch with the front door intake team with enquiries about the services LBBD provides for older people who have trouble managing by themselves.

Task 3

Assess value for money of current payroll agencies and explore other options: At the beginning of the project service user with a direct payment in Barking & Dagenham were either having the payment paid into their own bank account, or they were using one of two payroll agencies. Both payroll agencies are based in the local area, one was a registered charity and the other a for profit organisation. The cost for both agencies is very similar with the for profit agency charging a little bit more and the charity delivering a more individual service if required. During the time of writing this thesis nine more providers offering a similar service were found, and a hand out was created with name, information and cost for each of the providers. It is hoped that this will give more choice and at the same time generate the market to produce lower prices in the long run. Another welcome effect would be that unlike at the moment where large amounts of money are sitting with two providers, the risk is spread over several agencies.

Task 4

Inform providers of changing vision: At a provider forum meeting in October 2012 the providers were informed that LBBD is embarking on a project that will change the provision of care and support in the home. They were informed that these changes will have implications for their business. Due to it being early days in the project and the potential implications it will have on internal staff only an overview could be given as this information had not been shared with those individuals affected by the changes.

Task 5 & Task 6

Notify providers that only spot contracts will be offered in the future & Develop contingency arrangements in case providers pull out/ close services: No action has been taken regarding this task yet.

Task 7

Finalise work on hard to reach groups and define who is not able to have support from a personal assistant: hard to reach groups are those service users whose needs and or

circumstances are so complex that they consistently challenge services and need professional input to be supported. A personal assistant and a direct payment would not be the right solution for them. It is envisaged that a specialist service will provide support for this group. The commissioned care workstream has been tasked to establish how big this group is and what specification a service would need to meet the needs of this group of people. A decision has been made that this service will be delivered by in-house personal assistants as this allows the council to closely monitor the quality of this very important service.

Task 8

Develop a risk based approach to financial monitoring of direct payments that will reduce or simplify, where possible, the level of monitoring required: Currently direct payments are paid quarterly in advance, and at the end of the quarter. Each direct payment recipient has to complete a monitoring form and send this with bank statements, and any receipts, to the direct payment monitoring officer who would then go through this paperwork to ensure the monies have been spend in line with the regulations. As a result of this project an exponential growth in the amount of direct payments administered is expected, and in order to cope with the increase of workload for the direct payment monitoring officer, the processes followed have to become smarter and leaner. The infrastructure workstream has been tasked to look at current processes and establish ways to simplify the level of monitoring.

Task 9

Define menu of employment support**:** Employing your own personal assistant means that service user will have to adhere to employment law and inland revenue regulations. This is something most people will not have any experience or knowledge of, so most service users will need support with this. There are agencies who provide this support, but at the moment there is not a menu of prices and services. This task is to focus on creating a list.

Task 10

Advice for individuals and staff about appropriate employment approaches: Apart from direct employment advice, that can be tapped into when needed, general employment advice given upfront, about the key do's and don'ts should be available to service user and their personal assistants. Two leaflets one for the employer and one for the employee will be created. There are already examples of these documents available through other

sources, so this task includes sourcing what is available, and adapt this for the use in Barking & Dagenham.

Task 11

Make information on infrastructure available to the community: The key objective of this task is to ensure that everything that is available in regards of services around direct payments and care and support is available to the public. This will be achieved by drafting an information and advice strategy and implementing a in-depth communication plan.

Task 12

Create information for support planners to use when making new DP arrangements**:** Until the start of this project the direct payment monitoring officer was responsible to visit each new direct payment recipient to get a contract signed and advise them about all rules and regulations around spending the money and monitoring of such. The officer also provided support with any initial employment issues, like recruitment and contracts. Due to the rising number of direct payments expected through this project, one officer alone will no longer be able to cope with the workload and a decision was made for support planners to take over this part of the role. In order for them to do this they will need information ready to print off for their visit. This task is to make the information currently held by the direct payment officer available to them.

Task 13

Review role of direct payment support**:** As hinted at in some of the other tasks the role for direct payment support will need to be reviewed as currently only one officer deals with all tasks associated with direct payments. This includes setting up and monitoring but also any queries from service users or practitioners. With the volume increasing this will no longer be possible. So far the "as is" has been mapped and the "to be" will be established in a second step.

3.3.3 Project outputs so far

As the projects lifespan exceeds the timeframe in which this is written not all outcomes will have been achieved. This point will summarise the outputs that have been realised by the first week of January 2013. The project will not finish until the end of March 2013 and has now entered its busiest phase which will not be documented in this thesis.

Increase in direct payment numbers for older people

The most measurable output of the project is the overall increase in direct payments for older people since August 2012. Figure 15 overleaf shows that the net increase of direct payments versus managed budgets for older people was 1% between April and July, whereas the net increase between August and October is 5%. This is a significant increase which can be directly related back to the impact of the choice and control project.

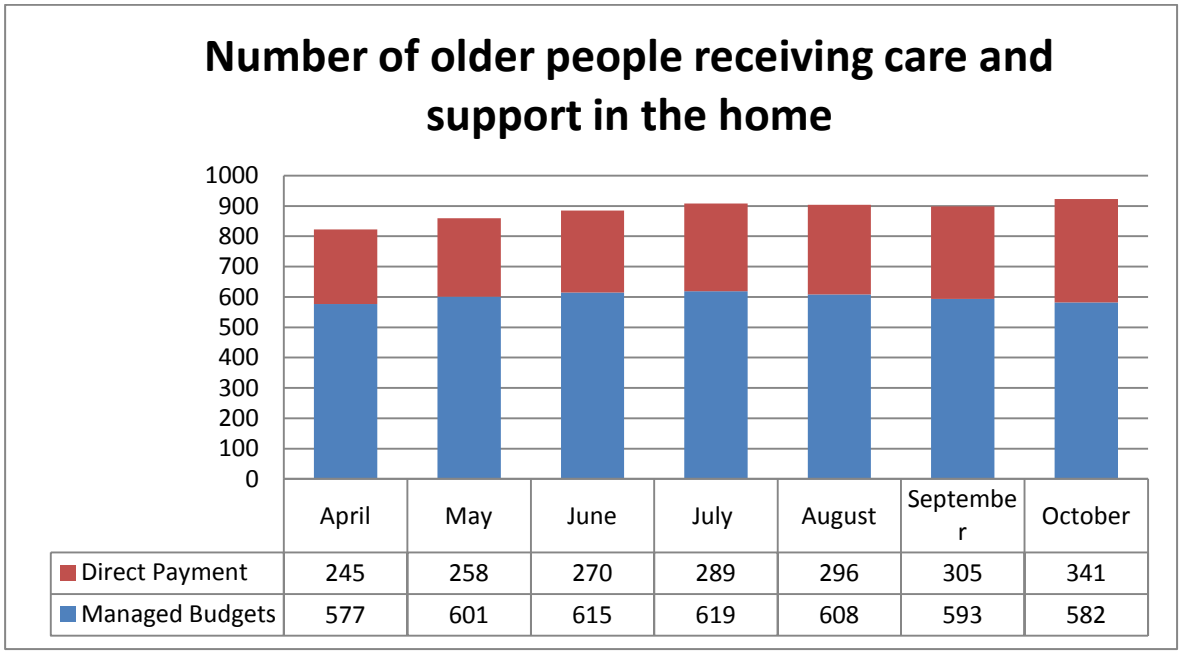


Figure 15: Number of older people receiving direct payments and managed budgets. LBBD 2012

Restructure of in-house homecare services

As defined in task 7 a solution needed to be found for those hard to reach service user whose needs and or circumstances are so complex that they consistently challenge services and need professional input to be supported. A Personal Assistant via a Direct payment would not be a viable solution for this client group. As a result of much consideration, which were to a large part also driven by the need to deliver efficiency savings, it was finally decided that the current in-house homecare and support services would be restructured and changed as follows:

The Council will no longer provide a Reablement homecare service, or a specialist dementia team. The role of community support worker will no longer exists. Community support worker are currently part of the Complex Needs Unit and provide non personal care services to promote and support independent living for service user who struggle to

organise their activities of daily living. Instead, a small in-house team of 20 in-house personal assistants will be created. The personal assistants will report to the Complex Needs Unit and provide personal assistant provision for the client group defined above. It is anticipated that those changes will finally take effect in September 2013.

Reorganisation of internal direct payment support

Two new posts have been created to assist the current internal direct payment support function which consists of one post that delivers support to service users that have any problems associated with their direct payment, or employment of personal assistants. This post also monitors each direct payment on a quarterly basis. These two new posts will be responsible for maintaining a personal assistants data base to ensure quality standards. They will also offer professional development and training opportunities for this otherwise unregulated workforce.

Move to light touch direct payment monitoring

Monitoring a direct payment means that the service user has to provide all bank statement, receipts and invoices relevant to their direct payment. In addition to this, a monitoring sheet which details their support related spending has to be completed. Previously every direct payment was monitored quarterly by the council. As more and more direct payments are being administered this was becoming very labour intensive and not very effective. Since December 2012 only new service users, and service users that have failed to show that they are reliable in submitting their returns in an organised fashion, will be monitored quarterly. Everybody else is monitored yearly. This not only reduces the workload of the direct payment officer but also allows a focus on the problem cases, in order to avoid funds being used innapropriately.

4. Current research into the homecare market for older people and personalisation

Previous chapters explored the political and social developments that have led to the project described in chapter 3. Chapter 4 will have a look at research into the homecare market and personalisation in order to clarify how the developments in LBBD fit into the scientific context. The developments around personalisation are still very new and LBBD has always been a pioneer within the self directed support domain due to being part of the initial individual budget pilot. Studies that capture the developments are still few and far between and there is very limited material to compare it to.

Two studies and one review were chosen which reflect the current situation. The study carried out by the University of York is due to be published in the spring of 2013 but for the purpose of this thesis permission has been given to use so far unpublished material only to be quoted in this context until the final results have been published. The study carried out by the Social Policy Research Unit (SPRU) of the University of York shows what consequences the introduction of managed personal budgets have had on the homecare market and also looks at whether control and flexibility is promoted through this delivery mechanism. The review carried out by the Institute of Public Care (IPC) at Oxford Brookes University has used different methods to establish the current state, challenges and future perspective of the home care market in England given the developments as part of the personalisation agenda. The study carried out by Think Local Act Personal (TLAP) in conjunction with In Control and the University of Lancaster, gives a more in depth overview about the impact of personalised services on the service user and how they see the advantages and disadvantages of current developments.

4.1 Managed personal budgets University of York

SPRU of the University of York undertook research in three local authorities in England to find out what changes have been made to try and facilitate personalised homecare in England. The names of the councils cannot be revealed but to put them into context the figure overleaf will reveal the characteristics of each research site:

	Local Authority A	**Local Authority B**	**Local Authority C**
Type of authority	Shire County	London Borough	Metropolitan Borough
Geography of authority	Rural	Urban	Sub-urban
Type of managed PB	LA-managed PBs	ISFs for all new clients	LA-managed PBs Some 'virtual budgets'
Year framework introduced	2011	2007	2008
Number of providers on framework	45	9 (including 4 with block contracts)	Originally 13 Increased to 37

Figure 16 Characteristics of the three study local authorities (Baxter et al 2012, p 5)

Based on the assumption, that many people will not want to take up a direct payment and organise services themselves, along with the evidence that also suggests the take up of direct payments has been particularly low for older people, the research focused on managed personal budgets to establish how these have been impacting on competition, choice, and diversity in the homecare market. Particular interest was focused on whether managed personal budgets are able to give people control and flexibility which are the perceived benefits of personalisation (Baxter et al 2012, p 2-3).

They chose sites throughout England which were known to be ahead in the agenda and had a large population of older people with a majority using managed personal budgets. The figure underneath shows the number of people aged 65 and over using personal budgets, by local authority:

	Local Authority A	Local Authority B	Local Authority C
Personal budgets			
DP only	125 (3%)	20 (2%)	95 (4%)
Directly-provided services only (i.e. managed PBs)	3630 (84%)	300 (24%)	2390 (90%)
Both DP and directly-provided services	300 (7%)	640 (51%)	110 (4%)
DP (not self-directed support)*	300 (7%)	295 (24%)	60 (2%)
Total	**4355 (100%)**	**1255 (100%)**	**2655 (100%)**

* Defined as 'the number of qualifying individuals who are in receipt of a direct payment, but who have not been through the Self Directed Support process (i.e. they do not have a personal budget)'. (The NHS Information Centre Adult Social Care, 2011, p92)

Figure 17: Number of people aged 65 and over using personal budgets, by local authority (Baxter et al 2012, p 6)

The research methods are described as follows: Data collection took place between August 2011 and October 2012 in three stages:

In stage one, commissioning managers from each council were interviewed in order to obtain information about the steps required to facilitate personalisation for managed PB users, including any changes in contracts or ways of working with home care agencies, as well as initiatives to develop the local home care market. In stage two, a focus group discussion with social workers/support planners in each local authority took place. These discussions aimed to explore support planners' roles in encouraging choice and shaping the demands that managed PB holders made on providers. In stage three, a total of 15 managers of home care agencies were interviewed to establish how they had experienced changes introduced by the council, including their experiences of providing support to people using managed personal budgets (Baxter et al 2012, p 6).

The findings as revealed so far can be summarised as follows:

Social workers and support planners so far did not experience a big change from what was done before managed personal budgets were introduced but were hopful that once a more diverse market was established things would change for the better and perceived quality of care would rise. Managers of home care agencies did not feel that service users, were given real choice about which agency they would like to receive care from, and that decisions were still made within the local authority by support planners or

commissioners. While social workers and support planners welcomed the perspective of a more vibrant market with more choice of providers, the managers of homecare agencies feared that more competition would mean that their business would become even less viable. Home care managers felt that the introduction of managed personal budgets had in some aspects allowed them to have a more direct relationship with the service, resulting in positive ratings. Still many others reported that they felt that the local authorities still enacted too much influence.

> *"Overall, it appears that, in the local authorities studied, changes that were being introduced at the commissioning level were well intended and aimed at increasing personalisation, but the practicalities of implementing these changes were raising some challenges that meant desired objectives were not always achieved." (Baxter et al 2012, p 14)*

4.2 A review of the older people's homecare market in England by IPC Market Analysis Centre, Oxford Brookes University

In October 2012 the Institute of Public Care (IPC) Market Analysis Centre at Oxford Brookes University published a review of the older people's homecare market in England. The report was written using data from published sources, interviews with a number of leading home care organisations, recent IPC studies and projects on the home care market, published research reports and company annual reports.

The review was compiled at the same time as the consultation on the proposals was put forward by the Government in the 2012 Care and Support White Paper. The report is written in three parts:

1. At the beginning a picture of the current home care market is drawn,
2. after which the challenges it faces are listed,
3. and finally its future development is modelled.

The current home care market

The IPC found that the market has a considerable size and there is a huge amount of money invested in it by local authorities and the NHS. Despite this it has so far not been sufficiently examined through evidence based evaluations. Therefore little is actually known about its impact. For example some argue that early intervention through the delivery of low threshold support like shopping and cleaning helps people to stay at home for longer. While others state that these same services make people more dependent, which will lead to them needing more intense support in the long term. Neither of those

arguments are sufficiently backed by enough evidence to evaluate which is right (IPC 2012, p 5).

The only part of the market that has experienced some in depth evaluation are those services intending to reduce dependency on long term care, like reablement for example. Those services have been found to have had impact in several areas. Having said that, there is not a consistent approach based on evidence of best practice across the country (IPC 2012, p 5).

Currently over 6 million hours of regulated homecare is purchased across England in a week. Sixty percent of homecare is purchased directly by public funds and the reminder is bought with private funds or direct payments (IPC 2012, p 6). The split is between private funding and Direct payment is still unclear. Even though it is known that in 2010/11 44,000 people over 65 were in receipt of a direct payment it is not known what proportion of their direct payment was spend on homecare (IPC 2012, p 9). The research finds that the majority of home care is still provided by small care agencies. Of the 4515 registered homecare agencies over 3900 were providers operating with a single office (IPC 2012, p 11). According to the review many local authority home care services have been turned into reablement care provision (IPC 2012, p 17).

Challenges for the homecare market

A recent growth of personal assistants has been noted which introduces a new sub - market within home care. Estimates of the numbers of personal assistants vary considerably. The review based on recent research into the social care workforce estimates that there may be as many as 355,000 jobs employing personal assistants. In comparison they estimate that home care accounts for approximately 771,000 jobs across all sectors (IPC 2012, p 18).

The workforce is characterised by a high proportion of female (80%) part time (60%) workers which according to Skills for Care is paid on a median wage of £6.65 per hour. For comparison the national minimum wage in 2011 was £6.08. Most recent data reveals that local authorities pay an average of £15 per hour to agencies for homecare (IPC 2012, p 19).

By reviewing published annual accounts the IPC found that some medium sized and larger home care companies are now operating home care services at a loss. Smaller providers have reported that they only continue their businesses because they cannot sell without incurring unsupportable losses; or because they personally do not want to let down clients and staff. Interestingly on the other hand local authorities stated that there

were still plenty of new (small) entrants to the market who offer even lower prices. The IPC concludes that consequences may not necessarily be fewer providers, but fewer viable businesses, and hence a higher turnover of providers (IPC 2012, p 20).

The review estimates that 80% of the market is still controlled by local authorities which means that at this time their influence on prices and supply is still considerable.

The future of homecare

The IPC estimates that in future the following will be the three groups of people will be the ones to consume the most homecare:

- "People who purchase their own care either from their own resources, via a direct payment or using a personal budget.
- People who make the choice about their care, but then allow the local authority to make purchases on their behalf, or perhaps have them recommend a preferred supplier from within a framework agreement.
- People on whose behalf the local authority purchases care." (ICP 2012 p21)

The IPC is of the opinion that for many older people choice of provider organisation is likely to be far less important than being able to chose the care worker who provides them with individual support and being the person who controls when they visit. They conclude that this means that for the foreseeable future the home care market will remain a quasi market controlled by what is on offer and the funds given to the consumer by the local authority. Local Authorities will still exercise a considerable amount of control over the market when being asked to act as a broker or simply by making recommendations and assuring quality (IPC 2012 p26).

They see the growth in personal assistants as a further step towards the deprofessionlisation of home care. To provide homecare at this time there is, no formal qualifications required, and little career structure. Personal assistants are also neither regulated nor requires trained personnel. Having to compete with personal assistants, smaller homecare agencies will find themselves reducing skills and charges accordingly (IPC 2012, p 28-30).

The question that remains is whether the recent changes will ultimately lead to a more traditional market being created. And if so how will the consumer behave.

> *"For example if the state reduces funding will more people find the money to 'top up' their care provision? Will those consumers want to buy lifestyle as compared to*

preventative services? Will a growth in self-funders create a demand for a more highly skilled workforce?" (IPC 2012, p 30)

4.3 Think Local Act Personal: The National Personal Budget Survey

The Think Local, Act Personal Partnership, In Control, and Lancaster University worked with 10 local authorities between January 2010 and April 2010 and conducted a survey of 1114 personal budget holders. 837 surveys were returned by personal budget holders from the 10 local authorities. The rest were returned online by personal budget holders from at least 76 other local authorities. 417 of these personal budget holders also wrote in a comment about their experience of personal budgets.

The survey was carried out by gathering views and experiences from personal budget holders by using the Personal Budgets Outcome Evaluation Tool (POET). POET was designed by the University of Lancaster in conjunction with In Control to measure how well local authorities are managing to implement personal budgets and to what effect. Questions explore service users experience of the personal budget process and the impact of the personal budget on their everyday life.

The sample group was divers in gender (61% women), ethnicity (11% non-White ethnicity) and religion (10% non-Christian religion; 14% no religion). Almost half of people responding to the survey were aged 65 years or more (43%); the social care needs of working age adults (aged 16-64 years) were largely split between learning disabilities (17%), mental health needs (8%) and physical disabilities (25%).

The results of the survey can be summarised as follows:

A pervasive variation across councils in regards of the outcomes reported by personal budget holders lead to the conclusion that processes implemented by the council have a major impact on outcomes. The most important measures appear to be the support service user receive through the process and the methods used to deliver personal budgets (TLAP 2011a p3). All personal budget holders reported positive outcomes, but those managing the budget themselves as a direct payment reported significantly more positive outcomes than people receiving council managed budgets (TLAP 2011a, p 3).The above is also true for older people personal budget holders. TLAP finds that direct payments can work just as well for older people, but councils seem less likely to actively promote and support direct payments as a personal budget option to older people (TLAP 2011a, p 4).

"In summary, it seems that personal budgets are likely to have generally positive impacts on the lives of all groups of personal budget holders and the people who care for them. The likelihood of people experiencing a positive impact from a personal budget is maximised by a personal budget support process that keeps people fully informed, puts people in control of the personal budget and how it is spent, supports people without undue constraint and bureaucracy, and fully involves carers. Under these conditions, personal budgets can and do work well for everyone." (TLAP 2011a, p 41)

5. Conclusion

In the introduction of this thesis it was stated that in order to understand the present one needs to know about the developments in the past. After extensive research in this area has been conducted it has become clear that it is also very important to know what has happened in the past in order to shape the future. This conclusion will try to bring the past and present together to make a recommendation for the future of the homecare market for older people in England, particularly within LBBD.

> *"To the politician 'community care' is a useful piece of rhetoric; to the sociologist, it is a stick to beat institutional care with; to the civil servant, it is a cheap alternative to institutional care which can be passed to the local authorities for action - or inaction; to the visionary, it is a dream of the new society in which people really do care; to social services departments, it is a nightmare of heightened public expectations and inadequate resources to meet them." (Jones, Brown and Bradshaw, 1983, p.102)*

The quote above was taken from a critical reflection with regards to community care 30 years ago. After what has been discussed in this thesis would it not be possible to exchange the words 'community care' with the word personalisation and still have a true reflection of the opinions represented in current developments? Furthermore does this mean adult social care has gone full circle and ended up where it started some 30 years ago? These are questions which can be answered by looking at the narrative this thesis found when examining the past, and current evaluations of the present. This conclusion will inspire to explain why and how.

After having shown what is happening in one local authority together with the journey adult social care has been on to get there and then backing this by current research. What do we know about the impact and possibilities of personalisation on the homecare market of older people? In summary it has been found that there is still a lack of evidence to go on but overall it seems though the social care market for older people is not yet ready to fully support personalisation. Local authorities are trying their best with some encouraging results, but often fail to make a real impact. Social work, the profession that is responsible for adult social care, is said to have undergone a journey from an autonomous profession to a profession regulated and stifled by care management protocol. Self directed support and direct payments in particular are celebrated by some as the solution to overcome the problems caused by community care. While others fear it will deprofessionalise the market even further. LBBD are trying to better the problems caused by introducing block contracts

to the social care market by replacing them as much as possible with personal assistants through direct payments.

To get back to the question whether adult social care has gone full circle and is repeating the mistakes of the past the answer is no. From the developments across the country, the policy papers, and the developments in Barking and Dagenham in particular, it can clearly be seen that efforts are being made to distance themselves from the mistakes made by the introduction of community care particularly the consequences to the social work profession and the older people homecare market. What cannot yet be said is whether the new developments will have other consequences which could be described as negative. Looking into the future the questions that remain are:

Whether the introduction of an open market to the homecare market will have the desired outcome of more choice for the consumer, or whether the homecare market will follow what happened on our high streets, where the market is dominated by major corporations and chain stores. Will independent providers in the homecare industry follow the example of independent stores which have more or less vanished form our highstreets? Will the wider introduction of direct payments really be able to create a personal assistant market, which will more or less replace homecare agencies? Is this even a desirable effect? Should we try to replace everything that was build in the last 30 years, and would this even possible? Or should we be inspired to better what we have now?

The questions raised by this thesis are not completely new, and even though they are not often formulated they are always present whenever discussions about the homecare market and personalisation take place. Recommendations from this thesis would be to further look at these questions, conduct more research and use the results to answer them, and then build any new concepts on those findings.

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Hiermit versichere ich gemäß § 17 Absatz 7 der ‚Prüfungsordnung für den postgradualen und weiterbildenden Fernstudiengang Sozialmanagement der Alice Salomon Hochschule Berlin', dass ich diese Masterarbeit selbständig verfasst und keine anderen als die angegebenen Quellen und Hilfsmittel benutzt und alle wörtlich oder sinngemäß übernommenen Textstellen als solche kenntlich gemacht habe. Die Masterarbeit hat keiner anderen Prüfungsbehörde vorgelegen.

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