This report advocates a simple yet transformational approach to public services – self-directed services – which allocate people budgets so they can shape, with the advice of professionals and peers, the support they need. This participative approach delivers personalised, lasting solutions to people's needs at lower cost than traditional, inflexible and top-down approaches, by mobilising the intelligence of thousands of service users to devise better solutions.

The self-directed services revolution, which began in social care with young disabled adults designing and commissioning their own packages of support, could transform public services used by millions of people, with budgets worth tens of billions of pounds. From older people to ex-offenders, maternity to youth services, mental health to long-term health conditions, self-directed services enable people to create solutions that work for them and as a result deliver better value for money for the taxpayer.

Self-directed services can be taken to scale safely while minimising fraud and risk. They can also be good for equity because they empower those people who are the least confident and able to get what they want from the current system. Self-directed services give people a real voice in shaping the service they want *and* the money to back it up. Previous approaches to public service reform have reorganised and rationalised public services. Self-directed services transform them.

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"Personal budgets and self-directed services mobilise the intelligence of thousands of people to get better outcomes for themselves and more value for public money..."

MAKING IT PERSONAL

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DEMOS

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Charles Leadbeater, Jamie Bartlett and Niamh Gallagher
January 2008

1 It's participation stupid

This report advocates a simple yet transformational approach to public services – self-directed services – which allocate people budgets so they can shape, with the advice of professionals, the support and services they need. This participative approach delivers highly personalised, lasting solutions to people's needs for social care, education and health at lower cost than traditional, inflexible and top-down approaches. It could transform not just social care but many other public services, including maternity services, mental health provision, education and training – especially for those excluded from school, drug users, offenders seeking rehabilitation and much more.

In a joint policy statement issued in December 2007 five government departments joined the Local Government Association and the Association of Directors of Adult Social Services and the NHS in committing to a more personalised approach to social care. Our research shows that the most effective way to deliver on this commitment is to introduce self-directed services based on personal budgets. When self-directed services are introduced with the right kind of support for people and their choices translate into how money is spent they deliver huge pay-offs: people get personalised solutions that give them a better quality of life, allow them to participate more in society and form strong relationships at lower cost than traditional service solutions that often isolate and leave them feeling dependent.

As with many radical innovations, self-directed services started life in a niche with demanding users with often complex needs – young adults with learning disabilities who started to design and commission their own packages of support. The principles of the approach they helped to work out, however, could have much wider application to social

care for older people and long-term health conditions. What started as a solution to the intense needs of a small group of social service users has the potential to transform public services used by millions of people, with budgets worth tens of billions of pounds.

The participative approach turns on its head traditional public service organisation. Traditional approaches put professionals at the centre of the process; participative approaches put the individual in charge. In social care, for example, the traditional approach is for an individual's needs to be assessed by a professional – a social worker – against overall criteria of eligibility. Once someone is judged eligible, the social workers then devise a care plan, which allocates the individual to services that are paid for and frequently provided by the local authority. It is very rare for the individual to have much of a say in how services are designed, to choose between service providers or to know how much money is being spent on their care.

Self-directed services put the person at the centre of the action. Professionals help an individual assess their need and once this is done, the person is given an indicative budget they can use to design the service solutions that make most sense to them. People draw up a self-directed support plan with advice from professionals, peers, family and friends. In other cases the plan emerges through informal discussion with a spouse. Once the plan is approved by the authority, usually a swift process, the indicative budget becomes real, the money flows to the individual and then on to the service provider of their choice. Budget-holders can stick with the status quo and spend their whole budget on traditional, in-house services or at the other extreme design a bespoke solution, commissioning all services themselves and employing support staff to help them. In between these two poles lies a range of options to mix in-house and personalised services to suit an individual's needs. Budget-holders often adjust their plans as they learn more about how best to manage their money. People who start off spending most of their budget on traditional services tend to experiment as they become more comfortable with the idea of commissioning their own services and learn from how other budget-holders like them are using their money.

Self-directed services are the best way to deliver on the government's promise to introduce more personalised approaches to social care, set out in *Putting People First*, published in early December 2007,[1] a concordat between the Department of Health, five other government departments, the Local Government Association, the NHS and the Association of Directors of Adult Social Services. The Concordat set aside £520 million to modernise social care over three years with the introduction of personal budgets for most people receiving care.

By the end of 2006 about 43,000 people were receiving direct payments and 2,300 were receiving personal budgets for their social care, a rapid rise over the previous two years. Self-directed services are likely to spread much further in the next three years. Already a string of councils including Essex and Manchester have committed to making this approach their standard in future. Within five years hundreds of thousands of people could be commissioning social care this way. The transformation enabled by this approach has five main ingredients.

First, it changes people's attitudes towards themselves and their role in the service. People who were recipients, whether passive or complaining, become participants in planning and commissioning the services that support them. The service users we interviewed said they became less isolated, depressed, dependent and more optimistic, energetic and confident.

Second, people's relationships with professionals change. In the traditional approach, professionals – in the case of social care it is social workers, in education it is teachers, in health doctors – assess need and entitlement, plan and often provide services and judge the quality of outcomes on the person's behalf. In self-directed services professionals retain a critical overview of service quality and outcomes but they become more like advisers, counsellors and brokers, guiding people to make better choices for themselves.

Third, self-directed services bring in new knowledge and information, which help shape services. Traditional services rely on the skills and knowledge of professionals and managers, often working under pressure and with large numbers of people, to assess what is needed and to design solutions for people who have little direct say in the process. The participative approach brings in a greater diversity of more detailed knowledge from users, their families, peers and friends, about what is important and how it could be done.

Fourth, as a result the supply side of service provision has to start to adjust to user demand. In social care this means a shift away from more inflexible, centralised, building-based services commissioned as block contracts, such as day care centres and residential homes, towards much more flexible, distributed, informal and decentralised provision, often organised around people's homes. This shift from a mass, centralised form of provision, designed to deliver economies of scale, towards a more networked and personalised provision is a huge challenge for local authorities and private sector providers.

Fifth, underlying all this is a shift in power, towards users as the focal point of the service to set goals and outcomes against which service provision should be judged, and away from professionals. With this shift in power also come responsibilities for users to assess and manage risks and to account for how resources are used. Users generally welcome these responsibilities.

Self-directed services create an incentive for users to mobilise their knowledge and energy to generate better outcomes for themselves and in the process they make the social care system more efficient and generate more value for money for the taxpayer.

Service users were more satisfied with solutions that were more tailored to their needs. Self-directed support planning makes people more aware of their needs; in the past they had accepted whatever service they were given. Even people who decided to stick with traditional in-house services felt more in control of their lives because they had been through the process of thinking through what they needed and what their options were. Service users reported being more confident and able to look after themselves, better able to combine informal and peer support with the services they commission with their budget. They get personalised solutions at lower cost, while the current system delivers standardised solutions that often frustrate people.

The participative approach, however, also yields significant benefits for local authorities, taxpayers and the wider system of social care. Authorities generate better outcomes at lower cost for more people. Councils such as Oldham have been able to reduce the amount spent on their highest cost, most complex cases, especially services for young adults with learning disabilities. Oldham has used those savings to fund more packages of support for people who have less intense needs. The shift towards personal budgets enforces greater transparency and consistency about costs and budgets: many authorities said that for the first time they had properly calculated how much different services cost.

Professionals and providers are most challenged by this shift. Professionals lose their power to control services. Producers – public, private and voluntary – have to attract demand from personal budget-holders – which requires marketing and innovation – rather than relying on block contracts. Yet most of the professionals we talked to said their jobs had improved because they were working directly with clients to help them devise solutions rather than acting as gatekeepers and administrators. Staff members feel more creative when they are helping people devise solutions that work for them. Some see this as a chance to re-discover social work.

Despite often-stated fears, the shift to self-directed services did *not* result in: fraud and misuse of funds; large increases in costs; widening inequalities; users floundering, unsure how best to spend their budgets.

Self-directed services built on personal budgets could transform public services where other policies have largely attempted to reorganise and rationalise them. Though there have been attempts to achieve person-centred services for many years, the means proposed to do this have remained largely the same and as a result the model of services is little changed.

Compulsory competitive tendering led to public services being contracted out to private and voluntary sector providers who offered a more efficient version of the same service. Contracting out has had wide application – especially to basic services like waste collection – but it has rarely transformed the service or the user experience. Self-directed services allow people to devise their own, often innovative, solutions. About 40 per cent of personal budget-holders commission services that the state does not provide. Contracting out provides a more efficient version of an existing service; self-directed services allow people to create new solutions.

In the 1990s management techniques borrowed from the corporate sector were introduced to drive improvement in public services through target-setting and tighter performance management. These initiatives rely on the know-how of a small group of central policy-makers and target-setters to redesign a service. Feedback loops between dissatisfied service users and service providers are still very elongated. Service users have to rely on politicians, regulators and policy-makers to bring about change on their behalf. Self-directed services instead mobilise thousands of people to set targets that are relevant to them; they monitor how well services deliver against those goals. Target-driven improvement relies on the knowledge and power of a relatively small group of politicians and policy-makers. Self-directed services mobilise the intelligence and incentives of hundreds of thousands of people to improve outcomes.

Self-directed services are a very different model of participation compared with measures such as citizens' juries and participatory budgeting, which are designed to address collective choices. These approaches give people greater voice in decisions over budget allocations and current services. Self-directed services do not mean more committees and talking shops. People get a direct voice in shaping the service they want *and* the money to back it up. It is not just more consultation. Traditional approaches to participation give people more of a voice; self-directed services allow people to put their money where their mouth is.

In the next chapter we explain the factors that make these participative approaches so attractive. In the third chapter we set out the way self-directed services work. Chapter 4 provides new evidence of the benefits of these approaches, for individuals and the system as a whole. Chapter 5 addresses some of the risks of this approach including fraud, financial management and whether more personalised approaches widen inequity. Chapter 6 explores some of the challenges of scaling up promising pilots into mass services. Chapter 7 indicates how far self-directed services could spread into other public services, such as health and education.

2 The public innovation triangle

The ingredients for most radical innovations are present long before the innovation takes flight. Steam engines were used for 60 years to pump water out of mines before they transformed transport when they were applied to ships and railways. The same is true for self-directed services. Many of the ingredients – direct payments, person-centred planning, peer and family support teams, and user-led organisations – are well-established approaches for people with learning and physical disabilities. The time is ripe for these approaches to move from the margins into the mainstream of social care and other public services. That is because four factors have come together in social care to spur public innovation.

The first factor is the growing recognition that current approaches to social care are failing to deliver value for money for the taxpayer and the personalised services people want. Clients of public social care services often praise the quality of the staff they work with but they also complain that services are inflexible (not available when and where people want them) and systems are bureaucratic. Many service users say traditional public services leave them feeling dependent, isolated and cut off from the rest of society. That critique, which was first articulated by people with physical and learning disabilities and the independent living movement, is now echoed by many recipients of state social care. Local authorities are in a tightening vice. They face rising demand for social care from an ageing population that has higher expectations for personalised services and yet authorities operate within tightly constrained budgets.

The growing recognition that current approaches are increasingly failing to deliver created a political environment favourable to innovation. This shift is reflected in government

policy, particularly the Department of Health white paper *Our Health, Our Care, Our Say*,[2] which set up 13 pilot sites to explore how personal budgets could be made to work as well as setting out a complementary vision of early intervention and prevention to reduce dependency, and *Putting People First*, the concordat on the future of personalised social care, published in December 2007.[3] Aspects of this approach have been endorsed by Conservative and Liberal Democrat spokespeople. The two inquiries into the future of health and social care conducted in 2004 and 2006 by Sir Derek Wanless, first for the Treasury and then for the King's Fund, made the case for more public participation in care.[4] The recent review of the future of public services led by Sir David Varney forecast growing demand for more personalised services.[5] Politicians and policy-makers in all parties are searching for a new account of how to improve public services after sustained criticism of overly prescriptive, top-down, target-driven approaches.

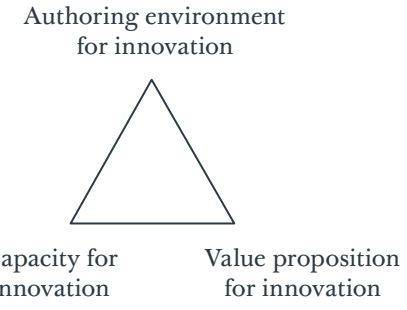
National policy-makers are behind their counterparts in local government. In the last two years many more council leaders and chief executives, across the political spectrum, have realised that rising demand from an ageing population combined with tighter budgets would compel them to find radical innovations to deliver flexible and personalised services at much lower costs. A new political space has been created in which more radical innovations – such as personal budgets – can develop.

That has put a premium on the third factor – the organisational capacity to deliver radical innovation. Suddenly niche and marginal innovation – largely confined to small groups with learning disabilities – took on a new value and significance. One prominent and successful model of self-directed services, in Control, was created in 2003 as a joint venture between the Department of Health, Mencap – a charity for people with learning disabilities, several development agencies focused on person-centred work, and six local authorities. By the end of 2007 more than 100 local authorities were members of the in Control programme, which was catering for almost 3,000 people. in Control has developed a simple and robust model for how self-directed services can work, which is about to be taken to scale. These three factors are illustrated in figure 1.

The final factor is a sense of urgency, bred by the looming crisis in social care as the population ages, expectations of quality rise, demand for personalised services becomes the norm and budgets remain tightly constrained.

When these components come together they create the conditions for radical innovation.

Figure 1 **The public innovation triangle**[6]



3 The self-directed service model

Innovation in services often involves users playing new roles in providing the services they consume. Federal Express has cut costs and increased consumer satisfaction by making it very easy for clients to track their packages online rather than relying on customer service reps to do it for them. Fast food restaurants turned traditional approaches to eating out on their head by getting consumers to pay for their food before they eat. Personal budgets create this somersault effect. They turn the traditional social care service model upside down by putting users at the heart of decision-making.

The in Control model is an example of innovation in social care, and is outlined in box 1.

Box 1

in Control

in Control is one of the most promising approaches to self-directed services. Building on years of work by disabled people to control the support they get, in Control began as a partnership between the Department of Health's Valuing People Support Team, Mencap, a group of local authorities and independent development organisations working in the field of disability. They came together in 2003 to help local authority social services departments adopt 'self-directed support' systems for social care in which disabled people would control how they live and the support they need.7 In 2003 six local authorities – Essex, Gateshead, Redcar and Cleveland, South Gloucestershire, West Sussex and Wigan – piloted in Control's self-directed support model focusing on

people with learning disabilities. The in Control model quickly spread from people with learning and physical disabilities to older people who make up most of those receiving social care. By November 2007, 107 local authorities were members of in Control, and 2,300 people were receiving personal budgets using its model, many of them elderly people.

The social care system

in Control offers a new 'operating system' for the social care system in England in which about 25,000 providers in private, public and voluntary sectors serve about 1.7 million people a year at a public expenditure cost of approximately £17.5 billion, with an additional £2 billion from local authority charges.[8]

People over 65 are the largest group of recipients: more than one million people in 2006.[9] Other groups using social care include adults and children with learning, physical and sensory disabilities; people with mental ill health; people with problems of substance misuse; and children and families where there are concerns about the safety and well-being of children.[10] Social care services range from residential care and home care to meals services, day services and social work, and for children and families – child protection, early years support and residential care. Local authority spending on adult social care – mainly for the elderly – rose from £10.93 billion in 2001/02 to £13.02 billion in 2003/04, a real terms increase of 13.4 per cent.[11] As the population ages this figure is set to rise further. Recipients of social care often also receive other state benefits such as housing benefit, income support and incapacity benefit.

How the current system works

Under the current system a care manager, usually a social worker, assesses an individual's needs and eligibility and then draws up a care plan, after talking to the individual and others in their life. The care plan is required by law to show how eligible needs will be met; how many hours of care the person is allocated; who will provide the care; how the person would like that care and support to be provided; and the risks associated with the plan.[12] The care plan is then priced and translated into a package of services commissioned by the local authority, which the user is given access to. Services are rarely commissioned for an individual; usually they have to fit into what the authority already makes available.

in Control turns this traditional model on its head, with a much simpler process which gives users greater freedom to shape their care and powerful incentives to get more value from public money. in Control does not just change the process people go through, it gives them incentives to use their knowledge and resources to get better value for money.

Budgets up front not at the end of the line

in Control allocates resources to people up front so they can plan how to use them. When people apply for support they are very quickly given an assessment of the resources they would have available to buy support. Many applicants self-assess their need using a simple points system; in some authorities this can be done over the phone. That self-assessment is checked and quickly translated into a resource allocation: a sum of money. Budgets range from the few tens of pounds a week a frail elderly person might use to buy home care support to tens of thousands of pounds a year for a young adult with disabilities who requires 24-hour support. Under the traditional approach resources are allocated at the end, as the result of the process. Under in Control people know early on what resources they are likely to have. That allows them to plan how to use their money and to consider alternatives to in-house or pre-purchased service provision. Friends and family can contribute to a person's care fund without worrying that this will affect their eligibility for public resources.

Self-directed support plans not a care plan

Based on the resources available people draw up a self-directed support plan rather than having to accept a care plan drawn up by a care manager. A self-directed support plan describes what matters most to a person, what they want to achieve in their life and how they will use their budget to enact these changes. A traditional care plan is an account of the services an individual will get from the local authority. A self-directed support plan starts from how someone wants to live and then works out the combination of formal and informal, private and public support that will achieve these goals. The aim is to find the best way to fit the services people need into their lives.

People devise these plans in a variety of ways. Some complete the support plan themselves with little external input. Many rely on the advice of family, friends and carers. Others work with a care manager appointed to help them or a professional broker, skilled at assembling complex packages of support or a voluntary organisation that provides advice and brokering services. Within in Control and the Individual Budget Pilot sites a range of approaches are being explored, including intensive person-centred planning, which involves a day-long workshop with the individual, their family, friends and carers, which has worked well for young adults with physical disabilities who have complex and changing needs and a large budget. Such an approach might be inappropriate for an elderly person with a small support package, established routines and much more specific needs.

A support plan is not a wish list. Each plan must specify how it will meet government policy objectives to keep a person healthy, safe and well and be signed off by a local authority care manager.

Plans should be adaptable

Local authority care plans tend to be inflexible and are often reviewed only periodically. in Control encourages people to revise their plans as they learn what works best for them or as their circumstances change. People with a progressive condition such as multiple sclerosis, for example, need to call on more support when they are going through a rough patch and less when they are feeling relatively robust. Local authority care plans find it difficult to respond swiftly and deftly to these changes. But when someone has their own budget they can save resources when they are doing well so they have more to draw on when they really need it.

Manage the money, organise your support

Few people other than professionals understand how local authorities allocate social care. The system is opaque. in Control allows people to take charge of their budget in the way that makes most sense for them and that makes the most of the public money they have been given, by eliminating waste and driving a good price for their care.[13] Many people choose to have the money transferred into their bank account so they can use it to pay for support services as they need them and purchase equipment. People who do not feel confident managing money can appoint a representative, such as another family member, a broker or a local authority care manager to manage the money for them. In some cases people choose to buy the services the local authority provides, in which case they return the money straight to the authority.

Individuals who take full control of their budget might choose to employ their own care staff. Others may prefer to use a support agency to manage payroll, pensions and holidays. Some people rely on a broker to identify the best services and negotiate payment options. Many people use their budget to mix local authority day care services with their own personal assistant a few days a week. Often people use the budgets to buy equipment – even cars – that would not be available

through local authority provision. Table 1 compares the in Control model for self-directed support with the traditional service model for delivering social care.

At the core of self-directed services is a simple but revolutionary change in process that gives people involved new incentives and power to shape services and get better value for money:

- Devolve personal budgets to be as close to people as possible.
- Enable them to make plans how to use the money to create solutions for them that also deliver public value for money, usually in conversation with an adviser.
- Allow people to use their budgets to commission services in line with these plans.
- Allow the plans to be modified by learning and changes in circumstances.
- Keep an overview of how well the plans perform to guard against undue risk.

When these conditions are in place people are mobilised as participants in shaping goals for the services they use and making sure the money is well spent. The power of these models derives from the way users are given incentives and power to make public money go further. What evidence is there that they really deliver, not just for the users but also for taxpayers, the wider system and indeed staff?

Table 1 **Traditional and self-directed support compared**

Traditional service model	in Control model
Assessment by professionals	Early self-assessment
Lack of transparency in the process of allocating resources; budget decided at the end	Transparency in resource allocation; budget decided at the start
Care plan developed by professionals	Support plan designed by individual with people or professionals of their choice
Money managed by local authority	Money managed by individual or nominated person or organisation
Services commissioned by local authority	Services commissioned by individual
One-off planning process, with yearly review	Reflexive process; support plan constantly reviewed and learned from
No flexibility in spending	Flexibility in spending
Responsibility for risk lies with local authority	Responsibility for risk lies with the individual and the local authority
Individual receives services from the state – no incentive to innovate	Individual designs and commissions their own services – opportunity to be creative and innovative
Individual as part of public services machine	Individual as empowered community member

4 The self-directed service dividend

Self-directed services bring significant benefits to individuals and their families, but also to councils, professionals, service providers and the wider community, especially when they are compared with the shortcomings of the current system of social care.

In this section we first set out the benefits of self-directed services to individuals and then examine the benefits for the system as a whole.

Personal value

Users of public social care services complain they are rigid and inflexible, typically provided in residential or day care centres, which have little room to adapt to people's distinctive needs. The system gives people limited opportunities to express their preferences about the support they need. Many people do not want the institutionalised services on offer but have no option but to accept what they are allocated because services have been commissioned as a block by the local authority.

Service users complain that traditional services often isolate them from their family, friends and society at large and so increasingly they became dependent on the service as the focal point of their life. People in residential centres find their lives are increasingly narrowed to what the service allows them to do, for example visit the TV lounge or have meals at set times.

An extreme example of the negative impact this can have is Karen, a service user in Oldham, who has bi-polar disorder, and used to spend between three weeks and three months a year in hospital, as she puts it, 'zombified' by medication. The atmosphere and the food made Karen sick and it took several months for her to recover from a spell in hospital. When Karen's care was directed by a traditional care plan she had

no choice but to take the medication and wait until she ended up in hospital again, trapped in a cycle of dependency. Karen wanted a supporter at home whom she could trust when she was ill, and access to alternative therapies – homeopathy, a chiropractor and a life coach – that she knew would prevent her having to go into hospital in the first place. When she moved onto a personal budget she was able to arrange that support and she has not been back into hospital since.

Home care services suffer from inflexibility because people have little control over the working hours of their personal assistants. That means the person's life revolves around when other people can visit them. Many local authority services do not offer support late at night, early in the morning or over weekends. That can mean elderly people are put to bed early in the evening simply because that is when the care staff are available.

Private sector care services offer more flexible hours, but then people often get a string of different helpers. Care depends on intimacy. Yet many users complain they are unable to build up a relationship with a shifting cast of 'carers', who might only visit them briefly. One family described the services they got as a 'blizzard'. Care is not just a transaction for personal services. It depends on a relationship of trust between carer and cared for. The contracted-out care services market often fails to deliver such relationships.

Nor do traditional services mesh well with the local and informal supports people depend on, especially from families and friends. At their worst traditional services cut people off from daily contact with the rest of society: disabled and elderly people are moved by special transport services, between day centres and their homes, minimising contact with other people. Elderly people may have to live in residential homes with people they've not chosen to be with. Most people want their care to be integrated into their daily lives but too often public services cut them off.

Even potential solutions to these problems, such as direct payments, have suffered from significant shortcomings in their implementation. Under a direct payment a person can take their care budget as a single payment so they can employ staff to support them. For many this is a major step forward compared with traditional services. Yet direct payments, in practice, have come with their own downsides, largely because of the myriad rules and regulations imposed by central government and local authorities.[14] Many disabled people argue that the original aims of direct payments have been frustrated by these restrictions.

For many people direct payments have been all or nothing. Someone in receipt of a direct payment has to employ their own support staff, taking responsibility for their tax, national insurance and holiday pay. Not everyone wants to take on this responsibility. Recipients of direct payments complain that stringent rules prevent them using the money flexibly to commission the kind of care they want, for example to buy some kinds of equipment to install at home or to provide respite care by going to a hotel. Some local authorities impose detailed audit trails to keep track of how people spend the money. Recipients of direct payments complained, for example, of having rows with their authority over receipts for takeway pizzas.

Many if not most of the people using the social care system are frustrated by burdensome rules, regulations and bureaucracy, which make for inflexible, impersonal services, often leaving people isolated and dependent. Self-directed support offers a very different approach.

Professor Chris Hatton of Lancaster University has analysed data from 196 people who are self-directing the support they get in 17 local authorities. This is the largest collection of data of its type so far, and offers a snapshot of the impact personal budgets have on people's lives.[15] Two-thirds of those questioned were relatively new to self-directed support, having had a personal budget for six months or less.[16] On the whole the findings were consistent across people using a range of different services to meet different needs. The benefits are not confined to just one group.

People in the project rated how eight aspects of their lives had changed since they started using self-directed support, which correspond to the goals for social care set out in the white paper *Our Health, Our Care, Our Say*.[17] The results show personal

budgets can help people meet their distinctive and personal needs and in the process help deliver wider social policy goals. Findings based on these eight aspects indicate how personal budgets are good for individuals but also for society as a whole:

- *Better health and well-being*: Almost half of people surveyed (47 per cent) reported improvements in their general health and well-being since starting self-directed support, with a similar number reporting no change (49 per cent) and 5 per cent reporting that their health had got worse.
- *Spending time with people you like*: Fifty-five per cent reported spending more time with people they liked since starting self-directed support with 42 per cent reporting no change, and 3 per cent stating things had got worse.
- *Improved quality of life*: More than three-quarters (77 per cent) said their quality of life had improved since starting on self-directed support with 22 per cent reporting no change and 1 per cent reporting things had got worse.
- *Taking part in community life*: Sixty-three per cent said they took part in and contributed to their communities more when they went onto self-directed support, with 34 per cent reporting no change and 2 per cent saying things got worse.
- *Feeling safer and more secure at home*: Twenty-nine per cent reported improvements in how safe they felt at home, 71 per cent reported no change and 1 per cent reported that things had got worse.
- *Choice and control*: Seventy-two per cent said they had more choice and control over their lives, with 27 per cent reporting no change, and 1 per cent stating things had got worse.
- *Personal dignity*: Fifty-nine per cent of people said they felt their lives had more dignity since starting on self-directed support, with 41 per cent reporting no change.
- *Economic well-being*: A substantial minority (36 per cent) estimated their economic well-being had improved with a majority (60 per cent) reporting no change and 5 per cent reporting that their economic well-being had got worse.

Professor Hatton's evaluation shows that most people using self-directed support believe it makes a positive difference to many aspects of their lives, whether they are young adults with learning disabilities or frail elderly people who are largely housebound. Only a small minority, about 5 per cent, feel their lives have got worse in any regard and the majority believe the quality of their lives has improved: they have more choice and control, see friends and engage in their communities more, have a greater sense of dignity, and enjoy better health. Most people do not understand the way the traditional social care system rations access to services. Professor Hatton's evaluation shows that people understand in Control very well: 91 per cent said they understood what they were supposed to be achieving with their personal budget.

These figures support the findings of our 40 interviews with service users in 12 authorities. We found that having the power to design one's own plan enables people to think more creatively about what services they want – and what they want to achieve in life. (The first question in an in Control self-assessment is 'where do I want to be in life?', whereas local authority assessments generally focus on identifying deficits with questions such as 'can you use the toilet without assistance?')

People on in Control are getting support at times that suit them, whether that is someone visiting their home, taking them out to go shopping or even abroad for respite care. Professor Hatton found that many people were writing their support plans with the help of family, friends and social workers.[18] As a result of this joint approach people self-directing their services were more able to combine formal, paid-for care, with informal support from family and friends as both sets of carers were working from a shared plan. An evaluation of in Control found 88 per cent of personal budget-holders accessed support available in their community that they had not previously drawn on.

Being able to combine informal and formal care brings more personal knowledge to bear: people close to the person are more likely to know what they like and need. Gavin, for example, who was diagnosed with multiple sclerosis four years ago knew

he did not want a traditional service at a day care centre. Instead Gavin uses his personal budget to pay Norma, who visits him to help out with ironing and cleaning. Norma's support frees up Gavin's wife Karen who looks after Gavin's personal and intimate care – dressing, bathing and washing – something he doesn't want anyone else to do. Personal budgets allow people much greater flexibility to create inventive packages of support. Brenda in Oldham, who is physically disabled, bought a car with her budget, which allows her to be driven to visit markets around the northwest with her friends. Simon, a personal budget-holder in Essex, has become less depressed and isolated because he can use his personal budget to pay a friend a few pounds to take him to the cinema, something that was virtually impossible under his local authority care plan.

The open, frank and often creative discussion involved in writing a good support plan brings benefits in its own right. Often people find they can write their support plan only by asking questions that traditional assessments of need do not address. Local authorities assess what local authority services someone might be eligible for. in Control starts by asking someone what matters in their life. As one user told us:

When I was asked, 'what is important in your life', I was suddenly stuck. No one had asked me that before, and it suddenly gave me a new perspective on where I wanted to be.

Personal budgets might be expected to give people more control over their lives. What is more surprising is that they also encourage people to be more social. People who are no longer dependent on services delivered in a day centre or residential home are more able to venture out, often with friends, to access education and training, go to the cinema or shopping, play a sport or undertake voluntary work. Personal budget-holders have set up user groups and networks to share information and ideas. Julia and a group of other personal budget-holders in Essex, for example, have formed the Liberation Partnership, a social enterprise that offers support and advocacy services to new personal budget users.

Traditional public services support people but often at the cost of cutting them off from society, reinforcing their sense of dependency. Personal budgets make it much easier for people to get the kinds of services they want *and* to be more social. It is better for individuals and society.

Public value

Publicly funded social care is caught in a vicious spiral of rising demand from people with more complex needs, increasing costs, tight budgets and falling productivity. In 2005/06, gross expenditure by councils in England on personal social services was £19.3 billion, an increase of 6 per cent in cash terms and 4 per cent in real terms on the previous year, and 10 per cent higher in real terms compared with 2003/04.[19] Spending on people with learning difficulties has more than doubled in real terms in the last ten years. The Wanless Review of the future of the NHS predicted further large increases in spending would be needed to cope with the rising number of elderly adults with complex social care needs. In 20 years' time, the elderly population with substantial social care needs could be 55 per cent greater than it is today.[20]

Yet the productivity of the social care system is falling. A recent National Audit Office report showed that productivity in social care fell by 2.1 per cent every year between 1995 and 2005.[21] The number of national minimum standards met by social care services has risen in the last four consecutive years, according to the Commission for Social Care Inspection (CSCI) but the rate of improvement is slowing and indicators are still being missed.[22]

Local authorities have responded to the crunch of rising demand and tighter budgets in the only way open to them: limiting who is eligible for social care. In 2004/05 the Association of Directors of Social Services reported that six in ten local authorities provided services only to those with substantial or critical needs (in practice people who cannot do the majority of things they need to do – bathe,

wash, dress, cook, shop – to lead their lives). Eight in ten councils are planning to tighten eligibility criteria.[23]

According to CSCI there is a growing gap between what public services deliver and what people want:

People say they want services that help them to realize their potential and make the most of their life chances. Services that offer them real choice about the care they use; flexible services that respect and fit with their lives... Over the last year people have continued to express concerns about the gap between policy aims and the reality of their experiences.[24]

The lack of responsiveness is revealed in what social care budgets are mainly spent on: 42 per cent goes on residential provision, and day and domiciliary care. About 70 per cent of the budget for adults with learning disabilities is spent on residential, nursing or day-care centres. Specialised residential services for young adults with learning and physical disability can cost up to £120,000 a year.

Administration, regulation and quality assurance eat up 16 per cent of the budget to fund social workers to devise care plans and allocate people to services they often do not want.[25] The system's multiple failings – despite the best efforts of many of the staff who work within it – make a compelling case for radical innovation. Self-directed services, combined with personal budgets, create a new operating system for social care that lowers costs, raises quality, improves productivity, offers greater choice, reconnects people to their social networks and helps to generate social capital.

That is the conclusion of the first in-depth calculations comparing before and after costs for 102 people who have moved from a traditional care plan onto a personal budget. They were drawn from ten local authorities: Barnsley, Cambridgeshire, City of London, Kensington & Chelsea, Lambeth, Lancashire, Newham, Norfolk, Northamptonshire and Staffordshire. Column 3 in table 2 shows the average costs for traditional services and column 4 the costs for the same users when they transferred to a personal budget.[26]

Table 2 **Cost of care package before and after a personal budget**

Local authority	No. of users	Traditional services average cost per user	Personal budgets average cost per user
Barnsley	11	£19,572	£21,707
Cambridgeshire	6	£26,767	£33,083
City of London	4	£16,076	£22,576
Kensington & Chelsea	13	£6,990	£6,864
Lambeth	8	£63,653	£54,994
Lancashire	31	£38,165	£30,708
Newham	2	£42,081	£56,524
Norfolk	9	£33,226	£27,039
Northamptonshire	13	£28,206	£22,927
Staffordshire	5	£10,871	£10,433
All	**102**	**£29,683**	**£26,621**

Note: The figures above represent unweighted averages for each county for purposes of comparison. The total included in the table represents the average of all costs across all counties. See appendix 1 for full data.

Personal budgets in this sample cost about 10 per cent less than comparable traditional services and generate substantial improvements in outcomes. The cases above include people who shifted onto a personal budget because their condition worsened and so their funding increased. When these cases are excluded the cost savings are closer to 15 per cent.

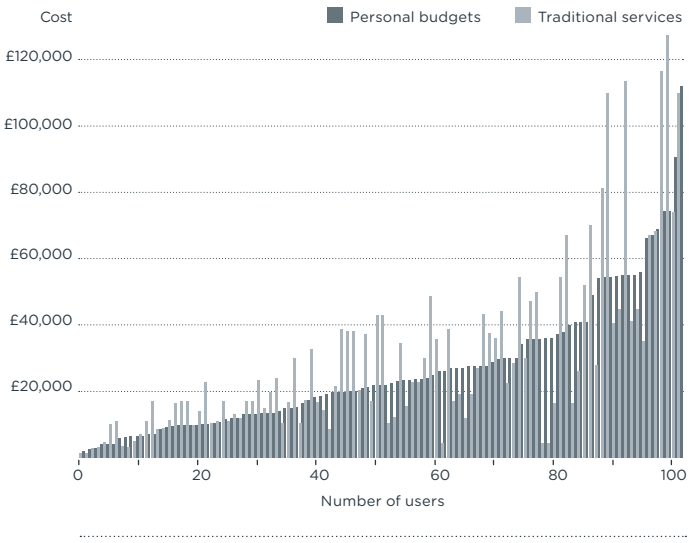
These findings are confirmed by a second analysis comparing 187 personal budgets against a representative set of 126 typical traditional service users with a comparable set of needs. The average personal budget care package was £14,343, compared with an average cost of £15,638 for similar individuals under the traditional model, a saving of about 10 per cent (see appendix 2).

Six small-scale surveys of in Control's first phase of development found that care packages cost between 12 per cent and 45 per cent less when someone went onto a personal budget. Bradford Council applied in Control's resource allocation system hypothetically to 300 service users and estimated that it would have reduced spending by 20 per cent. Studies outside the UK have come to similar conclusions. In Western Australia, the cost per client on its Local Area Coordinator programme for example is $32,526, which is 35 per cent below the national level of $49,956.[27]

Self-directed services are simpler to administer and users have an incentive to find cheaper packages. One of the main benefits is that intensive packages of support – round-the-clock residential care for young adults with learning disabilities, which can cost up to £100,000 a year – can be dramatically reduced by allowing people to design their own care programmes based around their own accommodation. A prime example is Simon[28] from West Sussex, who has autistic spectrum disorder and a severe learning disability. Simon had spent years in residential homes at a cost of £80,600 a year. With his personal budget, Simon moved into a house with a friend. He now goes out far more, sees friends and family more often, is more physically active – he trampolines – and he organises trips to Centre Parc's holiday villages.[29] Simon is happier and more stable than ever before on a personal budget costing half the care package provided by the local authority.[30]

Figure 2 shows how costs per user changed for 102 individuals who shifted onto personal budgets. It shows that individuals who had high-value packages (more than £60,000 per year) under traditional services receive less with a personal budget. Those with less intense needs and packages often get slightly more than they did under the old system. Of the 102 people who transferred to personal budgets, 53 got less money and 45 were given more money, and four stayed the same.

Figure 2 **Differences in cost per user before and after moving to self-directed support**



Source: in Control, November 2007 (see appendix 1)

The direct financial savings to the social care budget may be dwarfed, however, by the longer-term and indirect savings likely to flow to the public sector as a whole, especially health services. People who commission their own services plan to avoid long-term expensive care and crisis stays at hospitals. Julia, a personal budget-holder in Essex, for example, has a serious respiratory problem, which used to keep her in hospital for three months a year. Julia knew her problems would be eased if she had air conditioning installed in her house but neither traditional services nor direct payments could pay for that. When she went onto a personal budget she immediately invested in an air conditioning

system and has not been back into hospital since. Julia is not only consuming fewer resources from the social care budget but fewer from the health budget too. We see the following outcomes when people move onto self-directed services:

- They are more satisfied with the services they receive, feel happier about their lives, enjoy better health, socialise more and become more active in their communities. Personal budgets and self-directed services deliver better outcomes against the Department of Health's seven outcomes, outlined in *Our Health, Our Care, Our Say*.[31]
- Across the social care budget the direct costs savings are substantial. In the most expensive cases the savings can be up to 45 per cent. Across the board the average savings seems to be about 10 per cent.
- Personal budgets put people more in control of their lives and as a result they become more stable. As a result they are less likely to need crisis support and to call on other services, such as the health service. The indirect savings to other public services, especially health, could be as significant as the direct financial savings to the social care budget.

Under personal budgets and self-directed services people get higher-quality, more personalised services at lower overall cost, which generates savings to other public services and creates wider social benefits as people become more engaged with their communities. Personal budgets can create a more cohesive and integrated community while also allowing people to tailor services to their needs.

5 Risks and challenges

People fresh to the idea of self-directed services often raise doubts about whether it will work. Will people spend their money wisely? What about people who do not want to or cannot become participants? Will it give more freedom to those who are already well off and articulate, thus widening inequalities? Well-designed self-directed services can answer these questions robustly.

Will people use the money wisely?

Risk

Will people take undue risks and spend their money rashly once they are given freedom to do so?

Managing risks – visiting a swimming pool, crossing a road, going for a walk in a park – is an important part of everyday life, which young and non-disabled people take for granted. in Control shows that even people with severe learning and physical disabilities and frail elderly people want more scope to manage the risks associated with their care. As one personal budget-holder told us:

You feel like a baby with direct services, like an adolescent with direct payments, and like an adult with a personal budget. Because it means being allowed to take a risk which most people take for granted, but which is a big deal for me.

In the traditional system responsibility for ensuring people are safe from risk, for example the risk of harming themselves, rests with councils and service providers. Yet this responsibility means care managers err on the side of being risk averse when devising a plan for someone. Many

service users complain that in the name of ensuring the most vulnerable are kept safe the current system prevents everyone from exploring creative ways to organise their care.

Self-directed services puts debates about risk taking on a different footing because they engage people in managing the risks associated with their care. Social workers are not left to carry the can.

When people are given the freedom to design their own care packages they make sensible and mature choices that improve their quality of life and keep them safe.[32] Self-directed packages for disabled and elderly people, often devised with the help of family or friends, draw on detailed knowledge of what someone is capable of – knowledge that might not be available to a professional handling many different cases.[33] Personal budgets might be less risky than traditional packages because former mental health patients like Karen are less prone to crisis and depression because they are less isolated and more stable. Issues that could eventually endanger their health and safety are picked up earlier.[34]

Policy-makers are starting to acknowledge that excessive concern about risks can leave services snarled up in red tape. The green paper *Independence, Well-being and Choice* suggests that the governing principle for risk should be that people have the right to live their lives to the full as long as that doesn't stop others from doing the same.[35]

A shift to personal budgets does not relieve a local authority of its overall risk management role. A local authority has a responsibility to approve an individual's plan and it can intervene where it believes there is undue risk. Cumbria's Positive Risk Taking Group, for example, encourages 'informed decision-making' through open, recorded discussion between social care workers and service users. In Oldham any plans deemed to be dangerous are referred to a risk enablement panel for approval.

People with personal budgets do not take undue risks; often the care packages they design are lower risk than traditional services; there is more risk sharing between people and professionals; checks and balances can be designed into the system to eliminate undue risks.

Fraud

If personal budgets become the normal way to distribute social care funding then large amounts of money – perhaps £20 billion a year – could be involved. This opens up the risk of fraud. People might make fraudulent claims. Users given a budget might spend it on items not included in their plan: fine wine and dining. On in Control, someone can employ a family member as a personal assistant (some places outside the UK do not permit payment to family members acting as carers). A family member might manage the account on their relative's behalf and pay themselves a generous salary and expenses to 'care' for that person, while doing little of the sort. Budget-holders might be defrauded by 'cowboy' operators charging excessive fees to organise sub-standard service packages.

Fraud blighted other attempts to introduce personal budgets such as Individual Learning Accounts (ILAs), in which adults were able to apply for personalised funding to start education courses. ILAs collapsed amid fears that people were applying for funds for non-existent courses, resulting in losses of millions of pounds.[36] One tactic involved an alleged IT course that consisted of a computer disk containing a self-study package. Fraudulent providers encouraged people to sign up for a free course, whereon the provider would charge the government £150.

As yet there is no evidence fraud is a serious problem with personal budgets in social care. People are determined to get the most out of their money to improve their quality of life. Family members generally work hard to get the best deal for their family. Local authorities can minimise the risks of fraud by putting in place light-touch monitoring and auditing systems to check that a service user's needs are genuine and that their support plan is meeting those needs. Oldham Council, for example, has decided that family members should be employed as paid carers only in exceptional circumstances. And if a fraudulent case does arise the local authority can take action – perhaps taking control over that person's budget or imposing a tougher auditing regime. It makes no sense, however, to encumber personal budgets with onerous and detailed audit trails, which then severely limit the person's freedom of manoeuvre.

Another risk of fraud comes from the role of brokers who help people work out their support plan, advise on what services to choose and then help to commission them, for a fee calculated as a percentage of the personal budget.[37] This raises issues over who should be allowed to act as a broker and whether they should be licensed. Some brokers are also service providers. This has provoked fears that brokers might not be impartial and would channel users towards their own services. Cowboy brokers might target people with large personal budgets, worth more than £20,000 per year and charge exorbitant fees. There are no signs of this kind of fraud but it is early days. Authorities should make sure people can choose from a range of brokers. Voluntary organisations and peer networks will play a critical role in advising people. At least 15 per cent of the current social care budget is taken up by administration fees, akin to a brokerage fee. Brokers work on much lower percentage commissions.

Inappropriate uses of public money

Another common worry is that people will use their personal budgets to commission inappropriate services. Usually the only restriction placed on a personal budget is that it should be spent on services that are legal, contribute to meeting the goals of the person's support plan and keep them safe and well. Cases where people spend their money rashly or unwisely are extremely rare. Studies of patients involved in decision-making over budgets for long-term health needs, for example, found they make far fewer unreasonable or irrational demands than clinicians fear; one study showed that patients often prefer more conservative and cheaper treatment than the doctors recommend.[38]

Some personal budget plans will raise eyebrows. Brenda in Oldham, for example, spends some of her budget on a holiday in Tenerife at a hotel that caters for disabled people with her personal assistant Jan – a market trader – to give her husband Derek a break. She preferred this to the local authority respite care. For about the same cost she achieved a far better outcome. Gavin spends part of his budget on a season ticket to watch Rochdale FC so he can socialise with his friends who take him to the match, thus giving his wife – his main carer – a break. In both cases the spending clearly contributes to the support plan's goals yet even so some people would question whether public money should be used to buy holidays and football season tickets. There is an unstated assumption in these debates that people in receipt of public money should be needy and the services they get a bit like eating greens.

Is it bad for equity?

Will personal budgets merely empower people who are already confident, articulate and networked to get better services, while the more vulnerable and disadvantaged get left behind, creating even more inequity?[39]

Equity means people with similar needs should get a similar quality of public service regardless of their ability to pay.[40] Personal budgets promote choice and will expand the competitive market for social care services, from which budget-holders can choose. Critics argue that as markets tend to be inequitable, and reward those with the most spending power, personal budgets will be bad for equity.

This worry is misplaced. First, it implies that the current system treats people in a fair and consistent way. Yet often there is no consistent relationship between a person's needs and the resources spent on them: indeed often the relationship is unfathomable.[41] Hertfordshire Council, for example, examined in detail what it was spending on people with different degrees of need and found there was no consistent relationship: sometimes people with moderate needs got almost as much as people with substantial needs. This poor fit between what people need and the resources spent on them comes from the way local authorities buy blocks of provision, like day care centres. As a result people with very different needs get similar services. The current system rewards the most articulate at the expense of the less confident: those who

are most confident in complaining or most able to work the rules of the system stand more of a chance of getting the services they want. Giving people the same budgets to spend puts people on a much more equal footing.[42]

Personal budgets create a much fairer, more transparent match between the money being spent and a person's need.[43] Rather than the crude equity of the current system, which forces people to take the same service regardless of their need, personal budgets allow people to use the same resources in different ways to suit their distinctive preferences. The overall framework is fairer and more transparent; the outcomes are more personalised. Personal budgets are good for opening up access to services. People from minority ethnic groups, for example, access traditional social services at a much lower rate than other groups in the population.[44] Our research suggests that personal budgets can draw in minority ethnic groups because they give people the chance to create solutions that work for them in their localities. In Oldham, for example, minority ethnic groups make up 22 per cent of the population but only 1 per cent of people accessing social services. The move to personal budgets saw that figure rise to close to 10 per cent. Personal budgets are good for equity between different groups.

The greatest inequity in social care is the gap between those who can afford to self-fund their care and those who have to rely on poorly performing public services. The majority who self-fund already have some choice and freedom; those dependent on public services have little. Personal budgets offer state-funded clients the choices currently available only to the middle classes outside the system: that closes the biggest equity gap in the system rather than widening it.

in Control shows that people from all backgrounds can use personal budgets but some people need extra assistance to develop support plans that are right for them.

The current social care system generates inequity and rewards those most able to complain. Personal budgets can promote greater equity, by distributing resources more transparently and fairly, putting those receiving public support on the same footing as self-funders, opening up access to services to groups previously excluded and allowing people to tailor their services to their distinctive needs. The very groups that many assume will lose often benefit the most from self-directed services.[45] Increased choice within a fair framework of provision increases equity.

Will it work everywhere, for everyone?

Rural areas

Can self-directed services work in rural settings where service users may see care staff only occasionally because of the distances they have to travel and because service provision may be thinly spread? Someone with a personal budget living in a city might have several service providers to choose from; someone living in a small village in rural Scotland might have only a limited choice of provider. A personal budget might make little difference to the choices available to them.

This is not an insurmountable problem. Almost 90 per cent of the British population lives in urban areas, with over half resident in just 66 conurbations with populations of 100,000 or more. Particular problems in rural areas should not hold back wider system reform.[46] Yet the current social care model is not serving well people in rural communities. A recent Social Care Institute for Excellence report revealed widespread dissatisfaction in rural areas with the '15-minute slot' model of homecare services. The report argues that a personalised approach could better serve rural populations, by allowing users the freedom to develop creative solutions in their communities.[47] Take-up of personal budgets in rural areas suggest people see them as a viable solution. The Orkney Islands in Scotland has one of the highest take-up

rates for direct payments in the UK because it allows people to devise creative, localised solutions rather than relying on remote professional services that call only occasionally. In Western Australia, local area coordinators were introduced to respond to the needs of isolated rural communities.[48] Coordinators help people find the support they need in their locality rather than having to travel long distances to centralised provision.

People who do not want choice

What about people who want to exercise their right to have a standard service? Forcing everyone to be independent commissioners of services goes against the grain of personalisation: some people will want to choose traditional services they are familiar with.

The most detailed review of direct payments found no evidence that people who want traditional services are disadvantaged.[49] People build up the confidence to make more informed choices when they have peer support, digestible information and easy-to-use tools to help them visualise their plans. Evidence from similar schemes abroad[50] suggests that people using personal budgets gradually move away from traditional services and become more creative in designing their care.

Local authorities will face some tricky issues. People on personal budgets generally choose not to use local authority services day care and residential centres. Closure and consolidation of local authority services is almost inevitable. Yet some local authority provision will be necessary for a minority who still need and want it.

Compulsory users

Some people are compelled to use social care services, by order of a court, in a child protection case or as a result of a section under mental health legislation, for example. Can self-directed services work for people who are compelled to use a service they would not have chosen?

Compulsion is a feature of many public services. Welfare-to-work schemes require people who have been unemployed for a period to see a jobs adviser. Drug users are often sent on rehabilitation programmes. Even education has an element of compulsion: the school leaving age and the national curriculum. Does it make sense to give people choice over activities the state has already decided they should undertake?

When a welfare-to-work adviser engages with a client the framework is set by legislation that requires the job seeker to attend. However, within that setting, as schemes such as Work Directions show,[51] advisers and clients can collaboratively and creatively plan how they will get back to work. Several people we interviewed had been sectioned under mental health legislation but had subsequently recovered only when they had been able to devise a support plan with an adviser. Even where social workers are engaged in high-risk child protection cases joint planning between professionals and mothers brings benefits. In these activities where there is an element of compulsion there is less scope for choice and participation; the state and professionals play a larger role in assessing risk and devising plans. But the scope for participation is not extinguished altogether.[52]

Is a personal budget alone enough?

A personal budget means little without a plan to spend it. Support plans without money to turn them into reality can also mean little. Investing in well-trained people to support budget-holders to develop their support plan will be critical to make self-directed services a success.

A support plan describes what a person wants to change about their life and how they will use their personal budget to make these changes happen. The model of support planning developed by in Control and within the Individual Budget Pilot sites has four elements, outlined in box 2 – clear expectations, a range of ways for people to get support, images of possibility and a review process. Seven key questions are answered in a support plan – starting from ‘what is important to you?’ to ‘what are you going to do to make this happen?’[53]

Box 2 **The in Control model of support planning**[54]

Clear expectations – Expectations about decision-making and the contents of a support plan must be clear and shared between those involved; who makes the plan, and who will take which decisions is included in the plan

Range of support options – Local authorities should ensure that people can get the help they need to put together their support plan

Images of possibility – Use examples of how other people have spent their personal budgets

Review process – A process that considers all of the questions in the support plan is important; this should be proportionate to the person's plan, and to their individual needs

People should be allowed to devise these plans in a variety of ways: some people complete the support plan themselves; most people do so with the help of friends and family; some work with a broker, or advisers from a voluntary organisation; a few choose a local authority social worker; a small minority assign someone to devise the plan for them.

People feel more satisfied with services when they reflect a support plan they have devised *even if* they choose standard local authority services. The process of going through the plan makes people feel more in control. Good support planning is not a one-off event. With self-directed services people can learn, innovate and adapt as they use the budget to get better value for money. All support plans have to be approved by the local authority, which maintains its statutory duty of care and protection. Good support planning benefits the local authority and service providers who have a clearer sense of the services people will need. Support plans make it clearer what is expected of the individual, what risks they manage and what the state and social workers are responsible for.

6 Scaling up

One of the biggest challenges for any innovation is scaling it to reach a mass market. Approaches that work with highly committed staff serving niche markets of enthusiastic early adopters often do not work to reach mass markets of less committed users and workers. The people who enthusiastically start a project are often not the right people to develop it and operate it at scale. Geoffrey Moore, the US management consultant, famously called this challenge 'crossing the chasm': many innovations fall into the chasm between early adopters and the mass market.

This transition particularly bedevils public service innovation. Many localised public service innovations get trapped on location, where they started and fail to propagate to others areas because: the original innovators lack the skills, resources and incentives to spread them; other local authorities or service providers do not have a strong enough incentive or capacity to take them up; or an innovation developed in one locality, a small market town, might not be appropriate to a large urban conurbation. Often central government's attempts to scale up innovation by translating a promising approach into a policy prescription go too far too fast, scaling an inflexible model that is not appropriate in all circumstances. Examples of this are listed in box 3.

Self-directed services in social care are at this critical stage. Out of the 1.7 million people receiving publicly funded social care only 2,300 are on in Control and 43,000 receive direct payments. The first results from the 13 Individual Budget Pilot sites funded by the Department of Health will emerge in the spring of 2008. Already councils across the political spectrum are committed to extending these models to tens of thousands more people over the next few years.

Manchester City Council, for example, plans to have close to 7,000 people on personal budgets within the next five years. Among the fastest-moving local authorities we researched were:

- *Cumbria County Council (no overall control)*: Cumbria is an 'in Control Total Transformation' project site. So far 270 users with learning disabilities have personal budgets; the local authority aims to have 50 per cent of adult social care users, about 7,000 people, on personal budgets by May 2009.
- *Essex County Council (Conservative)*: Thirty users were involved in the pilot when we visited. The council aims to provide personal budgets for all 30,000 of its adult social care users within five to ten years.
- *Hartlepool Borough Council (Labour)*: All those currently receiving direct payments have been given a personal budget. Since December 2007, anyone new to the system and eligible for social care funding has completed a self-assessment questionnaire. Those already using adult care services will be told their individual allocation at their annual review.
- *Hertfordshire County Council (Conservative)*: Thirty-six people have been given a personal budget allocation. Since October 2007 this service has been offered to all those new to the service with learning disabilities. From April 2008 it will be offered to all new elderly users with physical disabilities and new users with mental health problems.
- *Oldham Metropolitan Borough Council (no overall control)*: Personal budgets are available to all those accessing adult social care services. About 864 of the 3,000–4,000 people who use adult care services have personal budgets. All new referrals – close on 3,000 a year – are to go through a self-assessment process. Those deemed eligible for local authority care will develop a self-directed support plan and personal budget.
- *West Sussex County Council (Conservative)*: In mid-2007 West Sussex had about 80 people on some form of personal budget with another 250 about to take one up. The authority caters for about 18,000 people receiving social care and aims for all to have personal budgets eventually. It also hopes its planning and self-assessment tools and support networks will do more for the 40,000 people in the authority who self-fund their care but get no council support at the moment.

Box 3

How scaling innovation can go wrong

The risks that a promising innovation might be scaled up in the wrong way are all too apparent from the experience of direct payments, Individual Learning Accounts (ILAs) and the Care in the Community programme.

Direct payments were introduced in 1997 after a long campaign by disability groups for people to be allowed to control their own budgets and to commission their own care by employing their own staff.[55] *Ten years after they were introduced, however, fewer than 42,000 of the approximately one million people eligible to receive a direct payment did so.*[56] *This low take-up rate was due to a combination of factors: local authority regulations on how the money could be used made direct payments less attractive; some people did not want the responsibility of employing their own staff, and professional resistance to the erosion of their power may also have played a role.*[57] *Too little attention was paid to fostering the conditions to make it easy for people to use them and as a result an innovation that looked promising in principle had disappointing take up in practice.*[58]

If direct payments were stunted by over-regulation, ILAs suffered from the opposite. ILAs were intended to widen participation in learning, particularly by helping those with few skills and qualifications. It offered discounts of up to 80 per cent on course fees and other incentives to take part in courses to improve literacy, maths and technology skills. ILAs were withdrawn in November 2001 after just 14 months in operation, following widespread fraud and abuse. The ILA scheme invited learning providers to market their services to prospective customers, and allowed learners to identify the most appropriate courses for them. But unscrupulous providers defrauded

the system by registering people for courses that did not take place, accessing dormant accounts and enrolling learners without their knowledge, often on non-existent courses. Subsequent reviews of the scheme found that pressure to implement it quickly meant it was inadequately planned and insufficiently funded. Risks in its design and implementation were not actively managed, and adequate monitoring systems were not in place. The department funding the scheme was unaware that 13 providers had registered more than 10,000 accounts and 20 had received payments in excess of £1.5 million.[59]

Community Care, introduced amid much enthusiasm and energy, also ran into significant difficulties early on. The National Health Service (NHS) and Community Care Act 1990 made local authority social services departments responsible for organising and funding support and care in the community to 'enable people affected by aging or disability to live as independently as possible'.[60] *But implementation fell short of expectation – resources were never suitably devolved and the culture of services changed little. In its early days Care in the Community was beset by criticism provoked by high-profile cases of abuse and risk. Lack of coordination between local authorities and health services created confusion and uncertainty over who was taking responsibility for patients discharged from long-stay hospitals. Often people were discharged with little support in the community.*

If self-directed services are to avoid the pitfalls of scaling highlighted by the cases of direct payments, ILAs and Care in the Community, then a well-worked strategy for propagating the ideas needs to be developed. The aim should be to spread a set of operating principles and values that can be adapted to different circumstances rather than a rigid template or operating models. Politicians and policy-makers in central government need to be clear about their role: one danger would be for central government to push an inflexible model too fast. While policy-makers will be mindful of the risks of under-regulation – the lesson of ILAs, the risks of over-regulation – the kinds of controls that held back direct payments are just as significant.

Below we focus on four main challenges of scaling up.

Will supply respond to demand?

Local authority care services are often commissioned on long-term inflexible contracts. In 2004, for example, 272,000 people of working age lived in residential care homes in England.[61] Typically such services are provided either in-house (by the local authority itself) or commissioned for up to three years from a voluntary or private sector provider. As self-directed services spread people are likely to choose different arrangements. Demand for traditional services will decline while demand for more flexible, personalised services based in the community will expand. Will the supply side of providers cope with this transition? Without the guarantee of long-term council income, some capital-intensive services may collapse or close and that might leave less choice for some people.

Exactly how demand will change under personal budgets is not clear. But early indications suggest change will be gradual rather than revolutionary. There will be less demand for residential care homes and day centres and an increase in the demand for personal assistants and informal support.[62] Traditional service providers – public, private and voluntary – will face upheaval and change. Even in areas such as Oldham, where the independent sector is not as highly developed as other authorities, people on personal budgets have not found it difficult to find services to meet their needs from friends, families and networks of support. In West Sussex a large residential care home provider, Adlingbourne Trust, has begun to offer tailored services to individual clients. Public service users are tapping into existing markets they have not previously accessed, like gym membership, dance classes, taxi services, IT training and trampoline classes at the local leisure centre. In West Sussex 70 per cent of elderly people already self-fund

their care; personal budgets will allow people with public funding to tap into the same markets. In Essex the county council is investing to develop the voluntary sector's capacity to respond with new advice and brokerage services. Local authorities will still retain an important strategic role in making sure the local market meets local needs and keeping an overview of quality. Councils will also have to work with users and providers to make sure the market does not become too fragmented and that there is enough demand to support product innovation, for example, in assistive technology.

Workforce reform

The shift towards personal budgets will bring important changes for the social care workforce. People directly employed by local authorities will be less in demand, including social workers. People working more informally, as personal assistants, brokers and advisers, will be more in demand. The shift towards personal budgets will not spell the end of the social worker but it will mean that they will play quite different roles.

Social workers are at the heart of traditional services, assessing need, commissioning services and managing risk. Self-directed services put the individual at the heart of decision-making. Early experience with in Control and Individual Budget Pilot sites shows that people generally need three kinds of support: advice to shape their support plan, which they often get from peers, family and friends but also sometimes from trusted professionals; personal support and services, which they often buy from the local market from people they trust but who do not have formal social work qualifications; and specialists with skills they value because they have a particular condition. If personal budgets were to become the norm across all of social care the social work shift – since 1993 – to care management might well be reversed.

That poses a challenge for local authorities on two fronts. First, they will want to ensure the local labour market creates personal assistants and care workers with the skills and quality that people want. Second, there may still be a need for social workers and social work skills, but the role of the social worker will change.

Social work as a profession is suffering from a malaise of low esteem and recruitment. Social workers complain they feel disconnected from their 'therapeutic' role and unable to deliver on the person-centred values and goals that initially drew them to the profession. Social workers have become risk managers, gatekeepers and controllers. Their scope for exercising judgement and discretion has been limited by rules and lack of resources. The mismatch between the role social workers want to play and the day-to-day reality of social work is a breeding ground for cynicism, disaffection and demoralisation. This is another symptom of the crisis infecting the social care system. Vacancies in social work in 2003, the latest date that figures are available, were running at twice the average for the economy as a whole. Fewer older people's homes can meet minimum staffing requirements, and about one in four residential homes cannot recruit sufficient staff.[63]

Self-directed services offer a way for a smaller workforce of social workers to play a more creative role as:

- *advisers*: helping clients to self-assess their needs and plan for their future care
- *navigators*: helping clients find their way to the services they want
- *brokers*: helping clients assemble the right ingredients for their care package from a variety of sources
- *service providers*: deploying their therapeutic and counselling skills directly with clients
- *risk assessors and auditors*: especially in complex cases and with vulnerable people deemed to be a risk to themselves or other people
- *designers of the social care system as a whole*: to help draw together formal, informal, voluntary and private sector providers[64]

Already, there are about 5.8 million informal carers in England.[65] In the UK as a whole the informal care workforce is saving the economy care costs equivalent to the cost of a second NHS.[66] When people switch to self-directed services many of the roles outlined above – broker, adviser and navigator – are carried out by family members, friends or the voluntary sector. In Western Australia, local area coordinators act as advisers, advocates and brokers helping people to meet their social care needs; very few of the 70 coordinators are social workers.[67]

Capacity to manage change

There is a danger that policy-makers and politicians at all levels underestimate the scale of change involved in moving to self-directed services. The risk is that they will see it as a quick fix to move people to personal budgets without adequate support planning, staff training and communication. In one authority we visited with ambitious plans to make personal budgets the norm the manager in charge of the programme was running it part-time. Self-directed services will throw up challenges. Some people will get less money than they expected and will be unable to commission the services they have been used to getting. Staff will have to change the roles they play. New processes and financial systems will be needed. To be successful local authorities will need to invest in the organisational and political capacity for change.

Organisationally, every authority we visited emphasised the importance of communication and cultural change, particularly among staff members who will have to relinquish more control to users and work collaboratively with them. Oldham, one of the authorities to have gone furthest, has invested heavily in staff training and communication to encourage people to help clients to make choices to help themselves rather than controlling services themselves. The team in Oldham also involved the council's finance department from the outset to make sure financial systems for allocating budgets were sound and the cost savings were well understood. This built up support for the change within the council. In Sheffield, budgets will not be implemented until 12 working groups – made up of a mix of service users, family carers, local authority staff and external experts – have developed a detailed plan.

Political buy-in is also critical to help managers handle the inevitable risks involved in such a transformation. In every authority we visited that had pioneered this approach it was led by an alliance between senior managers and politicians who believed in it because they thought it was the right approach, not just because it saved the council money. The biggest risk is that the switch to self-directed services is just seen as a cost-cutting measure. In St Helens, for example, garnering political support has proved a challenge because politicians are concerned about possible fraud and believe that the authority should still exercise its duty of care. In Cumbria the cabinet member for adult social care has personally explained personal budgets to colleagues as part of a broader personalisation agenda for social care, and as a solution to the challenges of delivering care in a rural setting.

Self-directed services will work only as the product of a collaborative innovation involving a variety of players in a community. The national Concordat on the future of social care published in December provides the framework for that to happen at a local level where politicians and policy-makers need to frame and articulate how systems will change in a way that staff, providers and users of social care understand and appreciate, and set out how local authorities, the voluntary sector and private sector providers will share responsibilities.[68]

Proving the value

Innovation cannot be sustained unless its value can be proven. The shift to self-directed services will require a new way to assess local authority performance. The current approach measures the efficiency and effectiveness of traditional services: how a local authority uses its resources to generate more measurable output.

National performance measurement systems, which award social services departments a rating, reward authorities for providing low-cost residential care rather than for keeping people out of residential care and supporting them to improve the quality of their lives. Self-directed services puts a new onus on person-centred measures of success: whether someone feels safe, well, socially engaged and in control of their life.

A new measurement system would have to be built around the outcomes people want from social care rather than the outputs local authorities now measure.[69] Local authorities would have to measure how well people in their locality were using their personal budgets to meet these outcomes, particularly whether they felt healthy and well, more in control of their lives and more socially engaged.

The CSCI is considering making the outcomes in *Independence, Well-being and Choice* [70] the basis for measuring the performance of social care standards across all local authorities. This would be a welcome step towards person-centred measures of outcomes.

7 Where next?

Self-directed services are proving to be a potent model for creating personalised solutions for people at lower cost than traditional, inflexible, in-house services. People are highly committed to making their support plans work and getting better value for money from the public money they spend. As demand for personalised solutions increases and public service budgets remain tight the case for innovative solutions will become stronger. The success of self-directed services and personal budgets in social care will attract the attention of people engaged in other public services that face similar problems.

Self-directed services certainly will not work in every setting. Some services such as national defence are public goods: the value one person gets from them does not reduce the value to someone else; if one person has access to the service it is difficult to exclude someone else. Other services, like waste collection, are more like natural monopolies, they are best provided on a collective basis. Then there are other services that require professional expertise – acute and emergency health care – where self-directed support plans make little sense. Still other services are no more than transactions that need to be conducted as quickly and effectively as possible: getting a new passport or driving licence. Many aspects of public services can be reformed and improved without introducing personal budgets.

Yet where the service in question will merit from a personalised approach that will mobilise the person involved as a participant in its production there will be huge scope for self-directed services and personal budgets. These pay-offs will particularly apply where people can mobilise their own knowledge and resources to make the service more effective or where – as in long-term health care, education and mental

health – their own attitude and behaviour is a critical factor. At their best traditional services deliver solutions to people who are the recipients of the service. At their best self-directed services motivate people to find and provide their own solutions to their distinctive needs.

Self-directed services have six main components:

- a personalised support plan that reflects an individual's ambitions for their life based on an early indication of the budget available
- access to sources of support and advice, perhaps from a personal adviser, to help them draw up their plans
- a personal budget devolved to them or to a personal adviser working with them, with as few restrictions as possible on what it can be spent on as long as it is legal and makes a clear contribution to the goals of the support plan
- the ability to mix formal and informal services and support in the community
- new measures of success which show how person-centred measures of outcomes related to quality of life contribute to overall public policy goals
- light-touch oversight by the local authority to ensure the money is well spent, fraud is rooted out and risks are well managed

Those ingredients can be applied to many other areas of public spending, from health and education to employment. Below we set out some areas where the government should start to develop self-directed services solutions. In many areas services have been developed that embody some of the principles of self-directed services: service-users co-design solutions with professionals; budgets are broken down to an individual level; and solutions can be commissioned from voluntary, informal and public services sources. The government should build on these initiatives to launch rapid prototyping pilots, incorporating the six principles above, to test the scope for shifting more people onto self-directed services.

Personal budgets for maternity services

A recent Healthcare Commission report found widespread dissatisfaction among mothers with the maternity services they had received from the NHS.[71] The commission interviewed 26,000 women who gave birth in January and February 2007. The survey found that 43 per cent did not always see the same midwife even though NHS trusts are committed to providing continuity of care through using the same midwife during the course of a pregnancy; 43 per cent were not offered the option of a home birth even though NHS trusts are meant to provide that choice; 36 per cent were not offered the chance to attend antenatal classes; and 24 per cent did not see a midwife as often as they wanted to after giving birth. At present, just 2 per cent of women give birth in the home, although demand is far higher. Not only that, home births are considerably cheaper than births in a hospital.[72] Maternity services would be a natural candidate for self-directed services. Mothers have strong incentives to spend their budgets wisely. They have detailed knowledge about what they want and need. Informal and peer support and advice is readily available. Non-NHS support and services can be used to complement traditional services.

The government should launch a set of pilots for self-directed maternity services in which expectant mothers are allocated personal budgets to devise support plans they can commission and oversee.

Personal budgets for job search and employment

The most successful job search services are partially self-directed services. Work Directions, for example, supports long-term unemployed people, single parents and those not working due to ill-health or disability to get back into work by taking a personal approach which recognises that many different factors might affect someone's motivation and ability to find work, from their skills and attitudes, to their health and well-being. Clients work one-to-one with a Work Directions adviser who seeks to understand in depth why they are unemployed, collaboratively develops plans, and supports

them to get back to work. The adviser's brief is to do 'whatever it takes' to get someone back into work and they work with that person to decide how best to spend the budget they have available to meet their goals. Work Directions runs a number of programmes across the UK including Employment Zones to reduce unemployment levels in 15 of the most deprived areas in the UK. About 25,000 clients are expected to go through this programme over five years.[73]

The government should launch a series of pilots to test whether, where and for which groups self-directed services based on personal budgets and intensive mentoring will deliver better outcomes than traditional job search services.

Drug user and offender rehabilitation

Self-directed support plans would make sense for ex-offenders and drug users committed to finding work and improving the quality of their lives. One example is Lifeline's services for drug users, which focus on intensive person-centred planning to shape the support they get. Lifeline started in 1971 as a day-centre for drug users in Manchester. Now it works in a diverse range of settings across the UK to relieve poverty, sickness and distress among people affected by drug use.

Lifeline's person-centred approach looks at every facet of a person's life – their housing, health and educational needs – as well as their drug habits. It aims to provide a flexible range of services beyond the traditional offerings, which focus on either crime reduction or drug replacement. Lifeline, for example, was able to assist one drug user with gym membership, something that kept him motivated. Internal reviews of Lifeline's performance show that it treats more people than traditional in-house services that offer drug replacement programmes with fewer staff, and produces better outcomes. Users report being more confident, better able to deal with mental illness and to steer clear of crime, especially if they are offenders who have recently come out of prison. Local citizens report too that Lifeline offices keep drugs users off the streets, because it provides somewhere interesting and stimulating for them to go.[74]

Services for drug users and ex-offenders are expensive and yet they still suffer from high failure rates and recidivism. In both cases the most effective long-term solutions build on an individual's motivation to change their life: this is a prime area for experiments with self-directed services.

Young people not in education, employment or training

In social care, self-directed services first proved themselves by working in the margins with the most vulnerable people with intense and complex needs. The same may be true for education and training: the biggest benefits of self-directed services might first come with young people who are the least engaged: those not in education, employment or training, the so-called Neets. The Connexions services in Hertfordshire, for example, are pioneering a personalised approach to Neets. The pilot, which started in late 2006, gives Connexions personal assistants a budget to spend on quick, effective solutions to get young people into education, employment or training, based on an action plan drawn up with the young person. A simplified common assessment framework is used to assess the young person's situation, create a plan and allocate a budget. The young people are not told the amount of funding they could be assigned to avoid outlandish demands, and care is taken to make sure Connexions does not pay for services that are already provided by other organisations, such as schools. The personal assistants make the purchases on the young person's behalf, such as gym passes and transport cards, clothes for interviews and basic hygiene assistance, counselling and life skills courses and vocational training.

Staff members say the approach allows them to solve problems more quickly and identify unmet needs; it also encourages innovation and increases job satisfaction. Young people say developing the plan with their assistant gives them a sense of control over what support they get. On average Connexions spent £618 per young person between September 2006 and March 2007, lower than expected, and it developed its

own tools to map an individual's progress. By March 2007, 86 per cent of the 51 young people who were Neet when they joined the pilot had progressed into education, employment or training. In 2007 the scheme was being rolled out across Hertfordshire.[75]

In the long run the government's commitment to introduce more personalised approaches to learning that engages children and parents may only really deliver if they embrace some element of self-directed services, combined with personal budgets, at least for children in the later stages of secondary education.

There are several options. One would be to focus on the hardest-to-reach children in education, those repeatedly excluded and in pupil referral units. Many authorities now question the value of these units that group together young people excluded from school often in expensive accommodation. Distance learning and home-based services are one alternative. The Department for Children, Schools and Families should commission a series of pilots to test self-directed services for pupils excluded from school, and those with complex needs and behavioural issues. A second option would be to provide personal budgets for parents who want to commission an alternative form of education, focusing on particular skills or experiences, for example for children with a particular skill or passion who cannot get the right support in a large secondary school. A third option would be to give every child in secondary school a notional budget for part of their education every term – say a week a term – to invest in the kind of learning they want. This would prepare children in secondary school to become investors in learning in later life.

Long-term health conditions

Many of those receiving a personal budget for social care also have a long-term health condition for which they need NHS services. Yet the NHS only rarely allocates services through personal budget. In one case we came across a young person with physical disabilities who had been receiving a personal budget but when he became eligible for NHS care the budget was taken away from him. Yet long-term conditions that are an increasing strain on NHS services are a natural candidate for self-directed solutions.

The NHS spends large sums on continuing care in parallel with the social care system. The NHS contribution to long-term care for older people in England was £3 billion in 2003.[76] The NHS spends £2.6 billion on learning disability related services.[77] Continuing care for people with mental health issues accounts for £384 million.[78] Together about 10 per cent of the NHS budget is spent on continuing care and so might be ripe for self-directed solutions, especially for people with long-term conditions that would benefit from improved self-management.[79] Diabetes costs the NHS about £1.3 billion a year.[80] The Department of Health estimates that every £100 invested in improved self-management of the condition yields savings of between £350 and £400.[81]

One model for this is Cash & Counseling, a self-directed care programme run by Medicaid in 15 US states for individuals and families with low incomes.[82] The programme is based on a controlled experiment in Florida, Arkansas and New Jersey between 1998 and 2002. Cash & Counseling provides Medicaid consumers who have disabilities, are elderly or are parents of children with disabilities the option to manage a flexible budget and decide for themselves what mix of goods and services will best meet their personal care needs. They can use their budget to hire their own workers, who may be friends or family members, and purchase goods and services, with the aim of allowing them to live independently.[83] Cash & Counseling allows consumers to use their allowances to modify their homes or vehicles or to purchase items that help them live independently. Compared with a control group, Cash & Counseling reduced participants' unmet needs for care and helped them maintain their health. It also significantly improved the lives of their primary caregivers, usually spouses or close relatives. The 556 participants in New Jersey purchased items in 25 different categories – from directly hired workers and household appliances to therapy and massage – many of which would not have been available through traditional channels.[84]

Initial concerns about possible Medicaid fraud and increased costs proved unfounded. Three states found that Cash & Counseling could be implemented without costing substantially more than traditional services.[85] In 2007 the programme was being rolled out to 12 more states.

Mental health

The NHS also spends large sums on mental health services. One in six people experience some kind of mental health problem during their life and one in a hundred are diagnosed with a problem so serious it demands treatment. In 2005/06 about £4.7 billion was spent on mental health services for adults of working age in England, £3.8 billion of it on direct services provision; compared with any other kind of illness, mental health is particular and recovery depends on personal factors. Formal policy states that services should reflect individual needs. The reality, according to a recent Healthcare Commission survey, is that a majority of people do not feel involved in shaping their care. Only 0.1 per cent of mental health spending is distributed in the form of a direct payment. One estimate suggests that at least a quarter of the mental health budget – about £1 billion a year – could be distributed through self-directed services.[86]

One model for this approach is the Empowerment Initiatives Brokerage (EIB) in Oregon, which is run *by* people who have recovered from mental health conditions *for* people with mental health conditions.[87] In addition to traditional clinical services, the county mental health departments provide budgets of $3,000 (£1,555) to about 50 individuals with persistent mental illness a year to support their recovery to live independent lives and participate in their communities without being dependent on specialist services. The brokerage aims to kick-start the recovery and over a year to move people towards independence, in line with the self-directed plans they have drawn up.

The brokerage recognises that mental illness affects many facets of a person's life and that someone's mental health can be improved by art therapy or meditation as much as by medication. At the start of the 12-month programme a participant is assigned a resource broker who works with them to identify goals in each of six areas – personal health, productivity, hobbies, environment, personal relationships and spirituality – and then organise support, ranging from medication to art therapy, sport and meditation. The brokers help individuals navigate the public system to access other sources of financial support and free community resources, thereby multiplying the impact of the money the brokerage is able to provide.

Participants and brokers stress that the scheme's success depends on the combination of personal goal setting, broker's support and knowledge, and personalised budgets. Brokers are usually peers with a personal understanding of mental illness and the mental health system.

Several mental health trusts in England are thinking of experimenting with elements of self-directed services but they need encouragement from central government to take the risks involved. The government recently announced new funding for mental health services in recognition of the increasing damage done by depression, anxiety and mental illness. The government should now launch a series of pilots of self-directed services and personal budgets for people receiving public services to help them deal with mental health issues and depression.

Supporting families at risk

Many local authorities estimate much of their demand for public services – social services, housing, police and community safety – comes from a small number of 'chaotic' low-income, extended families in which adults are not in employment, have few qualifications and single parents bring up children with little support. No single public service can address all the needs of these families, which claim a disproportionate share of public resources from multiple departments. A new kind of public service worker – who could address their complex needs, form with them a plan for improvement and use a flexible budget

to enact that plan – might make a difference. This new kind of public service worker would be in a position to pool and coordinate budgets and services from several different sources. One model for this approach is the system of the 'Local Area Coordinators' created in Western Australia to help people with learning disabilities.

Local area coordinators (LACs) have been working in Western Australia since 1988 with the aim of building supports and services around people with learning disabilities in their local communities and giving people choice and control in their lives. Each coordinator works with about 60 clients offering support and practical assistance to families to help clarify their goals, strengths and needs and access local support that will help them meet their goals. When someone with a learning disability approaches the LAC for help they first seek to understand the nature of the needs and devise a plan together, which minimises reliance on professional services. The last option that someone is offered is a visit from a social worker. Since 1992, all funding for people using LAC services has been individually allocated. A sum of up to $3,000 can be given as a one-off payment to an individual without an agreed plan.[88]

Subsequent funding is linked to an approved plan, which is reviewed annually. In 2002/03 about Aus$10.4 million of recurrent grants were given to 1,437 people, and Aus$1 million was distributed as untied grants. LACs are encouraged to focus on building people's capacity to help themselves rather than distributing money. A number of evaluations of the programme have shown it to be a success with low cost and high levels of consumer satisfaction. It has since been taken up in Queensland, New South Wales and the Northern Territory, and has also been implemented in metropolitan areas.

LACs work with people with complex needs to assemble packages of support which make sense for them. A model that was first developed in Australia for families with disabilities could bear fruit in the UK if applied to chaotic families with complex needs of a different kind. This is already being piloted in some parts of Scotland.

8 The politics of participation

Self-directed services create a new way to link the individual and the collective good: people who participate in creating solutions that meet their needs make public money work harder and help deliver public policy goals. Self-directed services work because they mobilise a democratic intelligence: the ideas, know-how and energy of thousands of people to devise solutions rather than relying on a few policy-makers to come up with the best approach.

That matters because we need a new way to create public goods. Increasingly the state cannot deliver collective solutions from on high: it is too cumbersome and distant. The state can help to create public goods – like better health – by encouraging them to emerge from within society. Public goods are rarely created by the state alone but by cumulative changes in private behaviour supported by public services.

The chief challenge facing government in a liberal and open society is to create public goods – like a well-educated population, with an appetite to learn, an elderly population that feels well cared for – in a society with a democratic ethos, which prizes individual freedom and wants to be self-organising and 'bottom-up'. Government cannot define the public good and impose it from above, at least not continually. Nor can it stand back and accept whatever emerges from a mass of individual choices. Government's role is to shape freedom: getting people to exercise choice in a collectively responsible way and so participate in creating public goods. Self-directed services provide a working model for just that: how to shape people's choices to promote socially beneficial, collective outcomes.

Public service productivity should rise because highly participative services mobilise users as co-developers of services, multiplying the resources available. Participation allows solutions to be more effective because they are

tailored more to individual needs and aspirations; people have to share responsibility for outcomes and devote some of their own inputs. Participation is the best antidote to dependency if people are equipped with tools so they can self-provide and self-manage rather than always rely on professional solutions. Participative approaches are not only vital to create more personalised versions of existing services – like health and education – but also to address emerging needs and issues – such as recycling, community safety and long-term conditions – where public outcomes depend on motivating widespread changes to individual behaviour. Participative public services connect the individual and the collective in new and far more powerful ways than seeing people as taxpayers, occasional consumers and even more infrequent voters.

The modern industrial-scale public sector depends on mass institutions – schools, hospital, prisons and day care centres – which provide services such as education, health and policing on a mass scale. These universal systems aspire to deliver services that are fair and reliable. Yet that in turn requires codes, protocols and procedures, which often make them dehumanising and harsh. Instead, public institutions and professionals should educate us towards self-help and self-reliance as much as possible. Public service should carry with it an invitation to people to participate, to make their contribution.

Encouraging people to participate more in the delivery of public services and the creation of public goods has long been an aspiration of both the left and the right, albeit in quite different ways.

The right attacks the dependency culture of long-term reliance on state support, distrusts the capacity of public servants to design effective solutions and believes that individuals can often do things better for themselves. The right's recipe has been to advocate the introduction of individual vouchers and internal markets to turn service users into consumers. This is too narrow and individualistic a view of what motivates people. People do not just want to become consumers in a public service mall; often they want a service that takes them into account, gives their needs recognition. Critics argue that this consumerist approach will undermine the shared basis for services that makes them more egalitarian than the market.

The left's approach to participation focuses on the role of the citizen. The distinctive feature of public services is that they are the collectively funded products of democratic choices. The left argues that support for public services will be strengthened if citizens have a more direct voice in how they are organised: the state would be more responsive to different needs if it were more open to citizens' views. For many people, however, the left's reliance on citizen voice to reshape services is often too vague a promise. People want a direct say in changing the services they get as individuals. And the reliance on citizen-voice as a means to improve services often favours the most articulate consumers who are able to argue their way to better service, which can widen inequality.

Left and right offer people a choice between becoming a consumer or a citizen. Self-directed services based on personal budgets overcome the shortcomings of both by focusing on the role people play as participants in taking control of their own lives. In self-directed services people have real choice over the services they get but they are not just consumers.

Our research shows that self-directed services are compatible with a smaller direct role for the state, combined with greater individual choice, more personalised services *and* increased equity. In social care the left's traditional approach to equity has failed. Equity means people with similar needs should get a similar quality of public service regardless of their ability to pay. Institutionalised solutions often deliver the same poor-quality services to people who have very different needs.

Personal budgets create a much fairer match between the money being spent and a person's need. Personal budgets open up access to services to people who do not want a 'state' service. In Oldham personal budgets have been taken up enthusiastically by disadvantaged minority ethnic groups who use traditional public services least. The greatest inequity in social care is the gap between those who can afford to self-fund their care and those who have to rely on poorly performing public services. The majority who self-fund already have some choice and freedom; those dependent on public services have little. Personal budgets offer state-funded clients the choices currently available only to the middle classes outside the system, which closes the biggest equity gap in the system rather than widening it. Self-directed services can be good for equity, extending individual choice within a fairer overall framework for provision.

Appendix 1

This data set is used to inform the figures cited in chapter 4.

The cost of a care package before and after a personal budget

Local authority	Users	Traditional services	Personal budgets
Barnsley	11	—	—
		£17,030	£13,110
		£17,030	£21,762
		£17,030	£7,120
		£17,030	£11,570
		£16,872	£13,172
		£3,000	£2,848
		N/A	£5,200
		£52,000	£40,820
		£16,433	£40,820
		£16,433	£37,050
		£16,433	£9,684
		£26,000	£40,820
		N/A	£25,376
		N/A	£10,700
Average Barnsley		**£19,572**	**£21,707**

Local authority	Users	Traditional services	Personal budgets
Cambridgeshire	6	—	—
		N/A	£38,000
		£4,500	£36,000
		£113,463	£55,000
		N/A	£20,000
		£4,500	£36,000
		£16,640	£18,500
		£4,500	£26,000
		N/A	£11,000
		£17,000	£27,000
		N/A	£12,000
Average Cambridgeshire		**£26,767**	**£33,083**
City of London	4	—	—
		£28,000	£54,000
		£10,400	£10,400
		£17,340	£17,340
		£8,565	£8,565
Average City of London		**£16,076**	**£22,576**
Kensington & Chelsea	13	—	—
		£8,872	£9,100
		£9,713	£9,880
		£1,183	£2,652
		£13,000	£12,012
		£11,949	£13,052
		£3,224	£3,952
		£6,968	£6,500
		£11,440	£9,360
		£4,992	£6,500
		£4,736	£3,952
		£10,056	£3,952
		£3,380	£6,240
		£1,352	£2,080
Average Kensington & Chelsea		**£6,990**	**£6,864**

Local authority	Users	Traditional services	Personal budgets
Lambeth	8	—	—
		£35,000	£66,250
		£14,240	£19,150
		£44,000	£30,050
		£110,000	£54,250
		£110,000	£112,000
		N/A	£21,250
		£44,831	£55,000
		£81,157	£54,250
		N/A	£15,000
		N/A	£20,000
		N/A	£20,000
		N/A	£15,000
		£70,000	£49,000
Average Lambeth		**£63,653**	**£54,994**
Lancashire	31	—	—
		£41,076	£55,071
		£68,412	£68,779
		£11,755	£27,497
		£44,793	£55,910
		£67,000	£39,827
		£17,109	£9,820
		£16,708	£15,058
		£17,109	£9,820
		£43,000	£21,958
		£43,000	£21,958
		£26,900	£27,497
		£19,000	£27,497
		£43,179	£27,497
		£19,000	£27,000
		£38,000	£20,000
		£38,000	£20,000
		£22,474	£30,054
		£28,500	£30,054

Local authority	Users	Traditional services	Personal budgets
Lancashire (contd)	31	—	—
		£32,613	£18,314
		£116,560	£74,182
		£127,445	£74,182
		£38,856	£26,880
		£23,437	£13,440
		£14,108	£10,258
		£15,082	£13,440
		£22,669	£10,258
		£40,523	£54,722
		£49,929	£35,841
		£29,890	£35,841
		£47,146	£35,841
		£19,849	£13,440
Average Lancashire		**£38,165**	**£30,708**
Newham	2		
		£10,275	£22,500
		£73,887	£90,548
Average Newham		**£42,081**	**£56,524**
Norfolk	9		
		£54,500	£37,881
		£54,500	£34,209
		£24,000	£14,000
		£15,500	£23,500
		£20,331	£21,000
		£30,000	£24,000
		£30,000	£15,260
		£67,000	£67,000
		£3,200	£6,500
Average Norfolk		**£33,226**	**£27,039**
Northamptonshire	13	—	—
		£36,142	£29,563
		£48,593	£24,782
		£34,632	£23,430
		£37,524	£28,663
		N/A	£9,912
		£8,562	£19,671
		£22,687	£23,720
		£22,687	£23,720
		£12,131	£22,980
		N/A	£18,924
		£37,154	£21,177
		£35,827	£25,956
		£10,466	£14,733
		£21,486	£19,825
		£38,792	£19,825
Average Northamptonshire		**£28,206**	**£22,927**
Staffordshire	5	—	—
		£10,450	£16,558
		£10,908	£10,714
		£10,908	£11,931
		£11,180	£5,899
		£10,908	£7,061
		N/A	£53,900
Average Staffordshire		**£10,871**	**£10,433**
Total average across all local authorities	**102**	**£29,683**	**£26,621**

These data were collected from the local authorities above between 2006 and 2007. They indicate the cost of care for individual service users, when on a personal budget, and how much the same person's package cost before they were given a personal budget.

Not every individual has before and after costs, as some went straight on to a personal budget when they first entered the social care system and so we do not have any before cost calculations. Only where before and after costs are available do we include them in the average calculations.

Appendix 2

Generalised comparisons on cost of a care package before and after a personal budget

Table A is based on estimations made by local authorities, and are a representative set of actual costs of traditional services. They have been used to help calculate the appropriate levels of personal budget allocations. However, each local authority had slightly different methods of calculations and some of the data are from the financial year 2006/07 and so probably understate the current position. Table B contains the actual costs of individuals currently holding personal budgets within these local authorities.

Unlike the data set provided in appendix 1, these data do not provide direct before and after costs for individuals with personal budgets, although they do provide a good general indication of a before and after comparison.

Table A

Before personal budgets – indicative costs across nine local authorities

Cambridgeshire

£4,500 £113,463 £17,000 £4,500 £16,640 £4,500

Lambeth

£35,000 £14,240 £44,000 £110,000 £110,000 £70,000 £44,831 £81,157

Kensington & Chelsea

£8,872 £1,352 £9,713 £1,183 £13,000 £11,949 £3,224 £3,380 £6,968 £19,065 £11,440 £4,992 £4,736 £10,056

Norfolk

£54,500 £54,500 £24,000 £15,500 £20,331 £30,000 £30,000 £67,000 £3,200

West Sussex

£18,886 £4,697 £2,889 £2,600 £2,889 £19,222 £6,505 £1,703 £2,889 £7,950 £1,703 £3,760 £7,609 £1,867 £4,333 £2,800 £16,341 £4,624 £2,972 £12,628 £7,950 £4,828 £8,171 £2,633 £1,919 £1,539 £7,349 £6,505 £3,444 £5,777 £1,508 £2,642 £9,394 £8,325 £6,449 £8,666 £4,719 £681 £4,333 £2,870 £2,126 £9,243 £4,333 £5,404 £13,010 £4,397 £7,349 £10,838 £1,703 £8,073 £7,439 £2,889 £5,616 £32,760 £22,932 £22,360 £8,320 £16,026 £5,408 £7,020 £8,357 £6,552 £20,220 £20,220 £4,333 £2,889

Table A

Before personal budgets – indicative costs across nine local authorities (contd)

Barnsley

£17,030 £17,030 £17,030 £17,030 £16,872 £3,000 £26,000 £52,000 £16,433 £16,433 £16,433 £16,433

City of London

£28,000 £10,400 £17,340 £8,565

Staffordshire

£10,450 £10,908 £10,908 £11,180 £10,908

Newham

£10,275 £73,887

Total cost	**£2,001,723**
Average cost	**£15,887**
Sample size	**126**

Table B

Personal budget costs

Cambridgeshire

£38,000 £36,000 £55,000 £20,000 £36,000 £18,500 £26,000 £11,000 £27,000 £12,000

Lambeth

£66,250 £19,150 £30,050 £54,250 £112,000 £21,250 £55,000 £54,250 £15,000 £20,000 £10,000 £20,000 £15,000 £49,000

Kensington & Chelsea

£6,708 £9,100 £11,440 £9,880 £2,652 £12,012 £13,052 £3,952 £7,800 £6,500 £14,300 £9,360 £6,500 £3,952 £3,952 £18,772 £6,240 £5,200 £2,080 £2,600

Norfolk

£37,881 £34,209 £14,000 £23,500 £21,000 £24,000 £15,260 £67,000 £6,500

West Sussex

£18,886 £4,680 £5,720 £5,200 £2,600 £5,200 £5,200 £2,600 £4,420 £13,000 £6,240 £18,200 £8,611 £4,680 £3,744 £5,200 £9,360 £12,636 £7,137 £8,079 £6,230 £13,093 £11,421 £7,800 £4,670 £5,571 £5,824 £6,407 £4,642 £4,680 £8,320 £8,320 £7,280 £3,640 £3,640 £8,320 £5,824 £7,800 £2,080 £4,610 £3,182 £11,003 £9,720 £7,745 £13,853 £6,131 £7,290 £4,680 £10,036 £8,060 £6,622 £6,136 £6,256 £6,926 £7,661 £4,586 £18,533 £7,521 £6,365 £21,528 £10,295 £19,656 £11,606 £20,592 £7,285 £3,827 £17,406 £11,441 £5,493 £7,487 £15,879 £12,432 £5,842 £17,829 £8,218 £15,714 £12,730 £15,043 £7,800 £12,480 £17,829 £8,357 £16,436 £10,416 £10,577 £7,394 £16,018 £4,457 £18,818 £293 £6,964 £2,392 £1,144 £1,508 £832 £2,028 £1,456 £1,560 £1,196 £1,144 £1,716 £1,248 £1,872 £1,222 £1,196 £832 £832

Table B

Personal budget costs (contd)

Barnsley

£13,110 £21,762 £7,120 £11,570 £13,172 £2,848 £5,200 £40,820 £40,820 £37,050 £38,350 £9,684 £40,820 £25,376 £10,700

City of London

£54,000 £10,400 £17,340 £8,565

Staffordshire

£16,558 £10,714 £11,931 £5,899 £7,061 £53,900

Newham

£22,500 £90,548

Total cost	**£2,682,112**
Average cost	**£14,343**
Sample size	**187**

Notes

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26 These are initial findings from the earliest wave of people transferring to personal budgets and comparisons with traditional services are not straightforward. Local authorities find it difficult accurately to estimate the cost of an individual's care package when it has to be disaggregated from a block contract and to ensure that all elements of a traditional service are included in the cost (for example the cost of transport to day care centres).

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85 See www.cashandcounseling.org/about (accessed 15 Nov 2007).

86 Alekson, *Putting Patients in Control*.

87 For an overview see www.disabilitycompass.org/product.php?id=8686 (accessed 19 Dec 2007). See also Ibid.

88 From a presentation to Demos by Eddie Bartnik, Sep 2007.

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