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Stevens, Martin and Moriarty, Jo and Harris, Jess and Manthorpe, Jill and Hussein, Shereen and Cornes, Michelle (2019) Social care managers and care workers' understandings of personalisation in older people's services. *Working with Older People*, 23 (1). pp. 37-45. ISSN 1366-3666.

DOI

<https://doi.org/10.1108/WWOP-11-2018-0022>

Link to record in KAR

<https://kar.kent.ac.uk/71020/>

Document Version

Author's Accepted Manuscript

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Social care managers' and care workers' understandings of personalisation in older people's services

Accepted by Working with Older People.

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To cite this article:

Stevens, M., Moriarty, J., Manthorpe, J., Harris, J., Hussein, S. and Cornes, M. (2018) Social care managers' and care workers' understandings of personalisation in older people's services, *Working with Older People* First published online: 2019

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Keywords

Personalisation; Neoliberalism; Austerity, Workforce, Service Provision, Long-Term Care

Acknowledgements

The authors would like to thank the professionals, older and disabled people and carers who gave their time to take part in the research. Thanks are also due to the NIHR Policy Research Programme, which funded the research. The views expressed in the publication are those of the author(s) and not necessarily those of the NHS, the NIHR, the Department of Health and Social Care or its arm's length bodies or other government departments.

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Abstract

Purpose

This article explores the impact of personalisation policy on providers of social care services in England, mainly to older people, within the context of austerity and different conceptions of personalisation

Design/methodology/approach

The article draws on part of a longitudinal study of the care workforce, which involved 188 interviews with managers and staff, undertaken in two rounds.

Findings

Four themes were identified: changing understandings and awareness of personalisation; adapting services to fit new requirements; differences in contracting; and the impact on business viability.

Research limitations/implications

The article reflects a second look at the data focusing on a particular theme, which was not the focus of the research study. Furthermore, the data were gathered from self-selecting participants working in services in four contrasting areas, rather than a representative sample.

Practical implications

The research raises questions about the impact of a commercial model of 'personalised care', involving personal budgets (PBs) and spot contracts, on the stability of social care markets. Without a pluralistic, well-funded and vibrant social care market, it is hard to increase consumer choice of services from a range of possible providers and therefore fulfil the government's purposes for personalisation, particularly in a context of falling revenues from local authorities.

Originality/value

The research presents an analysis of interviews with care providers and care workers mainly working with older people. Their views on personalisation have not often been considered in contrast to the sizeable literature on Personal Budgets recipients and social workers.

Keywords

Social Care; Personalisation; Neoliberalism; Austerity; Workforce' Older People

Introduction

Over the past two decades, social care policy in England for older people and other adults has been dominated by ideas of personalisation. However, many commentators have drawn attention to the underlying ambiguities behind the concept. Carr (2012) states that: 'Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support' (Carr 2012: 2), which could be termed 'person-centred care' (Woolham et al. 2015). However, others also identify personalisation as being concerned with developing consumer choice, particularly in relation to choosing from a range of commercialised services (Ellis 2015).

The different ways personalisation has been understood and implemented by social care managers and care workers will be explored in the context of diverse and potentially contradictory underpinning ideas driving personalisation policy in England. The background to and implementation of personalisation policy in England will be briefly explored and suggestions made about how far this reflects developments internationally. The aims and methods of the (to be inserted after peer review) study will be outlined, while findings relating to the impact of personalisation presented, and placed in the context of the conceptual framework. The final discussion section will explore implications for personalisation and social care provision.

Personalisation policy context

The Community Care (Direct Payments) Act 1996 introduced direct payments in social care in England, which was an early example of the ‘cash for care’ systems. While initially excluding older people from such options, the original idea of a direct payment to a minority of social care users to enable them to purchase their own care has since become subsumed into the much broader concept of personal budgets (PBs) which are the key means by which ‘personalisation’ has been implemented (Slasberg et al. 2012). A PB is an amount of money allocated to a person assessed as being eligible for publicly-funded adult social care. PBs can either be managed by the local authority, passed to a care provider or other intermediaries such as voluntary or user-led organisations (these approaches are known collectively as ‘managed PBs’), or can be paid directly to adults or carers as a direct payment (carers can also be proxy recipients).

Since 2010 personalisation has been implemented in a context of a sharp decrease in public funding of adult social care in England (Needham 2015). The King’s Fund (2015) reported that spending on adult social care had reduced by 9% in real terms in the period between 2009/10 and 2013/2014, at a time of increased demand. Without a transfer of some NHS funds, in the form of the Better Care Fund, this figure would have been 14%. This reflects trends to reduce public expenditure across Europe (McKee and Belcher 2012) and higher thresholds of eligibility for publicly funded social care, which have affected many thousands of older people (Age UK, 2018). One consequence of this was that prices paid by local authorities to social care providers reduced in real terms, investment in the social care workforce was limited and that many providers have been unable to provide care for people funded by local authorities.

As noted in the Introduction, some have argued that personalisation is underpinned by contradictory impulses. The first is tailoring care and support to a holistic understanding of the individual’s needs, to maximise quality of life (a ‘person-centred’ approach) (see Manthorpe and Samsi 2016). The second is ‘personalised’ purchasing, which emphasises the value of individuals and families using allocated budgets to assess their own needs and purchase care and support. Combined with austerity measures, the ‘personalised’ approach has been thought part of a ‘project to shrink the welfare state and displace public services in the public imagination’ (Baines and Cunningham 2015: p183).

The meaning of personalisation for social care providers

In England the independent sector (for-profit and not-for profit care providers) provides 81% of home care services and 92% of care homes (Lewis and West 2014). However, the views of care providers and care workers have often been overlooked in contrast to the sizeable literature on PBs recipients and social workers.

Wilberforce et al. (2011) reported findings of the national Individual Budgets (IBs) Pilots Evaluation (IBSEN), one of the few studies that incorporated care providers' views in addition to those of service users, carers and professionals. The care provider managers interviewed were mainly positive about the theory of personalisation and some reported being able to provide more 'person-centred' care such as short-notice respite care and enabling more leisure activities, 'such as day trips and holidays' (Wilberforce et al. 2011: 598). However, other providers considered that older people in particular were not very likely to want to change their services and the staff that delivered them.

Concerns were raised about implementing the new, more commercial, arrangements required for 'personalised' care. Managers predicted greater transaction costs (such as connected with administration, payments and service changes) would result from IBs, compared with traditional care managed services (Wilberforce et al. 2011), although a later study of PBs among older people did not find that such fears were realized (Rodrigues and Glendinning 2015). Wilberforce et al. (2011) also identified some concerns about whether some care workers would resign from care agencies in order to become directly employed (by the care user or family) as Personal Assistants (PAs). Nonetheless, hopes were expressed by some managers that IB holders would continue to use their services, despite greater choices being available, because of their good reputation.

Baxter et al. (2013) later described changes in service contracting associated with the introduction of PBs. Previously, many authorities had 'block' contracts with local care providers to provide certain number of care home beds. They reported that some local authorities had developed 'framework agreements', a commissioning version of 'zero-hour contracts', which set out the authority's price and quality requirements, but do not guarantee any business (Cunningham 2016: 662). Providers tender for these contracts, and if successful are placed on the authority's 'preferred list' which is offered as a first option to individuals. Baxter et al. (2013) observed that framework agreements may reduce the time taken in contracting and also increase competition, potentially improving quality of care. However, Marczak and Wistow (2016) concluded that competition leads to downward pressure on price, which is likely to reduce quality. In addition, Boyle (2013) argued that the existence of provider lists may restrict choice and, along with the charity Age UK (2013), called upon local authorities (LAs) to stop using them.

Reduced or stagnant social care spending affects both on LAs and many social care providers as demonstrated by the commissioning of home care visits lasting as little as 15 minutes (Younger 2017). Such practices potentially make it harder for staff to provide the emotional or relational aspects of care, which are central to good quality physical care and also contribute to maintaining wellbeing (Lewis and West 2014). They also relate to the different underlying goals of personalisation. Person-centred approaches of tailoring care and support and enabling control over the kinds of care provided may enhance employees' commitment to their work and is required for 'sustaining people as emotionally and relationally engaged social beings' (Lynch 2007: 553). However, the increasing marketisation and commodification of care may act against the ability to provide this kind of support, particularly during periods of austerity and reduced care packages.

The key tension is between a desire to provide tailored, person-centred services to improve wellbeing and a marketised vision in which a 'hollowed out state' (Rhodes 1994) sets goals and

boundaries for independent providers of directly purchased services. Woolham et al. (2015) characterised this tension as the ‘Evolution of person-centred care to personalised Care’ (p145). Overlaying this tension is the impact of austerity, which has reduced state funding for social care. This article therefore aims to address two questions. First: how do care home and home care managers’ and staff’s understandings of personalisation reflect the balance between person-centred goals and the move to a more commercial or ‘personalised’ approach? Second: how do both conceptions of personalisation impact on the businesses providing social care, within increasingly tight financial constraints? The discussion explores the future direction of personalisation policy in the light of the perceived balance between these competing concepts.

The Longitudinal Care Workforce Study

This article draws on a large, longitudinal study that aims to increase understanding of the factors that facilitate or constrain recruitment and retention in the adult social care workforce in England. Started in 2008, (to be inserted after review) consists of a longitudinal panel survey of a sample of social care providers and their workforce in four different local authority research sites in England and semi structured interviews at different time points with social care employees, employers (managers), care recipients and family carers. The article focuses on the part of the interviews with care home and home care managers and staff that sought views on the impact of personalisation on social care work and on providers. Four diverse areas were selected to include different parts of England, (North, Midlands, London and the South) and different sizes and types of council (large county, small unitary and London Borough). Ethical approval was granted by (to be inserted after peer review) and each local authority gave research governance approval.

Data collection

The paper draws on 129 interviews with care home and home care managers and staff in older people services, in which text was coded under a ‘personalisation’ node (see below). There were 91 participants, 38 of whom were interviewed twice, as shown in Table 1. The interviews were carried out over two phases.

Table 1: Participant role and service interviews

Participant role and Service	No. interviews	No. Participants
Care Home Manager	37	23
Care Home Staff	37	27
Home Care Manager	20	15
Home Care Staff	12	15
Other Social Care manager	19	8
Other Social Care Staff	4	3
Total	129	91

The first round of interviews (T1, n=72) took place between 2009 and 2012 and the second round (T2, n=57) took place between 2010 and 2014, as shown in Table 2. While T1 and T2 overlapped, second interviews with participants were between 18 months and two years apart.

Table 2: Year of interview by role of participant and round of interview

Year	Managers			Staff			Total
	T1 & T2	T1 Only	T2 Only	T1 & T2	T1 Only	T2 Only	
2009	18	15					33
2010	9	5		4	4		22
2011	19	1	1	5	4		30
2012			1	10	5		16
2013				1		1	2
2014				11		15	26
Total	46	21	2	31	13	16	129

Data analysis

Almost all interviews were recorded, with permission, transcribed in full and entered into N-Vivo qualitative analysis software. Where participants were unwilling to be recorded, detailed verbatim notes were taken and similarly coded. A broad coding frame was agreed by the research team, based on the aims of the study, themes from existing research and preliminary analyses of the transcripts. This included a broad ‘personalisation’ node, under which all material relating to personalisation was coded, which team members read and developed a coding frame to explore the sub-themes within personalisation and re-coded the text.

Limitations of the research

Personalisation was not a main focus of this research, although participants were asked directly about how personalisation had impacted on their organisation. Thus, the article reflects a second look at the data, focusing on a particular theme. Furthermore, the data was gathered from participants working in services in four contrasting areas, rather than a representative sample. There was an element of self-selection in the interviews, as we depended on managers agreeing to being interviewed and for their staff to be interviewed. However, the sample (n=91 participants, n=129 interviews) includes staff and managers from a wide range of services for older people and contexts and provides a large and varied dataset from which to abstract these themes. The research was undertaken in England, and should not be presumed to present a UK perspective.

Findings

Four sub-themes emerged from the analysis of interviews with social care providers (both managers and staff): 1- Understandings of personalisation; 2- adapting services; 3- contracting; and 4- impact on business viability. Within each theme the interplay of ‘person-centred’ and ‘personalised’ care is highlighted, within the overall context of austerity.

Understandings of personalisation

The two senses of personalisation were clearly evident in the understandings of care home and home care staff respectively. About half of the care home managers and frontline care home staff (who had heard of personalisation) interviewed at T1 and T2 equated personalisation with person-centred approaches. For example, this care home manager described how residents had been involved in discussions about how care within the home could be made more ‘personalised’

It’s very very much thinking of the individual as an individual. Building up

profiles and pictures of who they are. What was their job? What did they like? Which football team did they support? What did they do on a Saturday morning, usually or on a Sunday afternoon and looking very much at personalising the whole thing.

(Care Home Manager 15 2009 T1)

However, about two thirds of the home care managers and staff who understood personalisation, interviewed at T1 and T2 identified personalisation with PBs or direct payments. These participants described personalisation as being more about how care support was paid for and the roles of service users and families in choosing services rather than on the possibility of tailoring services to individual needs.

Adapting services

Many care home staff and managers felt that the care and support provided in their homes had become more person-centred, which was understood as being more personalised. However, care workers and managers of care homes for older people did not identify many adaptations to the way their service was being offered.

A small number of home care managers in the early interviews had stressed the importance of being flexible in the kinds of help, with tasks offered to a person with a PB, in order to improve outcomes, and encourage them to continue to purchase their services. These perceptions echoed comments made by care home managers and staff about the importance of being more person-centred. Thus, home care managers might permit frontline home care workers to exercise more discretion about what they did and how, as this example illustrates:

As a Direct Payment, I think it's wonderful. I had a blind lady that didn't want you to wash her; she just wanted someone to do her post and pay her catalogues (home shopping by mail order) and just take her shopping, where Direct Payment was brilliant. (Home Care Manager 188 2010 T1)

However, some home care managers at T2 discussed the limitations that the local authority placed on their ability to offer a personalised approach to clients funded by the local authority (in contrast to self-funders), in terms of times and types of tasks offered:

From social services, it's task orientated. We tend to be more flexible with our private packages and things and that's because we manage them packages personally rather than do it through a third party. We can be a bit more flexible then. (Home Care Manager 78 2012 T2)

Contracting

At T1, managers of care homes and home care services reported that their local authorities were moving away from block contracts (in which the local authority guaranteed to purchase a certain number of beds or hours of service), towards individualised contracting processes, which are essential for implementation of PBs. Many providers felt this meant a move into a more uncertain future in relation to their business, unless families or care users 'voted with their feet' and stayed with their service. More of these kinds of developments were in progress at the time of the second round of interviews when providers were having to adapt to the new ways of contracting, although the level of uncertainty continued to make some managers feel uncertain

about their service's viability. However, for some, offering people a choice of provider had increased demand for their services:

What we've found now is because the block contracts have ended, a lot of clients can choose where they go, so they're asking to come to us because they weren't happy where they were, which is good. (Home Care Manager 172 2011 T2)

Perceived impact of austerity

A belief was expressed by a small number of managers at T1 that personalisation, which was then at an early stage of implementation, was simply a thinly veiled attempt to save money by the local authority or central government, illustrating a perception that austerity is woven into the picture of personalising social care provision. This quote from a care home manager exemplifies these views:

It's cost driven as well, I think, if I'm being honest, the perception is that it's cheaper to do it that way and I don't think it is. (Care Home Manager 10 2009 T1)

This belief continued through the second round interviews, with some expressing a view that choice would be reduced by the reliance on the market, and a continued suspicion that the changes were driven by the need to cut costs:

Although they originally said it would be the people's choice [about which provider would support them], actually what it will come down to, will be the marketplace and the hourly rate. So I do think people's choices will be taken away that way because it will come down to money, which is quite sad. (Care Home Manager 70 2010 T2)

Several managers believed that the move to direct payments and individual purchasing had resulted in cuts to the hourly rates for services, requiring ongoing negotiations with local authorities. This was felt to be potentially damaging to the long-term survival of some home care providers, for whom margins were already very tight:

You're negotiating on price all the time and we don't make any money as it is, so it's like the volume of hours and sort of they're just trying to knock you down. (Home Care Manager 172 2011 T2)

Discussion

This article aimed to explore views about personalisation within independent sector social care providers, seen in the context of different driving ideas underpinning the policy and by the impact of austerity, which we explored in the Introduction. The longitudinal nature of the data provides a sense of developing understanding and reaction to personalisation amongst social care providers.

Care workers and managers in care homes for older people often identified person-centred working as personalisation. Their characterisations of the importance of tailoring services to

individual needs and preferences of the individual reflect the aims of the disability movement of increasing choice and control over their lives (Stevens et al. 2011). While the changes they discussed were often related to practice within the care home, they do suggest an understanding of and commitment to increasing choice and control within the constraints of the service. Similarly, in home care services, some participants at T1 valued the more flexible approach that might be possible under personalisation. They noted limitations generated by the local authority referral and contracting processes, which may illustrate the potential for personalised approaches limiting person-centred approaches, or may simply be a limiting effect of austerity. However, these findings may reflect the language used in early policy documents, which often gave the impression that that PBs would lead to more personally-controlled care (e.g. DH 2007).

The introduction of PBs as the standard way of administering publicly funded social care substantially changed in contracting arrangements, which are of great importance in a marketised system. Care home and home care managers taking part in the research at T1 and T2 regarded the changes in contracts offered by local authorities as one of the most important effects of personalisation again illustrating the increasing importance of 'personalised' care above and beyond provider sustainability. Lewis and West (2014) described how local authorities started to offer 'block contracts for certain quantities of "set list" services' (Lewis and West 2014: p5) in the early 1990s, as part of changes mandated by the National Health Service (NHS) and Community Care Act 1990. As we describe in the introduction, block contracts were, in many places, being replaced by 'framework agreements', which set out price and quality, but do not guarantee any work. Some managers in this study believed that these changes created undue uncertainty over the future of their businesses. Rodrigues and Glendinning (2015) also highlighted that these contract changes may lead to consequent instability in social care markets, which may limit capacity and ultimately reduce choice.

Reduced hourly rates being paid for services were also identified by participants in the study (mainly at T2) as a consequence of the personalisation reforms. While it is not clear if these reductions were directly attributable to personalisation or to growing austerity and cuts in public expenditure, Boyle (2013) also noted that many in social care perceived personalisation to have been a cost-cutting measure. Furthermore, austerity policies have had a negative effect on care services across much of Europe (McFee and Belcher 2012). By T2 the restrictions on public spending introduced by the then UK Coalition Government had been in place for between one and three years. Thus, it may have been difficult for participants to distinguish between the impact of reduced public spending on social care and the effects of personalisation.

However, there seems to be a clearer link between a context of austerity and a focus on a consumerist, market-driven view of personalisation, in which the goal is to transfer risk and responsibility from the state to the individual (Ferguson 2007). This article suggests that risk is also being transferred to care providers. Further research will be needed to identify the long-term impact on social care markets, exploring how social care providers survive within it; whether they choose to leave social care provision or alter their customer base; or whether new forms of, perhaps more user-led, care organisations emerge. Despite cash for care policies in some countries aiming to increase the range of social care providers available, 'in practice, a social care market is lacking or relatively undeveloped in many countries' (Arksey and Kemp 2008: 11). Not only has there appeared to be little progress towards developing a choice of

providers, but fears of market failure, where significant portion of providers pull out of the sector are developing (Hudson, 2017).

Conclusion

The research raises questions about the impact of a commercial model of 'personalised care', involving PBs and spot contracts, on the stability of social care markets. Without a pluralistic and vibrant social care market, it is much harder to increase consumer choice of services from a range of possible providers and therefore fulfil the government's purposes for personalisation, particularly in a context of falling revenues from local authorities. However, choice of provider is no guarantee of increased quality or better caring relationships, which are seen as more important indicators of good quality care for older people (Lewis and West 2014). Being able to meet the aims of person-centred support appears even more difficult in this context. How local authorities approach the task of market shaping (a duty placed on them by the Care Act 2014) will be an important factor affecting progress towards both of these goals.

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