When care gets personal: the impact of personal budgets on social innovation
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Title:
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Headings addressed

Logics of Social Innovation and Social Innovation
The Role of the State:
When care gets personal: the impact of personal budgets on social innovation

Abstract

Personal care budgets have become a key element in government policy and involve a clear move away from a producer focused approach to the determination of personal care needs. They are not just a UK phenomena but also are found in the Netherlands and the USA (Timonen et al 2005, Van Harten 2007)

In December 2007 Alan Johnson, the key UK government minister at the time of introduction, commented:

"Our commitment that the majority of social care funding will be controlled by individuals, though personal budgets represent a radical transfer of power from the state to the public.
"Everyone, irrespective of their illness or disability, has the right to self determinations and maximum control over their own lives."

The personal care budget potentially places significant potential power on the hands of the client and means that a service provider usually needs to negotiate directly with the client on an individual basis. Considerable flexibility in the nature of provision is feasible and indeed resources may be utilised in a way not envisaged or planned in the original assessment of need. It may well shift the balance of power away from large well established providers to smaller and nimbler entities better able to respond on an individual basis. (Patmore 2006)

There is considerable potential for social enterprise and social entrepreneurship in this context. The Royal Society of Arts ‘Dragons Den’ social entrepreneur competition winners were largely focused on this area of provision. Conversely the impact of personal budgets may well be to enhance the role of private provision in this area.

This paper will explore the nature of innovatory impact of personal care budgets and identify the role played by social enterprise and social entrepreneurship in developing a response. The paper will assess to what extent the innovatory aspects represent ‘incremental change’ or whether they are opening up new paradigms in this area of key need.
Introduction

William Beveridge talked about the 5 evils which he felt confronted society. He listed them as Want, Idleness, Squalor, Ignorance and Disease. He was writing before the end of the Second World War at a time of both anxiety, uncertainty and expectation. (Abel Smith 1992)

The post war welfare state and the growth of prosperity would arguably have served to resolve some of the evils listed by Beveridge. The absolute poverty which he referred to is no longer as prevalent and education is now a legal requirement and funded by the state at least up to school leaving age.

However society has changed and the demands and challenges of post war reconstruction are now replaced by challenges of age and disability. The Beveridge solution accorded a central role to the state not simply in terms of providing the resources but also via actually organising and determining how these resources were to be applied. The Thatcher years changed the welfare state paradigm and now society is more individualist in nature. Solutions to major problems are no longer statist in nature.

Therefore we should not be surprised that centrally determined and regulated solutions have been replaced by measures which both enable and indeed encourage a high level of personal choice and discretion. These measures, individualistic in nature, have been introduced not by a Conservative Government but by the current Labour government. Whatever the result of the next general election they are likely to persist and possibly even be extended further.

The Social Care Challenge

The demographic challenge is well documented and discussed. Life expectancy is increasing (by a rough average of one week for every month). This is a composite of improvements in health care, the reduction in diseases which used to carry people off in younger years and other factors. The Kings Fund in a recent briefing summed the situation up as follows.

The demand for care and support is set to increase significantly. Life expectancy for both men and women has increased by around 11 years since 1948, and younger adults with physical and learning disabilities are surviving longer. Demographic projections suggest that between 2005 and 2026 there will be 1.65 million more disabled adults in England aged over 18, of whom 1.3 million will be over 65. This represents an increase of around 12 per cent in the number of disabled adults aged 18 to 64, and an increase of around 50 per cent in the number of older disabled adults. (Kings Fund 2009)

The increased proportion of both elderly and disabled people will pose significant demands for both residential and non-residential care and support.
This gives rise to questions of both cost and delivery. As this paper will show there are issues of the affordability of such care and also who will provide it. Social care as an occupation is a relatively poorly paid and often struggles to recruit appropriate staff. The workforce is substantially female and there is a high proportion of voluntary care offered by relatives and neighbours.

In both the UK and in other countries there has been a clear move in public policy towards enabling greater choice and control for the recipient of social care services. Audit Commission (2006), HM Government (2007). Though the discussion below focuses upon the UK it is evident that these changes are not specific to the UK but have been found in a number of other countries. Da Roit, Le Bihan & Österle (2007), Tilly Wiene & Cuellar (2000), Cloutier, Malloy & Hagner (2006), Pavolini & Ranci (2008).

There is a growing comparative literature which suggest that there is a growing scope for international learning in this area Timonen, Convery & Cahill S. (2006). Recent international conferences have strongly featured conference papers which focus on this area of work. Daly & Roebuck (2008)

There are a number of implications for this move which holds implications for the nature and form of the welfare state. Writers taking on a wider view point bring out the possibility that what is happening here is not a policy shift but rather a paradigm shift which is likely to have fundamental implications for the relationship between the state, the individual and the nature of services and support provided. Ferrera & Rhodes (2000), Newman, Glendinning & Hughes (2008) Pierson (1994 & 2001). Ungerson & Yeandle (2007)

In the UK the concept of direct payments and personalisation is not a sudden invention. Direct payments in respect of child allowances and disability are well established. However what is new is the concept that services which would have been determined and delivered via state agency – either through state employees or through contracts with providers – are increasingly being determined via the recipient who, having been deemed eligible through assessment, is put in a position to choose the actual nature of the service and provider. The evaluation of this development has been undertaken and the pilot projects have been viewed as successful. Audit Commission (2006), Glasby (2008), Priestley et al (2007). A key regulatory body for social care in the UK has also reported favourably and positively on the development of individual budgets and personalisation SCIE Research Briefing 20 (2007 and 2009). Perhaps most significantly for the social enterprises we have seen the formation of an influential social enterprise (In-Control) which has had a significant impact in shaping the developments of personalisation and which has received positive plaudits for its work. Poll, et al (2006)

The key issue – Agency
The difference which personalisation and individual care budget makes in social care is linked closely to the nature of choice and control. This can be illustrated by comparing 2 types of market situations. It is the typical situation encountered in any family. A purchase is to be made – let us assume it is an item of clothing for a child. In case A – Type 1 – the parent decides to allow the child to make the choice of the item within a particular price range. In case B – Type 2 – the parent decides that they will determine what is to be bought based upon the parents.

It represents to some extent the well known ‘principal agent’ problem which operates in many contexts including the social enterprise sector. (Eisenhardt 1989). The dilemma is how does the recipient of a product of service which is organized through another (the agent) ensure that the agent acts in the best interests of the recipient of the service?

A way to address this is to enable the recipient to both have greater control over the resource and a greater choice of the how, when, who and where of provision. This does not entirely remove the agency problem as the nature of social care is that the recipient is receiving a service from another. However it does simplify it because the agency chain is reduced and the recipient interacts more directly with the provider of the service.

**Choice – a more detailed exploration.**

The concept of choice has become well established in the UK provision of social care. SCIE Research Briefing 20 (2007) The choice aspect has been identified and analysed as representing, in public service terms, something analogous to Adam Smiths’ invisible hand guiding the capitalist economy. Le Grand, Julian (2007).

Most journalists and indeed many researchers are familiar with the excerpt from Rudyard Kipling to enable understanding of a situation. Here we propose to apply it to understand the concept of choice in social care. (Box 1)
The reality of choice is viewed as critical to both giving people a sense of independence and also in enabling more effective and efficient service provision. Vernon and Qureshi (2000). Choice in the public sector context is often seen primarily in terms of choice of provider – whether it was public, private or third sector. However to use Kipling's famous serving men as an analogy this only addresses one aspect of choice – that of who.

The reality of choice has to also pick up on the other ‘serving men’ of Kipling namely: what, when, where, how and why. Let us explore these in a little more detail

• What

The decision of what social care involves is typically one where the professional – typically in the form of a qualified social worker or a medically qualified professional – makes an assessment regarding what should be provided to the recipient. This often is based on some kind of pro-forma assessment and tends typically to be provider driven. Thus the services offered in a traditional producer determined context are focused on the producer perspective.

In a recipient choice situation then the ‘what’ is not based upon necessarily either the assessment of need made by the professional or the particular availability of services. To use a hotel industry analogy it moves from the set menu through ordering a la carte to a customer determined dish – which may be a ‘one off’.

This difference in ‘what’ is highly significant in personalisation of care services and – by implication – means that ‘menu driven’ services will no longer be always – or even generally – appropriate.

• When

The when of care services to some extent has already gone through a significant amount of change. Home Care services used to be provided during ‘working hours’ on a Monday to Friday basis. It was very much along the ‘bus service’ model whereby a service was provided at a time determined by the supplier as opposed to the customer. Even prior to personalisation of care services this had changed driven to some extent by the exigencies of endeavouring to maintain people in the community. The service paradigm is now moving towards a ‘taxi’ model whereby the recipient determines when they wish the service. If, for example, they wish to be assisted to get up late in the morning and assisted to bed late at night then that is their right.

**BOX 1 Kipling's Serving Men**

I keep six honest serving-men
(They taught me all I knew);
Their names are What and Why and When
And How and Where and Who.
Rudyard Kipling
• Where

Public service provision has often focused upon institutionally based provision. Babies are expected to be delivered in hospital contexts despite the preference of some for home births. Despite being the oldest of my 3 siblings (with a mother who was 31 when I was born) I was the only one to have a hospital birth. Under personalisation then – within limits – the recipient can be expected to have a choice as to where the service is delivered. This is likely to present a challenge to providers who may have a tradition and strong preference for a particular delivery location. In health contexts this may be associated with an increase in home visits to not just assess but also deliver treatment.

• How

This is an area of particular interest in personalisation because of the potential for difference in perception between recipient and provider. In some areas such as bathing and personal care there are particular rules and practices which providers have established. Some of these are linked to perceptions of Health and Safety rules. The provision of meals in the home is often based upon a particular form of delivery (cook chill etc).

The recipients however may vary in their desired form of service provision. This may vary very considerably and involve a determination of form which was never envisaged in the original assessment of need. A person seen as isolated, for example, might wish to use their allowance to purchase a dog or an annual football ticket to give them a purpose and potential to counter this. Both of these are real examples and have been lauded as positive examples of personal choice.

• Why

The professed reason for this is to ‘give choice’ to the recipient. However it can be argued that this choice is not unconstrained. The underlying object implicit in state documentation is to both promote independence and to encourage people to become more physically and mentally active. These are on the face of it laudable aims.

However the argument could be made that choice on the part of the recipient may well mean a choice NOT to accede to these expectations. Supposing a person wishes to spend the majority of their time in bed and uses their personal care budget to in further that purpose. The question is not entirely academic. Florence Nightingale spent more than 10 years in bed after the Crimean war and there is some question as to whether this was altogether occasioned by ill health.

Specified allowances in the UK such as child benefit, attendance allowance and carers allowance are not audited on an individual basis to assess whether the recipient has spent the money appropriately to the apparent purpose. Personalisation may give rise to issues as to whether the person subscribes to a shared view of the ‘why’ of the allowance. This is very different from the
question of fraud – rather it is identifying a potential difference between the states’ perception and that of the recipient as to why the allowance is there.

**The way the UK sees choice**

In Care services the UK government has made a clear commitment to a new form of care based in personally tailored services. These services should enable the recipients to have a much higher degree of choice, control and power. Beresford,(2008)

“The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive”. HM Government (2007:2)

In a key White Paper published in December 2008 the UK Department of Work and Pensions set out a concept of choice and control for individuals. (Box 4). This model was specifically used to illustrate the spectrum in terms of disabled people. (CM 7506 – see Box 4)

The clear message of the report was in favour of a move towards the right hand side (more choice) part of the spectrum.

“Our goal is a system where everyone has personalised support and conditions to help them get back to work, underpinned by a simpler benefits system and genuine choice and control for disabled people.” (CM7506:9)

This is worthy of comment and exploration because this is in the context of employment services which involve a higher degree of conditionality for receipt of benefits than do care services.
Box 2 Choice and Control
(CM 7506 (2008:57))

The spectrum shown in Box 2 demonstrates a clear perception that choice and control go together. This is a significant pairing in that it is possible to separate these concepts. For example, a parent might have choice over which school their child attends without also having control over what is taught. Similarly, a person might have some control (for example over the administration of medication) without having a choice over which medication is prescribed.

The linking of choice and control in the areas of social care thus represents a major paradigm shift in the way that both the recipient is perceived and also – implicitly – in the nature of the relationship between the recipient, provider, and the state.

The value set of third sector organisations and in particular Social Enterprises means that such organisations should – in theory – be well placed to deliver in this new care environment. In particular, the individual nature of the care contract should favour organisations which are able – and willing – to tailor their offer to the specific needs of each recipient. Large ‘Fordist’ style organisations arguably should find this more challenging as their model is based upon large contracts for relatively standardised services.

This can be illustrated by the following comparisons between the two forms of contractual relationships.
The Implications of choice for Individual budgets?

From the preceding it can be seen that personalisation will have some implications for the nature of transactions with the move to individual carer budgets in the social care context.

This can be assessed through the comparison of transactions in the two different paradigms. In Box 3 we examine the nature of individual budgets which would typically be small transactions, where the buyer (recipient) is much smaller than the provider. (a contract between an individual and a provider for specific services which can be terminated at short notice)

There are clear market signals – if the service is not seen as either desirable or appropriate by the recipient then the feedback would be expected to be clear (I don’t want this service which I am paying for). There is a degree of freedom for both parties in that the transaction is not forced on either. The Prime objective is usually evident and both parties have a shared understanding as to what this is.

In the Agent led situation (which is typical of purchaser – provider contracts) then the nature of the transactions are significantly different. The transactions are typically large in both size and duration (a contract for 1000 people in need of personal care for a one year or more duration). The purchaser (typically a public sector body) is large and usually larger than the provider. See Box 4

The market signals are obscure in that the purchaser is not the direct user of the services and has to use sometimes indirect or imperfect satisfaction measures (such as feedback questionnaires or professional judgment)

The agreements are governed by a range of regulations which may or may not permit variations. These regulations may affect the freedom of the end recipient to vary what is on offer, They may restrict choice in terms of ‘Kiplings Serving Men’ – Indeed it would be unusual if they did not.

The prime objective may not always be evident – A contract may be given to a particular provider because they have offered a lower price rather than because they are the best provider. Contracts may be constructed in such a way as to favour or disadvantage particular providers. The provider may have a range of motivations for bidding in addition than the provision of the services

Box 3 Recipient led

<table>
<thead>
<tr>
<th>TYPE 1 (Individual Budget)</th>
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<tbody>
<tr>
<td>○ Often small transactions</td>
</tr>
<tr>
<td>○ Buyer usually smaller than seller</td>
</tr>
<tr>
<td>○ Clear market signals</td>
</tr>
<tr>
<td>○ Freedom for both parties</td>
</tr>
<tr>
<td>○ Prime objective is usually evident</td>
</tr>
</tbody>
</table>
in accordance with the objectives of the end recipient. (Such as gaining entry to a new market, making more efficient use of staff or resources etc)

Box 4 Agent Led
Type 2 (Public Service Contracts)
- Usually large transactions
- Buyer usually larger than seller
- Obscure market signals
- Contract/grant regulations
- Prime object not always evident

The impact of Personalisation and individual Budgets

The effect in the UK of Direct payments in Social Care is shown in Box 5 drawing on work commissioned by CSCI (Commission for Social Care Inspectorate). This indicates that some 73,000 people were using direct payments (as of March 2008) and that this had represented a significant increase over the previous 6 years. These figures may now have substantially increased

Box 5 Direct payments
- Over 73,500 people are now using Direct Payments, including carers,
- A significant increase over six years
- A substantial shift towards putting people in control of their own support.

Individual Care Budgets
- 4,800 people had an Individual Budget at March 2008
- Just under half have a Direct Payment as part of the arrangement.
- The average annual gross value of an ICB has been estimated as £11,450 – most of which is social care funding.

CSCI State of Social Care in England Jan 2009

Individual care budgets appear to have had a slower take up with just 4,400 at March 2008. However things may well have moved on from then.

For Individual budgets Box 5 shows the views expressed by Key Stakeholders from the government sector. The Association of Directors of Social Services perhaps unconsciously emulating a quote often attributed to Margaret
Thatcher (the former UK Conservative Prime Minister) offer the view that ‘there is no alternative’. The Care Services Improvement Partnership taking perhaps a different perspective see them as offering ‘better value for money’. Perhaps significantly research which they commissioned from Birmingham University also drew attention to the blurring of boundaries between health and social care which individual budgets might effect. The research reported that recipients were not so concerned about this as the actual agencies involved. Glasby (2008).

Glasby observed also that the Individual budget sites have ‘developed a number of innovative models and approaches to resolving these issues (the blurring of boundaries) and social care funding was being used in some cases to fund health related tasks’. Glasby (2008:14)

The Department of Health itself was quoted as indicating that “personalisation will be the new operating system”

### Box 6 Individual budgets – views of key stakeholders

- There is really no alternative (ADSS Briefing)
- Getting better value for money (CISP)
- Personalisation will be the new operating system (DoH)

Source: Cordis Bright Social Care Briefing April 2008

### ThePossibly Darker side of the Official View

Given the observations about the pressures on the care system identified earlier it would be scarcely surprising it there were not views expressed that Personalisation may work to resolve these (regardless of whether they are better for the individual)

Cordis Bright Social Care Briefing April 2008 provided some observations from their work in which they found that there were a number of expectations from Government representatives which they interviewed. The views variously suggested that there could be a possible saving of 30%; that it represented a way forward to fund future care needs and that individuals who were given more control tended to use it for short periods of support (albeit at a more intensive level) than individuals under the conventional care system

There was also the question of reduction of administrative overheads and ‘In-Control’ the social enterprise focused on this area had also suggested that a substantial amount of overhead costs could be removed by giving recipients control of their budgets. This is somewhat reminiscent of the Inland Revenue (the UK Tax Authority) requiring taxpayers to complete and file (and sometimes
calculate their tax liability) themselves. In short it represents a cost transfer as opposed to a saving with the recipient or their nominated agent having to manage and administer something previously undertaken by the state. However the analogy is not a perfect one as in the case of personalized care budgets the individual is able to exercise choice over the nature of the services which they receive.

The nature of the shift

The Consultants (Cordis Bright) mentioned previously have produced an interesting diagrammatic representation of the differences between the conventional and the new system. (Box 7). The lighter shaded areas represent the conventional system and the darker areas the new.

The diagram shows the significant moves which take place in the direction of the individual. In particular with Direct payments the Individual receives the funding which they then pass to the provider. They also have the option of identifying providers and are in control of Contract Management (CM) and review of the contract. They are directly involved in performance management and deciding the nature of the contract – areas which they did not have a direct role in under the conventional care system.

Box 7 The Individual Budgets Process

Source Cordis Bright Social Care Briefing April 2008
The Impact on providers?

The implications of the foregoing account would appear to suggest that there is a significant opportunity for third sector providers in this new paradigm of provision. Social Enterprises with their trading (customer) orientation one would think would be especially attracted. The recent encouragement of social enterprise in health care would presumably positively link with a blurring of boundaries between health and social care.

However drawing again on the Cordis Bright report this opportunity does not seem to have been exploited by the social enterprise sector. (Box 8) whilst there has been a very significant increase in the number of Home care agencies (especially from 2004-2006) this is largely accounted for by the private sector. Local authority provision has in fact fallen slightly since 2006 and the third sector is at best stable.

**Box 8 Home Care Agencies (source Cordis Bright 2008)**

Possibly an argument could be made that it is the structure of the home care sector which impedes social enterprise – namely that the private sector has gone to scale and that it is hard for the start up social enterprise to enter the market.
Cordis Bright did not break down the individual categories of provides but they did look at the size in terms of number of users served by each agency. (Box 9). This suggests that though there are indeed some large agencies the largest category by far was small agencies serving less than 50 users. This would seem to indicate that this sector has not moved to scale and standardisation and is well suited to responding to personalisation in social care.

**Box 9 Size of Home Care agencies in terms of number of users**

There are some other aspects with entry of social enterprise to this market. The social care sector is notoriously poorly paid in comparison to other occupations. Box 10 shows just how poorly paid is the voluntary sector care worker in terms of other possibly comparable public sector workers. The figures tell the story and perhaps most depressingly indicate that the disparities have persisted over the past 5 years with the refuse collector and road sweeper keeping proportionately ahead of the voluntary sector care worker. Feminists might observe that the former are primarily male and the later primarily female.
<table>
<thead>
<tr>
<th>Occupation</th>
<th>2003</th>
<th>2006</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train driver</td>
<td>£595</td>
<td>£673</td>
<td>£700</td>
</tr>
<tr>
<td>Secondary school teacher</td>
<td>£582</td>
<td>£641</td>
<td>£673</td>
</tr>
<tr>
<td>Fire fighter</td>
<td>£465</td>
<td>£536</td>
<td>£553</td>
</tr>
<tr>
<td>Nurse</td>
<td>£457</td>
<td>£494</td>
<td>£516</td>
</tr>
<tr>
<td>Refuse collector</td>
<td>£324</td>
<td>£384</td>
<td>£406</td>
</tr>
<tr>
<td>Road sweeper</td>
<td>£294</td>
<td>£331</td>
<td>£351</td>
</tr>
<tr>
<td>Care assistant (vol sector)</td>
<td>£183</td>
<td>£211</td>
<td>£243</td>
</tr>
</tbody>
</table>

Source: SCEC (2008) Based on Income Data Services – Public Sector Pay
Personal Assistants: the new kid on the block

Associated with direct payments and individual care budgets, a new form of employee has emerged – that of a personal assistant. The term is often applied in the context of private sector organisations. MIND commissioned research into the use of direct payments by mental health recipients. The research noted that

“In a national pilot of DPs in mental health (2001 to 2003), approximately half of all Direct Payment recipients employed a personal assistant (PA) to provide social and personal support – including assisting them with daily activities (shopping, cooking, cleaning), helping them access community and leisure facilities, or providing respite and night sits. Direct Payments were also used for transport, education, short breaks, arts activities and accessing mainstream leisure services “. MIND (2009)

The use of a PA employed by the recipient has implications which may not be obvious at first sight. Currently social care staff employed via organisations are required to meet standards of registration. The organisations typically seek experience and qualifications which are pertinent to social care. The Social Care Employers Consortium cited research which identified some of these concerns. (Box 11)

Box 11 Personal assistants

- 90% of personal employers do not believe that the compulsory registration would ensure PAs are qualified or improve the quality of care.
- 90% of personal employers did not ask for a qualification when recruiting a PA.
- 80% of personal employers did not ask for previous experience when recruiting a PA.
- 70% of PAs want compulsory registration.
- 40% of PAs do not have a contract of employment.
- 33% of personal employers did not obtain references or CRB checks.
- 10% of personal employers experienced mistreatment, neglect and abuse from their PAs.

Source: SCEC (2008)

Personal employment by individual employers is a significant factor in social care and this is likely to be enhanced by Direct payments and Individual care budgets. However will these new employees – whether called personal assistants or whatever – be drawn from the current workforce. The challenges for third sector organisations could be considerable.

“Research carried out on behalf of Skills for Care has estimated that
the current workforce employed by individual employers is around 76,000. Of these, 33% are new to social care, whilst another 20% have moved from more traditional care roles. However, only 2% have moved from local authorities. If these proportions hold constant, as personal care expands it will have serious consequences for the voluntary sector workforce. “ SCEE 2008;12

Conclusion

The future for social care both in the UK and elsewhere looks like it is going to both embed choice and a higher degree of recipient control. This is going to potentially change the tradition conception of social care as mediated through contracts and arrangements between organisations, The individual is going to become an equal (possibly more than equal?) partner in the equation. (See Box 12)

The development of Direct Payments and Individual Care budgets is likely to be associated with a wider choice of providers and services. The freedom of choice may also involve decision not to purchase but instead ‘bank’ the resource and use it when need arises.

Box 12 New forms of relationship in social care delivery

The move towards personalisation and individual care budgets is both clear and well indicated in the UK. This can be seen as a paradigm shift rather than an incremental change. It is not simply a UK phenomena but also represents a wider change across a range of countries. In essence the change involves a move toward recipient choice and control in social care.
This change has major implications for organisations in all sectors who are involved in social care. These organisations will need to move from a model of contracts based on large organisations to individually negotiated contacts. Social enterprises have both a challenge and an opportunity to respond to this new environment.

The blurring of social care and health with their attendant funding streams will also introduce opportunities and complexity. Innovative ways to deliver support may well emerge to deal with this new situation. Finally the new role of Personal Assistant may offer a whole new career based on drawing in people to the field who do not have the traditional social care background.
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