

Transforming Adult Social Care in Northern Ireland: personalisation

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Introduction

Adult social care has become a major issue on governments' agendas, not just in the UK and Ireland but in many countries, and has increasingly been the subject of public debate. A number of factors have contributed to the increased prominence of this area of social policy including; demographic change, welfare retrenchment, promotion of independence and concerns about access to and quality of services. The historic policy neglect of social care, the over reliance on institutional care and the residualisation of many services since the 1980s has left a challenging legacy. However, the importance of adult social care has been increasingly acknowledged. It has been described as 'an important fabric of a caring society' (DH, 1998) and as an 'essential human need' (DH, 2010). Discussions of future provision have included critical examination of underpinning principles. Among these are questions about the balance of responsibility between the individual and the state, the most appropriate mechanisms for funding and delivering care, the implications arising from considerable reliance on unpaid care and the legal entitlement to social care services.

Policy Developments – Adult Social Care

Adult social care in Northern Ireland, as in Scotland and Wales, is a wholly devolved matter. Social care policy and provision has developed in England, Scotland, Wales and Northern Ireland in ways that demonstrate both convergence and divergence (Birrell, 2009, Mooney and Scott, 2012). The period since 2010 in particular has seen major policy initiatives on adult social care in Britain. In England the outcome of two major reviews – the Dilnot Commission on the future funding of long term care (Dilnot Commission, 2011) and the Law Commission review of adult social care law (Law Commission, 2011) provided the basis for much of the discussion about the direction of policy. Recent policy developments in England include a White Paper on adult social care (DoH, 2012a) and a Care and Support Bill (DH, 2012b). Governments in Wales and Scotland have also produced strategy documents addressing aspects of adult care (Welsh Assembly Government, 2010; 2013; Scottish Parliament, 2010; 2012).

In Northern Ireland policy developments and initiatives on adult social care have been more recent. The major review of health and social care services *Transforming Your Care*, (DHSSPS, 2011) included broad ideas and proposals on the future of adult social care. This was followed by a consultative document (DHSSPS, 2012a) and, most recently, a post consultation report. (HSCB, 2013) A separate brief discussion paper *Who cares? The Future of Adult Care and Support in Northern Ireland* was published in 2012 (DHSSPS, 2012b).

It is clear that there is substantive agreement across jurisdictions on a number of the main problems with current adult social care provision: entitlement to care and support; safeguarding and risk; the role of unpaid carers; issues regarding the social care workforce and the need for workforce development, although the Northern Ireland documents do not say much about the social care workforce apart from social work; lack of integration between health and social care; and funding arrangements, including the commissioning of domiciliary care. A House of Commons Inquiry (2010) also found that many of the shortcomings in adult social care with regard to older people relate to a persistent ageism'.

Across the UK some common themes are cited as important to future policy and provision. Predominant among these is personalisation, integration of social care and other services and enhancing user participation. In England, the Coalition government links its vision on adult social care to the values of 'freedom, fairness and responsibility' with a strong emphasis of devolving responsibility to local authorities. The Care and Support Bill establishes a national threshold for eligibility, creates a legal entitlement to a personal budget, including for carers and a new statutory framework for adult safeguarding. Critical comment on policy development has been dominated by what is argued to be the failure of the White Paper to address the growing crisis in adult social care and subsequent financial pressures.

Wales and Scotland have taken a somewhat different approach to adult social care policy. The Welsh government has talked on 'citizen centred social services', rejecting what it saw as a strategy of retrenchment in favour of renewal, delivery and innovation (Welsh Government, 2011). It has rejected the vision of personalization adopted in England arguing that it was too closely associated with a market led model of consumer choice, although there is a commitment to increase the use of direct payments. The Welsh government is also enacting a legal framework for social services which includes a national eligibility framework. In Scotland, policy has been introduced on Self Directed Support which must be offered by local authorities to those assessed as requiring care services. In 2012 the Scottish government published a major report on the integration of adult health and social care in Scotland (Scottish Government, 2012) which sets out a vision of a statutory underpinning and integrated budgets.

In Northern Ireland the TYC review (DHSSPS, 2011) anticipates social care as a key component of the transformation from acute to community services. The review did note the limited progress in NI with personalisation and drew attention to the need for

a debate on the issue on funding. However, the values and principles of personalisation and user involvement which have been at the centre of agendas in Britain were not fully developed in the review document. Subsequent documents noted above (HSCB, 2013; DHSSPS, 2012) have set out broad principles for adult social care but no detailed discussion of objectives or how these would be achieved. There is as yet no proposal to introduce new legislation to put social care developments on a statutory footing.

This paper focuses largely on personalisation as one of the main themes at the centre of developments in adult social care and sets out some of the potentially pertinent issues arising from the experience to date.

Personalisation of Care

Transforming Your Care (TYC) identifies personalised and more individualised care as one of twelve major principles which should underpin the future of health and social care in NI. While it was quite a strong theme running through the original review document (DHSSPS, 2011) it did not have quite the same prominence in the consultative document or the post consultation document (HSCB, 2013 and DHSSPS, 2012b). Detailed proposals for personalisation have not yet been published but it is clear that personalisation is largely identified with personal budgets for domiciliary care through which the holder could exercise greater choice and control. The post consultation document on TYC acknowledges that there is confusion about the terms used to describe personalisation, how these differ and what personalisation actually means. Many of the ideas associated with personalisation, such as independent living, have their origins in the disability and user movements which evolved in the 1970s with a focus on a rights based philosophy based on disabled people's full civil and human rights. Importantly, those advocating this approach would stress that personalisation is not about an *individualistic* approach with people managing on their own; rather it is about the right kind of support, when people need it, which they do not have to rely on families to provide.

The Social Care Institute for Excellence (2010), attempting to clarify the concept of personalisation in terms of how it can be applied to adult social care suggests that it could be understood as :

- tailoring support to individual need
- ensuring people have access to information, advocacy and support to make informed decisions
- finding new ways of collaborative working so that people can be actively engaged in the design delivery and evaluation of services

- having leadership and organisational systems that enable staff to work in person centred ways
- embedding intervention, reablement and prevention
- ensuring a 'total system response' whereby all citizens have access to universal community services and resources

This is a fairly holistic model of personalisation but ultimately whether these are the outcomes depends on the interpretation of personalisation adopted by policy makers and there is evidence that current policy in the UK falls short of securing these outcomes. There is no doubt that the personalisation agenda has influenced the direction of social care policy but there are increasingly contentious debates in Britain about the future of personalisation in a context of major structural change to health and social services and significant reductions in public expenditure.

1. Personalisation in Practice

In practice personalisation has largely been operationalised through mechanisms such as direct payments and personal budgets. While direct payments in the form of cash payments to users with which they could purchase their own care (mostly through the employment of care assistants) have been established since the mid 1990s, personal budgets are a more recent development. The personalisation agenda has been pursued with greatest vigor in England. Individuals assessed as being eligible are allocated a budget using a points based allocation system. The budget can also be topped up by users to pay for additional support. They can be managed by the individual, the local authority or a third party. All users eligible for non residential personal care are to have a personal budget by April 2013 and the intention is to extend eligibility to personal budgets to people living in residential care.

The national evaluation of the personal budget pilot in England (Glendinning et al, 2008) and other quantitative and qualitative studies (Association of Directors of Adult Services (ADASS), 2012; Callaghan et al, 2011) report a number of very positive outcomes including greater user satisfaction for individuals holding personal budgets than those using conventional services, improvements in quality of life and greater control. However, despite the potential for personal budgets to be used for a greater range of purposes most users still spent their budget on conventional services and personal care assistants. An important aspect of the pilot had been the potential to integrate funding from a range of different funding streams (such as Supporting People and the Independent Living Fund) but the evaluation identified substantial legislative and administrative barriers to this.

Analysis of personal budgets since 2011 has shown that the number of budget holders has grown, doubling between 2011 and 2012 (ADASS, 2012). However, there remain differences in uptake geographically and across different client groups. In particular the small number of people with a learning disability who are recipients of personal budgets has raised issues about the level of support for these users and their families (Abbott and Marriot, 2012).

2. Implications of Personalisation for Commissioning

Ultimately personalisation suggests a fundamental shift in traditional commissioning approaches with individual users contracting directly with provider organisations or personal assistants. Or, for those who are not personally managing a budget, personalisation suggests commissioners having to purchase a much greater range of services including advocacy and support services, leisure services etc. A number of challenges have been identified with regard to commissioning. Successful outcomes are dependant on users successfully negotiating a social care market and on the existence of providers and services in local areas. Yet, many local authorities have been slow to identify alternative services with research pointing to some fundamental difficulties around the 'decommissioning' of existing services to free up resources and the costing and pricing of support plans which accurately reflect the cost of services. There is also the uncertainty around the full impact on cuts in local authority budgets on commissioning practices and the potential for this to actually reduce the choice of suppliers. In response to such concerns the 2012 White Paper on adult social care in England imposes new *duties* on local authorities to shape markets by providing diversity of providers.

The expectation, seen in a succession of government papers in England, that commissioning would be undertaken jointly with NHS and other authorities has for the most part not materialised. The Audit Commission (2009) accepted that fundamental differences in entitlement to NHS services (free at the point of delivery) and social care services create practical difficulties in the pooling of budgets. Of course the establishment of the new clinical commissioning groups in April 2013 fundamentally changes the commissioning landscape.

3. Values Underpinning Personalisation

Few would disagree with the principles at the heart of personalisation or the positive outcomes identified to date. However, there are deeply opposing views about personalisation as it is developing in England and potentially in other parts of the UK. Critics argue that it is over individualistic with its emphasis on personal budgets which could result in creating inequality and vulnerability and potentially a residualisation of social care. The outsourcing associated with personal budgets they argue will result in an ever diminishing social care sector- a point illustrated by the controversial closure of day centres (Needham, 2011). The failure to place entitlement at the heart of the model

of personalisation has been argued to lead to a number of problems including an over-bureaucratic and complex resource allocation system and expensive planning and monitoring systems which make the process for users and families more complex.

4. Emerging Issues

Personalisation stands out as the key theme to drive forward higher quality and more responsive services. There is no doubt that it requires transformational change on the part of organisations, social care professionals and other providers. Whether this has been adequately planned for is a moot point. With regard to workforce issues, while personalisation has implications for all social care staff it is the impact on personal care assistants which has received most attention. In particular the focus has been on the use of these workers in an unregulated and unmanaged way and the potentially negative impact on workers and on users of services. There is no comprehensive data on the number of directly employed personal assistants, no regulatory or registration framework, and no requirement to be trained or to have a police check. In NI the RQIA has already flagged up issues regarding the regulation of the domiciliary care workforce (HSCB, 2013). Risk has also been discussed in terms of the adverse impact that could result from inadequate resourcing of personalisation and the financial implications of the welfare reform and the abolition of the Independent Living Fund for many people who are social care users.

Evidence Informed Policy Making

The personalisation agenda is a major influence on the development of adult social care policy but there is divergence within the UK in terms of the nature and pace of policy change and implementation. In England which has the longest experience of personalisation there is evidence that it can enable users to access better tailored and more innovative provision. Positive outcomes have been linked to effective support planning processes and to duration of use –those using them longest reported most positive outcomes. A greater weekly amount of personal budget was strongly associated with positive outcomes.

Much of the critique and concern has focused on the individualistic model of care which has been adopted. There are significant workforce issues to be addressed – including regulatory issues. A number of challenges regarding commissioning have been identified including fundamental issues such as costing and pricing. There is not yet evidence of the transformational change required to secure the best outcomes from personalisation.

Personalisation of care in NI cannot be considered in isolation from other aspects of social care policy including a review of social care law in NI, consideration of future plans with regard to social care workforce issues and unpaid carers and decisions about the

future funding of care. There needs also to be consideration of structural issues, the degree of localism required and the adequacy of expert support and advocacy services. It also needs to be looked at in the context of broader policy issues- access to transport, appropriate housing, education and employment opportunities and poverty issues

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