

# Putting People First: Personal budgets for older people – making it happen



Personal budgets for older people – making it happen

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<b>For Recipient's Use</b>	

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# Executive summary

**This guide has been produced for councils and their partners to assist in developments for increasing older people's choice and control over their support. It particularly focuses on those elements of personalisation associated with making personal budgets work well for older people and their families. Although the main focus is on the flexible use of social care funding, there is huge potential for person centred approaches to be adopted by services and organisations supporting older people who are not eligible for council funded support.**

Personal budgets need to be introduced in the context of a whole system change. This transformation includes universal access to good information, advice, advocacy, and enablement services. In recognising this wider context (see *Chapter 1*) it remains important to ensure that older people in receipt of social care funding benefit from the increased choice, control and flexibility that personal budgets can provide. Achieving the vision outlined in *Putting People First* (HM Government 2007) means enabling people of all ages to make real choices about the nature and level of support they access from a wide range of networks, options and opportunities. Older people make up the largest group of those in receipt of support from social care and hence receive the largest proportion of social care expenditure. Getting it right for diverse

groups of older people will help councils and their partners get it right for everyone.

Older people often come into services at a time of crisis with little previous experience of or need for support services. The sudden onset of disability or ill health, or the gradual but progressive decline experienced with dementia, sometimes accompanied with other life changes such as bereavement or moving home, require individual approaches and solutions. Older people may also find themselves either gradually or suddenly taking on a new role as carer. Supporting these kinds of personal changes and transitions requires responsive and flexible approaches.

The practical person centred approaches outlined in *Chapter 2* when used in partnership with the older person, their families and friends can help organise and guide changes in people's lives and supports. Proactive support plans enable everyone involved to think freely and creatively about priorities and goals and making best use of resources to achieve them.

Having a personal budget, with choice and control over how it is spent to meet support needs, brings with it new challenges. *Chapter 3* outlines different ways in which older people can manage the money associated with their social care needs. It highlights the key factors that councils making progress in this area have identified as being central



to widening access to personal budgets for as many people as possible. These include easily accessible information and advice, high quality support arrangements, and systems that respond to individual circumstances and preferences.

To respond to the diverse aspirations and preferences of older people there needs to be a wider range of options available in the market. The task for commissioners and providers is to work more effectively with older people towards developing these opportunities. Some key considerations for achieving this are outlined in *Chapter 4*.

Throughout this guide there are practical examples and stories from individuals and local councils that highlight how increased choice and control with appropriate support can make real differences in the lives of older people. Councils and their partners are encouraged to use this guide along with the related planning tool in *Appendix 3* to identify priorities for action and investment in this area.

# Introduction

## About this guide

This guide on personalisation and older people has been produced for local councils and their partners. It covers people who receive funding from the council for support to live at home in their local community. It focuses on how councils can make personal budgets work well with older people and their families. A personal budget is defined as:

*'the amount of money that will fund a person's care and support costs. It is calculated by assessing a person's needs. It is spent in line with a support plan that has been agreed by both the person and the council. It can be either a full or a partial contribution to such costs. The person may also choose to pay for additional support on top of the budget. So the term personal budget refers to social care money.'*<sup>1</sup>

## Why have a guide focusing on older people?

Older people make up an increasing proportion of our population. There are nearly

12 million people aged over 65 – almost one in five of the UK's population – and this number is expected to rise by over 60% in the next 25 years to almost 15.8 million by 2031. The numbers of people living to a very old age are also increasing: one in four children born today will live to be 100 years old.

The independent evaluation of the Government's Individual Budget Pilot Programme reported that older people did not find the individual budget system used during the pilot as easy to use as some other groups. In particular, it stated that older people did not appear to want the additional burdens associated with planning and managing their support<sup>2</sup>. The Social Care Institute for Excellence (SCIE) review of relevant research observes that older people and people with complex needs may need greater time and support to help them get the most from individual budget schemes, particularly the cash direct payment option.<sup>3</sup>

Since the final evaluation report, the Department of Health has published guidance on making personal budgets and other aspects of personalisation work for older people.<sup>4</sup> The number of older people taking

1 Putting People First: measuring progress the Local Government Association and Association of Directors of Adult Social Care, May 2009

2 Evaluation of the Individual Budget Pilot Programme: final report. Glendinning et al [IBSEN Network]. October 2008. York SPRU

3 SCIE research briefing 20: The implementation of individual budget schemes in adult social care January 2007, Updated February 2009. Social Care Institute for excellence

4 Making Personal Budgets Work for Older People: developing experience, DH, 2008.

up personal budgets is increasing as councils find ways to overcome obstacles, offer choice about how resources can be managed, involve local communities in developing support options and provide tailored information and assistance so that older people know what's available in order to make informed decisions. By 31 March 2009, 92,878 people were receiving personal budgets, and of these 38,000 were older people<sup>5</sup>. This means an estimated 41% of all personal budgets go to older people. However, the proportion of older service users in receipt of personal budgets within individual councils still varies widely – from 1% to 31%.

## Using this guide

There are four chapters in this guide, each one looking at the fundamental building blocks for personalising support for older people.

### Chapter 1: Taking a whole systems approach to personalising services and support

Places the introduction of personal budgets for older people in the wider context of whole system transformation and development. It emphasises the importance of making progress in all four quadrants of *Putting People First* (choice and control, social capital, early intervention and prevention, universal services) and of strong links with other policy initiatives.

### Chapter 2: Person centred support planning with older people

Shares important lessons and examples from an initiative designed to introduce the core person centred thinking and planning skills and tools in working with older people who need support. It refers to the range of approaches used to organise and guide changes in people's lives and supports, in partnership with the older person, their families and friends.

### Chapter 3: Providing different ways for older people to manage their social care money

Explores some of the different ways in which older people can have and manage the money associated with their social care needs. It sets out five success factors for councils to consider in enabling older people to choose between the different options that exist and to manage their personal budget.

### Chapter 4: Developing a flexible and diverse market

Focuses on how the market place (commissioners and providers) can work together to increase older people's choice and control over the support they need to lead their everyday lives. It offers a way of reviewing what's currently on offer and learning how to change this based on older people's priorities and choices.

<sup>5</sup> Putting People First: measuring progress. Local Government Association and Association of Directors of Adult Social Care. May 2009.



## Appendices:

- 1) A simple planning tool and checklist for success to help councils and their partners gauge where they think they are at and as an aid to identifying priorities for action and investment
- 2) A summary of key policy drivers
- 3) Details practical core person centred thinking and planning skills and tools
- 4) Outlines considerations for managing the balance between choice and risk and locating safeguarding in the wider policy goals of personalisation. Provides examples of developing practice and a framework for developing positive risk enablement practices and plans.
- 5) Information on how the guide was developed

## CHAPTER 1

# Taking a whole systems approach to personalising services and support

***Putting People First* makes it clear that the transformation of social care requires a whole system change. Councils making progress in transforming services for older people emphasise the importance of this and of changing what some refer to as the ‘front door’ or gateway to the care and support system. They emphasise that introducing personal budgets for older people must be done as part of a programme that enables universal access to good information, advice and advocacy services, and enablement services.**

### **Working with all sectors and communities to deliver whole system change and build social capital**

*Putting People First* (HM Government, 2007) makes it clear that transformation requires a partnership between central government, local government, the NHS and the whole of the social care sector. It sets out what needs to be achieved to enable people to have the best quality of life and equal access to opportunities for independent living.

The transformation of social care requires a whole system change of which personal budgets are only one part. Introducing personal budgets for older people must be done as part of a wider programme of empowering and enabling all older people to have better lives. Access to good information, advice, advocacy, and enablement services should be central to this. Achieving change involves strengthening connections between different initiatives, services and resources and engaging older people as active participants in their community.

### **The fundamental principles of personalisation can be summarised as follows:**

- Personalisation is about choice and control over any assistance and support that older people need to live their daily life.
- It is about the whole of older people’s lives, improving their quality of life and sense of control; it is not just about health and social care or service-based solutions even if, for some people, these are crucial for day-to-day survival.

- The biggest attraction for many older people is staying in control and having a different menu of support, and choices about how the money available to them is spent.
- Promoting choice and control can increase access to community resources and natural networks of support, strengthen civic participation and enhance feelings of belonging and community cohesion.

Taking a 'whole systems approach' means working with all local council departments, NHS organisations, private and voluntary sector organisations and local community organisations and groups. This requires a strong, unifying vision and direction – for example through Local Strategic Partnerships, Older People's Partnership Boards and Local Area Agreements – so that different investment and spending commitments on information, advice, advocacy, support planning and brokerage functions are joined up and used efficiently. The current policy landscape includes numerous references and incentives for councils and their partners to work together to develop a joined up approach to achieve better outcomes for older people. *Appendix 1* outlines some of the relevant policies and reform agenda that local partnerships will want to pay particular attention to when making strategic

investment and commissioning decisions concerned with reshaping local systems.

### Co-production with older people, providers and commissioners

Change will not succeed unless providers and commissioners work together with older people throughout. Co-production refers to: *'active input by the people who use services, as well as – or instead of – those who have traditionally provided them. So it contrasts with approaches that treat people as passive recipients of services designed and delivered by someone else. It emphasises that the people who use services have assets which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise and mutual support that service users can contribute to effective public services'*<sup>6</sup>. A publication produced in conjunction with this guide – *Personalisation, don't just do it, co-produce it and live it!*<sup>7</sup> – has been designed to help councils to work in partnership with older people at a local level. It provides stories and practical steps that illustrate how transformational change can happen, and is more likely to be effective, when different stakeholders come together to find solutions that work for everyone.

6 SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation. Dr Catherine Needham, Queen Mary University of London and Sarah Carr, Social Care Institute for Excellence. March 2009

7 Personalisation, don't just do it, co-produce it and live it! National Development Team for Inclusion and Helen Sanderson Associates, December 2009

## Universal access to information, advice and support for older people

Information and advice, and assistance to use it, are fundamental to delivering the aims of the personalisation agenda set out in *Putting People First*. For older people they are top of every discussion about local priorities for improving health, independence and wellbeing in later life.<sup>8</sup> Research shows that enabling older people to access information in ways that suit them is beneficial for them and their families, delivers better value for money, and achieves greater efficiencies for the system as a whole.<sup>9</sup> The term 'universal offer' first appeared in the *Putting People First* concordat<sup>10</sup> and describes people who are funding their own support and care as well as those who are assessed as eligible for social care funding.<sup>11</sup>

*"...a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding."*

## Early intervention and prevention

Making a shift towards early intervention and prevention is a key feature of the transformation of social care and other services (e.g. primary health care and housing services) set out in *Putting People First*. An increasing body of evidence exists that demonstrates how investing in a wide range of preventative approaches helps to maintain older people's independence and wellbeing and contributes to greater efficiencies within the local health and social care system<sup>13</sup>.

In addition, many of the community capacity building initiatives that have emerged through the LinkAge and Partnerships for Older People Projects (POPP) pilots provide the essential foundations required for personal budgets and support planning to work really well with and for older people. Knowing what's available and having good support networks within local neighbourhoods, as well as through formal

8 Living well in later life, OPP (2003); Promoting independence and wellbeing, Audit Commission (2004); Sure Start to Later Life (2005); Opportunity Age: meeting the challenge of ageing in the 21st century. DWP, 2005

9 Transforming lives: Tackling Poverty and Promoting Independence and Dignity through Information and Advice, Age Concern England, 2008; The Right Advice at the Right Time, Age Concern England, 2009

10 That Little Bit of Help, Raynes et al, 2005; Lifetime Homes, Lifetime Neighbourhoods, 2008; Independent Living Strategy, 2008; Is Information Power? Older people, information, advice and advocacy. O'Neil & Dunning, JRF, 2005.

11 Putting People First: measuring progress. Local Government Association and Association of Directors of Adult Social Care, May 2009.

12 LAC (DH)(2009)1: Transforming Adult Social Care. Department of Health, 2009.

13 Making the Strategic Shift to Prevention and Early Intervention: A guide. Department of Health, 2008.

agencies, is crucial to making all of this work well, and for older people to remain connected and in control of their lives<sup>14</sup>.

## **Enablement services and intermediate care**

Community enablement services aim to help people achieve their optimum level of independence with the lowest appropriate level of ongoing support or care. They focus on helping people to do things for themselves rather than having things done for them.

Community enablement services are most effective when commissioned as part of the spectrum of intermediate care services. In July 2009, the Department of Health issued new guidance on intermediate care<sup>15</sup> emphasising that joint commissioning of a wide range of integrated services is required to fulfil the intermediate care function, including social care enablement. Focusing on enabling independence should always precede decisions about ongoing support needs for older people. A study by CSED established that in the best performing local councils, approximately 50% of older people using enablement based intermediate care return home without requiring any need for ongoing support.<sup>16</sup>

14 Navigating care: a discussion paper. The Resolution Foundation, 2008; National Evaluation of Partnerships for Older People Projects: interim report of progress. October 2008.

15 Intermediate Care – Halfway Home: Updated Guidance for the NHS and Local Authorities

16 Benefits of Homecare enablement for people at different levels of need [www.dhcarenetworks.org.uk/csed/Solutions/homeCareenablement/prospectiveLongStudy](http://www.dhcarenetworks.org.uk/csed/Solutions/homeCareenablement/prospectiveLongStudy)



## CHAPTER 2

# Person centred support planning with older people

Being person centred is about services and professionals working in ways that genuinely put the individual at the centre of decision-making about their life and the services and support they want and need. The most important feature is that the older person, and their family and friends, are central to all decisions and discussions about the nature and provision of their support. Many older people find they also have a role as a carer and can make contributions as expert care partners, as well as being recognised as having needs of their own and supported to have a life outside caring. Wider decisions relating to commissioning and providing services for whole populations need to be informed by information based on individuals' priorities, goals and preferences. A person centred approach is therefore crucial for transforming public services and the personalisation of adult social care.

This chapter shares important lessons and examples from making support planning and associated person centred planning tools and resources work well with and for older people.

### What is support planning?

Support planning is crucial for working out how an older person's personal budget will be used to meet their goals and priorities and support needs. Four core elements are: clear expectations; a range of ways for people to get support if they need it; images of possibility; a review process.<sup>17</sup> In addition to these four core elements, knowing what is important to and for someone, their important relationships and what is working and not working are fundamental ingredients of older people's support plans. Participants involved in the co-production events stressed that whatever people's roles in organisations or local partnership arrangements, it is crucial that everyone starts with older people and what's important in their lives, regardless of their need for support, their 'usual care setting' or condition.

#### Mrs N's Support Plan

Mrs N used to be a music teacher, is 69 years old and lives with her husband in an adapted bungalow in West Sussex. Her health difficulties include spondylitis, osteo- and

<sup>17</sup> Visit [www.supportplanning.org](http://www.supportplanning.org) for more information.

rheumatoid arthritis and glaucoma. She uses an electric wheelchair. Her husband has had two strokes and has become forgetful and sometimes has difficulty walking. Although initially reluctant to accept any personal help, after a period in hospital some years ago, Mrs N agreed to try agency care morning and evening to help her with getting washed and dressed.

When personal budgets were introduced in West Sussex, Mrs N's social worker helped her through the self directed assessment process and Mrs N was allocated a personal budget.

Mrs N decided she would try to get the best value for money from her personal budget and was encouraged to think about things that could make her life better. She identified that her priorities would be to continue her personal care, get help with the garden, household jobs and shopping trips, and keep her Motability car in good condition. Her support plan helped her to:

- Change the domiciliary care agency to a smaller local one that charged less and only charged for hours actually used. This saved money to spend on other support.
- Shop around to get the best deal for car cleaning (quotes ranged from £40 to £8) and engage a gardener at the most economical rate.
- Employ her grandson as her personal assistant for shopping trips (having checked that she only needed to pay him student rates).
- Employ a personal assistant to help with household jobs.

- Afford chiropody once a month.
- Hold a small float for such things as bank holiday agency rates.

Mrs N has enjoyed the process of planning her support: "I didn't find it tedious. I knew that support was available from the Independent Living Association (ILA) and my social worker, but it gave me a real sense of purpose doing it myself. I don't use the ILA's Payroll Service either – I have found it is quite easy to do it myself with helpful assistance from the Inland Revenue."

Mrs N found the whole process helped her to be more in control – "Everyone has been wonderful – I haven't been made to feel dependent and the personal budget has given me my freedom. It's not an easy thing to admit to being disabled, and before the personal budget it felt as if people were doing me a favour – now the relationship has changed and we work together."

She has found that her personal budget has made her more independent and it has altered her relationship with her family, which includes three sons: "I don't feel so dependent on my family – I like to be part of their lives, but I don't want to be their lives."

*Figure 1* sets out some key considerations that local councils should address when developing support planning arrangements that work well with and for older people.

### Figure 1 – Supporting older people's choice and control

- Invest in independent, joined up brokerage and support planning arrangements that help older people identify their goals and aspirations, as well as their need for care and support. Pooling resources to achieve this investment will help to achieve efficiencies as well as meet local needs.
- Person centred support plans help to determine how to have and manage an individual's personal budget (see *Chapter 3*) and whether there are other resources that can be used to help meet their goals and aspirations.
- Offer a range of options for older people to have assistance in developing their support plan. For example:
  - completing a support plan yourself
  - being part of a small group of people who are developing their own support (and life) plans
  - working with a group of people who form a circle of support in order to provide practical and emotional help.
- Think about and adapt to the variety of ways and times that older people reach services and respond to that person's priorities at that time. Many older people come into contact with services for the first time due to a crisis, e.g. admission to hospital or breakdown in existing/informal support arrangements
- Use different ways of capturing this information, to show all aspects of someone's life that they want to change and how their personal budget will be used to support and achieve these goals.

### Developing person centred approaches

The following are some practical steps involved in developing person centred support planning with older people which highlight where person centred thinking tools can be used to help this work well for older people and their families.

- Some older people need assistance to get started with individual support planning or to articulate their views, experiences and goals. This support could be provided informally (e.g. from a family member, neighbour or friend) or on a more formal basis (e.g. an advocate, key worker, or independent broker). The key thing is that this support is provided by someone chosen by the older person or is the person who knows them best.
- Think about the first contact that an older person may have with formal health and social care services, including during assessments:
  - **appreciations tool** and **one page profiles** can be used to learn who the older person is, what is important from their perspective and how they want to be supported.
  - **communication charts/tools** and **decision-making agreements** can help ensure the older person has choice and control in their life if verbal or written communication is difficult, if the person has memory problems or has dementia, or if the person requires assistance to make decisions.
  - **important to and for** an older person is vital information to be included in care

plans, and is as relevant to staff supporting older people in NHS settings as it is for social care staff or care workers.

- **one page profiles** are a simplified version of a support plan, and when placed at the front of a care plan give an excellent summary of who the person is and how best to support them.
- learning what makes a **good day and a bad day** for the older person is a first step to creating better days and a better quality of life.
- understanding the person's **wishes** and their story or **history** are important ways for personalising services and support.
- Person centred reviews help everyone involved to understand what is working and not working from the perspectives of the older person, their families and friends and staff.

**Terry lives alone in his flat in a sheltered housing scheme in Tameside.** He enjoys company and has a wonderful gift for making people laugh. He has a sharp sense of humour, is very witty and always has a joke to share. Terry receives home care support three times a day – in the mornings, at teatime and in the evenings. He gets frustrated by the number of different people involved in his care, for example when staff get moved or can't stay long to help him sort things out for himself. He tries not to get upset by this, saying:

*"At the end of the day I suppose I should be grateful someone turns up."*

Staff working with Terry developed a one page profile based on reviewing what was working and not working for him in these arrangements. They also looked at what is important to Terry and how best to support him to do the things that are important in his life. They agreed actions to start changing what was not working for him.

As a result they have identified other people in Terry's life that he wants to see more of and how this can happen, he is using more local facilities and opportunities for socialising than before and making his own arrangements to get there. This means fewer staff calls are needed and this helps reduce the number of different people involved in Terry's care. Joan, who helps Terry with his support, says:

*"I think Terry and I are more connected now because I've learned more about the things that are important to him and got to know him much better. I have naturally shared things about myself as well, so we feel as though we know more about each other. As a team we are focusing more on what matters to the people we support, learning what will bring a smile to their face. I have been amazed at just how much it's about the little things."*

- Information in support plans and person centred reviews can be aggregated and used to inform service planning, change and commissioning decisions.

Person centred approaches can improve the performance of different services, including the way that people, teams and agencies work together to achieve national and local targets and indicators<sup>18</sup>. Enabling older people to have a good life through greater choice and control over the support that helps them do this can bring greater efficiencies, not just better outcomes.

**Cheshire County Council** worked with a wide group of stakeholders to develop a shared understanding of person-centred thinking and planning with older people; increase awareness of the concepts and language of person centred approaches; familiarise partners with the core person-centred tools; and to think about how to develop person-centred support plans with older people.

They initially identified a number of very broad areas where they wanted to start this work which were predominantly “service and system focused”, as opposed to changing services based on what was important to older people.

Further discussions with older people, Age Concern, the Alzheimer’s Society and the Carers’ Centre identified that the key priority was helping older people, families and staff understand what is involved in support planning and how this differs from current ways of providing services. These discussions took place at the same time that commissioning staff were being introduced to the County’s new support planning model – with person centred thinking and planning being a key component of this training.

All staff went through a comprehensive training programme ensuring wide implementation of person centred approaches. Ongoing monitoring of outcomes achieved as a result of this investment are reported to the Adult Social Care Senior Management Team.

Stories of what’s working and changing for older people are shared with all staff through the Council’s Self Directed Support web page. A large event for provider organisations, sponsored by Skills for Care, also included a session on person centred approaches, following which training was organised for provider organisations through the Council’s Learning Resource Network for providers.

Jane Evans, the Older People’s Commissioning Lead for the Council says:

*“We have learnt that some people need time to engage fully with this new approach but the stories gathered to date – as a result of staff using the tools with older people – have already shown significant, positive outcomes including services being more personalised and people having more choice and control”.*

They also show that this has had a positive impact on staff using the tools with older people, increasing the likelihood of their ongoing positive use.

We have started an informal network of Champions and feel the positivity from this, plus the training and strategy for implementation, can only expand the number of older people who experience personalized services offering greater choice and control.

18 Practicalities and Possibilities: resource pack reference. NDTi/HSA, 2009. [www.practicalitiesandpossibilities.com](http://www.practicalitiesandpossibilities.com)



The fundamental person centred thinking skills and tools are outlined in *Appendix 3*, with a brief description of what's involved and how each can be used to increase older people's self-determination and to personalise support.

supporting them can tell if what they are experiencing really is person centred.

## How to check that your services are “person centred”

There are five key features that indicate that the approaches used by professionals, teams and services are truly person centred:

- 1) The person is at the centre of planning for their lives.
- 2) Family members and friends are partners in planning (and reviewing/assessing support arrangements and plans). Everyone is supported to listen and learn about what people want from their lives.
- 3) The plan shows what is important to the person – now and for the future. It shows their strengths and the support they need.
- 4) The plan helps the person to be a part of their community and helps the community to welcome them.
- 5) The plan is ongoing. Everyone keeps listening and learning to make things happen. The plan puts into action the things that the person wants to get out of their support and, fundamentally, their life.

*Figure 2* highlights what distinguishes person centred support planning from more traditional forms of care planning and delivery, and how older people and those

**Figure 2: Understanding what being person centred means**

Service/professionally centred	Person centred
• Planning for you	• Planning with you
• Talking about you	• Talking with you
• Starting with what's wrong	• Starting with what's important
• Health & Safety dictate where you live	• Health and safety addressed where you live
• 'Dead' plans updated annually	• Living plans that change with the person

**Jack lives alone at his home in Tameside.** He receives daily support from the local home care service. Together with Jack the home care staff looked at what was working and not working in Jack's life from his perspective. They discovered that he wanted to learn how to cook and be involved in the preparation of his meals, rather than just receiving meals delivered to him. He now attends a cookery course so he can plan and prepare his meals, with support when required, instead of depending on others to do this for him.

Staff learnt that great support for Jack means being helped to “do for myself as much as I can”, spotting if he becomes anxious and talking

it through with him to reassure and boost his confidence rather than doing everything for him. Being in control of daily routines (like cleaning and laundry) and making choices about his lifestyle (like going to the pub on the bus every Saturday evening to see his friends for a pint) make the world of difference to Jack.

## Connecting individual's lives to planning for populations

A key challenge in older people's services is connecting changes in individual's lives to changes for a much larger population. Starting with and keeping the focus on individual older people rather than on global forecasts and population projections can be particularly helpful in understanding the diversity of needs in the community and considering flexible, innovative ways of addressing these.

Moving from individual to strategic change, will help to combine the detailed population analyses that local areas will have available (e.g. through their Joint Strategic Needs Assessments) with fundamental shifts towards person centred practices at all levels of commissioning and delivery.

It can be helpful to have a small number of practical issues or areas in which to focus on developing new approaches to working with older people in person centred ways (e.g. geographically, or with very small numbers of people, or with specific teams/services). This can be important because:

- It is much easier to begin discussions and get going on practical actions when people can focus their thinking on the individual people involved, and how life can be different for them.
- It allows everyone involved to get to know and trust each other, which enables fundamental shifts in attitudes, behaviours and practices.
- It is easier to see what's changing and what's different as a result of adopting person centred approaches.
- It is therefore also easier to capture stories and examples that can be used to share what works and extend these lessons beyond the initial areas and, importantly, with older people. These stories provide crucial 'images of possibility' that otherwise might not occur to the individuals, families and professionals involved.
- It can enable priorities and concerns specific to different communities and minority ethnic groups to emerge and be addressed at a very local level.<sup>19</sup>

*Figure 3* provides a framework for local partners and communities to use in order to agree where to start in adopting person centred approaches with older people, to help them home in on local priorities, populations and possible areas of focus. Displaying these questions as a large wall poster can help engage all participants and create a shared record of issues, actions and outcomes to be achieved.

<sup>19</sup> Attitudes of Ethnic Minority Communities to Patient Choice, November 2008. Department of Health

**Figure 3: Agreeing where to start in adopting person centred approaches with older people**

- 1) Where/on what do you want to focus local attention on adopting person centred approaches with older people and why?
- 2) What will success look like for:
  - older people and their families?
  - staff and teams (across agencies/sectors)?
  - local services and organisations?
  - the system as a whole?
- 3) Which person centred thinking tools will help to achieve these goals?
- 4) What will help move this forward locally?
- 5) What might get in the way?
- 6) Agreed next steps, by when, whom and how.

## CHAPTER 3

# Providing different ways for older people to manage their social care money

### Introduction and background

This chapter explores different ways in which older people can manage the money associated with their social care needs. It sets out five success factors for councils to consider in enabling older people to choose between the different options that exist and manage their money to get the support they need.

The aim of personal budgets is to give individuals the power to decide the nature of their own support. Having a transparent allocation of money and the right to choose how this money is spent and managed is central to the personalisation agenda set out in *Putting People First*. A personal budget may be taken by an eligible person:

- In the form of a direct (cash) payment, held directly by the person or where they lack capacity, by a “suitable person” (from 9 November 2009).
- By way of an ‘account’ held and managed by the council in line with the person’s wishes i.e. to pay for community care

services which are commissioned by the council, or as an account placed with a third party (provider) and ‘called-off’ by the user in direct negotiation with the provider

- As a mixture of the above<sup>20</sup>.

Many councils provide a range of options to support individuals to manage their money, with the flexibility to mix and match in order to reach an arrangement that suits them best. Some of these options are illustrated in this chapter. As personalised services and support develop for older people, additional new approaches will emerge.

### Building on what works

Recent history and lessons from making direct payments accessible to older people indicate that given the right information and support, older people use their resources in creative ways to enable them to access personalised care and support that helps them get on with their lives.<sup>21</sup>

20 *Putting People First: measuring progress* the Local Government Association and Association of Directors of Adult Social Care, May 2009

21 *It pays dividends: direct payments and older people* Clark, Gough and Macfarlane, 2004

*“the personal budget has given me my freedom. It’s not an easy thing to admit to being disabled, and before the personal budget it felt as if people were doing me a favour – now the relationship has changed and we work together.”*

Mrs N West Sussex

*“Direct payments have transformed my life from being a recipient of traditional services that did not meet my needs, to a life that included returning to paid employment as well as opening many new horizons. Personalisation represents a real opportunity for individuals to focus on the outcomes they want, rather than traditional services.”*

Ann Macfarlane, older person, direct payments user and SCIE board member<sup>22</sup>

A number of councils have been surprised to find that, contrary to their expectations, direct payments are emerging as the option of choice for many older people. This is demonstrated in the following table from Barnsley.

**Figure 4: Percentage of older people using different budgetary options in Barnsley (September 2009)**

Resource deployment method	Direct payment	User controlled trust	Individual service fund	Virtual budget
Percentage of 452 older people choosing...	44%	0.0%	1%	55%

From this total of 452 older people with a personal budget in Barnsley, 31% have chosen to employ personal assistants, 51% have used an agency or local domiciliary care providers to arrange their support and 18% use a mixture of options to get a package that works for them.

Further information was obtained about how older people are using their direct or indirect payment or virtual budget from an evaluation of a sample of 100 older people. This found that:

- 55% [of the sample of 100] made changes to their support/care arrangements
- 47% reported feeling safer at home
- 41% reported that their care arrangements were more respectful of their personal dignity
- 40% reported that they had greater choice and control
- 20% felt that they had more opportunity to take part in the local community.

This information is helping local partners in Barnsley to work with older people to identify priorities for future developments to keep personalising services, increasing opportunities and enabling older people to exercise choice and control.

The increased use of direct payments by older people is supported by national statistics. CSCI figures for direct payments at March 2008 showed that the largest numerical increase of any single group in 2007-08 was with older people. Older people accounted for over one third (38.2%) of the total national increase in

22 Taken from an article in Community Care, 5 March 2009



the take up of direct payments – taking the number of older people (20,610) above the number of people with physical impairments (19,920) for the first time. This made them numerically the largest group receiving direct payments as at 31 March 2008.

The ADASS survey, referred to in the introduction,<sup>23</sup> encourages councils to develop and use reliable information about local consumer choice, needs and preferences. At the time of writing, less than half of all councils had systems in place to find out what local people need and want from their support.<sup>24</sup> This indicates that local developments about extending choice and control through personal budgets may be restricted by a lack of intelligence about what older people want and which aspects of local support work best for them.

### Key success factors

Discussions with participants at a coproduction event in March 2009 highlighted five factors for success to ensure that older people have real choice and increased control over the resources associated with their support.

Participants included self-directed support and personalisation leads, older people's strategic

commissioning leads, and older people who are directing their own support through personal budgets. *Figure 5* summarises these five factors.

#### Figure 5: Five factors for making personal budgets work for older people

- 1) Work with older people to make the change towards self-directed support.
- 2) Have a flexible range of options available for older people to have and manage their money.
- 3) Make it easy for older people to understand these options and decide which will work best for them.
- 4) Provide high quality ongoing support services.
- 5) Review, learn and implement change where needed – for individuals, communities and the wider system of support.

*Appendix 3* presents these five success factors as a set of outcomes and indicators that can be used by partners and communities working together to ensure that personal budgets become a part of local developments designed to increase older people's choice and control.

23 Putting People First: measuring progress the Local Government Association and Association of Directors of Adult Social Care, May 2009

24 Putting People First: measuring progress (page 8) Local Government Association and Association of Directors of Adult Social Care. May 2009

**Factor 1: Work with older people to make the change towards self-directed support**

One of the central tenets of self-directed support is that the person directing their own support, with help from their family and friends if they want, is often the best person to work out what the choices are and how to make them happen. The key message here is: don't make assumptions about what older people will or will not want. Many older people have been juggling resources, managing organisations and keeping household budgets in balance for a long time and will probably have clear and individual views, based on this experience, about how their money should be managed and spent.

Research in Essex,<sup>25</sup> to consider how best to inform the introduction of personal budgets with older people, found that promoting the different ways personal budgets can meet a huge diversity of needs and preferences is central to making this work:

*“Many participants welcomed the idea that personal budgets could be used for more than personal or residential care. For some, cleaning and domestic duties, being able to get to meet friends, help with pets and other things which affected their personal life, were seen to be much more important than personal care.”*

Sharing positive stories and images of older people, including their different contributions to making this system of support work well, helps to challenge stereotypes and develop positive attitudes towards ageing. To support

this cultural shift in attitudes and mindsets, age diversity and equality training and development, which respects human rights and promotes citizenship, need to be embedded in staff support programmes and in relevant policies and procedures across all agencies and sectors. The value of involving older people in support brokerage and delivering peer support is illustrated in the following example from Barnsley.

**Frank's story – A volunteer support broker in Barnsley**

I've been there and got the t-shirt. My wife used services and I was a carer. We had an individual budget, so I have personal experience of what it is like. As I am a senior citizen working with a senior citizen (as a volunteer support broker) there is an unsaid mutual trust. My time is unlimited so I can truly work at the person's pace. But, there are some challenges:

- Based on some people's assumptions – I shouldn't be here today. I should be sat at home with my heated slippers, in my rocking chair with my cup of Horlicks and imperial mints trying to work out how to use the TV remote!
- Some people assume that the person will be taken advantage of in relation to finances because of their age.

But we don't find these things are true. This is what some people have said to me:

25 Herbert, G. Personalised budgets. What do older people want? May 2008. Essex County Council

- Individual budgets help me feel more secure.
- It has given me more confidence – my self esteem has grown – I now know that I can get out and meet people.

**Factor 2: Have a flexible range of options available for older people to have and manage their money**

A personal budget is the amount of money that a council decides is necessary to spend in order to meet an individual's assessed needs. The budget can be allocated as a direct payment or the council can retain direct control of the budget. An increasing number of councils are putting mechanisms in place that offer older people greater choice over the range of options open to them for having and managing the money in their personal budget. This includes the ability for older people to mix and match between these different options and the flexibility to move seamlessly from one method to another as individual circumstances and preferences change over time.

This means there is no one way that older people have to take their personal budget and that personal preferences and experience should determine how their money is organised and managed to suit their individual circumstances.

The following are illustrations of a few of the ways in which people can manage their personal budget.

**An Individual Service Fund (ISF)** is an agreement between the individual and the provider that sits beneath the framework contract. The person asks the council to lodge funds with a provider on their behalf while retaining choice and control over the support and services provided. An ISF is a means by which someone who does not opt for a direct payment can draw on existing or new contracts in an individualised and person centred way without taking on direct budget management responsibilities. It is important that the organisation can demonstrate that the personal budget monies are kept separate from other monies relating to the organisation, and that the support is being provided exactly as specified within the support plan, and not in the standard generic way that the organisation would usually provide support. The package must be personally tailored to the individual.

For more information go to Department of Health report *Contracting for personalised outcomes*: [www.dhcarenetworks.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/CFPO.pdf](http://www.dhcarenetworks.org.uk/_library/Resources/Personalisation/Personalisation_advice/CFPO.pdf)

**An example of an ISF from London Borough of Barking and Dagenham**

Margaret is 64 years old and lives with her husband. She had numerous strokes in the past which has left her with reduced mobility and she also suffers from angina and arthritis. Her husband is unable to care for his wife or maintain the house due to his own health problems.

**Margaret has an Individual Service Fund,** which means she has been able to keep the same carers and agency involved in her care, but has changed how they support her in the things she particularly needs and wants help with.

Margaret developed her support plan with help from the care agency managing her Individual Service Fund, her care manager and her husband. She says:

“I wanted to get my independence back and to get my house sorted out. I don't feel safe going out alone, so having someone to come with me when I go shopping really helps, rather than them doing the shopping for me. I've got my social life back as well, as I've started going back to the social club I went to at the British Legion before all of this happened.”

**A virtual budget** is translated into a support package through a partnership between the older person, their family and a care manager to ensure resources are used to meet their personal goals and needs. This involves the council/partnership as a purchasing service working on behalf of the individual, acting as a bridge between their decisions and the services they wish to buy. It involves no transfer of funds or delegation of money management responsibility to the individual, but aspires to offer a similar degree of choice and flexibility as a direct payment. This option may appeal to those who do not wish to manage a direct payment, or who are not

eligible to receive one. Services can be arranged through a combination of 'in-house' services and/or services commissioned from providers, voluntary/community sector organisations, businesses or other community resources.

**George, 69, is fun-loving and has a great sense of humour.** He lives alone in a bungalow and doesn't have contact with his family. He uses a wheelchair and has difficulties maintaining personal care and the hygiene of his home. He couldn't sleep in his bed because he couldn't get to it and he didn't have any clothes, meaning he couldn't get dressed. Even though he had a social worker, housing officer, district nurse and carers in his life, they were generally unable to go into his home because of the risk to their own health. His health and home deteriorated and he was at risk of being evicted.

George's social worker Liz used the person centred tool Histories to find out more about his interests and views about his situation. It was clear he wasn't happy as things were. Liz worked with his carers on an Appreciations tool to help them see what people like and admire about George and to understand the situation from his perspective. Liz then started working to develop a one page profile that looked at what was working and not working in George's life and how best to support him.

Now, the support George receives has changed from visits at specific times of the day to the option to use the resources available to him more flexibly and creatively.

He has been helped to make physical changes to his home environment and can vary the level of support he receives from week to week. As a result of the changes in approach George feels less agitated and happier in himself, sleeps much better in his own bed instead of his wheelchair and his home and hygiene have been transformed. He has also achieved something he has wanted for a long time – he has a new dog.

**A direct payment paid directly to the individual** with the option of help from a locally commissioned Direct Payments Support Service (DPSS).

**Shirley found her care provision from the council to be inflexible and she had no choice about who provided her care.** She chose to have a personal budget which she receives as a direct payment. She uses her personal budget to employ a personal assistant who she feels understands her needs and fits in well with her. She looks forward to her coming and feels her health and wellbeing have improved significantly. Her rheumatoid arthritis makes it difficult to write so she gets her daughter to help her fill in forms and she files and manages them herself. Shirley says that the paperwork is not difficult to manage and she knows that the direct payment support service is always there to help should she need it.

**A direct payment to a 'suitable person'** where the person with eligible needs does not have the capacity to consent to direct payments, the payments can be made to an appointed suitable person who will manage them on their behalf. With certain exceptions, councils now have a duty to make direct payments in respect of a person lacking capacity, provided there is a willing suitable person who meets all the conditions set out in the regulations.<sup>26</sup>

**Joan has dementia and lacks capacity to consent to a direct payment.** Her friend Sheila has enduring power of attorney over her affairs. Joan tried living in a care home and although the home was of a high standard, it didn't suit her. Friends and family found that she lost confidence and became agitated and unhappy. They felt that her wishes and needs would be better catered for if she could have tailored support at home. It was agreed that Joan's personal budget could be provided as a direct payment to a suitable person.

Sheila was appointed by the council to act in this capacity and receive the direct payment on Joan's behalf. She involves Joan in the choice of personal assistant. By knowing and understanding her behaviours and responses, Sheila can tell if Joan is happy with the decisions made. Joan is supported with a range of activities and personal care and seems more content and relaxed. Sheila, who

26 Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009



manages all the payments, says that at first she was daunted at the prospect of these additional responsibilities but in fact it has never been a problem. The personal assistant is employed through an agency who manages all the employment issues including ongoing training. The paperwork is straightforward and she knows there is always help on hand through the council should there be any issues or concerns.

It is vital that each person's capacity is assessed on an individual basis in relation to the specific decision to be made. Assumptions should never be made that someone will lack mental capacity simply because of the existence of a particular condition.

Someone cannot just decide to be a suitable person in order to receive direct payments on behalf of another person. In most cases, the suitable person will be a family member or a close friend already involved in the provision of care for the person concerned. However, whatever the relationship, the council must still follow the process set out in the regulations, to ensure that the best interests of the person lacking capacity are prioritised above all other considerations. For detailed information go to Department of Health Guidance on Direct Payments 2009 [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_104895.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104895.pdf)

**Direct payment through prepaid cards** – a prepaid card can provide a secure and convenient way for some people to receive

direct payments. Cards can be topped up at regular intervals and funds can be available to spend with any organisation able to accept card payments. They can be used to pay for services face-to-face, over the internet, or on the telephone and to release cash. This system supports people who choose not to or are unable to receive money in a personal bank account and removes the need to provide financial records to the local council. The extent of their use will be controlled by the council providing the card and therefore can restrict the individual's choice and control.

**A number of councils including for example Kent County Council and the London Borough of Enfield** have introduced prepaid cards which can be used by people who have a direct payment. Prepaid cards can be used both to buy conventional care and support, and also to buy goods and services in shops, online or by phone.

Mrs N is a 97 year old woman living in Enfield and originally from East Africa. She is of Hindu religion and speaks Gujarati and needs an interpreter to help her express her needs. Mrs N has short term memory loss and was previously getting home care directly through the council's agency provider but this arrangement proved difficult and inflexible with regards to her communication and cultural needs.

The situation was reviewed and a personal budget was allocated to Mrs N. A support plan was developed that includes employing



Gujarati personal assistants who speak her language and understand her cultural needs. They provide support throughout the day including accompanying Mrs N to the shops and helping her cook fresh vegetables as she is a strict vegetarian. Mrs N also attends an Asian Day Centre, where she meets friends who share her background and similar experiences from East Africa, and participates in religious festivities. She also uses some of her money to visit family members in another London borough.

Mrs N receives her money as a direct payment through the E-card. She feels that the E-card makes life easier, more convenient and secure, and her granddaughter helps her by checking transactions and balances online. Mrs N uses her E-card to pay for her personal assistants. This relieves her and her family of the paperwork and only involves two phone calls to the bank each month. She also uses the card for the Asian Day Centre where she goes three times a week. She has names and contact numbers if she or her personal assistant ever need clarification or support from Social Services. She also knows that she can change her mind about her support arrangements, including transferring the financial arrangements back to the local council (e.g. as a virtual budget).

**A third party supported managed account** can be used when someone does not have a bank account but plans to use a direct payment to purchase their support. In these situations, an individual's direct payment is paid to a third party organisation at their request.

This is particularly useful for people who a) have not been able to access the facilities of the main banks and building societies or b) may not wish to manage the money themselves but do not have anyone who could act as their agent or c) if there are any risk issues around the person receiving the monies. There is usually a charge for a supported managed account which must be included within the support plan costing.

**Mr and Mrs L are an older couple living in a quiet road close to the local bus route.** Mrs L has been caring for her husband since 1995, when he had surgery for a triple bypass. As a result of the surgery, he has severe memory problems and sudden and acute episodes of collapse when paramedics need to be called. Mrs L has found herself increasingly reluctant to leave her husband on his own, even for short shopping trips.

Last year, when her husband was in hospital, the doctor recognised the stress Mrs L was under and referred her husband to Adult Services for assessment. The social worker suggested a personal budget as she felt it would give Mr and Mrs L the flexibility they needed.

Mrs L found everything really straightforward as "the social worker helped me with everything, and I also had help working out the money. It was no worry at all".

She decided to have a Supported Managed Account, as she is already dealing with all the household paperwork and did not want to take on anything extra. The personal budget is paid to a third party organisation who

manage the money on behalf of Mr and Mrs L.

### The personal budget is used to:

- Provide four hours of support from Crossroads, to enable Mrs L to do her shopping and also to have time for herself.
- One day a fortnight provided by a local agency to enable Mrs L to have a day's respite and for care to be provided for Mr L, a meal cooked for him and assistance with the housework. On this day Mrs L is often taken out to lunch by her daughter and has also been able to use it to visit her sister who lives in Hampshire.
- Other hours are saved up for periods of respite as required. Mrs L has just had knee surgery and Mr L received respite care from a local service that he likes.

Mrs L feels that it has made a huge difference to her – “I used to rush out to get the shopping done, but never knew when he was going to be ill. It was just so worrying to leave him”. But now she feels she can go shopping with peace of mind.

She feels that one of the best things about the service is its flexibility – the ‘floating’ time means she can have extra support when she needs it, and she can also save up the hours for a longer period of respite. This is ideal for her and her husband because of the uncertainty of his condition from day to day. She feels the service has helped to achieve the outcomes of providing care for her husband, while providing her with a regular period of respite and helping to relieve her anxieties.

**Direct payment managed through a trust** – some people who would benefit from direct payments find it difficult to manage their own money, or arrange their own support, without a lot of assistance. Setting up a trust fund might help them benefit from the choice and control that direct payments bring. A group of people who are prepared to act on behalf of such people can act as trustees and take on the responsibility for managing the money and organising the support. A trust must be made up of at least three people who have the service user's best interests at heart. The cost of setting up the trust needs to be considered within the support plan costing.

**Group purchasing through pooling direct payments** – groups of people may wish to get together to collectively purchase a service or participate in an activity. A third party supported managed account (above) is one method that can be useful to enable groups to purchase collectively. Group purchasing can also be arranged directly through a provider or through establishing a special bank account.

**In Slough a group of 25 adults from diverse BME backgrounds, including older people, have agreed to pool individual direct payments of £100 each, for use in group activities that promote social inclusion and have a particular cultural flavour to them.**

Members of the group have taken part in a range of activities which in other circumstances may not have been possible including:

- A day at the Asian Lifestyle Event
- A visit to a temple
- An outing to the latest Bollywood movie.

Each individual has a record sheet of monies spent and balance remaining which they sign when any activity takes place. The money is managed through a not-for-profit bank account with three named account holders, two of whom are required to sign to authorise expenditure.

**Schemes for making small payments** – some councils operate small payments schemes where direct payments within a pre-agreed limit can be given direct to individuals for support needs. A direct payment agreement is still required, but the person does not need a separate bank account and monitoring is done principally through the review process. This can provide a straightforward way for people to purchase equipment or one-off services. In other instances councils use vouchers to make these payments, although these can be more restrictive (e.g. are limited to specific purchases/brands/outlets).

Warwickshire County Council operates a scheme for small payments up to £500 whereby one-off payments can be made to individuals without the need for a separate bank account. The following example shows how this can benefit a family carer.

**Mrs M is aged 81 years old and has Alzheimer's type dementia.** Her husband receives very little informal support in his caring

role and is struggling to meet his wife's complex needs. Mr M wishes to continue to care for his wife at home but this is becoming increasingly difficult as she is extremely anxious when he is not in her presence. The only time Mr M receives a break from his caring role is when Mrs M is in receipt of respite care.

During an initial home visit a social worker used person centred planning tools and explored what was important to Mr M. Mr M has always enjoyed his garden but was not able to find the time to look after it. This was really worrying him as it was looking neglected. Mr M was offered a direct payment to cover the cost of a private gardener. The small payment enables Mr M to employ a gardener for two hours a week. He says that this has made a big difference to him. The process has been very easy for Mr M to manage as the gardener is self-employed and manages his own financial affairs.

A crucial lesson from councils making progress with personal budgets with older people is the need for the greatest flexibility in the ways that resources can be allocated and managed, so that older people can 'mix and match' across these and other options to find the right combination to suit their individual circumstances.

**Factor 3: Make it easy for older people to understand the options and decide which will work best for them**

The key to making all this work well is ensuring that older people and those who

support them (family members, friends, carers and paid staff) are aware of and understand the different options available. Examples and stories that illustrate how older people's lives are changing through using personal budgets – and what enables this to happen – are powerful tools for boosting confidence and raising expectations about what's available and how to access it.

Essex County Council has produced a guide to self-directed support including stories of how older and disabled people have been using personal budgets. Putting Essex People First<sup>27</sup> also includes information about the options for having and managing your money, examples of the different kinds of support that can be accessed with a personal budget, and who can provide individualised and detailed support across the county to make this happen.

Norfolk County Council and their partners are sharing stories about how older people and their families are using their personal budgets to access very different kinds of help, especially support that enables them to staying in control of day-to-day life, routines and family relationships.

South Tyneside are also using stories to show how some older people have managed with a direct payment, while others have opted for a managed account to remove the paperwork elements while retaining control over key decisions about how their money is spent.

**Mr and Mrs B live together at home in South Tyneside and both are in poor health.** Mr B's health deteriorated after breaking his hip in a fall; he had a stroke under anaesthetic while having surgery to repair his hip. Both had been supporting each other with help from their family, but were increasingly feeling uncomfortable with this arrangement and that they were 'becoming a burden'.

Following assessment they were offered the option of a direct payment and, after discussion with their family, chose to employ their son as a personal assistant (PA) with their daughter-in-law providing personal care support. They had both lost a lot of weight and were not eating properly, so with help from their PA they decided to focus on getting fresh fruit and vegetables, meat and fish into their daily diet. This has made a huge difference to their overall health and wellbeing. Mrs B has started to help with the cooking again, which she loves, including passing family recipes on to her son. They have also used their direct payment to take a holiday with support, rather than using traditional short respite services meaning time away from each other in a residential care setting at great expense to local services.

Participants in the co-production events identified the following actions that help in making the shift from current, traditional forms of support with relatively few options available, to older people, with very different

27 [www.essexcc.gov.uk/vip8/ecc/ECCWebsite/content/binaries/documents/Your\\_Questions\\_Answered\\_LR.pdf](http://www.essexcc.gov.uk/vip8/ecc/ECCWebsite/content/binaries/documents/Your_Questions_Answered_LR.pdf)

needs, taking control and making decisions about what will work for them.

### Figure 12 – Getting good information out there

- Pay attention to the language and images used to promote what's available and how it can be accessed by older people.
- Emphasise the benefits in clear and simple terms using examples, quotes and stories from older people.
- Have a range of ways that older people can access this information and different sources of advice, including advocacy, to make best use of it. Peer support, printed and web-based materials, the use of local media (local papers, TV and radio) are all trusted sources of information and advice for older people.
- Increase the availability of and improve access to independent advocacy by diverse communities of older people.
- Share stories and examples about how people have used this information to make important decisions (e.g. whether to opt for a direct payment or a commissioned service/support) to demystify this new system of support and increase confidence for individuals, their families, and for professional staff – including care managers and provider organisations.

### Factor 4: Provide high quality ongoing support services

Providing high quality, ongoing support to older people – with a range of options for how this support is accessed and delivered – is fundamental to supporting older people to benefit from the choice and control that personal budgets can bring. It is crucial that individualised support is in place from the point of self or supported assessment onwards.

Lessons from the last five years of direct payments emphasise the importance of an effective and independent support service that helps the older person with payroll and other employment matters<sup>28</sup> – often provided by third sector and user-led organisations.

Support services are often provided by user-led organisations or in partnership with third sector organisations.

**Barnsley Metropolitan Borough Council** and a coalition of voluntary and community sector organisations led by Age Concern, Barnsley, are working together to develop a local support system that enables older people to choose, manage and use a personal budget:

Flexible and accessible brokerage services are available through an Independent Brokerage Hub through which a range of workable options is promoted to older people.

28 It Pays Dividends: direct payments and older people. Clark, Gough and Macfarlane, 2004; Direct Payments Solutions Set, <http://kc.csip.org.uk/solutionset.php?grp=601>



This includes equally flexible ways of providing information and support to enable older people to make decisions that work for them, and then to have support in making those things happen.

Our co-production participants stressed the importance of peer and mutual support arrangements for older people, as in the case of Frank who is a volunteer support broker in Barnsley. Frank emphasises that peer support can be truly effective when being a peer involves a range of dimensions, including:

- People with shared experiences of the need for support (e.g. as a result of a stroke or dementia)
- People living in similar circumstances (e.g. in the same area or type of accommodation, or if they live alone or with family)
- Someone of a similar age and stage in life (the generation effect)
- People with experience in managing and using a personal or virtual budget (e.g. an expert by experience).

Councils making good progress in implementing personal budgets with older people also stress the importance of adopting person centred approaches that involve older people as equal and valued citizens (see *Chapter 2*), and working across sectors to ensure a range of support for managing

money is easily available. Local voluntary and community organisations play a vital role here, as do user and peer-led organisations.

**Norfolk County Council** is working with two independent organisations that can offer advice to people writing their support plan: Age Concern Norfolk and Independent Living Norfolk. Work is ongoing to provide information and training in support planning to at least 25 local voluntary organisations. While current levels of take up of personal budget numbers are modest, they are increasing all the time: at present there are about 120 older people using personal budgets to get the support that suits their needs and preferences.

**Factor 5: Review, learn and implement change where needed – for individuals, communities and the wider system of support**

Research and best practice examples from councils participating in the Individual Budget, POPP and Link Age Plus pilot initiatives<sup>29</sup> have repeatedly shown that the process for making decisions and managing money needs to be easy to use and simple to monitor. There also needs to be a link between what makes this work for individuals and making this work for communities and the broader population as a whole.

29 LinkAge Plus: Benefits for older people. Daly, G. Research report No. 554. DWP (2008); Making a strategic shift to early intervention and prevention: A guide DH (2008); Person centred thinking and planning with older people: practicalities and possibilities. OPP/H S A, H S A Press (2007)



The three key aspects to this success factor are:

- Developing person centred monitoring arrangements to help older people keep track of and account for their budget and how it has been used to achieve their support plan.
- Using person centred reviews to find out what's working and not working in someone's life and support.
- Aggregating the information from both of these sources to inform wider commissioning decisions and further develop flexible and responsive support options that older people want.

Since In Control's pilot phase in 2003<sup>30</sup> numerous briefing papers and studies have advocated the benefits of 'light touch' monitoring systems that encourage personal accountability for public resources, while adopting a problem-solving approach that seeks to resolve technical and practical issues as soon as they arise.

Guidance from the Chartered Institute of Public Finance and Accountancy (CIPFA) has reinforced this approach and up-to-date guidance can be accessed from their online learning centre.<sup>31</sup> This means finance and accounting departments adopting new roles and styles of working, for example in supporting older people to manage (self direct) the options they have and resolve any problems encountered.

The key test for any monitoring system associated with personalisation is the question: are the goals in the support plan being achieved and what, if anything, needs to change to enable this to happen?

30 A Report on In Control's First Phase. Poll, C., Duffy, S., Hatton, C., Sanderson, H., Routledge, M. 2006.

31 Direct payments and individual budgets: managing the finance. CIPFA (2007); [http://learning.cipfa.org.uk/default.asp?content\\_ref=2978](http://learning.cipfa.org.uk/default.asp?content_ref=2978)

## CHAPTER 4

# Developing a flexible and responsive market for older people

**As earlier chapters of this guide have shown, personalisation means thinking about services, support and care in a completely different way: starting with what's important to older people as well as considering what's important for them. It follows that activities associated with planning and providing support for whole communities also need to change.<sup>32</sup>**

This means commissioners and providers working together with local people to ensure the availability of high quality, responsive and flexible care and support. This chapter focuses on what commissioners and providers can do to increase older people's choice and control.

### Where are we now?

The survey undertaken by the Association of Directors of Adult Social Care (ADASS) and the Local Government Association (LGA) to review progress in the first year of implementing *Putting People First*<sup>33</sup> highlighted the need for further work to support commissioners and providers to develop a 'vibrant market'. The survey indicated that while significant activity is

taking place, engagement and progress is slow in a number of respects:

- Only 4% of councils have a commissioning and market development strategy in place that is fully aligned with *Putting People First*.
- 71% of councils report that such a strategy is in development, but 25% indicated they have no plans in this area.
- Councils reported generally high levels of engagement with the voluntary and community sector and far lower engagement with independent sector providers around the implications of *Putting People First*.

The survey also made clear that market development is a priority area for many councils moving into the second and third years of local transformation programmes.

### Where do we need to be?

*Putting People First* states that the shared ambition across government is for a radical reform of public service which "enables

32 Personalisation briefing for commissioners, At a glance briefing 06. SCIE, June 2009

33 Putting People First: Measuring Progress LGA/ADASS. March 2009

people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, wellbeing and dignity.”

The task for commissioners and providers is to work more effectively with older people to develop a wider range of options in the market, which meet their expectations and respond better to their aspirations for the future. Some key considerations in realising the vision of *Putting People First* for older people include:

- 1) **Focus on older people's outcomes and goals** captured in person centred support plans and reviews and use this information collectively, across many support plans, to inform broader commissioning decisions.
- 2) Work with older people to identify priorities and **co-produce commissioning plans for delivering a wide range of diverse opportunities** across a wide range of needs, experiences and situations.
- 3) Develop and nurture partnerships to **build local capacity for providing diverse and sustainable options for support**.
- 4) **Support local providers to make changes** in order to remain in the market long term.
- 5) **Support and develop a local, flexible workforce** to enable older people to make choices, stay in control and deliver creative support across the spectrum of lifestyles, goals and needs they may have.

## The challenge ahead

Increasing older people's choice and control over their support needs successful and healthy providers as much as it relies on effective commissioning decisions by local councils and primary care trusts. 'Healthy and successful' means organisations that are reliable, flexible and viable in order to provide sustainable solutions at a local level for people and families who rely on services to live their everyday lives.

Some of the key challenges commissioners and providers face are:

- Ensuring that good quality and accessible information, advice, advocacy and guidance is available for older people, whether state or self-funded.
- Shifting the culture away from gate keeping and paternalism to choice, opportunity and support that is tailored to older people;
- Reconfiguring contractual arrangements so that these are not barriers to choice and control.
- Developing local knowledge and a community presence even as a national or multi-national provider.
- Recruiting and retaining skilled, values-based staff who are committed to age equality and inclusion.
- Being clear about changing roles, skills and competencies for the workforce at all levels.
- Making the shift from commissioning for outputs and specific times and tasks to

person-centred commissioning for outcomes.

- Communicating the benefits to diverse audiences with different and often vested interests.
- Learning what works and collecting examples of different 'images of possibility' for older people with high support needs
- Doing all of this in meaningful partnership with older people themselves, their carers, families and supporters.

The recent DH report on the use of resources in adult social care serves to illustrate perhaps the greatest aspect of this challenge, with spend on council funded care home placements shown to account for as much as 70% of the total budget for older people's care and support in some local council areas. While a significant amount of money remains tied up in services that the majority of older people do not want and would not choose if alternative options were available there can be only limited scope for genuine choice and control, and this needs to change.<sup>34</sup>

## Ways forward

This section includes a number of short, practical examples of approaches that can be taken to start overcoming these challenges, to move in the right direction.

### Offering direct payments with the right kinds of support for older people

### Direct payments for older people in West Sussex

Edna and Jack had been married for 60 years, brought up their five children and lived in the same council house for 50 years. They were active church goers and as a retired school teacher, Jack was well known in the local area.

As Edna's health deteriorated, Jack's caring role began to take its toll; his own health needs meant he needed care too. Edna and Jack received a joint care package mainly consisting of pop in calls throughout the day. Family and friends continued to support them to manage domestic tasks. It was important to them both that they should remain living in their own home and be a part of their local community

These arrangements worked adequately but their quality of life deteriorated as carers had little time to enable Edna and Jack to remain independent or make personal choices about their lifestyles and day-to-day activities. Their worlds shrank, they became dependent on their carers, and their diet deteriorated as it consisted of ready meals that neither of them really enjoyed. Attending church and taking part in social activities became more problematic, particularly for Edna. They regularly used the call button on their alarm system both day and night, which impacted upon their family and the emergency services. Edna was highly anxious and both were at high risk of falling.

34 Older people's vision for long term care. Bowers et al, Joseph Rowntree Foundation, 2009. [www.jrf.org.uk/publications/older-people-vision-long-term-care](http://www.jrf.org.uk/publications/older-people-vision-long-term-care)

As they reached their 90s, their health and wellbeing deteriorated further. Jack had a fall and broke his hip while trying to help Edna in the bathroom. This meant he could no longer support Edna.

Edna and Jack were offered the chance to direct their own support with a personal budget which they took in the form of a direct payment. Their individual and shared outcomes were identified and a combined funding rate was agreed. They initially purchased care from an agency that provided a 24-hour live in carer. They also employed one of their daughters – who lived abroad – to act as a personal assistant when she was in the country. This arrangement proved extremely beneficial to Edna, Jack and the local council, as providing care through this route was both cost effective and met their personal needs.

Their quality of life greatly improved, the risks associated with their health conditions were reduced by 24hr care, and Jack no longer felt the burden of caring for Edna. More importantly, Edna and Jack were able to remain living in their own home and community. Edna was again able to participate in community life and for 18 months she attended church regularly – something she had not been able to do for several years. From the perspective of the family, direct payments enabled them to relax and feel that Jack and Edna were safe and well looked after.

Unfortunately, Edna's health further deteriorated and her physical needs increased. Through the flexibility of local self-directed

support, the added cost of this care was incorporated into their direct payment by adjusting their package. Edna's daughter was able to act as a personal assistant during Edna's last few weeks of life and she died peacefully in her own home. The family all feel that this was a positive experience. Edna was able to spend the final years of her life in her home with her husband, surrounded by people who loved her, and receiving care and support from people she knew well and who were able to meet her individual needs.

Jack continues to receive a personal budget. The support plan has been adapted by his family to reflect the change in the level of funding and he now has a self-employed, 24-hour, live in carer – this suits him and is more cost effective than using an agency or more traditional options such as residential care.

### Redesign day opportunities

The current model of focusing day-time support in day centres and traditional home care services needs to shift to a much wider range of options and opportunities.

**Leicestershire County Council** wanted to move from their current provision of day time support for older people based around day centres, to much broader community based support for older people assessed as eligible for social care services. Their aim was to engage with older people using their services, carers and the wider community to deliver their personal goals and desired outcomes. They realised that this would



mean working in very different ways, including developing much stronger partnerships with local communities and older people currently using day services. They also acknowledged that this would challenge service providers to change their current offer, to deliver a much wider range of different kinds of support.

**They identified two key steps for taking this work forward:**

- 1) Working with current day service users to identify their goals, needs and dreams – and supporting them to become more actively involved in their own assessments and in planning their support.
- 2) Using direct payments as the means to make the shift from older people attending day centres to having a much broader range of options and opportunities for support.

Discussions also took place with elected members, lead officers and staff teams – resulting in an agreement that future day service developments must be taken forward within a wider social inclusion agenda, in order to:

- Promote independence to enable older people to remain at home after a trauma or other event in their lives
- Provide support for carers with whom an older person lives to enable them to maintain relationships and continue in their caring role
- Provide social stimulation, reduce isolation and improve general health and wellbeing.

It was recognised that direct payments could offer older people greater control and choice over the

services they receive and the way these are organised and help to stimulate the market for day time support, achieving a greater diversity of local provision. The Local Area Agreement therefore also includes a target to increase the use of direct payments for older people for recreational, leisure and educational purposes.

**The following examples illustrate what has been achieved as a result:**

**Mr and Mrs J live in a small village and were feeling isolated as a result of increasing support needs.** Their children were all busy at work and they felt cut off from culturally appropriate services centred in towns and cities some distance away. Direct payments enabled the couple to organise travel to enable them to attend their nearest temple and, with the help of an agency support worker, they combined these trips with shopping and other cultural activities of their choice.

**Mrs P lives alone and her closest relative, her son, lives some distance away in West Sussex.** She has very few friends who live nearby. She is 90 years old, has mobility difficulties following a stroke and is hard of hearing. She used her direct payment to organise the loan of a wheelchair so she can get to the shops herself – especially on market days when she loves to browse around, choose her own fruit and vegetables and be outside in the fresh air. She also pays for a support worker, through an agency, to take her out. She did not want the responsibilities of being an employer herself, so pays the agency instead on a monthly invoice.



## Build strong, local partnerships

Strong, local leadership is essential for shifting established attitudes and patterns of delivery and there are some signs of progress in some places where councils, local strategic partnerships and older people's organisations are working together to make this happen. The 29 POPP pilots, the eight LinkAge Plus pilots and the individual budget pilot sites that focused their work on older people's needs and preferences all have practical examples and inspiring stories to share about a changing pattern of provision and strategic direction.

**In Dorset, the County Council and six district councils have worked together** and with their NHS partners, voluntary and community sector organisations, older people's groups and forums across the county, to develop a Locality Planning Tool to identify older people's priorities that can be translated into both locally specific actions and shared strategic decisions.

This tool is a large graphic poster designed to capture 'what's working/not working' in relation to living well in Dorset in later life. It is coordinated at a parish level by 33 community leaders – older people appointed through the Dorset POPP initiative to increase older people's voice and influence within local communities and countywide. The information gathered through this process is captured on the poster in meetings and

discussions with local organisations, different service teams, community members and local groups – and fed upwards to District Council Partnerships and county planning leads to inform wider plans and investment decisions.

At a countywide level, the issues and priorities identified are analysed using a framework of eight outcome areas previously identified as a result of the local POPP initiative, now embedded within the Local Area Agreement and Ageing Well Strategy for Dorset.

## Focus on older people's outcomes and goals

Focusing on outcomes identified by older people requires an understanding of what helps people to continue with their lifestyles, commitments and relationships if they need support. It is also about ensuring that support arrangements are extremely flexible, so that changing needs and circumstances don't become insurmountable barriers to achieving personal goals and priorities.

**Oldham Borough Council** funds an advocacy service and development forum, 4 Age, led by older people offering peer support to older people using personal budgets to make decisions about what types of support will help them achieve their goals and meet their needs. Information gathered is also used to inform wider commissioning decisions by the council and its partners.

### Co-produce commissioning plans

Genuinely co-producing commissioning strategies and plans with older people, their families and those who support them can help deliver better outcomes for older people and organisations. This requires a range of different mechanisms for engaging older people at all stages of commissioning and service development. One successful approach is Working Together for Change:

**Working Together for Change** is a simple, six-stage process for using person-centred information from individuals support plans and reviews through workshops with people using services, commissioners and providers to inform strategic planning and commissioning. It uses information about what is working and not working in older people's lives as well as what is important to them for the future to improve commissioning and can also be applied by providers as an effective tool for person-centred business planning and service development. Further information is available at: [www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/Commissionersandproviders/?parent=2735&child=5802](http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/Commissionersandproviders/?parent=2735&child=5802)

### Develop small scale provision to respond to individual needs

**A two year Department of Health funded project** aimed at stimulating micro markets in Oldham and Kent, by reducing or removing barriers to both the survival of existing providers and to enable new services to develop, has been

carried out by Naaps (visit [www.naaps.co.uk](http://www.naaps.co.uk) for further information about Shared Lives and other small community services).

A practical handbook for local councils to help them understand and stimulate their local markets is available to download at [www.dhcarenetworks.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/SSMSCSEkeymessages.pdf](http://www.dhcarenetworks.org.uk/_library/Resources/Personalisation/Personalisation_advice/SSMSCSEkeymessages.pdf)

### Help providers to adapt and respond

Many providers are indicating that they need additional support to help them think about changing what they do and how they do it, or to enter the market in the first place. The degree of support needed varies considerably according to size, experience and capacity to change. Provider forums can be a useful way of supporting the market to come together, share experiences and learn from one another about what is working. Such networks also provide mutual support, rather than direct competition, in managing the transition for those who have long established relationships with local commissioners.

**Devon Provider Engagement Network** enables provider organisations across sectors and agencies to come together on a regular basis to liaise with other providers, hear about future developments and explore business planning opportunities. They include 'hot topics' sessions enabling providers to raise issues that are important to them, which are explored at future meetings. Further information is available at: [www.devon.gov.uk/providerengagement](http://www.devon.gov.uk/providerengagement)

### Stimulate user-led and peer support

User and peer-led organisations and the unique support they can offer are a crucial part of a diverse market. Many areas are finding that developing a consortium approach to resolving common issues such as employment and payroll management is a helpful way forward for (typically) small user and peer-led providers (formal or informal) to pool their limited resources and build local capacity.

**Bath People First** is a user led organisation originally established as part of the national federation of organisations providing support by and for people with a learning disability. They have established and now host a much broader network of user- and peer-led organisations, including those with a focus on older people, called Organisations Supporting Independence. Download [www.bathpeoplefirst.org.uk/org-sup-ind.pdf](http://www.bathpeoplefirst.org.uk/org-sup-ind.pdf) for further information about this network and how it operates.

## APPENDIX 1

# Understanding the key policy drivers

Some important components that local partnerships will want to pay particular attention to when making strategic investment and commissioning decisions concerned with reshaping local systems of support are set out below.

### **Achieving Age Equality in Health and Social Care, October 2009**

The report of the national review of age discrimination and age equality in the health and social care sector set up to help health and social care organisations meet the ban on age discrimination and the new public sector equality duty in the Equality Bill. The review analysed evidence about the nature, extent and variability of age discrimination in health and social care services and found that older people's mental health services and access to and equity of funding for social care, and cancer survival rates are the crucial areas where more needs to be done to achieve age equality. It also considered what reforms are already in train to tackle age discrimination and support greater age equality, highlighting personalisation as a fundamental route for ending age discrimination in health and social care.

### **Shaping the Future of Care Together Green Paper, July 2009**

The Green Paper sets out the Government's vision for a new care and support system based on a National Care Service that is fair, simple and affordable. It outlines six elements that people should be able to expect from the new service: prevention services, national assessment, a joined-up service, information and advice, personalised care and support and fair funding. Three key changes are required to help meet these six objectives: more joined-up working, a wider range of services in care and support and better quality and innovation.

### **Building a Society for All Ages, July 2009**

This builds on the cross-government Opportunity Age strategy to meet the challenges and realise the opportunities of an ageing population. The Government's vision is "a society for all ages, where people are no longer defined by age and everyone is able to play a full part." This will require major cultural change. This refreshed strategy includes details on how to help individuals plan better for later life, support families

across generations, encourage businesses to adapt to a changing workforce and markets, ensure public services encompass all age groups, and make communities accessible to people of all ages.

### **Living Well with Dementia: a National Dementia Strategy, February 2009**

The National Dementia Strategy (NDS) sets out initiatives designed to improve the lives of people with dementia, their carers and families. It aims to increase awareness of dementia, ensure early diagnosis and intervention and radically improve the quality of care that people living with dementia receive. The NDS Joint Commissioning Framework (June 2009) provides best practice guidance for commissioning dementia services. The Framework includes a Joint Strategic Needs Assessment template, a summary of NICE and SCIE evidence for dementia services and commissioning levers against each of the NDS Objectives.

### **Empowering Engagement: a stronger voice for older people. The government response to the Elbourne Review, February 2009**

The Government has broadly supported the recommendations made by John Elbourne in his report examining older people's engagement with Government at all levels, published in November 2008.

It proposes to set up national leadership for older people in a UK Advisory Forum on Ageing to provide advice and support on the implementation and development of the Government's strategy for older people and an ageing society. It is also creating a new structure, with a designated lead regional coordinator for older people's engagement in each English region, to help set up Regional Forums on Ageing where they do not already exist and to continue to support Older People's Advisory Groups (OPAGs) and other forums through government offices.

### **The State of Social Care in England 2007-08, CSCI report, January 2009**

The Commission for Social Care Inspection (CSCI) issued its fourth and final report on the state of social care in England, finding that a year on from the publication of *Putting People First* most people still experience a 'one size fits all' model of care that is not geared towards people's individual needs. Developments in social care are described as patchy and vary between different groups. Concerns remain about people who are 'lost to the system' because they are ineligible for publicly-funded support or are 'self funders'. There continues to be tension between resourcing support for those with the highest levels of need and investing in a range of services which can maintain people's independence and improve their quality of life.

### **Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society, Department for Communities and Local Government, February 2008**

Cross-government housing strategy published February 2008, setting out a plan to provide 'lifetime' homes for older people and increase their housing options beyond care homes and sheltered housing. Includes information about a new national housing and advice information service linked with local housing information services; introduce new rapid repairs and adaptation services; and increase funding for the Disabled Facilities Grant (First Stop Care and Advice). All publicly funded homes will have to be built to Lifetime Homes Standards (LTHS) by 2011, with the expectation that all new homes will be built to LTHS by 2013; there will be improved joined-up assessment, service provision and commissioning across housing, health and care; and the government will work towards a new positive vision for specialised housing.

### **National Carers Strategy: Carers at the heart of 21st century families and communities, Department of Health, June 2008**

The carers' strategy sets out the Government's short-term agenda and long-term vision for the future care and support of carers. It is

underpinned by £255 million to implement some immediate steps alongside with medium and long-term plans. New commitments include: £150 million towards planned short breaks for carers; £38 million towards supporting carers to enter or re-enter the job market and £6 million towards improving support for young carers. A more integrated and personalised support service for carers will be offered through easily accessible information, targeted training for key professionals to support carers, and pilots to examine how the NHS can better support carers.

### **Independent Living Strategy, March 2008**

This cross-government Independent Living Strategy (ILS) was developed in partnership with disabled people and takes a life course approach, from young people in transition to adulthood through to very old age. The aims of the strategy are that:

- disabled people (including older disabled people) who need support to go about their daily lives will have greater choice and control over how support is provided
- disabled people (including older disabled people) will have greater access to housing, education, employment, leisure and transport opportunities and to participation in family and community life.

The strategy contributes towards the Government's work to ratify the United Nations Convention on Disability Rights.



## **Putting People First, December 2007**

This ministerial concordat establishes the collaboration between central and local government, the sector's professional leadership, providers and the regulator to transform adult social care and associated services.

It is a commitment from the government and representatives from the health and social care sector to make sure that all public, private and third sector bodies are working towards a society which values the contribution that all citizens can make. It describes a society where people who need care and support can exercise choice and control to live independent lives wherever possible.

It sets out the shared aims and values which will guide this transformation, and recognises that the sector will work across agendas with users and carers to transform people's experience of local support and services.

## **Opportunity age: Meeting the challenges of ageing in the 21st century, March 2005**

Opportunity Age is the Government's strategy for an ageing society. The strategy aims to end the perception of older people as dependent; ensure that longer life is healthy and fulfilling; and that older people are full participants in society.

The strategy is now coordinated and led by the DWP Minister of State for Pensions and the Ageing Society, in her role as Champion for Older People. The strategy focuses on three key areas:

- work and income – to achieve higher employment rates overall and greater flexibility for over 50s in continuing careers, managing any health conditions and combining work with family (and other) commitments
- active ageing – to enable older people to play a full and active role in society
- services – that allow us all to keep independence and control over our lives as we grow older, even if we are constrained by the health problems which can occur in old age.

## APPENDIX 2

# Core person centred thinking and planning skills and tools

### 1) Appreciations

Focus on what people who know the person like and admire about them:

- This is crucial for developing and building a relationship.
- It includes the input of families, friends, neighbours and staff.
- It generates vital information to include in one page profiles.

### 2) Relationships

A simple map or circle is a good way of identifying and capturing who is important to that person, and how they are important:

- This includes partners, friends, family members, staff and volunteers.
- It can also identify possible new relationships and those that could be re-discovered.

### 3) Important to and for people

Identifying and focusing on what is important to someone (from their own perspective) is central to person centred support and planning:

- What is important for someone (from others' perspectives) is also important but can often dominate discussions about support.
- Getting a balance between the two is vital and helps to identify how best to support someone.
- This is vital information to include in support plans and one page profiles.

### 4) Communication

Being able to communicate and be understood is central to choice and control:

- It is easy to assume that those who find it difficult to talk have little to say.
- Communication charts provide a practical format for understanding what is going on and what someone means when they do or say certain things, and how best to respond.

## 5) Histories (personal histories and stories)

There are many ways to capture people's stories – e.g. display boards and graphic histories:

- This helps communication and relationship building.
- Getting to know someone and the story of their life is a powerful tool to use at the beginning of assessments and support planning.

## 6) Wishing

Wishing and dreaming can help in identifying personal goals and supporting people to reach them:

- The process can be enriching, confidence-building and boost low mood.
- Conversations about wishes and dreams can highlight shared interests and complementary skills in groups.

## 7) Good days and bad days

Knowing what someone's good and bad days look like can help us learn important things in their life, including how to support them and who is best to do this:

- It helps people to aim for more good than bad days.

## 8) Working/not working

Asking what's working and not working can help people to stand back and look at a situation, and try to change what can be changed:

- This aids resolution of problems and concerns.
- It can also highlight what is working/not working for family members and staff as well as the individual.

## APPENDIX 3

# What success looks like when personal budgets are working well for older people

Key success factors	Making it happen	Outcomes
<p><b>1) Work with older people to make the change to self-directed support – focusing on their goals and priorities:</b></p> <ul style="list-style-type: none"> <li>• Make connections, building on current and past initiatives that work well for older people.</li> <li>• Personal budgets are a means to an end: the goal is greater choice and control over someone's support to enable them to have a good life.</li> <li>• Don't make assumptions about what older people will or will not want</li> <li>• Be open minded: remember older people have a lot of experience of managing money and making it work well for them.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify what works now for older people – in local communities, family networks, with friends and peers as well as formal services and support.</li> <li>• Work with partners to map and understand local communities' experiences, histories, expectations and preferences.</li> <li>• Engage older people in designing local systems of support and delivering information, advice and support.</li> <li>• Strengthen links with concurrent developments in health, housing, transport, leisure, education and community development to build social capital and preventative approaches.</li> <li>• Tackle ageist attitudes and mindsets: share positive images and stories of older people that challenge stereotypes.</li> <li>• Adopt person centred thinking approaches.</li> <li>• Make information available in a variety of formats about how older people's lives are changing through using personal budgets.</li> <li>• Work together to ensure that the market is providing the types of products and services that older people look for.</li> </ul>	<ul style="list-style-type: none"> <li>• Older people are choosing from a wide range of options and opportunities to achieve their personal goals as well as knowing that their support needs are met.</li> <li>• Older people are connected and participating in all aspects of their life, with their family, friends and local communities and civic life.</li> <li>• Older people report increased confidence and satisfaction with their support.</li> <li>• Older people are moving towards options which give more choice and control (eg. from virtual budgets to direct payments).</li> <li>• Local developments that strengthen communities and build social capital are being used to spread lessons and examples about self-directed support and using personal budgets to meet individual needs and goals.</li> </ul>

Key success factors	Making it happen	Outcomes
<p><b>2) Have a flexible range of options available for older people to have and manage their money:</b></p> <ul style="list-style-type: none"> <li>• Adopt flexible and creative approaches.</li> <li>• Offer a range of practical mechanisms that can be mixed and matched to suit individual needs and circumstances.</li> <li>• Increase the capacity of user- and peer-led organisations and groups to work with older people to direct their own support.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and promote a range of mechanisms available for older people to have and manage their money.</li> <li>• Build in flexibility so older people can mix and match options – and change between them as needs change.</li> <li>• Make the systems for choosing from these options and then managing money straight forward and simple to use.</li> <li>• Get feedback from older people and their families about what works and doesn't work for them.</li> <li>• Be open to new ideas and approaches.</li> <li>• Make it easy for older people to use very small amounts of money as a direct payment.</li> </ul>	<ul style="list-style-type: none"> <li>• Older people are using different options available to have and manage their money.</li> <li>• Older people indicate that the route they have chosen is helping them to achieve their support plan (ie are effective in meeting their goals and needs).</li> <li>• Older people are accessing user and peer led organisations to make decisions, plan their support and review what's working.</li> </ul>
<p><b>3) Make it easy for older people to understand the options and decide which one will suit them:</b></p> <ul style="list-style-type: none"> <li>• The key is ensuring that older people and those who support them (family members, carers and paid staff) are aware of and understand these options.</li> <li>• Use stories to share what's involved and what helps to make this work.</li> </ul>	<ul style="list-style-type: none"> <li>• Use clear language and positive images of diverse older people to promote the options, and how you decide which route is right.</li> <li>• Use examples - stories and quotes from older people using different options to meet their needs and achieve their goals.</li> <li>• Use different formats and channels of communication to reach all groups (e.g. written, DVD, YouTube, poetry, drama, postcards and posters).</li> <li>• Make advocacy and brokerage support accessible and widely available.</li> </ul>	<ul style="list-style-type: none"> <li>• Older people know about the range of ways that they can have and manage their money.</li> <li>• Older people are involved in designing, delivering and reviewing information, advice and support about personal budgets and how to use them.</li> <li>• Older people are trained in support planning and brokerage functions/tasks.</li> </ul>
<p><b>4) Providing high quality ongoing support:</b></p> <ul style="list-style-type: none"> <li>• Provide high quality ongoing support with a range of options</li> </ul>	<ul style="list-style-type: none"> <li>• Invest in training and support to adopt person centred planning /approaches, including for older people and their families, staff from all agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Person centred support planning arrangements are in place for older people.</li> <li>• Older people with personal and</li> </ul>



Key success factors	Making it happen	Outcomes
<p>for providing this assistance e.g. brokerage and advocacy services, user/peer-led organisations.</p> <ul style="list-style-type: none"> <li>• Adopt person centred support planning with older people.</li> <li>• Consider all the ways that older people reach or come into contact with services.</li> </ul>	<p>and sectors, managers and senior leads.</p> <ul style="list-style-type: none"> <li>• Ensure a shared understanding of brokerage is adopted, and develop brokerage systems and support that work for older people.</li> <li>• Encourage and enable user-led and peer support organisations to work with older people to make decisions and manage their money/plans across the spectrum of needs experienced.</li> </ul>	<p>virtual budgets have a 'live' support plan that sets out their goals and needs and arrangements for how their budget will be used to achieve them.</p> <ul style="list-style-type: none"> <li>• Older people using a personal budget have led the process of developing their own support plan with as much or little assistance as they wanted.</li> <li>• Individual support plans include contingency arrangements including cover for sickness/holiday, help with employment, what to do in a crisis.</li> <li>• Assistance in support planning is available from a range of sources: brokerage, user and peer led support.</li> </ul>
<p><b>5) Review, learn and implement change where needed for individuals, communities and wider system of support:</b></p> <ul style="list-style-type: none"> <li>• Person centred monitoring arrangements that help older people keep track of what's been spent and how this helps.</li> <li>• Person centred reviews to find out what's working and not working in someone's life and support.</li> <li>• Aggregating information from the above to inform wider commissioning decisions, and further develop self-directed support.</li> </ul>	<ul style="list-style-type: none"> <li>• Design and implement light touch monitoring systems that can be easily used by older people and their families.</li> <li>• Support finance and legal departments to provide customer focused support adopting a problem-solving approach.</li> <li>• Ensure organisational systems and infrastructure is based on the same person centred values and approaches that enable virtual and personal budgets to work well for older people.</li> <li>• Collect data on which resource options older people are choosing, why, and how these arrangements have been used to meet needs and goals.</li> <li>• Monitor the take-up of different options and access to different support options by diverse communities of older people.</li> </ul>	<ul style="list-style-type: none"> <li>• Older people do not feel overwhelmed or burdened by the process of managing their personal budget.</li> <li>• Older people identify what's working and not working for them on a regular basis through person centred reviews.</li> <li>• Person centred reviews are used in aggregate to inform ongoing developments and local commissioning plans for older people.</li> <li>• The local system of health and social care uses information collected about older people's decisions and patterns of resource use to continuously develop the market and increase the diversity of choice and opportunity.</li> </ul>

A simple action planning tool to help councils and their partners gauge progress in areas that are critical to making personalisation work well for older people.

Ensuring safeguarding and personalisation work hand in hand			
Developing a flexible and diverse market			
Providing different ways for older people to have and manage their money			
Person centred support planning with older people			
Understanding co-production and how to make it happen			
Taking a whole system approach to personalising services (information & advice, early intervention, enablement etc)			
	What are we doing to make this aspect of personalisation work well with and for older people?	How well do we think this is working (in increasing older people's voice, choice and control)?	What needs to change now to address any problems or gaps for older people locally?
1)			1)
2)			2)
3)			3)

## APPENDIX 4

# Ensuring personalisation and safeguarding work hand-in-hand

**Managing the balance between choice and risk includes locating safeguarding in the broader context of implementing the policy goals of personalisation. Participants involved in developing this guide agreed that personalisation can contribute to better risk management as a result of inclusive, person centred practice and a fundamental shift in power from professionals and, sometimes, family members to the person and the people they choose to support them.**

In a sample of 100 older people with a personal budget in Barnsley, 47% reported feeling safer at home as a result of changes made to the way their care and support was arranged, and 40% that they felt they had much greater choice and control over the things that mattered to them<sup>35</sup>.

These views concur with those in a recent discussion paper from In Control which outlines six different ways that, done properly, personalisation can make people safer:

**1)** Personalisation is focused on strengthening citizenship and using the most appropriate

measures, balancing freedom and control, to help people be safe.

- 2)** Personalisation improves the current care management system by the use of self-directed support within which a comprehensive risk management system sits.
- 3)** Personalisation enables people to move away from ineffective and institutional systems of control, which create a dangerous illusion of safety but have proved inherently risky.
- 4)** Personalisation offers an ideal model for responding to complex cases of vulnerability and abuse where careful risk management and person centred practice are essential.
- 5)** Personalisation creates the correct framework for preventing abuse by strengthening citizenship and communities.
- 6)** Finally, and most importantly, personalisation works – and it makes life safer for people by getting them in control of their life and away from harmful environments.<sup>36</sup>

<sup>35</sup> Unpublished evaluation report of the self directed support system used by older people in Barnsley, 2009

<sup>36</sup> Personalisation and Safeguarding: a discussion paper. Duffy, S and Gillespie, J, 2009

Having choices and taking risks has been specifically identified by older people as one of the key dimensions for living well in later life – irrespective of people's individual circumstances and level of support required.<sup>37</sup>

**Figure 1: Seven dimensions to living well in later life**

- 1) Being active, staying healthy and contributing.
- 2) The importance of family and relationships.
- 3) Friends and community – being valued and belonging.
- 4) Valuing diversity.
- 5) Continuing to learn.
- 6) Having choices, taking risks.
- 7) Approachable local services.

Recent research with older people living in care homes also identified the desire for older people with very high support needs to be in control of their support, taking decisions with assistance when required, and having the right to do things that they have always done throughout their life.<sup>38</sup>

The following practical considerations identified by round table participants should

help to ensure that these aspirations and local safeguarding and personalisation arrangements work hand-in-hand, rather than being seen as polar opposites.

**Shifting cultural attitudes around older people, capacity, choice and control**

Staff, older people who need support and families to work together to ensure:

- Assumptions are not made about people's capacity and capability to make decisions.
- Creative ways of enabling people to communicate their wishes are developed and used, so that their own views and aspirations about their choices over support are heard and that decisions made fit with their individual lifestyle and personal preferences.

In situations where someone lacks capacity or has fluctuating capacity, it is important that all practicable steps to help him or her to make decisions and express preferences are taken. Using person centred approaches to support planning can help elicit potential risks and vulnerability to abuse and determine ways to prevent or manage these. It is also important that no one should be deemed to lack capacity merely because their decisions appear unwise.

Further specific guidance and practical ideas for working with people who lack capacity or

37 Living Well in Later Life: an agenda for national and local action to improve the lives of older people in Britain in the 21st Century. Bowers et al, 2002. Older People Shaping Policy and Practice. (2003). Joseph Rowntree Foundation.

38 Older people's vision for long term care. Bowers et al. JRF (awaiting publication, November 2009).

who need support to make their views known, is available at [www.scie.org.uk/adults/mentalcapacitypub.asp](http://www.scie.org.uk/adults/mentalcapacitypub.asp)

This shift away from 'doing for' to 'working with' older people requires:

- Clear vision and leadership that helps staff and communities maintain their focus on the principles and goals of personalisation.
- Effective communication about what is expected from staff in enabling older people to live their lives.
- Awareness raising, training and support for staff, including learning from others and protected time for supervision and reflection.
- Sharing stories and experiences of older people and their families working together with staff and others to manage risk.
- A positive risk-taking policy, supplemented by reviewing what works and what doesn't work for older people, families and staff.

**Gateshead Council's Positive Risk Taking Policy** sets out the local council's approach towards and expectations of all community based staff to adopt an enabling attitude to risk issues when supporting older and disabled people. It is part of local multi-agency arrangements for safeguarding adults, with a focus on person centred planning and associated approaches for maximising individual choice and control.

*From Gateshead Council's Community Based Services Positive Risk Taking Policy, 2007*

## Managing financial risk

One of the concerns in relation to finance includes the risk that public money is spent inappropriately. These concerns are not all new, but it can often be easier to spot the risks involved in making a change than the risks bound up in the current way of doing things. There is a growing view that putting individuals in control of their resources can result in more effective use of public money:

*"[Personalisation] offers a new way to target public spending more efficiently and engage the enthusiasm and passion of the public as resources in achieving public benefit... Giving service users more direct control over what they receive will mean that people only get what they need and what they want — not whatever is available — and with a vibrant and competitive market, the costs of the service should also fall."*<sup>39</sup>

Apart from the risk that money is spent inappropriately, there are also risks of opportunistic and predatory abuse. Both these happen with and without personal budgets, so awareness of these risks is not specific to direct payments or personal budgets. Both local council and voluntary sector staff need safeguarding and awareness training; as do older people receiving or directing their services and support. Older people must be at the front line of protecting themselves – through awareness that financial abuse happens and through easy access to help if they have concerns. Where an individual

39 Getting more for less. Efficiency in the public sector. (2009) Jamie Bartlett. Demos



reports concerns, or where a review identifies concerns, the aim must be to work with the older person to address it – and not to ‘take over’. The empowerment of the older person should be at the forefront of all action.

*“There is a delicate balance between empowerment and safeguarding, choice and risk. It is important for practitioners to consider when the need for protection would override the decision to promote choice and empowerment. People are not necessarily vulnerable per se – it is barriers to putting in place proper procedures that cause vulnerability. Care planning therefore needs to ensure that an individual’s safety is not put at risk through delays in providing services, and that a clear distinction is drawn between putting a person at risk and enabling them to manage risks appropriately.”<sup>40</sup>*

The following practical methods for supporting older people in working through decision-making in respect of these concerns can be thought of as the key features of an effective system of personalised care and support for older people:

- **Incorporating a ‘supported decision-making tool’ into assessment**<sup>41</sup>

This is designed to guide and record discussions when a person’s choices involve an element of risk. It is particularly helpful for

people with complex needs e.g. dementia, or for someone who wants to undertake activities that appear particularly risky and can be amended to suit the different circumstances and likely issues and needs that may arise. A detailed and practical guide to supported decision-making has been published by Paradigm in partnership with In Control partners working to increase older and disabled people’s voice, choice and control.<sup>42</sup>

- **Establishing a risk enablement panel**

Risk Enablement Panels have been established by a number of local councils to enable shared decision-making if there are concerns about risk. They can help to:

- provide support, guidance and direction to staff, including conflict resolution
- provide consistency
- improve the management of risk decision-making with a focus on risks to maintaining independence
- share the responsibility for the management of complex risk cases
- develop local learning and dissemination of best practice in this area.

Oldham’s policy for referring complex cases to their Risk Enablement Panel states that: risk is part of everyday life, it is inherent in everything we do and often it is the element that allows us to grow and learn.

40 Independence, choice and risk: a guide to best practice in supported decision making – DH 2007

41 Independence, choice and risk, DH 2007

42 [www.paradigm-uk.org/articles/Supported\\_Decision\\_Making\\_Book/2449/43.aspx](http://www.paradigm-uk.org/articles/Supported_Decision_Making_Book/2449/43.aspx)

**Oldham's risk enablement panel** was set up to manage complex cases where risks were perceived as a barrier to enabling the person to achieve their outcomes. This arrangement ensures that the proposed use of a personal budget – set out in the person's support plan – will meet their needs and goals.

The panel's membership includes senior social care and health staff with budgetary responsibility who are able to make timely decisions about accessing resources in order to support people well, and give advice on managing complex issues that arise.

The strength of this approach is that it is multi-disciplinary and holistic, which ensures that all possible options are explored and plans put in place with the appropriate resources – along with the person's personal budget – to reduce or manage risks. Anyone can attend the panel, and people using services are supported to meet two panel members if there are areas of disagreement to discuss further.

- **Using a support matrix for direct payments to help determine level of support required**

This allows practitioners and individuals to agree an appropriate level of independent living support based on the person's capacity to manage their direct payment and the level of support they already have in place:  
[www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/DirectPayments/RiskManagement/AssessingRisk/?parent=6444&child=6534](http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/DirectPayments/RiskManagement/AssessingRisk/?parent=6444&child=6534)

- **Using local council commissioned services in a personal budget when there is high risk**

Adopting a mix and match approach to how older people can have and manage their money can help to meet individuals' specific needs and ensure they and others are safe, healthy and well. Person centred support planning, using the tools outlined in *Chapter 2*, can determine whether this approach would help, and ensure the person and their carer/family are at the centre of these decisions.

## Employment risks

A number of concerns associated with employing personal assistants and others through an individual's personal budget were highlighted in the IBSEN evaluation report and in recent online and journal debates on personalisation.<sup>43</sup> These concerns fall into two main areas:

- Risks associated with individuals employing someone who abuses them – financially, emotionally, sexually or physically.
- Concerns and uncertainties about the accountability and regulation of an increasing range of providers and use of non-traditional services that fall outside current regulatory arrangements.

There is evidence that indicates that the risk of harm is actually reduced when individuals take responsibility for directly employing their own staff compared to those using traditional services.

43 Empower and protect. Louise Hunt. *Community Care*, issue 1732, 24 July 2008, pp 28-29; In Control? Making Sure We're not Out of Control! Some issues for people considering a direct payment or individual budget. Anonymous family carer. *Journal of Adult Protection*, vol 10, no 3, August 2008, pp 14-22.

A large scale study by Skills for Care of direct payments employers and their personal assistants (PAs) found that 79% of employers were very satisfied with the care and support they receive from PAs, compared to 26% being very satisfied with local council support. The study also showed that the shift from local council paid staff to the use of staff directly employed by the individual resulted in a significant reduction in risk across a range of measures.<sup>44</sup>

### **Supporting people with their employment responsibilities**

In Derby, Disability Direct (a user-led organisation) offers a fully managed service whereby payments are made direct to people who need support from a local council and they take care of the paperwork, pay staff directly by bank transfer, provide audit information to the local council etc. It aims “to take the worry off your hands and give you peace of mind that your obligation as an employer is being met”.

However there are steps that can be taken to support people to further minimise risk and increase feelings of safety and wellbeing. Criminal Records Bureau (CRB) checks are not of themselves going to guarantee safety, but can be a helpful part of the process of identifying a suitable person to employ and increase peace of mind. Many councils offer

access to CRB checks free of charge. Referring people to organisations that assist with employment responsibilities can remove or reduce unwanted administrative responsibilities, while still enabling the person to retain choice and control over their support arrangements.

### **Taking a strategic approach to risk – creating stronger communities**

Personalisation in general, and safeguarding and risk management in particular, are not just the responsibility of adult social care – these are issues that affect all of us and require community-wide responsibility. Creating stronger citizens and stronger communities will encourage individuals to speak up and be more alert to abuse and less likely to become victims.

Developing a multi-agency response to safeguarding and risk between councils and partner organisations helps articulate this shift in power and shared responsibility. This includes mechanisms for sharing information, establishing simple and person centred systems for identifying and managing risks and making decisions relating to risk, including specific areas of support people need to do this. Having a positive risk policy and supporting operational procedures helps staff working in a variety of settings and organisations to manage risk

44 Employment aspects and workforce implications of direct payment. IFF research. Skills for Care, 2008.

and supports them in making difficult decisions in partnership with older people.

**The Isle of Wight's Transforming Social Care Board** is a partnership of agencies to develop sustainable communities and person centred services and support for older and disabled people. They have developed a multi-layered and multi-agency approach to safeguarding, alongside an ambitious programme of reform, to embed person centred approaches in all public services. This covers strategic, operational and individual responses, underpinned by four key goals and work programmes:

- a positive risk-taking policy covering all agencies
- a joined up, non risk averse culture
- supporting the social care workforce to change and adapt
- specific arrangements for care governance and safeguarding.

Local initiatives that strengthen communities and encourage neighbourhoods to develop mutual support networks<sup>45</sup> can ensure that older people, irrespective of their circumstances, are able to tap into a range of locally based natural networks, which in turn can widen their circles of support. This helps to increase the number of people involved in supporting people generally, and engender a

feeling of being connected to others. It can also promote the development of small, flexible and locally based support options that respond to what older people want and need.

Increasing the capacity of user and peer-led organisations to provide support on specific issues such as employment, CRB checks, managing difficult or changing relationships can promote older people's confidence and feelings of safety, personal autonomy and control.

**Mrs Jones of Dudley** suffers from rheumatoid arthritis and has difficulty managing personal hygiene and meals. After an assessment by a social worker, she was offered either a care plan from the local council home care service or a direct payment based on a 10 hour a week allocation. She chose to use her direct payments money to employ her own personal assistant. She already knew Carol from her local church and thought would be interested in the role.

Carol now helps Mrs Jones with personal hygiene and they enjoy planning and preparing meals together. Mrs Jones feels these arrangements have "worked out wonderfully". They plan together when Carol's visits are needed so they fit around Mrs Jones' commitments.

A local Direct Payment Support Service has appointed an advisor to work with Mrs Jones to help her set up and manage her personal

45 Sure Start to Later Life. Social Exclusion Unit, 2005; Making a strategic shift to early intervention and prevention: key messages for decision makers. Department of Health, 2008

budget. She has built up a good relationship with her, and finds it much more comfortable to speak to the same person each time. It's also reassuring to her to know there is help at hand if she should need it.

### **Incorporating explicit discussions about risk in support planning**

Discussions about risk and risk-taking should become an inherent feature of shared assessments and support planning with older people and their families. It is at this stage, when older people are being encouraged to think about what would help them to live fulfilling lives, that meaningful discussions about potential risks can be explored.

This helps to keep the person at the centre of discussions about the level of risk associated with different options and how they envisage they will manage. It is important to build on the person's strengths, while ensuring that the necessary support systems are in place, if and when needed to help them achieve their aspirations.

Risk management is a shared responsibility. Older people should decide how much risk they wish to manage and should be empowered to manage these. Part of this empowerment is about discussing what they would do if things went wrong. Part of this empowerment is also about enabling older people to make the decisions when things do go wrong, and when they decide they want a different package of support.

### **Quality assurance based on personal outcomes, not finances**

A number of councils have adopted light touch monitoring systems that focus on assuring quality and managing risk through good care management and relationships, rather than an emphasis on paperwork checks and lengthy reports.

In Warwickshire this approach means that only bank statements are required from people using a personal budget – there are no forms to fill in. This is supported with back office paperwork such as a 'keeping safe plan' and a risk matrix completed with the individual before agreeing to allocate personal budgets as a direct payment.

### **Embedding positive risk enablement practices and plans**

Participants involved in producing this guide worked together to develop a framework for embedding positive risk enablement strategies and practices through the use of person centred approaches at a strategic, operational and individual level. This framework can be used to guide local partnership developments at a strategic level, as well as the detailed, operational arrangements that councils are establishing for safeguarding, to ensure older people get the support they need to help them stay healthy, safe and connected. It can also be used to review what's working and not working with respect to these arrangements



across the different perspectives of older people, their families, professionals and others

working with them, senior managers and agencies responsible for making this happen.

Promoting individual choice and control	Developing positive risk-taking practices	Adopting a strategic approach
<p>I am supported by people who take time to know me as I know myself</p>	<ul style="list-style-type: none"> <li>• All staff across agencies and sectors have been trained and supported to adopt person centred approaches with older people.</li> <li>• All older people have a support plan which identifies who will help them to deliver it.</li> <li>• Older people with high support needs have a circle of support to help them live their plan.</li> <li>• Families and circle members are supported to deliver person centred support plans, promoting positive risk-taking and supported decision-making.</li> <li>• There is a wide range of support options for older people with high support needs.</li> <li>• A Single Assessment Process is in place with a focus on supported and self directed assessment arrangements that ensure information flows easily and quickly between teams, agencies and sectors.<sup>46</sup></li> </ul>	<ul style="list-style-type: none"> <li>• There is a shared understanding of person centred approaches that promote positive risk-taking practices and supported decision-making to maximise older people's choice and control.</li> <li>• Workforce development plans identify how staff are trained in age equality and diversity awareness, person centred approaches and supported decision-making.</li> <li>• Equal access to early intervention and preventative support is a key part of local ageing strategies and transformation plans.</li> <li>• Multi-agency information sharing protocols and practices ensure older people at risk from abuse can access the support they need to have a good life, safe from harm.</li> <li>• Agencies use their Local Area Agreement (LAA) to promote choice and control and safeguarding at all levels.</li> </ul>
<p>I know where to go to get accessible and relevant information and advice</p>	<ul style="list-style-type: none"> <li>• A range of support is available to enable older people to access information, advice, advocacy and assistance.</li> <li>• Local networks provide effective signposting and streamlined referral arrangements to universal and specialist advice.</li> </ul>	<ul style="list-style-type: none"> <li>• Adopt a multi-agency approach e.g. develop coordinated, jointly commissioned networks of information, advice and advocacy.</li> <li>• Ensure the Local Strategic Partnership (LSP) &amp; Older</li> </ul>

46 The Common Assessment Framework (CAF) for Adults is under development and there is a Demonstrator Programme to develop and test improved information sharing. For more information see [www.dhcarenetworks.org.uk/CAF/](http://www.dhcarenetworks.org.uk/CAF/)

Promoting individual choice and control	Developing positive risk-taking practices	Adopting a strategic approach
	<ul style="list-style-type: none"> <li>• Older people can access user-led and peer support relevant to their specific needs and situations (e.g. BME older people, older people with mental health support needs).</li> </ul>	<p>People's Partnership Board have identified personalisation and safeguarding as local priorities with clear arrangements for addressing gaps in information / advice / advocacy provision.</p>
<p>If I lack capacity to seek out information and advice, I have people around me who will support me to express my views and wishes as much as I can, and will take account of these</p>	<p>Specialist advocates, staff with good knowledge of the mental capacity act, and family and carers will be involved in Best Interest decisions where risks will be examined in the context of quality of life decisions.</p>	<ul style="list-style-type: none"> <li>• There will be clear guidance on delivering personalisation to people who lack capacity and staff will be held accountable for following it.</li> </ul>
<p>I feel part of my community and have a part to play</p>	<ul style="list-style-type: none"> <li>• There are different options for older people to have and manage their personal budget.</li> <li>• There is a range of opportunities for older people to be involved and have their voices heard, at all levels.</li> <li>• There is a variety of arrangements for ensuring that the voice of older people who lack capacity is captured. This will include independent advocates where necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• The LSP and individual partners' responses to their Duty to Involve take a creative and proactive approach to working with older people who need support or are isolated / excluded.</li> <li>• There is a documented methodology for listening to the voices of older people.</li> </ul>
<p>If I need help to keep me safe, I know that support will be there for me when I need it</p>	<ul style="list-style-type: none"> <li>• A wide network of services is accessed by older people including support, advocacy and brokerage, user- and peer-led support.</li> <li>• Older people's support plans include what a good day and bad day looks like for them, what's important to them and what's makes them feel safe, healthy, happy and well.</li> <li>• Reviews are used to jointly explore with older people any concerns they have and any changes they want.</li> </ul>	<ul style="list-style-type: none"> <li>• A whole system commissioning strategy drives innovation in service delivery, informed by older people's priorities and experiences of self-directed support.</li> <li>• This includes the full range of universal and specialist services including 24-hour services and crisis response.</li> </ul>

## APPENDIX 5

# How this guide was produced

**The thinking and approaches to this guide were informed by a series of coproduction events held spring and early summer 2009 involving:**

- older people
- representatives from local councils leading transformation plans and personalisation developments
- project managers from Partnerships for Older People Projects (POPP)
- Individual Budget Programme and Link Age Plus pilots
- strategic commissioning and delivery leads in older people's services in local councils.

The aim was to learn from a diverse range of people what personalisation means to them and how they are making developments associated with personalisation work well with and for older people. People leading local initiatives and new approaches, including older people's groups and networks as well as statutory, voluntary and private sector organisations, worked together to identify features of practice that will help other areas to adopt similar approaches.

These events and this guide were designed by the Older People and Ageing Programme at the National Development Team for Inclusion (NDTi) and the *Putting People First* delivery team at the Department of Health, in

partnership with the Social Care Institute for Excellence (SCIE). A small coproduction design team involving older people and strategic leads from three local councils worked with NDTi and Helen Sanderson Associates to produce the specific elements on understanding coproduction and how to make it happen with older people.

### Coproduction event participants

The following are the people who took part in the coproduction events and contributed examples, ideas and practical solutions for addressing barriers:

**Helen Allen**, *Oldham Borough Council/Naap project*

**Andrew Archibald**, *Dorset County Council/Coproduction design team*

**Julie Barclay**, *Helen Sanderson Associates/Coproduction design team*

**Sylvia Barker**, *Dorset POPP Local Evaluator/Coproduction design team*

**John Barry**, *Older People's Council, Brighton & Hove/Coproduction design team*

**Peter Bates**, *National Development Team for Inclusion*

**Ray Beatty**, *CSED*

**Louise Bradshaw**, *South Tyneside Council*

**Sam Bennett**, *Department of Health*

**Lis Boulton**, *Calderdale POPP*

**Helen Bowers**, *National Development Team for Inclusion*

**Abbie Brearley**, *Salford Primary Care Trust*

**Iona Brimson**, *Somerset POPP*

**Felicity Britton**, *Nottinghamshire County Council*

**Stephen Bunford**, *Essex County Council*

**Frank Burgin**, *Arena, Barnsley/Coproduction design team*

**Tony Callaghan**, *Leeds Linkage Pilot*

**Rosie Callinan**, *Gloucestershire County Council*

**Graham Carey**, *Thurrock Safeguarding Champion*

**Sarah Carr**, *SCIE*

**Angela Catley**, *Naaps*

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