

You getting personal?

In the current climate of political austerity, the personalisation agenda needs to be handled with care.

By Sara McGrail.

You'd have to have been living as a hermit on South Uist or paddling up the Amazon in a coracle to have missed the fact that personalisation has been big news for some time now, promising to radically shift the relationship between the service user and the services used.

For some in the drugs field, personalisation has become about developing individual budgets – a way of cutting up the pie that ensures resources are allocated according to need and directly managed by the individual or their representative. For others, personalisation has come to mean developing more effective mechanisms for care management, placing a client-directed care plan at the centre of the treatment experience.

For many the most critical aspect of personalisation is about moving away from one-size-fits-all and the restricted menu of options that have in many areas become the backbone of our modern treatment systems. In this, the personalisation agenda has become aligned with the recovery agenda in a way that enhances both.

Critical to the working of both a more recovery-oriented and a personalised treatment system is the creation of opportunities for service users to access a much wider range of specialist and mainstream interventions. Both also require a significant shift in our culture away from 'we know best' (whether that 'we' is the NTA, the local commissioner, a clinician or a drugs worker) to instead

place the service user in the driving seat of their own treatment experience

You have to go a long way to find people critical of the personalisation agenda. In some quarters, to question personalisation and the application of individual budgets or direct payments is akin to a form of blasphemy. Across the country, the personalisation approach has been credited with delivering some real improvements in people's quality of life. However, difficult issues are beginning to emerge, chiefly around the inherent tensions of an approach that marries the social rights perspective of the disability movement to the modernisation and market consumer perspectives of successive governments. For some, personalisation is simply piecemeal privatisation by the back door.

So should we accept this approach as the best and most appropriate way to organize service delivery in this new time of austerity in public funding?

In his commentary on personalisation across the social care sector, Iain Fergusson, Senior Lecturer in Social Work at Stirling University, has suggested the way ahead may not be plain sailing. "We have often been seduced by very progressive language," says Fergusson, "and I think we have to be a little bit careful about the different agendas which are involved in personalization."

Through the work of people like Charles Leadbetter at Demos, personalisation has become closely associated with new ways of arranging

and managing local government. Its successful implementation not only requires a shift in the culture of service delivery, but also a belief in the ability of the market to provide choice, and assure quality. People will choose the best and most appropriate services, it is argued, and as investment shifts, poor quality services will close. Choice requires a plural market – one that offers a genuine range of providers and interventions. However, as the cuts in the public sector bite, it's likely that some, particularly smaller, voluntary sector providers, will become financially unviable, way before the market, and consumer choice, is able to arbitrate on their service offerings.

As the Equality and Human Rights Commission (EHRC), in their 2009 report "From Safety Net to Springboard" observed: "The business models of many service providers are based on the certainty provided by block-purchasing by local authorities, often through long-term contracts. Without such certainty, some providers may not survive, leaving individuals with few if any options to choose from."

Reducing budgets may not simply restrict choice, but could also make it more likely that decisions about service provision will be based on cost – rather than value for money.

For people with complex – and expensive – needs, the difficulties of managing care from a limited and economically strangled field of provision may prove very challenging indeed.

Some commentators have suggested that during the current period of economic austerity, far from enabling people to enhance their experience of treatment, personalisation and individual budgets may simply provide a way for commissioners to require people to cut their own services.

PERSONALISATION DURING AN ERA OF REDUCTIONS IN PUBLIC SPENDING MAY BECOME A DANGEROUS BEAST

There are further challenges. The tendency in some areas has been for the brokerage role – that of enabling people to spend their budgets – to become the main work of professionals. This leaves them as little more than resource managers, rather than care managers. For the most stable, articulate and creative service users this may be of little concern. However for those who struggle to manage their own recovery, or who are simply bewildered by a range of providers and services, this could cause real problems. Without significant investment in advocacy, any shift to personal budgets would simply widen health inequalities.

The coalition government commitment to personalisation is clear. Not only through its decision not to cut back on development money for local authorities for this area of work, but also through its promotion of solution to some of our most intractable and expensive social problems, the ‘Big Society’.

Mike Freer – whose leadership of Barnet Council led to it being dubbed the EasyCouncil – following his widely publicised comparison of public service provision to running a budget airline – has proposed that personalisation is fundamental to the idea of a no frills council, with its cut down, top-up-yourself services. He said: “We need to develop more personalised services, potentially with a greater intensity for those who need it – but with an end date.”

For personalisation to deliver on its promises to those who use drugs services, we in the drugs field need to be careful to ensure that some key



safeguards are not forgotten. We must ensure that service users are not forced into systems of care they do not want or understand and that those who do not wish to – or who cannot manage their own budgets – do not suffer because of this. We must support our smaller voluntary sector providers, and lobby for additional support for them.

Commissioners must renew their commitment to funding effective advocacy services and government must be reminded of the necessity of a strong user informed voice in decision making. We should learn the lessons from our own pilots – and those in other sectors – and not simply be seduced by the progressive language.

Quality must not simply be left to the market. It remains the commissioners job to decommission bad services and support good ones. The inspectorates

must be given the resources to do their jobs properly. Perhaps most importantly of all, we need to ensure that the different agendas of government, service users, commissioners and services all align around a model of working which focuses meaningfully on individually defined outcomes.

Personalisation during an era of reductions in public spending may become a dangerous beast. Without losing our commitment to improving user control of service provision, we should be cautious about establishing mechanisms for funding and commissioning which could reduce quality and choice and leave users less in control of their own care, and simply more in control of their own rationing.

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