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## **Individual Budgets and the Future of Adult Social Care**

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## Introduction

This paper discusses some of the wider issues arising from the piloting and evaluation of Individual Budgets (IBs) in England. It locates the IB pilots within the histories of policy measures aimed at extending and refining the operation of market mechanisms within welfare services and, at the same time, responding to on-going concerns about the flexibility and responsiveness of publicly-funded services to individual desires, aspirations and lifestyles. The paper argues that IBs, and their successor personal budgets, raise important questions about the balance of costs and benefits that arise as a consequence of employing choice as the main organising mechanism for social care reform. In particular, it points to the potential for a major shift from the state to the individual service user – and to a lesser extent to front line social care staff – in responsibilities for managing risk. These changes have implications for the concept and exercise of governance, as individual service users are drawn into making decisions about the allocation and deployment of public resources that have hitherto been the responsibility of welfare state processes and professionals.

However, at the same time these shifts are rendered more complex, and their outcomes more uncertain, by the increasingly diffuse boundaries of 'social care' services and support. As conventional definitions of 'social care' are breached by the more imaginative and unusual ways of deploying public resources that are possible through IBs and Personal Budgets (PBs), the boundaries of collective responsibilities are further erased so that uncertainties and risks – both positive and negative - for users are correspondingly increased. Such transfers of responsibility for risk will also affect front-line care workers who will potentially find themselves playing greater roles in monitoring services to individuals if, as is possible, care management staff are involved much less after support plans have been agreed and 'signed off' by local authority staff. Consequently, providers of services will need to increase the levels of skill among their staff in assessing and managing risk.

The paper begins by summarising the history of policies to increase choice in adult social care in England through a series of market-related mechanisms and assesses their success. It then briefly describes the national evaluation of IBs, with particular attention to those strands of the evaluation from which the empirical data for this paper are drawn. The paper then presents data from the evaluation on two key issues. First, it reports the perspectives of front-line staff and service users on the potential for IBs to lead to increased negative risks for service users – risks of personal abuse, of financial abuse and risks arising from a failure to manage a finite amount of resource to maximum benefit. The paper then reports staff and service users' perceptions of the increasingly fluid and uncertain boundaries of adult 'social care', as they were encouraged to use IBs to purchase ordinary commodities instead of special services. These perceptions challenge conventional values and assumptions about the behaviours and lifestyles that are appropriate for people using

publicly-funded social care. At the same time, they also emphasise individual consumption at the expense of collective experience. Together, these developments raise important questions about the future of adult social care and the increasingly intrinsic location of service users at the heart of its governance.

## **Markets and the modernisation of adult social care**

Public sector provision of social care services dominated the market for most of the post war period (Burton and Kagan, 2006). This picture started to change in the late 1970s, with the rise of 'New Right' politics, which resulted in an increasing faith in the power of markets to develop good quality services and led to much provision – particularly in the residential sector – being outsourced to private sector providers. Such ideas gained a great deal of influence during the 1980s, culminating in the Griffiths report and the White Paper of 1989, which offered 'a striking Thatcherite synthesis of the principles of the free market and the attitudes of a strong state' (Langan, 1990: 59). Such principles were subsequently enshrined in the NHS and Community Care Act (1990) that was eventually implemented in 1993 and required local authorities to foster the development of a 'mixed economy' of local care markets (Lewis *et al.*, 1995). Furthermore, the Act stipulated that 85 per cent of the money transferred to cover local authorities' then new responsibility for funding residential care (previously funded from social security budgets) had to be spent in the independent (private and voluntary) sector (Tanner and Harris, 2008). Indeed these developments led to 'a radical transformation of the manner in which public social care services are funded and delivered' (Baldock, 1997: 70), with a focus on care management and consumer choice as a means of improving services through the 'invisible hand' of the market. As implemented, these reforms led to direct purchasing decisions being made by front-line staff – primarily local authority care managers – on behalf of older and disabled people (Glendinning, 2008).

Direct Payments, introduced by the Community Care (Direct Payments) Act 1996 in the UK, allowed people eligible for social care support to receive cash payments with which to purchase services and support themselves. Initially only available to people of working age, the option was extended to people aged over 65 and to parents of disabled children in 2000 through amendments to the 1996 Act. The 2001 Health and Social Care Act further required local authorities to offer Direct Payments to all people eligible for services (Ellis, 2007). However, take up remained low (Ellis, 2007) and there were continuing concerns about the appropriateness of Direct Payments for many social care service users, including people with learning disabilities and older people. The need for information, advice and support in using direct payments was highlighted as essential in enabling people to take up the option (Newman *et al.* 2008).

In the early 2000s, there was renewed emphasis on increasing choice and control for people using social care services from the disability movement and in several government-sponsored and supported developments such as In Control, which in 2003 introduced a programme of self-directed support for people with learning disabilities (see [www.in-control.org.uk](http://www.in-control.org.uk)). Individual Budgets (IBs), first mentioned in *Improving the Life Chances of Disabled People* (Prime Minister's Strategy Unit, 2005), built on both Direct Payments and In Control and aimed to offer increased choice and control to people who did not want to take full responsibility for managing their own care as required by Direct Payments. A commitment to pilot IBs was made in the Green Paper of that year (Department of Health, 2005).

The principles underpinning IBs required that service users were aware of the resources available to them before planning their support; that outcomes be conceived broadly and related to wellbeing; and that a wide range of means to reach desired outcomes were acceptable, not just traditional social care services or the employment of personal assistants as Direct Payments tended to be used for. A number of deployment options were available, so that individuals unwilling or unable to take their IB in the form of a cash Direct Payment could increase their control over money being spent on their behalf. In 2008, the government announced its intention to extend this approach with the universal roll-out of Personal Budgets<sup>1</sup> (PBs) as the basis of a 'transformation' of social care between 2008 and 2011 (HMG, 2008). At the heart of this transformation is a major transfer of responsibility for purchasing social care services from professionals – care managers acting as proxy purchasers on behalf of service users – to service users themselves. Even if service users choose not to take their Personal Budget in the form of a cash Direct Payment and ask the local authority care manager or another third party to manage it for them, nevertheless the facts of knowing the resources available and having the opportunity to decide how best to use those resources are expected to confer greater choice and control.

Earlier research into the 'modernisation' of adult social care (Newman *et al.*, 2008) identified two potential strategies for creating organisational change. A transactional approach creates compliance through regulation and performance targets related to payments and tends to be top-down in nature. A 'transformational' approach, in contrast, creates commitment, through training, fostering of relationships and the communication of values. Newman *et al.* (2008) argue that earlier social care modernisation placed too much emphasis on transactional rather than transformational approaches. This led to constraints on policy aspirations for self-governance on the part of service users, because of the continuing dominant emphasis on managerial forms of governance.

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<sup>1</sup> A further feature of IBs was that they were required to pilot the integration of multiple funding streams, including Supporting People, Disabled Facilities Grant, Independent Living Fund and Integrated Community Equipment Services, alongside adult social care. This dimension of the pilots was largely unsuccessful. Personal budgets, in contrast, involve only adult social care resources.

Arguably the new IB and personal budget developments represent a distinct attempt to reduce the influence of top-down managerial governance and create a further shift towards service user self-governance. As Newman *et al.* (2008: 548) point out:

... government, having attempted with only limited success to reform public services, is now turning away from 'top-down' levers that focus on changing structures and systems towards a reliance on service users themselves – as consumers in a new public service marketplace – to lever change through the ways in which they exercise choice.

It may be argued that underpinning these developments is a shift towards what has been termed governmentality – a linking of macro and micro-level structures of power through the widespread diffusion of mechanisms of power throughout society including, in this case, individual social care service users. Through their internalisation of desired attitudinal and behavioural norms, individuals come to reflect dominant political and policy discourses. In the course of this shift, individual welfare subjects may also take on new risks that were previously collectively managed through more top-down regulatory mechanisms by welfare agencies and professionals. However, as this paper will argue, many of those involved in the implementation of the IB pilots – not least social care service users and IB holders themselves – were concerned that the resulting balance between self-governance, regulation and risk may have shifted too far.

### **Transferring responsibility for risk**

Despite claims that personal budgets are compatible with safety (DH, 2008; SCIE, 2008), others have argued that their implementation has not been well-integrated with other important policy developments (Manthorpe *et al.*, submitted), particularly the increasing emphasis on safeguarding vulnerable adult social care users (Petch, 2008). Fears have been expressed about the greater risks of financial and physical harm arising from the use of unregulated, informal services; about the increased responsibilities of service users and family members for monitoring such risks; and, indeed, about the increased responsibilities of service users and their families for arranging and monitoring the behaviour of staff from mainstream service providers whose support is purchased from IBs. Such concerns have been expressed in relation to both direct payments and individual/personal budgets and the resulting conflict for social workers' roles, as Ellis (2007: 407) notes:

...social workers face a conflict between their ethical duty to empower on the one hand and their professional and legal obligation to prevent harm on the other.

Indeed, direct links have been made between choice and levels of risk for example in relation to risk management when promoting autonomy in care homes (Boyle, 2008); and in the restricted choice of services available to people with dementia as a result of the reluctance of generic services to provide help to them because of perceived risks to staff and other service users (Beattie *et al.*, 2005).

Safeguarding policy has had a relatively short history. Although adult abuse as a concept emerged in the 1970s and accounts of what was initially termed 'Granny bashing' became known in the 1980s (Galpin and Parker, 2007), the first statutory-based Guidance, *No Secrets*, was not published until 2000 (DH). *No Secrets* marked a shift from separate approaches to managing the potential abuse of people with different kinds of needs to a generic notion of adult protection (Cambridge and Parkes, 2004). This subsequently developed into 'safeguarding', which has an even wider scope as it aims to focus attention on the circumstances and settings that generate risk of harm rather than on the characteristics of the individuals involved (Fitzgerald, 2008). However, while the terminology reflects a focus on contexts rather than individual vulnerability, the Safeguarding Vulnerable Groups Act (2006) defines all users of social care services (and others) as 'vulnerable'. This suggests a potential major area of tension with policies of personalisation, which aim to give more responsibility, freedom and control to people using services.

The increasing policy attention to adult protection and safeguarding has led to greater regulation of the formally employed social care workforce and to multi-agency approaches to managing risk, along similar lines to developments in child protection in the 1980s and 1990s. However people managing their social care services through Direct Payments have not been required to request Criminal Records Bureau checks for people they employ or to check whether they are on the Protection of Vulnerable Adults (POVA) list, which would bar them from working in regulated services (Stevens *et al.*, 2008). Such concerns have been raised in other debates about personalisation (James, 2008; Morse, 2008). Indeed it was only after the implementation of the Safeguarding Vulnerable Groups Act (2006) that anyone employing people to work in their own homes was able to check and refer to the POVA list. This suggests a lag in thinking about developing appropriate regulatory structures to accompany major developments in adult social care policy and practice.

## **The national evaluation of the Individual Budget pilot projects (IBSEN)**

In 2005, the Department of Health (DH) initiated a large scale pilot of IBs in 13 local authorities across England and commissioned a major evaluation of the pilot projects. A multi-method approach was adopted (Glendinning *et al.*, 2008). At the

core of the evaluation was a large-scale randomised trial, in which almost 1,000 people were either offered an IB or continued to receive conventional services. Outcomes for both groups were assessed after six months. In order to obtain more detailed insights into these outcomes and to explore issues of implementation, semi-structured interviews were undertaken with a wide range of stakeholders, including a subsample of IB users, as shown in Table 1 below:

**Table 1      Semi-structured interviews undertaken as part of the IBSEN evaluation**

<i>Group interviewed</i>	<i>Numbers of interviews</i>		<i>Total</i>
	<i>Round one</i>	<i>Round two</i>	
People using services and carers	-	-	130
Care management staff	-	-	48
First line managers	-	-	43
Adult protection or safeguarding staff	13	14	27
Training personnel	17	9	26
Senior managers implementing IB pilots	13	20*	26
Local Authority commissioning managers	-	-	7
Independent sector providers	-	-	16
<b>Total</b>			<b>323</b>

\*Extra interviews were undertaken with these managers as part of a more in-depth exploration undertaken in seven sites.

All semi-structured interviews were audio recorded, with permission, transcribed in full, and entered into the N-Vivo or MaxQDA qualitative analysis software packages. A coding frame was developed by reading a number of interviews and in the light of theoretical concerns identified by the literature. This was further developed following a process of template coding (DiCicco-Bloom and Crabtree, 2006) and subsequently reordered as ideas about the importance of specific themes emerged. During coding, the researchers were in regular contact and also developed descriptions of the major categories and subcategories, along with a series of analytical memos and 'random thoughts', which contributed greatly to developing understanding of the data.

The research received ethics approval from a NHS Research Ethics Committee and from Kent University Research Ethics Committee. In addition, it was supported by the Association of Directors of Adult Social Services Research Advisory System and by Research Governance approval from all 13 pilot sites. Although the research was undertaken before the Mental Capacity Act came into operation, we sought advice from professionals and carers about the ability of people using services to consent to and take part in the research. Where it was thought this was not possible we

interviewed relatives or carers as proxies for the service users. This was necessary for 24 percent of the structured six month outcome interviews with service users.

## Findings

Two strands of findings from the IBSEN study are reported in detail here: the experiences of staff and IB users in relation to risk and risk management; and the widespread concerns about the increasingly unclear boundaries of social care. Both issues emerged as key themes in interviews. These two areas are valuable in highlighting the changing focus of public policy and the experiences of people using publicly-funded social care services.

### Risk and risk management

While no primary evidence of increased risks for people using services emerged from the IBSEN study, there were a number of areas where care management staff and IB users alike perceived the potential for increases in risk:

- personal and financial abuse
- poor quality care services
- a poor match between allocated resources and actual need.

Although not necessarily based on actual evidence, such perceptions nevertheless have the potential to impact on professional practice and also on the decisions made by people using services and their carers. For example, one social care team manager noted that such concerns were heard 'in general conversation', indicating their speculative – but nevertheless potentially influential nature:

Whereas, you know, if, and I suppose it's not just me, I've heard it in general conversation that is people going to be more at risk perhaps if they've got family or friends doing their care. You know, could they be more inclined not to get the hours that they should be getting in, in personal care?

(Team manager, older people's team)

Many of these concerns arose directly from relaxation of opportunities for social care staff to exercise regulation and control, which were seen as potentially protective factors.

Risk was not always perceived negatively, however. An important theme emerging from the interviews with care management staff and to some extent also with IB users, was the need to transfer more responsibility for taking risks to the individual. 'Positive risk-taking' was considered to be part of the philosophy of IBs, in contrast to

previous practice which was characterised by a tendency for service users to be 'wrapped up in cotton wool'. But this was also seen as a difficult culture shift for care managers to make and also created tensions in relation to their responsibilities for safeguarding vulnerable adults:

We're having to undo many years of people's rigid thinking in terms of service users about, 'I know what's best for you'. And I think that has existed in Psychiatry for a long time. And I've heard Psychiatrists say, 'But I know what's best for you. I know what you need'. But they don't. It's an arrogant statement. We actually need to point out to service users, 'Maybe the reason we don't want you to do that is because you could get hurt, and we can see it'. But again, it's about risk learning. You know, it's positive risk taking. And we're not good at that. And so that's fear for us.

(Care Coordinator, Mental Health)

### ***Personal and financial abuse***

IBs were widely expected to lead to an increase in the use of cash Direct Payments as the main method of deploying social care resources; indeed, some two thirds of IB users in the evaluation study took their IB in the form of a Direct Payment. A cash payment allowed the IB holder to employ one or more personal assistants, or to pay members of her/his informal networks to provide personal care and social support. However, once the support plan setting out the intended care arrangements had been approved by the local authority, and reviewed after six weeks, there was in some cases no on-going surveillance or monitoring and therefore no opportunity to check on the quality of the care that was being provided through these arrangements:

If they are being potentially, emotionally abused by the person they may well accept it because they wouldn't know it was happening. Whereas [in the past] we'd identify it through systems.

(Care coordinator, physical disability team)

Moreover, social care staff pointed out that it could be difficult to deal with suspected abuse where this was thought to be perpetrated by a close relative, or in the context of an otherwise close relationship between the IB user and a paid carer or supporter.

### ***Quality of care services***

Where services were arranged by individuals or carers, some professionals were concerned about a lack of control, leading to poor quality care:

Because a service is going in, and if you're not having a reporting system

back, the service could be almost broken down by the time we're involved, and that's sometimes quite difficult to, or it takes longer to pick somebody up out of that situation.

(Adult social care team manager)

### ***Agreeing plans***

'Signing off', or approving, an IB user's support plan is the point at which public policy and legislation are operationalised. Particularly when the plan has been developed largely by the service user, relatives, carers and/or independent advocates, 'signing off' is a pivotal moment in which the state 'legitimises' the users' (and others') desired approach to meeting their social care support needs.

A great deal of variation was evident across the 13 pilot sites about who was responsible for 'signing off' support plans. In some sites, care management team managers were able to approve plans; in other sites a standard approach was implemented across the authority involving the submission of all support plans to a panel of senior managers. This could lead to conflicts and delays:

We had such a palaver about how to word it. On the plan we put down 'befriender' and when we tried to get it signed off higher up it got rejected because of that. So we all got back together and changed the word to 'companion'. All that added an extra 4-5 days of our time.

(Mental health service user)

### ***Resource Allocation***

Allocating an amount of money as an IB which is sufficient and appropriate for meeting users' needs, ensuring quality support and good outcomes and minimising risk were fundamental to the success of IBs. The 13 pilot sites were strongly encouraged to develop Resource Allocation Systems (RAS). These translate standardised approaches to the assessment of needs, through the application of an algorithm, into a sum of money. Despite the fundamental importance of the RAS approach to the success of IBs, the quality of the support that IB users were able to procure and their eventual outcomes, there was little debate during the IB pilot projects about the principles that should underpin the RAS; the levels of need that allocated IBs were intended to cover; or the extent to which the RAS should achieve equity between individuals or groups of service users. In the context of a chronically under-funded adult social care system, the absence of any public debate about levels of IB and their adequacy was a major shortcoming.

Moreover, within the IB pilot sites, there was considerable controversy among front line and managerial social care staff about the appropriate balance between

standardised, average approaches to determining resource allocation and those based on more individual considerations of each persons circumstances and needs. The RAS approach was welcomed as clear and simple to use by some care managers and team managers, but others questioned the lack of flexibility. In any case, standardised RAS formulae were often not used on their own without further interpretation:

It's only used as a guide; it is only a tool at the end of the day. So, we usually have a chat with the team manager or chat with each other and see perhaps we haven't put something in the right way or maybe we could have done this better. So, I'm not saying we don't tweak it because we do. We do tweak it. Sometimes they are just not tweakable, so you'd be lying, so I can't do that.  
(Care Coordinator, Older People)

It is likely that responsibility for assessing need and allocating resources will remain with public servants of one kind or another. Again this represents a point of contact between individual service users and the operation of policy and legislation. However, the variability of approaches, coupled with the lack of public debate over the RAS and the principles underpinning the allocation of resources may well lead to a perception that any shortfalls in service users' ability to manage their budgets reflect the poor management skills and/or irresponsibility of the user.

## **Managing risk**

### ***Regulation***

The lack of a requirement for service users to obtain CRB and/or POVA checks for workers they employ through an IB to provide care were explicitly referred to by many care management staff, people using services and their carers alike. All groups of interviewees expressed concerns about the potentially increased risks posed by personalisation and particularly by a rapid expansion in the use of Direct Payments:

Another disadvantage ... was that if people are allowed to select their own carers, and employ, advertise in the local shop and employ people, those people they employ have not necessarily had a CRB check or the training that we would find mandatory, and so it can place vulnerable people at greater risk.

Care coordinator, older people's team

While no primary evidence of increased negative risks for people using services emerged during the course of the IBSEN evaluation, there were a number of areas in which care management staff and IB users perceived a potential for increased harm.

### ***Monitoring support plans***

A social care manager with lead responsibility for adult protection described how the local implementation of both In Control and IBs relied on people supporting service users – informal carers, support staff and other more informal networks – rather than formal monitoring systems to identify problems such as a deterioration in the service user's condition or an increase in needs:

There's no audit for In Control as far as I'm aware – we will be reliant on someone supporting the person to identify abuse. We know our families and their support networks – you know other people are monitoring the situation well.

(Adult Protection lead, first round of interviews)

However, the risks of these informal monitoring arrangements breaking down were expected to increase where IBs were used to pay for help from friends, relatives and neighbours. Such care providers were thought unlikely to take responsibility for alerting the local authority to any changes in the service user's needs:

If somebody is receiving an individual budget and then paying Fred up the road to actually provide them with the care that they need as is their want, will Fred come back to us and say, this person is not managing any more and needs more care or we don't know.

(Care coordinator, older people's team)

### ***Integrating safeguarding and personalisation policies***

Towards the end of the IB pilot period, the 13 local authority pilot sites were beginning to develop safeguarding policies consistent with the radical new developments in the provision of adult social care. Comparisons of interviews carried out near the beginning and towards the end of the IB evaluation with social care managers with lead responsibility for adult protection/safeguarding in the 13 local authorities indicated that, in some of the pilot sites at least, their roles had broadened and become more strategic. By the time of the second interviews, most of the adult protection/safeguarding lead officers reported increased involvement in implementing their authority's personalisation and social care transformation work (Manthorpe et al., in press). This involvement included developing approaches to risk assessment; meetings about safeguarding issues; discussions about who should pay for CRB and POVA list checks and whether IB users should be encouraged to carry these out; questions of capacity to make decisions in the light of the requirements flowing from the Mental Capacity Act; and generally raising awareness of risk and protection issues:

... we also looked at the issue of mental capacity and consent and whether people needed Best Interest meetings about Best Interest decisions prior to the IB being progressed. And, also, the importance of providing information to service users about their entitlement to CRB checks and the POVA List – making sure they were really clear.  
(Adult Safeguarding Co-ordinator)

## **The boundaries of adult social care**

Local authorities piloting IBs were encouraged by the Department of Health and the Care Services Improvement Partnership team supporting implementation to use IBs flexibly and encourage IB users to purchase services and goods outside those normally considered to constitute 'social care'. Rather, users were to be encouraged to identify both their desired outcomes and the optimum way of achieving those outcomes, albeit within the financial constraints of a given level of IB. Pilot sites varied in their interpretation of this flexibility. Some sites actively promoted creativity in planning support, encouraging IB users and those helping them to consider buying a range of commercial and mainstream services. Here the emphasis was on encouraging a move away from using designated social care services as a means of encouraging social inclusion – 'anything so long as it's legal and safe'. In other pilot sites, however, there was much greater caution among both senior and front-line social care staff and limits were placed on what could be included in support plans.

This variability reflected considerable confusion and uncertainty about the boundaries of what resources allocated to individuals for the purposes of social care support could be used for. One dimension of this uncertainty concerned whether money allocated on the basis of (self-) assessed needs for personal care or social support could be used to purchase other kinds of help, such as gardening, cleaning or activities outside the home. Thus a team manager described a situation in which someone with an assessed 'need' for help with personal care chose to struggle unassisted with that part of his life in order to be able to afford help with other activities. This was considered a legitimate and realistic way of spending an IB:

He is a very proud man and doesn't want personal care. What he wants is other things, so that, when he is up and dressed and tired out, somebody will be there to do other things for him like, [keep] a house tidy. That is a legitimate way to spend their budget.

(Team Manager, Physical Disability Team)

A further dilemma was identified by several care managers and team managers over whether, and what kinds of, material goods such as computers and car 'sat nav' systems could be legitimately purchased from an IB. Such goods could legitimately assist a social care service user in achieving desired goals such as maintaining

contact with family and friends through email or skype; or enhancing independence and mobility outside the home.

But for me about being confident driving around wasn't, that wasn't even essential because (inaudible) the care. So you wouldn't spend it on a sat nav. But in another case it might be that the sat nav did meet that need.  
(Team Manager, physical disabilities' team)

Having realistic and relevant goals and being able to show that the support plan could help meet them were seen as important by many care managers. However, several care managers gave examples of service users who wanted their family carers to provide essential personal care on an unpaid basis, in order to free up resources for social and leisure support.

Whether family members could be paid to provide care to an IB user was another boundary issue. Where an IB was awarded as a cash Direct Payment, regulations stated that co-resident close relatives could not normally be paid to provide care. However, care managers and team managers expressed concerns about IB users paying relatives living elsewhere, not least because normal eligibility criteria for adult social care would take into account any help given by informal carers:

Do I actually do the assessment and say, well, this person is entitled to an individual budget, because they want to actually to pay the family member or do I actually put FACS into place and say, if the family member is providing the service then they are not eligible?  
(Care Manager, Older People)

## **Discussion and conclusions**

The piloting of IBs and the roll-out of personal budgets across the whole of English adult social care have been driven by some powerful aspirations:

Personal budgets and self-directed services mobilize the intelligence of thousands of people to get better outcomes for themselves and more value for public money  
(Leadbeater *et al.*, 2008)

It is important to remember that this aspiration is not just an emphatic expression of the politics of public service modernisation. It also reflects the demands that have been expressed by younger disabled people in particular over the past three decades for greater choice and control over their support arrangements. Indeed, these demands were behind the introduction of cash Direct Payments as an alternative to 'in kind' social care services in the late 1990s; moreover, they were backed up with

arguments that greater choice and control would, by delivering better outcomes at lower cost, also be cost-effective.

However, as the evidence from the evaluation of the IB pilots has shown, achieving this aspiration is not unproblematic. One problem arises from the fact that:

... the typical user of social work services will often not match Ulrich Beck's description of the 'choosing, deciding, shaping human being who aspires to be the author of their life' ... most social work clients have more modest ambitions ... especially for those designated as 'involuntary clients'.  
(Ferguson, 2007: 396)

As with direct payments (Ellis, 2007), front-line social work staff and other specialist advice and brokerage services will remain key in supporting social care users to make and implement choice and control.

Thus making decisions about spending a given level of resource to purchase care and support involves understanding both what range of needs are legitimate and what range of mechanisms for meeting those needs are also legitimate. The flexibilities and freedoms associated with personal budgets raise important questions about the legitimate boundaries of state welfare. What restrictions should there be on the use of IBs and personal budgets? Debates over the boundaries of social care also relate to more general concerns about equity – both general inequalities in assets and incomes, and inequalities in lifestyles that may popularly be assumed to be congruent with needing support from publicly-funded social care. In the context of England's underfunded, residual and means-tested system of social care, how far should public resources be used to purchase goods and services that at least some non-social care service users might regard as luxuries (or at least non-essential)? Moreover, many non-social care service users at equivalent low income levels are unlikely to be able to afford such items. Thus because personal budgets can be used to acquire mainstream consumer goods and services, they have the potential to remove (or at least reduce) any stigma attached to the role of welfare recipient through the use of 'special' services – but they also have the potential to create new inequalities.

None of these wider issues were debated during the IB pilot projects. Instead, front line care managers and team leaders, and IB users themselves, struggled with setting boundaries and identifying what were, and were not, legitimate uses of IBs. Addressing some of these tensions requires both wide public debate and the kinds of transformational interventions suggested by Newman *et al.* (2008). For example, clear guidance for front-line staff and personal budget users respectively is essential for care managers to manage any potential tensions and for personal budget users to feel confident that their support plans and use of social care resources are legitimate.

In practice, the freedoms offered by IBs and personal budgets are likely to be relatively limited and constrained by the level of the budget awarded to each individual. In the IB pilot projects, opportunities to use IBs in unusual, creative ways were seriously constrained simply by the relatively low level of resources available. Thus across the pilots as a whole, the majority of IBs were spent on essential, mainstream social care support, particularly personal care and other help around the home. This was particularly the case for older IB users, whose levels of IBs were much lower than those of younger disabled people.

These financial constraints introduce new risks for IB and personal budget holders – the challenges of managing a limited financial resource to meet essential personal and social support needs and achieve agreed outcomes. As noted above, the methodology used to calculate levels of individual IBs (and that will also be used in rolling out personal budgets) was not based upon any consensus about what levels of need or which outcomes public resources ought to cover or the extent to which social care users should expect all their relevant needs to be met through public funding. Without any explicit debate or criteria of this kind, risk once again falls back on the individual; it is the individual IB user who is assumed to be responsible for failing to manage resources appropriately or to achieve agreed outcomes. The question of whether the allocation of resources was, at macro and micro-levels, adequate in the first place remains unasked.

The IB pilots illustrated other ways in which responsibilities and risks are transferred to social care users. There was far less scope for care management practitioners to maintain an on-going overview of the quality of care received by IB holders, or to monitor changes in their condition and needs. Moreover, responsibility for maximising outcomes from a finite budget creates incentives to purchase less than optimum care, to cut back on types of support that professionals considered important, or to introduce new risks of abuse by paying unregulated friends and relatives. While some professional concerns might perhaps be dismissed as unnecessarily paternalistic, front-line staff nevertheless struggled to maintain a professional ‘duty of care’ and professional accountability. Recent shortcomings in child protection should alert us to the major political consequences of failures to fulfil these responsibilities. Developing new ways to manage such tensions and a new space for practitioners to play appropriate roles in the new social care world of personal budgets is vitally important.

In summary, IBs and personal budgets introduce major new tensions into the delivery of social care support and prompt important new areas of debate. The freedoms and flexibilities that they offer have, and will, undoubtedly transform the lives of many service users – as with Direct Payments, there is no shortage of ‘good news’ accounts of their benefits. But they also require that

... the service user takes on more of the functions, risks and responsibilities which would formerly have been the remit of the state. This process ... requires that the service user not only manages themselves but that they also become the manager of public funds ... and, with the inputs they have been allocated, they assume responsibility for achieving agreed outcomes. (Scourfield 2007: 116)

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