Safety for Citizens

Personalisation & Safeguarding

Draft Working Paper Version 2.0

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Summary

Personalisation makes people safer. Done properly personalisation makes people safer in 6 different ways:

1. Personalisation is focused on strengthening citizenship and using the most appropriate measures, balancing freedom and control, to help people be safe.

2. Personalisation improves the current care management system by the use of Self-Directed Support which provides a comprehensive of risk management system.

3. Personalisation enables people to move away from ineffective and institutional systems of control which create a dangerous illusion of safety but have proved inherently risky.

4. Personalisation offers an ideal model for responding to complex cases of vulnerability and abuse where careful risk-management and person-centred practice are essential.

5. Personalisation creates the correct framework for preventing abuse by strengthening citizenship and communities.

6. Finally, and most importantly of all, personalisation works - and it makes life safer for people by getting them in control of their life and away from harmful environments.

It is right that policy-makers are focusing on personalisation and safeguarding. But there needs to be a much more realistic understanding of both personalisation and the risks inherent in current community care services. Without this there will be an unnecessary level of confusion and conflict within the adult social care sector.

Introduction

Some people think that there is a conflict between the ideas associated with the term 'personalisation' and those associated with the term 'safeguarding' but the reality is that this conflict has more to do with deep misunderstandings about both ideas than with any real conflict.

In fact we can identify 3 primary misunderstandings that bedevil much of the current discussion around personalisation and safeguarding:

- The goal of personalisation is freedom from control, not safety
- The practice of personalisation is less concerned with the reduction of risk
- The rules and systems required for personalisation will increase risk

The fact that these misunderstandings are prevalent is not surprising. Personalisation has only just begun (only 1% of citizens receiving adult social care are currently given a individual budget). Very few people have paid attention to the detailed practical and theoretical thinking that underpins personalisation and the limited press coverage on personalisation tends to treat it as merely an extension of Direct Payments. At a deeper level the weakness of this understanding may reflect the resilience of simplistic ideological left-right thinking which incorrectly sees Self-Directed Support as a neo-liberal reform of public services rather than a reform based upon the principles of social justice.

This does not mean there are no real issues, problems or policy questions. There are many, and far too many for this paper to fully map. However we can perhaps examine these confusions in some more detail, help clear away some of the confusions and then identify some of the strategies that will help bring clarity to some of the policy choices that the Government has to make.

We will end by arguing that there no conflict between personalisation and safeguarding, instead personalisation is the way to achieve more effective safeguarding. Personalisation makes people safer.

1. Safety is one of the goals of personalisation

The simplest confusion comes by treating personalisation as if it is simply about 'freedom' and treating safeguarding as if it is simply about 'control'. But this is not a sensible way of defining these terms. These definitions are wrong for every sensible practitioner and citizen knows that a good life requires a balance between freedom and control - and the trick is to find the right balance.

Control can be personalised

In fact personalisation is not about maximising freedom. As the use of the very term implies it is primarily concerned with how to design support arrangements so they are more 'personal' - which means they need to fit the person, be suitable for them. And, contrary to the current stereotype, one of things you can personalise is *control itself*. Not only can you personalise control but *personalised control* is sometimes the key to excellent support:

> *Karen is a woman with a moderate learning disability. In her twenties Karen began to drink, mixed with a rough crowd and began to get involved in prostitution. Although she was supported by a service provider the service provider did not seem to be able to alter Karen's behaviour, which became more and more extreme. Eventually, drunk one night, she was hit by a car. She acquired a brain injury and was placed in an institution while she recovered.*
>
> *Karen was desperate to leave the institution and within the institution she was unable to drink and her behaviour was very controlled. A new service provider was asked to work with Karen to help her move out of the institution and initially, when Karen moved into a flat of her own things went very well. However, after some time Karen chose to buy herself alcohol. Very quickly her behaviour spiralled out of control again.*
>
> *The service provider was determined not to repeat the mistakes of the past. Together with the social worker the provider met with Karen's family and began to identify every strategy that they thought might deal with Karen's drinking problem. Although they identified over 10 strategies to begin with, they then had to eliminate strategies that did not look like they would be effective. In the end only one strategy seemed likely to be successful - to ban Karen from drinking alcohol.*
>
> *This strategy may seem extreme, however it was very successful. When Karen purchased alcohol the organisation's Director came to her house and poured the alcohol down the sink. Once Karen realised her behaviour would not be tolerated she stopped trying to drink. Moreover she seemed to feel that the firmness with which she was being treated actually demonstrated the commitment of the service provider to stick with her and to not allow her life to descend into chaos.*

This story is told not to demonstrate that coercion and control is always justified, it is not. However, it *can* be justified when it has been properly thought through and where it is demonstrably the most effective strategy for reducing the overall level of risk. It would **not** have been justified if:

a) Karen could be judged to have full capacity to make all her own decisions

b) The approach would have provoked even more dangerous or risky behaviour

c) A less restrictive approach, like attendance at AA sessions, would have worked

Control can be personalised, just like any other aspect of a support service. But it must be justified with due regard for (a) capacity (b) effectiveness and (c) proportionality.

Control does not guarantee safety

Of course the reason why personalisation has become associated with freedom is also not hard to identify; for the current Community Care system is typically very poor at providing people with opportunities to exercise freedom and control. Citizens who need support find themselves offered little or no choice over the support they can receive. Once they are then 'in a service' they routinely lose freedoms that other citizens take for granted - everyday choices from when to wake up in the morning, how they live, who they live with and even fundamental cultural values cannot easily be accommodated within typical forms of service provision. With the best will in the world registered homes, day centres, and impersonal domiciliary services will all struggle to provide personalised support that enables the citizen choice and control over their everyday lives. This is often a source of stress and disappointment, not just to the people receiving these services, but also to paid staff as well, who typically strive to do the best possible job they can.

These restrictions on freedom are rarely justified by any increase in safety or by improvement in any other aspect of well-being. Instead the loss of freedom is mostly determined by structural necessities of bureaucratically organised and delivered services. In turn this creates either dependency or frustration and can quickly lead to further risks:

> *Martin, who had autism and a learning disability, lived in a group home, but his violent outbursts had lead to the police being called to his home and there was concern that Martin may have to go and live in a secure unit or prison. To forestall this possibility the social work department asked for some independent advice on Martin's behaviour.*
>
> *The independent consultant discovered that Martin's violent outbursts were connected to the regime within the group home which set a series of restrictive rules, which applied specifically to Martin and which were justified for reasons of public safety: for example, Martin was not allowed to go out on to the street alone to purchase an ice cream when the ice cream van arrived while is housemates could.*
>
> *Martin's behaviour seemed to becoming more risky as he reacted to policies which aimed to promote public safety and limit the liabilities of the organisation. What made Martin's situation particularly striking was that the restrictions on Martin's movement made by the group home only applied in that environment:*
>
> *a) When Martin spent the weekend with his mother she had developed a careful designed and incremental programme to encourage Martin's independence (but she was frightened of telling anyone of her very thoughtful approach in case the social work department thought it was 'wrong' and stopped Martin from staying with her).*
>
> *b) When Martin was at the day centre he would often leave early, before the bus arrived to pick him up and take him home (he was bored and frustrated by the regime at the day centre also). Martin would then walk several miles across town to get to his group home, with no support or escort. The day centre staff had no responsibility for him once he'd left; the group home staff had no responsibility until he got home. It was only when he was at 'home' that the tight restrictions could begin.*
>
> *This story show the poor quality thinking that follows from a partial focus on one risk ('what might happen if we let Martin out on to the local streets') without really understanding the impact that the restriction actually has on the whole of Martin's life. In*

fact it seemed, in this case, that the service provider had lost a sense of perspective - they had failed to understand Martin as a whole human being and by focusing on one minor risk they had created an enormous and very real risk for Martin.

Applying controls, rules and restrictions can be very useful when they are applied thoughtfully, and if they are personalised. But we had best be thoughtful about how we apply such restrictions or we can easily put people at greater risk.

The goal of personalisation should be citizenship

These stories have been told to help remove the simplistic association of personalisation with freedom and control with safety - personalisation does not just mean freedom and safeguarding does not mean control. In fact this confusion arises more easily because of the history of the technical terms 'personalisation' and 'safeguarding'.

The term 'personalisation' has been taken from Charles Leadbeater and others to refer to a broad range of possible strategies which could be used to reform welfare service by including people in the design of services that suit them better.[1] Since the Government's Concordat *Putting People First* the term has taken a slightly narrower definition and is generally used to apply to three distinct but connected reforms:[2]

- **Self-Directed Support and Individual Budgets** - the system developed to reorganise most social care provision[3]
- **Re-ablement** - support provided to people to help them improve their skills and capacities, often to help people to return home from hospital
- **Community Development** - strategies used to increase community cohesion and social capital, reducing the level of need in communities, e.g. some of the POP pilots[4]

It is interesting to note that all these definitions primarily focus on a process - or a means to an end. Just like the term personalisation itself these terms do not tell you what goal they are trying to achieve - this is assumed, but not stated, and this creates a certain ambiguity and potential for fear or uncertainty in those who are not familiar with these techniques.

On the other hand safeguarding is defined primarily by its goal - keeping people safe, and more particularly, keeping people safe from abuse by other people. Here we are reasonably clear about what is to be achieved, what is much less clear is *how* this goal is to be achieved. Moreover in debates about safeguarding it is not untypical to see very different possible strategies treated as if they were broadly similar, because they all share the same goal:

- Regulating and inspecting services
- Regulating and accrediting staff
- Criminalising certain behaviours
- Organising leadership and coordination responsibilities

Later in this paper we will explore some of these strategies in a little more detail, but here we want to make a more basic and fundamental point. Decisions about the benefits of different reforms and strategies can only be made in the light of some understanding of what we are trying to achieve and with evidence as to the approaches that are most likely to achieve that goal. We also need to

understand the nature of the goal we seek and the way it does or does not link to other things we seek.

Safety is a good thing. We ordinarily organise our lives and the lives of others so that we can be safe. However safety can only be properly understood as one aspect of life - safety cannot be the absolute or only goal of life, that would meaningless. We cannot just wish to be safe - we can only wish to be as safe as we can be while getting on with the business of life.

Moreover this is also true when we love or support someone. We may want them to be safe, but we cannot *only* want them to be safe - this has no meaning. In fact, if we *only* focus on safety, there is a grave danger that, like Michael's service provider, we will not even achieve safety. In order to both evaluate and understand safety it must be seen as an essential part of a bigger whole.

One useful framework for thinking about the purpose of welfare services is that, at their best, they should promote citizenship. And citizenship is not some wooly or merely political ideal.

Our communities are composed of individuals who are connected with one another and the local area in a wide variety of ways – through ties of family, neighbourliness, friendship, shared interests, and so on. We need to nurture and build on these ties and to provide particular encouragement for those who find it difficult to make the most of their connections with others and to play a full and active part in community life. We might define citizenship in terms of the following 7 properties:

1. We each should be in control of our own lives and, if we need help with decisions, those decisions are kept as close as possible to us - self-determination

2. We should each have our own path and sense of purpose to help give our life meaning and significance - direction

3. We should each have sufficient money that we are not unduly dependent upon others and can live an independent life - money

4. We should each have a home that is our own, living with people that we really want to live with - home

5. We should each get support that helps us to live our own life and which is under our control - support

6. We should be able to fully participate in and contribute to family and community life - community life

7. We should have our legal and civil rights respected and be able to take action if they are not - rights.

Our first suggestion is therefore that the government should frame the debate about risk and safeguarding within its proper context, which for us would be an understanding of all that threatens to our citizenship. Moreover this does not complicate the task of evaluating different possible strategies because, in reality, achieving greater citizenship for all will increase the safety of all - weakened citizens are at the greatest risk of abuse:

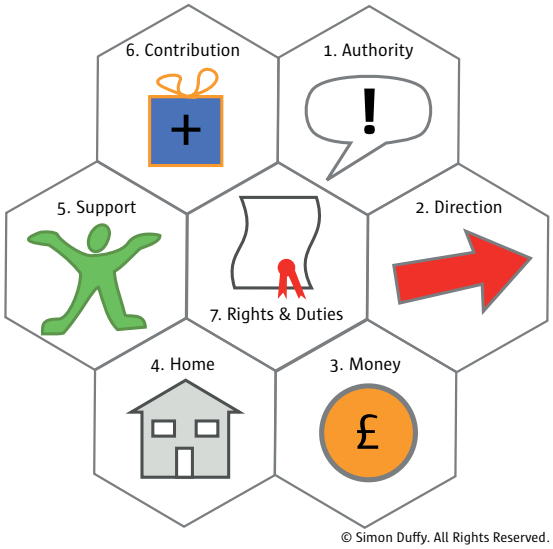
1. **Self-determination** - I am at greater risk of abuse if I cannot direct my life, if I cannot communicate and if I am not listened to.

2. **Direction** - I am at greater risk of abuse if my life does not suit my preferences or character and if I am perceived by others as lacking social value.

3. **Money** - I am at greater risk of abuse if I lack money or if I cannot control my own money.

4. **Home** - I am at greater risk of abuse if I cannot control who I live with, who comes into my home and if I cannot protect my privacy.

5. **Support** - I am at greater risk of abuse if I've no one to help me and if I cannot control who helps me.



6. **Community Life** - I am at greater risk of abuse if I am not part of my community, if people do not know me and I have no chance to contribute to it.

7. **Rights** - I am at greater risk of abuse if there is no publicly understood and enforced protection for me from the abuse of my rights.

These are universal principles and there is already significant experience to show that everyone can be supported to be a citizen, as long as we pay attention to providing appropriate support in each domain.[5] A rights-based approach to safeguarding, framed by an understanding of citizenship may be the best guarantee of a more robust, coherent and successful strategy for protecting citizens from abuse. Those at greatest risk of abuse are, almost certainly, those who lack these seven keys to citizenship.

2. Personalisation is better able to reduce risk

The second misunderstanding of personalisation is that (whatever its intention) it is *in practice* less concerned with reducing risk and promoting safety than the old system for organising services.

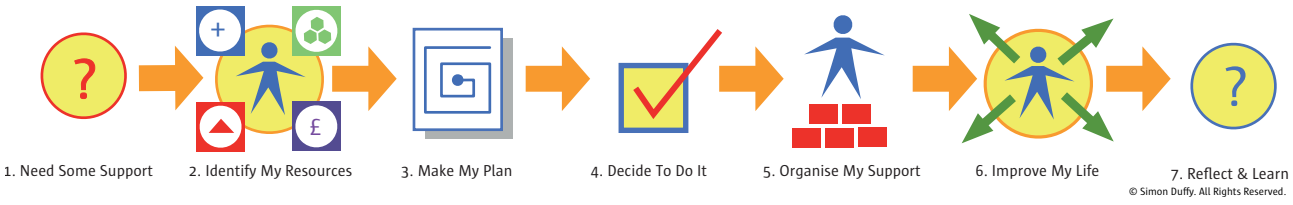
Now, as we have already argued, there are a number of practical forms which personalisation can take and ideally we would review all of these forms. However it doesn't seem likely that when people worry about personalisation they are worrying about the practice of re-ablement or of community development. It is primarily Self-Directed Support which is considered controversial and it is appropriate that we focus on exploring whether the practice of Self-Directed Support improves or reduces a focus on safety and risk reduction.

Self-Directed Support

Self-Directed Support is a coherent system for organising the delivery of support services so that they really fit the needs and capacities of the individual. It is a sophisticated, universal and flexible system which includes several inter-connected elements:

- Personal or Individual Budgets
- Resource Allocation Systems
- Support Planning
- 6 sources of systems of support for managing the budget
- 6 contractual options for controlling the budget
- Outcome-based reviews

Frequently how these different ideas have been connected as a coherent process has been represented through the *7 Step Model of Self-Directed Support* which is represented graphically below:



Step by step this process describes the pathway of the citizen through their engagement with the local authority in planning, organising and amending their support service:

1. Everyone is told their level of entitlement (their individual budget) and they decide what level of control they wish to take over their budget.

2. People can plan how they will use their budget to get the help that's best for them; if they need help to plan then family, friends, service providers, social workers, advocates or brokers can support them.

3. The local authority still helps people to create good support plans, checks they are safe and makes sure that people have any necessary representation.

4. People control their budget to the extent they choose; there are 6 distinct control options, ranging from direct payment, indirect payment, a trust, a provider managed fund, an independently managed fund or by having services commissioned by your local authority.

5. People can use their money flexibly; they can use statutory services, (the cost of which can be taken out of the individual budget) and any other forms of support; if they change their minds they can quickly re-direct their budget.

6. People can use their money to achieve the outcomes that are important to them in the context of their whole life and to support their role and contribution within the wider community.

7. The authority continues to check people are okay, share what is being learned and can change things if people are not achieving the outcomes they need to achieve.

This process has been designed so that it works for everyone who has a significant need for support. It is not suitable for people who need immediate or crisis interventions nor for people who only need very short-term help. But it is well suited to include:

- People of all abilities, including people with very severe disabilities
- People of all mental capacities, including people who need representation for critical decisions
- People of all ages, including children, adults and older people
- People with health problems, including mental ill-health and long-term conditions

Self-Directed Support and risk management

The public understanding of personalisation and Self-Directed Support has suffered because it is sometimes treated as the equivalent to 'just giving people the money'. But this is not what Self-Directed Support involves. In fact it involves 6 critical checks and balances to improve risk management:

1. **First Contact** - The local authority must set up a system for enabling people to easily contact them or for taking referrals from families, professionals and the general public. It must also make this system alerted to the possibility of abuse and able to react appropriately. At the moment local authorities will tend to 'triage' people who come forward: (a) offering some people information, advice and referral to other forms of more appropriate support (b) ensuring people get immediate support, therapy, adaptation and assistance to be safe and improve capacities where possible and (c) enabling an assessment for a budget.

2. **Assessment** - The local authority will meet with the citizen, help them to assess their needs and to apply for their budget. At this time there is a clear duty on the local authority to identify any possible risks, including the risk of abuse and to act appropriately where the situation demands it.

3. **Capacity Test** - The local authority must identify whether the person has capacity to make critical decisions and, if not, it must follow the principles of the Mental Capacity Act and enable appropriate representation.[6] One of the major advantages of Self-Directed Support over the old social care system is the fact that it requires a test of capacity in order to put in place the necessary contractual arrangements. The old 'professional gift model' of services does not require the same rigour - as consent is not essential to the provision of a gift.[7]

4. **Support Planning** - The local authority must enable the citizen to develop their own support plan. Unlike the older system, which makes planning the responsibility of a care manager Self-Directed Support requires that planning is carried out by those most likely to develop the best quality plan.

5. **Plan Review and Sign-Off** - The local authority must then review the proposed support arrangements and check that they are reasonable. Again the quality of decision-making is improved precisely because the local authority is not primarily responsible for planning but for *evaluating* plans, offering constructive criticism and advice and, if necessary rejecting plans and instigating a fresh planning process. This is a much more coherent process which avoids the danger or the local authority 'marking its own exam papers'. Several local authorities have developed panels and appropriate risk management policies for this process.[8]

6. **Outcomes Review** - The local authority must then check that the individual is doing well and achieving the appropriate outcomes. Reviews must be timed to reflect the relative risks and the possibility of significant changes in need.

In this way Self-Directed Support offers a thorough process for quality assurance with at least 6 distinct checks for risk and all the necessary means to terminate or alter the arrangements they enter into. As a decision-making process Self-Directed Support is thorough, detailed and holistic. By shifting the primary focus of planning towards the individual and those closer to them it increases the possibility of generating high quality plans and solutions. But, by shifting the role of the local authority towards that of interrogator, checker and approver it encourages a creative dialogue that radically reduces the risk of ill considered plans and services.

All of this should demonstrate that Self-Directed Support is not a simple transfer of cash to the individual. Instead it is the the creation of an appropriate *Conditional Resource Entitlement* - a managed partnership between the citizen and the state:[9]

- The citizen receives their entitlement, but must use it to meet their needs

- The local authority fulfils its duty of care by delegating power and resources to the individual most likely to make the best decisions - usually either the person or someone close to the person

Self-Directed Support in no way weakens the local authority's duty of care towards its local citizens; instead it provides a framework for meeting those duties with greater competence. As an aside to this analysis it is important to note that the NHS is increasingly playing the role that is here assigned to the local authority. Primary Care Trusts and the other NHS organisations will also often find themselves managing risk as part of a personalisation strategy. It will be important that the NHS also reflects on best practice in personalisation as it embraces the new reform agenda.

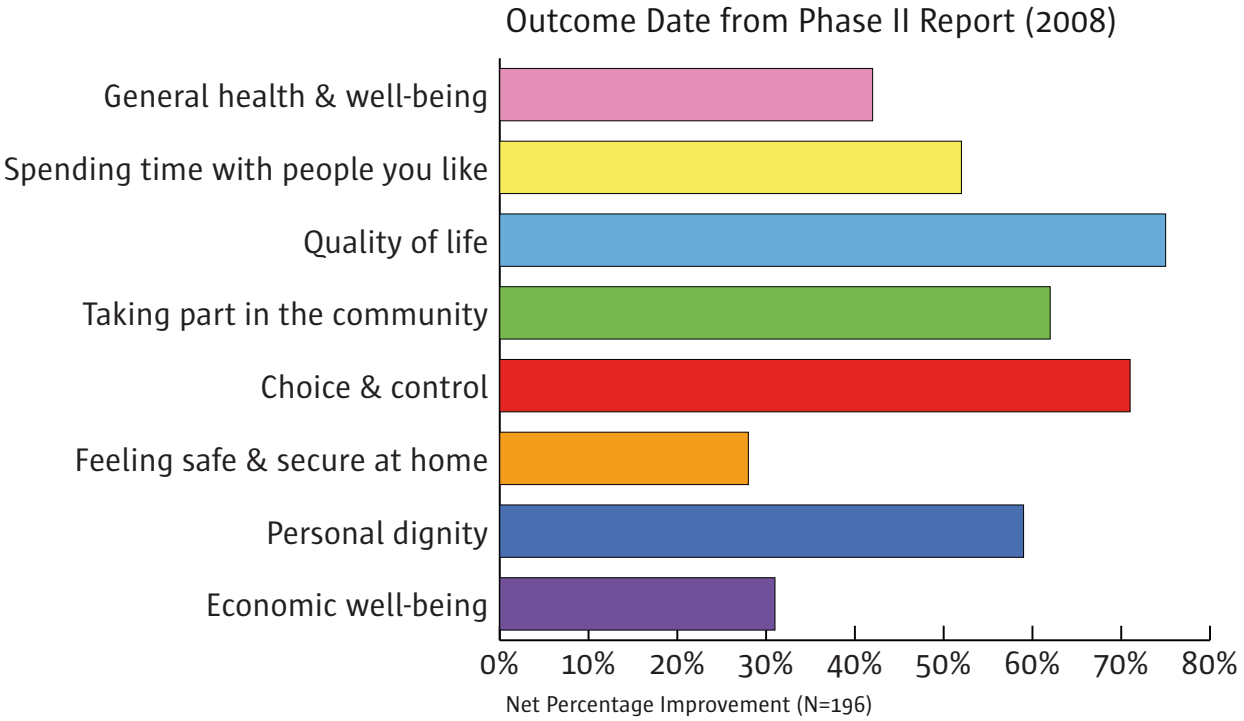
The actual outcomes of Self-Directed Support

As we have seen what this process aims to achieve is far more sophisticated than just more freedom for the citizen who needs support - although it does usually mean more freedom in particular cases - the main purpose of Self-Directed Support is to promote the outcomes of citizenship itself. Moreover there is evidence that it is doing so, for instance the 2008 report showed people reporting a range of improvements, with significant improvements across all the domains measured - including safety and security itself.[10]

This does not mean the actual delivery of Self-Directed Support will always be perfect. There is always room to improve quality:

- Many places have not even begun to implement Self-Directed Support (only 60 local authorities had given anyone an individual budget at the beginning of 2009).
- Some places have a confused conception of Self-Directed Support and a few even disagree that it is the right model for reorganizing support services.
- Actual delivery of Self-Directed Support will inevitably be patchy, particularly to begin with (some local authorities are developing versions of Self-Directed Support which seem inflexible and bureaucratic).
- It will be possible to improve the 7 step model of Self-Directed Support or to improve some of its elements if we enable further innovations
- There are unresolved legal and policy issues which will continue to cause some practical difficulties on the ground (e.g. charging rules, the increased application of VAT, lack of clarity about employment responsibilities, multiple and duplicative funding streams like the ILF, incoherent regulatory regimes - to name but a few).

But these difficulties and uncertainties are inevitable in any complex change process. Moreover no observer of the current system would be confident that current system is more competent at managing risk or improving safety. As it stands Self-Directed Support, and therefore to a large extent personalisation, is a process which has been designed to improve safety and there are encouraging signs that it is doing exactly that.



3. Personalisation can help build safer communities

The third misunderstanding is that personalisation must *indirectly* imply or even require the implementation of national policies, regulations and practices which will increase the risk of abuse. In other words, the fear is that personalisation creates an indirect threat to safeguarding by demanding a more liberal regulatory environment.

The simplest response to this misunderstanding is to point out that Self-Directed Support was designed to fit into the current, highly regulated system and it seems to be thriving within that context. So clearly personalisation does not *require* an utterly liberal regulatory environment. However, it is true to say that personalisation does raise some important questions about the current regulatory environment.

To begin with it may be worth noting that for those who see a policy threat to safeguarding from personalisation, the reasons for their fear may depend on varied beliefs, some of which are logically independent of each other. Perhaps the most common assumptions about the benefits of regulation are that:

1. People are safer when they are in congregate or institutional environments

2. People are safer when they are in regulated services

3. People are safer when they have staff who are trained in a particular way

4. People are safer when their staff have had police checks (CRBs)

It is important to note that each of these propositions is really quite independent and it is possible to believe one statement without holding to any of the others. Here we will take each belief in turn and subject it to a little scrutiny.

Institutions are unsafe

The history of institutional environments for disabled people teaches us that they are perhaps the most dangerous places in which to live. Nor are the reasons for this hard to discern. Our model of citizenship already indicates the many dangers people are likely to face:

1. **Diminished self-determination** - People have a limited voice; bureaucratic structures, the aggregating needs of many people and the essential power structures within an institution make it inevitable that the individual will struggle to exercise autonomy and that they will be in the power of others.

2. **Devalued life** - Institutions struggle to offer people the means to express their unique identities and live a life of meaning, this further contributes to their vulnerability and encourages abusers to treat people as objects.

3. **Impoverished** - Institutions take away people's money and people's control of money, instead essential needs are met in ways that cannot be reshaped by the individual who lacks the means to exercise power and control.

4. **Sheltered but homeless** - Institutions offer the barest form of shelter but remove all the other benefits we associate with home. People cannot choose who they are with, who supports them and they lack privacy. They can easily be victimised by staff or by fellow inmates.

5. **Care not support** - The very isolation of institutions from the everyday world and the implicit power structures mean that while people may be cared for or looked after as passive patients they do not receive support; they are not active and they are not enabled to be active. The culture of care, by weakening awareness of the individual's autonomy and rights, creates further risk of abuse.

6. **Disconnected from community** - Institutions take people out of communities, out of neighbourhoods, out of families, away from friends. Sometimes their very justification is linked to an awareness that communities are not always good places to be. But the price of this exclusion is too high; cut-off from loved ones and the opportunity to contribute to our community, this is when we are at our most vulnerable.

To many this analysis will seem too negative, but perhaps that is because as a society we rarely take time to consider the damage done by institutions.[11] When abuse occurs we treat this as an 'isolated incident' even though we have decades of evidence suggesting that abuse is encouraged by institutional structures. It would be much healthier for society to recognise the relationship between abuse and institutionalisation.

Regulation provides a weak guarantee of safety

Given the abusive history of institutional services it is not surprising that governments try to control for quality and reduce risk by putting in place rules and systems of inspection. The two most important sets of rules are those for care and nursing homes and those for domiciliary care services.[12] By the creation of those rules we have thereby created 'registered services' and, naturally enough, there is now a prevalent belief that registration does offer some assurance of safety. Indeed some people may even fall into the trap of thinking that systems which were put into place to try and limit the risk in inherently risky environments actually in some way create safe environments. This shows a complete misunderstanding of the history of community care services.

As people began to make the shift away from institutions there a subsidy was created by the Government to providers of Residential Care called 'Board & Lodging'; while this did help to accelerate the shift away from large scale institutions there were two unforeseen effects: (a) it encouraged many older people to seek heavily subsidised care within care homes and (b) it led to the development of new forms of institutional community services that limited personal autonomy.[13] By the 1990s, when this particular subsidy was terminated, Social Care had developed into the following major components:[14]

- **Residential Care** - Units where many people live and receive 'care' (the average size for people over 65 is 34). 267,000 people live in residential care homes (and a further 160,000 people live in nursing care homes).

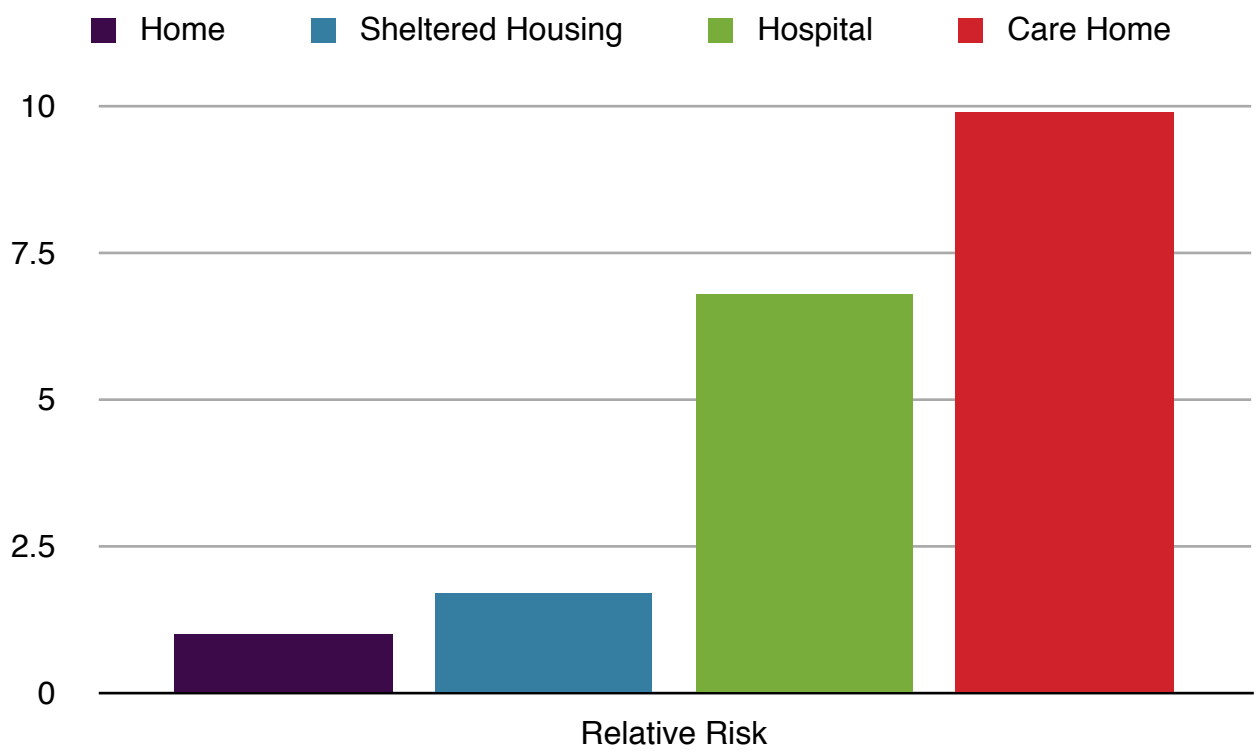
- **Day Centres** - a place where people go during the day. 242,000 people attend day centres.

- **Domiciliary Care** - help in your own home. 98,000 people receive 'intensive home care' (more than 10 hours per week).

- **Institutional Care** - in addition many people have continued to be placed in hospitals (increasingly private) or similar large-scale institutional environments. Exact numbers are difficult to identify.

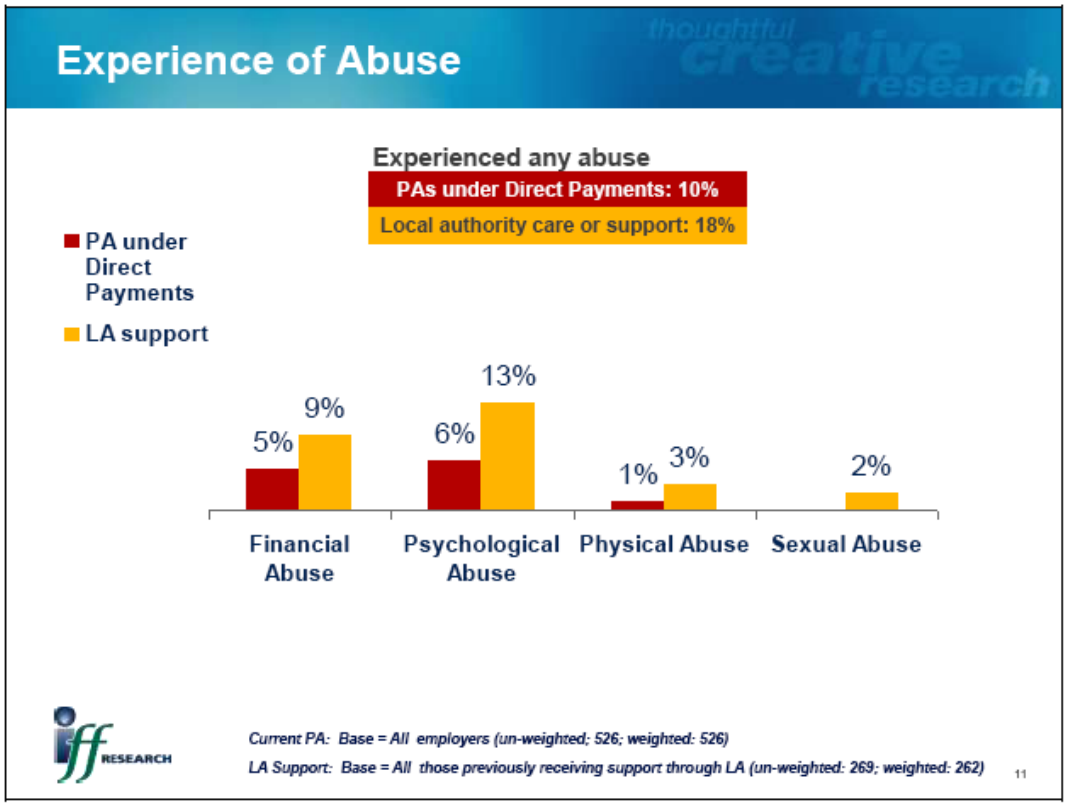
Moreover, despite the existence of regulations and inspections, it appears likely that the level of risk from abuse for older people in residential care is much greater than that for people in their own homes. For instance, figures from Action on Elder Abuse published in 2004 seemed to show that the

risk of being abused was 9.9 times greater if you lived in a registered care home (residential or nursing) and even 1.8 times greater if you lived in the relatively less institutional environment of sheltered accommodation.[15]



We have also seen interesting research from Skills for Care which showed that the shift from local authority paid staff to the use of staff employed by the person was correlated with a significant reduction in risk:

Figure 4.5 – Proportion of employers experiencing abuse, mistreatment or neglect from current or previous Personal Assistants employed under Direct Payments and under Local Authority support services



Moreover these homes are also devalued and unattractive to the general population. For example Commission for Social Care Inspection (CSCI) commissioned a MORI poll of the general population and concluded "Few people would choose to live in a residential care home when they are older, reflecting the desire for independence and choice. Those who do, prefer a privately-run home (12%) to council-run (8%) or charity-run homes (3%)."

Moreover, even if monitoring reduces the relative risks of residential care, it has proved challenging to get the providers of residential care to meet the minimal standards by which they are regulated. For example in 2005-06 53% of care homes for younger disabled adults had "insufficient verification of the suitability of staff through recruitment checks and references."

The problem of regulation is not restricted to registered homes. It is striking that even where the existing Social Care system provides relatively personalised services, in the form of registered domiciliary care, it does so in a cumbersome and restricted manner. More than half of all home care services to adults are provided through pre-commissioned block contracts or in house services and, as CSCI have noted:

> *Most councils restrict the help they will offer to a list of prescribed activities. Care managers draw up individual care plans that tightly specify both the tasks to be undertaken and the time to be devoted to these tasks. During this study, people using services, their families and their care workers told us that it could be difficult to carry out the required tasks in the time available. They also expressed frustration with the inflexibility of this system. (Time to Care? p. 5)*

Furthermore in 2005-20066 CSCI inspections revealed the degree to which the Domicilary Care Agencies they inspected failed to meet required minimum standards. Poor performance was highlighted in all key service areas (see Tables 1 & 2).

Service Area	% failing
User focused services	22%
Personal care	26%
Protection	29%
Managers and staff	33%
Organisation and running of the business	23%

Table 1 Performance of Domiciliary Care Agencies

Standard	% failing
The needs, wishes, preferences and personal goals for each user are recorded in a personal service user plan	48%
Staff are supervised and appraised	43%
Safe procedures for medication, with users keeping control where possible	42%
Rigorous recruitment and selection procedures	39%
The risk of accidents for users and staff is minimised	37%

Table 2 Standards in Domiciliary Care Agencies

Today we are faced by a double paradox. The services which were developed to replace the institutions often seem to be both institutional and risky. And the regulatory regime which aims to at least limit the risk of abuse appears to offer the false 'blessing' of 'registration'.

The right training might help

A further important belief is that training staff will help them to do their job better and may reduce the risk of abusive behaviour by staff.[16] In itself this is uncontentious and at least plausible; the concerns arise when this proposition is further developed into one of two possible policy recommendations:

- The government, or one of its accredited agencies, is the right organisation to shape, design and accredit appropriate training, and
- People should only be able to spend their individual budgets on employing people who have been 'suitably trained' (or organisations who employ such people).

We have the direct testimony of many disabled people that both of these propositions are highly questionable. And again, the reasons for resisting these propositions reflect the history of welfare provision and the institutional culture from which it has developed. In practice this means that many people find that the 'official training' their staff receive does **not** seem to focus on:

- Listening carefully and respectfully to them
- Ensuring that they present themselves in ways which enhance the status and presence of the disabled person
- Thinking through risks in a person-centred and appropriate way

- Communicating with the person they support and others appropriately

Most importantly of all disabled people report that they want staff who are trained for and by themselves. The vast majority of support work is to act as a direct support to a particular individual, who happens to have some kind of impairment or health problem. To be regularly supported by a person who you do not like, who does not understand your needs (as you define them) or who does not treat you with respect, acknowledging that it is *your life* that is an intolerable burden.

It is particularly noticeable that personalisation is not only attractive to those children, families, adults and older people who use it; it is also very attractive to staff. Leece's study of the relative stress rates between home care care staff and personal assistants showed "that the group of personal assistants in the study reported lower stress levels and higher job satisfaction that the comparison sample of home care workers."[17] We also know that high stress levels are correlated with abusive behaviour.

Perhaps we need to learn much more about what makes for success in the employment and training of support staff before putting in place any new regulatory controls based upon 'training qualifications'. In fact a more powerful strategy might be to rethink the whole emphasis on staff training within the current system. Broadly, in the English social care system there are, at any one time:

- 1 million paid staff
- 1 million people receiving support
- 6 million unpaid family members and others offering free support

It seems peculiar, if training is as useful as it would seem to be, that it is actually focused on only 17% of the core community, and as Self-Directed Support becomes the norm it would make more sense to develop a much broader sense of the audience for training and to develop approaches to training that are much more consistent with the principles of personalisation. There are some very interesting models of more person-centred training for staff which may offer some useful models.[18] Moreover many authorities at the leading edge of implementing personalisation, like Oldham and Hartlepool, have already integrated the training of PAs and others into the current system.

Information on criminal offenses can be useful

Many people also believe that people will also benefit from being able to find out whether their staff have criminal records or whether they are on the POVA list (Protection of Vulnerable Adults). This is certainly an uncontentious reform as long as:

- Statutory bodies **make available** necessary information in a timely way which does not load undue costs on to the disabled person
- The person **isn't forbidden** from employing a suitable person, who just happens to have a criminal record - the character of crimes and criminals vary and many disabled people have a very positive experience of employing people who have had a criminal history.

Moreover we need to be very clear that the checking of criminal records is not likely a fail-safe guarantee: (a) many abusers are not caught, or are not charged or are not found guilty (b) there can be no record for someone who is abusing for the first time. Nevertheless it must be prudent to seek this information if it is available along with other important information, such as proper references.

Local authorities who are implementing personalisation thoughtfully are making sure people have access to this facility.

Personalisation will lead to new forms of provision

What is certainly true and important about the shift towards personalisation is that it will lead to the creation of many new forms of support. This should be welcomed. Support services can only improve if they can innovate and innovation requires changes from the existing norms. We have found that as people take more control over their own support they tend to seek:

- Greater use of personal assistance
- New forms of flexible provision by service providers
- Informal support from family, friends and neighbours
- Micro-provision - small service providers[19]
- Self-employed support providers
- Connecting to existing community services
- Support to find and keep work
- Forms of live-in support
- Systems of brokerage and planning support

In other words an increasing number of people are seeking support that is flexible and which is better suited to help them live the life they really want to live.[20] This makes it particularly concerning that some argue for the increased regulation of these emerging forms of support. When there is no evidence that regulation reduces risk and evidence that Self-Directed Support reduces risk then creating new and costly forms of bureaucratic control over emerging social innovations is deeply unhelpful.

4. Integrating personalisation and safeguarding

This whole discussion paper has been dominated by the need to defend personalisation from the idea that in some way it might increase the risk of abuse. Broadly we have argued:

1. Personalisation should be committed to improving safety as an integral part of promoting well-being and enhancing citizenship.

2. Personalisation offers techniques and approaches, in particular Self-Directed Support, which provide an excellent framework for minimising the risk of harm and protecting people from abuse.

3. Personalisation does not demand an utterly liberal regulatory regime; however we did question some of the assumptions that seem to drive some of the policy initiatives that are proposed under the heading of safeguarding.

We want to use the rest of this discussion paper to explore an alternative approach to safeguarding - personalised safeguarding. For, given everything we have argued above, there is a strong case for fully integrating personalisation and safeguarding into one coherent approach for reforming social care.

Vulnerability and community care services

Currently the idea of safeguarding operates in two very different policy environments: 'child protection' and 'vulnerable adults'. However we might wonder whether it is sensible to split our social concern that people are free from abuse between children and adults - clearly our age can make some difference to the legal framework, but this is surely a secondary matter from the perspective of the citizen. Perhaps it would be more helpful to focus on safeguarding all people from abuse (not adults **or** children).

However if we do limit our focus to adults then it is important to note that the existing policy begins by trying to identify a special group of people as "Vulnerable Adults" and these are defined in existing guidance as "a person aged 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is or who may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or exploitation."[21]

There are a number of problems with this definition, in particular it seems viciously circular and confusing to define a vulnerable adult by their need of community care services: (a) many people who need support (i.e. community care services) are not especially vulnerable to abuse while (b) many people who are vulnerable may not need anything that looks like a 'community care service'. For example Baroness Jane Campbell needs support, but she is not especially vulnerable; whereas an adult may be abused by a family member without having any disability, or impairment.

Furthermore this definition also seems to imply that receiving a 'community care service' is inherently safe or safer, whereas, as we have seen, people in care services, especially where those services are institutional in character, are at an increased risk of harm from physical abuse, sexual abuse, financial abuse, increased social isolation and ill health.

Abuse is a crime

Instead perhaps we need to begin our thinking in a different way. The definition of abuse contained within *No Secrets* is that "abuse is a violation of an individual's human and civil rights by any other person or persons". Furthermore, it lists the different kinds of abuse:

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual abuse**, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;
- **discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

What is obvious from this list is that most abuse is almost always a crime. This means that we need to keep at the centre of our thinking the fact that the police and the criminal justice system must be intimately involved in any proposed strategy.

Dealing with 'complex cases'

We might even wonder why social services, given what we have said already, needs to be involved in the protection of vulnerable adults - however there are at least 3 good reasons why the police might need the help of social services:

a) **Insufficient evidence** - Some people may seem to be being abused, but the evidence for the abuse is too weak to enable police action. In these circumstances we may want a different kind of intervention that tries to work either by persuasion, support, planning or the use of the local authority's ability to put people under their own care. Social workers often have the skills necessary to help make people safer in these 'suspicious but not yet proven' cases.

b) **Gentler measures** - Even if there is sufficient evidence of abuse it is not always the case that the law offers the right response to a possible abuse. For instance, a family may be very dysfunctional and mutually abusive, but a criminal punishment would be unduly harsh and unhelpful. Again, social workers can be excellent agents for helping people change their behaviour without recourse to police action.

c) **Prevention** - Of course we do not want to simply react to actual or suspected abuse, we also need to think about how to prevent abuse. This will inevitably require leadership and partnerships. Ultimately the responsibility for building safer communities would seem to lie in a critical partnership between local government and the police and social workers may also play a valuable role in helping particular individuals reduce the risk of abuse.

If this analysis is correct then this suggests that there is an important problem in the way the current policy debate on safeguarding has been framed. For it seems to have located the challenge of safeguarding as fundamentally focused upon the application of community care services, even though 'community care services' are not really the right solution to the problems of safeguarding.

The probable explanation for this confusion is that there is a genuine need for social workers (for children and adults) in these 'complex cases' for they can help people to try and find solutions for complex problems outside the operation of criminal justice. However, unless we reframe the problem correctly and remove this undue focus on community care services we run a number of serious risks:

1. **Complex cases might become detached from the police function** - Even when there is a 'complex case' which sits on the edge of the criminal justice system it must not slip into simply being the responsibility of social services. The question of whether a crime has or has not been committed or whether the response to a crime is a police response or not must surely sit with the police and criminal justice system itself - no civil actor can take responsibility for those judgements. This confusion also may have the unintentional side-effect of down-grading the criminal status of abuse, leaving social workers in a highly ambiguous role - handling criminal cases as if they are not criminal cases - this is an unfair burden to place upon social workers.

2. **The social work role might be confused with the care management role** - Social workers should be excellent partners with the police in helping people resolve complex social problems; however it is important to ensure that their role is not confused with the old 'gate-keeping' role of care managers. Instead their role as partners in resolving complex social problems of risk and responsibility should be seen as much more open, focused primarily on using the best possible techniques of planning and problem-solving to help people escape dangerous situations.

3. **Prevention should not be only located with Adult Social Care** - There are many strategies for preventing abuse (a) some focused on the citizen (b) some focused on the community and (c) some focused on system improvements. It makes sense to see the prevention of abuse as an important social objective and not just a crime to which we must respond. Wherever leadership for this objective is located it will be important to use the full range of social partners to bring about improvements: police, education, housing, social services and children services. In particular, it does seem somewhat peculiar to have created such a strong institutional divide between the responses to child abuse and the abuse of adults and this would seem to reduce the chances of developing the most coherent local strategy.

If this analysis is correct then a more effective strategy for safeguarding might be to:

a) Ensure the role of the police as primary agents of criminal justice is clear and unambiguous

b) Offer the police the support of social workers to resolve complex problems that require additional support, representation or 'care orders' and

c) Wider systemic commitment on prevention which includes but is not limited to social service departments

5. Self-Directed Support helps in 'complex cases'

As we saw at the beginning of this paper it is a fallacy to think that Self-Directed Support is just for people who are easy to support. Properly understood Self-Directed Support is critical to effectively supporting:

- People who behave badly or dangerously
- 'Problem' families
- People who are at risk from abuse by others

The reason for this is that Self-Directed Support is very flexible and it contains within it a number of tools which make it easier to solve complex human problems.

1. **Resources targeted at outcomes** - Self-Directed Support targets the right level of resources to achieve outcomes. Instead of offering people service slots that may or may not be suitable, it identifies the right level of funding given the particular situation and needs of the individual. This can be in the form of an individual budget, multiple funding sources, small or transitional grants.

2. **High quality planning** - Self-Directed Support is not prescriptive about the type of planning necessary, rather it demands that the social worker identifies with the citizen the most appropriate approach for them. For some people rigorous planning processes like Essential Lifestyle Planning can be very useful, for others less formal support from peers or family can be most effective, for others systematic group processes such as family group conferencing are ideal.[22] To be effective the style of planning must be personalised to the individual and their community context.

3. **Risk assessment** - As we have already seen Self-Directed Support also offers an excellent process for clarifying responsibilities about risk. Organisations like Oldham Metropolitan Borough Council and others have redesigned their whole care management process around the principles of Self-Directed Support in order to make clear and open decisions about risk central to the local authority role. For individuals where abuse is suspected or where criminal measures might become necessary it will make sense for the police to be integral to the final decision on the balance of risk.

4. **Appropriate control** - As we have seen Self-Directed Support places control of funding in the hands of the most appropriate person - this does not have to be the person themselves. It can be anyone, including an appropriate professional and the Budget Holding Lead Professional model which has been successfully developed within children services is, in effect, a partial version of Self-Directed Support.

5. **Appropriate support** - Nor does Self-Directed Support leave people to manage support on their own. People can use traditional services, new services or systems of peer support. It remains a responsibility of the local authority to be assured that any help people need to manage their support is in place.

6. **Flexible resources** - Resources are put to the best possible use, they are not locked into services which may be inadequate to meet needs. Instead they can be used creatively to support people to solve their problems, build on their capacities and make better use of their positive social or community connections.

7. **Outcomes review** - Outcomes not processes are the focus of the review and the review process can be designed to fit the needs and risks faced by the individual - it should not be a standard visit. The design of the outcomes review process is an integral part of the risk management process for the local authority.

These ideas are not theoretical. The application of Self-Directed Support to 'complex cases' has already been put into practice in a number of areas:

- Providers of robust services such as Inclusion Glasgow, C-Change for Inclusion and Partners for Inclusion.[23]

- As part of the Budget Holding Lead Professional programme piloted with support from the Office of Public Management, where individual budgets have been used to support young people's use of substance abuse services.[24]

- Embrace in Wigan are managing a combined children and adults budget to successfully support a family whose children were at risk of being taken into the care of the local authority.[25]

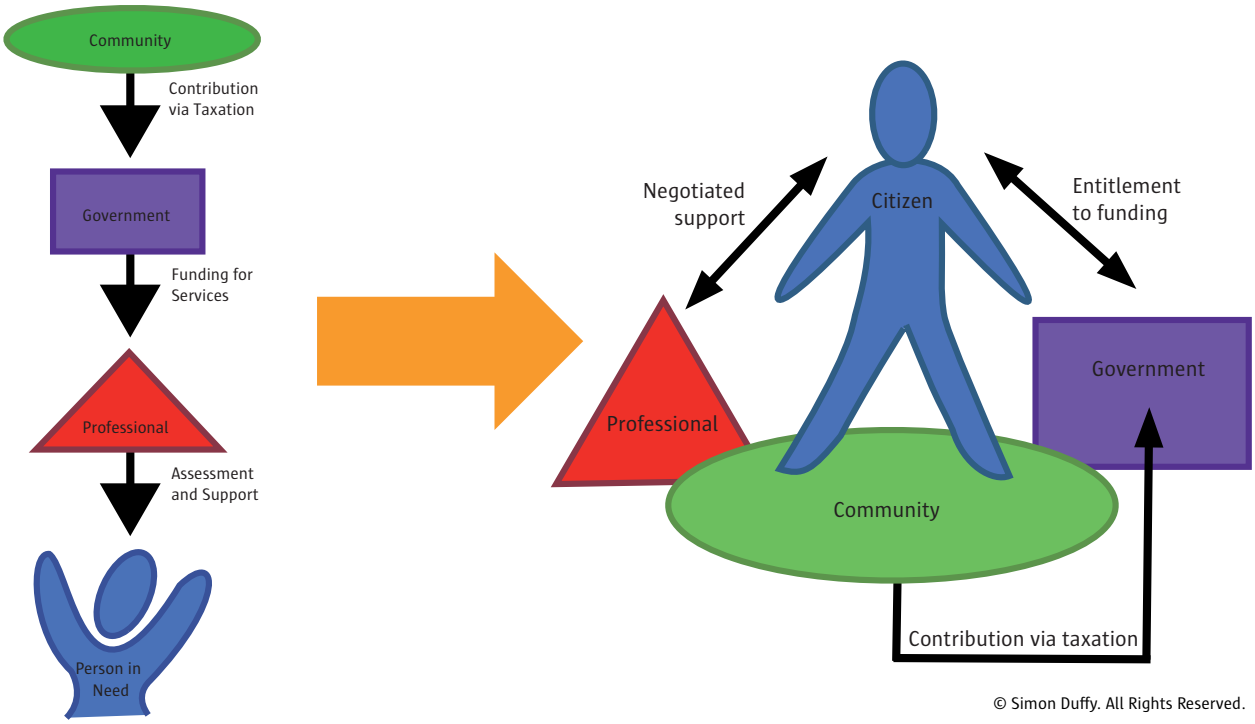
Self-Directed Support was designed as a universal system, but with particular attention to supporting the most complex situations; if it is not applied in this way it will both damage the move to personalisation and, even more importantly, fail people and families who are vulnerable to abuse.

Everyone who needs support sustained over time, including people who are vulnerable to abuse, receive Self-Directed Support because this process offers a rigorous risk reduction and management process. In addition it is critical that the Government gives more attention to supporting people to fully understand Self-Directed Support, in all its detail and to working with the social work profession to help develop its skills and capacities so that they can work effectively in all cases where Self-Directed Support is applied. More attention needs to be given to help people assess risk, plan effectively and support creative service design.

6. Citizen-based prevention

Moving away from the details of Self-Directed Support and thinking more broadly about how to prevent abuse it is interesting to note that the underlying paradigm shift which supports Self-Directed Support also offers a useful framework for prevention.

This paradigm shift in thinking is away from the *professional gift model* (which locates all power and expertise with professional services) towards the *citizenship model*. In this new paradigm we are encouraged to start with the individual, to identify first how to make them stronger, more capable and with greater resources.[26]



In fact we can see that Self-Directed Support is just one particular strategy for strengthening the capacity or 'wealth' of the citizen. We might even try and identify all the different resources which make the citizen 'wealthy' - not just money, but also skills, capacities, relationships (including family and friends) home, and even our knowledge of our community. We might even include within this framework the citizen's inner resilience, that which enables people to operate with hope and utilise all their gifts and assets.

Building citizen wealth

If we then apply this citizen-based approach to safeguarding we can see that there are a whole range of possible strategies possible which aim to strengthen the citizen's wealth:

1. **Resilience** - Helping people to develop the determination, vision and hope to change their own situation is possibly the most difficult and yet most important challenge. And it must be at the heart of any effective strategy - otherwise we will inevitably weaken the very person who needs to become more in control of their life. *People who lack self-confidence are at increased risk of abuse.*

2. **Skills** - Every human being is capable, even people who are treated as 'severely disabled' are actually gifted people. However we know that people's gifts and capacities often go unrealised - people do not express their gifts. To unlock this potential we must raise our expectations of

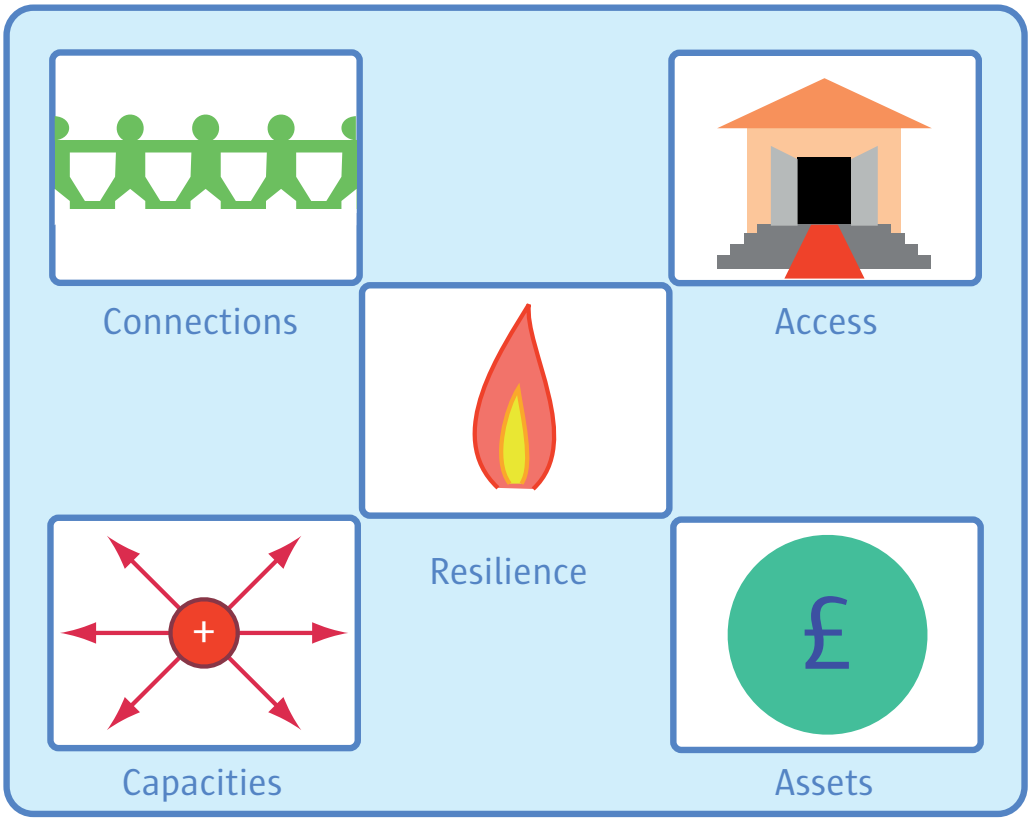
people, expecting and encouraging people to exercise their skills. *People and families who do not know how to assert themselves are at increased risk of abuse.*

3. **Money** - Self-Directed Support is one way of increasing the financial assets of citizens so they can exert more power in their own lives. But this is only one possible measure for increasing financial power. In addition people can earn money through work, the tax and benefit system can be improved, grants (e.g. Small Sparks) can be used. *People who cannot exercise control over their lives and over their support services are at increased risk of abuse.*

4. **Home** - We need to help people to maintain themselves in their own home or to move to a new home with people they can trust. This means making sure people can get support at home, can adapt or move home and can collaborate with friends or family to create new homely environments where they can be safe and secure. *People who lack privacy and who cannot control their immediate environment are at increased risk of abuse.*

5. **Relationships** - If you are connected to others, if you have friends and family or if you are part of the community (whether it be a neighbourhood, church, work place or any place that brings you together with like-minded people) then you are stronger. You have someone you can talk to, someone who can help you or connect with you or stand up for you. *People who are lonely are at increased risk of abuse.*

6. **Part of your community** - If you are part of your community, present in your neighbourhood, whether as someone who is giving or receiving, then you are constructing social wealth and understanding. *People who are isolated and alienated are at increased risk of abuse.*

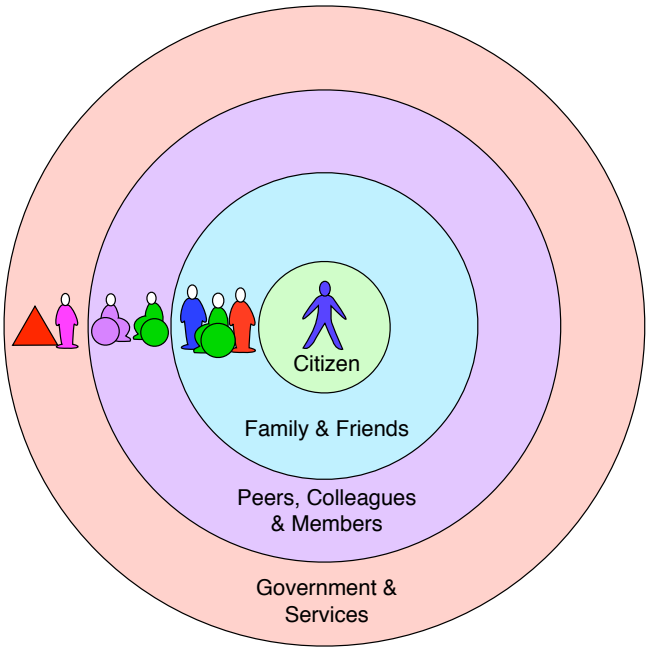


If we apply this model of citizen wealth to the problem of prevention it suggests that we will need a broadly based strategy which will focus on mental health, skills, information, resources, home, physical environment and relationships.

Building Community Capacity

Not only do we need to attend to citizen wealth we also need to strengthen the community into which the citizen will use their wealth. And again the citizenship model is suggestive of the most effective strategy. For if we think of the citizen as, to some degree or other, located within a particular community then we can see that the primary factors which will shape the risks and opportunities that the citizen faces will reflect the strength of that community.

Moreover a community's character depends upon the nature of the relationship between the different parts of the community. One useful model which simplifies but clarifies the central character of communities is represented in this graphic:



And this graphic is useful because it reminds us that there are different groups which need to be engaged.

- We also know that working family leadership programmes like *Partners in Policy-Making* have measurable improvements by helping families work together, network and grow in confidence as a family.[27]

- We know, for example, that work with peer support or self-advocacy organisations like *Skills for People*, can be a very effective way of helping people think about sexuality. The dynamics of peer-to-peer relationships are very helpful in getting people to listen with trust.[28]

- We know that many agencies, for example the Office of Fair Trading's *Don't Let Them Con You*, will work to develop mainstream resources which will help people reduce the risk of abuse.[29]

So when developing a prevention strategy it will important to think how to effectively target resources through these different forms of community.

Conclusion

We began this discussion paper by tackling the myths and confusions which have led some people to mistakenly fear that personalisation is in some way a threat to people's safety. Instead we have seen that personalisation is all about improving safety:

1. Personalisation aims to strengthen citizenship and uses the most appropriate measures, balancing freedom and control, to help people be safe.

2. Personalisation improves the current care management system by the use of Self-Directed Support to create a comprehensive risk management system.

3. Personalisation helps people move away from unsafe and institutional services.

4. Personalisation offers an ideal model for responding to complex cases of vulnerability and abuse where careful risk-management and person-centred practice are essential.

5. Personalisation creates the correct framework for preventing abuse by strengthening citizenship and communities.

And personalisation is working now. It helps people get to get control of their life, avoid harm and feel safer. It is still early days and the vast majority of services (99%) are not genuinely personalised. If the government wishes to improve the safety of citizens and the community it should help ensure the effective transformation of the current health and social care systems.

Notes

The figures for abuse below are taken from Action on Elder Abuses 2004 *Report Hidden Voices*. National Statistics (2007) tells us that the number of people living who are over 65 Population in the UK 12.2 million. Care & Repair England tells us that there are 400,000 people living in Sheltered Accommodation (which implies a slightly higher figure for the UK as a whole). The Office of Fare Trading (2005) estimated that there are 410,000 people living in Care Homes (Nursing Homes or Residential Care Homes). The NHS Confederation Report *Why We Need Fewer Hospital Beds* estimates that there are 130,000 hospital beds.

For the purposes of calculating relative risk the 'Other' category has been ignored. Notice that the risk factor is not a measure of absolute risk - however we can compare the risk factors to estimate relative risk. It should go without saying that there are numerous difficulties of gathering reliable data about risk and much more research is necessary, in particular that correlating the risk of abuse with age is likely to be rather insensitive to more important questions of disability, social isolation etc. However the positive correlation of risk to institutional settings is consistent with the hypothesis of this paper that people are at greatest risk when their status as active citizens is not sustained and when people find themselves in institutional environments that tend to treat the person as an object.

	Distribution	Instances	Population	Risk Factor	Relative
Own Home	64%	4,394.88	11250000	0.00039	1.0
Sheltered Housing	4%	274.68	410000	0.00067	1.7
Hospital	5%	343.35	130000	0.00264	6.8
Care Home	23%	1,579.41	410000	0.00385	9.9
Other	4%	274.68	n/a		

[1] Ref to Demos work

[2] Ref PPF

[3] Ref Phase I Report

[4] Ref POP Report

[5] Ref Keys to Citizenship

[6] Ref Supported Decisions Policy

[7] Ref Unlocking the Imagination

[8] See Cumbria and Oldham

[9] Ref Integrating Funding Report

[10] Ref Phase II Report - IBSEN?

[11] Ref Goffman et al.

[12] See CSCI

[13] The Board & Lodging entitlement was created in 1980 but there was no similar entitlement to support in the community was created and from 1979 to 1990 the numbers using this entitlement to enter residential care jumped from 12,000 to 199,000. Note that this is hardly much smaller than the numbers in residential care today (267,000); the impression therefore is that the very existence of the residential care market as a dominant form of service provision is primarily a function of central government's policy-making. See Lunt et al. (1996)

[14] See CSCI (2006a)

[15] See *Hidden Voices: Older People's Experience of Abuse (2004)*. Interestingly the headlines following this report tended to focus on the high levels of abuse that people received in their own home. Interestingly there was much less focus on the fact that, once the relative size of the populations had been taken into account, it appeared that staying your own home was the safest option. This again demonstrates some of the presentational challenges facing anyone trying to discuss these issues rationally - there seems to be a natural desire to hope and believe that someone else can 'take care of us' or those we love and that this is the safe and sensible thing to do - this belief seems to exist in spite of the evidence to the contrary.

[16] See GSCC

[17] 'It's Not Like Being at Work': A Study to Investigate Stress and Job Satisfaction in Employees of Direct Payment Users by Janet Leece

[18] Ref Liverpool and Edinburgh courses

[19] See NAAPS & Oldham data

[20] See evidence within the research report from Skills for Care *Employment Aspects and Workforce Implications of Direct Payments*

[21] Ref No Secrets

[22] Ref Planning tools

[23] Ref Inclusion Papers

[24] Ref OPM Papers

[25] Ref Embrace

[26] Ref Unlocking the Imagination

[27] Ref PPM data

[28] Ref Skills for People

[29] Ref OFT Report