“we’re helping providers and commissioners to collaborate”

personalisation – the workforce implications
what do commissioners and providers need to do?

north west joint improvement partnership

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Personalisation – the workforce implications
what do commissioners and providers need to do?
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executive summary

This report summarises the outcomes of two one-day workshops that brought together commissioners and providers to explore the impact of personalisation on the social care workforce. Funded by the North West Joint Improvement Partnership and Skills for Care North West and facilitated by the Office for Public Management (OPM), the workshops explored how the roles of different groups of staff within both local authority commissioning teams and provider organisations must change to meet the requirements of personalisation, and how commissioners and providers can work together to enable the change.

personalising services

The impact of personalisation on the following four provider roles in both domiciliary and residential care were considered - care workers, support staff e.g. finance and human relations operational managers and business development managers. The changes that staff would experience were set within the context of a scenario describing a fictitious local authority that was moving from very traditional models of domiciliary and residential care to newly specified personalised models. The new personalised models were underpinned by four key principles:

- **self directed support** – people should be able to determine, within the limits of their personal budgets, the support that would best meet their social care needs
- **choice** – this will include choice of provider, the range of support provided, when it is provided and which members of staff do so
- **self care** – services will be reshaped to support people's own capacities to care for themselves and that of their social networks, and further develop these capacities
- **part of the community** – there will be an emphasis on enabling people to make use of existing universal services and be part of their local communities.

Whilst the workshops identified some differences in the likely impacts of personalisation on staff between domiciliary and residential care settings it is the common themes that are the most striking. These are summarised over the next few pages.

care workers

The main change that care workers will experience (see table 1) is a shift in focus from undertaking defined care tasks to working with people to help them achieve agreed outcomes. This person centred approach will embrace supporting, reablement and enabling people to access community services and facilities and complementary services provided by other social care providers. All staff will be aware of individuals' self directed support plans and will, to a greater or lesser degree, be involved in their development. There will be a new approach to risk management design to both enable people to take the risks that they choose but also to safeguard. These shifts in the care worker role will require changes in working conditions, to enable more flexible working, and in pay.

table 1: care workers - key role shifts

features of role	traditional service	personalised service
aim	providing care	helping people live their lives
focus	care tasks	the person
scope	the defined service	personalised support and use of other services
support planning	none or little involvement	some or detailed involvement
risk management	risk averse	enabling risk taking
relationship to people	doing for	supporting and enabling
pay and conditions	basic roles and pay and set conditions	some extended roles with enhanced pay, flexible conditions

"all staff will be aware of individuals' self-directed support plans"

support staff

The workshop mostly focused on changes that finance and human relations staff will experience (see table 2). The transition from block and spot contracts to a retail model will be accompanied by a switch to individual billing and bring finance staff into more direct contact with budget holders. Human relations staff will help in the redesign of care worker job descriptions, working conditions and pay rates. The training and staff development programmes for all staff will have to be re-thought and affordable ways of procuring and delivering them developed. The market intelligence that providers require to understand how their own business is fairing and to pool data with others to understand overall market trends will come from people's self directed support plans and the organisation's financial systems. Support staff will be involved in aggregating this information.

table 2: support staff – key role shifts

features of role	traditional service	personalised service
aim	supporting delivery of task and volume contracts	enabling personalised support
finance		
process	block contract accounting and invoicing	individualised accounting and billing
relationship to people	none or arm's length	closer and individualised
human relations		
job design	task focused, low flexibility	person centred, broader and more flexible
training and development	updating training within established arrangements	new requirements and training arrangements
market intelligence	provision of contract monitoring data	aggregation of personalised data

operational managers

The role that operational managers play varies between provider organisations. Some also have a business development role. In others, as was in the case of the scenario used in the workshop, business development is a separate role. Operational managers are pivotal in both enabling staff to adapt to personalisation and ensuring that the organisation provides the services that budget holders want (see table 3). They are best placed to understand the supports that budget holders need and ensure their services respond to them. Enabling the development of bespoke support that attracts and retains customers will be essential to business success. This will include being able to 'add value' by linking budget holders into community facilities and services as well as complementary services supplied by other social care providers. Hence operational managers will be much more involved in business development than before. They will also play a key role in helping staff to understand the requirements of personalisation and make the changes in practice required. This will include an emphasis on the quality and value of the service provided and working more with people's families and social networks.

table 3: operational managers – key role shifts

features of role	traditional service	personalised service
aim	practice improvement	practice transformation
focus	cost and volume	quality and value
families	part of the context of care	active engagement
other services	few links	many links and partnerships
pricing	fixed via block or spot buy contracts	bespoke to individuals
competition	securing block contracts	attracting and retaining customers
business development	contributors	key players

“ enabling the development of bespoke support that attracts and retains customers will be essential to business success ”

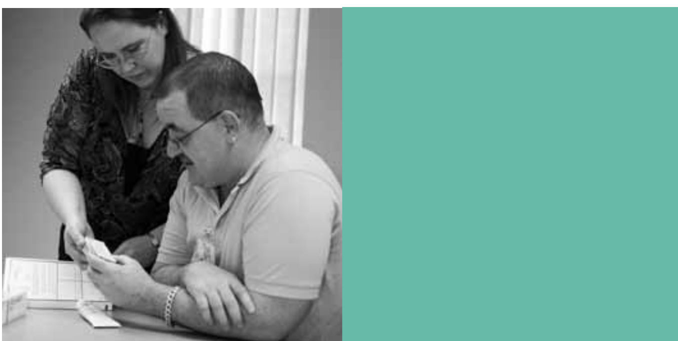
business development managers

Personalisation will require a change both in the role business development managers play within their organisations and how they relate to others outside (see table 4). It will switch from block contract management to focusing on budget holders' lives and outcomes. The development of attractive and affordable services that meet the requirements of self directed support plans will be a major business driver. This is likely to lead to them working on service diversifications that will blur the traditional boundaries between domiciliary, residential and other forms of support or make them disappear altogether.

Business development managers will also be working with operational managers, strategic commissioners and other providers to develop a strategic overview of the personalised services market. This will be underpinned by a shift in the relationship between providers and between providers and commissioners. One that is closer and collaborative must replace the traditional arms length adversarial relationship with commissioners. The potential for sharing between providers around staff training, the design of back office systems and in partnering to offer a wider range of complementary services to individual budget holders should be explored.

table 4: business development managers – key role shifts

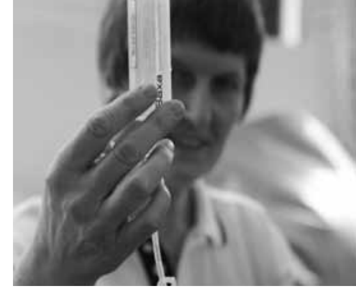
features of role	traditional service	personalised service
aim	securing contracts	development of attractive and affordable retail services
focus	the service and the contract	people's lives and outcomes
range of services	specified by contract	diversified to meet personal requirements
provider – provider collaboration	mostly self sufficient	cost sharing, provision of complementary services
relationship with commissioners	arm's length and adversarial	closer and collaborative



the changed role of commissioners

The workshops explored the impact of commissioning in four roles - care managers, their team managers, contracts managers and strategic commissioners. The personalised approach to commissioning described in the workshop scenario was characterised by:

- **supporting choice** - enabling budget holders to develop and realise their own self directed support plans.
- **purchasing and managing services** – it is expected that a few people may opt for their care manager to manage their services on their behalf but to their order. Most people will either self manage via direct payments, draw on support from brokers or from providers via Individual Service Funds (ISFs).
- **devolved funding** – development of pooled personal budgets with health and others and the management of overall funding in line with need.
- **marketing and service development** – provision of active support to providers to personalise their services and inform budget holders of about them.
- **framework contracting** – used to secure a quality assured personalised supply of services whilst retaining budget holders right to purchase services off framework.
- **personalising services not funded by personal budgets** – by working with commissioners of services outside social care including targeted services that are not funded via personal budgets including currently many health services, and universal public services e.g. leisure and transport, and commercial services e.g. shops.
- **building social capital** – of individual budget holders in terms of their personal social networks, opening up access to community associations and ensuring people are welcomed when out and about in the local community.
- **the new commissioner – provider relationship** – moving away from the current arm's length adversarial relationship to one that is closer and collaborative.



care managers

In the scenario considered by the workshops, the role of care managers (see table 5) will vary depending on the self directed support route that individual budget holders take. Enabling self directed support and providing extra help to people to manage their budgets and extra support where required will replace the traditional professional led care management process. Brokers, and providers through ISFs, will supply the majority of the detailed support. The focus of self directed support plans will be much wider than the traditional care plan and hence the range of services that people may wish to purchase from their budgets or access outside their budgets will also increase. Care managers will have a role in enabling this wider range of choice. Helping people to live full lives will also mean enabling them to take the risks they choose whilst also ensuring safeguarding.

table 5: care managers – key role shifts

features of role	traditional service	personalised service
aim	provide best professional advice and assistance	enabling self direction and control
focus	professional assessment, service procurement and review	negotiating, enabling and reviewing self directed support plans and budgets
person centred	providing assistance with personal care and other tasks and safeguarding	enabling a person to live a full life
service procurement	working mostly from a menu of pre-contracted social care services	enabling access to the full range of support within and outside social care
risk management	risk averse approach to life and safeguarding	enabling people to take risks and be safeguarded

team managers

The support that team managers provide to their teams and the way they engage with other commissioners will change (see table 6).The main shift will be enabling the self directed support process including the use of brokers and ISFs whilst ensuring the most vulnerable budget holders are given the support they require to be in control. Team managers will be extremely important in enabling care managers to develop the new personalised practice and establish the new culture. For example, helping people to develop stronger social networks and enabling risk taking by budget holders. This will not happen overnight and will require constant supervision and development. One area in which care managers will require support is in keeping abreast

of the developing personalised services market and how to enable budget holders to make use of other targeted services that are funded outside of personal budgets, universal services and community facilities. Team managers and their care managers will be an important source of market intelligence. For this to be appropriately shared they should have a much closer engagement in strategic commissioning than before.

table 6: team managers – key role shifts

features of role	traditional service	personalised service
aim	procuring the best response mostly within contracted services	maximising choice, self care and community participation
focus	ensuring effective care management for all	enabling self directed support whilst supporting the most vulnerable
practice management	practice improvement	building the new personalised practice and culture
market knowledge	mostly the services of contracted providers	full personalised services market and community facilities and services
strategic commissioning	little involvement beyond periodic planning exercises	key source of market intelligence

contracts managers

As the scenario presented to workshop participants envisages the phasing out of contracts for all services that are directly purchased by budget holders the general view was that contracts managers will only now have a transitional role (see table 7). However new roles may need to be created to enable active market development and management. Contracts will also still be used to secure social care services that fall outside of personal budgets e.g. short term reablement where no further support will be needed.

The main focus of the transitional role of contract managers will be to enable a smooth transition to a retail social care market via an ordered phasing out of block contracts. Typically this may involve a staged reduction in contract value. At the same time contract managers will be supporting the personalisation of services within the remaining contracts by changing them from being cost and volume to outcomes focused. They will also have a major role in introducing framework contracting and developing new quality assurance approaches to replace the previous contract management process.

table 7: contracts managers – key role shifts

features of role	traditional service	personalised service
aim	procuring quality services	ensuring a smooth transition to a retail market
focus	block and spot contracting and management	phasing out existing contracts
outcomes	contracts mostly focus on cost and volume	including outcomes into contracts and frameworks agreements
quality assurance	contract management process	develop new approaches to quality assurance

“new roles may need to be created to enable active market development and management”

strategic commissioners

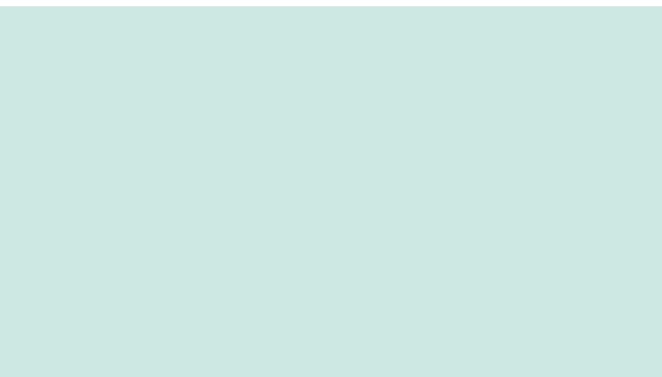
Whilst strategic commissioners have always had a remit to consider people's needs in the whole they have inevitably focused mostly on social care needs and building integrated working with health. Personalisation will widen the scope of the role (see table 8) to take into account the personalisation of universal services and of targeted services in other sectors that are funded outside of personal budgets. Whilst some contracting will still be used, most of the leverage on service development available to strategic commissioners will come from their ability to stimulate the development of the market and how it works. This will include the development and use of framework contracting, internet based platforms to enable providers to easily market their services and for budget holders to exchange views, the development and procuring of training that can be shared between providers and enabling providers to collaborate in the development of back office systems required to support personalisation.

The leadership style and processes needed to enable personalisation will change from one of planning and control through contracts to consensus building and proactively fostering innovation. This must be underpinned by the development of collaborative relationships with providers and joint working with commissioners of universal services and targeted services outside social care. Joint commissioning will also be used to develop shared market development and support infrastructure across neighbouring local authorities to enable ease

of entry for providers into local markets and to share the cost of infrastructure development between local authorities.

table 8: strategic commissioners – key role shifts

features of role	traditional service	personalised service
aim	securing a range of social care provision integrated mostly with health care	personalising all services, including social care, to meet individuals' support requirements in the whole
focus	strategic planning and contracting	strategic planning, market development and management and some contracting
leadership	influencing other commissioners and contracting with providers	developing a jointly owned vision with providers and with commissioners in other sectors and proactively fostering innovation
collaboration	mostly joint commissioning with health	with providers and joint commissioning with health, other sectors and neighbouring local authorities



commissioner - provider collaboration

The Department of Health's report on evolving commissioning practices being used to support personalisation[1] found that all of the case study local authorities noted that the building of much closer and collaborative relationships between commissioners and providers was essential to success. Hence the workshop participants were asked to consider how commissioner - provider collaboration should be further developed to enable the transition to personalisation.

1 - 'Contracting for personalised outcomes Learning from emerging practice', DH 2009

suggestions included:

- **training and staff development** – for both commissioning and provider staff and at all levels. This should cover an overall understanding of personalisation, the way it impacts on service provision and commissioning and enabling people to change the way in which they enact their current or changed roles. The major culture change involved suggests that this should be supported through a continuing stream of training and staff development opportunities that evolves as personalisation progresses.
- **risk management** – developing a risk management framework that enables budget holders to take the risks that adults should be free to choose whilst safeguarding budget holders and appropriately protecting front line commissioning and provider staff from inappropriate blame.
- **provider – provider collaboration** – commissioners enabling providers to collaborate around development of personalised and affordable models of care, sharing the cost of back office systems redesign or buying into shared back office services and sharing the design, procurement and delivery of staff training.
- l**ocal authority to local authority collaboration** – developing cross local authority approaches to billing, capture and analysis of market intelligence, marketing platforms and framework contracting.
- **small business support** – working with small business and micro-providers to ensure that all collaborative arrangements take into account their particular needs.
- **regulation** – developing a shared view with budget holders and providers about how regulation must change and jointly lobbying the Care Quality Commission.
- **change management support** – over and above training opportunities, the provision of change management support to managers both in provider organisations and commissioning to help them keep abreast of the evolving personalisation agenda and innovations and enable active collaborative problem solving.

conclusion

The role shifts identified in this report begin to put flesh on the bones of what many commentators refer to as the 'culture shift' required to implement personalisation. However the role shifts identified should only be treated as indicative. For example, whilst they provide a useful sample they do not cover all of the roles in either provider organisations or in commissioning. The role shifts were also identified within the context of a borough moving from very traditional models of social care to a particular vision of personalised practice. Other commissioners and providers will be more advanced in their current practice and be working to different visions of personalisation. The time available within the workshops to explore the role shifts was also limited and hence the findings cannot be considered comprehensive. However the workforce impact analysis presented in this report does provide a good basis for further discussion and exploration as does that of the opportunities for commissioner provider collaboration and collaboration between neighbouring local authorities.

1. introduction

Much has been written about how commissioners and providers must change in order to ensure the range of personalised services that personal budget holders want to purchase are available. However little is known about how personalisation will impact on the roles of the different groups of staff within commissioning and provider organisations. This report describes some of those changes and how they can be enabled through collaboration between commissioners and providers.

The report summarises the outcomes of two, one day workshops each comprising a mix of commissioners and providers. The workshops were commissioned by the North West Joint Improvement Partnership and Skills for Care North West and designed and facilitated by the Office for Public Management (OPM).

2. the workshops

The objectives of the workshops were to bring together commissioners and providers to enable them to jointly:

- understand the policy drivers that are powering the service reshaping agenda and the requirements for a new relationship between commissioners and providers
- hear examples of how commissioners and providers are reshaping care at home and residential services to broaden choice and give individuals control over the support they receive
- analyse the ways in which the roles of key groups of staff must change to both commission and deliver the reshaped services
- identify ways in which commissioners and providers can work together to enable the change.

The workshop programme (see appendix 1) included:

- presentations – providing briefings on the policy back ground a provider's guide to personalisation and an example of personalised care for older people with dementia
- workforce implications – two waves of group work in which mixed groups of commissioners and providers worked from a scenario depicting the current position in a fictitious unitary authority to identify how personalisation would impact on different roles in provider organisations and in commissioning. The scenario described the authority's vision for personalised domiciliary and residential care services and how commissioning will have to change to support it.

The two waves of group work involved:

- service personalisation – participants opted to work in groups that either focused on domiciliary care or residential care. Groups were tasked to identify, within the fictitious borough, how the roles of the following groups of staff would change and how commissioners and providers could collaborate to facilitate the change:
  - care workers
  - operational managers
  - support service staff (e.g. finance, personnel)
  - business development managers.

- commissioning – mixed groups of commissioners and providers were tasked to identify, within the fictitious borough, how the roles of the following groups of staff would change and how commissioners and providers could collaborate to facilitate the change:
  - care managers
  - team managers
  - contracts managers
  - strategic commissioners.

3. presentations

The workshops were opened by Alix Crawford, Regional Development Manager at Skills for Care and were followed by three presentations.

The slides used in all of the workshop presentations are available at www.skillsforcare.org.uk/northwest.

'Reshaping services for the future: policy imperatives and the new commissioning relationship' - David Whyte, North West Joint Improvement Partnership

Personalisation is wider than the use of personalised budgets[2]. It includes:

- **universal services** - (including information and advice) that are open and tailored to all and help people to help people maintain their independence.
- **targeted early intervention** - that prevents needs escalating and consequently avoids unnecessary use of expensive social care and health services.
- **self directed support** – as the normal way in which people who have longer-term social care needs will access personalised services.
- **develop the use of social capital** - including through user-led organisations, so that people can meet their needs with the least recourse to specialist services.

This can only be achieved through a new collaborative relationship between commissioners and providers around:

- **prevention and wellbeing services** – that ensure access to information and to universal services tailored to all.
- **reshaping the market** – through the use of more flexible service specifications and getting the right balance of investment between different types of service.
- **collaboration** – between providers as well as between commissioners and providers, and the development of local partnerships.

Key Department of Health targets and milestones are:

- the Department of Health expects that every local authority will be offering personal budgets as a matter of normal practice during 2010.

DH, 2009, Use of Resources in Adult Social Care

- the Government's vision for social care includes a commitment that every customer approaching social care for care or support after April 2012 will go through a process of self directed support with a personal budget.

DH, 2009, Use of Resources in Adult Social Care

- by April 2011 at least 30% of eligible people who use services/carers have a personal budget.

ADASS/LGA, 2009, Putting People First Milestones

The new direct purchasing relationship between budget holders and providers will

2 - 'Personalisation: OPM public interest briefing', OPM, 2010 www.opm.co.uk

change the role that commissioners play. This will move from being mostly focused on block and spot contracting to market development and management. There will also need to be a move away from the current adversarial relationship between commissioners and providers to a collaborative relationship.

'Reshaping services: a view from the sector' - Maria Patterson, English Community Care Association

The English Community Care Association, backed by the Care Providers Alliance, has published a guide[3] to the implications of personalisation for the care providers. Key messages are:

- **personalisation** – involves services responding to the needs of people who use services, providers delivering flexible services, commissioners monitoring outcomes not outputs and staff empowering people not imposing.
- **opportunities** - better outcomes for people who use services, opportunities to engage staff, chance to review and improve services and direct marketing of services.
- **obstacles** – funding, lack of engagement from commissioners, commissioners engaging parts of sectors only, lack of market intelligence, instability and misinterpretation of, and conflicting, guidance.
- **facilitators** - genuine partnerships, market intelligence sharing, guidance about service demands, flexible block contracts, change management advice and support, 10-15 year commissioning strategies and legal templates and toolkits.

'Personalising residential services for people with dementia: practical challenges from experience' - Martin Clark, Care Concepts Ltd

Care Concepts Ltd is a care provider based in Manchester that has personalised its services.

- **the starting point** - in 2005 Care Concepts provided a 46 place nursing home with single and double rooms set in 1.5 acres of land. They provided specialist dementia nursing care, drawing on a small partially trained workforce. Research into what people really wanted revealed views such as: 'I can get my husband dressed. I just need someone to be with him while I go to the bank', 'I could keep going if only I could have a drink with my pals', 'why must respite start on a Sunday for seven days when I go on holiday on Thursday?'

- **the opportunity** - at that time Manchester City Council wanted to change the way it commissioned to create "new, innovative, outcome based services". Care Concepts also wanted to do something different to meet peoples needs and have the opportunity to

3 - 'Personalising Care: a route map to delivery for care providers', ECCA with the Care Provider Alliance, 2010

change what we had to ensure a future for the business.

- **their plan** - involved registering to become a home care provider, seeking funding for a new build extension, developing their reputation as a ‘specialist provider’, providing outreach, day care, respite and assessment in the new build and providing dementia nursing and residential care in the extended and refurbished existing home, all backed by a specialist workforce with a different view on care.

- **the change process** – was not smooth and involved difficulties with joint commissioning between the Local Authority (LA) and the primary care trust, an extended tender period for a new block contract, changes in LA commissioning staff with different priorities, financial pressures for both the LA and Care Concepts, the development of a skilled and trained workforce and assisting our management team to recognise the requirements of a new way of working.

- **outcomes** – an independent evaluation of the service personalisation revealed the following views:
  “I am treated as an adult and I have a say in what I do” (person using the service)
  “the flexible support means so much, I always know there is someone there to help” (carer at home)
  “less worry and concern when I am not there” (remote carer)
  “enjoy delivering varied care to meet peoples needs” (care worker)
  “provides a person centered approach rather than task based care” (social worker).

4. personalising services

The scenario on which the two waves of group work were based was located in *People’s Borough*, a fictitious unitary authority that had decided to reshape its domiciliary and residential care provision in line with the following four principles of personalisation:

- **self directed support** – people should be able to determine, within the limits of their personal budgets, the support that would best meet their social care needs.
- **choice** – this will include choice of provider, range of supports provided, when it is provided and which members of staff do so.
- **self care** – services will be reshaped to support people’s own capacities to care for themselves and that of their social networks, and further develop these capacities.
- **part of the community** – there will be an emphasis on enabling people to make use of existing universal services and be part of their local communities.

Each group focused on the personalisation of either domiciliary or residential care and its impact on care workers, operational managers, support service staff and business development managers. In both cases the scenario described both the very traditional models of care currently in use in *People's Borough* and the authority's vision for personalised domiciliary and residential care.

domiciliary care

The model of personalised domiciliary care that *People's Borough* proposed to adopt was characterised by:

self directed support – people, whether budget holders or self funders, will be enabled to develop their own support plans that, within the budget they have available, best meet their social care needs. This will include looking at how best to support self care and make use of existing universal and voluntary sector services funded outside of their personal budgets. They will be able to opt to completely manage their budgets on their own via a direct payment or control its use but devolving the purchasing and day to day management tasks via an Individual Service Fund (ISF) (see box 1) to a service provider. Budget holders will pay a management fee to the ISF provider and may choose to purchase all, some or none of their services from their ISF provider. A very few budget holders will control the use of their budgets but devolve its day to day management to a care manager.

choice – budget holders, like self funders, will be able to choose who provides their service. This will include providers who are included in the new local authority framework contract[1] (see also page 32 of this report) and those that are not. As long as their agreed social care needs are met people may use their budgets to purchase the support that would best suit them. Drawing from current discussions with potential budget holders, these may include budget holders:

- being able to select which care assistants will provide their personal care
- substituting time that a care assistant currently spends on preparing a meal by a meals service. This will both increase the range of choice and nutritional value of meals but also save some money that the budget holder can use on other forms of support
- buying into a telecare service that replaces check in visits by care assistants. This again both provides the required support and saves money that the budget holder is able to recycle in other forms of support
- paying for support to be able to use services outside of the home and hence not being reliant on short visits from care assistants as the major way of combating isolation.

self care – this might include budget holders:

- paying a bit more for extra time from a care assistant to spend enabling a person to care for themselves
- paying a family member to provide the care that is currently provided by care assistants which relieves the strain of having to provide care on top of working in their current part time job.

part of the community – using part of the budget to be enabled to get out and about in the community and hence once again be part of everyday life. Joining in with voluntary activity where the person is able to both contribute and receive support. For budget holders who so choose, this will be enabled by providers who offer an ISF budget management service.

1 - 'Contracting for personalised outcomes Learning from emerging practice', DH 2009

box 1: Individual Service Funds (ISFs)[1]

- a money management option, used in social care, for personal budget holders who choose not to direct some or all of their support through direct payments – the council lodges money with a provider on an individual's behalf ensuring they have maximum control over any support provided.
- a sum of money held by a provider on an individual's behalf that is restricted for use on that person's support.
- a sum of money for which the time, task and type of support has not been predetermined, i.e. the individual is empowered to work together with the provider to decide the exact detail of any support provided.
- this can be for some or all of the available budget, i.e. someone may have multiple ISFs with different providers or a combination of ISF(s) and direct payments.
- an arrangement that requires providers to account for spending on an individual basis – i.e. the money is attached to the individual for whom the ISF is established and is accounted for in this way.
- an arrangement that defines upfront any elements of the budget that will be used to cover the provider's core management and support costs, with all of the remaining budget restricted for expenditure on the needs of the person for whom it was established (core costs should not generally exceed 10-15%).
- a sum of money that remains portable – i.e. the personal budget holder can choose to use the money in a different way or with a different provider – the 'agreement' should include details of how the ISF can be ended by either party and should usually include a notice period (this is often 1 month).
- an arrangement that enables flexibility for the individual in terms of the type and volume of service used, i.e. money (or hours of support) can be rolled over into future weeks or months or banked for particular purposes and the ISF can contain services bought from other providers.

1 - 'Contracting for personalised outcomes Learning from emerging practice', DH 2009

workforce implications

Groups were asked to identify the changes that staff in four different roles would experience as domiciliary care is personalised and how commissioners and providers could work together to enable the changes.

care workers

Personalisation will require a shift in the mindset for care workers who provide the day to day support to people. This will include:

- **understanding and enacting the vision** – of what personalisation aims to achieve and what this means in terms of a changed service culture and relationship with people requiring support.

  Care workers are the key role models for people in demonstrating the changed approach and relationship. Their role is to empower and with that comes a shift in the balance of accountabilities and responsibilities between staff and the people they support.

- **planning and doing** – working with budget holders to help develop their detailed support plans as well as providing some of the support required.

  Care workers will provide a vital link in co-creating the detailed support plan with individual budget holders rather than simply working to plans created by others. Staff with good listening skills are able to 'think outside of the box' and work with people to develop creative solutions will be particularly valued.

- **re-enablement** – enabling people to regain skills and capacities and do things for themselves.

  Understanding what people can currently do, and would like to do and supporting them to get there, will replace identifying needs and filling the gaps via service provision as the main approach to providing support. The care worker role switches from carrying out defined tasks for people to working as a support worker alongside people. Hence the provision of training for budget holders will become a common feature in support plans.

- **beyond the service** – care workers will enable people to draw on services outside of domiciliary care.

  Either brokering or directly enabling people to make use of services and facilities beyond domiciliary care will become an integral part of the care worker role. Care workers should be enabled to draw on their existing local knowledge of services and community resources and further extend it.

- **effective risk management** – that enables people to take the risks that adults should be free to choose whilst also being enabled to manage their risk taking.

  Care workers should be aware of both people's right to take risks and how to enable them to do so. This will require a rethinking of risk management, a move away from a risk averse culture and a new approach to supporting staff that does not leave them having to shoulder the burden of responsibility for the extra risk taking.

- **pay** – care workers will need incentives and the motivation to take on the extra responsibilities.

Some of the new requirements of care workers, such as enablement, may relate to all roles. Others, for example, detailed support planning, may be carried out by more specialist care workers. In both cases the implications for remuneration will need to be thought through.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable care workers to most effectively make the transition to personalisation are:

- **training and staff development** – in what personalisation means in practice and developing the new knowledge and skills required. Commissioners should work with providers to specify the training requirements and procure the training at an affordable cost. NVQ training will also need to be overhauled.
- **risk management** – enabling the joint development of the new approach to risk management with budget holders, their families and providers.
- **jobs and pay** – the development of outline job descriptions that can be modified by individual providers that encapsulate the range of new care worker roles that may be required. Providing non monetary recognition such as an annual local 'innovative care worker' award.
- **community knowledge and links** – brokering links between providers and also with other community services and facilities so that care workers can more easily help people to access them.

support service staff

For example, staff working in administration, finance and personnel.

- **individual billing** - rather than billing one commissioner for a whole contract each budget holder will be billed separately.

  This will increase the volume of billing, and potentially invoice chasing, and will require a more individualised approach to invoicing. It will also require a redesign of financial systems

- **direct liaison with budget holders** – as billing is individualised finance staff are likely to have much greater contact with budget holders than before and will need to have the interpersonal skills required to do so.

  Individual budget holders will want to check that they are being provided with the services as billed, have services which change with their needs and have help in costing new more personalised packages of support. This will bring finance staff into a much more direct relationship with budget holders, often for the first time. The new relationship may focus as much on advice and guidance as on sorting out financial transactions.

- **workforce training and development** – will need to be redesigned to encompass the new requirements of personalisation.

  Human relations staff will have to understand the implications of personalisation for the organisation as a whole, its impact on different jobs and the new requirements for staff development and training. They will also have to make arrangements to design and procure the new training and continuing staff development in an affordable way.

- **workforce restructuring** – may be required to take into account the expanded roles of care workers.

  Job descriptions may have to be redrafted, pay rates reconsidered, parts of the organisation restructured and recruitment procedures changed to meet the new requirements of personalisation.

- **aggregation of information** – from care workers and support plans to provide an analysis of trends that is of use to the organisation and can be shared with other providers and with commissioners

  Effective market development and management requires access to aggregate data on outcomes, support services supplied and the ways in which personal budgets are being spent. This information will be captured through support plans and billing systems but will need to be aggregated if it is to be used to identify trends. Support staff will undertake the first stage of aggregating this information.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable support workers to most effectively make the transition to personalisation are:

- **systems redesign** – clarifying the requirements for billing, capturing and aggregating outcomes and support plans. Where appropriate pooling the costs of system redesign including enabling providers to share development costs and possibly support services.
- **training and staff development** – enabling human relations staff to collaborate in specifying and procuring affordable training for all staff including

themselves and other support staff.

- **understanding budget management** – developing easy read and other supportive materials that will help finance staff explain how personal budgets work to both budget holders and their friends and relatives.
- **aggregating information** – agreeing the basic data that commissioners and providers require to operated effectively in the new retail market and how it will be aggregated and analysed.

operational managers

Operational managers primarily focus on the management of the day to day running of the service. In smaller organisations, and those with more devolved management processes, this role is often merged or overlaps with that of the business development manager.

- **making the change real for staff** – by ensuring staff are made aware of the need for change and updated on changes as they occur.

  Operational managers have a key role to play in supporting staff through the transition. This means making the new world real for staff by translating the strategic agenda into practice changes, communicating threats to the business and how staff can help tackle them, keeping staff on board and watching out for their wellbeing.

- **change managers** – instilling confidence in staff and supporting them in pro-actively changing.

  Enabling all staff to work in a person centred way. Operational managers will have to enable innovation through stimulating thinking, asking questions and being open to answers coming from any part of the organisation and from budget holders. This will include enabling their own junior staff to manage and influence upwards and doing so themselves. Operational managers will be in the front line in ensuring their staff get both the training and the continuing supervision and support they require.

- **bespoke pricing** – operational managers will have to become skilled in costing up bespoke support arrangements for budget holders.

  Personal budgets unleash the potential for support to be provided in many different ways. Staff will be faced with a wider range of requests for support. Some of these will fit within the organisation's new individualised pricing framework, others will not. Operational managers will have to have the devolved power to vary the pricing framework within an overall system of pricing and budgetary control.

- **retail competition** – competition between providers for individual custom rather than for block contracts will now become part of everyday life.

  Operational managers will therefore need to know what similar providers are offering

and decide whether or not to respond in changing their own organisation's services and prices. Organisations could increase their attractiveness to budget holders by developing partnerships with other organisations to provide a wider range of complementary forms of support. Demonstrating integrated working with other services funded outside of personal budgets, for example in health, would also be attractive to many budget holders.

- **outward facing** - being out and about, ensuring the organisation is well known and making working links with others.

  The most effective marketing comes through building relationships with people. Therefore ensuring the organisation is well known to commissioners, brokers and providers of complementary services is essential. Being able to provide a flexible response to individual budget holders' needs will also require a good knowledge of who locally is providing what services and how to access them. Hence the new role is much more outward facing than before.

- **business development** – the widening of the operational manager's role will lead many to become engaged in business development activities for the first time.

  Operational managers will therefore need to know the scope that they have to develop bespoke services and be closely involved in the overall business development process of their organisation. A key role will be to stimulate thinking and ask awkward questions about the viability of business decisions.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable operational managers to most effectively make the transition to personalisation are:

- **development opportunities for operational managers** – through, for example, commissioners offering small 'innovations grants' that provide small amount of funding for operational managers to try out new ideas.
- **enabling marketing** – providing opportunities for providers to meet together and, with budget holders, understand what is on offer, develop partnerships and stimulate thinking about developing new services.
- **change management support** – the use of action learning and other forms of support organised on a local or regional basis to enable operational managers to learn from one another and problem solve live.

business development managers

These managers typically handle business planning, contracting, marketing and enable overall staff and organisational development. In some organisations, particularly smaller organisations, the business development and operational manager roles are combined.

- **outcomes focused business planning** – reflecting the emphasis within personalisation on enabling people to live fuller lives rather than the provision of specified forms of support.

  Providers will embed outcomes focused working throughout their organisations. This will include replacing the current task

focused approach based on systems and procedures to one that supports self directed teams that can offer a flexible menu of services to meet individuals' needs. Business development managers will play a major role in leading this change. They will also want to negotiate consequential changes in the way services are quality assured at a local level and regulated at the national level.

- **innovations tracking** – with increased competition it will be even more important to be aware of new developments in provision and to be able to evaluate their relevance to the organisation.

  Business development managers will need to be well networked so as to easily pick up on new service innovations, able to evaluate how they fit with their organisation's current range of services and advise on their implications for its overall business model. Despite competition between providers there is also scope for collaboration in joint development which can reduce the risks and costs of innovation.

- **service diversification** – broadening the scope of their organisation's offer to be able to more flexibly respond to budget holders' requirements.

  This might include the development of 'low cost' services that enable people to improve their self care, help in preventing needs escalating and are a low risk to develop. For example, a domiciliary care provider begun to provide information services (such as healthy eating workshops) run by its experienced staff in generic community settings. These became a primary information point, improved general wellbeing and acted as a gateway to more bespoke care if needs escalated. In this way the organisation became embedded in the local integrated preventative services pathway.

- **connecting with strategic commissioning** – to understand how the personalised services market is changing. Influencing the market development and management activities undertaken by local authority and other sectors' commissioners.

  Whilst business development managers are involved in overall strategic planning their main link into commissioning is currently via contracts managers. Personalisation will still require providers to ensure that their business development decisions influence, and are informed by, the joint strategic needs assessments and are in line with what are likely to be cross sector market development strategies and new government policies. A key role for business development managers will be to get a grip on the main market trends and be able to relate them to their own organisation's planning at a strategic level.

- **ensuring viable small organisations** – by finding ways of lowering and sharing the costs of innovation and change.

  Small organisations can neither afford dedicated roles such as business development managers nor do they typically have the resources required to retrain staff, redesign systems and market their services. These organisations can however be highly innovative and some budget holders prefer to receive their support from small organisations. Hence

there is a need to find ways of ensuring their viability.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable business development managers to most effectively make the transition to personalisation are:

- **market intelligence** - for this to be shared commissioners and providers should agree how best to capture and aggregate data on services, quality, prices and outcomes.
- **skills development** – many organisations only have one business development manager hence they lack the opportunity to learn from peers. Development opportunities should be created at either local or regional level to meet the needs of this group of staff.
- **small business support** – should be developed be tailored to the needs of individual organisations. This may include the creation of secondary support organisations that can provide the back office functions that are now required to operate in a retail market.
- **regulation** – identifying where CQC regulations either cut across or work against personalisation and presenting a jointly agreed commissioner and provider case for change.

residential care

The model of personalised residential care that *People's Borough* proposes to adopt is characterised by:

self directed support – people, whether budget holders or self funders, will be enabled to develop their own support plans that, within the budget they have available, best meet their social care needs and enable them to live a full life. The support plan will encompass the care plan. This will include looking at how best to support self care and make use of existing universal and voluntary sector services funded outside of their personal budgets. They will be able to opt to completely manage their budgets on their own via a direct payment or control its use but devolve the purchasing and day to day management tasks via an Individual Service Fund (ISF) (see box 1) to the residential service provider. Budget holders will pay a management fee to the ISF provider to help them make use of their budget in a flexible way (see below).

choice – budget holders, like self funders, will be able to choose their residential service provider and location. This will include providers who are included in the new local authority framework contract[1] (see page 32 of this report for more information) and those that are not. Having chosen a residential setting the further choices open to budget holders will be:

- making use of the core support service that is provided to all residents – paid for from an allocation of 75% of each person's budget. Tele care will be in use throughout the residential setting to enable prompt support to be provided when required, allow people to move about freely and to free up staff time from 'checking up' to be used on other

1 - 'Contracting for personalised outcomes Learning from emerging practice', DH 2009

activities. This will include enabling people to determine and vary their own personal daily timetable including when they get up in the morning, go to bed and meal times.

- Ichoice of extra personal support – paid for from an allocation of 20% of a person's support budget to be used to enable them to purchase a defined number of hours support from the core staff group to carry out activities agreed in their self directed support plan.
- cash budget – paid for from the remaining 5% of a person's budget. This can be used to purchase goods and services provided by staff and organisations outside of the residential care setting. For example, paying for transport and other support to enable people to use universal service such as shops, restaurants, cinemas, leisure centres, parks, libraries and to visit friends and relations.

self care – this might include:

- core staff encouraging and supporting people, as a normal part of everyday life, to carry out as many self care and other daily living activities for themselves as is possible
- where residents wish it, supporting friendships and mutual self help
- where possible enabling relatives and friends living outside of the residential setting to play an active part in caring both in and outside of the residential care setting.

part of the community – as part of the core staff role, making links with local community groups for older people and others and, where individual residents so choose, enabling them to both join in and contribute to activities outside of the residential setting. Budget holders may choose to use part of their budget to be enabled to get out and about in the community and hence take part in everyday life.

> “people will be able to opt to completely manage their budgets”

workforce implications

Groups were asked to identify the changes that staff in four different roles would experience as residential care is personalised and how commissioners and providers could work together to enable the changes.

care workers

Personalisation will require a shift in the roles of care workers who provide the day to day support to people. This will include:

- **bespoke support** – focused on the person rather than being required to carry out a narrow band of tasks.

  The role of some care workers would therefore be closer to those of personal assistants. This personal relationship will necessitate organisational changes. For example, staff rota-systems would no longer be designed around home management, but instead focused on meeting the differing needs of budget holders which may change from day to day. Budget holders will want to select the care worker who provides them with their support.

- **beyond residential care** – care workers will be enabling people to access services

and everyday facilities outside of the residential care setting.

This will require care workers and operational managers to make links with services and facilities outside of the residential setting. Care workers could either directly support budget holders to access these opportunities or act as brokers.

- **extended knowledge and skills** – will be required to deliver personalised care.

  As the roles of some care workers become much more akin to personal assistants the range of core knowledge and skills that they require should be revised. Some, for example, will be involved in working with budget holders to develop their detailed support plans and tracking outcomes. This will require higher levels of literacy and numeracy than are currently required. This could lead providers to developing teams of staff with complementary skills who together can meet the demand from budget holders for greater flexibility. The new requirements will also change existing staff progression routes.

- **freedom to take risks** – that are required to enable budget holders to choose how to lead their lives but not be the brunt of it when things go wrong.

  As choice is transferred from care manager to budget holder there is a real potential for the burden of risk management to be shifted from being a shared commissioner – provider responsibility to being shouldered by providers and in particular front line staff. Risk management needs to be re-thought to meet the new requirements of personalisation.

- **pay and conditions** – will need to be changed to support both the new role and the requirements of flexible working.

  This level of skills and knowledge that would now be required will require change in remuneration and the requirements of flexible working reflected in new contractual terms and conditions. This may lead to different grades of care workers whose time is the charged at different rates. Hence a budget holder could choose between, for example, receiving 10 hours of more highly skilled support or 18 hours more basic support.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable care workers to most effectively make the transition to personalisation are:

- **training and staff development** - will have to be redesigned to take into account the different and broader roles.
- **risk management** - commissioners and providers should agree on joint risk management and avoid any rush to litigation which will restrict the ability of budget holders to live their lives in the way they choose to do so.
- **affordable service delivery** – the demand for more personalised bespoke care and a wider role for care workers will have knock on implications for job descriptions and remuneration. Commissioners may need to help budget holders and providers negotiate both what is required and what is affordable.

support service staff

For example, staff working in administration, finance and personnel.

- **understanding personalisation** – and the consequent changes required in support services.

  Support staff need to know what is driving personalisation, what it will look like, how personal budgets in their different forms will operate and how the shift from block contracting to a retail market will impact on the organisation. They will also need help to translate this broader understanding into how it will impact on key support processes such as pricing and billing, staff pay, recruitment and development.

- **developing the new personalised support systems** – such as those required for personal budget invoicing and management.

  The move from block contracting to individualised billing will increase the billing workload of support staff and require new financial systems. Staff will need training and support to handle this shift in focus and to get to grips with the new systems.

- **working directly with budget holders** – will be a new feature of the role of some finance staff.

  The shift from block contracting to budget holders directly purchasing services from providers and some providers operating Individual Service Funds (ISFs) on their behalf will bring finance staff into a personal relationship with budget holders. This will require them to both develop the necessary interpersonal skills but also be able to explain the new financial arrangements in clear everyday terms and support the flexibility of use of budgets.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable support workers to most effectively make the transition to personalisation are:

- **staff development** – to enable support staff to both understand the new requirements of personalisation and to develop the new skills required. For example, enabling finance staff to develop their interpersonal skills in liaising with budget holders and their families.
- **system development** - there is a demand from providers for support from commissioners to help them develop new business systems, stream line personal budget management processes and develop joint approaches to staff development. This could be developed via regular discussions in local joint provider - commissioner forums. There is also great scope for commissioners to enable provider - provider collaboration to share costs and in some cases staff and systems.

operational managers

Operational managers primarily focus on the management of the day to day running of the service. In smaller organisations, and those with more devolved management processes, this role is often merged or overlaps with that of the business development manager.

- **empowering care workers** – to not be risk averse in developing personalised responses to individual budget holder's needs.

  Personalisation involves a major culture change. Training can help but this will need to be followed up by further support to ensure care workers understand that they are allowed to work in personalised way and that they will be backed up if things do not always go right. This may involve operational managers providing day to day reassurance and support to care workers and through raising and discussing practice issues at regular staff development meetings.

- **working with families** – to explain what personalisation means and to work through the practical consequences.

  Personalisation involves the fine detail of how someone wishes to live their day to day life. Relatives may mistakenly think that it involves a 'laissez faire' and casual approach that is tantamount to not caring for their relative. These and other misconceptions will take time to work through. Operational managers will often take the lead in these types of discussions.

- **linking with everyday services** – so that budget holders can join in the activities of local community associations and use the services and facilities like other local people.

  Enabling people to participate in activities and use services outside of the residential care setting can be a challenge. Very often community associations are not geared up to support people who use residential care. Operational managers will have a role in making the links with organisations that can offer the opportunities that are identified in a person's self directed support plan.

- **focusing on quality and value** – as defined by budget holders rather than cost and volume as in block contracts.

  Helping budget holders achieve outcomes agreed in their support plans will require a much wider repertoire of support than before. The old relationship between hours required and outcomes will no longer hold. Operational managers will have to become skilled at working with both staff and budget holders to find different ways of meeting needs. This will include, where possible, enabling budget holders more scope to do things for themselves.

- **financial management** – the operating unit as a whole will need to allow for both the extra costs required to provide some forms of support. and savings through

prevention and budget holder self care.

Staff time should be managed such that there is enough time for care workers to act flexibly. Where budget holders do opt to take on some tasks themselves or regain skills and capacities the amount and type of support they require will decrease. This will need to be reflected in the costs of their support. Hence flexible individual pricing may be needed.

- **local market awareness** – understanding who is providing what, and at what price, locally and how others' services are developing.

  The change from block contracts to a retail market means that providers will need to be able to adapt their services quickly to changing patterns of supply and demand. Operational managers will be in the front line in sensing and responding to these changes. Up to date market intelligence will also be required by providers who offer ISFs through which they enable budget holders to purchase services both from themselves and other providers.

- **business development** – taking a stronger role in day to day business development.

  Both personalisation and the demands of a retail market will require providers to respond much more quickly to changes in supply and demand. Operational managers are increasingly taking on more business development roles. This trend will need to be further supported by clarifying the financial and business imperatives that will enable them to make the most creative use of their room to manoeuvre.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable operational managers to most effectively make the transition to personalisation are:

- **understanding personalisation** - commissioners will have a key role in helping providers understand how personalisation may impact on their organisations and enabling operational managers to rethink their roles.
- **opening up community services and facilities** – to people in residential care will require some redesign of these services. Commissioners will play an important role in explaining personalisation to these organisations and enabling them to open up their services to meet a wider range of budget holders' needs.

business development managers

These managers typically handle business planning, contracting, marketing and enable overall staff and organisational development. In some organisations, particularly smaller organisations, the business development and operational manager roles are combined.

- **focusing on whole people** – rather than the needs that can be met by residential care support.

  Business development managers should not solely focus on providing residential care. They should also work with local commissioners and other service providers to develop links with community associations, universal services and other targeted services that are required to realise individual budget holder's support plans.

- **beyond bricks and mortar** – enabling their organisations to diversify into providing support at home, very flexible respite and day service support to meet the fluctuating needs of many people.

  Many residential providers are heavily constrained in what they can do by a business model that requires them to ensure they fill all of their beds all of the time. Personalised residential care will require staff support for people both inside and outside of the residential setting. Respite, night time only and partial day time care are likely to become more and more in demand. Hence business development managers will have to develop the skills in business modelling and service development to encompass this wider range of services and the richer mix of demand.

- **supporting group deals** – where personal budget holders might wish to pool some of their budgets to procure new services.

  It is likely that some personal budget holders who have common support needs and want a particular type of service might club together to purchase it. However this assumes that budget holders can easily get in touch with one another and are prepared to do the leg work required to procure the service. Some will do this; others will require help to do so.

- **provider to provider collaboration** - in sharing market intelligence, back office and marketing functions.

  It is very difficult for any one provider to develop an overview of the local market and how it is developing. This requires provider to provider collaboration in information collection and sharing. It also makes sense to share the costs of data analysis. For smaller providers sharing of back office functions, or buying them in from another provider, may reduce the costs of moving to personalised service provision.

- **a new relationship with commissioners and regulators** – involving regular and open and honest dialogue.

  Block contracting led to a narrow bidding and performance management relationship between commissioners and providers. The move to a retail market will change both the roles of commissioners and providers. Neither will dominate and both require one another to enable them

to do their jobs effectively in supporting better outcomes for local people.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable business development managers to most effectively make the transition to personalisation are:

- **enabling group purchasing** - providing a mechanism whereby people can get in touch with one another, work out what they want and then have it procured for them is another business opportunity to which providers may wish to respond. It is also a process that commissioners could help facilitate.
- **provider to provider collaboration** – commissioners can play a key role in enabling providers to pool information and produce overall market analyses, and share the costs of developing the new personalised back office functions.
- **regulation** - the new models of support demanded by personalisation will also require changes in the way regulators conceptualise and regulate care in different settings. Commissioners can work with providers to identify those changes and jointly lobby regulators.

“commissioners can play a key role in enabling providers to pool information”

5. the changed role of commissioners

The new approach to commissioning that *People's Borough* proposes to adopt is characterised by:

supporting choice

Care managers will be expected to enable budget holders to develop their own self directed support plans. Some people will do most of this themselves, others will draw on support from independent brokers and a few will rely on help from care managers. A comprehensive website will provide people with lists of providers, both on and off the local authorities' framework contract, their prices and enable people to exchange views 'trip advisor' style on the services and the value for money delivered. Care managers will have a critical role in negotiating, quality assuring and signing off and reviewing the final plans. They along with user led organisations may also have a role in enabling budget holders and self funders who so choose to pool some of their budgets and jointly purchase new types of services.

purchasing and managing services

Some people will take their funding in the form of a Direct Payment (DP) and purchase and manage all of their services themselves. It is anticipated that many more people will make use of ISFs or manage part of their services via an ISF and part through a DP. A few people may opt for their care manager to manage their services on their behalf but to their order.

devolved funding

Commissioners will be involved in the monitoring of the overall use of funding, its impact on outcomes and in the continuing

development of the local Resource Allocation System (RAS) that enables the size of a personal budget to be allocated in line with an individual's level and range of needs. We will be seeking to develop either aligned or pooled personal budgets with health and to extend the use of personal budget into areas such as education and employment.

marketing and service development

It will be the job of providers to market their services via the local website, brokers and directly to budget holders, self funders and their families. Providers will also be encouraged to personalise their services in line with changing demand. To help them do this, strategic commissioners will work with them, care managers, budget holders and self funders to understand what they are purchasing, from whom and what they would like to purchase, and to make this aggregate information available to all. Commissioners will also be actively involved in enabling providers to personalise their services. This may involve organising service fairs where they can meet directly with budget holders and self funders and learn from other providers; enabling provider to provider collaborations either in the provision of shared back office functions e.g. billings systems and staff development or in marketing complementary sets of services.

framework contracting

As a means of enabling the transfer to the new way of working we will be phasing out both our current block and spot buy contracts. Instead we will be drawing on leading edge practice developed elsewhere[1] to support personalisation by offering the opportunity to providers to bid to be included in a new framework contract. This will require providers to meet certain quality requirements such as CQC's standards, provide personalised services, advertise their services and prices in a transparent way and, where budget holders choose this option, to manage ISFs on their behalf. Whilst the contract will not guarantee the purchase of services, providers will be able to advertise that they are local authority approved providers.

personalising services not funded by personal budgets

Many of the services on which people draw or would like to do so are funded outside of personal budgets. These include targeted services, such as rapid reablement in health and support to gain employment. Whilst much is being done to develop integrated pathways within targeted services these often focus on service to service integration rather than being built around individual needs and preferences. Some of the personalisation of these services will occur through the further extension of the use of individual budgets but in the meanwhile much needs to be done to change the way they are commissioned.

Equally important to budget holders is access to universal publically funded services such as leisure centres, parks, policing, primary health care, public transport and street scene and universal commercial services such as cinemas, financial services and shops. Whilst much has been done to improve physical access these services are still mostly designed to meet the needs of the average range of people who use services. Personalisation will involve our commissioners working with these services to increase the range of services they offer to include those desired by personal budget holders.

building social capital

Being part of the community involves being able to both gain support from and provide it

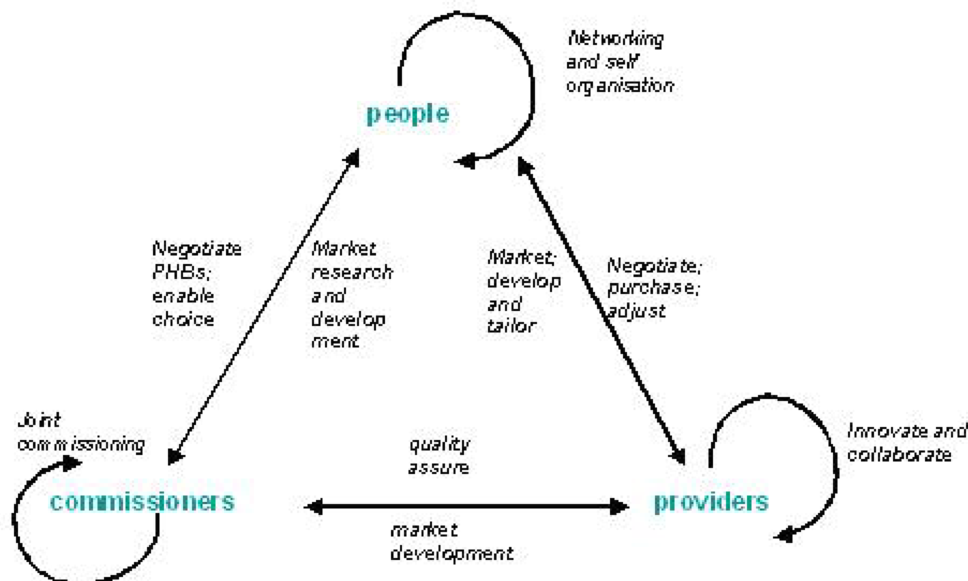
1 - 'Contracting for personalised outcomes Learning from emerging practice', DH 2009

to others. Much of this occurs spontaneously but many personal budget holders and self funders have not known about or been able to make contact with the self help networks that are around. There is also a large number of people in any community who would like to be more actively engaged with others but do not wish to do so through existing community associations. Our commissioners will have the role of enabling people to connect up together, through developing new initiatives[4] such as time banks, key ring, small sparks and to enable people with social care support needs to be able to contribute as well as receive support. Commissioners will also be tasked to enable current community associations to open up their activities to all.

the new commissioner – provider relationship

We recognise that the new relationship is one in which budget holders and self funders, providers and commissioners will be jointly involved in reshaping and personalising services (see figure 1). This will require a culture shift on everyone's behalf away from the old style adversarial to a new collaborative relationship.

figure 1: the new style commissioning relationship



4 - 'In Community', Carl Poll, Jo Kennedy and Helen Sanderson ed, In Control 2009

workforce implications

Groups were asked to identify the changes that staff in four different roles would experience in adopting the new personalised approach and how commissioners and providers could work together to enable the changes.

Many of the provider staff at the workshop acknowledged that they had little knowledge of the roles of team managers and strategic commissioners as currently they had very little contact with them. Under the *People's Borough* scenario this would change in the future.

care managers

The current role involves assessing needs agreeing care plans, procuring the service supports required and regularly reviewing outcomes against plans.

- **self directed support** – enabling the budget holder to be in the driving seat in developing their support plan and in its review.

  Whilst there is a statutory requirement for the local authority to carry out social care needs assessments the new self directed support process greatly reduces the amount of that work which will be undertaken by care managers and changes part of the role they play in doing so. It may also reduce the amount of detail contained in the formal care plan with the detailed support plans that budget holders negotiate with providers becoming, for them, the key documents.

- **outcomes focused** – being skilled in enabling budget holders to specify outcomes and review the degree to which they are achieved.

  Traditional care plans, although meant to be outcomes focused, mostly detail the support to be provided to a person. Being able to specify outcomes in a way that makes sense to budget holders and evidence any impacts and how these have been supported is central to personalisation and provides the bedrock of the intelligence required to inform strategic commissioning.

- **whole life** – care management must enable people to look at their lives in the whole and explore options that lie outside of the previous realms of social care support.

  Whilst care management was intended to be holistic in its focus most attention has been paid to assessing social care needs and how to meet them using designated social care services. In contrast self directed support focuses on people's whole lives, knowledge of their past histories, the personal and community resources and opportunities available to them, and how they can best make use of them. Engagement with a budget holder's family and wider social network will be integral to support planning. It is within this context that purchases of additional social care supports are then considered. The adoption of a whole life perspective will involve a mind shift for care managers and a redefinition of what the job is about.

- **obtaining value for money** – ensuring that budget holders understand the limits of their budget and are enabled to make best use of it.

Personal budgets are both means tested and limited. Budget holders will want to know both the size of their budget and the prices and content of the different types of support they can purchase. This may lead them to rethink the support they need and to come up with alternatives. Care managers should be skilled in helping people 'think outside of the box'.

- **risk management** – enabling people to make their own choices also involves a different approach to risk management.

  The legal obligations on care managers, budget holders and providers need to be clarified and reset to enable self directed support. Care managers will need both training and day to day support to enable them to support people to make what are currently perceived as being riskier life choices.

- **understanding the provider market** – care managers will need a much more detailed knowledge of the local personalised services market.

  Under block contracting and pre negotiated spot buy agreements care managers had only a limited range of providers on whose services they could draw. The ability of budget holders to buy from any source they choose will lead to demands on care managers to signpost a far wider range of services and providers. This will require care managers to develop a much more sophisticated understanding of the local market and information services and, where required, take on the role of active brokers.

- **supporting budget holder collaboration** – where this is desired by budget holders to enable them to pool budgets and resources to jointly better meet their needs.

  Some budget holders may welcome the opportunity to pool part of their budgets in order to jointly purchase services. Where the services they require do not yet exist care managers and user led organisations will have a role to play in helping develop them.

> "care managers should be skilled in helping people 'think outside of the box'"

how commissioner – provider collaboration can help

The main areas in which collaboration could enable care managers to most effectively make the transition to personalisation are:

- **redefining care management** – potentially care managers, brokers and provider staff could all be involved in some way in helping budget holders develop and realise their support plans. This requires coordination and agreement between the different parties if it is not to result in confusion for budget holders, as well as duplication and waste of resources by all.
- **training and staff development** – for care mangers to enable them to understand the rationale underpinning personalisation, the change required in their roles and develop the new skills and knowledge to support self directed support in a retail service market.
- **risk management** – the development

of a framework for risk management that both enables the discharge of the duty of care but also enables budget holders to take the risks that they wish to take.

- **supporting group purchasing** - by commissioners organising regular local events to put budget holders in touch with one another and providers to showcase different sorts of services that have been developed through individual level budget pooling and discuss how to bring others on board.

team managers

Manage and provide support to care managers and 'gate keep' access to some services.

- **focusing on the most vulnerable** – by freeing up time through enabling other budget holders to self manage.

  It will be important for care managers to prioritise their time to ensure that those budget holders who are the most vulnerable are as able to realise the benefits of personalisation as others.

- **permission giving** – to care managers to take on their changed role and be innovative.
  Personalisation requires a major change in the care management culture. Even where care managers understand it at an intellectual level they will need reassurance and support to put into practice changes that they may perceive as risky. Negotiating accountabilities for risk management at an individual level, providing this reassurance and inspiring care managers to make the transition to the new culture will be a major part of the team manager's role.

- **building the new practice culture** – that is needed to support personalisation.

  Team managers are critical to enabling care managers to change their relationship with budget holders and help them grasp the opportunities provided by personalisation. This involves a double devolution of power from team to care managers allowing the greater freedom of decision making and from care managers to budget holders to enable self directed support.

- **understanding the new business systems** – that will be available to both support personalised purchasing and enable the capture and analysis of market intelligence.

  It is likely that the business support systems required by personalisation will be more sophisticated and IT enabled. Hence it will be important to ensure that team managers receive the training and support they require to make best use of these systems.

- **providing market intelligence** – in response to care manager and budget holder demands.
  Team managers can enhance the ability of care managers to inform budget holders about local services and information sources by searching out relevant information and making sure that their teams are aware of it.

- **understanding the big picture** – both in terms of national and local policy and local market trends.

  Team managers are the critical link in the chain in both ensuring that care managers understand how policy is supporting changes in practice but also in informing strategic commissioners about how the policy is working out in practice.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable team managers to most effectively make the transition to personalisation are:

- **enabling staff to make the transition** – provision of continuing support to team managers to help them understand how the commissioning contribution to market development and management is evolving and the role that they and their team members can play.
- **management of team managers** – must also change to enable them the freedoms required to support creative working by care managers with budget holders. This will include a shift away from a focus on allocating services to one that looks at outcomes met and the use people are enabled to make of community and other resources and their own social capital.

contracts managers

Contracts managers are typically involved in running the tendering process and contract managing the resulting block and spot contracts. As there is a move away from block contracting to a retail market the traditional role of contracts manager will greatly reduced and be replaced by market development and management roles.

- **phasing out block contracts** – at a rate that enables individual providers to both adapt to the retail market and transform their services.

  The decommissioning of block contracts provides a strong signal to providers that personalisation is real. The phasing out of contracts enables an ordered transition that will minimise the possibility of destabilising the current provider market. However phasing out must be accompanied by service personalisation if the new retail market is not to simply provide the existing traditional services under a new label. Hence contracts managers need to change the ways they specify and manage the remaining

block contracts to focus on outcomes and person centred planning and service delivery.

- **outcomes focused contracting** – where block contracts are still required will replace current task and volume contracts.

  It is as important to personalise services that are commissioned outside of personal budgets as those that are within. Hence it is important to also change the culture within services such a rapid reablement where many people will receive support for only a time limited period and then regain independence. Where these services are block contracted this can be supported by replacing existing contracts with ones that are based on outcomes.

- **provider scrutiny** – to ensure that providers are acting in the best interests of budget holders.

  With the replacement of block contracts by individual purchasing of services there will still need to be some overall scrutiny of services to ensure that the needs of people are being met. Partly this will be achieved through the care management process and through active self directed support by budget holders. However some budget holders who are less able to direct their care will lack the leverage available to others. Providers will also vary with some providing excellent personalised services and others not. Hence there will be a need for continuing scrutiny of the provider market.

how commissioner – provider collaboration can help

The main area in which collaboration could enable contract managers to most effectively make the transition to personalisation is:

- **personalisation within contracts** – this can no longer be achieved through the detailed one – way specification of tasks. Instead it will require an active dialogue between commissioners and providers.

strategic commissioners

Work with other agencies to develop the joint strategic needs assessment, consult with people who use services and decide the future shape of services and how this should be realised via block and spot contracting under-pinned by joint commissioning.

- **setting and communicating the overall vision** – so that the fundamentals and the direction of travel on personalisation are understood.

  Whilst the details of personalisation are still being worked out the fundamentals in terms of self directed support, a whole life outcomes focus, building individual and social capital and ensuring that all universal and targeted services fit people rather than vice versa are known. So too are the implementation milestones. Strategic commissioners are best placed to ensure that all local stakeholders understand these and can relate it to their roles.

- **supporting outcomes focused working** - so that it is central to the way personalised services are both commissioned and delivered.

Key groups of staff in both commissioning and provider organisations will be required to adopt outcomes focused working as a normal part of their daily work. All will need to be skilled in defining outcomes. Strategic commissioners can help by embedding outcomes focused tools and frameworks in the way services are commissioned and market intelligence gathered and aggregated.

- **enabling budget pooling** – across sectors to personalise services for people with more complex and often enduring needs.

  Personal budgets are being piloted in health and the new coalition government is committed to enabling pooled health and social care personal budgets. Total Place pilots have recommended similar arrangements. Strategic commissioners will play a major role in enabling pooling arrangements to be put in place and to enable joint market development and management across sector boundaries.

> "personal budgets are being piloted in health"

- **risk management** – policy that supports personalisation and takes into account the changed roles of budget holders, commissioners, providers and regulators.

  Strategic commissioners are best placed to bring together all stakeholders to develop a local agreement on risk management and to test out its acceptability at national level.

- **market intelligence** – that links needs to services and outcomes will be even more essential to both providers and to strategic commissioners in their new role.

  Strategic commissioners, working across sectors, are best placed to bring together providers and budget holders to understand the information they require to work together effectively and that are required by commissioners to enable market development and management. This will go further than the current practice of joint strategic needs assessment and strategic planning. It will require both an efficient process of aggregating information but also a highly interactive process to enable all stakeholders to make best use of it.

- **build on innovative work** – to ensure that providers are aware of new innovations and are enabled to build on them.

  Much of the innovative work on personalisation has been undertaken by providers. It is important that strategic commissioners both recognise this innovative potential and enable other providers to learn from and build on these new developments.

- **living with uncertainty** – everyone is working out what personalisation will mean. No one has the right answers. Hence having access to everybody's thinking is essential.

  Given the uncertainty that necessarily accompanies a major transition it will be impossible to achieve a consensus on many of the aspects of personalisation. Being able to live with this uncertainty and enable information to be shared sensibly will be a key skill required of strategic commissioners.

- **working across local authority boundaries** – both to share the cost of market development and management infrastructure and work more efficiently with regional and national providers.

  The infrastructures required to, for example, quality assure providers, enable budget holders to have up to date information on what services are available and develop personalised financial accounting, are common across local authorities. Many providers supply services to people spread across a number of neighbouring local authorities or wider areas. Having to deal with different systems requirements in each local authority is a barrier to entry to new localities. Hence it makes sense for local authorities to collaborate both to share the costs of infrastructure development and ensure easy access to markets by providers. Developing this collaboration and realising its benefits will be a major requirement of the new strategic commissioning role.

how commissioner – provider collaboration can help

The main areas in which collaboration could enable strategic commissioners to most effectively make the transition to personalisation are:

- regional development processes – that enable strategic commissioners to identify their own development needs and have them met.
- joint provider – commissioner development – that enables commissioners and providers to work together on live issues and jointly problem solve.
- developing cross local authority infrastructure – to enable easy access for providers to local markets thus increasing the availability of personalised services.

6. conclusion

The role shifts identified in this report begin to put flesh on the bones of what many commentators refer to as the ‘culture shift’ required to implement personalisation. However the role shifts identified should only be treated as indicative. For example, whilst they provide a useful sample they do not cover all of the roles in provider organisations or in commissioning. The role shifts were also identified within the context of a borough moving from very traditional models of social care to a particular vision of personalised practice. Other commissioners and providers will be more advanced in their current practice and be working to different visions of personalisation. The time available within the workshops to explore the role shifts was also limited and hence the findings cannot be considered comprehensive. However the analysis presented in this report does provide

a basis for further discussion and exploration as do the opportunities for commissioner provider collaboration and collaboration between neighbouring local authorities.

The reports findings could be used in a number of ways, for example:

- **individual local authorities and providers** – could:
    - scenarios - edit the personalised scenarios to fit their own vision of personalisation and re run the workshop locally to both raise awareness and as a means of building a joint agenda for change
    - role shifts – use the role shifts identified in the report to stimulate further discussion and develop a finer grained understanding of impact of personalisation on the workforce and how the changes can be enabled.

- regionally – strategic commissioners and provider staff, facilitated by the North West Joint Improvement Partnership and Skills for Care:
    - common infrastructure – could be enabled to explore whether and how to make best use of the opportunities for cross local authority development of common market development and management infrastructure
    - shared training and development – both the design and procurement of training programmes to be run locally in local authorities and cross local authority development opportunities.

useful materials

- 'only a footstep away'?: neighbourhoods, social capital & their place in the 'big society'. Download from http://www.skillsforcare.org.uk/workforce_strategy - click on new types of worker and then choose the publications section.

- the principles of workforce redesign. Download from www.newtypesofworker.co.uk - click on 'useful documents'.

for more information on:

Skills for Care visit www.skillsforcare.org.uk.

North West Joint Improvement Partnership visit www.northwestjip.co.uk.

appendix 1: workshop programme

Putting People First: - broadening choice and improvement in quality of care and support service supply through commissioners and providers.

objectives:

- understand the policy drivers that are powering the service reshaping agenda and the requirements for a new relationship between commissioners and providers
- hear examples of how commissioners and providers are reshaping care at home and residential services to broaden choice and give individuals control over their support they receive
- analyse the ways in which the roles of key groups of staff must change to both commission and deliver the reshaped services
- identify ways in which commissioners and providers can work together to enable the change.

event programme

9.30 -10.00am - registration

10.00 - 10.15am - introduction and overview - Alix Crawford, Skills for Care

10.15 - 10.35am - reshaping services for the future: "policy imperatives and the new commissioning relationship" - David Whyte, Commissioning Work Stream Lead, North West Joint Improvement Partnership

10.35 - 10.55am - reshaping services: a view from the sector - Maria Patterson, External Relations Manager, English Community Care Association

10.55 - 11.15am - personalising residential services for people with dementia: practical challenges from experience - Martin Clark, Managing Director, Care Concepts

11.15 - 1.00pm - group work scenario part 1: the impact of reshaping on provider staff - plenary briefing followed by group work.
Each table to focus on four groups of staff. For each group, identify a major change in their role that will be needed to make the new service work effectively and one way in which commissioners and providers can work together to enable the change.
Tea and coffee will be available during this group work session.

1.00 - 1.45pm - lunch

1.45 - 2.15pm - feedback from the morning group work session

2.15 - 3.30pm - group work scenario part 2: reshaping services; the changed role of commissioners - plenary briefing followed by group work.
Each table to focus on four groups of commissioning staff. For each, identify a major change in their role that will be needed to make the new service work effectively and one way in which commissioners and providers can work together to enable the new approach to commissioning.
Tea and coffee will be available during this group work session.

3.30 - 4.00pm - feedback from the afternoon group work session

4.00pm - next steps

4.10pm - event close. Collect your CPD certificate if you requested one and hand your badge and evaluation form in.

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