

Personalisation

Acute Need, wherever possible, wishes to empower all its clients allowing them to choose the shape and direction of their care provision. Personal health budgets are currently being piloted in the NHS in England, with over 2,700 participants across 20 sites. A number of sites are piloting personal health budgets with people eligible for NHS Continuing Healthcare. In October 2011, the Secretary of State for Health announced that subject to the evaluation, by April 2014 everyone in receipt of NHS Continuing Healthcare will have a right to ask for a personal health budget, including a direct payment. This will form part of a broader rollout of personal health budgets to people with long-term health conditions.

A personal health budget is an amount of money that is allocated to an individual to allow them to meet their health and wellbeing needs in a way that best suits them. At the heart of a personal health budget is a care plan. This sets out the individual's health (and social care) needs and includes the desired outcomes, the amount of money in the budget and how this will be spent. The care plan is agreed between the individual and the professional, before being checked and signed off by the NHS. The money in a personal health budget can be managed in three different ways:

- *A notional budget*

- *A third party arrangement: an organisation legally independent of both the individual and the NHS (for example, an Independent User Trust or a voluntary organisation) holds the money on the individual's behalf, and buys or provides the goods and services the person has chosen.*

- *A direct payment for healthcare: the money is transferred to the individual, and the individual buys the goods and services the person has chosen. Some direct payments support organisations will act as an agent and help the individual manage the direct payment. Only DH approved pilots sites can offer direct payments at the moment. The NHS is already able to offer personal health budgets via a notional budget or third party arrangement.*

Brokerage

Acute Need aims to deliver support services in a way that gives people using that service more choice, responsibility and control in relation to the service they receive.

Personalisation in the context of public services is about giving individuals the power – and the responsibility – to choose what services they want and control over how they are delivered. A key assumption is that the individual receiving the service is best placed to decide what they need and how those needs can be met. Acute Need is not only keen to promote personalisation in the context of adult social care, but the issues discussed are relevant to the future of any voluntary advice sector organisation whose work links in some way to the delivery of public services. Individuals are now being encouraged to commission, shape, participate in, manage (and even procure) their own care. Such an approach generates demand for services: services that help people understand whether they can get public funding for the care they need (and how they can challenge such eligibility decisions); but also services to provide support brokerage, as defined in Section 1 above. Personalisation involves a move away from a model of service delivery (often adopted by the voluntary advice sector) in which clients are advised on their rights and entitlements and helped to realise them. Instead, personalisation favours a model of service delivery in which clients are supported to be informed consumers of that service, or even cast as commissioners and managers of that service.

Local authorities and Primary Care Trusts are increasingly commissioning adult social care support brokerage services through competitive procurement processes. Current contracts focus on providing services for the following target groups and their carers: people with physical disabilities

and sensory impairments, older people, people with mental health issues, and people with learning disabilities.

Background to personalisation and adult social care

The provision of free and independent advice by the voluntary sector has typically been targeted at those who are most vulnerable or marginalised: people who need help to live independently, those without a job or on a low income, or those from particularly disadvantaged groups and communities. The personalisation agenda is likely to impact the provision of public services to all these groups, and looks likely to retain its significance irrespective of specific policies adopted by the major political parties. To take an example other than adult social care, personalisation is being explored by the NHS through a pilot programme of personal budgets, with most pilot areas now offering personal health budgets for certain services (excluding emergency care and core GP services). The new coalition government announced at the end of June that a further pilot scheme involving 8 Primary Care Trusts (PCTs) will begin to road test direct payments for personal health budgets. This will allow PCTs to give the money for someone's care directly to them, allowing individuals to decide how, where and from whom they receive their healthcare, in partnership with the local NHS. Previously, personal health budgets could only be held by a Primary Care Trust or third party. Personalisation is linked with other key drivers for change that face many communities in the UK: an ageing population (people living longer and fewer people being born); changes to retirement and pension provision; increased numbers of people living with long-term health conditions such as dementia; decreasing capacity of many historically-significant support structures (for example, extended family structures); the current recession; government debt and an expected squeeze on public sector spending; and a population increasingly able and willing to assert their rights and demand good value for money.

For adult social care, a list of the main categories of people receiving services would include: people with physical disabilities / sensory impairments; older people; people with mental health issues; and people with learning disabilities. As in other areas of public service delivery, adult social care services are increasingly being commissioned and procured through competitive contracting. Personalisation is a further step along this path, with individual service users now being encouraged to shape, participate in, manage, commission and even procure their own care.

Such an approach generates a need for information, advice, advocacy and support to be available to people with social care needs. This need was recognised by government in Putting People First (December 2007), which talked of "a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding" and describes a "first shop stop, which could be accessed by phone, letter, e-mail, internet or at accessible community locations."

This universal service is not just about eligibility for increasingly stretched public funding and how such eligibility decisions can be challenged; it crucially includes information and advice linked both to the support brokerage process and to the other broad objectives of the Transforming Social Care agenda: building social capital and promoting wellbeing; prevention, early intervention and re-ablement; and choice and control through personal budgets and self-directed support. As the pressure on the adult social care budget increases, eligibility criteria will become increasingly strict. Many people will find that they need social care services to continue to lead independent lives, but will have to cover the costs of this care themselves – as selffunders.

At the time of writing, local authorities have consulted staff directly affected by personalisation (such as in-house social workers that currently plan care for older people as part of their work). Since April 2010, local commissioners have had commissioning strategies in place and to have started implementing them.