1. ‘Choice and control’ has become a familiar mantra and the underlying concept is accepted as key in the delivery of personalisation. There are two reasons for this. The first is the belief that people intuitively know what is right for themselves. The second the familiar human trait that people are committed to ideas that are their own. When people create their own support arrangements, they are more likely to work for that reason alone.

2. However, as is always the case with programmes of change, there is a risk that the mantra becomes a cliché and loses real meaning and impact. There is also a risk of not fully appreciating the complexity of the agenda. The consequence will be that personalisation will not be successfully delivered (if success is to be measured in terms of the extent to which people get supports that enable to have the quality of life they want and not simply through a process based PI). A route to ensure this risk is mitigated is to unpack the choice agenda, and ensure there are strategies to tackle it in full.

3. The range of choices in relation to which control is important can be broken down to four stages that are sequential in terms of time:

   - The first might be called the **agenda setting** level – what **issues** will be tackled, with what **outcomes** sought
   - The second is what **supports** and what **services** to tackle the agenda
   - The third (relevant where a service is chosen that has more than one provider) is **which provider**
   - The fourth level is what the provider **actually does** and **how** they do it

For people to be fully in control, they need to be making the choices at each of these stages.

4. Each level has a place and some history;

   - Classically, the ‘choice’ agenda is seen as being concerned with the **third stage**. It is rooted in a market philosophy based on a belief that enabling choice results in competition which leads to raising of standards and lowering of costs. The Community Care reforms were based largely on the thinking that the creation of a pluralistic social care market in the early 1990’s would lead to more responsive services. Whilst the market was created, it failed to achieve the change envisioned. Linked to this, as for most public services, choice of provider is not a major concern for most people. They want their local service to be of good quality.

   - Latterly the personalisation agenda nationally has shifted the emphasis on to the **second stage**. If people have cash, they will choose their own supports and move away from what are labelled ‘traditional’ services that have been seen to have failed to deliver the flexible and responsive services so long sought. For those service users who are able to take the money and create their own support systems, this does work. However, the big question is how many people will this work for, and how many will continue to want commissioned social care. Evidence is that many, probably most, will continue to want such supports. For these people, there is no reason to believe that choice at this level will lead to personalisation. There is a long history in social care of self funding, which usually results in people having services of similar quality to those who are publicly funded, and often having to pay more for them.
• Choice at the **fourth stage** is often the one service users say they value the most. Recent work on **outcome based commissioning** functions at this stage. For people who use commissioned services, it is showing the ability to go a long way to promoting the flexible and responsive services that are highly valued by service users. Importantly this is being achieved within current resource levels through changed practices and processes.

• Arguably the most important - but also least developed - is the **first stage**. What value can supports have if they are not working to the right agenda? Work at this level drives everything that happens and determines whether or not it will work. Assessment and Care Management has the original ambition to deliver *needs led working*, but has failed to deliver. The word ‘need’ quickly changed from being a noun to a verb and became synonymous with *service requirement*. Assessment and Care Management has been profession dominated with the concept of ‘assessment’ to the fore, emphasising the need of professionals to gather data and form judgements. This has been supported by Government initiatives such as SAP and now CAF which seek standardisation of data.

5. Achieving choice for service users at the first level is a challenge that must not be under-estimated for any Council that really wants to get on top of it.

• This part of the planning agenda is often under-developed and under-stated by all parties. Most people – service users, their carers, professionals – are more comfortable conducting the agenda in service terms. No-body contacts the Council to ask for help to sort out their outcomes. Whilst people do have their view of the relevant issues and outcomes (albeit they would not use those words to describe them), they are often not fully articulated, let alone challenged.

• Service users are very vulnerable to people with good intentions around then controlling the definition of issues and outcomes. This includes family and friends, but also professionals. A decade of direct access to funding for social care in the 1980's led to exponential growth in the residential care sector. Almost certainly this will have reflected family members controlling the agenda.

• Practitioners are conditioned to control this part of the agenda themselves. CSCI still test Council’s Assessment and Care Management systems against a criteria of the extent to which the service user’s views are ‘taken into account’. This falls a long way short of the service user controlling this part of the process. It remains common place for the service user contribution to be phrased in terms like ‘the service user agrees with...’

• A service led process suits the objectives of Councils who are dominated budgetary control concerns and seek to deliver these by short term strategies. The culture is about having a range of services with eligibility tests. Case decision making is drawn up to senior levels. CSCI recently found that FACS had become twisted from its original risk based approach (albeit very poorly worded) into a service based approach. Practitioners are required to deliver assessments that set out service requirements.

6. A Council that is serious about creating choice at this first stage will have to have serious strategies for doing so – it will not happen through stating of good intentions alone. It will need the following.

• A culture change whereby all staff – including the most senior staff – take a real interest in the actual value of services and supports that people receive. They should be talked about as much as the issues currently talked about by all, not least senior managers
- Practice processes that support person directed working at this first stage of the planning process

- Job and team structures to support person directed working

- Development of skills and competencies to deliver person directed working

- Resources will not increase relative to demand, so resource allocation processes that are entirely risk based are the only way to manage this fairly and in a way that is not service led (even if Councils go for a RAS, they all still retain the ability to make additional allocations where the RAS does not deliver enough)

- Quality and performance processes that support and test effective delivery. This to include senior management wanting to know if the process is helping service users to take control of their support planning from this first stage.

- An IT system that is fully consistent with the required practice processes. Too often they operate with their own messages and assumptions based on the software firm’s view of the process.

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