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This edition of *Research, Policy and Planning* provides four interesting papers that focus on various aspects of some of the current challenges in providing health and social care (in the main to adults) in the UK, that is:

- the views of service users and carers of developments in mental health service provision
- the use of service users' self-assessment to allocate equipment and adaptations in adult social care
- a critique of the development of personal budgets as a vehicle to empower social care service users
- the design of a new set of social care eligibility criteria that will result in the fair allocation of resources to meet adult social care needs.

Brenda Roe and colleagues report on a study conducted in two English mental health services NHS trusts of the views of service users, carers and staff of service developments. Transformational change in service provision is a key priority currently and this paper presents analysis of how these key stakeholders believe services should develop, namely a move away from traditional models of psychiatric care to more integrated person-centred community care which focuses on recovery, rehabilitation and self-care.

Sue Tucker and colleagues present the findings of research into the service user's use of self-assessment to assist in the allocation of equipment and adaptations in adult social care. As they observe, little work has been published thus far on the effectiveness of self-assessment. Their paper looks to address five key questions: how might self-assessment be employed; who is self-assessment suitable for; what services should be provided via self-assessment; what does self-assessment cost; and, fifthly, how satisfied are service users with self-assessment? They conclude that there is a need: for clarity of what is meant by self-assessment and the roles to be played by any facilitators / mediators in the self-assessment process by service users; for clarity over the purpose of self-assessment, not least whether it is intended to substitute for or complement traditional professional assessment processes; to provide alternative arrangements for those service users who will find it difficult to self-assess; and, for an appraisal of the potential costs and benefits of introducing or expanding the use of self-assessment.

Peter Beresford presents a topical piece on whether personal budgets (PBs) in social care empower service users and, if they do not, what the purpose and effects of their promotion are. For Beresford, there is a need to critique the promotion of PBs as the mechanism to promote greater flexibility, choice and control as well as greater efficiency. Beresford states that the mechanisms used in the implementation of PBs are bureaucratic, reduce eligibility and levels of support in terms of cash/budget size, and do not provide service users with sufficient support to manage their PBs. In addition, local authorities are responding to the policy imperative in such differing ways as to create a 'postcode lottery' of social care provision and, in addition, one in which some local authorities are simply rebadging adult social care arrangements as a PB in order to meet central government targets for PB take up. Beresford expresses his disappointment that the development of PBs has not built on the positive work associated with the implementation of direct payments, that is being predicated on the social model of disability, service users being in control, and with the wider aims of social inclusion and service users' full and equal participation in society. In order, therefore, that the (at best) ambiguous development of PBs and personalisation is to be truly progressive, Beresford argues it will need to associate itself more closely with the principles of independent living and the disabled people's movement.

Colin Slasberg presents the case for a new eligibility framework to be used to aid the allocation of social care resources to service users. He acknowledges that there is a need for an eligibility framework due to finite resources and the need to ensure that rationing is fair, transparent and effective. In his paper, he describes why the current 'Fair Access to Care Services' (FACS) is not fit for purpose. Slasberg then presents a new framework, based on notions of universal human needs which, it is argued, would ensure the fair allocation of resources.

The book review section includes reviews of texts on the topics of: cognitive behavioural interventions for mental health practitioners, child well-being, developing reflective practice in child care social work, professional decision making in social work practice and, finally, courtroom and report writing skills for social workers. All are topical and of relevance to practitioners, researchers and managers. Our thanks, therefore, go to the book reviewers as well as to our reviewers of the four papers in this issue. As ever, the journal would not be possible without their valued contribution. Indeed, we welcome offers from readers of the journal willing to join our review teams as we are always looking to add to these.

Guy Daly

December 2011

Developments in mental health service provision: views of service users and carers

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Abstract

This paper reports on a study in two NHS Mental Health Trusts in England in 2008-2009. Data were collected from staff, service users and carers to inform service and workforce developments. The findings reported relate to service users and carers and concur with staff views. They relate to modernisation of services, the challenges of a multiplicity of stakeholders and organisations, as well as the need to involve users and carers in developments. The findings resonate with national and local policy with a move away from traditional psychiatric care to integrated person-centred community care with a focus on recovery, rehabilitation and self care.

Keywords: Mental health, service users, carers, service delivery, organisation

Introduction

Development of mental health services has been a policy priority for health services over the last decade in the UK, along with requirements for its workforce (DH 2000, 2004a; DH/Care Services Improvement Partnerships, 2005; NIMHE, 2005; DH, 2006; NHS North West, 2008). An additional stimulus has been provided through the quality review of the NHS with a focus on quality care for all (Darzi, 2008). The more recent cross-government mental health strategy for England makes explicit the focus on mental health services and cross-agency working with prevention, outcomes and recovery for all within populations being requirements (HM Government, 2011 a,b,c).

Mental ill health is a substantial cause of disability accounting for 22.8% of the total burden in the UK compared to 16.3% for cardiovascular disease and 15.9% cancer (WHO, 2008). The economic costs of mental illness in England have been estimated to be

£105.2 billion per year including direct costs of services, lost work productivity as well as reduced quality of life (Centre for Mental Health, 2010). For 2008/2009 the NHS spent 10.8% of its annual secondary healthcare budget on mental health services which accounted for £10.4 billion (DH, 2010). The service costs which included NHS, social and informal care accounted for £22.5 billion in 2007 in England (McCrone *et al.*, 2008).

Relocation of mental health services from hospitals to also include integrated community care, the involvement of service users and carers in design and delivery of services, and the increasing development of evidence-based interventions, have directly impacted on service delivery and the workforce (SCMH, 2001; DH, 2006). For example, increasingly varied service provision and evidence-based care relies on a workforce that engages with a range of agencies across primary care, housing and social services, as well as specialist mental health and learning disability services (Reilly

et al., 2007). In addition, the review of Mental Health Nursing (DH, 2006) acknowledged the implications of new roles for nurses (for example, nurse consultant, modern matron, nurse prescriber, the development of the advanced practitioner), and new ways of working for psychiatrists and psychologists (DH, 2005a). 'Gateway workers' (DH, 2003a), 'support, time and recovery' workers (DH, 2003b), graduate primary health care workers (DH, 2003c) are novel and were further augmented by the requirement for 'talking therapies', such as counselling (HM Government, 2011d). As well as health and social care policy focusing on patients and care outcomes, there has been a drive for greater involvement of service users and carers as well as the empowerment of clinicians to innovate and improve services (SCIE, 2007; DH, 2010).

As part of a joint initiative and collaboration between two NHS Mental Health Trusts and a University partner, a needs analysis was commissioned to inform future workforce development strategies. A systematic review of policy and literature identified key drivers of mental health service provision that related to contextual issues surrounding mental health care services provision, general education and training and mental health specific education (Jinks *et al.*, 2008). Subsequently, the views and perspectives of staff and service user and carer representatives, within the NHS Trusts, on current and future mental health services provision and development were obtained. This paper reports the findings from service users and carers relating to modernisation and service development compared with those from staff perspectives and serves to inform the development of mental health services in context with the policy literature.

Methods

The objectives of this study were:

1. To identify the main challenges for future mental health service provision

and their implications for workforce development and service provision.

2. To explore service user and carer representatives' views on service provision and their future development.

Design

Evaluation research involving iterative working of the project team including service user representation was used. An evaluative framework was adopted which used qualitative research methods, involving semi-structured interviews and focus groups (Polit *et al.*, 2001).

Populations and samples

Samples

Each respective NHS Mental Health Trust partner identified potential purposive samples based on existing organisational service structures and functions and the project timeframe. Key executive director stakeholders from each Trust were identified for interview. Staff who participated in Learning and Development forums as part of the existing consultative arrangements were identified from each of the Trusts to participate in focus groups. Staff were representative of the professional groups providing services employed by the Trusts. Service user and carer representatives who provide user views as part of routine consultations to each of the Trusts were also identified to participate in service user and carer focus groups. Composition of the groups indicated that all the professional groups were represented on the forums and by virtue of being members of the group were committed to service and workforce development. Similarly, members of the service user and carers' forum were committed to improving service delivery.

A potential sample of eight stakeholders who were executive directors responsible for strategic and overall management of each Trust was identified. A potential sample of 120 staff (60 in each Trust) and 24 service user or carers (12 in each Trust) were also identified and contacted to participate in 10

staff focus groups and two service user and carer focus groups (5 staff and 1 service user focus group per Trust). One Trust contacted staff that participated in their Learning and Development forums and members of the service user and carer forum, while the other Trust widened potential involvement and sent out a general initial invitation to all staff via their intranet as well involving members of the service user and carer forum.

Methods of data collection

Data were collected from October 2008 to April 2009 and took place within locations in each of the Trusts. Analysis and write-up was undertaken from May to August 2009. Project management and data collection were undertaken by University staff, with liaison, coordination and access for data collection within each Trust by the respective NHS staff on the team. Invitation letters, project information sheets and informed consent sheets were sent to each potential participant and their willingness to participate in the project was requested by returning a completed slip in a pre-paid envelope or via email.

Interviews

Semi-structured digitally recorded interviews lasting up to 45 minutes were conducted with the key stakeholder directors. Information was collected on their current role, title, qualifications, local and national policy for mental health services organisation and delivery, current provision of learning and development, skills required by staff for future provision of mental health services and challenges.

Focus groups

A series of 12 focus groups were held (5 staff groups and 1 service user and carer group for each Trust), each lasting around an hour. Staff groups were either inter-disciplinary or uni-disciplinary. Participants were drawn from the professional groups employed at the Trusts including: nurses, psychiatrists, occupational therapists, social workers and clinical psychologists. Service users and carers were recruited from the Trusts' service user and carer meetings and their expenses were met and an honorarium available as part of Trust policy.

Two members of the University team acted as lead facilitator (LF) or note taker at each focus group. There are recognised limitations to the use of focus groups such as when more vocal members predominate (Jinks & Daniels, 1999). However, such difficulties can be circumvented by experienced facilitators, as in this study. The focus groups were tape recorded and adhered to recognised good practice (Morgan, 1993; Silverman, 1993; Cresswell, 1998).

Prior to data collection, informed consent was obtained from all participants. Semi-structured guides were used for both sets of focus groups (Figures 1 and 2). Before the staff focus groups were conducted participants completed an anonymous semi-structured questionnaire regarding their job title, location of work, academic and professional qualifications and any organised educational activities they had attended in the previous 12 months.

Figure 1 Questions Used in the Staff Focus Groups

1. What is your understanding of how services are going to evolve over the next five to ten years?
2. What skills do you think you will need in order to deliver these services?
3. How would you prefer to engage in the education/training evolving in order to meet your needs?

Figure 2 Questions Used in the Service User and Carer Focus Groups

1. What skills would you like staff to have?
2. How can we improve the care that a service user would receive?
3. How do you think services should be developed over the next five to ten years?
4. What skills and learning development do you think staff will need in order to deliver these services?
5. From your role in this forum, what do you think are your skills and learning development needs?

Ethical considerations

Ethics approval for the project was obtained via the National Research Ethics Service from a Local Research Ethics Committee prior to commencement of data collection. Research Governance complied with existing University procedures and each Trust's R&D Committees as required by the NHS.

Written informed consent was obtained prior to data collection, to ensure participation in the study was voluntary, and assurance given that data were confidential and identities anonymous. Written informed consent was also obtained for the use of any direct quotes.

Data management and analysis

Data from the staff focus groups relating to participants' job titles, locations of work, academic and professional qualifications and any organised educational activities they had attended in the previous 12 months were collated and reported as frequencies. All recordings were transcribed and thematic content analysis of the qualitative data performed to identify key themes and sub-themes using the initial questions as an analytical framework (Denzin & Lincoln, 1998; Krippendorff, 2004). A minimum of two members of the project team undertook the thematic content analysis to identify the themes. These themes were discussed and agreed by three members of the project team and saturation of the data agreed. The themes

identified relate to both interviews and focus groups.

Reliability and validity

Initial interviews and focus groups constituted pilot work to establish the feasibility of sample recruitment and methods of data collection. No changes were required to either the interview or focus group schedules. Validity was assured during the interviews and focus groups by ensuring lines of inquiry verified the accuracy and consistency of responses. Members of the project team were experienced in data collection methods and analysis, which also contributed to both reliability and validity. Reliability of the analysis was further assured by independent reading of the interview and focus group transcripts followed by discussion and agreement of the themes and sub-themes until saturation was obtained. The non-NHS institutional affiliation of the focus group facilitators and stakeholder interviewer added to the validity and reliability of the analysis and the interpretation of findings (Krueger & Casey, 2000; Wall, 2001).

Findings

The findings reported in this paper relate to the focus groups (FG), in particular those of service users and carers (SUC) and overlap with those of staff (S) related to the themes of modernisation and service developments.

A total of 64 respondents participated in the focus groups (50 staff; 14 service users/carers) giving an overall response rate of 47%. Table 1 shows individual response rates. Due to the different approaches to recruitment/invitation to participate in the focus groups, a valid comparison between Trust response rates was not realistic although individuals expressing an interest did appear to maximise participation.

All clinical areas were represented in the staff focus groups with the majority coming from high secure or forensic services, elderly adult services and acute adult services. Staff participants came from a range of clinical, managerial or administrative roles providing a range of staff from each Trust, with the highest proportions holding nursing, non-professional or operational management roles. Most participants in the focus groups held nursing qualifications and were graduates. Service users and carers were representatives who regularly participated in each of the Trusts' routine involvement and consultation forums.

Modernisation

The theme of modernisation emerged from all respondents. For example, service users and carers articulated concerns about the type of service required in relation to user needs:

... if I ever get admitted again, I want a service that is going to work for me. The service that I want: something that's got more things to do on the ward; more

therapies; more activities; something that doesn't let my brain go stagnant and make me feel more mentally ill... so there's always challenges I think for everyone when they have an illness; it's about maintaining this level and feeling good about yourself I think. (Respondent, SUCFG1)

One service user's comments resonated with this by stating:

Less psychiatry and more psychology. (Respondent, SUCFG1)

In addition, ideas for service re-design were suggested that involved existing services provided by other professionals and organisations:

I'd like to see a new family service for all the people that are affected, not, you know, when somebody becomes ill... there's a lot of grief left behind within the family which needs to be solved. But it needs to be solved by somebody other than the person that's dealing with the patient. You need to give people an opportunity to explore what's happened within the family, how it's affected different members and what the support needs are, particularly with reference to children... a lot could be done in the six, seven week summer holidays for kids with a little bit of support through the education systems which are already there. It's not that we have to set up something new that's going to cost a

Table 1 Response rates for Focus Groups according to Trust

Focus Groups	Trust 1			Trust 2		
	Numbers Invited	Numbers Attended	% Response	Numbers Expressed Interest	Numbers Attended	% Response
1	35	9	26%	7	6	86%
2	12	6	50%	12	7	58%
3	12	6	50%	4	3	75%
4	12	5	42%	7	2	29%
5	14	2	14%	4	4	100%
6	12 *	8	67%	6 *	6	100%
Total	97	36	37%	40	28	70%

Key * = Service User and Carer Focus Groups

fortune, the thing is already there within every education service... You could provide structured activities for young people and children with your junior trainee psychologists, educationalists... to give them a general background... then you will begin to do a lot more so that when the person is being treated... and they're then returning (if that's what's going to happen) to the family, there'll be a lot more of a cushion because people within the family will feel more comfortable about what's happened. (Respondent, SUCFG1)

Some focus group respondents held views on service deficiencies and what users want in relation to psychosocial interventions and talking therapies. (For example, Table 2, quote 1). This view was also reflected in terms of striking a balance between episodic and longer-term rehabilitative interventions with the need for psychological therapies as opposed to containment, evidenced by an interaction between two focus group respondents (Table 2, quotes 2).

Service users' and carers' perspectives about episodic treatment may be different to the perspective of staff, for example, in relation to the effectiveness of short term therapy (see Table 2, quote 3). This approach was also reflected by other focus group respondents working directly with service users in the community to help build their psychosocial capabilities (Table 2, quote 4). This renewed social focus was also evident in parts of the services where the perception was of imbalance between notions of containment and rehabilitation, for example (Table 2, quote 5).

In relation to the personalisation agenda, staff focus group respondents' awareness of the change towards partnership working was set against real world constraints. For service users, an individual focus was seen as paramount:

... every client requires an individual relationship, there isn't a one method will fit all model and it's down to the skill of the particular employee as to how they first initiate that reaction in the client and then manage the onward progression and support because you know we don't always progress forward, sometimes we take two steps... but from that point on every individual requires an individual relationship. (Respondent, SUCFG1 emphasis added)

For some respondents, the earlier shift towards using psychosocial interventions in mental health services alongside other forms of intervention has helped create a positive context for implementation of the personalisation agenda.

Crucially, the personalisation agenda was found to be strongly promoted by those staff in community settings, whose objective is to focus on the individual and their needs, using a non-stigmatizing and non-pathological approach (see Corbett & Westwood, 2005; Kowlessar & Corbett, 2009). Integration of care was reported in relation to the perception of the increasing number and complexity of co-existing diagnoses, such as drug misuse, alcohol misuse, personality disorders, or self harm. However, from the perspective of service users and carers, a singular focus on the psychiatric diagnostic label may skew the clinical focus of the attending physician. Service users' accounts show that more pressing care needs can be overlooked when greater attention is paid to their psychiatric diagnosis as opposed to physical health needs (Table 2, quote 6).

The multiplicity of stakeholders and future service provision

The theme of multiple stakeholders emerged in relation to the increased involvement of service users and carers and was seen as a positive driver for future service provision and the development of new approaches to care and treatment.

Table 2 Direct quotes from participants in the Focus Groups according to theme

Focus Group	Quote
<p>Modernisation</p> <p>SFG6</p> <p>Quote 1</p>	<p>There's a lot of service user frustration and disappointment in kind of the limits really of the medical approach in helping people with psychosocial difficulties. And that's not you know necessarily the fault of the medical approach. It does its best... But nevertheless I hear enough complaints from service users about a lack of time; a lack of talking therapies; huge waiting lists for talking therapies. And I just think that there's going to be much more demand and expectation for time to talk, you know, talking therapies, skills based groups and less of this kind of almost containment, of long-term chronic patients-review kind of based, risk focused interventions. <i>People want more than that.</i> (Respondent, SFG6, emphasis added)</p>
<p>SFG 6</p> <p>Quotes 2</p>	<p>Respondent 2: ... care planning, you know training, rehabilitation programmes. <i>And we're not encouraged to do that. We're encouraged to do the one to one therapy and it's something about, there's something about the assumption, it's almost like the primary care model of people with moderate, mild difficulties is wrongly applied to us in secondary care. It's like well ten [to] twenty sessions of CBT will fix this person but actually that mindset and model does not fit and the kind of psychiatric model doesn't always fit. They kind of medicate and sedate away people's distress. They need more long term skill development and rehabilitation and we're not that good at that really and we need much more of a rehabilitation mindset and skills development and how do you help people with long term trauma, untreated trauma.</i> And that's the other frustration that I hear... we see people who've been in the system for donkeys years and they've just had a purely medical containing approach, kind of reviews, encouragement, support but no psychological therapies for example and we get that all the time don't we, we meet people years and years and years along the line who have become chronic career patients. Now we want to get away from that obviously... Respondent 1: ... absolutely. (Respondents, SFG 6, emphasis added)</p>
<p>SUCFG1</p> <p>Quote 3</p>	<p>And after your six weeks it's bye, ok you're alright now ... you've had no feedback, you've had nothing. And it might work for a minority but anybody I've spoken to... and I think it's just your GP's way of getting you away from his desk. Counselling, there's the answer. And it doesn't answer your problems, because you're still churned up inside and you can't go and see a stranger for six sessions and open your heart to them. You just can't do it. Not if you're not getting any feedback. (Respondent, SUCFG1)</p>
<p>SFG7</p> <p>Quote 4</p>	<p>Respondent 1: I do think there seems to be more of a focus now on getting people involved in social, meaningful social activities rather than just medication. That's a big part of my role. I take quite a</p>

	few service users to different gyms in the borough that I work in, support them with that. Get them motivated and working towards them going independently. Other service users I take playing five-a-side football in groups. Others I go bowling with. (SFG 7)
SFG9 Quote 5	... we've... identified that there's a need for a <i>step downward</i> which is different to a pre-discharge ward, which we have at the moment, but looks at preparing people for transfer to other facilities, or back into the community... we've identified... from the service model that the social component of treatment, rehabilitation, management or (not even rehabilitation but) habilitation - because lots of them come from impoverished backgrounds and go back to impoverished existences - we've identified there's a need certainly to be <i>more inclusive of a social component in in-patient services</i> and I suppose rather than being a treatment modality it's more an inclusive approach around those needs. (Respondent, SFG9, emphasis added)
SUCFG1 Quote 6	... but <i>because there's like a label</i> then somehow the rest of it... and I'll give you an example. It was last year... I went off to see my GP and I'd been on repeat meds for a few years... and all the rest of it... I rolled up yet again and sat down and he was on his computer screen and typing away and I'm sat there and... he's going through all these [questions]: Am I suicidal? Am I still taking this medication? Blah de blah de blah. So a few minutes of this and he's a nice GP, you know I quite like him, or whatever, but he was there and he got to the end and he sits back and says: So what can I do for you? I said well actually my finger has got infected, I don't know how... I just phoned and actually I could get in so, access not a problem whatever, and I do feel an idiot but actually it's getting really bad. I don't know how it's happened, I must have banged it or whatever, the two fingers and, and it's really, it's getting all pussy and whatever. Oh no, no right you know... And there was an example that I'd rolled umpteen times over the years and I was on all these... you have on the screens and the physical side (is missed)... And, and so because of the <i>label</i> and whatever I think we forget... they're somehow going to ignore you, it's the attitude that's wrong or whatever... (Respondent, SUCFG1)
The multiplicity of stakeholders and future service provision	
SFG8 Quote 7	But really the shift is around <i>enablement, around recovery</i> , and I think staff need to be able to almost like take a step back and know when it's their turn to give, you know like advice on medication or monitor a process of going through benefits, you know, I think. But it's also a time to know [when] to enable somebody. There's <i>a different approach required</i> and it's about tapping into what's out there. It's about tapping into the individual skills, family networks and to be able to say to staff that assessment is key to be able to write up, you know, recovery plans is the key. But actually doing it all is changing, that's my personal view. I think if I was a nurse now on, on the

	<p>road, <i>my approach would be different, using very similar skills</i>, assessment care planning, risk management. (Respondent, SFG8, emphasis added)</p>
<p>SUCFG 2 Quotes 8</p>	<p>Respondent 2: And I suppose the big driver in terms of mental health has been much, my surprise, is around recovery... and it's basically it's open season... everything from definition to you know all the various elements were kind of open to debate and I suppose really ultimately it's a case of the Trust... aspiring to be recovery focused. <i>The question is what does that mean?</i> ... I keep having plenty of debates as to what recovery means because <i>recovery to staff and organisations is they've got their own ideas. And recovery from our perspective there's a bit of a mismatch at the moment</i> and so I just wonder whether maybe that's something...</p> <p>Respondent 1: Well recovery is really important but for some people. Where that's not possible but management is, and I think managing a condition if you're living with it long term, <i>I think that's just as important</i>. It shouldn't be getting you complete, some people will never be fully recovered, they might need medication but it's controllable and I think management is just as important as recovery as a focus. (Respondents, SUCFG2, emphasis added)</p>
<p>SFG6 Quote 9</p>	<p>I think that's part of the risk underpinning risk culture, isn't it that we're being pushed to the episodic all the time and just do very short, discreet episodes of care. But for people in fact staying involved in their lives in some way maintains them to be as well as they can be. (Respondent, SFG6)</p>
<p>SUCFG2 Quote 10</p>	<p>But equally it's something around what messages Trusts and the government give. I'm tongue in cheek but actually come to use it a few times now I say, we've talked about the Department of Health guidelines you know, all these things you mentioned away from the medical model to that <i>wider integrated recovery</i>, whatever... whatever. Yet here's a Trust, they've all got them, a <i>Medical Director</i>, we don't have a <i>Director for Recovery</i>, yeah. (Respondent, SUCFG2, emphasis added)</p>
<p>SFG8 Quote 11</p>	<p>... whereby people can do it because it's all well and good talking about recovery and it's all well and good saying to people you've got the skills within you but if that person has got that <i>dependency on services</i> we need to do an awful lot of work around removing that dependency in the first instance I think. (Respondent, SFG8, emphasis added)</p>

Key: SUCFG = Service User and Carer Focus Group; SFG = Staff Focus Group

Respondents saw this future as being defined by self care, users developing their own care plans, undertaking their own needs assessments and service planning:

Rather than them doing what the PCT has decided they want a service for, to actually

go out and tell the PCT this is the service you should be funding and I'd like to see users and carers getting involved in planning the service we would like and then go and sell that service to get the funding for it. Not the other way about.
(Respondent, SUCFG1)

Staff respondents thought such changes could be achieved through joint (learning and development) activities involving service users and carers as teachers or peer recipients of professionals. All of these changes were seen to require significant effort, a change in professional culture from paternalism to enablement and empowerment, with the health sector lagging behind such developments in social care:

Staff are not geared up for that because staff see themselves as “we’re here to do the assessment”, “we’re here to listen to your needs and tell you what your needs are and here are the resources I’ve got”. We’re moving to where somebody rings up and you say “right well here, here’s the assessment form, you write down your needs and I can be creative with the resources”. We are nowhere near ready for staff to be able to do that but in a social care arena they are doing that. You ring up social services and they’ll post you out a self-assessment and you send it back, they’ll look at it and allocate resources to you and health is moving in the same, similar direction. (Respondent, SFG1, emphasis added)

This changing service focus resulting from trying to embed recent policy was seen as influencing a cultural change within NHS providers (for example, see Table 2, quote 7). Embracing enablement or recovery concepts were seen by some respondents as problematic in that different definitions of recovery exist and moves towards shorter and more discrete interventions may not suit all service user and carer needs. For example, see Table 2, quotes 8, where two respondents deliberate on the issues and existence of different definitions of recovery and perspectives between staff/service users, as well as the need for long-term management. Other staff respondents echoed that there was a balance to be struck between episodic or maintenance types of intervention and recovery (see Table 2, quote 9, for example).

A more fundamental point was articulated about the rhetoric of recovery and the need for consistency between policy and operational delivery (Table 2, quote 10). Some staff respondents pictured a shift in dealing with the dependency previously created by professionals, through partnership working with change achieved at a mutually satisfactory pace (Table 2, quote 11). The therapies were reportedly better at embracing the recovery model and its associated expectations and that service users may be seen by those professions as having potential to recover, albeit, in a limited way for some with longer term conditions. Some respondents reported the need to acknowledge that people with psychosis or severe personality difficulties require continuing support and not necessarily recovery. Better operational definitions of the concept of recovery were requested yet were also seen as difficult given the public push for ‘fixing people’ via ‘talking therapies’ such as cognitive behavioural therapy. The latter emerged in context of a general move away from rigid frameworks that label and thus stigmatise people with psychiatric pathologies (‘schizophrenics’ etc, see Kowlessar & Corbett, 2009) towards an approach involving understanding abstract/complex information and transmitting it in a way meaningful for care planning and service users. This was seen to require translation and understanding of information to something more intelligible and less traditionally pathological for service users and staff. Similarly service users/carers had a nuanced understanding of the issues surrounding the implementation of a recovery model. For example, the following interaction between three service users/carers:

Respondent 3: ... you’re giving false hope to people when you say about recovery because especially if you’ve got somebody who’s got a severe enduring mental illness such as schizophrenia or bipolar or whatever... unfortunately they’re going to have to be maintained on medication and... they need to have some hope without being [given] false hope where

everybody[’s] saying, “we aim for recovery”. They are going to be aiming for...

Respondent 1: For management.

Respondent 3: Yes.

Respondent 1: So they can have a normal life as normal as they can.

(Respondents, SUCFG 2)

Similarly, different definitions of recovery exist amongst service users and carers; for example:

Respondent 3: I personally would like to see that modernised, if you like, and person centred, and not actually called recovery, called something, you know, that is more suited to that person’s needs.

LF: So is that around the management of patients rather than...?

Respondent 3: Yeah because, because recovery does mean you know you look at the other side of the scale when you talk about people with organic conditions and medical conditions you know, you give them a few tablets and they then go on to recover from the flu or whatever. But you know in certain situations people are never going to recover but they are going to be managed and they are going to be able to enter and have a normal active life within society. And that’s what we aim for.

(Respondents, SUCFG2)

Service user and carer learning and development

There was evidence in each organisation of involving professionals and service users and carers in workforce learning and development activities and employment interview panels. Individual learning was recognised as being required by service users and carers in order to recover, get better or remain stable:

I feel like I’m learning every single day and I feel like I’ve learnt to deal with my ups and downs and that I’ve learnt to be a bit more open in certain areas about what happens and what goes wrong and potential, even the worse things I can do. I’ve learnt to be more honest and

recognise them and I just feel like every day is a challenge, every day I’ve got to challenge myself and my attitude sometimes because I can be as prejudiced about something as the next person but for me it’s all this process... it’s more about what I do for my own learning needs, how I can build up my own skills and how I can get better every day and try and remain stable. (Respondent, SUCFG1)

Discussion

Limitations of the study

Working within the Trusts’ existing consultative mechanisms meant that the range of views incorporated into the focus groups were limited to those of members of the existing consultative forums and self selecting staff groups and may not be fully representative of all employees, service users or carers. However, by virtue of the fact that the focus group participants were members of these forums, they had particularly expressed interest, commitment and expertise in service provision. Interviews with key stakeholders, a convenience sample of directors, provided a broader strategic context to also inform, compare and contrast the themes and issues raised. Use of direct quotes to illustrate themes has allowed ‘voices’ of staff and service users and carers to be heard and to contribute to future workforce and service development.

Modernisation, integration and outcomes

Incorporating principles of quality, efficiency and effectiveness to underpin service delivery is a requirement for health and social care services and individual staff (Darzi, 2008). Mental health providers and commissioners are also recommended to focus on outcomes that are meaningful to service users and carers (NHS North West, 2008; HM Government 2011 a,b,c). Evidence is required for the continual review of quality of services experienced by users and carers linked to payment by results, market competition, and for establishing effective delivery (Darzi, 2008). All respondents supported creating a ‘modernised’ service that focused on users

and carers, persons and families by optimising resources and integrating care congruent with national and local policy (NIMHE, 2005; Darzi, 2008; Department of Health, 1999, 2000, 2003a, 2003b, 2003c, 2004, 2005, 2006, 2009; NHS North West, 2008; Bradley, 2009; Skills for Care, 2009; Skills for Health, 2009; HM Government, 2011 a,b,c). Findings from staff concurred with those of service users and carers in relation to the need for modernised services and involvement of multiple stakeholders in their development and delivery.

A key requirement that was identified was the need to balance, on the one hand, the current drive towards episodic, 'quick-fix' interventions with, on the other, the need to provide longer term rehabilitation and maintenance interventions, based on recovery models and self care, with measures and outcomes including perspectives of both clinicians and service users and carers (NHS North West, 2008). Whilst the former may require professional knowledge and analytical skills, the latter require more supportive engagements where clinicians deploy rehabilitative, care planning and case management skills within psycho-socially focused partnerships with service users and carers, evident in the practice of community support workers. This re-focus on recovery, rehabilitation, care planning and case management was thought to raise important issues for service delivery and locally based workforce development (Reilly *et al.*, 2007; Imison *et al.*, 2009).

A further imperative identified was the complexity of co-existing clinical needs around lifestyle issues, such as drug or alcohol misuse, personality disorders and self harm that required particular workforce development and adoption of more integrated approaches to care and partnership working between agencies (Skills for Health, 2009; Skills for Care, 2009). For example, the need for assessing and treating both physical and mental health needs. Given that prior knowledge of a psychiatric diagnosis may skew the focus of care, there is a need to

challenge existing practices by reappraising how physical assessments of people with psychiatric diagnoses are undertaken in primary and secondary care (see Time to Change 2009 cited in NHS North West, 2008, p.27). As embedding recovery is reportedly problematic, and complicated by different understandings and definitions from staff and service user and carer perspectives, use of recommended tools for assessing service performance and outcomes for recovery are advocated (NHS North West, 2008).

Recovery, rehabilitation and re-ablement

The findings from service users, carers and staff were in agreement on shifting the focus of services and care to recovery, rehabilitation or re-ablement with talking therapies identified as being under-provided. The latter is being addressed by national policy so that more people can access talking therapies as part of a national programme (HM Government, 2011d). Within the Trusts there is evidence of arts and humanities based activities also being available, for example reading groups (see The Reader Organisation, 2011). Although not traditional therapies, they may be therapeutic by engaging people socially and culturally, allowing their expression as individuals and within groups (Clift & Hancox, 2001; Morrison & Clift, 2006, 2007; Morrison *et al.*, 2008).

There was a consensus on a requirement for a more social focus in services and care as opposed to a traditional psychiatric approach that involved people and families with a view to social function, normalisation and engagement. This was thought to require staff and services to work differently and examples were cited of community support workers using these approaches. Some service users and carers thought recovery may not always be feasible, yet being able to function and engage socially was always possible by focusing on rehabilitation, self care and self determination. This acknowledges re-ablement, which is a feature of social care provision. There is still confusion around the terms used, rehabilitation being the term used in health care and re-ablement in social care

but essentially having the same meaning (Conroy, 2011). A further example of this was participants' suggestions and recommendations for more person-centred approaches related to individuals and families. Such approaches have long been a feature of dementia care and services (Kitwood, 1997). They also recommended that services and care should include physical health and well-being unlinked from a psychiatric focus and to also include lifestyle behaviours and support and recognition of the complexities of dual or co-existing diagnoses which require cross-agency working and integrated care. These recommendations also resonate with recent national mental health strategy and policy (HM Government, 2011 a,b,c).

Self care, needs assessment, care planning and service delivery

Professionals envisaged service users undertaking self care and being involved with their needs assessments and service planning, citing how social care already has individuals undertaking self-completed needs assessments. This is congruent with existing policies for managing long term conditions in the community, even for those with complex needs, in order to avoid unnecessary hospital admission and to provide community care using case management (Boaden *et al.*, 2005; DH, 2005b,c; DH, 2006; Robertson *et al.*, 2007; Russell *et al.*, 2009). More specific and recent policy for mental health services recommends a re-focus on community care adopting a preventive, self care and case management approach to the promotion of mental health and well-being with integrated care and services that involve working in partnership with numerous stakeholders, service users and carers (Reilly *et al.*, 2007; PSSRU, 2010). The shift in focus to prevention, recovery, self care and outcomes with involvement of service users, carers and families is opposed to traditional containment or limited time restricted interventions that have predominated (NHS North West, 2008; HM Government, 2011 a,b,c). These findings are in keeping with recent policy and there was agreement between staff, service user

and carer perspectives on these aspects of self care and service delivery.

Cultural changes and service development

The findings indicate a need to establish requisite workforce skills and competences for changing roles and environments as part of service development, rather than commissioning traditional skills sets as suggested by recent policy (NHS Modernisation Agency, 2005; Reilly *et al.*, 2007; Imison *et al.*, 2009). A multi-skilled workforce with transferable skills can achieve more responsive services through flexible, adaptable and integrated work roles or interdisciplinary working rather than a traditional 'uni-professional' approach (DH, 2004). Better use of the broader or enhanced skills and competences of professional groups may deliver more value for money, for example, rehabilitation by those with generic or specific skills, or research led by those with enhanced skills. Such changes in roles and service developments require organisational and cultural changes by workforce and management to reconfigure services and care delivery. The enormity of this task should not be underestimated as it involves working creatively with service users and carers and other stakeholder organisations as partners to provide integrated services and care. Organisational structures alone do not ensure integrated practice and further work is needed to establish which factors promote or inhibit care coordination and management in terms of structure and workforce development (Reilly *et al.*, 2007). In this regard, a recent national survey of community mental health services for older people reported changes with 60% of teams being multi-disciplinary and having an integrated care coordinator (PSSRU, 2010).

Involvement of service users and carers

Initiatives exist in each Trust for involving professionals and service users and carers in learning and development activities and staff recruitment, which are recognised strengths and in keeping with policy (NHS North West, 2008). Involving a variety of stakeholders in service development and research is

recommended, although it is recognised that there are different levels of involvement ranging from consultation to participation (Ross *et al.*, 2005; Caldwell *et al.*, 2008; INVOLVE 2009a,b). There is a need for consensus between different stakeholders (providers, staff, service users and carers) as to what constitutes service user and carer involvement and what form it should take. This would allow a local evidence base to be developed for optimising service user and carer contributions that are important for developing mental health services and locally-based workforce development (Imison *et al.*, 2009).

Conclusion

The range of issues identified by service users and carers and staff suggest that there are new ways of organising and delivering services, as well as promoting inter-agency and partnership working, staff development and service user and carer involvement. There was agreement of the need for person and family centred care with outcomes that are focused on prevention, mental health and well-being, recovery, rehabilitation, self care and case management, with an accompanying shift of focus from pathology to social function and engagement. Whilst their scope is broad and challenging, these provide opportunities to further develop mental health services and a workforce that are responsive to the needs of local populations and that are valuable and fit for purpose.

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Providing community equipment and adaptations in adult social care: lessons from an evaluation of the use of self-assessment in five English local authorities

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Abstract

Whilst community equipment and adaptations promote the independence of millions of people, ongoing problems have been identified with the delivery of such services by local authorities. Self-assessment has been identified as one possible means of improving service effectiveness, giving service users more choice and control and providing faster, easier access to services. However, little is known about the use of self-assessment in social care. Against this background, this paper reports the findings of a mixed methods evaluation of the use of self-assessment in five local authority occupational therapy services. This drew on internal documents, management interviews, service user and administrative records, and a service user satisfaction survey. Important insights are provided about the operationalisation and possible functions of self-assessment in local authority occupational therapy departments; the characteristics of service users for whom self-assessment may be suitable (and those for whom it may not); the range of equipment suitable for provision via self-assessment; the costs of self-assessment; and service users' experience of self-assessment. The results are discussed in the context of the relevant policy and legal framework and a number of important lessons are highlighted for service commissioners and providers.

Keywords: Self-assessment, social care, occupational therapy, community equipment

Introduction and policy background

This paper reports an evaluation of the use of self-assessment for the provision of community equipment and adaptations, a function long recognised as an important element of local authority adult social care's remit. Indeed, occupational therapists were first employed by local authorities in response to the introduction of the 1970 Chronically Sick and Disabled Persons Act which obliged local authorities to provide equipment and housing adaptation services for disabled people, and over the past five decades the work of occupational therapists in social care has been dominated by this requirement (Mountain, 2000; Department of Health & College of Occupational Therapists, 2008). This entails a substantial financial

commitment. In 2006/7 an estimated £230 million was spent on adaptations (Department for Communities & Local Government, 2007), whilst in 2007/8 more than two million items of community equipment were delivered to service users (NHS Information Centre for Health and Social Care, 2008).

Although evidence suggests that the provision of equipment and adaptations can improve service users' quality of life, enable independence and obviate the need for inappropriate admissions to institutional care, the effectiveness of such interventions depends upon their timely implementation (College of Occupational Therapists & Housing Corporation, 2006; Riley, 2007). Nevertheless, over the years a series of concerns have been voiced about this aspect

of care provision, including the historically lengthy waiting lists for occupational therapy assessments, the complexity of different funding streams and the low priority given to referrals for relatively inexpensive pieces of equipment and adaptations (Audit Commission, 1998; Department of Health, 1998). Summarising these, two highly critical Audit Commission reports pointed to marked geographical variations in all aspects of service delivery (Audit Commission, 2000 & 2002). Services were said to lack leadership, commissioning standards were weak, and the wisdom of the established division between the supply of equipment for home nursing (by the NHS) and daily living (by adult social care services) was challenged.

The Government's response aspired to the development of single integrated (health and social care) community equipment services that would enable a greater number of people to access a wider range of products (Department of Health, 2000 & 2001). In addition, the first national eligibility framework for adult services was introduced, following which it was confirmed that community equipment services should be delivered in accordance with local eligibility criteria, with items up to £1,000 provided free of charge (Department of Health, 2002 & 2003). Despite such reorganisation, however, equipment services remained variable, and as growing numbers of authorities tightened their eligibility criteria in response to successive spending reviews, there was concern that by excluding clients with low-level needs, increasing levels of dependency might result longer-term (Riley, 2007; Commission for Social Care Inspection, 2008).

In 2008 a subsequent Audit Commission report warned that local authorities were not ready to meet the needs of an ageing population and proposed a radical re-engineering of the way adult social care was delivered. Demographic change is not the only challenge facing social care services today, however. Further pressures stem from the ongoing drive to support more service

users (with more complex needs) in their own homes, current trends in obesity and lifestyle related diseases and people's rising expectations (Department of Health, 2008a & 2009). Moreover, in a climate of tight financial constraint, local authorities are simultaneously being asked to achieve large cost savings and become ever more efficient (Appleby & Humphries, 2010).

Acknowledging these tensions, central government announced plans to transform the provision of adult social care in England (Department of Health, 2008b). These included two flagship policies: a focus on prevention, early intervention and enablement (on the grounds of long-term cost-effectiveness); and a desire to give service users more choice and control (Wanless *et al.*, 2006; Her Majesty's Government, 2007; Department of Health, 2005, 2006 & 2008b). At about the same time a further review of community equipment services was undertaken and a new service delivery model proposed that would move the provision of simple aids to daily living into the retail marketplace, improving access via the establishment of independent needs assessors and online assessment tools (Care Services Efficiency Delivery, 2007; Her Majesty's Government, 2007). Participation was not mandatory, however, and subsequent roll-out has been patchy, whilst those authorities that have participated have retained discretion about which items to distribute via the retail sector (Centre for Economics and Business Research, 2009; The Homecare Industry Information Service, 2010).

In the meantime, the desire to improve access to smaller pieces of equipment and adaptations has led some authorities to explore other ways of working. These include the training of trusted assessors and the use of mediated or supported self-assessment (Winchcombe & Ballinger, 2005; College of Occupational Therapists & Housing Corporation, 2006; Department of Health & College of Occupational Therapists, 2008; Glendinning *et al.*, 2008). Whilst the employment of self-assessment in the

provision of community equipment and adaptations sits comfortably with recent government policy in having the potential to provide faster, easier access to services, promote self-determination, release staff time and save costs (Department of Health, 2005, 2006a & 2006b; Care Services Efficiency Delivery, 2007), its use in social care is a relatively new phenomenon. Evidence about virtually every aspect of its employment – its form, scope, acceptability, cost and effectiveness – is thus undeveloped.

Against this background, in August 2006 the government in England published details of 11 local authorities that would pilot the use of self-assessment in adult social care (Department of Health, 2006b). The intention was to determine if self-assessment was feasible in this sector and identify its risks and benefits and, to this end, a multi-site evaluation was commissioned. This aimed to classify and describe the different approaches taken to self-assessment, gauge service users' experience of self-assessment, evaluate the cost-effectiveness of self-assessment and appraise the implementation and sustainability of new assessment practices (Challis *et al.*, 2008). The work described in this paper formed part of this evaluation and concentrates on the first three of these aims using data collected in five projects located in local authority occupational therapy services. It addresses the following key questions:

- How might self-assessment be employed?
- Who is self-assessment suitable for?
- What services should be provided via self-assessment?
- What does self-assessment cost?
- How satisfied are service users with self-assessment?

Methods

An extensive data collection exercise was undertaken in 2006-7 using a mixed-methods approach. Six strands of this are relevant to this paper.

Firstly, research staff examined internal documentation and interviewed key personnel in each pilot site to identify how they perceived self-assessment and its place within the care process. Together with the results from a selective literature review (Challis *et al.*, 2008) this information was used to formulate a classification of the employment of self-assessment in social care. This identified both its location (within occupational therapy, assessment and care management or preventative services) and function (screening to identify individuals who require further professional assessment, contributing to a wider professionally-led assessment, contributing to care-planning or providing direct service access).

Secondly, local sites collected a range of information about the socio-demographic characteristics, health and functioning of service users who completed self or traditional (usually professional, face-to-face) assessments. Each item was drawn from the EASY-Care assessment tool (Philp, 2000) and information about user dependency was combined to identify the number of daily activities with which people needed help (Katz *et al.*, 1963). The statistical significance of any variation between groups was assessed by the use of 95 per cent confidence intervals and, where applicable, chi-square, t-tests and non-parametric Mann-Whitney tests, with differences reported at the conventional 5 per cent significance level. As the breadth and process of the data collection varied between authorities (with some building this into their usual assessment process and others employing an independent data collection exercise) and the samples were not random, a selection of key variables (e.g. age, gender, ethnicity and dependency) were compared with information from a large national study (NHS Information Centre for Health and Social Care, 2008) to confirm the studied groups were not untypical of the expected service user group. This also surveyed service users receiving community equipment and adaptations (if not some of the more major adaptations offered within the current study),

and provided the best comparative information available.

Thirdly, local authorities collated data on the services received by people receiving self or traditional assessments. Whilst in most sites this was available by individual service user, some could only provide aggregate figures. This information was subsequently summarised in a 24-cell matrix according to its cost and function. Unit costs (4 bandings based on a classification used by Care Services Efficiency Delivery, 2007) were estimated from a range of equipment brochures, websites and local sources supplemented, where applicable, by installation costs calculated from nationally published data (Curtis & Netten, 2006). The primary function of each item of equipment (eight categories, including the provision of assistance with meal preparation, bathing and dressing) was coded according to guidance developed by the occupational therapist within the research team (Challis *et al.*, 2008).

Fourthly, pilot projects provided data on the length of time between three key aspects of the assessment process as experienced by people receiving self and traditional assessments: the time from first contact (referral) to assessment; the time from completion of assessment to first service receipt; and the aggregate time from referral to first service receipt.

Fifthly, the costs of self and traditional assessment were estimated from information provided by the authorities. The methodology for calculating costs followed that adopted in previous research and demonstration projects (Netten & Beecham, 1993) and detailed full economic costs, not just expenditure employed. Capital or set-up (investment) costs encompassed both the initial funding received from the Department of Health and the authorities' own matched funding, whilst revenue costs comprised both the costs of the assessments themselves and the costs of the services received consequent upon

assessment. In those instances in which self-assessments essentially replaced traditional assessments, the additional (marginal) costs or savings incurred by adopting self-assessment were considered. However, where these could not be calculated or data was unavailable, costs were calculated in aggregate form (Challis *et al.*, 2008).

Lastly, a structured satisfaction survey was administered to individuals receiving self and traditional assessments. This was based on a tool developed by research staff and service users in a previous study (Challis *et al.*, 2007) and contained 13 pre-coded questions facilitating the development of three summary scores. These were: an 'ease of use' score, capturing whether respondents found it easy to self-assess or be assessed (maximum value 9); an information score, reviewing the extent to which the assessment embodied certain elements of good practice with regard to the collection and sharing of information (maximum value 4); and a general satisfaction score, expressing the respondent's overall user satisfaction (maximum value 12) (Challis *et al.*, 2008). Reflecting the different nature of the pilot projects, there was some variation in the quantity and timing of the questionnaires distributed. Nevertheless, all were administered within a month of the assessment and were returned by post. The Mann-Whitney test (again set at the 5 per cent significance level) was used to compare summary satisfaction scores between groups.

The majority of the analysis was thus descriptive in nature, exploring the reality of self-assessment in practice and, wherever possible, comparing this with traditional assessment procedures. Approval for the study was given by the Association of Directors of Adult Social Services (ADASS) Research Group and the Committee on the Ethics of Research on Human Beings at the University of Manchester and research governance procedures in each pilot site were fulfilled.

Table 1 The aim and form of the self-assessment projects

Project number*	Aim	Target group	Primary form of assessment
1	To improve access to equipment, the customer experience and cost efficiencies by piloting the use of an electronic tool	Adults and older people	Electronic
4	To expand existing opportunities to self-assess for minor adaptations and equipment by a ‘fast track’ client-led self-assessment system	Adults and older people	Telephone, or paper plus telephone
5	To promote direct access to occupational therapy services and access to equipment to reduce waiting list times	Adults and older people	Electronic
7	To evaluate the introduction of self-assessment for simple pieces of equipment and moderate levels of home care	Adults and older people	Paper
9	To develop different methods of assessment for shower/bath adaptations	Disabled adults and older people	Telephone

* The project numbers are those used in the original evaluation and have been used here in order to maintain consistency of reporting across publications.

Findings

Context

As noted above, five pilot projects were located in local authority occupational therapy services. Two were London boroughs, two were shire unitary authorities and one was a metropolitan city i.e. all single tier authorities.

Aims and forms of self-assessment

All five projects aimed to improve access to community equipment and adaptations and targeted a combination of older and disabled adults (Table 1). However, some projects had further secondary goals, such as improving the customer experience or reducing waiting lists. The way in which the different authorities conceived of and operationalised self-assessment varied markedly, with assessments variously available on paper, by telephone and electronically. Nevertheless, in all instances local authority staff played some part in the completion of the assessment and the determination of an appropriate response.

Service users

In Table 2 information about the socio-demographic characteristics, health and functioning of more than 630 people who

undertook self-assessments is set alongside that of approximately 330 people who had a professional, usually face-to-face assessment. Whilst all five projects provided information about self-assessment users, information about people who received a traditional assessment was available from just three – Projects 4, 5 and 7. The number of authorities that provided information about each individual variable also varied considerably.

As Table 2 shows, the average service user undertaking a self-assessment for community equipment or adaptations in these projects was in their late 60s/early 70s, female, white and in poor or fair health, although still relatively able to undertake key daily activities of living. Only modest differences were found between the general health and functioning of people who undertook self-assessments and people who received traditional assessments, although the former group were significantly more likely to live alone and more ethnically diverse than the latter. There was also some suggestion that people who completed self-assessments were younger than people who received a traditional assessment and experienced more memory problems and low mood. However, closer examination of the data showed this

was largely due to the influence of Project 1 (which provided information about a disproportionately large number of cases and targeted a more youthful, disabled population) and was not true of other projects. Furthermore, when data from Project 1 was excluded, the general health and daily

functioning of those people who completed self-assessments appeared to be rather better than that of people who had professional assessments (proportion of people in poor health 33.5% versus 50.7%; mean dependency score 1.1 versus 1.5).

Table 2 Characteristics of self and traditional assessment recipients

Variable		Self-assessment recipients		Traditional assessment recipients	
		<i>mean</i>	<i>n</i>	<i>mean</i>	<i>n</i>
Age	Mean years	68.5	636	73.4	337
		<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>
	75+	38.7	246	56.4	190
Gender	Male	32.2	205	36.0	122
	Female	67.8	431	64.0	217
Ethnicity	White	75.2	473	94.6	298
	Asian	16.5	104	4.4	14
	Black	6.4	40	1.0	3
	Other	1.9	12	-	-
Living situation	Not living alone	57.2	362	71.0	201
	Living alone	42.8	271	29.0	82
General health	Excellent	0.9	5	2.8	2
	Very good	3.6	19	1.4	1
	Good	12.0	64	5.6	4
	Fair	37.3	199	39.4	28
	Poor	46.2	246	50.7	36
Incontinence	No	79.8	138	68.4	78
	Yes	20.2	35	31.6	36
Memory problems	No	58.9	314	70.0	70
	Yes	41.1	219	30.0	30
Low mood	No	51.5	274	63.6	63
	Yes	48.5	258	36.4	36
Dependency* score	0	22.3	112	30.9	21
	1	37.8	190	29.4	20
	2	20.9	105	16.2	11
	3	10.2	51	10.3	7
	4	6.2	31	5.9	4
	5	2.6	13	7.4	5
		<i>score</i>	<i>n</i>	<i>score</i>	<i>n</i>
	Mean dependency score	1.5	502	1.5	68

* The number of activities that help is needed with: bathing, dressing, toileting, bed/chair transfer, eating and drinking.

Service receipt

Information on the community equipment and adaptations received by people undertaking self-assessments was obtained from all five projects. However, only two projects (Projects 4 and 7) provided data about the services supplied to people receiving a traditional assessment. As the services considered suitable for provision via self-assessment varied markedly from site to site and most authorities made only a subset of services available to self-assesseees, any differences between the items received by people receiving self and traditional assessments may simply reflect the different mix of services available to them. Table 3 thus focuses on the function and cost of the services supplied (or, in the case of major adaptations such as level access showers and

stair lifts, recommended) by each authority as opposed to their exact description.

As can be seen, a large percentage of the equipment and adaptations provided to people who completed self-assessments in Projects 1, 4 and 9 was intended to help people bathe or shower (e.g. bath boards and bath seats). In contrast, the largest group of equipment supplied in Project 5 (e.g. calendar clocks and flashing doorbells) was designed to help people with visual or hearing impairments, whilst many of the items supplied in Project 7 (e.g. grab and stair rails) were targeted at individuals with mobility problems. The equipment and adaptations supplied to people who had a traditional assessment, appeared to relate to a wider range of needs.

Table 3 Function and cost of items supplied to self and traditional assessment (SA and TA) recipients

Variable	Items supplied to SA recipients Project 1	Items supplied to SA recipients Project 4	Items supplied to SA recipients Project 5	Items supplied to SA recipients Project 7	Items supplied to SA recipients Project 9	Items supplied to TA recipients Projects 4 & 7
Total number of items*	826	121	464	96	230	413
<i>Function:</i>	%	%	%	%	%	%
Meal preparation	5	1	-	1	4	3
Mobility	13	28	16	49	8	24
Transfer (bed & chair)	9	7	8	3	18	20
Dressing	13	-	-	-	7	<1
Bathing & showering	55	43	-	29	47	29
Eating & drinking	-	-	19	-	-	1
Toileting	4	22	13	18	16	22
Seeing, hearing & communicating	-	-	44	-	<1	1
<i>Cost band:</i>	%	%	%	%	%	%
Low (< £20)	42	31	47	24	31	17
Medium (≥ £20, < £100)	32	54	53	56	35	57
High (≥ £100, < £1,000)	16	15	-	20	22	21
Very high (≥ £1000)	11	-	-	-	12	5

* Please note that many individuals received more than one item.

Most of the equipment and adaptations supplied to people who completed self-assessments were at the lower end of the cost spectrum, with 40 and 41 per cent of items in the low (<£20) and medium (<£100) cost bands respectively. In comparison, 17 and 57 per cent of the items supplied to people who received a traditional assessment were in these cost bands. Given that one of the three arms of Project 9 focused on the provision of major adaptations enabling people to bathe/shower, the concentration of very high cost (\geq £1000) items here (12%) is understandable. However, a sizeable minority of the services provided in Project 1 (11%) were also in this banding, and upon further investigation, most of these also related to recommendations for level access showers.

The timeliness of service delivery

Just two authorities (Projects 4 and 7) provided data on the timeliness of service receipt for comparable groups. In both cases the mean time between referral and completion of assessment was shorter for the self-assessment recipients than for the traditional assessment recipients. Within Project 4 this led to a shorter waiting time between referral and first service receipt (5 as opposed to 23 days). In Project 7 the shorter period between referral and assessment was counteracted by a longer wait between assessment and service receipt, such that the aggregate time from first contact to first service receipt was almost identical (56 as opposed to 55 days).

Costs

As can be seen in Table 4, some pilot projects incurred greater costs than others. In light of the variation in the quality of the data provided by different authorities, it should be reiterated that these costs are not directly comparable across sites. Nevertheless, the figures indicate that although all pilot projects incurred substantial capital costs, one produced revenue cost savings (Project 5), whilst the remainder incurred additional revenue costs. Interestingly, three projects (Projects 5, 7 and 9) saved resources in respect of the cost of the assessment itself, through the use of less professional time. However, in two instances (Projects 7 and 9) these were counterbalanced by the cost of the additional services provided.

Service user satisfaction

Completed satisfaction surveys were received from 648 people undertaking self-assessments in Projects 1, 4, 5 and 7 and 590 people receiving traditional assessments in Projects 4, 5 and 7 (an overall response rate of 55 per cent). The vast majority of both self and traditional assessment recipients in all projects found their assessment easy to complete (mean values 7.9 and 8.0, maximum possible value 9) and expressed a high degree of satisfaction with their experience (mean values 10.5 and 10.6 respectively, maximum possible value 12). Indeed, an examination of the responses to each individual question used to construct these scores identified no

Table 4 Estimated cost of self-assessment (2006/7 £s)

	Project 1	Project 4	Project 5	Project 7	Project 9
Capital cost of self-assessment project	102,000	168,000	173,846	63,795	110,000
Revenue cost or saving (-) of self-assessment project*	48,138	1,985	-21,689	154	13,346
Total cost of self-assessment project	150,138	169,985	152,157	63,949	123,346

* The average incremental cost or saving of the assessment itself plus aggregate service costs;

N.B. the costs of web-based tools, where employed, were discounted over 5 years apart from Project 1 where the use of such a tool was discontinued in the project period.

statistically significant difference between self and traditional assessments. Furthermore, whilst there was considerable between-project variation in the extent to which assessments encompassed certain elements of good practice with regard to the collection and sharing of information, there was no suggestion that either self or traditional assessments were better at this *per se*. (mean values 2.9 and 3.1 respectively, maximum possible value 4).

Discussion

Local authority community equipment and adaptation services have been subject to ongoing criticism and reorganisation over many years. Against this backdrop, the use of self-assessment has been identified as one possible means of delivering both more effective and more person-centred care, improving access to low-level services and giving service users greater choice and control (Department of Health, 2005, 2006a & 2006b; Her Majesty's Government, 2007). Such aspirations have been predicated upon largely untested assumptions about the relative effectiveness of different assessment approaches, however, whilst the context in which self-assessment is either legitimate or legal is itself the subject of debate (Mandelstam, 2008; Law Commission, 2011).

The material presented in this paper, which provides some of the first detailed information about the way in which self-assessment has been implemented within occupational therapy services, the people who use it, the services they receive and their satisfaction with this process was intended to facilitate an exploration of these issues. Firstly, however, it is important to note a number of methodological limitations, not least of which is that the framework for evaluation was not agreed until after the initiative commenced, by which date the selection of the research sites and the timeframe for data collection had already been decided by the Department of Health. There was, furthermore, considerable variation in the amount of funding the

different authorities received, their project designs and the extent of the information they were able to provide (particularly with regard to timeliness and costs) such that the generalisability of the findings may be reduced.

Other methodological concerns relate to the nature of the samples, which cannot be regarded as true random samples of the target population. Thus whilst the traditional assessment recipients may be viewed as a 'naturalistic' sample of the authorities' usual service population, the self-assessment sample is likely to have been moderated by the fact that some pilot projects targeted specific sub groups, e.g. people from ethnic minorities. The varied numbers of service users accessing assessments at different sites, and the aggregation of data across authorities, are also inherently problematic, for such composite figures can produce arbitrary grouping effects whereby the highly contextual impact of one locality creates the impression of a national phenomenon. Checks for this were made, however, whilst as noted above, comparison of our data with a large nationally representative survey suggested that the studied groups, and combinations thereof, were not dissimilar from the expected service user populations.

How might self-assessment be employed in occupational therapy services?

Whilst the classification noted earlier identified four possible functions of self-assessment, all five pilots used it to facilitate direct service access. This is in marked contrast with the situation in the NHS, where self-completed screening questionnaires have more commonly been used to identify individuals who might benefit from further professional assessment or advice (e.g. Tulloch & Moore, 1979; Bowns *et al.*, 1991). In actual fact two of the self-assessment projects in this evaluation *did* identify a number of people who required a professional assessment. However, this appeared to be a chance rather than a planned event, leaving one to wonder if there might not be the potential to do this more systematically.

The fact that social services or other statutory agency staff played some part in all the assessments is also noteworthy and suggests that the term self-assessment as used in this initiative may be a little misleading, with the approach taken perhaps better conceptualised as mediated or supported assessment. Indeed, as Mandelstam (2008) has stated, it is difficult to see how self-reports alone could constitute lawful assessments under section 47 of the NHS and Community Care Act 1990, for although where a practitioner is content with a service user's self-assessment they *can* adopt it as the organisation's formal assessment of need, they cannot simply delegate this duty to the service user, but must, as recently reiterated by the Law Commission (2011), retain overall control of the assessment process.

Who is self-assessment suitable for?

In light of the push to promote greater personalisation, including a strategic shift towards early intervention and prevention (Department of Health, 2008b & 2010), the introduction of self-assessment has been advocated as one way of reaching out to people who do not normally come to the attention of social care services. To what extent does this appear to be the case? On the one hand, our data indicates that those people who completed self-assessments for community equipment and adaptations were not that dissimilar from people receiving traditional assessments, whilst on the other hand there was some suggestion that these new initiatives attracted a somewhat healthier, more able population. Furthermore, at least some projects successfully attracted a more ethnically diverse service user group than would normally be expected, suggesting that the provision of self-assessment may go some way to engaging certain previously disengaged individuals.

Just how widely might local authorities want to cast their nets? Recent years have seen the public sector increasingly urged to broaden access to support on the grounds of progressive universalism (Commission for Social Care Inspection, 2008; House of

Commons Health Committee, 2010). Indeed, the most recent review of eligibility criteria reiterated that everyone, whether they are eligible for public funds or not, should receive an assessment of their care needs and access to information and advice. However, the associated survey suggested 62 per cent of respondents who did not fulfil eligibility criteria were not signposted to any alternative help (Commission for Social Care Inspection, 2008). In an increasingly cash-limited system, directing such individuals towards some form of mediated self-assessment system that enables them to both assess their need for, and access information on simple pieces of community equipment located outside the authority (perhaps in the voluntary sector?) may be one way of squaring this circle. In addition, information collected in this way might subsequently feed into Joint Strategic Needs Assessments, informing future commissioning.

What services should be provided via self-assessment?

This study found that the equipment provided via self-assessment was primarily intended to help people bathe and mobilise, assist individuals with visual and hearing impairments and promote independence and reablement. Furthermore, most of the items supplied cost less than £100. This would seem to suggest that self-assessment is compatible with a retail model of service provision (Care Services Efficiency Delivery, 2007) or a similar approach. The study also demonstrated a range of circumstances in which it may be appropriate to deliver more expensive equipment via self-assessment, notably the installation of showers. In these circumstances it is likely that the person is already known to the local authority, such that details of their dependency and living situation have already been documented and the element of self-assessment relates specifically to the adaptation required, which will be checked prior to structural work being undertaken.

These findings together demonstrate the importance of determining the range of

services which will be made available via self-assessment within the local nexus of health and social care provision, taking account of national guidance and legal requirements. Such an approach will permit local managers and commissioners to select combinations of indicators and descriptors of contextual factors which permit judgements to be made about the role and extent of self-assessment in service provision and to develop locally determined measures of outcome (Department of Health, 2006a).

What does self-assessment cost?

The need to achieve efficiencies forms the background to all recent developments in occupational therapy services. Thus the Best Value (Department of the Environment, Transport and the Regions, 1998) regime, with its requirement to demonstrate value for money and quality in specific services, was superseded by Comprehensive Performance Assessment reviews (Department of Transport, Local Government and the Regions, 2001) focusing on the delivery of councils as a whole. Of particular note is the requirement following the 2004 Comprehensive Spending Review to make Gershon (2004) efficiencies in terms of savings in 'back office' functions such as administration and paperwork, releasing resources to front-line services.

The data from this study were intended to evaluate the nature of any savings arising from the introduction of self-assessment through a comprehensive measurement of costs. Interestingly, the study found that the biggest potential for cost saving appeared to be in the cost of the assessment itself, with three of the five projects making savings here. These arose from the use of less professional time, with relatively more costly professional assessments replaced by (albeit mediated) self-assessments. Such savings are thus rather 'front office' (Chase, 1978; Tinnilä & Vepsäläinen, 1995) than 'back office' efficiencies in terms of what happens during the assessment process and who provides the assessment. As a related gain, at least one project used less qualified/assistant staff

rather than occupational therapists to support the self-assessment process, freeing more qualified staff to focus on service users with complex needs. Little is known about the effects of such substitution on service users' dependency levels and/or well-being, however, and further research is needed here.

In two of the three projects that incurred cost savings from changed assessment processes, these gains were offset by the cost of providing additional equipment. It is important to note that this was in keeping with these projects' objectives, which sought to widen service access and enhance service responsiveness. This highlights the fact that such new initiatives may have multiple – sometimes conflicting – objectives. It is also important to make a distinction between the incremental costs of the individual projects (which include investment as well as revenue costs and depend on the number of service users recruited) and the additional costs (or indeed savings) of the self-assessments themselves. Indeed, it is essential that a comprehensive costing approach informs decisions about rolling out such initiatives. Thus whilst our study suggested that potential savings may be made from introducing self-assessment in this setting in terms of the assessment process itself, when investment costs were also taken into account, the overall costs of each pilot rose. However, compared to the overall expenditure on adaptations (Department for Communities and Local Government, 2007), the projects' capital costs were relatively modest.

How satisfied are service users with self-assessment?

If managers and commissioners are understandably concerned with the need to manage budgets and achieve efficiencies, Lymbery (2000) suggests that service users are more interested in the way services are delivered and whether they meet their needs. With regard to the process of service delivery, this evaluation suggests that there is no reason to believe that the introduction of self-assessment is associated with any change to the generally very high levels of satisfaction

reported with traditional assessment processes. This mirrors the findings of the aforementioned national survey of community equipment users which identified little relationship between how respondents' needs were discussed (in person, on the telephone or self-assessment on the internet) and how satisfied they were with their equipment/adaptation (NHS Information Centre for Health and Social Care, 2008). Moreover, a review that examined older people's experience of self-assessment in a variety of settings including social care concluded that they found (supported) self-assessment acceptable (Griffiths *et al.*, 2005).

Conclusion

The above findings highlight some important lessons for commissioners and providers considering the introduction of self-assessment in local authority occupational therapy departments. These include the need to:

1. Clarify what is meant by self-assessment and the roles to be played by any facilitators / mediators.
2. Be clear about the purpose of self-assessment and whether it is intended to substitute for or complement traditional professional assessment processes.
3. Provide alternative arrangements for people who will find it difficult to self-assess.
4. Critically appraise the potential costs and benefits of introducing or expanding the use of self-assessment, recognising that this may involve certain trade-offs.

Designing the service is, however, just the first step. There is then the challenge of translating the vision into practical change on the ground that will 'make a real difference to the way individuals engage with services and support and, in so doing, make a real difference to their lives' (Department of Health, 2008b, p.5).

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Are personal budgets necessarily empowering for service users? If not, what's it all about?

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Abstract

A growing body of evidence highlights problems with moves to personal budgets and 'personalisation'. At the heart of these problems are the continuing low priority and inadequate funding of social care - issues that look set to get worse. This article seeks to remind us of the underpinning values of person-centred support and the urgent need for a radical re-prioritisation of social care.

Keywords: Personal budgets, direct payments, service users, disabled people

A 2011 text identifies five key themes in the narrative of personal budgets and personalisation. One of these is that 'personalisation saves money':

Improved outcomes need not come at a higher cost, since personalisation is likely to save money. (Needham, 2011, p.50)

A number of studies and authors associated in one way or another with In Control and Simon Duffy, the high profile early advocates of individual and personal budgets, made this claim (Glasby & Littlechild, 2009, p.125; Duffy, 2010). Perhaps the most extreme of these was Charles Leadbeater of Demos. In 2008, he suggested that savings 'could be as high as 45%' (Leadbeater, 2008; Leadbeater *et al.*, 2008).

Yet this claim has never been convincingly evidenced by independent studies and what research has addressed this point has generally come to the conclusion that such developments are at best 'cost neutral' (Glendinning *et al.*, 2008). As Catherine Needham says: 'the "it works" and "it saves money" rationales are the key hard indicators that justify personalisation' (Needham, 2011, p.51). Put another way, politicians and policymakers have been unable to resist the siren cry of a policy that it was promised

would both save them money and improve services and support. The likelihood, especially in social care, a notoriously under-funded area of policy constantly in search of cost-saving changes, of such promises being true, seems minimal. Social care's history is littered with previous examples of such over-claimed and inadequately evidenced innovations, from 'patch' social services in the 1980s through to care management in the 1990s. All of these have subsequently been seen to fail.

However 'better for less' was the story that attracted politicians to individual and personal budgets. This is in significant contrast to the direct payments from which they were derived, which were developed only hesitantly and patchily at both central and local state levels. The narrative of individual/personal budgets was then sold powerfully through stories from some service users of new flexibility and opportunities in their lives, far better than reliance on traditional services. Better also than existing over-policed and over-managed direct payment schemes (<http://www.guardian.co.uk/society/2008/jul/02/longtermcare.socialcare2> accessed 7 September 2011). We then moved from a few pilot projects to a massive cash injection from central government to 'transform' social care and targets of moving service users to personal budgets that ranged

from one third to all. The latter is the current goal set by government for 2013 (SCIE, 2010).

There were, nonetheless, dissenting voices; people who said this development would not necessarily be cheaper; that there was much more to it than was being suggested. Such voices, such cautions, however, were not welcomed. I know that it is the case, because I was one of them and I watched others marginalised who expressed similar concerns, excluded from conference platforms, key forums and public and political discussions (Beresford 2007, 2008).

This was prior to the emergence of a strong body of evidence, when even before government had the results of its own research, it was committing itself to making massive policy change in favour of personal budgets. Then when it gained evidence from the IBSEN study, this highlighted that it was difficult to unify different funding streams – as had been promised of the individual budgets that had then been most talked about and that there seemed to be major problems accessing all groups to personal budgets, notably the largest group, older people (Glendinning *et al.*, 2008).

Now more evidence is available about personal budgets. There has, for example, been the recent Community Care Unison survey. Headlines from this include that:

- 83% of those surveyed said cuts to adult care budgets in their areas would impede the operation of personal budgets;
- almost half (48%) thought personal budgets were not of sufficient value to help users meet their needs;
- 37% disagreed that the resource allocation system in their area effectively allocated money to people in line with their needs - 47% agreed;
- 33% said resources had been the greatest barrier in making progress with implementing personalisation;
- 57% saying that users did not have a

genuine choice of services from the social care market, and evidence that personal budgets were not changing the services that people received;

- 44% of respondents said people were generally buying the same kinds of support under personal budgets as under traditionally commissioned packages of care. Just 3% said most people in their areas were buying different kinds of support with personal budgets than before.

Now, only a minority of social workers believe that personal budgets will benefit services users in the medium to long-term (<http://www.communitycare.co.uk/Articles/2011/05/25/116868/social-workers-losing-faith-in-personalisation.htm>, accessed 25 August 2011).

Two major studies in mid 2011, an Association of Directors of Adult Social Care survey of progress on personalisation and the Personal Budgets Outcome Evaluation Tool (POET) survey, both highlighted problems and a lack of progress. The national personal budget survey carried out in 2011 by In Control, the organisation most closely associated with the advancement of personal budgets, reports positive results, but also according to David Brindle of the Guardian:

... adds the critical rider that personal budgets work well for everyone when they get full support to maximise the advantages. Short of that, the idea can be tarnished. (Brindle, 2011)

And he cites Rob Greenland of Social Business Brokers who says:

People are starting to publicly acknowledge that we are struggling to make personal budgets work.

Brindle also cites the Association of Directors of Adult Social Services as admitting:

... that only one in three budgets is given

in the form of a direct payment. Most people are told how much they are entitled to, but never get to handle the money. "Nearly all the increase has been in 'managed' personal budgets, with no significant increase in direct payment numbers in the last year", the association says. (Brindle, 2011)

These are exactly the points that critics concerned with the rights and needs of service users and carers have been raising since government first determinedly nailed its flag to the massive roll out of personal budgets.

To sum up, putting together accounts repeatedly reported back from the ground and what independent evidence we have, the picture now is of:

- frequently heavily bureaucratic resource allocation systems;
- reducing eligibility in a time of severe cuts;
- reduced (personal) budgets;
- cash sums top-sliced for administration;
- service users without adequate support to manage schemes;
- some local authorities simply treating the move to personal budgets as a numbers game, rebadging the same old service arrangements in cash terms as if it meant anything different;
- a postcode lottery of how transformation actually implemented, with some localities making real attempts to improve and change and others acting as if they hoped if they did nothing it would all eventually go away.

While this is the context for developments around personal budgets and personalisation, it is far from the whole story.

To address the questions posed in the title of this paper, we have to look at two really big issues involved:

1. The shift from the direct payments developed by the disabled people's movement to the individual and personal budgets we have come to talk about.
2. What personalisation really means?

Individual budgets (IBs) and personal budgets (PBs) were advanced earlier in the noughties as a brave *new* idea. But the reality is they are precisely derived from the direct payments created and developed by the disabled people's movement almost a generation earlier. Direct payments are a groundbreaking development rooted in pioneering philosophy, values and theory. They grow out of the social model of disability and the independent living movement. Their essential aim was to put disabled people, and then other service users, in control of their support as part of a broader independent living approach, which would also work for full and equal inclusion, access and participation in mainstream life and services to enable them to live on as equal terms as non-disabled people (non-service users).

Thus from the start they were rooted in a set of clear values and yardsticks:

- the service user would be in control of their support;
- they would have the support they needed to be able to manage a direct payments system – probably provided through a local user led or disabled people's organisation;
- the amount of money provided would match the needs they had in order to secure their equal human and civil rights (Campbell & Oliver, 1996; Oliver & Barnes, 1998).

Direct payments were slow to develop, especially in some areas. There was little determined pressure from the centre for them to do so. They were frequently over-policed and over-controlled and not necessarily even understood by the local authorities made responsible for implementing them –

although disabled people's organisations always had reservations about them being in charge.

But the new impetus for PBs and IBs was very different. It was divorced from all these key criteria established by disabled people:

- they would not necessarily truly be in control;
- they certainly would not necessarily be ensured the support to run them;
- the amount of money provided was not linked with any criteria of independent living, but rather simply a reallocation of existing generally inadequate funding within arbitrary and unhelpful eligibility criteria and means testing.

Because of this it is not surprising if they are now being associated with the problems we have heard about. It is also no wonder if they are heavily ambiguous in operation. Understandably, many committed practitioners have increasing reservations about them and they are being called into question both by practitioners and service users' organisations.

From a means to empowerment, we have moved to what is essentially an under-funded voucher system. From a replacement for a traditional and inadequate set of services, we have moved to an exchange relationship, which casts the service user as a consumer, not a citizen with rights – to a model that is market based and market driven rather than liberatory in intent. Of course personal budgets may still benefit some service users. This would not be difficult, unfortunately, given the poor quality of much traditional social care provision. But that is not what we were promised. We were promised something much better for *all* and that is not happening. There is also no evidence it ever will, when the existing approach chimes so well with the cutting, privatising, individualising approach to social care and indeed other public services, that has in recent years to different degrees gained major cross-party political support.

This leads to the second big issue under consideration here; as to what the term personalisation really means. Some time ago government began to encourage us not to see personal budgets and personalisation as synonymous, even though that is how they were initially presented both by government and the initiative's supporters. Personal budgets, we were now told, were meant as a delivery system. The *goals* were choice and control. We are now learning from the evidence that personal budgets can fail as a means to deliver just like any other. So it is perhaps helpful to get back to the goals. It will be beneficial to stay for a moment with the government's understanding of personalisation as meaning increasing choice and control, by whatever means (HM Government, 2007; SCIE, 2010).

To make more sense of personalisation and its meanings, focus can be turned to the large four-year research and development project supported by the Joseph Rowntree Foundation in which I have been a partner and whose findings were published in 2011, the Standards We Expect project (Beresford *et al.*, 2011). We didn't use the word 'personalisation' – which we found an inaccessible jargon term and instead we started with the term person-centred support.

The project had three main aims. We wanted to hear what people at the front line of social care saw personalisation or person-centred support as meaning, what barriers were in its way and how these could be overcome. There was considerable consensus among these constituencies about these issues, a lot of common meanings and understandings emerged among service users, carers, face-to-face practitioners and middle managers – the groups whose views we sought and focused on, even though there were some differences of emphasis.

They talk about person-centred support in terms of seeing people as individuals and organising services and support around them, rather than vice versa – 'treating people how you would want to be treated' so that 'the

power is with the person, not the organisation’.

The barriers in the way of personalisation, or person-centred support, highlighted in the project were many and they interacted to magnify the problems they created. They include:

- the poor terms and conditions of workers which make it impossible to sustain the reliable high quality workers workforce required;
- over-reliance on unpaid carers who lack the support to have real choice themselves, or to ensure it for service users;
- continuing institutionalisation for long term service users both in their own homes and in some residential services;
- organisations that are just not geared up to ensuring choice and control for service users;
- occupational practice that too often still is inadequate and based on a one size fits all approach;
- service users lacking adequate access to mainstream life, services and opportunities;
- user involvement that is still more often tokenistic and ineffective than making possible user led change.

We encountered many really positive developments in our projects at local level on the ground, examples of good practice, examples of workers showing enormous commitment against the odds - despite poor pay and conditions, lack of support and supervision. But the fact we found all these positives should not be used as an argument or, indeed, excuse - as it often has been in the past - for not addressing the fundamental barriers that more and more seem to be facing in social care and getting in the way of real personalisation, or person-centred support.

And these fundamental barriers emerge as the chronic under-funding of social care and the inherently defective dominant culture of social care. Both of these stand root and

branch in the way of ensuring person-centred support for all; for mental health service users, people with learning difficulties, with chronic and life limiting conditions, drug and alcohol problems, with physical and sensory impairments, people who are old and physically or mentally frail. Just changing the delivery system from services to cash payments, not surprisingly, does not overcome this.

Instead what we encountered over and over were service users of all kinds and all ages, not having their needs met and routinely having their civil and human rights restricted and undermined; where social care is reduced to personal maintenance; where help if it comes at all, too often comes at the last minute.

All this cannot be stressed enough. What was good about the system we explored and worked with were the people within it. What was bad essentially was the complex relation of many years of under-funding and an outdated institutionalising means and needs testing culture.

And now of course we can expect things to be made even worse by the current massive cuts being imposed from the centre on social care, in benefits and broader public services and employment, with social care service users being stigmatised more and more as dependent and scrounging. The recommendations of the Dilnot Commission and the hesitant response to them so far from the Coalition Government do not encourage any confidence that these nettles are really going to be grasped and a sustainable system of social care made possible, which will ensure equity and independent living for all – both older people and service users of working age.

I feel being involved in the Standards We Expect project has been a privilege and a culmination of my working life. It has felt so important, not only because it has been a big, long, demanding and successful project, but because of how we have done it and who we

have prioritised to listen to – which seems to me vital if we are to get social care and social support out of the backwater of neglect where it still is and has long been. This is crucial if it is to command the political and policy priority that must be key for a sustainable future – both for the policy and for us – as more and more of us come to need social support. This will be true as we live longer and more of us with impairments are able to live lives and our rights increasingly cannot be ignored or denied. We sought in the project to put the perspectives of service users, carers and practitioners first and that is what future policy must do. We will not resolve the problems facing social care, service users and their families by coming up with yet more unsupported promises of ‘better for less’.

What I still find difficult to understand, and to deal with, is that a policy of such fundamental and growing importance to so many of us as social care is, can still be treated both politically and in policy terms as marginal. When the situation for many is so dire, so uncertain, so risky – in real terms – how is it there seems to be, relatively speaking, so little real political interest in such a large and growing proportion of our population. Are their rights and needs really that inconsequential?

Our project reinforced the view that really great and imaginative things are possible to support people in person-centred ways; which make possible that crucial unification between health, social care, housing and other mainstream services. There is truly a massive matter of work needed to speak truth to power – that many of us have as yet been unable or failed to do. There is a crucial task and responsibility of ensuring that the direct views, ideas, experience and proposals of people centrally involved should be a key shaper of policy and practice in a meaningful process of co-production. We have a long way yet to go to make that happen. We hope the findings from the Standards We Expect project can help by providing one more brick in the wall.

In her 2011 study, Catherine Needham frames personal budgets and personalisation in terms of the competing views of its ‘advocates’ and ‘problematizers’. She reports that she is reassured to have held on to her ‘ambivalence’ about the issue (Needham, 2011, p.4). However, being ambivalent about a highly ambiguous development such as personal budgets and personalisation seems a doubtful position to hold. Very many service users feel harassed and oppressed by the way that the policy has been extended and implemented, often without effective choice or involvement. If personalisation is to have a progressive rather than reactionary future, then we may expect it will need to associate itself much more closely with the founding principles of the independent living and disabled people’s movement, and the kind of values and definition that the Standards We Expect project found service users, carers and face-to-face practitioners attached to it.

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Toward a new eligibility framework that serves the interests of both service users and councils

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Abstract

The call by the Dilnot Commission for an overhaul of the eligibility and assessment framework will be broadly welcomed. It creates a golden opportunity to put right some fundamental issues that have bedevilled social care for a long time. Whatever the fate of the other recommendations of Dilnot, it has to be hoped that this particular recommendation will be accepted. However, continuing belief in some key, but flawed, concepts creates a risk that a review will perpetuate the worst, and not the best, aspects of current and past policies. This would condemn social care to continued confusion, unfairness and lack of transparency. This paper argues that if a review were to build from the best of what has so far been attempted, and accept the lessons of what has not worked, an approach can be created that enables the best possible realisation of the vision for social care for the greatest number of service users within existing funding, with the best hope in the longer term of bringing about a closer match of needs and funding.

Keywords: Person-centred practice, eligibility, service users, social care

Introduction

The requirement for an eligibility framework arises from the premise that the resource available will not be enough to meet the volume of need the community would wish to meet. The job of the framework is to ensure the rationing of resources is carried out in a way that is fair, transparent and effective.

Few would disagree with this aim. However, it has proved elusive to achieve. Practitioners have long complained that while they strive for best practice in getting to understand and support their service users, their work is undermined by what the council requires of them in delivering the processes to ration resources. Commentators have observed that there is an inevitable conflict of interest between the interests of the service user and the interests of the council.

This paper contends that it is perfectly possible for the two sets of interests to be reconciled. It is not the fact that resources have to be rationed that has caused the current tensions, but the way it has been carried out. However, achieving this reconciliation of

interests will require significant changes to the current approach to eligibility. These changes will, in turn, both require and lead to:

- a re-invigoration of the political processes that determine funding levels;
- best, person-centred practice moving from being merely *desirable* to a *requirement* to ensure delivery of the new policy.

The paper examines the prospects for a new eligibility framework by discussing:

- **the extent to which the current eligibility framework - Fair Access to Care Services (FACS) - has failed** – to provide a sense of the scale of change required;
- **why FACS has failed** – to inform the nature of change required;
- **the vision of what an eligibility framework should achieve** – to set the test of fitness for purpose;
- **the innovations required to deliver the vision**;
- **the resource allocation process and prioritisation of needs** – it is important

to be clear about the points at which decisions are made and in particular, how the eligibility framework works with Personal Budgets;

- **what needs to be in place to deliver the proposed approach** – the elements of practice, process and politics that will be required to deliver the new framework.

a. The extent to which the current framework has failed

Fair Access to Care Services (FACS) is the current eligibility framework. It was introduced in 2002 to bring national consistency in the way councils made decisions about resource allocation.

Whilst FACS is often blamed for restrictive and short sighted decisions, paradoxically the evidence is that it has a very weak influence.

In 2008, the Audit Commission examined patterns of spending of all councils and compared it to the different eligibility thresholds they employed. They found there was no significant relationship between the criteria councils used and their level of spend.

The Guardian reported in 2011 that Sunderland was the only council in the country to have no eligibility threshold, and were meeting needs at all four levels of priority (Brindle, 2011). However, this was not creating a financial pressure. Indeed, in 2009/10 Sunderland spent £4.8K per 10,000 population compared with a national average of £4.6K, within a range of £2.9K to £7K. Given that Sunderland serves the 29th most

deprived community in the country (out of 152), with deprivation increasing demand, their level of spend is, if anything, comparatively low.

No council operates a different set of eligibility criteria between user groups. However, Table 1 shows very different levels of spend per service user between older people and working age people.

Table 1 Average national net spend per service user 2009/10

OLDER PEOPLE	WORKING AGE PEOPLE
£6.5k	£12.2k

Raw data regarding number of service users and aggregate spend taken from the Department of Health National Adult Social Care Information System

Though it could be claimed that it costs less to meet the needs of older people than working age people, there is no evidence to support this view. The more likely explanation, which accords with anecdotal evidence from practitioners, is that working age people are more likely to have a broader range of needs addressed. In practice, ‘critical’ and ‘substantial’ has very different meaning for different user groups, with FACS failing to expose, let alone address, what many believe to be inherent ageism within the service.

Table 2 Spend per service user with Direct Payments and all other service users with community services 2009/10

OLDER PEOPLE		WORKING AGE PEOPLE	
Direct Payments	All other community	Direct Payments	All other community
£5.2k	£2.9k	£9.0k	£6.1k

Raw data regarding number of service users and aggregate spend taken from Department of Health National Adult Social Care Information System

There is a large differential between Direct Payment recipients and all others who receive non residential care, even within the different age groups, despite there being no difference in application of FACS policy between Direct Payment recipients and the rest (Table 2).

All service users who need continuing support are offered Direct Payments, so complexity does not account for this differential. There are low value as well as high value Direct Payments. The explanation is more likely to rest in the way resource allocation decisions are made. A study by the Office for Public Management into outcomes for Direct Payment recipients in Essex (Holloway, 2011) found that service users reported the importance of being articulate and able to stand their ground when dealing with the council's staff. This can be expected to apply when discussing levels of resource (likely to have been further influenced by council staff under target based pressure to increase numbers with a Direct Payment). Service users with a Direct Payment were able to meet a much broader range of needs including leisure and social engagement, and family carers under much less stress. Some were even able to meet health care needs their local NHS did not.

These findings were replicated in a much larger survey in 2011 of 2,000 people with Personal Budgets carried out by In Control – a not-for-profit organisation that campaigned for the introduction of Personal Budgets. This was the *National Personal Budget Survey*, June 2011 (Hatton, 2011). The survey found that those who took their budget as a Direct Payment were more likely to have a greater range of needs met, and their family carers under less stress, than those who did not have a Direct Payment. Another study (Woolham, 2009), in a Midlands council, compared the costs and benefits of Personal Budget recipients with those without. All Direct Payment service users became Personal Budget holders, resulting in most Personal Budget holders being Direct Payment recipients. It found that the average value of the package for those with a Personal Budget was 44% greater than for those without. The

figure was 111% in relation to older people. Those with a Direct Payment had better outcomes, albeit not substantially.

The very real problems of resource shortfall experienced by service users in recent years are more likely due to the growing gap between demand (with well known causes) and resources. The real criticism of FACS is that it has failed to have any impact, with the patterns of spend set out above little different from how it was in 2001 before FACS was introduced. Having nearly 90% of councils with the same eligibility threshold ('critical' and 'substantial') might give the appearance of fairness and consistency. However, the data above shows the appearance is entirely spurious, concealing very different interpretations between service user groups and of resource levels.

b. Why is FACS not working?

Henwood and Hudson (2008) carried out qualitative research into the workings of FACS for the Commission for Social Care Inspection. Interviewing over 100 practitioners and service users, they found what might be described as cold indifference to people not considered eligible and also to the lower priority needs of those who were. One of their findings (Henwood & Hudson, 2008, p.122) was that:

The precise point at which councils establish the threshold for FACS eligibility is not necessarily a predictor of how criteria operate in practice.

They differentiated between resource rationing policy set by *direction* through hierarchical authority, and that by *discretion* through practitioners' interpretation, and found the two not pulling together. Their work informed the Commission in developing the report *Cutting the Cake Fairly* (CSCI, 2008). CSCI recommended the replacement of FACS with a new framework with three levels of '*priority for intervention*' in turn based on the immediacy of the need – immediate, early intervention and longer term intervention.

This paper argues that the CSCI analysis does not go far enough. The rest of this section addresses three fundamental flaws that render the current approach to FACS unfit for purpose:

- the financial strategy is undeliverable;
- it damagingly conflates two very different groups of needs into one;
- the band definitions are confused and require too much subjectivity.

The financial strategy is undeliverable

FACS makes clear that while all of a person’s needs should be explored (the ‘presenting’ needs) only some of them need to be met. These are called ‘eligible’ needs. The council should set its eligibility threshold at one of the four levels of priority and do so on the basis of how much money it has available. Needs above the threshold will be met and needs below it need not be. FACS does encourage councils to invest in services to meet needs at lower levels of priority to be accessed outside the assessment process. However, the amounts of money are in practice small as are the levels of service. There can be no expectation that the services purchased will address all lower priority

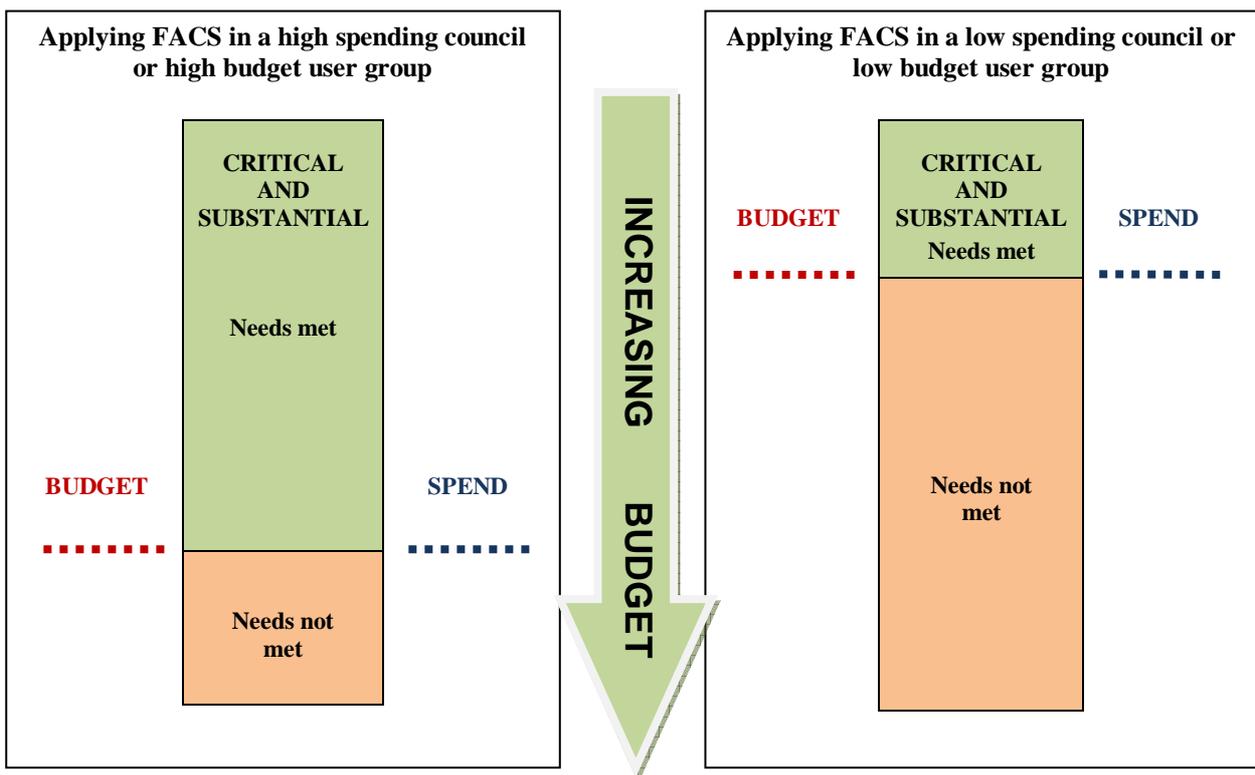
needs. Further, the approach replicates the very worst practices that the personalisation strategy seeks to overcome, whereby people either have to fit into pre-purchased services, or have nothing.

The probability that the available level of resource will cover precisely the categories above the chosen threshold is virtually nil:

- councils meet a very large number of needs, with no two needs the same and each calling for their own unique level of resource to meet;
- as the FACS guidance acknowledges, there is no relationship between the priority of a need and the cost of meeting it;
- some needs are one-off, some short term and some continuing.

What happens in practice derives from the overriding imperative to ensure spend matches budget. Once the budget is set, spend is matched to it by the definition of an ‘eligible’ need expanding or contracting according to budget availability. This applies between councils, and between user groups within councils.

Diagram 1 The relationship between budget, spend and interpretations of the priority bands



The 'eligibility threshold' is used as little more than a crude signal as to relative generosity or parsimony. A recent paper prepared for the London Branch of Association of Directors of Adult Social Services (Carlin, 2010) showed:

- one council contemplating going from 'moderate' to 'critical' only – a 66% reduction in needs to be met – but estimated this would reduce spending by a mere 4%;
- another was thinking of going from 'moderate' to 'critical' and 'substantial' – a 33% reduction in needs to be met – but estimated this would reduce spending by 0.2%;
- a third proposed going to 'critical' only from 'substantial' – a 50% reduction in needs to be met – and estimated this would reduce spending by 2.5%.

Conflation of two very different groups of needs into one

The approach fails to distinguish two very different types of need below the eligibility threshold:

- **Needs it would be appropriate for the person to meet for him or herself**, or their support system or community. This includes needs that otherwise would be 'eligible' but it is right and proper they are met by the person or their network having regard to willingness and ability.
- **Needs it would be appropriate for the council to meet** but which fall below the eligibility threshold. The threshold is set by reference to *affordability*, not *appropriateness* of response through reference to reasonableness of expectations within contemporary society.

Conflating these two groups into one taints the view of both. It is not uncommon to hear it said that councils should not meet 'moderate' and 'low' needs as a matter of worthy principle. Either they are not important, or people should meet such needs

themselves. However, a need cannot cease to be a need simply by virtue of a council being unable to afford to meet it. This point was starkly highlighted in the recent case heard in the Supreme Court of *McDonald v Kensington* (2011). McDonald required support to go to the toilet during the night as she could not safely transfer from her bed. The council said that use of incontinence pads would meet her needs. McDonald's view was a carer would enable her to make the transfer and retain her dignity. However, this would cost £200 a week. That, in effect, was the cost of meeting her need for dignity.

The Department of Health created this position in the context of a widely held anxiety that if a need were to be acknowledged, it would oblige the council to meet it. However, this is an overreaction to the law. Lord Clyde, who sat in the landmark *Gloucestershire v Barry* judgment in 1997 that drove the original drafting of FACS, made the following observation in relation to section 2 of the Chronically Sick and Disabled Persons Act 1970, which was and remains the key statute driving national policy. Section 2 places a duty on councils to meet needs which it believes are 'necessary for it to meet'.

... The words 'necessary' and 'needs' are both relative expressions, admitting in each case a considerable range of meaning. They are not defined in the Act... In deciding whether there is a necessity to meet the needs of the individual some criteria have to be provided. Such criteria are required both to determine whether there is a necessity at all or only, for example, a desirability, and also to assess the degree of necessity.

The true legal position is therefore that needs which fall below the council's chosen 'eligibility threshold' *can*, of course, be met. Whether or not they *are* met is a matter of *discretion* for the council. Whether or not they are met can lawfully be determined by budget availability, unlike needs above the 'eligibility threshold'.

This does, of course, raise the spectre of unmet need as not all needs will be affordable. However, Professor Luke Clements makes the point (*Community Care and the Law*, 2004, p.122) that there can be:

... no legal problem with the term if defined (as it is in the Welsh guidance) as presented needs that are not evaluated as eligible.

Unmet need below the threshold can lawfully be a matter of record. He goes on to note that the English FACS guidance does not contradict this, but is *'oblique on the question'*.

Definition of the bands

The descriptors of the bands render clarity and consistency all but impossible.

- In *Cutting the Cake Fairly*, CSCI described the wording of the bands as *'convoluted'*. The language is jargonistic and inaccessible to practitioners and service users.
- Decisions about eligibility are based on the separate needs the person has, which is key to driving the amount of resource (or size of Personal Budget) offered. However, much of the wording can only be applied to the *whole person*. This is because the distinction between the bands is frequently couched in terms of the *numbers* of their needs – 'few', 'several', 'majority'. This is impossible to apply to a person's separate needs.
- The descriptors confuse *needs* with *tasks, activities* and *processes*:

'Personal care' is a task not a need. Provision of the personal care *may* be the difference between a person being clean or not and is therefore (probably) a 'substantial' need. But if, say, the person would struggle to do the task themselves (or with a carer) without undue danger to their safety, but a service will make their lives a little easier, the underlying *need* is of a different order.

'Ability to carry out domestic routines' may be the difference between living in a hygienic home, or an aesthetically pleasing one.

'Choice and control' relate to the *process* to determine needs, support requirements and how support is delivered. The risk to levels of empowerment comes from practice and process more than resource allocation decisions.

There are several words, such as *'vital'*, requiring highly subjective interpretation.

These flaws conspire to create the conditions that led to the sorry findings of Henwood and Hudson referred to in the opening paragraph of this section, and to the failure of FACS to have the constructive impact required of it.

c. The vision of what an eligibility framework must achieve

It is important to be clear what the new framework should achieve.

Supporting a resource allocation process that does not undermine the vision for social care
The assessment and support planning process needs to deliver two key functions:

- articulation of issues, needs, outcomes and service requirements to ensure the best possible choices are made along with the engagement of the service user;
- creation of the understanding to support resource allocation decisions.

The eligibility framework has to ensure these two functions are fully reconciled. The view that the interests of councils and those of their service users make this impossible is a fallacy that should be challenged. There is valuable research that identifies the elements of best, person-centred practice. Most recently, Peter Beresford *et al.* (2011) published the outcomes of extensive research into person-centred practice under the auspices of Joseph Rowntree's: *The Standards We Expect*. The function of policy should be not merely to

support, but positively to require such best practice.

Enablement of precise matching of spend to budget

It is an inarguable reality that directors have an imperative to spend within budget each year – they face dismissal if they do not.

Enablement of sensible decisions about use of resources

Getting the most value from resources requires flexible decision making.

Enablement of legal responsibilities to be met
Councils must be crystal clear about what the law requires and permits.

Enablement of decisions about resource allocation that are rooted in concepts that are clear and meaningful to service users, members of the public and politicians

It is important that all stakeholders – primarily those who receive resources and those who fund them – understand why needs are met, and why they are not. Service users may have to come to terms with managing with less support than they require. It is important for political leaders to understand what is being achieved by the level of funding they are making available.

Enablement of the right balance between centralism and localism

Whilst some argue for social care to be funded in the same way as the NHS, this does not appear likely. It is important to achieve the right balance between the national and local responsibilities in the desire to secure an appropriate degree of equity nationally.

d. The innovations required to deliver the vision

It is contended that the following two innovations will address the flaws set out in section b and deliver the vision in section c:

- defining the bands so they are based on *universal needs*;

- *redefining the threshold of eligibility* and introducing a concept of a *threshold of duty*.

Define the priority bands based on universal needs

Ultimately, whilst there are outcomes to be achieved along the way, the value of all social care activity can be judged in terms of the extent to which any of the universal human needs are met. An example is a person who is unable to use their stairs and has to sleep downstairs and use a commode downstairs. While the immediate outcome of a service might be to enable the person to use their whole house again, the ultimate outcome will be about restoring dignity and self worth. Alternatively, if the person cannot sleep downstairs or use a commode, the ultimate outcome will be about meeting basic physiological needs – arguably, of a different order of importance. It is the *ultimate* outcome that is of importance to the person. It also provides the rationale for providing the service. This should be the basis of making decisions about priority.

The existence of universal human need is not contended. There is scope to define them in different ways, and critically, scope to understand the relationship between them. Albert Maslow (*Motivation and Personality*, 1954) proposed a hierarchy, progressing from physiological to self realisation needs, having to meet the former needs before progressing to the latter. This theory lends itself well to the idea of prioritising needs in a straightforward way. However, Victor Frankl (*Man's Search for Meaning*, 1946) believed the relationship between needs was more complex. Drawing on his experience as a holocaust survivor, he saw that those who survived the physical suffering were those able to satisfy needs that give meaning to life. This introduces the notion of each individual having their own view of the relative importance of their needs, or perhaps, the level of satisfaction at each level that they require.

The new framework should have the ability to work with both approaches. If the key test is what should be done with the last pound available, and help can be given to someone who is hungry or someone requiring support to meet a leisure need, most people are likely to believe it is right to spend it on the former. However, there can be scope for flexibility, set out in the next section, for each individual for whom meeting what for most might be a lower priority need is of greater importance.

The following levels of needs, based on the current number of four within FACS, are ones that are likely to be familiar to people involved in social care:

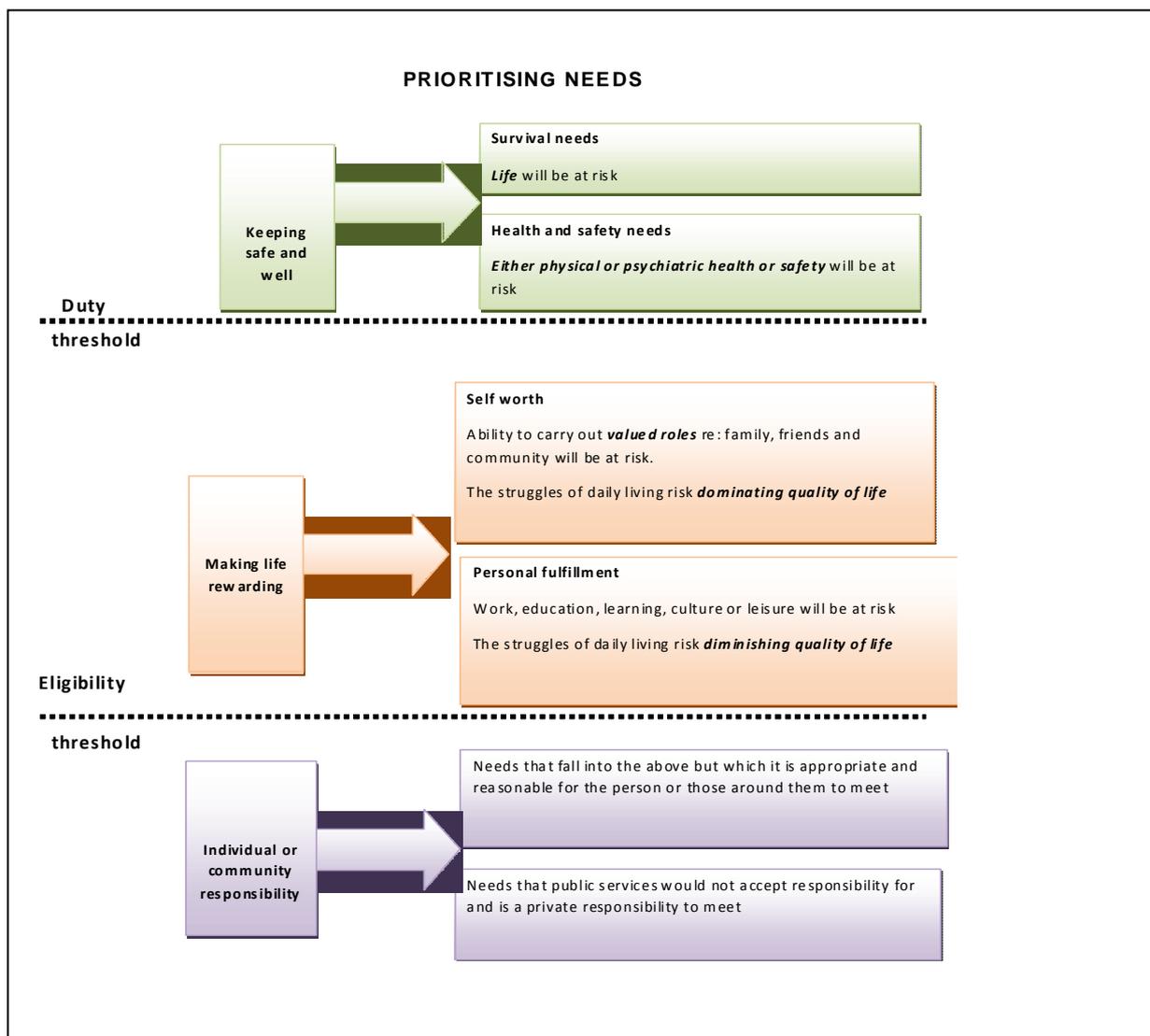
- the need to *survive*

- the need to be *safe and healthy*
- the need for *self worth*
- the need for *personal fulfilment*.

However, it is important to replace the words ‘critical’, ‘substantial’, ‘moderate’ and ‘low’. They create the impression that the lower priority needs are not important. This is not the case, with needs of a more social and emotional nature of fundamental importance to quality of life and therefore the aims of social care.

In effect, the top two levels of need represent *keeping safe and well*, while levels three and four are about *making life rewarding*.

Diagram 2 A possible needs based eligibility framework



Using these definitions will support consistency of application given that all people will be able to recognise needs seen in this way. Service users will better understand the priority attached to their needs, practitioners able to identify the appropriate level of priority, and for supervisors to identify any ‘gaming’ behaviour designed to increase priority.

Redefining eligibility and introducing a new concept of a threshold of duty

A need should be described as *eligible* if, firstly, it is one that has to be met to achieve the council’s declared vision for social care (which can be expected to include reference to independence and well-being), and secondly, if it is not appropriate for it to be met by the person, their support network or the local community. This should be the point of the *eligibility threshold*. This would replace the current tying of *eligibility* to *affordability*.

Eligible needs should, then, be divided into those that are a *duty* for the council to meet, and those that are *discretionary*. This creates a *duty threshold*. Needs that fall above the threshold of duty have to be met, albeit in the most cost-efficient way. The priority framework should continue to be used to determine where this falls. This creates an opportunity to set a national minimum offer, most likely set at the top two levels, thereby guaranteeing that all people can expect to be helped to be safe and well (Diagram 2).

A similar approach can be taken for carers’ needs (although the legal framework currently makes all contribution to supporting carers discretionary, and not duty-based).

The decision to meet a need that falls into the discretionary area should take into account:

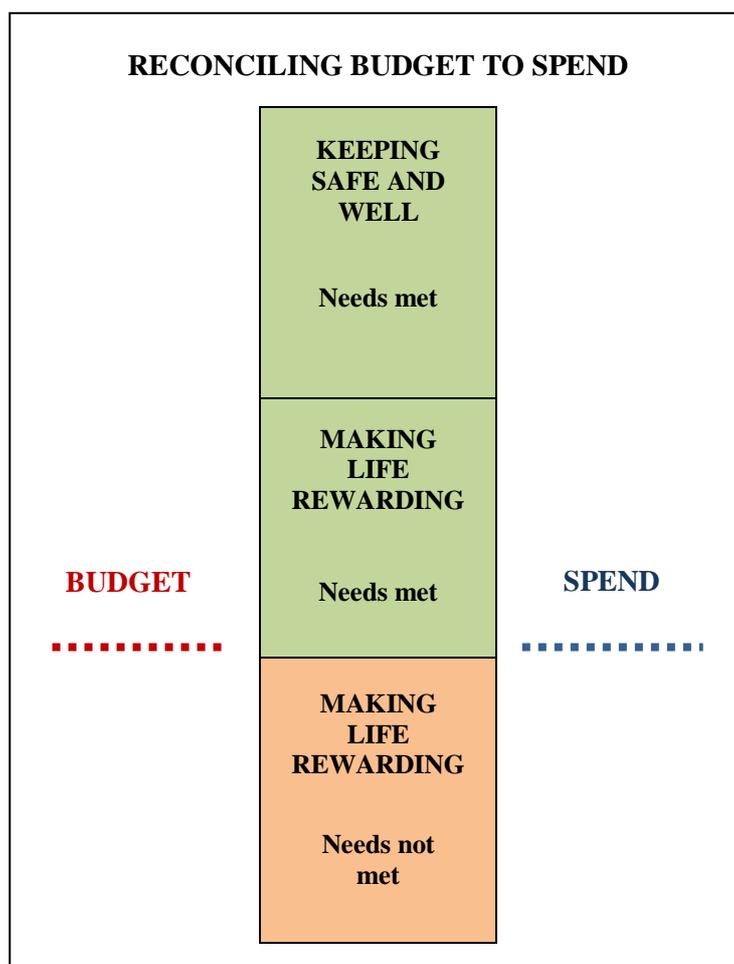
- the cost
- budget availability
- the priority
- value for money in terms of preventive impact it may have.

Working in this way will have the following benefits:

- Subject to having the resource to meet all needs above the *duty threshold* (which has to be the case), the council will be able to precisely match spend to budget *without subverting the meaning of the bands*.
- It makes best possible use of resources.
- The council will know the cost of unmet need. This can be used in two ways. Firstly to adjust local budgets to achieve equity across user groups. Secondly, it will ensure the council will have information about the full cost of delivering its vision for social care.
- Diagram 3 shows the new relationship between priority of need, budget and spend, comparing with the current relationship as described in section b.

This approach creates a framework to achieve an appropriate relationship between centralism and localism. There are equal risks at both ends of the spectrum. At one end is the ‘postcode lottery’ where there can be little relationship between the ways in which two different councils operate.

However, at the other extreme is the wish to achieve a level of objective standardisation - supported by a range of assessment tools such as the Single Assessment Process and the Resource Allocation System (RAS) - that can drive out the quality of exchange that enables a true and accurate understanding of the person and their situation. There are great risks in the concept of the ‘portable assessment’ that Dilnot (however understandably) favours. It is based on the premise that a person’s needs do not change with locality. However, this is a false premise. While their *impairment* may not change, all other factors that interact with the impairment to create the issues to address can change enormously. The person may be more or less confident and optimistic, their informal support systems very different, the local community supports very different.

Diagram 3 Appropriate relationship between budget, spend and priority bands

It would be a serious error if the drive for consistency between councils was rooted in a continued belief in the objectification of social care needs that does not match reality. It will lead to the continuation of a spurious appearance of consistency which conceals major inconsistencies.

The national position should have the following requirements:

- The threshold of duty set at a national level, with the most likely to be set at ensuring people are *safe and well*. This, in effect, becomes a ***national minimum guarantee***.
- Councils are required, ideally through a new statutory principle following the planned review of the law, to base their decisions about eligibility of needs on seeking to ensure that all enjoy well-

being and independent living, but falling short of a *duty* to meet all relevant needs in the short term.

- Councils to make public the extent of the eligible needs they cannot meet and the cost of doing so and feed this into the political resource allocation processes. This should be supported through a change in the law to place a new duty on Directors of Social Services to deliver this.

This approach will, on first hearing, create two sources of anxiety:

- Councils will say they can scarcely keep pace with demand within the *duty* band, and so the *discretionary* band will be irrelevant. However, the re-definition of the bands will reveal a lower level of current spending at what councils

believe is the *duty* level than they presently realise. They are already, for some groups at least, and in an unmanaged way, meeting a substantial volume of needs in what will be the discretionary band.

- Service user representatives will be concerned councils will respond by meeting needs above the duty threshold only and to see the discretionary element as not important. The counter argument is that councils who behave in this way will be forced to declare their vision is limited to only keeping people safe and well, and that they have no commitment to the well-being and independence of their most vulnerable citizens. This will create political tension. Service user groups will need to switch their attention from the judicial processes as a way to enforce higher spending to ensuring local political processes are working as they should.

e. The resource allocation process and prioritisation of needs

There are three options for the point at which it is decided how much resource to allocate, each with different implications for which needs are met:

1. A full ‘upfront’ allocation of money for a Personal Budget. It would require the up-coming review of the law to place an obligation on councils to meet all levels of need. The financial risks would be enormous. It is hard to imagine any government agreeing to it.
2. Retain the concept of ‘upfront’ allocation, but coming between assessment of need and support planning and with it reduced to being ‘indicative’ only.
3. Allocate resources following both assessment and support planning.

Currently, there is a hybrid of two and three. The following sets out the reasons for making a firm choice between them.

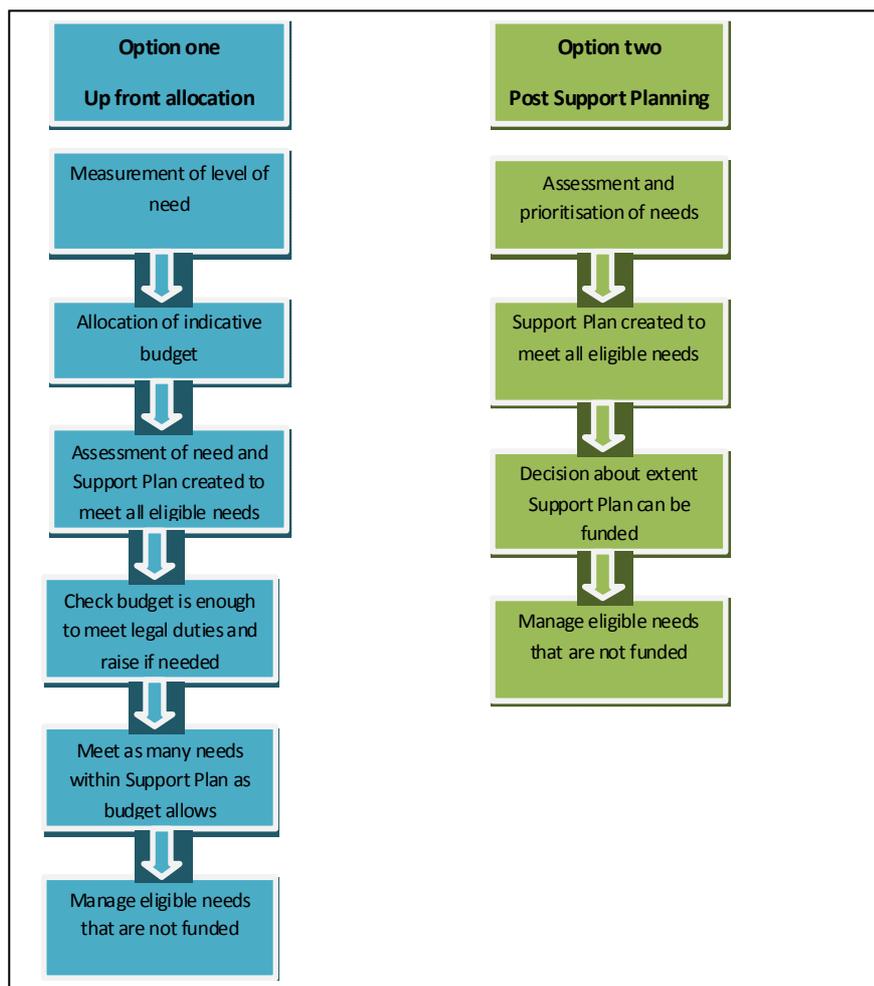
The steps required are set out in Diagram 4.

A reason for choosing the ‘upfront’ option is that it retains as much as possible of the original notion of what a Personal Budget means. However, it creates key difficulties:

- It puts a step in the process in order to create the ‘indicative budget’. This has often been delivered by various Resource Allocation Systems (RAS). They require tick box processes to arrive at a quantitative value to attach to dependencies and the informal social capital available to meet them. This cannot take the place of a proper assessment of need, which calls for a creative and person-centred process to arrive at an understanding of the person and their situation.
- The ‘indicative budget’, to meet the requirement of the Department of Health’s definition of a Personal Budget, has to be a minimum entitlement to have any meaning. This is set out in the criteria for satisfying the requirement to meet the target for the numbers of people with a Personal Budget:

The person (or their representative) has been informed about a clear, upfront allocation of funding, enabling them to plan their support arrangements. (CLG, 2009, p.144)

Whilst it will be in order for the actual Personal Budget to be *more* than the indicative budget (usually when required to ensure legal duties are met), it will arguably be a breach of the above requirement for it to be *less*. In effect, the indicative budget becomes an *entitlement* below which the actual budget will not fall.

Diagram 4 The options for points of decision about resource allocation

Such a position would be close to the original In Control vision for upfront allocations. Indeed this interpretation is reinforced by the recent work by Duffy (see *Simplifying the RAS*):

Families must know that they can safely plan up to the agreed level without having their plan picked over. (Duffy, 2011, para. 21)

This potentially creates a lottery in relation to which needs that fall below the duty threshold are met. If the person is fortunate enough to be able to have their needs at the duty level met relatively inexpensively, they can go on to meet more of their needs that determine quality of life than if they were not so fortunate. It cannot be ruled out that they will even be given more money than required to meet all their needs.

In practice, it appears even this limited vision of what upfront allocation is about is not happening. Councils are continuing to make decisions about the actual Personal Budget after support planning.

A report by Tyson (2009) for In Control about Hartlepool's progress in delivering the In Control model (see *Self Directed Support in Hartlepool, 2006-9*) shows that the actual budget is as likely to be below the indicative budget as above it. A freedom of information request of Essex revealed that throughout 2010/11, there was no occasion when the actual Personal Budget was the same as the indicative budget, while on 68% of occasions it was over 20% different. This suggests while the indicative budget adds bureaucracy, it has little or no effective operational value.

Option 2 offers the least bureaucratic and most straightforward option. This will invoke the criticism that it simply retains the failed status quo. The counter argument is that up front allocations were primarily no more than a means to an end, i.e. to allow people to choose the supports and services that will best meet their needs rather than choose from a pre-purchased menu. Option 2 will work perfectly well with that aim as long as councils divest themselves of pre-purchased services to the greatest appropriate degree so that their resources are cash based. Such freedom of choice would allow the option of continuing to describe the council's contribution to the Support Plan as a Personal Budget. This will no doubt be important given the commitment this government has declared to the concept.

f. What needs to be in place to make this work

The nature of assessments

The assessment has to create an understanding of the person's situation that analyses and makes the links between:

- the *issues* confronting the person
- the *needs* arising from the issues
- the current and potential value of the *person's social capital* in addressing these issues
- the *outcomes* to be pursued in addressing the issues.

This requires best, person-centred practice. It cannot be achieved without the person's engagement from beginning to end (or a representative who is acting authentically in the person's best interests as required by the Mental Capacity Act 2005) given the complexity and nuances involved, even in low risk situations. Approaches recently developed such as the Single Assessment Process and the RAS that are designed to collect information for the council through a battery of closed questions will not deliver this requirement.

Effective budget management systems

Defining eligibility on the basis of need, not affordability, will result in a higher rate of operational decisions to be made. Budgets will best be held at team level. To support budget holders, councils will need to provide them with reliable information about the budget and commitments on a continuous basis.

Strategic information systems

Councils will need information systems that report on the levels of need that are met and the levels of eligible need that are not met on a user group by user group basis.

New national guidance

Clearly, revised national guidance will be important. However, it is arguably possible for a council to work in the ways set out here within current guidance. This does not rule out the ability of councils to meet needs below the 'eligibility' threshold (as currently defined), or the concept of unmet need (Clements, 2004). Also, the 2010 guidance permits subtly broader interpretation of the bands than the 2003 guidance allowed.

Change to the law

No change to the law in relation to the way needs are assessed and funded is required to make the ideas in this paper work. However, it may be helpful if the idea in the Dilnot Report - of having a national minimum level of need to be met (Dilnot, 2011) - was to form the basis of the level of legal duty to replace section 2 of the Chronically Sick and Disabled Persons Act, which is anachronistic given that it lists services particular to the 1970s. Dilnot recommends that this should be at the current level of 'substantial', which would equate to ensuring that all people who need state support are *safe and well*.

It will, however, be very valuable if the new laws include Statutory Principles as the Law Commission proposes, and those principles include a statement of what the Commission calls a 'single unifying purpose' (Law Commission, 2011, p.19). It should be

expressed in terms of well-being and independence.

It will also be helpful to place a legal duty on Directors of Social Services to ensure their members are kept informed about the extent to which needs are met and not met, and the level of resource required to meet all needs that will ensure people are able to live independently and enjoy well-being.

Invigorated political process

In recent years, the tension between needs and funding has been played out through the judicial system within a rights based approach to funding. Both councils and user representatives have committed to this. However, it is arguably an inappropriate way to resolve what are essentially political issues. The judge in the recent High Court case addressing Birmingham's plan to reduce eligibility to 'critical' only, made the following point (*W, M, G & H v Birmingham City Council*, May 2011):

In general it was submitted that courts should be very wary not to intervene in questions involving the balancing of competing claims, which were matters for expertise, specialist knowledge, local policy and democratic accountability. Lord Millett in Southwark London Borough Council v Mills [2001] 1 AC 1 had said that judges were not equipped to resolve issues of priority in the allocation of resources.

The proposals in this paper shift the focus back to the political system. Exposure of unmet need will create political tension. This will test the commitment of national and local politicians to a more transparent politics. It will be hard, however, to argue against making publicly available intelligence about the cost of delivering a community's vision for a key public service, with a view to either changing the vision following public debate or progressively finding the resource to deliver it. To use a common phrase, it will be about 'putting your money where your mouth is'.

Conclusion

A wholly new approach to eligibility is required if the resource allocation process is to support, and not undermine, social care delivering on its commitment to offer independence and well-being as best it can, to do so fairly and transparently, and to inform strategic planning. The new eligibility framework should be based on universal human needs; whereby everyone is able to make sense of it and engage in the individual and strategic issues that are engendered by the rationing process. It should provide a national minimum guarantee of needs to be met, and beyond that, support flexible decision making within the budget to ensure the best possible value is secured from scarce resources. It should require the best standards of person-centred practice to inform skilled and intelligent decision making. It should bring about the full engagement of the political process in managing the dynamic between funding levels and the range of needs that can be met.

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Notes on Contributor

Colin Slasberg is a qualified Social Worker and has worked for over thirty years in Shire and Unitary Councils as a practitioner, team manager, area manager, strategic planner, Assistant Director of Resources and independent consultant. He led a programme of transformation over a five year period in a Unitary Council built around the concept of outcome based commissioning. This changed the way strategic commissioning was delivered, the way providers delivered care and support, and the way assessment and support planning was delivered. Colin has had an enduring interest in addressing the issues of eligibility and priority of need dating back to the Community Care reforms of the early 1990s.

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Book Reviews

Cognitive Behavioural Interventions for Mental Health Practitioners

Grant, A. (Ed.)

Exeter: Learning Matters Ltd, 2010, pp. 136, ISBN: 978-1-84445-210-1, £14.99

This is an ideal introductory text for mental health practitioners who want to acquaint themselves with the broad principles of a Cognitive Behavioural Therapy (CBT) approach. It is written specifically with mental health nurses in mind, but is relevant to other allied health professionals and all those working within the broader multidisciplinary context of mental health.

The book chapters model CBT sessions, so each chapter is presented in a clear and structured format in keeping with a CBT approach. An agenda for the chapter is set in the form of 'chapter aims'. This is followed by an introduction to the chapter, and then the chapter material itself. This material is easy to read, with lots of sub-headings to orientate the reader to the part of the agenda which is currently being dealt with. The text also includes suggested activities and reflection points, which aid readers in exploring and considering the topic themselves, and drawing their own conclusions, with similarities to the Socratic dialogue of a CBT session. Theory-practice links are made through the presentation of the evidence base, grounded in the context of examples (such as therapy excerpts) of how this relates to therapeutic work. Each chapter concludes with a summary, and gives suggestions for further reading.

The first two chapters contextualise CBT, both in terms of its historical development (Chapter 1) and in terms of the current policy context within mental health practice and policy in 21st century Britain (Chapter 2). Chapter 3 provides an overview of assessment and formulation in CBT. It includes an informative and thought-provoking discussion about the process of

referral to CBT, and how the client's experience of being referred for CBT might affect the initial stages of engagement in therapy. Even if the practitioner is not working with an explicitly Cognitive-Behavioural approach, they are likely to be in contact with clients who are due to have, are having, or have had CBT; and an understanding of this therapy by the practitioner could enhance their own therapeutic relationship with the client, and have an impact on the client's engagement in the therapy itself. Chapters 4 to 7 summarise the CBT approach to working with adults with anxiety, depression, people who hear voices and have false beliefs, and people with borderline personality disorder. The final chapter provides a conclusion through a discussion of CBT in the context of work-place culture in Britain, encouraging practitioners to consider how they may apply to their work-place practice the knowledge, gained through reading this text.

The text's major strength lies in its brevity; it will familiarise practitioners with the basic concepts of CBT in an accessible format, allowing them to better serve the clients they work with, and possibly sparking their enthusiasm to further explore CBT as a therapeutic modality. However, its brevity is also its weakness; reading this text is not going to enable the practitioner to become a proficient CBT therapist. So long as this is recognised Grant and colleagues provide a thoroughly accessible and coherent overview of CBT for the practitioner, be they practitioner-in-training or experienced mental health practitioner.

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Child Well-Being: Understanding Children's Lives

McAuley, C. & Rose, W. (Eds)

London: Jessica Kingsley, 2010, pp. 256,

ISBN: 978-1-84310-925-9, £24.99 (pbk.)

Child Well-Being, by editors Colette McAuley and Wendy Rose, provides a timely and well-informed text that offers essential reading about a notion – well-being – that, while in common currency, has been exposed to relatively little critical treatment of its value for driving policy, practice and research in children's services. Now we have an admirable collection of chapters by international experts, who describe in some detail the conceptual and practical application of well-being as a tool for a better understanding of change in children's lives. They provide examples from countries other than England, where the term has assumed pre-eminence in its adoption by government as foundational in the way children are positioned in policy and implementation, and their needs met in practice.

The book commences with an impressive tour by Aldgate around the concept, with emphasis upon its relevance for child development, notably in regard to its use in indicators to promote better outcomes. Critical to the notion of well-being is its temporal fix on 'now' as opposed to 'well-becoming' – that is, the longer run benefits of growing up in some specific historical and cultural context. In this sense the term's emphasis upon the contemporary should not rely solely on public service professionals for its meaning and application, but must include a sense of what children themselves think about their well-being. In addressing this very point, Chapter 2, by editors McAuley and Rose, provides valuable insights from a range of children with different needs stemming from their emotional and material worlds, and which provide the text with an essential grounding of the term in childhood itself.

Chapter 3, by Rose and Rowlands, provides an important insider grasp of how 'well-being' became the dominant policy motif in

England. This terrain is cleverly charted by two former government policy leads with impressive credentials in building and steering children's policy. They identify the long-run and multiply-stranded ideas and initiatives that underpinned the emergence of well-being as government's mechanism to promote and measure the impact of its many policies for children in England. Additionally, the relevant schema in Wales and Scotland are outlined. The sheer scale of (then New Labour) government ambitions are more prominently captured in this chapter's reprise of the major policy themes underpinning the over-arching strategy of England's *Every Child Matters* framework, one that was intended to shape broad policy and implementation for well-being. A little more on the rarely glimpsed world of policy formation, as it was constructed in particular political / administrative contexts, would have added to this stimulating overview of key events surrounding the emergence of this landmark policy.

The contrast between chapters and perspectives is a real strength of this book; and Munn's chapter on school settings and their innovative utilisation to support a more targeted approach to children's needs helps re-orient the reader back to people and practice. Here we get a good introduction to the complexities and potential of the school setting in its different guises: pedagogy, visible and hidden curricula, and the different types of social and cultural 'capital' that a school can engender, and thereby contribute decisively to children's well-being. The broad brush of the chapter does not neglect the challenge in using schools more intensively, particularly around meshing the different agendas of professionals, pupils and communities. Schools are explicitly about creating citizens now and for the future, and this theme is developed further in Dolan's chapter on youth engagement, resilience, mentoring and social support. These different and large conceptual fields are tackled effectively in the chapter and their integration sought via the notion of well-being. This is achieved by drawing upon empirical and

policy examples that reveal the importance of mobilising young people in self-help schemes, particularly in fragile societies where well-being is more likely to be defined by its marginal and precarious nature.

Chapters 6, 7, 8 and 9 shift direction, using international sources to describe the ways different societies monitor and measure well-being. Chapters 6 by Ben-Arieh and 8 by Pecora and Harrison-Jackson, offer impressive and persuasive expositions of how 'indicators' as measures of well-being have developed over time and continue to be refined and extended as information gathering becomes more sophisticated. The authors achieve the remarkable feat of making the history of indicators in child well-being a fascinating journey across time, topics, methods and debates, particularly around the thorny area of the child's subjective experience. Important theoretical links are made with rights, the child's ecology, and recent developments in the sociology of childhood. These two key chapters help position well-being as a methodological challenge, and will be of considerable interest to research and planning professionals as well as in policy and practice.

The application of indicators and their fitness for purpose is of course the ultimate test of national measures, and this is demonstrated by Brooks, Hanafin and Langford in Chapter 7, on national reporting of child well-being in the Republic of Ireland. We get a good overview of key definitions and their selection criteria via a review of international, national and regional indicator sets. They describe the use of the Delphi Technique to obtain the views of nearly 70 policy makers to help generate an agreed cluster of national well-being indicators. More on the way the views of children were incorporated would have added to a thought-provoking chapter but this issue is covered admirably in Chapter 9 by Bradshaw, Rees, Keung and Goswami. The authors offer a highly illuminating and critical foray into the realm of measuring child subjectivity via various scales and characteristics. They consider the use of

regression and factor analyses and the confounding problems in explaining the variations in subjectivity they then found. Issues about the adequacy of measures in this area seem likely to remain important for some time, but the authors rightly assert the need to continue the search for valid measures of child subjectivity if we are to properly capture a rounded grasp of well-being.

The final chapter, by the editors, re-traces the key conceptual insights that arise from this accessible and important text, particularly around aspects of ecology, rights, and the search for indicators that more faithfully capture the varied lives of children. The book casts much needed light on a central element of welfare discourse – well-being – and charts the likely direction of future debates in this field. Essential reading.

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Post-Qualifying Child Care Social Work: Developing Reflective Practice

Ruch, G. (Ed.)

London: Sage Publications, 2009, pp. 176,

ISBN: 978-1-412-928267, £22.99 (pbk.)

E-book: ISBN: 978-0-857-023070, £26.39

What does good quality social work look like in the context of work with children and families? How do social workers manage the competing demands of bureaucracy and direct contact time with children and their families? How can social work teams provide ongoing, stimulating learning environments whilst managing high numbers of complex cases?

These important questions provide the background for this comprehensive, well-planned guide to developing reflective practice. Both newly qualified workers and those well-established in practice can benefit from the idea of a learning organisation supporting a work-based learner to acquire and develop reflection skills. The emphasis

throughout the book is on how to use the review and planning cycle to inform future practice. This involves consideration of how to evaluate an interaction or a piece of work - for example, for its strengths, weaknesses and the obstacles and opportunities it presents.

As editor, Gillian Ruch produces a well-organised structure. The chapters build logically, incorporating explanations for the ideas explored in each chapter, identifying the relevant social work challenges and the observational and analytical skills which can be developed to overcome them. Each chapter has a summary highlighting learning points and framing reflective questions which practitioners can incorporate into their day-to-day work.

The book is divided into two sections. The first outlines the key principles, core teaching and learning generic to all post-qualifying programmes. The second section integrates theory and practice specific to child development, child observation, working in partnership with children, the regulatory context and collaborative working. The authors use case examples and dilemmas to illuminate the theoretical perspectives.

The text offers a range of theoretical approaches to appeal to different learning and working styles. For example, it includes reflection-on-action (after the event) and reflection-in-action (contemporaneous reflection to alter the interaction on the spot) and four types of reflective practice: technical reflection, practical reflection, process reflection and critical reflection.

Gill Tunney (Chapter 2) reminds readers that 'social work is a profession contingent on context' (p.8). For me, this statement can be extended to incorporate effective learning - that is 'social work learning and staff development are contingent on context'. Most social work practitioners evolve their own mixture of community work and case work approaches, supported by a range of theoretical perspectives, observational and assessment tools, and therapeutic approaches to direct work. In my view, this book offers a

framework for practitioners to develop a 'tool box' based on examination of direct work experiences and application of relevant theory, while locating responsibility with the employing organisation to support this development.

On a very practical level, I would have appreciated the font size throughout the book being larger. Frequently, in busy social care environments, reading tends to take place 'after hours' and tiny fonts are not kind to tired eyes - perhaps a recommendation for the E-book version! But this should not be considered a barrier. The book is one I will be selecting for training purposes to help both managers and practitioners to better incorporate reflective practice into their day-to-day working lives. It is the best text I have read in recent years, not only for recognising the constraints and obstacles to analytical social work, but also for offering practical, relevant solutions to overcome these. Definitely one to read!

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Professional Decision Making in Social Work Practice

Taylor, B.

Exeter: Learning Matters Ltd, 2010, pp. 200, ISBN: 978-1844453597, £21.99 (pbk.)

This is an interesting discussion of professional decision-making, providing a clear introduction to, and overview of many of the key areas of practice. The book offers clear definitions of important terms and concepts throughout, providing good links between theory and practice, and ample stimulus for the reader to apply the knowledge and understanding they have gained to their own field of experience/expertise. Importantly, for the more practised post-qualification social worker, it also enables the reader to quickly identify, refresh and develop their own skill-base.

The book outlines the importance of decision-making in a variety of settings and circumstances, and provides the reader with a number of case examples and activities (from a variety of organisational and individual situations), all working to support the development of professional understanding. Chapters follow a logical order and provide an excellent opportunity for the reader to assess their own knowledge and understanding of those particular concepts and processes which form key aspects of the role they play in the support, guidance and protection of 'vulnerable' persons (in its broadest sense).

The opening chapters (Chapters 1 to 4) explore roles, concepts and frameworks; crises, emotions and support; consent and human rights; collaborative and contested decisions, bound up in discussions of definition, law, and risk, in client-centred decision making. Chapter 5 offers an insight on the processes and challenges that may face the individual when making a professional judgement, such as heuristics and biases (p.64), and offers professional supervision and personal reflection as good bases and processes for learning and understanding both the decisions you make and reasons for them.

Chapter 6 gives a clear indication of risk factors - both static and dynamic, which the author is quick to point out, are key to protection and change. All too often emphasis is placed upon historical or static risks, those we can do little to alter. Yet the dynamic factors, as highlighted by Taylor, can bear the greatest fruit and offer the greatest opportunity to predict risk and support active change in behaviour.

Chapters 7 to 10 consider the management, planning, support, and assessment of risk involved in decision-making in social work. For instance, Chapter 7 centres upon the risk debate and the successful balancing of benefits and harms in supporting clients to take appropriate steps to greater independence, motivation and self-reliance, quality of life and to re-unite families.

Chapter 8 provides a discussion of appropriate assessment tools and decision-making processes. Chapter 9 briefly considers the planned implementation of decisions, which although proposed in a logical sequence, may (at times) also require a contingency plan. It is through the continuous monitoring of a decision and its implementation that the risk can be managed, updated and amended as the case requires. Finally, Chapter 10 provides a discussion of the management and allocation of what are, at times, very limited or scarce resources. It looks at the importance of good policy development and implementation, yet also notes the importance of good communication, professional supervision, training and staff development, in order to promote reasonable and reasoned decision-making.

However, as the need to work collaboratively with other agencies grows (especially in the field of public protection, risk, and/or criminal justice), multi-agency working and public protection become areas of great concern and critical discourse; and although the book highlights some of the issues, I would like to have seen a greater emphasis placed upon these inter-agency arrangements.

Finally, this is a book which the author suggests is aimed at 'professionally qualified social workers undertaking post-qualifying education and training', continuing that it assumes 'that reader has a foundation in the roles and tasks of social work' (p.2). However, I would argue it is as relevant for students of social work as it is to practitioners.

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Courtroom and Report Writing Skills for Social Workers
(2nd Edition)

Seymour, C. & Seymour, R.

Exeter: Learning Matters, 2011, pp. 192,
ISBN: 978-0857254092, £22.99 (pbk.)

In May 2011 the Munro Report into child protection was published (DfE: 2011). Commissioned by the new government, this major report was widely welcomed as a comprehensive rethink of how statutory services can best support vulnerable children and their families. Specific recommendations were made on how to improve and develop social work expertise and these were broadly accepted by the government. In reaching her findings, Munro drew on an extensive range of research including work commissioned by the Department of Justice into the workings of UK courts. A number of common themes were cited in relation to social work in court: lack of preparation for court, poor presentation in court, and failure to comply with directions. Seymour and Seymour's book therefore is a timely addition to social work literature in that it seeks to address these issues and provide social workers with the confidence to practise effectively in the legal arena.

The book is a revised edition of Seymour and Seymour's 2007 '*Courtroom Skills for Social Workers*'. As the revised title suggests, the new edition has included more material on report writing skills, as well as updating the legal and research content underpinning the book. Like many other books on courtroom skills for social work, the aim is to demystify court proceedings and thus make working in and with the legal system a familiar and positive aspect of daily social work practice. This is achieved through case studies from both service-user and professional perspectives, research summaries and activities for the reader to reflect on.

From the beginning of the book, the perspectives of users of the court system and of social work services are emphasised, with

a case study of a father whose daughter was subject to care and ultimately adoption proceedings. It makes uncomfortable reading, but highlights the importance of ensuring correct procedures are followed and best practice achieved. The authors draw on their considerable accumulated experience of the English legal system in order to give an informative historical overview. This helps to place legal processes and language in context and enables the reader to understand how these have evolved.

As might be expected from a text in the *Learning Matters* series, every chapter is linked to the National Occupational Standards for social work. This enables the pre-qualifying social work student to immediately see the relevance of the text to their studies. However, the book is equally useful for the experienced practitioner, whether undertaking post-qualifying studies or not.

Chapters entitled 'Achieving Excellence in Case Recording' and 'Writing Formal Reports for Court' help the reader to understand the difference between analysis and opinion, and also to be aware of the difficulties they could experience in court if they use imprecise language.

Overall, this is a well written and very accessible book that manages to avoid the charges of dryness that are often levelled at legal textbooks. It meets the needs of a broad spectrum of social workers, from students to experienced practitioners, and would be a useful addition to any social work office.

Reference

Munro, E. (2011) *The Munro Review of Child Protection: Final Report - A child-centred system*, London: Department for Education (cm 8062).

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What are SSRG's objectives?

- to provide a network of mutual support and a forum for the exchange of ideas and information on social and health care services;
- to promote high standards in social and health care services research, information, planning and evaluation;
- encourage collaboration in social, housing and health services activities;
- to develop an informed body of opinion on social and health care services activities;
- to provide a channel of communication for the collective views of the Group to central and local government, other professional bodies and the public;
- to sponsor relevant research and identify neglected areas of research;
- to encourage and, where appropriate, sponsor high quality training in research techniques.

Who belongs?

SSRG is open to anyone who subscribes to the objectives of the Group. Members are drawn from a wide range of professional groups and organisations sharing a common interest in the work of the caring services.

How is it organised?

SSRG is run by an 'Executive Committee' (EC) which comprises elected and selected officers, elected members, co-opted members and representatives from SSRG Scotland, whose principal tasks are to promote the objectives of the group and to co-ordinate its activities.

What does it do?

SSRG publishes a Journal and a Newsletter which are distributed free to all members. It maintains working links with central government departments, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Children's Services (ADCS) and other professional bodies and organises an annual three-day workshop on a topical theme in social and health care services research, and occasional day conferences, for which members receive generous discounts on fees. It also co-ordinates the work of Special Interest Groups which provide members with an opportunity to contribute to the formulation of SSRG responses to national policy initiatives and current issues in the social and health care services.

Equal Opportunities Policy Aims

- To ensure that every SSRG member, user, job applicant, employee or any person working with, or in contact with, the organisation receives fair treatment irrespective of their age, colour, disability, gender, ethnic origin, marital status, nationality, race, religion, sexual orientation, responsibility for dependents, political affiliation or membership of a trade union.
- To ensure that the contribution of research, information, planning and evaluation work in social care and health is sensitive to this issue.
- To ensure that SSRG promotes the equalities agenda in all its activities.

Research, Policy and Planning is the Journal of SSRG