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Personalisation and Partnership: Competing Objectives in English Adult Social Care? The Individual Budget Pilot Projects and the NHS

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As in other countries, improving collaboration between health and social care services is a long-established objective of English social policy. A more recent priority has been the personalisation of social care for adults and older people through the introduction of individualised funding arrangements. Individual budgets (IBs) were piloted in 13 English local authorities from 2005 to 2007, but they explicitly excluded NHS resources and services. This article draws on interviews with lead officers responsible for implementing IBs. It shows how the contexts of local collaboration created problems for the implementation of the personalisation pilots, jeopardised inter-sectoral relationships and threatened some of the collaborative arrangements that had developed over the previous decade. Personal budgets for some health services have subsequently also been piloted. These will need to build upon the experiences of the social care IB pilots, so that policy objectives of personalisation do not undermine previous collaborative achievements.

Introduction

This article examines the intersection of two policy themes: inter-sectoral and service partnerships and personalised approaches to delivering health and social care. It describes the introduction of personalised funding arrangements in adult social care in England and the impact on local collaborative relationships with National Health Service (NHS) partners and services. The article outlines the relevant policy contexts of pressures to improve collaboration between NHS and social care services and the more recent extension of personalisation into adult social care. It reports evidence, from a major evaluation, of the difficulties experienced by local service managers in managing these dual policy imperatives. The article concludes with recommendations for policy and research.

Collaboration between health and social care in England

Positive outcomes for service users are widely believed to require close relationships between services at the point of delivery (Newman *et al.*, 2008). However, relationships between the English NHS and local authority social care services have a long and problematic history, originating in the funding mechanisms and structures of the post-war welfare state. The NHS was assigned responsibility for 'treatment' and 'cure', with local authorities providing longer-term personal and practical support to older and disabled people (Means and Smith, 1998). These responsibilities, underpinned by different accountability mechanisms, remain fundamentally unchanged. Meanwhile, budgetary constraints create continuing pressures to shift demand and costs between the two sectors.

Following the election of the Labour government in 1997, a plethora of measures promoting collaboration between health and social care services was introduced (Hudson, 1999). These included statutory duties for NHS organisations and local authorities to work in partnership, 'ring-fenced' funding to develop joint local services (particularly those aimed at preventing hospital admission and supporting early discharge), national service frameworks setting benchmarks across both sectors and the relaxation of legal barriers to closer organisational collaboration (see Glendinning *et al.*, 2003). The latter involved pooling health and social care budgets for specific services, joint or lead commissioning and/or integrating health and social care staff and services within a single organisational framework.

Many local joint services have resulted, particularly for older people, people with learning disabilities and those with mental health problems. For example, intermediate care services to support early hospital discharge have been established in most English localities, jointly commissioned and funded by NHS and local authority partners and employing nursing, therapist and care staff (DH, 2000; University of Leeds, 2005). Assessments of older people are expected to cover both health and social care needs (DH, 2001). Joint strategic needs assessments and joint commissioning between local authorities and NHS organisations are widespread across many areas of adult services. Collaboration and partnership are now mainstream activities for many managers and practitioners in both sectors (Glendinning and Clarke, 2002).

Personalisation in adult social care

Over the same period, pressures for more personalised social care arrangements developed, first from younger disabled people and latterly promoted by government as mainstream policy in England. Policy ambitions expanded, from enabling disabled and older people to configure their social care support to meet individual preferences, to individualised funding allocations with each user being awarded a budget from which their desired support arrangements are funded.

The option of receiving a cash 'direct payment' (DP) equivalent to services in kind was introduced in England from 1997. Low and variable take-up prompted further measures requiring local authorities to promote the direct payment option (Fernández *et al.*, 2007). Meanwhile, the social enterprise organisation *in Control* developed new techniques for determining individualised funding allocations and promoted greater flexibility in their use by people with learning disabilities. Thus *in Control* encouraged the purchase of

mainstream social, transport, leisure and daytime activity services, aimed at promoting social inclusion and integration (Tyson *et al*., 2010).

Building on these experiences, a major review of policies for disabled people (Cabinet Office Strategy Unit, 2005) proposed the piloting of individual budgets (IBs). IBs would bring together the different resources to which a disabled individual was entitled, reduce multiple assessments and allow greater choice and flexibility in the use of these resources to achieve agreed outcomes. Such mechanisms would enhance consumer choice and reduce provider power, both considered to be essential features of public sector modernisation (Clarke *et al*., 2007). However, the pilots excluded NHS resources and services. This appeared inconsistent with the previous decade of policies that had encouraged collaboration between health and social care. It raises the question of how the modernisation goal of improving collaboration was to be combined with other goals of choice, control and personalisation. As Newman *et al*. (2008: 547) comment, 'The trope of "partnership" is particularly significant in that this not only suggests tensions within the social care system but also between different government priorities, and between different modernisation programmes.'

The individual budget pilot projects and evaluation

Individual budgets were piloted in 13 English local authorities between 2005 and 2007. IBs could be taken as a cash direct payment, or held by a third party (care manager, service provider, family member) on the user's behalf. Flexibility and innovation in the use of IBs were encouraged, including spending on mainstream commercial services instead of conventional social care. Between them, the pilots offered IBs to older people, people with learning disabilities, mental health service users and people with physical and/or sensory impairments.

The pilots were subject to a major evaluation (Glendinning *et al*., 2008). This aimed to assess whether IBs improved outcomes for disabled and older people compared with conventional services and, if so, at what cost. The multi-method design included a randomised controlled trial to compare costs and outcomes between IBs and standard services (including direct payments). It found people receiving an IB were more likely to feel in control of their daily lives, compared to those receiving conventional social care support; satisfaction was highest among those with mental health and physical disabilities. Overall, there was limited evidence that IBs were cost-effective with respect to social care outcomes and even weaker evidence with respect to psychological wellbeing and satisfaction. However, there were marked differences between user groups in these findings.

The evaluation included an in-depth examination of the contexts and processes (Pawson and Tilley, 1997) of implementing IBs. This generated potential explanations of the quantitative outcome measures generated by the trial and details of the challenges if IBs were implemented more widely. This article uses data derived from semi-structured interviews conducted with the social care lead managers responsible for implementing IBs, six months into the pilots and again 15 months later. These managers had extensive strategic and operational contacts with local NHS counterparts throughout the pilot projects.

During the first round of interviews, IB lead officers were asked about existing partnerships with local NHS organisations; the anticipated implications of these arrangements for implementing IBs, particularly for those groups also using NHS services;

and how any difficulties might be addressed. During the second round of interviews, officers were asked what problems they had actually experienced and how these had been resolved.

The interviews were tape-recorded, transcribed and coded using MAXqda. All data relating to relationships with NHS partners, health services and the use of IBs for health-related purposes were extracted from the interviews. Repeated reading of the data, by two of the research team independently, identified four main themes: assessments, IBs for people with NHS continuing care and mental health care needs, difficulties in distinguishing between social and health care needs and outcomes and the wider impacts on collaboration between health and social care services in the 13 pilot localities. First, the collaborative contexts within which social care IBs were piloted are described.

Adult social care and NHS partners – local contexts and anticipated challenges

All pilot site lead officers reported extensive collaboration between local adult social care and health services. Everywhere, at least some services were jointly commissioned; pooled budgets, lead commissioning and integrated provision were particularly common in mental health and learning disability services:

> We actually have a section 31 agreement on mental health, which is around integrated service provision . . . We had a proper full pooled budget for the [integrated community equipment service] . . . we have a pooled budget for the learning disability development fund . . . and we are almost at the point of concluding . . . a pooled budget partnership arrangement . . . We have . . . a number of posts that are jointly funded partnership posts. [Site 3]

Interviewees anticipated from the outset that IBs would have strategic and operational implications for their relationships with health partners. Where services were delivered by an integrated health and social care organisation, social care managers would have no direct managerial control over implementation. Where social care resources were committed to pooled budgets, these would not be available for social care IBs:

> the LD [learning disability] budget, which is about – I don't know, 60:40 adult social care:health, so I mean that's a lot of money that's excluded from the individual budget . . . [Site 6]

As noted above, social care IBs could be taken as a cash direct payment, but legal and practice opinion was unclear as to whether the same applied to assessed health needs and NHS responsibilities (Glendinning *et al.*, 2000; Glendinning, 2006). However, in some sites, informal arrangements – themselves significant indicators of close collaboration – had been agreed to maximise continuity for service users. Thus, some sites had agreed with their NHS counterparts that people receiving social care direct payments, whose condition deteriorated to the extent that they became eligible for fully funded NHS continuing care,[1] could continue to receive this as a direct payment:

> We're one of the few authorities that have got, have persuaded our [primary care trust] to allow us to continue offering direct payments, even though we're then passing the full costs of the

> direct payments onto them . . . because that individual has been deemed to be in need of 100 per cent continuing care. [Site 8]

IB lead officers unanimously criticised the IB pilots for excluding health funding, because of the potential disruption to existing collaborative arrangements:

> to be honest, one of the big disappointments of IBs for us in learning disabilities was that it excluded the health economy and it was just about the social care economy . . . 'Oh, this is really holistic and it's about your entire life – oh, apart from your health needs'. [Site 6]

Specific implementation problems

Over and above this general disappointment, there were specific areas in which implementing IBs in social care alone was highly problematic.

Self-assessments versus integrated assessments

IBs brought new opportunities for user-led self-assessment of social care support needs. However, this was not compatible with existing practices of integrated assessments to cover social care and health needs, particularly for older people (DH, 2001).

> We've certainly agreed that we don't drop our health needs assessment element . . . You've actually got to make sure you've got a holistic assessment, your health colleagues are on board . . . [Site 7]

By the second round of interviews, another site had adapted its self-assessment documentation so that health needs and service needs could be identified:

> When we're completing the self-assessment we might also identify some health needs in there . . . the bottom line is that health are still contributing to the outcomes in that person's plan. [Site 9]

IBs and NHS continuing care

In the first round of interviews, two sites reported previous informal agreements to include NHS funding in cash direct payments for people who were entitled to fully funded NHS continuing care. By the second round of interviews, four more sites reported that a few people with very complex needs had IBs that included some NHS funding:

> there are . . . several people in there who have health money within their individual budget because it's [reclaimed] from the NHS. If it's for someone with a learning disability, it [NHS funding] might be spent on the additional support they need to manage their risky behaviour. [Site 3]

However, other sites had experienced considerable difficulty in including NHS funds in social care IBs, particularly for people who had received their IB as a cash payment, but

whose condition deteriorated to the extent that they became eligible for fully funded NHS continuing care:

> We've got a number of direct payments where we'd set up the direct payment, the person's health had deteriorated, we'd persuaded our [NHS] colleagues that they should accept full financial responsibility for the package but we really didn't want to take away from the individual or from the families concerned that flexibility . . . It's going to be frustrating, I think, not to be able to offer some of those individuals the full flexibility of an individual budget. [Site 8]

Indeed, additional difficulties arose during the IB pilots following publication of new guidelines on NHS continuing care. These stated that:

> NHS services cannot be provided as part of an individual budget or through direct payments . . . This means that when an individual begins to receive NHS continuing healthcare they may experience a loss of control over their care, which they had previously exercised through direct payments or similar. (DH, 2007a: para 77)

Consequently, in at least four pilot sites previous informal arrangements had been terminated; this was considered to curtail opportunities for personalisation and choice by people with unstable or deteriorating conditions:

> Continuing healthcare, that's another group of people where we're really, really struggling . . . those people who have previously enjoyed direct payments have got to sack all their [personal assistant] staff because they've got more ill. [Site 10]

Indeed, in one site, a review of local NHS arrangements had pronounced such arrangements to be illegal:

> We were appalled at the way it was carried out . . . Those service users were previously getting a direct payment until – the direct payment now stops 'We're not going to fund it, instead you're going to have a conventional service' and the only provider they're going to use is a provider that . . . is no longer used by the local authority because they're rubbish! [Site 8]

Another site anticipated that restrictions on the deployment of NHS funds as a direct payment would deter potentially eligible people from applying if they risked losing the flexibility of their IB. This meant that the local authority would continue to fund very high levels of support that were actually a NHS responsibility.

Strong arguments were put forward for including NHS continuing care funding in IBs:

> I think there's been a missed opportunity . . . For me continuing health care is so individualised that it would fit beautifully into this model . . . Is it not an individualised budget already? It can only be spent on the person. [Site 2]

> it would be just absolutely lovely to have access to free nursing care and continuing care monies to actually use to buy all of the support, to have someone have nursing care in their

> own home . . . People at end-of-life care and things like that, having access to health funds very quickly that we could use in a very flexible way. [Site 13]

Another IB lead officer pointed out that although the new NHS guidelines advocated personalised commissioning of NHS continuing care, this was:

> bunkum really, 'cause actually you know, it's the person being in control, that's the thing that matters. You can't commission, if you're commissioning *for* somebody, the whole point of DPs and whatever is that they commission themselves. [Site 4]

Individual budgets and mental health services

A further area of difficulty was reported from the five pilot sites offering IBs to people with mental health problems (Manthorpe *et al.*, 2008):

> Mental health needs don't fit neatly into health or social care do they? [Site 4]

These pilot sites had previously established integrated mental health services, often involving pooled budgets and integrated organisations providing both health and social care. They therefore had to identify and cost those social care resources that could be made available for IBs. Thus in one site only a small proportion of the social care mental health budget, currently used for case-by-case spot purchase of the day and other support services, was available for allocation through IBs. Another site came to a working agreement with NHS colleagues over their joint-funded mental health service – 'if it's treatment it's health and everything else is social care' – but recognised that this arrangement might not be financially sustainable in the longer term. In two sites, the NHS partner agreed to transfer social care's contribution to a joint-funded mental health service back to the authority if the latter could estimate how many service users would take up an IB. However, much of the social care contribution was used to fund day services from which only limited resources could be withdrawn, at least in the short-term, without destabilizing existing provision.

Implementing social care IBs in integrated mental health services was also challenging because the front-line staff on whom implementation depended were NHS employees, over whom social care managers had no direct managerial control:

> it's an integrated mental health service, so what we're doing is quite a radical shift in terms of social care policy being delivered by a health service and that certainly had its tensions in terms of we don't have direct operational management responsibility for the people we're asking to deliver this. [Site 4]

Furthermore, the costs of supporting someone with a mental health problem through an IB fell entirely on the local authority adult social care budget, rather than being met from a joint budget shared with NHS partners:

> At the moment, there are clear pressures in terms of us providing a social care service that might have previously been jointly funded by health and social care . . . We're taking half the pot and saying – and offering it to all the people. [Site 4]

> it's costing social care more but is it costing health less, is the big [question]. . . [Site 11]

Perceived shifts in costs to the local authority were accentuated where users had regarded conventional mental health services as stigmatising or not beneficial, but where the flexibility offered by IBs – particularly where it could be taken as a DP – was far more attractive:

> Our problem is that we can't actually cost those services with people who've been going to an acute day hospital; they just haven't been using social care services . . . We have growing numbers in terms of direct payments, again that's an issue. So it's not just about individual budgets, but clearly we're making more and more direct payments where we would once have provided a day service that was jointly funded. [Site 4]

Uses and outcomes of individual budgets

Interviewees reported difficulty ensuring that social care-funded IBs were used to buy social, as distinct from health, care. This challenge arose across the full range of user groups offered IBs, but it was most pronounced in relation to mental health services:

> *Officer 1:* We've had one [IB] signed off where the person wants to use some of the money for acupuncture.
>
> *Officer 2:* Acupuncture, yeah, yeah. So, complementary therapies probably and massage . . .
>
> *Officer 1*: . . . things like gym membership and you know, that sort of thing where maybe health should be providing physiotherapy. [Site 11]
>
> they're gonna want physiotherapy, they're gonna want aromatherapy . . . strictly we can't put that in an IB and as a Council we can't say that they can have it because it's our funding. . . but some of those kinds of low level health services are critical to people's well-being. [Site 1]

Officers in the latter site tried to ensure that IBs were not used for services that could be funded from other sources, although they recognised that they had limited mechanisms for doing so once an IB support plan had been approved. However, officers in another site were less concerned about ensuring that IBs were used only for social care, arguing that it was user outcomes that mattered:

> None of us live in a silo, I don't mind if somebody wants to use the allocation they have as long as they can meet their needs overall . . . We've got people who go dancing or fishing, it actually keeps their mental health at a level where they feel relaxed, they feel comfortable . . . [Site 2]

Such flexibility raised a number of issues. First, it meant using social care resources for activities that could be considered NHS responsibilities, where outcomes were primarily health-related and where potential benefits, in terms of reduced demand for services, also accrued to the NHS:

> The chap [whose IB was paying for a photography course] was having . . . three days in an acute hospital funded by health . . . His [Individual] Budget was about £4,000 . . . But actually the saving, you know, I don't know how much those days at an acute day hospital costs, but I suspect it's more than £4,000 a year. [Site 11]

Secondly, although an IB might be used for health-related support and have health benefits, as with other social care services the whole amount was liable for means-tested charges, in contrast to the services provided through the NHS that were free of charge. This was considered unfair to IB holders:

> Charging is the big elephant in the room, isn't it? I mean, you still have to separate out which element is social care and which element is healthcare, because we can't afford to say, 'You can have it for nothing'. [Site 7]

A further difficulty, also reported in earlier research on direct payments (Glendinning *et al*., 2000), concerned responsibilities for training and risk management in respect of personal assistants (PAs), employed by IB holders to provide social and personal care, who also undertook health-related tasks:

> We already have a basic training programme for personal assistants, but one of the things that we need to deal with, I think, is for people who've got a joint package . . . some of those PAs need training in relation to meeting the individual's health needs, and who should pay for that? [Site 9]

> we've had this with direct payments – we've had PAs doing tasks that frankly are really health tasks and there's some concern about safety . . . around what's safe. [Site 7]

Other evidence from the IB evaluation suggests that these issues were recognised by training officers in some pilot sites. One site had begun to work with its NHS partner to develop training for PAs working with people with extensive healthcare needs; another had provided information for IB users on safe practice in employing PAs (Manthorpe *et al*., 2010).

Overall, restricting IBs to social care funding only was expected to risk damaging relationships with NHS partners and undermine earlier collaborative achievements:

> There have been issues about what should be health funding and what should be social care funding . . . the danger is that we each go off at a tangent and what we're trying to do is to be working more together. [Site 11]

> If we're going to move towards any form of integration of our services with our health partners, then that funding issue is always going to stand in the way so it's got to be sorted. [Site 8]

Discussion and conclusions

As Newman *et al*. (2008) comment, English adult social care has been subject to multiple modernising pressures, but these are not always wholly mutually compatible. In this instance, aspirations for users to play a bigger role as active agents in the

co-production of their own services (Leadbeater, 2004) created tensions with more managerialist imperatives to improve efficiency through inter-sectoral collaboration. This article has reported the impact and challenges of implementing a new policy to extend personalisation, choice and control in adult social care, in the context of the history – and considerable success – of previous measures intended to develop partnerships between local health and social care services. It illustrates the tensions between these two cross-cutting policy themes and, in particular, the threats to existing collaborative relationships from the introduction of personalisation in one sector only.

Thus, the introduction of personalisation into involving social care alone was problematic because an extensive range of adult services was now jointly commissioned and/or funded, or delivered through integrated organisations. This was especially the case with mental health services. Other problems were encountered in the transition from social care to NHS funded continuing care and in attempts to restrict the spending of IBs to 'social-' rather than 'health'-related support.

More generally, there were signs of the re-emergence of the 'boundary' disputes that had characterised health–social care relationships prior to the major collaborative policy imperatives from 1997 onwards. Social care officers began again to note with concern their spending on health-related items and the potential benefits of that spending for NHS budgets. While this cost-shifting might be manageable in a short-term pilot project, there was less confidence about its longer-term sustainability, particularly if IBs proved more popular than conventional services and generated increased demand.

Moreover, social care managers considered that the reintroduction of distinctions between health and social care was incompatible with the holistic, person-focused principles underpinning personalisation. Including selected NHS resources in IBs was considered essential for effective, integrated services for patients and users. Evidence on the outcomes of collaborative arrangements for health and social care service users remains weak (Dowling *et al*., 2004). Nevertheless, implicit in the accounts reported here was the belief that local collaborations had at least led to greater efficiency and were in some instances reported to have led to significant benefits for some particularly vulnerable service users. These gains were now threatened.

One of the conditions for effective partnerships is the identification and agreement of common goals (Hudson and Hardy, 2002). IBs, and the organisational and cultural transformations they entailed, involved only social care partners; other evidence from the IB evaluation (Moran *et al*., 2010 forthcoming) has shown how implementation of the IB pilot projects was shaped by narrow social care, rather than wider inter-sectoral, policy interests. As a consequence, existing local collaborative relationships risked being undermined and future joint developments jeopardised. Policies to promote partnership and collaboration between services and sectors have wider and longer-term implications and may therefore constrain opportunities to introduce new initiatives in one sector only.

This article has focused on only one aspect of the IB pilots. Full details of the outcomes for IB holders, compared with standard social care services, are available elsewhere (Glendinning *et al*., 2008). Moreover, the article draws on only one source of data – the views and experiences of social care managers leading the IB pilots. Had NHS staff also been interviewed, it is possible that they would have given different accounts; they would almost certainly not have experienced the same implementation challenges. Nevertheless, some IB lead managers reported considerable interest in the pilots among their NHS counterparts, who were aware of the potential for learning, should similar personalisation approaches be introduced in the NHS.

Implications for future policy and research

Since the end of the IB pilots, there have been two relevant developments. First, personal budgets (similar in principle to IBs) have been extended across English adult social care in a 'transformation' programme between 2008 and 2011 (DH, 2007b). Secondly, Personal *Health* Budgets (PHBs), using NHS resources, are being piloted from 2010 (Secretary of State for Health, 2008). The PHB pilots include services where the social care IB pilots encountered particular problems – continuing healthcare, mental health services and some long-term conditions. New legislation allows selected PHB pilots to offer cash direct payments, so budget-holders can purchase their own support; pilots are urged to develop assessment and resource allocation systems in partnership with local authority social care; and integrated personal budgets, including both health and social care resources, are encouraged (NHS, 2009).

The relationships between these two personalisation initiatives will require careful evaluation. It remains to be seen how far the PHB pilots will build on the experiences of social care IBs and on the personal budgets now being mainstreamed across adult social care. In localities with experience of both, there are major opportunities to build on local partnerships and offer integrated health and social care personal budgets to those whose needs span both sectors. Evaluation will need to include the cost and efficiency implications for health and social care services, and wellbeing-related outcomes for service users. In localities without personal health budget pilots, greater flexibility may be needed to allow some health resources to contribute to social care personal budgets.

Given the overarching policy aim of increasing choice and control for users of both social and health care services, greater flexibility in the use of these respective resources at individual levels seems essential. From the evidence of the IB pilot projects, such flexibility would also appear vitally important to the health of local collaborative relationships, in order to avoid undermining a decade of local collaboration and partnerships.

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Note

1 The NHS has a continuing responsibility to fund all the care needed by people with complex, intensive or deteriorating healthcare needs, but who can nevertheless be discharged from acute hospital care – a funding regime effectively equivalent to hospital inpatient status.

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