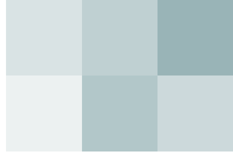
Choice and Control for All

The role of Individual Service Funds in delivering fully personalised care and support



Choice and Control for All: The role of Individual Service Funds in delivering fully personalised care and support

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Acknowledgements

Thank you to the following people and organisations for sharing their experiences and learning around Individual Service Funds:

Steve Scown from Dimensions, Owen Cooper and Ruth Gorman from IAS, Gill Bailey from H.S.A, and Suzie and Jennie Franklin.

About Groundswell

Groundswell works with health and social care organisations to transform support and improve people's lives. We are a partnership between Bennett & Stockton Ltd and Helen Sanderson Associates (H S A) comprising Sam Bennett, Helen Sanderson and Simon Stockton as Directors and a small team of associates. We are working to support sustainable change in organisations through personalisation and community-based support and are committed to sharing our learning and spreading innovation across the sector.

We have learned a lot about the potential of individual service funds through extensive work with providers and commissioners over the last few years, including by supporting several organisations to adopt wholesale changes using this model to personalise support. This is the first of a number of papers from Groundswell that sets out our learning so far about what works in making a reality of fully personalised support.

Introduction

"If you had said to me 10 years ago that Jennie would be living independently in her own home, I would never have believed it. I was worried that she might be in an institutional setting or in supported living with people she didn't like or, worse still, didn't choose to live with. But now all the worry has gone which has been amazing for me. Using Jennie's personal budget with an provider, through an Individual Service Fund made all the difference"

Suzie, Jennie's mum.

The continued drive to transform social care through personalisation and the ongoing focus of Government on personal budgets for everyone who is eligible by 2013 presents a huge challenge to the sector. Making a reality of transformation of this scale in a way that really changes lives at a time of continued pressure on public finances places great demands on councils and providers alike.

The demands are so great they provoke questions in some quarters about whether the changes expected are realistic, deliverable, or in some cases even desirable. It is our firm view that the answer to each of these questions is yes and in the last case profoundly so. Our work with providers over the past few years has shown that there are strategies and approaches that can play a big part in ensuring success which are not yet common practice. One such approach is the development of individual service funds (ISFs). It is our goal in this paper to share our learning to date about ISFs and the important role they can play in realising the ambition of fully personalised support for all.

The extent of the government's plans for personal budgets has served recently to reignite the debate about how and if it is possible to make them work for everyone. One response has been to question the government's concentration on personal budgets as somehow "blinkered" and to the exclusion of other approaches more suited to delivering personalised support to people with the most complex needs. According to this argument, the answer lies in adopting a broader view of personalisation that includes a greater focus on the quality of interaction between staff and people supported, more person-centred working practices and installing "democratic structures" that better involve people in decision making.

While Groundswell strongly advocates all of these things, we are also clear that they are not an alternative to personal budgets, but rather the necessary features of any environment where they are to work well for people. Personal budgets can and should be part of the picture for people with complex needs.

Part of the difficulty up to now has been the lack of emphasis in most places on developing options for people to manage their money in ways other than council managed budgets or direct payments. There has also been an unwillingness to properly involve providers in the way personal budgets have developed. The most recent figures from the Association of Directors of Adult Social Services (ADASS) show that 338,000 people had a personal budget in September 2011, with the largest proportion of these being council managed budgets.[1] For people with very complex needs, direct payments may be less viable, while council managed budgets have tended to be very restrictive, offering less impressive outcomes[2] and usually stopping short of the care home door.

We think that working with providers to develop ISFs is a big part of the answer to this problem and that there are incremental steps that can be taken in any service to pave the way for choice and control that works for everyone. This paper will be of interest and practical use for commissioners, providers and anyone tasked with making a reality of personalised support.

We explore:

- What ISFs are.
- How they have evolved.
- The key features of what you will see when ISFs are done well.
- Who is using them at the moment and how they are working, including a brief analysis of the benefits of each approach taken by services supporting older people, people with learning disabilities and by people using mental health services.
- How to do them; and
- The opportunities there might be for their further development in the future.

What are Individual Service Funds?

One way to have a personal budget is through an ISF. When someone wants to use their personal budget to buy support from a chosen provider, that provider can use the person's budget on their behalf in the way that the person specifies.

It means that:

- The person being supported has a clear idea of how much resource is available for their care and support.
- The money is held by the provider on the individual's behalf.
- The individual decides how to spend the money.
- The provider is accountable to the individual.
- The provider commits to spend the money only on the individual's service and the management and support necessary to provide that service (not into a general pooled budget).

There are two ways that providers can develop ISFs. One is to respond to individual commissions from people or their families acting on their behalf, or from care managers through the commissioning process. The other is to proactively transform the block contract monies that providers receive and commit to using that money in an individualised way. Ideally this would be done in partnership with the commissioner.

A brief history of Individual Service Funds

The concept of an ISF was first used in Scotland by Inclusion Glasgow and Partners for Inclusion, supporting people with learning disabilities in the late 1990's. Individual Service Funds were then included within In Control's model of Self-Directed Support[3]. From 2005 – 2007, the councils involved in the Government's Individual Budget Pilot started to look at ISFs to enable people to have greater choice in using their individual budget within commissioned or in-house services. From 2009, many more councils became interested in ISFs as a way to boost personal budget numbers and meet Department of Health targets. There was no set model, and ISFs started to be used within domiciliary care for older people.

A number of innovative providers started to share what they were learning about developing ISFs with learning disabilities and mental health services:

- IAS (a provider in Greater Manchester) produced a paper describing a process for developing ISFs through closing a small group home for four people with learning disabilities.[4]
- Look Ahead Housing[5], reported on a way to use person-centred planning to give people who use mental health services control over a small amount of cash and a few hours of staff time each week.
- In 2010, Dimensions[6] described how they had learned from Jennie and her Circle of Support (who used her personal budget to buy services from a provider through an ISF) to develop the role of 'support advisors' to work with individuals and families to set up ISFs.
- In 2011, Dimensions[7] produced a book on how they began to deconstruct a block contract to develop ISFs within a residential care home supporting six people, and introduced a six-stage process developed by Helen Sanderson Associates.
- Early work in doing this at scale has been led by Choice Support and the London Borough of Southwark for 81 people over four years. Real Life Options and Birmingham City Council are doing the same for 90 people over one year. Both providers are deconstructing a block contract and replacing night support with assistive technology. Learning from this work should be available in late 2012.

These approaches are all based on person-centred thinking (a range of practical tools and skills that staff can use on a day-to-day basis to personalise services) and person-centred planning (processes around an individual that focus on creating a positive future and being part of a community). Look Ahead Housing used person-centred planning as the foundation of their steps towards ISFs, as did Inclusion Glasgow and Partners for Inclusion. IAS and Dimensions used person-centred thinking, and the process 'Planning Live' to develop ISFs.

Key Features of an Individual Service Fund

While working at the Department of Health in 2009, Sam Bennett wrote the paper *Contracting for personalised outcomes* that summarises the five key features of ISFs.[8] The paper focused primarily on developments around the commissioning and provision of homecare services and was based on research conducted with five councils who had, at that time, amongst the highest numbers of personal budget holders in the country. The key features identified in this work still ring true to our current understanding of how ISFs are developing in any support setting and in our own work to support their implementation.

The five key features of an ISF are:

1. All or part of a personal budget is held by a provider on an individual's behalf where the money is restricted for use on that person's support and accounted for accordingly.
2. No specific tasks are predetermined so that the personal budget holder is empowered to plan with the provider the who, how, where, when and what of any support provided.
3. There is flexibility to roll money/support over into future weeks or months and to bank support for particular purposes.
4. The ISF is accompanied by written information that clearly explains the arrangement and confirms any management costs to come from the personal budget.
5. There is portability, so the personal budget holder can choose to use the money in a different way or with a different provider.

The Department of Health therefore defines ISFs as the individualisation of funding without pre-determining specific support tasks. The features make explicit reference to personal budgets and to money as opposed to hours. These are important distinctions when we look at different approaches to individualising support arrangements in the next section of this paper.

More recently, Groundswell has developed a model to describe what good ISFs look like in practice from the perspective of people using them. This model draws on our understanding of how truly personalised support can work for people, is grounded in the language used by the disability movement to describe what should be different in services and was co-produced together with people with support needs, their carers and families. It consists of a number of first person statements for what people might be saying if each element were working well.

Individual Service Funds

WHAT "I can use my hours/budget flexibly and can choose what I am supported with."

WHERE "I am supported where it makes sense for me, at home and out and about."

WHO "I choose who I want to support me, my support worker knows me and I know them."

WHEN "I get support on the days and at the times that are right for me."

HOW "I choose how I am supported and my support workers know this is important to me."

CO-PRODUCTION "I am fully involved in decisions about my own support and how the wider service develops."

Figure 1. What, where, who, when, how and co-production

How ISFs have developed – a brief look at three different approaches

As the move towards ISFs continues, three different approaches to individualising services in this way have started to emerge:

- **Partial disaggregation (core and flexi):** starting small with people controlling small amounts of money or support without doing individual allocations. Look Ahead Housing and the Riverview older people's home in Fylde have both explored this approach. It is also being used by a Stockport care home that supports 41 people with dementia.
- **Micro commissioning:** setting up new services for individuals as ISFs from the outset. This approach was first described by Inclusion Glasgow and Partners for Inclusion. It involves individuals, families and Circles of Support, as we'll show with Jennie's story later in the paper.
- **Full disaggregation:** converting existing block contracts into ISFs, working with commissioners as much as possible. IAS and Dimensions have used this approach.

In the following sections, we offer examples of how each of these approaches has been used by providers. While each approach has its merits and all are grounded in a commitment to improve people's experience of support, they are not equal in terms of the choice and control they extend or the outcomes for people. For example, partial disaggregation has the benefit of being an option that can be pursued by a provider independent of commissioning involvement or the use of personal budgets. There should, in theory, be nothing to stop any provider extending some greater degree of control over hours of support or a small budget in this way, so we have included an example of this approach. However, we feel that the best outcomes will come by not seeing this as an end in itself, but rather a means of paving the way for more substantial individualisation through micro commissioning and full disaggregation of existing contracts, examples of which are also included.

The graph below plots these three approaches where the horizontal axis is the degree of **choice** supported and the vertical axis is the extent of **control** people have over the funds available for their support. While all three are approaches to individualizing services, only micro commissioning and full disaggregation are ISFs by the Department of Health definition.

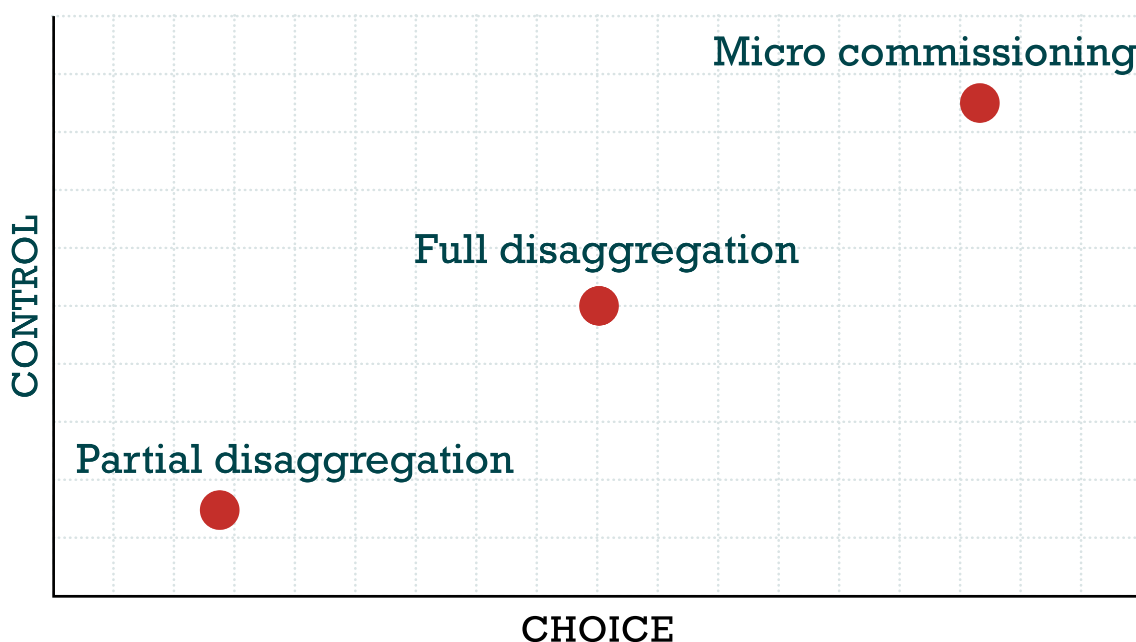

Figure 2. Choice and control in commissioned services

We now go on to describe each of these approaches in some detail, including examples of how they have worked in practice.

Partial disaggregation (core and flexi)

Key points:

- Any provider can do a version of this within their service.
- Does not always have to involve the commissioner (see the Fylde example).
- Increases people's direct control over particular elements of the service.
- Can support people to have more choice in who supports them and when.
- Can be used as a building block towards ISFs.
- Doesn't require individual resource allocation, can be about hours of support.
- Not dependent on personal budgets being used.
- Success depends on great person-centred thinking and planning.

"It's not just about giving us the money: it's giving us the responsibility too."

As set out in the following examples, Look Ahead Housing and Care and the Riverview older people's home on the Fylde coast both started to individualise services through identifying resources for individuals that they could control. Look Ahead Housing and Care did not do an allocation of resources, but worked out what they could afford, both in money and hours. This is one way to move towards an ISF. A service provider could then move to allocating everyone their entire resource which would, of course, be different for different people.

Look Ahead Housing and Care

Look Ahead Housing and Care, and the London Borough of Tower Hamlets worked in partnership to trial an approach to people having a budget and staff hours. The contract is still a block contract, but control is devolved to the customer. The Coventry Road service in Tower Hamlets is described as a 'high needs mental health accommodation-based service' that has self-contained flats for 20 people. All customers have a range of complex needs including ongoing substance misuse, gambling addictions and forensic histories, and are subject to the Care Programme Approach (CPA).

Look Ahead developed a 'core and flexi model.' The core refers to the fixed range of support required by everyone in order to run the accommodation-based service, while the 'flexi' refers to individual support that enables people to use their staff time in a personalised and flexible way. What is significant about this approach is that whilst not being the whole of the person's budget allocation, 'the model need not be limited to those eligible for social care funding, nor to any particular kind of service. It can also be adapted according to levels of resourcing and staffing structures, with each service determining the exact characteristics and proportions of each element of the model'.[9]

They are therefore setting out a way of individualising services, regardless of the funding stream or service. The pilot approached the issue of money by using the established principles of clarity and control around use of personal budgets. That is, that people should know from the start how much money they can spend on their support; people should be clear about what outcomes must be achieved with the money; and people should be able to spend their money in ways and times that make sense to them.

The staff had training in person-centred thinking and planning, so that they were able to assist people in developing their support plans if required. Nineteen out of 20 people used person-centred thinking and planning in their support plans.

In practice, the ''core'' was two staff on shift and on site for 24 hours. The ''flexi'' was a cash allocation of £40 per week (this could be saved over a number of weeks to make a bigger purchase if this was signed off in their personalised plan). In addition, the flexi included 3.5 hours of one-to-one support time per person per week, over and above the core. This was delivered by the Coventry Road staff at a time the customer chose to help achieve the outcomes in their support plan.

The changes made through this process were significant. People felt in control of their lives and were commissioning their service.

One customer, when asked in March 2009 about how she could increase control in her life, said:

> ***"I don't know the other choices I could make."***

She had identified her key worker as the main decision maker in her life. By November 2009, she rated her level of control as five out of five, saying:

> ***"I make the decisions and I tell staff what I want."***

Another customer in March 2009 self-rated his level of control over his support services as one out of five:

> ***"No control, but I don't mind doing it."***

In November 2009 he self-rated three out of five, and became very active commissioning his own support:

> ***"If I had the choice, I would rather go out than buy an extra hour of key work."***

At the beginning of the project, 50 per cent of people said their key worker was the main decision maker in their lives. Eight months later, no-one at all thought their key worker was the primary decision maker, showing a positive shift in power between staff and customers.

In this project, people had a facilitated person-centred plan and this generated the outcomes the person used their budget and additional key worker time to achieve. *This is one way to efficiently generate a support plan, whilst still going at the person's pace.*

Riverview – a residential care home[10]

Sue is the manager of Riverview, a residential care home supporting older people on the Fylde Coast. She attended a person-centred thinking course and wanted to start individualising services and move towards ISFs. Sue decided to do this on a small scale at first, one person at a time, to test the process out. She started with Sam, who is 78-years-old and had lived in the care home for several years.

Sue began to consider how the organisation could effectively do an internal resource allocation around hours so that they could work out the hours that a person living there was entitled to. This divided into "background hours" (the hours a resident shares with others living in the home so that they stay healthy and safe) and "individual hours" (the dedicated individual hours that the person had).

Sue approached Sam and explained that she had worked out his background hours and his individual hours that could be dedicated to him. She explained that he was entitled to four individual hours a month and she would help him develop a support plan to help him think about how he wanted to spend those hours. This would ensure that he was spending the hours in relation to what was important to him and Sue would put that into a contract and review it with him every six months.

Sue and Sam started off by developing a timeline to represent key points from his life story so far. They also spent time developing his one page profile and then used the person-centred thinking tool 'Working and not working' to think about what needed to change. This formed the basis of a support plan showing how he would use his individual hours. The main thing that wasn't working for Sam was that his friendships had all been lost after spending three months in hospital and then coming to live in the home four years earlier. Sam particularly missed his connection with the crown green bowling club he had belonged to for a number of years. He had lost all contact with his old mates.

Sam was supported to develop his relationship circle and he identified the key relationships. He was then supported to write to some of his old friends, and as they responded, Sam gained the confidence to think about how he could reconnect with the bowling club which wasn't far away from the home.

The challenge now was finding the right staff member to support Sam to go and watch the bowling. They needed a match between his interests and how he wanted to use his hours, with staff characteristics and interests. Sue and Sam

used the matching tool to find the right person. They looked at the one page profiles for staff which included their hobbies and interests and found that Greg, a new member of staff, looked the perfect match for Sam as he too was a keen bowler. Sam agreed. Within a month, they went off to the bowling club together. Sam cannot bowl because of his hip injury. However he enjoyed catching up with his old friends while Greg played a few games.

After a couple of months, it was as though Sam had never been away. Greg and Sam went once a fortnight and they both enjoyed the company. They were now challenged to think about how we could support Sam to have a real sense of purpose, given that he was unable to bowl. Sam said that he would give playing dominoes a go and that worked out really well. Sue and Greg used the person-centred thinking tool 'presence to contribution' with Sam to help them think about how Sam could make a contribution. Prior to retiring, Sam was a keen writer and produced the church newsletter each week. Sam now writes the monthly newsletter for the bowling club and feels that he is giving something back.

Sam's life is very different now and as he said recently:

> ***"I've got something to get up for, meeting the lads and I'm working on a newsletter."***

This showed that with a "can do" attitude, listening and recording differently and some creative thinking, differences can be made without extra staff or money

Micro commissioning: setting up a new service as an ISF

Key points:

- Starts from the individual rather than the service: building something from scratch rather than breaking something down.
- Requires the individual to have a personal budget.
- Helps people have choice and control over all elements of their support.
- Can work for people arranging their own support (e.g. through a Circle of Support) or where the local authority spot purchases support on their behalf.
- Success depends on great person-centred thinking and planning[11] as Jennie's story shows.

Jennie's Circle of Support

Jennie is a young woman with autism who lives in Stockport in her own flat and uses her individual budget to purchase support from a local provider, Independent Options. Suzie, Jennie's Mum, set up a circle of support around Jennie when she was 15-years-old, as a result of a person-centred transition review in Year 10. Suzie knew that she was not always going to be around to support her daughter and wanted to ensure there were enough people in Jennie's life with the same interests and concerns for her future, who knew her well enough, and who could make the right choices about what she wants when she is older.

The Circle of Support was a way to achieve this. People participate in the Circle on a voluntary basis and according to Suzie, Jennie's Circle is:

> *"a brilliant combination of family, friends and professionals who know Jennie well and have her best interests at heart".*

The Circle did a PATH – a way of looking into the future for Jennie – so they could work out what was positive and possible for her, and then what would need to happen in two years, one year, and six months, to reach that point.

A few years later, when Jennie became 18, the Circle worked with the local authority to get an individual budget for Jennie and to use this as an Individual Service Fund.

Once they had a resource allocation for Jennie, they used information from her person-centred description and PATH to put together a support plan.

As Suzie said:

> *"Everything we had learned about Jennie from person-centred thinking and planning pointed to the fact that it was crucially important for Jennie to live on her own supported by people who understand her. We based our decisions on our collective understanding of Jennie."*

The Circle also did a community map (a person-centred thinking tool) and looked at local activities, groups or places that Jennie could visit or be part of that were linked to things that they knew were important to her. For example, could she visit an art gallery or take art classes or were there any groups where she could develop friendships? This was all recorded in Jennie's support plan. It clearly states how her personal budget will be used; sets out her 'perfect week'; and includes a communication chart and decision-making profile.

"It was about making sure that she had a full, rich, active life and was spending time with people that were important to her; the sort of thing that we would all strive to have in our lives."

Suzie says that life for Jennie, who is now living in her own flat, is fantastic.

"If you had said to me 10 years ago this would have happened, I would never have believed it. I was worried that by then she might be in an institutional setting or in supported living with people she didn't like or, worse still, didn't choose to live with. But now all the worry has gone which has been amazing for me."

Once the Circle had developed the support plan, and had secured the flat (Jennie has a mortgage for a share of the flat) they looked for a provider who could deliver support in exactly the way Jennie wanted it. They found three providers that they were interested in, and invited a representative from each to a circle meeting for an informal interview. The questions were based on how they would deliver what is in Jennie's support plan; how they would recruit staff just for Jennie; how they could work in partnership with the circle, and their approach to enabling risk. The Circle decided on Independent Options. Over the next few months they worked with the manager of the service to recruit staff just to support Jennie.

Jennie, Suzie, and the Circle worked with Independent Options to recruit Jennie's staff team. They started with Jennie's person-centred plan and then developed the 'matching staff' information as the person specification and from this developed the job description.

The job description is split into responsibilities to Jennie, the Circle and the organisation. Within each of these, there are headings from the person-centred thinking tool ''the doughnut'' to specify core responsibilities and where people can use their creativity and judgment. The family and the manager, Joanne, then developed a decision-making agreement so that everyone was clear how decisions were going to be made and that Jennie and the Circle would make the final decision on who to appoint. This included deciding that Suzie would short-list with Joanne, and Jennie and the Circle would meet the short listed candidates (doing art together – an important part of Jennie's life) before the formal interviews.

The advert introduced Jennie, used some of what people appreciate about her from her person-centred plan, and information from the 'matching' tool. The interview questions were based around Jennie's person-centred plan and asked in the order of responsibilities – to Jennie, to the Circle and then the organisation. Suzie and another member of the Circle were part of the interview panel. Jennie

had done her 'interviews' by seeing how people responded to her during the art session. Suzie made the final decisions, with Joanne, about which staff to appoint.

Jennie is very happy with her staff team and Suzie is delighted with how the team is working to support Jennie. Working hard to both get a good match, and ensure that Jennie, her family and the Circle were central to the process made all the difference.

Every six month's Jennie has a person-centred review with the Circle and the manager and staff who support her to reflect on how everything is going from Jennie's perspective, the family and Circle's perspective, and the provider's perspective.

It is easier to set up a new service as an ISF that is bought directly by the individual through their personal budget or commissioned individually on their behalf.

Partners for Inclusion's work on developing ISFs has resulted in the following key principles for using this approach.

- Everyone should have an ISF, with spending decisions made by and for that person.
- This should be treated as the person's money and respected as a restricted fund.
- Decisions need to be made as close to the person as possible.
- How the money is spent should be clearly and transparently reported.
- Most of the ISF should be spent directly on the person.
- People need to manage within their budget – if they haven't got the money, they cannot spend it; if they do, they choose how to spend it.

Full disaggregation: shifting from a block contract to ISFs

Key points:

- Starts with an existing block contract which is broken down into its constituent parts. It can work in small group homes or in large residential settings.
- Involves individual resource allocation, usually after counting hours or applying the Care Funding Calculator.[12]
- Not dependent on personal budgets being used but works best when they are. This means you can use this approach in a residential or supported living environment whether or not the council has moved people supported there onto personal budgets.
- Helps people have choice and control over most elements of their support.
- Success depends on great person-centred thinking and planning.

IAS (a provider in greater Manchester) and Dimensions (a national provider) have both begun the process of deconstructing block contracts into Individual Service Funds, as we explain in the following examples. In IAS, they used ISFs as a key part of moving from a traditional group home model to individualised living arrangements.

Down Street

Down Street was a four-person group home that had seen three new people move in during the last three years. Considerable effort had gone into assessing compatibility, but the reality was that living like that wouldn't have been anyone's real choice.

One man was gradually finding it difficult to live with the others, as well as making it difficult for others to live with him. A person-centred review sharply clarified that the person needed a new living arrangement. IAS negotiated with the Local Authority to redistribute resources to deconstruct the group home and provide individually designed services.

There were sufficient resources already allocated to the four men which allowed one man to move into a flat with 24/7 support, and another to move into his own

place with a few hours of support per day. This left two men living at Down Street with 10 hours of support a day.

These two men got on really well and wanted to carry on living together. Staying at Down Street and having two 'strangers' move in wasn't an option given IAS's determination to move away from a group home model to individual supports. They decided they wanted to look for a place nearby, just for the two of them, and choose who'd support them, and when they wanted to be supported.

The two men moved into their new home a month later. For all four men, resources have been identified and ring-fenced and are only be used to implement their support plan. For the two men living together, this presented a new challenge for IAS. ISFs are established for each man, and the support plans need to recognise the shared support they want, as well as individually tailored support. The ISFs are reviewed annually with the individual using a person-centred review.

IAS have extended ISFs to other people they support, and here are a few examples of how people are using their money and hours.

Paul moved from a long-stay institution into a shared tenancy for four people in 1994. He was on a Home Office section and this acted to curb any thoughts about other possibilities. Paul was aware of other people moving on from the 'group home' model, and he began to talk about his aspirations and dreams. Paul invited key people in his life to a PATH meeting where, amongst other things, he revealed he 'wanted freedom'. Paul moved into his own two-bed terraced house in September 2004, two years after his PATH meeting and ten years after moving back to Wigan.

Paul has a very different lifestyle now, with many of his friends and acquaintances. Paul's ISF is the equivalent of 30 hours staff support a week. He has a very different relationship with the staff that support him.

He can decide:

- When he's supported.
- Who he's supported by.
- Whether he wants all 30 hours in a particular week.

Paul monitors the use of his 30 hours with his team leader and they keep a running total of hours used and therefore a balance. Paul loves to travel. When he's in unfamiliar places, he needs greater support. He can plan a 'City Break' by saving up the additional hours he'll need.

Sally really enjoys dancing and night clubs and she needs support for this. She has been able to employ staff that also like to do this, and they are paid time and a half after 11:00pm. She can convert 'standard hours' into 'enhanced hours', for example, six standard hours equals four enhanced hours. Sally can plan late nights out knowing what it 'costs' from her allocation of twenty-four standard hours.

Brian has an ISF and regularly converts the hours of his support into money to purchase personal trainer time at a local gym, massages and computer games.

All these actions - saving up hours for a highly desired activity, converting standard hours into enhanced hours and converting standard hours into pounds are ways of enabling people to use their hours and money flexibly through their ISF.

Whilst IAS was intentionally deconstructing their group home model, Dimensions wanted to learn how to establish ISFs with people who lived together in a residential care home. They focused on 'Old Street', a home to six people with a learning disability who had previously moved from a long stay hospital.

Old Street

The first step was to agree the individual allocation. Old Street was a traditional service costed in a traditional way with the same cost for everyone regardless of individual needs: one sixth of the block contract price. In practice, more of the budget had been spent on those with higher needs, though this wasn't reflected in the accounts or contractual arrangements.[13] Dimensions used the Care Funding Calculator to determine the individual allocations.

The next step was to plan with each person and create a costed support plan based on the individual allocation, and then put this into an agreement and start to implement it. Dimensions used a range of person-centred thinking tools to achieve this.

They started with making sure they knew what is important to and for each individual, and what people wanted to change in their life using Working and Not Working. By looking at community mapping as well, they could then put together an ideal week/month for each person (including what each person wanted to do, where in the community, and when).

With this information they then created personalised rotas for each person, and used an approach to match staff to each person and what they wanted to do. Using a relationship map, they asked each individual who they support to think about who they preferred to support them, out of the staff team of 16. Anne-Marie, for example, put four team members on the inner circle of her relationship map, indicating that these were the staff that she wanted to support her. Then the manager looked at the gifts and interests of each of these four staff members, by looking at their one page profiles, to work out the best fit of these four staff members and what and where Anne-Marie wanted to go on her 'perfect week'. This resulted in substantial changes at a team level in the way that staff were deployed and what was expected of them, and introducing personalised rotas. The support plans for each individual were developed through using 'Planning Live'.

Planning Live involved getting the individuals, families, and staff together for two days, to gather the information and plan. Planning Live balances sharing information and examples with the whole group, with working in small 'teams' around each individual (the person, family, key worker and other staff). There are also opportunities to share back how people are doing with the whole group (and therefore staff an opportunity to contribute information to everyone's planning). Working with six individuals in teams this way required two external facilitators, who could both lead the session and work directly supporting the individual teams. Planning Live took place with each individual, family members and most of the staff team, led by two facilitators (one internal to Dimensions, trained in person-centred thinking and person-centred reviews, and one from HSA).

One of the benefits of this approach is sharing the same information with everyone at the same time – about the person-centred thinking tools, about why this is important, about how the information will be used. We learned later that one of the significant challenges was keeping a staff team of 16 well informed, and Planning Live contributed positively to that.

Through the Planning Live two days people learned what is important to each individual and how they want to be supported, and this information was developed into one-page profiles. The group learned about how each person communicates (particularly if they do not use words to speak) and how they make decisions (using the decision making agreement) and used all this information to describe what best support looks like for the person. Through the relationship circles people learned about who are the important people in each person's life, and this information was added to the community map, of the places that matter to each person.

As well as this day-to-day information, the groups learned about what is working and not working right now, and how to change what is not working. This information was put together with what the person wants in the future – how do they want their life to be in a year's time (dreams and aspirations)? Together this gives us the outcomes that the person wants for the following year. The group looked at the information about the person's dreams and aspirations, with an appreciation of the person's gifts and skills, and asked whether there were paid work or enterprise opportunities that could be included in the outcomes. Carolynn (the manager) described the process as fantastic:

> *" It really felt like the start of the journey for us all. My staff and I spent two whole days listening – and that's it, just listening to the people we support. We gleaned so much information over those two days and enabled the people we support to think more about how their life was for them and their families. So much was covered in Planning Live."*

Developing an ISF with Anne-Marie and enabling her to choose the staff that she wanted to deliver her service, were central to her having choice and control in her life. The ISF was reviewed with Anne-Marie, her family, staff and manager every six months using person-centred reviews.

The Individual Service Fund Process

Developing an ISF begins with an individual allocation of resources, followed by planning, agreement, implementation, on-going learning and regular review. We will go through this step-by-step including:

- Allocation
- Planning
- Agreeing the plan and contract
- Implementing the plan
- Capturing learning
- Reviewing how it's going

Here is a summary of the different issues to consider at each stage, and how the providers we have highlighted in the previous section have addressed them.

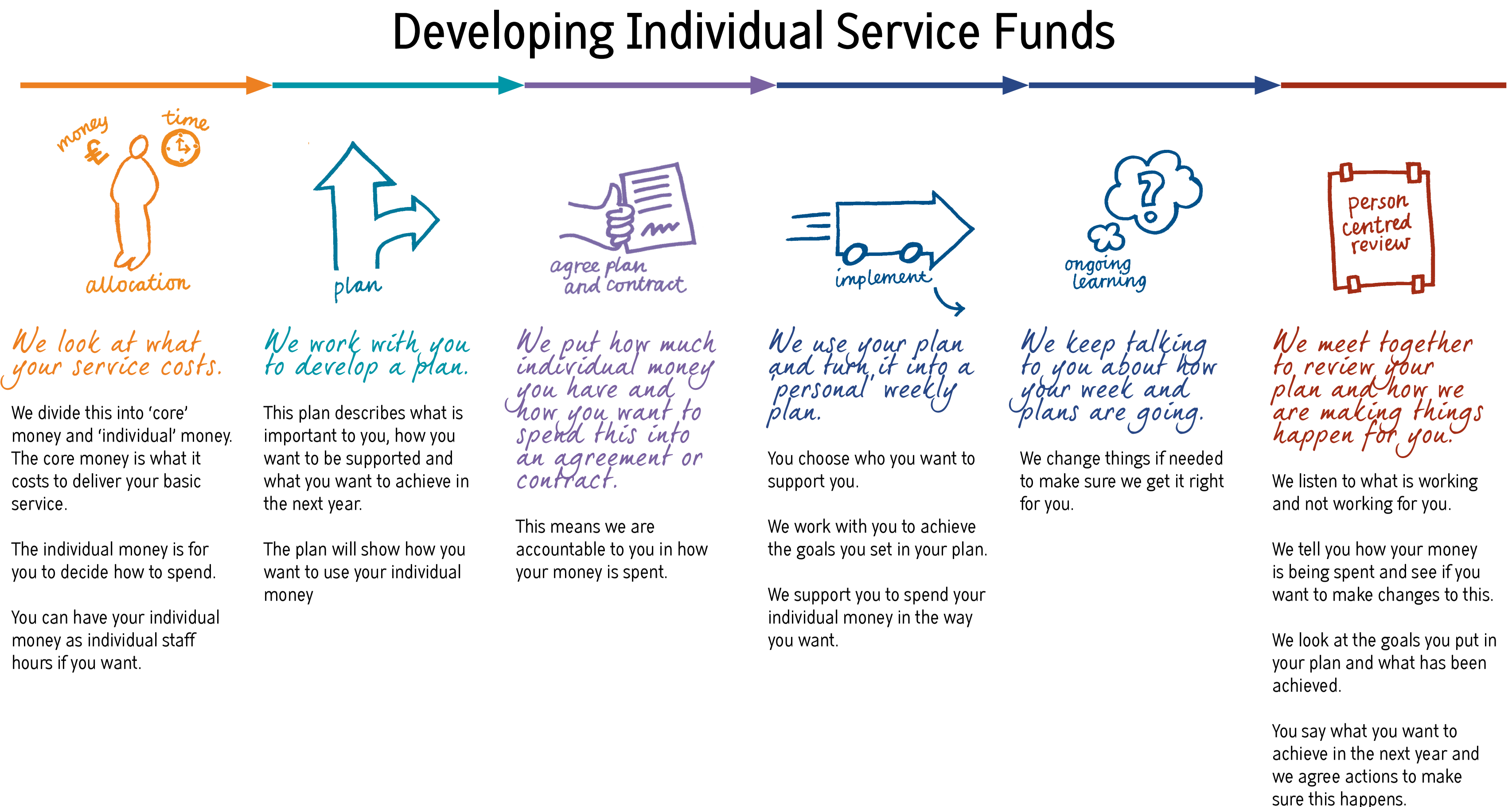

Figure 3. Developing Individual Service Funds

In moving to ISFs, Dimensions were trying to create a framework that would identify each person's:

- Individual allocation of the overall pot of money on the basis of their needs.
- The support and core costs that are shared.
- The proportion of the allocation left over for each person's discretionary fund and the processes and ways of working that would help to maximize their control over this resource.

For example, by applying the principles of simplicity, transparency and reasonableness, Dimensions decided that:

- Each person would pay an equal share of core costs and costs of shared support.
- Each person would have full choice and control over their discretionary fund, including the freedom to spend it with another provider.
- If a person leaves the service, the budget (including staff) could be reduced immediately by the value of his/her discretionary fund.

They tried several tools to disaggregate the funding for the service and settled on the Care Funding Calculator which they felt gave them the most accurate picture of the cost of people's support.

IAS developed their allocation based on three elements:

- Hourly rate.
- Cost of night-time support (if applicable).
- Service Co-ordination Premium (hourly rate).

They developed an inclusive cost, which covers direct support costs, service co-ordination and development, and company costs, and includes a contingency insurance.

For example, in IAS, costs are normally broken up in the following way:

- Direct support averages 77 per cent of the total.
- Service co-ordination and development are normally 13.5 per cent of the total.
- Company costs are normally 9.5 per cent of the total.

They worked out how many hours they provided for each person and then they could give people both a budget and what that meant in hours.

Partners for Inclusion found that people with lower direct support needs and costs still need the same amount of service coordination and central leadership which justifies a fixed fee for everyone. In addition to this, each person makes an individually negotiated contribution to a General Service Fund for "the common good." This is "insurance funding" that anyone can access if/when needed (e.g. when there is a temporary need for higher service or when the organisation is experiencing a particularly high staff absence rates). Inclusion Glasgow has a similar but discretionary insurance fund into which people can contribute up to 10 per cent of their budget.

The support plan is based on person-centred thinking and should describe:

- Who the person is (and what is important to them).
- How they want to be supported.
- What they want to change about their life over the next year – their outcomes; and
- How they want to stay in control of their life and service.

Support plans for personal budgets have to be signed off against specific criteria. It is important that equivalent criteria are used to evaluate the plans that form the basis of ISFs, otherwise there is the risk of a two–tier expectation between personal budgets delivered through a direct payment, and personal budgets used as an ISF.

Based on our experience of planning with people who are using ISFs, the following check list sets out what should be included in the support plan.

Does the support plan clearly describe:

- Who the person is and what matters to them from their perspective?
- How the person wants to be supported? Where they want to be supported and when?
- What the person wants to change in their life and their outcomes for a year's time?
- How they will spend their budget/hours?
- How the support will be delivered (Assistive technology? Natural supports? Paid support and how this is matched to the person? Personalised rota?)
- How the person will stay in control of decision making about their life and support?
- How and when the support plan will be reviewed?

There are many ways to create support plans that achieve these standards.

This is how Dimensions used person-centred thinking tools to create Anne-Marie's support plan[14]:

WE NEEDED TO LEARN FOR AN INDIVIDUAL SERVICE FUND	THE PERSON-CENTRED THINKING TOOL THAT CAN HELP GATHER THAT INFORMATION
What is important to Anne-Marie/what good support looks like to her (we summarised this into a one-page profile). What this looks like in a week (we called this a 'perfect week').	**Relationship map** (a way to learn who is important). **Good days and bad days** (a way to learn what is important and what good support looks like). **Morning routine** (a way to learn what is important and what good support looks like).
Where are the important places for Anne-Marie?	**My places in the community** (community mapping – to learn where the things that are important to Anne-Marie take place and where she wants to spend her time).
Where Anne-Marie wants to be in a year's time (these are her outcomes).	**What is working and not working** (a way to think about what needs to change to build on what is working and change what is not working). **Hopes and dreams for the future** (a way to imagine a better future, based on what matters to Anne-Marie). **My gifts and contributions** (identifying Anne-Marie's gifts, strengths and talents to build on and share in the future).
Co-production – ensuring that Anne-Marie has as much choice and control as possible.	**Decision-making agreement** (a way to know what decisions Anne-Marie makes in her life and how staff support this). **Communication charts**

IAS and Dimensions both used Planning Live as a way to use person-centred thinking to begin the support plan. In IAS, the manager brought together people receiving support, their families and support teams alongside senior management to develop their support plans 'Live' in a facilitated process.

"The service had been funded in a way that meant people needed to continue living together, supported by IAS, and therefore it made sense that their budgets were converted into hours, based on the company's hourly rate. Families in particular found this much easier to understand and were able to identify where they felt hours could be best used to meet the wishes and needs of their sons or daughters. The process was successful in ensuring that the hours available were used as creatively as possible and that everyone's opinions were listened to. The families involved felt that they had had an opportunity to work in partnership with their chosen provider where the focus was on working things out together."

Owen Cooper

Agree contracts and implement

The support plan will describe how the person wants to use their money, to be supported in the way that they want on a day-to-day basis, and achieve their outcomes. This needs to be put into an agreement so that everyone is clear how much the ISF is (amount) and how it will be used. In practice, thinking about implementation often needs to happen before the agreement can be signed.

Dimensions used a process called Just Enough Support[15] to think carefully about different ways that peoples support could be provided, to ensure that people got the support they needed, in a way that reflected what is important to them and ensure the best value for money for the person. This is a process for looking at assistive technology, natural supports and creative ways of using staff time and matching support. In the Dimensions example, it was not possible to recruit new staff so they looked at how they could get the best match possible with existing staff using staff one page profiles.

IAS looked at recruiting new staff to deliver an ISF. They explored how to start with the support plan and use the 'matching tool' to inform:

- A person specification.
- A job description.
- A local recruitment and selection process.
- A contract for individual staff.
- A contract with the organisation.

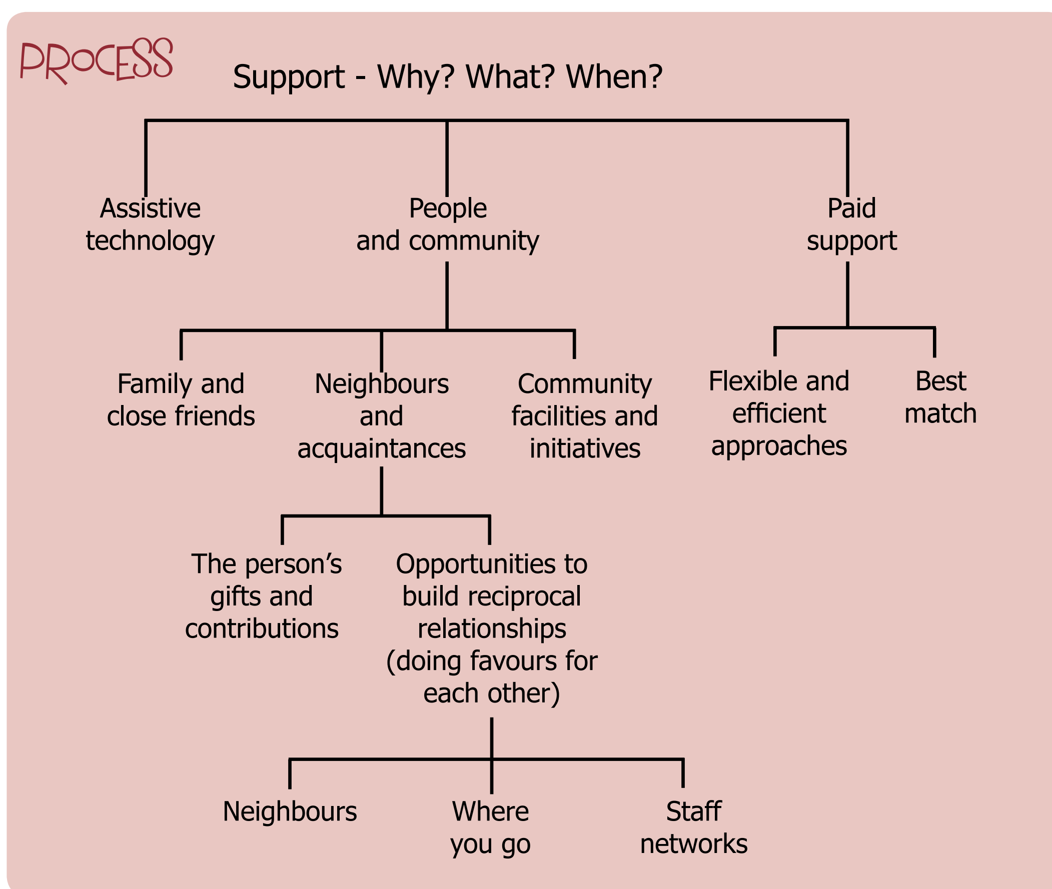

Figure 4. Just Enough Support Diagram

When a new member of staff is needed, the position is advertised locally, by word of mouth, in the local newspaper, shop windows, jobcentre etc. Returned applications are short-listed based on the information contained in the person specification and the 'what are the characteristics of the people I'd like to work with me?' sections.

Interviewing is seen as a two-step process. New staff are recruited to the organisation first, to ensure that they have the values and talents required to fit the organisation. Only people who meet these requirements are then available to be selected by the individual as part of their own staff team.

In step one, the formal interview to recruit to the organisation, the person or people wanting staff only take part if it makes sense to them; otherwise team leaders along with family members or support staff take care of this stage. If the person being interviewed meets the organisational values and standards, they are sent on to step two of the interview. It is usually the case that three or four candidates get this far.

In step two, the informal interview for recruiting to the individual, each person or small group of people sharing support determine the best environment for this to take place. It is usually somewhere familiar and comfortable for the person looking for new staff. For example, the two men who live at 'The Way' chose to use a local pub to check out their prospective staff. People closest to the individual(s) are invited to help with this stage of the process as they would have most likely been involved in the development of the recruitment file and are therefore aware of the person's wishes and what is important to them. An informal series of conversations take place, photos are taken of candidates, and then the person chooses which of the candidates they want to join their team.

Although this seems pretty simple, it involves a real shift in thinking. IAS needed to balance their legal responsibilities as employers with the belief that recruitment should be lead by those requiring support. In the past, they and others would have chosen the best candidate based on a generic process and what they thought would be a best match. This new process ensures that the people they support are consulted and listened to from the outset and have the final say.

Ongoing learning and review

Once a support plan or person-centred plan is being used, providers need to have a person-centred review process. Implementation of a support plan and use of the hours are regularly reviewed to ensure the person is getting the life they want. The person, family member(s), friend(s), social worker and team leader are involved in this. The hours can be creatively used in different ways or even converted into cash where the person wishes to spend their entitlement in a different way.

In IAS they try to foster an attitude of continual learning and are using an annual person-centred review process, with more frequent reviews when necessary. There is a person-centred supervision process that means that reviewing how they are doing in supporting the person is a key issue in all supervisions, and a focus for team meetings. The review ends with an action plan that looks at what needs to happen to maintain what is working, and what needs to change to address what is not working. Other people providing different perspectives could be the individual and possibly family and friends, and the manager and team members providing support.

Conclusion

"I make the decisions and I tell staff what I want."

Resident of the Coventry Road accommodation service, Tower Hamlets

Groundswell has learned a lot about approaches to individualising services through our work and by supporting significant change within provider organisations. While it is still relatively early days, we have seen enough to know that ISFs could play a much greater part in the personalisation of care and support in the future.

This paper has set out some of our thinking and learning so far, in particular that:

- ISFs are the key to ensuring that truly personalised support does not stop at the care home door.
- Providers can lead the way in individualising support arrangements and extending choice and control to people in shared services.
- There are incremental steps all providers can take to pave the way for more substantial change.
- ISFs are a means to greater choice and control rather than an end in themselves – great person-centred thinking and working are the keys to people getting the best out of them.
- ISFs should be an important part of any local strategy to increase the uptake of personal budgets – particularly for those with complex needs.

Over the next twelve months, we will be continuing to work with forward thinking organisations to develop ISFs. This includes working with a large residential care home for people with dementia in Stockport and one of the largest disaggregations of a block contract into individual service funds for over 90 people in Birmingham, which will be evaluated with Birmingham University.

We look forward to sharing our further learning and welcome your thoughts on this report and the issues raised.

Please keep in touch through our website, facebook and twitter:

Web: **www.groundswellpartnership.co.uk**
Twitter: **@groundswellUK**
Facebook: **www.facebook.com/GroundswellPartnership**

References

1 ADASS Report on Personalisation Survey, September 2011

2 The National Personal Budgets Survey, In Control & Lancaster University, June 2011

3 Poll, C., Duffy, S., Hatton, C., Sanderson, H., Routledge, M. (2006), *A Report on in Control's First Phase 2003-2005.* London: In Control Publications.

4 Cooper,O., Sanderson,H., Gorman,R., Livesley,M., and Keely,T. (2008). *What are we learning about Individual Service Funds?* **http://www.supportplanning.org/Support_Planning_Downloads/SP_40_What_are_we_learning_about_Individual_Service_Funds_Sept_08.pdf**

5 Look Ahead and Care and The London Borough of Tower Hamlets (2010) *Choice, control and independence- Personalising block contract in supported housing,* **http://www.lookahead.org.uk/Site/23/Documents/Look%20Ahead%20Personalisation_Report.pdf**

6 Scown, S., and Sanderson, H. (2010) *Making it Personal* – A *Provider's Journey from Tradition to Transformation*. Stockport: HSA Press.

7 Scown, S., Sanderson, H. (2011) *Making it Personal for Everyone – From Block Contracts To Individual Service Funds*. Stockport: HSA Press.

8 Bennett, S., Miller, C. (2009) Department of Health *Contracting for personalised outcomes: learning from emerging practice*, **http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/CFPO.pdf**

9 Look Ahead and Care and The London Borough of Tower Hamlets (2010) *Choice, control and independence- Personalising block contract in supported housing,* **http://www.lookahead.org.uk/Site/23/Documents/Look%20Ahead%20Personalisation_Report.pdf**

10 Sanderson., H, Lewis., J, (2011), *A Practical Guide to Delivering Personalisation- Person-Centred Practice in Health and Social Care,* London: Jessica Kingsley Publishers

11 Ibid

12 The Care Funding Calculator is a national pricing tool designed to help providers and local authorities develop a better understanding of the cost of care in residential care and supported living for adults. More information is available at: **www.socialcare.improvementefficiency.org.uk/**

13 Scown, S., Sanderson, H. (2011). *Making it Personal- From Block Contacts Towards Individual Service.* Stockport: HSA Press

14 Sanderson., H, Lewis., J, (2011), *A Practical Guide to Delivering Personalisation- Person-Centred Practice in Health and Social Care,* London: Jessica Kingsley Publishers

15 Scown, S., Sanderson, H. (2011). *Making it Personal- From Block Contracts Towards Individual Service Funds.* Stockport: HSA Press

Further information

Person-centred thinking, planning and practices:
www.helensandersonassociates.co.uk

Dimension's experience of developing Individual Service Funds: please contact Claire@helensandersonassociates.co.uk for a complimentary copy

Just Enough Support: there is a detailed example in 'Making it Personal – from Block Contracts Towards Individual Service Funds and further examples and information on www.helensandersonassociates.co.uk

Planning Live: www.helensandersonassociates.co.uk

Support Planning: www.supportplanning.org

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