The personalisation of adult social care in rural areas
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Foreword

9.5 million people, 19% of England’s population, live in rural areas and the number is growing. But there are some challenging trends within this headline figure – in particular an ageing of the rural population. Just as more people retire to enjoy the widespread attractions of rural life, at the same time a significant number of younger people are drawn by the city lights or indeed forced away by rising costs of living in rural places.

An ageing population presents a number of benefits to rural communities. Older people are an important social resource. Their investment in the local economy and deep social networks can be the backbone of a strong rural community. Older people also help make rural communities sustainable through voluntary work, active involvement in a wide range of community groups and their support for local services.

However, as people grow older they are more likely to need care and support to maintain their independence and wellbeing in later life. Many older people receive support from families and friends, but this can be difficult to sustain and is not always possible or practical. For those who are eligible, formal social care is provided and covers a huge variety of services from residential care and drop-in centres to meals on wheels and at home support.

The personalisation of adult social care brings both opportunities and challenges for rural communities. Importantly, it will give individuals greater choice and control over the services they receive. However, the viability and cost implications of delivering personalised services in sparse rural areas have to be carefully considered. To ensure the personalisation of social care brings real benefit to those with the greatest needs in rural areas, the Department of Health and its partners in central Government and locally will need to rural proof their policies and programmes so that they consider rural circumstances and tailor their approach accordingly.

This report is informed by the views of a range of people working with older people in rural communities as well as people engaged in the recent Individual Budgets pilot programmes. It is intended to inform and stimulate debate amongst policy makers and practitioners involved in the personalisation of social care for people in rural areas.

Dr Stuart Burgess
Chairman, Commission for Rural Communities, and Rural Advocate.

August 2008
Introduction

The aim of this report is to inform debate about the transformation of social care and to produce a set of specific messages about and for rural communities based on evidence from rural areas.

While personalised social care has many definitions and the details are only emerging, it is clearly relevant to the lives of rural older people and their communities. This report examines the likely impact of the personalisation of social care on older people living in rural areas and those supporting them. It focuses on the development of personal budgets since this area is more developed than others and will be fundamental to promoting greater independence and wellbeing in later life.

Despite the potential ramifications of the personalisation of social care on the lives of older people in rural areas this report is the first detailed consideration of these issues. It calls for the Department of Health and its partner agencies to ‘rural proof’ their social care policies and programmes, to ensure they recognise and address rural circumstances. Similarly, it recommends the medium and long-term effects of the personalisation of social care are monitored and assessed to ensure equitable outcomes in rural areas.

The report shows that it will be important to examine the impact of personalisation in rural areas on resource allocations, community social cohesion and the social care workforce. It identifies the vital role the voluntary sector will play in supporting the personalisation of social care and reveals the need for local government to work in partnership with outside agencies, including rural interest groups, on the personalisation of services. It highlights the need to listen and learn from the experiences of older people themselves and draws attention to the role of older people’s forums and other advocacy groups in transmitting the benefits of the personalisation of social care.
Background

Government policy

In the public services strand of the Government’s policy review, Building on Progress: Public Services, the Government’s approach to personalisation is summarised as ‘the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive’.

The transformation of social care was signalled in the Department of Health’s (DH) social care Green Paper, Independence, Well-being and Choice and reinforced in the White Paper Our health, our care, our say: a new direction for community services. It was confirmed in the concordat Putting People First.

The aim of the personalisation of social care is to ensure that everyone who is eligible for social care support, regardless of their level of need, in any setting, whether from statutory services, the voluntary and community or private sector, from public funds or by funding it themselves, has more choice and control over what that support is, how that support is delivered and by whom. If effective, it will mean that people are better able to live their own lives as they wish, confident that services are of high quality, are safe and promote their independence, well-being and dignity.

Putting People First set out several policy goals that are highly relevant to the lives of older people today and tomorrow’s older generations. These include:

• the development of personal budgets;
• a commitment that local authorities and the NHS will not use ‘poor performers’ that is services where quality is not good;
• the development of First Stop Shops – providing information, advice and advocacy, available to people needing support regardless of their eligibility for public funding;
• tackling loneliness and isolation;
• promoting intergenerational activities;
• investment in new technologies; and
• prevention of disability and early intervention to address problems that may be helped by timely support (see also the Partnerships for Older People Projects funded by the Department of Health in 2004).

In England many rural areas are experiencing a marked increase in the proportions of older people in their communities. In the context of a generally ageing population, rural areas in England are experiencing the effects of ageing sooner and more profoundly than the country as a whole.

‘Figures show that over the next 25 years the numbers of those aged over 75 will increase by 90% in rural areas, compared to just 47% in urban areas’

Generally, rural areas have older populations than their urban equivalents and so any changes to social care are likely to affect them more profoundly, but not only as users of social care services. Whilst population ageing is often portrayed as a social problem, there is considerable evidence that older people are important social resources in rural areas. They often provide much ‘informal’ care and support communities though their contributions to local economies, social networks, cultural and environmental activities. However, while it is impossible to generalise about rural older people, there is increasing recognition that some rural older people may be at special risk of social exclusion. This affects their own wellbeing, as it is associated
with poor physical and mental health, but also their needs for social support. This has contributed to a growing interest amongst policy makers, statutory agencies and voluntary organisations in collecting and developing experiences and ideas about what works in social care and support, particularly for people who are socially excluded\textsuperscript{13}. While older people's needs for social support may be similar whether they live in urban or rural areas\textsuperscript{12}, different patterns and amounts of services may exist in rural areas, among the public, private, voluntary and community sectors. Rural older populations may sometimes experience greater difficulty getting the help that they require than other older people\textsuperscript{11 14 15}. This may apply regardless of income and people who arrange their own care for themselves or their families may be excluded from advice and support from local councils\textsuperscript{16}.

Early evaluation of Direct Payments schemes in England (the system of cash payments made to individuals who have been assessed as needing social care services to buy the support they need, in place of provision made through the local authority) found that the recruitment of personal assistants in rural areas remains problematic\textsuperscript{17}. Constraints on workforce supply include limited access to transport, low wages, or simply that local people may not want to do this type of work. Problems of recruitment, training and retention of care workers in some rural communities are not new\textsuperscript{18 19}. These problems may, in part, explain higher levels of unit cost for domiciliary (home care) social care services in rural areas and difficulties in achieving economies of scale using a market approach\textsuperscript{19 20 21 22}. English rural councils have argued that central government funding allocation for domiciliary social services provision does not adequately reflect higher rural care costs\textsuperscript{22 23 24 25}. 
The personalisation of adult social care in rural areas

Since July 2004 an official definition of rural areas has been in place for England and Wales. This definition, which is based on population density, was developed to provide a framework for statistical analysis and reporting. It defines settlements of over 10,000 people as ‘urban’ and places smaller, ‘rural’ settlements, into three categories: ‘town and fringe’, ‘villages’, or ‘hamlets and isolated dwellings’. In addition, settlements are defined as to whether they are in ‘sparse’ or ‘less sparse’ areas. We use these terms in this report although some of the older people we interviewed used their own terms.

This report uses the word personalisation to describe policy goals in social care, which were outlined in the Background section of this report. These have been summarised by the Government as transforming social care to give people greater choice, control and flexibility over the publicly funded support they receive and providing greater advice and assistance to people paying for their own care. The term Individual Budgets refers to the integration of several funding streams which were piloted by 13 local authorities from 2006-2008. In these pilot projects, eligible people were able to organise their own support if they wished (with family or friends involved if that is what they wanted), or to have a ‘virtual budget’ where services were arranged by an organisation (local authority or an independent organisation), or a mix of these approaches. One of the defining characteristics of this approach is that people are informed what sum of money is available, which in some places is calculated though a Resource Allocation System (RAS). Personal budgets is a term now being used to describe this new system of social care options, which is a central part of the DH vision for transforming social care. In many ways both these schemes build on and extend cash for care schemes such as Direct Payments (see Box 1) and in Control, a scheme for self-directed support, as well as self-assessment for support and equipment. The term self-directed support is also widely used and encompasses many of the themes of personalisation. These changes are taking place internationally, although rural implications have not always been considered. In one of the few studies where rural comparisons have been made, in Arkansas in the United States, researchers have concluded that such schemes make for improvements in the lives of disabled people, though not to any greater or worse extent for people living in rural areas.

Box 1
An example of using Direct Payments in a rural area

“I think Individual Budgets (IBs) will be great for people in rural areas because of their flexibility. People don’t want to have to travel many miles for a service like a day centre when actually getting together with a few others in someone’s front room would be infinitely preferable. IBs should make it possible for people to get their personal support needs met locally without the expense of having to pay large amounts for travel… It’s win win mostly”.
How this study was conducted

This study is based largely on 33 interviews with people (see Table 1) working and living in rural areas of England in early 2008. Some of the participants knew a great deal about individual budgets (IBs) and were asked to think about the rural implications of the personalisation of social care based on their experiences; others were asked to think through the implications of the personalisation of social care for rural communities. While the term personal budgets is now increasingly used, at the time of the interviews the term individual budgets (IBs) was more commonly employed. We have used this term in this report.

The focus of the work was on older people (over 75 years) and those supporting them. This is an important group because they are high users of social care services and of particular relevance for rural areas, because of the population trends described above. Personalisation will also affect other people using social care services and we hope that this report will contain much of interest and relevance. In addition to the interviews, the study drew on discussions with lead officers, mainly social services managers, from rural local authorities where individual budgets were piloted. The study was funded by the Commission for Rural Communities.

Table 1:
Participants by sector

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<th>Community group for/of older people</th>
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<tr>
<td>Large charitable/voluntary sector organisation</td>
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</tr>
<tr>
<td>Not for profit provider of social care</td>
<td>8</td>
</tr>
<tr>
<td>For profit provider of social care</td>
<td>3</td>
</tr>
<tr>
<td>Local authority officer</td>
<td>3</td>
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<td><strong>Total number of interviews</strong></td>
<td><strong>33</strong></td>
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Part 1
Individual budgets in rural areas

This section reports, for the first time, consideration of rural issues and the personalisation agenda by some of the most informed people in the country. Council staff who were responsible for implementing the Individual Budget (IB) schemes (called IB Leads) within the pilot local authorities in rural areas have had over two years experience of developing services that are in the vanguard of personalisation. Many have long experiences of work in rural areas predating this current work. Their experiences relate to social care and other local government funding streams (such as Supporting People funds for housing related support), rather than other elements of personalisation which were largely bought under the umbrella of personalisation after the IB pilots had finished (see Box 1).

IB Leads reported that there are positive and negative aspects of personalisation for rural communities. The positive aspects include being able to pay for support that fits the person receiving it. People without friends and families can pay local people to work for them or make use of social or leisure activities by paying for transport. Negative aspects include the still vexed questions of finding people to work or paying for care. Factors that seemed to help make the espoused outcomes of the personalisation of social care (choice, control and flexibility) more likely to be realised in rural areas included the availability of advice and support. Some of this depended on certain features of rural communities, such as whether the voluntary and community sector had a tradition of providing good advice and information or whether there was high unemployment and reasonable public transport, which could make recruitment easier.

IB Leads stressed that it is important to be aware of different reasons why older people live in the countryside: people choose to move there for a good place to live, but may have worked away, or have largely lived there at the weekends. Those born and bred there may have a different commitment to and involvement with the local community. Also, people moving into small communities may become more isolated than others, because of lack of long-standing local links.

Likewise, they commented on the multifaceted nature of rural communities. Many small communities have lost facilities such as a shop, post office, church and so on. Such villages and very small 'hamlets' have less of a focal point and therefore have much less community cohesion. Slightly bigger and more established areas were felt to retain community identity; for example, a view was expressed that it would be less likely for older people to die at home and no one be aware of this for weeks, as may happen in bigger towns and cities. Information about local communities was seen to be important for local councils, and local newsletters and papers were seen as useful as sources for those working in older people's services to learn about the local community and as means of publicising sources of support. Some slightly larger communities were said to be very resourceful, with lots of informal activity, which could be and were being supported with small amounts
of money. Patterns of services were highly varied, with residential care homes, for example, often being a long way from many people's homes even if care homes were in the county.

More specifically, in terms of actual IBs in rural areas, some people were described as ‘lapping it up’ in terms of learning how to manage their support needs, particularly around activities. People with experience of previous services who were not satisfied with these were more enthusiastic about IBs. However, some existing service users were reported to be fearful of losing what they had if they made a move. This raised the question of how to respond if people’s needs reduced over time to the extent that they no longer met eligibility criteria under Fair Access to Care Services (the threshold for eligibility for publicly funded social care) and whether the absence of the IB or other support would then contribute to increasing needs and ‘yo-yoing in and out of services’. Current high levels of eligibility criteria were regarded as restrictive to developments of support.

Aspects that facilitate personalised social care in rural areas were proving to be:

1. Being careful about contingency planning to reduce the risk of gaps in social care provision or to make sure that a sudden crisis or accident can be managed well – this may be more important as established resources may become less generally available (e.g. possible closure of day centres that no longer attract sufficient numbers).

2. Recognising that paying for transport is an issue for people accessing support but also for home care staff. If staff are paid for their time travelling, this adds to the cost of supporting people who may wish to stay at home and it may double or treble the costs involved. However, if staff are not paid for this then they may be exploited or will not be able to afford to work in rural areas, or in social care.

3. Acknowledging that this key issue of travel time may make it harder to use traditional agencies as they often do not employ local staff.

4. Information on advocacy schemes and about practical services, such as handyperson services and ‘traders registers’ for reliable and safe contractors, is often useful to older people.

5. The support planning process for IBs and personal budgets may often take longer and will need to be undertaken at the person’s own pace. It may promote greater control and independence in the long run but careful preparation will be essential. If it is led by the older person then it may be more empowering because the person will be able to design their own support plan. This means that older people will be the ‘experts’ in knowing what matters to them and what they want to achieve.
The IB Leads were also able to make some informed guesswork or predictions about issues that might emerge and new forms of social care that might be fostered by more personalised support. These included:

1. Different ways of providing respite care may develop, particularly ideas of neighbours, friends or paid care workers staying in older people’s homes.

2. Examples of lunch clubs run in pubs and of individuals with common interests becoming involved as care workers in an informal sense; these may be facilitated by personalised support.

3. The possibilities for local social enterprises were seen as greater in rural areas than in urban areas and of more importance, given the difficulties of accessing the services of larger agencies. IB Leads thought that examples from Control sites (early initiatives in self-directed support, mainly for people with learning disabilities) and POPPs (Partnerships for Older People Pilots) schemes may also contribute to such developments, using local funds to set up interest or activity groups; for example, fishing clubs and so on. It was felt to be cheaper to set up local endeavours, and this was considered to be a more cost effective option in rural areas.

4. Market development of social care was considered very important in rural areas among local small organisations which are likely to be able to provide services close to where people live. The concept of what is a service was likely to be questioned in this regard, and the blurring of the edges between informal, unpaid support and paid care work would have to be addressed.

5. The influence of ‘affluence’ when some people were able to pay for care but others are not was seen to be complex. While this may reduce needs among the local community for publicly funded support, the possibility of it disrupting local arrangements for informal help was identified. If more people are able to offer money to people to do things like make meals, for example, this may affect existing informal relationships.

6. Time banks (exchanges of time or resources in return for assistance) were mentioned as another example of potential local resources but were not yet available, despite being encouraged over many years.
Part 2
Experiences and expectations

This section reports the findings from 33 interviews with people working and living in rural areas (see Box 1). The material is grouped around the following questions:

1. What are the problems in rural areas that the personalisation of social care may address? (the context)
2. Is the personalisation of social care a way to change outcomes for individual older people? (process issues)
3. What might be the outcomes or results of the personalisation of social care for local rural communities, including older people and those supporting them?
4. Will the personalisation of social care affect rural areas differently?
5. Has your organisation been thinking about the specific implications for people living in rural areas?

1 Rural issues that the personalisation of social care may address

This section reports participants' views on how the personalisation of social care may address a number of rural issues.

There was general agreement about the many issues facing older people in rural areas and most participants agreed on what these were, despite coming from different parts of the country and different types of rural locations. Many of the issues they raised were interlinked. Participants were asked to think about these challenges in the context of the personalisation of social care.

Service availability and costs

Participants generally considered that traditional services could be more expensive in rural areas and, in some areas, there were said to be 'Very few local services to buy'.

Access to services

Even if services were available then rural locations could present problems of accessibility for older people and services, linked to geography and the weather. One voluntary group worker commented on the situation in very remote areas:
“Care workers will not travel to remote areas. For example, one lady lives out in the sticks – she needed a complex care package, people doing the care were found to be inappropriate, we tried to get other care workers but after much negotiation could not find anyone suitable. This lady had to leave her home, the place she had known and all her social contacts and live with her daughter.”

**Transport and travel**

Access to community services and facilities was reported to be often difficult for many older people because transport was a problem in terms of cost and availability: ‘even if it was available, taxis are expensive and fuel for private cars is expensive’. In many areas there were few public transport routes and the cost of travel from and to sparsely populated areas weighed heavily on older people.

One voluntary group member commented: “Access to social activities and services is dependent on mobility. We do have community transport, this is good but you have to book, anyone can access it and it can do long journeys in the area, but the booking times have to fit in with where the bus is going this can be limiting and can take time.”

Difficulties in getting care staff who are willing to travel were reported by many participants who provided services. Care workers used their own cars in the majority of cases (the costs and time often not being remunerated from agencies). One care home manager paid staff extra wages to cover these costs and teamed up workers who did not have a car with others who did so that the manager could fill shifts.

**Isolation**

The isolation of a minority of rural older people was of concern to many participants. The risks of isolation, such as depression and self-neglect, were said to be compounded by problems such as fewer community facilities, inaccessibility, poor and expensive transport. Remoteness could be the feature of an area or people could live outside general settlements as one community ‘umbrella’ organisation coordinator explained:

“Isolation is a problem, particularly if they have no mobility or difficulties in getting out. Some people live in isolated spots not close to other dwellings and distant from communities.”

2 **Is the personalisation of social care a way to change outcomes for individual older people? (process issues)**

This section reports participants’ predictions about the implications of the personalisation of social care, with a focus on older people in rural communities and the outcomes of these changes for individuals. It is important to note that the views of some people were that the changes would not be beneficial or fundamental unless accompanied
The personalisation of adult social care in rural areas

by major investment. “My only concern is that people will continue to get a second rate service that does not meet individual need” observed the manager of an older people’s project, conscious of the limits of resources. Others were uncertain if the personalisation of social care would lead to changes in all public services? “Will there be any universal services still or will all service budgets be devolved e.g. including subsidised buses at off peak times that may be predominantly used by older people?” “…What will happen to people who don’t want to take up direct payments within IBs?”

In contrast, a support organisation worker who was familiar with IBs noted the huge potential for “personalised budgets to make a real difference. Workers can be more creative, users of care services and carers can be more creative – it can be about the individual.” In this person’s experience “as individuals understand more about IBs they will demand more and more opportunities will arise.”

Others noted different opportunities and challenges. For example:

• “If IBs work, people may make different decisions than the council would have made” said the manager of a Direct Payments scheme, who predicted that domiciliary care would be used more but that “being a good purchaser is also essential. Older people may not have these skills.”

• “Older people want to go on outings; want culture and different things, they want to see family and they want to shop.”

• “The more flexible the money is, the more people will be able to cope in rural areas.”

• “Service availability is essential.”

• “The advantage will be that older people will not be tied to traditional services.” It will be care at their own convenience not that of the care company who put people to bed at 5pm.

Like many participants, a member of staff from an umbrella organisation of voluntary sector and community groups saw multiple advantages and said “If older people had relatives living close by and care staff then the personalisation of social care would be very good, but it needs to be overseen. The main thing is if care assistants/staff were treated as professionals, you would get more people to work in the care field. They need more kudos, care assistants need to be valued, trained and given recognition for what they do; they need a career structure. Care workers who are looking after ‘precious’ people (like child care workers) get recognition.’ Others thought that personalised care had the potential to enhance social inclusion for older people, particularly providing them with much desired personal contact. “They (older people) want time especially if they live in isolated areas” and with “people who understand them.” One participant thought that social care workers could potentially have greater job satisfaction and a more balanced relationship with service users and “maybe” do less paperwork. A worker with black and minority ethnic groups thought that support could potentially be more appropriate for older people from diverse groups and gave as an example the provision of care at times that might suit a person who had worked in the restaurant trade and who was used to eating later in the day and going to bed late.
The desired and desirable outcomes of the personalisation of social care were summed up by one person running a peer support group for older people who said “I hope that people will be able to buy more care, buy more support, buy quality care but it will be dependent on the availability of staff in the locality.” Another participant working for a care home provided a similar perspective: “IBs should enable much greater choice and flexibility in how people spend their ‘support’ money to meet the outcomes that they desire rather than having services imposed upon them that meet care managers’ determinations of their needs.” This participant was one of the few to mention the ability of IBs to cover items of equipment and thought that older people might want to buy electric wheelchairs or robust laundry equipment if they had the cash available and thought these would improve their quality of life. A participant from an IB site provided a range of examples of the type of purchases being made: “Equipment has been purchased as an alternative to a carer carrying out a task, for example, using a bath lift with a swivel seat has meant only one carer is needed, equipment has been purchased to alleviate strain for a main carer; for example, an electric wheelchair has been bought and an electric bed.” One participant thought that personalised budgets had the potential to enable services to be “more sympathetic to rural life” and said that older people appreciate workers who understand rural communities.

Having greater choice was an important part of the outcomes of personalised social care. It could be that people went to a bed and breakfast for a break instead of respite care, as illustrated by a member of a support group for people with IBs. Or it could mean that people would be able to choose who provided their care. One member of staff working with people with mental health problems said that this “may help to foster stronger community links or to maintain these. For example, ‘Mrs B’ has had help in the past from the girl down the road, a mum at home looking after her children, ‘Mrs B’ is now able to choose and pay her on a regular basis, which would benefit both of them.” However, she continued “On the other hand, if people are buying in ‘unregulated’ care, how is this going to be monitored and could this leave people more open to abuse?”

Some participants thought it was important to remember that personalised care and support were already operating to some extent and so the transformation desired was a matter of degree, and not complete change. For example, one group supporting older people with mental health problems had experience of tailoring support to meet their circumstances. The group reported how they used a taxi service where the drivers and managers know individuals. “We have a preferred firm where the taxi firm knows most of the clients; they talk to them and understand issues related to the individual, they are helpful and patient. Money does not get paid by the service users, we recoup that, and the taxi firm bills us, taking the stress away.”

Many participants considered that the advantages of the personalisation of social care also opened up new risks or enhanced them. As one older people’s group argued, “there will be a greater need to monitor the provision and quality of what may become disparate services to rural areas.” A care home manager considered that there might develop rather “disjointed systems of care.”
Other participants pointed out that the personalisation of social care would be unlikely to solve all the problems of growing old, in the countryside, or elsewhere. One representative of a group of older people in an IB pilot site considered that they “will be able to remain living where they are in rural areas only as long as services are available and can be accessed speedily and easily.” This group had observed that existing arrangements did have some advantages and commented “Without social services commissioning services, older people will be left to buy in what they need without the spending power and quality control of a large organisation. This means they may not get value for money and may end up with unmonitored, expensive and inferior services.” This group had some familiarity with the IB system and pointed out some of the intricacies of the system, for example, that people might have to pay for support brokerage. It was not the case as they would have liked that ‘one pound’s IB funding should equal one pound’s care’. A housing association worker pointed to “the loss of economies of scale.” And an advocacy group observed that if an older person is buying the services of a care worker who has to travel, there would need to be arrangements to allocate the existing 15% rural premium (extra funding agreed by some local authorities to some rural services) at source. “This must be taken into consideration for individuals buying support/care” its representative argued.

**Market stimulation**

Market stimulation or development was proposed by some participants as a way in which the personalisation of social care would encourage developments in rural areas that might lead to improved outcomes for older people. For example, there were predictions that there will be more “business enterprises emerging,” because “if there is a demand then services will start to emerge – more service provision that is local.” This was seen as a way to “provide services where now there are few” suggested the manager of a peer mentoring project. In a different area, an Age Concern director argued for incentives for companies to move into rural areas where populations are sparse and she proposed that any rural premiums, currently paid to companies providing social care in some areas, should be re-examined to ensure that they filter down to individuals.

The manager of a mental health service considered “Hopefully some enterprising people will see the gaps in the care market and make things better for those in rural locations.” However, some argued that it was not just more of the same that was wanted: “service providers will need to be sensitive to changing demands” said a Direct Payments officer drawing on experiences of older people embarking on this form of social care arrangement.

As noted above, a number of participants said that the key question for older people was the “availability of services” in rural areas. A sheltered housing scheme manager considered that there was a “need for care providers to form partnerships/consortia to ensure service availability is uniform across a county.” It was acknowledged by some participants that the profitability of providing services may not be at the same level in rural as in urban areas and this could lead to loss making services being withdrawn, especially if they were no longer subsidised out of
more profitable urban services. One care home manager reported that the Home charged more when people used direct payments to pay for their care than when it was funded directly by the local council. This is because the council has a contract for a set number of places for which the home gives a discount, as this income is guaranteed, even if a place is empty.

On the other hand, participants thought it possible that some providers may set up services specifically for people in rural areas to meet the expressed needs of older people. If this does happen, one older people’s group’s representative thought it likely that their costs will be higher than in urban areas if only because clients will live further apart and travel will be a big factor. The coordinator of a transport service that provides highly subsidised journeys thought that personal budgets might enable the scheme to put up its prices, because more people will be able to pay for travel, and that this would make their services more sustainable, if more costly, for individuals.

**Choice and control**

Choice and enabling older people to buy what they want were key threads and the following examples illustrated what people thought the outcomes of the personalisation of social care might be:

- freedom for older people to use money as they wish and to spend it on things that are important in their lives;
- older people particularly want social activities;
- individuals can come up with their own terms and conditions for care workers, time can be flexible;
- older people will have the opportunity to employ who they want;
- there may be a choice of people – different people for different tasks; and
- it will give families or the older person control, so long as all is well and if there are no disputes. Things could work out better by giving older people control that raises their self esteem.

**Changing expenditure patterns**

Examples were given of how personalised support could enable people to meet needs for company or social inclusion, and participate in ordinary or desired activities. For example, an older people’s campaigning group member noted that IBs could be spent on taxis and/or buses, even though “in rural areas both are very scarce and taxis are very expensive.” He observed that because transport in rural areas is costly it could take up “a disproportionate amount of an older person’s IB that should be spent on personal care.” This would be one of the changes of the personalisation of social care, but it might be controversial.

This group outlined a number of items that could be included under personalised support and which might help prevent ill health or disability, such as “painting houses, gardening, cleaning, ironing, housework etc, all of which have a very positive effect on older people’s
sense of wellbeing.” Money might also be spent on helping a person “go to the pub for a drink and to meet others to maintain social networks and reduce isolation” or to join clubs, especially in villages. This group predicted “greater use of Internet and IT especially for shopping. Webcams are very important and can allow older people to keep in contact with their families.” They noted that some people may require training to use computers and it would be important that courses are held locally, commenting that “the ability to use IT is likely to improve over time as today’s generations are much more computer aware and competent.” One Age Concern group reported that it was already running computer activities for older people. A group with experience of IBs gave examples of funding being available for a person to buy a laptop computer, pay for gym membership and travel costs to attend a drop-in group, all of which had increased people’s social participation.

**Localised support**

Turning to personal care, which was an area where there was great interest and much experience of this being the focus of council social services, there were predictions that personalised support would mean that there was greater likelihood that older people would be able to pay for care services that could be delivered by people living in their areas. This proximity was associated with better outcomes and welcomed; as one manager of an older people’s project suggested: “Carers who live close can deliver care when and where it is needed.” This would benefit older people who would not necessarily have the time or ability to travel to care services; “Having services that are provided in your own home means there is no need to travel miles.” A council for voluntary service officer considered that “This could be good for some especially where there are good support networks.” A housing association manager thought this might widen the pool of potential supporters and foresaw an “Opportunity to involve others, that is, not taking care-providers from the usual sources but accessing neighbours or other members of the community.” The need for more care-providers, support workers and so on could lead to more employment in rural areas.

Older people might be able to get the type of support they need at times that suit them with personal budgets. People who are prepared to work ‘inconvenient’ hours such as early mornings and later in the evenings could benefit and, in return, if it would be possible to purchase services from people living in villages and rural settings, then older people could continue to maintain their country lifestyles.

An advocacy organisation working across a number of local authority areas considered that the personalisation of social care might extend the availability of the workforce; for example, recruitment would be done by “word of mouth; local people know locals who are looking for this type of work.” Older people “often have good community networks and family close at hand” and so being able to use money directly might mean “people would be able to access care sooner.” Another group commented that home care agency staff were sometimes brought out to their local area from nearby cities and this “caused problems at times when care workers speak little English and did not understand local culture. Service users won’t complain as they fear losing care and allegations of being racist.”
An older people’s mental health group representative suggested that in places where there is a ‘real community’ then people will help more if the personalisation of social care promotes flexibility and informality, and thought that this might help with community cohesion. Another predicted that if local people were trained in care work, the outcome would be better employment opportunities for local people. In turn, this could have an impact in that younger people would not travel away to work and they would use local shops, helping the local economy and regeneration.

However, longstanding issues might remain despite the personalisation of social care, such as the need to look at legal ‘duty of care’ responsibilities by those supporting older people or for older people who are at risk of harm (some asked if these duties would still exist and did not appear to be convinced that local authorities’ duties of care would remain) and the quality of services, which were reported to be a continued problem for Direct Payments schemes. Some argued that the availability of services might well limit what can be bought by older people and that agency care coverage would likely continue to be patchy. In the opinions of a small minority IBs were seen cynically as a way for local government to offload its current responsibilities.

While targeting social care services (providing more to fewer people in greatest need) has been used as a way to meet people’s needs with what is available from the local council, there was some hope that IBs may expand the range of what money can be spent on. This might make money go further by bringing in other forms of support to enable people to meet their needs differently. This could have positive benefits for older people but did not necessarily apply to any more or less extent to those living in rural areas than urban areas.

**Workforce issues**

The potential for improved outcomes for older people lies in increasing workforce availability, skills and roles according to many of those interviewed. Specific points were that the personalisation of social care might lead to a greater blurring of paid and informal support. “Local people in rural communities do assist older members of the community anyway, but IBs may lead to them receiving some money for the help they give in cleaning, shopping and so on” reported an older people’s group very familiar with the IB pilots. This could mean an increase in the numbers of people working in the care workforce but roles could be unclear.

Participants reflected upon the workforce implications of people paying for or arranging personalised support and how these might affect outcomes for older people. Most thought about the effects on personal care, since this was the main type of support needed by older people to remain living at home. Their predictions included:

- Skilled, well trained, local people that are valued would be needed and the voluntary sector would have to be involved in: monitoring, information, developing of befriending, development across the board.

- There would be a need to address practical and legal matters and to
think of indemnity and the costs of training and costs of travel if staff were not local, and how these might add to the cost for the individual older person seeking support or needing care.

- Training would need to be a prerequisite for anyone who is a care worker: covering manual handling, first aid, food hygiene, home safety and so on and especially for complex needs.
- Questions would emerge about what might happen to an older person if a care worker or relative goes sick? Would there be a pool of staff that can cover such gaps?
- Part time, cheap and local staff would be most likely to be in demand; not necessarily those with skills or experience.
- There may be a need for staff such as bookkeepers and/or administrative staff or personal assistants to undertake administration around employment and other legal aspects of care provision. This will also come at a cost and it may be the older person who will have to meet these costs, with the effect that they have less to spend on other things. These professionals might work in local support services, such as Centres for Independent Living.

One mental health group with experience of working in an IB pilot area said: “Workforce issues – who helps to administer these? I anticipate some people having problems with this aspect. There are several home care agencies in this area and, traditionally, it is a town full of part-time workers, so there maybe more of an available workforce. Will people poach carers that they already know, from existing agencies, how will this affect the agencies and their business?...I’m sure that there are plenty of people who would like this type of work, not office based, because it is practical, and people work, and it fits with their life style. On the other hand, individuals may not have the skills required to work with certain groups, such as the elderly, mentally ill, learning difficulties etc. There is a difference between thinking you can do a job and actually being able to do it. Possibility is that people might start with someone and not be able to maintain this for various reasons. One of the main issues for clients is that they want consistency and reliability of home care; they don’t want to be telling different people the same thing, over and over again.”

There seemed to be some optimism about the potential for increasing the pool of potential care workers so that outcomes for older people might be better but this was often related to local circumstances. Some mixed views emerged about the greater formality of support for older people and the opportunities and risks this might present:

- “Neighbours may be paid for what they currently do without recompense.”
- “There probably aren’t the right people in rural communities who have the right skills and experience who are willing and able to undertake care and support work in rural areas.”
- “If less well-trained people undertake care and support, there is a great potential for the job of caring not being done properly or professionally and also for financial and other forms of abuse. They will lead to a devaluing of older people’s quality of life.”
• “(We) need to explore women at home with children, or fit older people who have hours to spare as potential workers.”

• (The work) “may appeal to people who are not traditional entrants to the care labour force, for example, retired people and others who might not otherwise have come into the care industry.”

**High wage and high cost areas**

Workforce matters were reported to be particularly difficult in areas where wages were high and the cost of living affected workforce availability. In one area, the local umbrella organisation for community and voluntary groups considered that, as the personalisation of social care developed, then the “availability of personal care assistants could be a problem; in this area we have almost full employment, house prices are high and low income families have little chance of renting. There is a shortage of people to recruit and additional travel time and cost because of distances one has to travel. This will limit choice and reduce flexibility.” This participant added “fewer young people stay in the area as we have no universities or higher education facilities – they go away and tend to stay away. We also have a higher than average disabled population.”

This was not a lone example. One older people’s support group commented “People tend to be affluent in this area; they work in the towns and cities and commute for high wages.” However, in the same area, one participant thought “There are a lot of untapped potential older people, disabled people. People with learning disability could offer a shopping service, I have seen this in action it works well” and added, “if young adults in school could see benefits they may look at caring as an option” or “young mothers with a few hours to spare” might be able to offer some hours. From another area, an advocacy group also identified young mothers with children at school and unskilled people who could be ‘skilled up’ as possible workers but argued “If we want staff from the local area, there needs to be an investment in training. Pay must be comparable to cleaning or casual work.”

This latter point touched on the low image and status of social care. “Caring is not seen as a respectable area of work” said one participant from an older people’s support organisation, who thought that there was no career progression for staff.

**Supporting the workforce**

Participants identified a number of risk factors affecting workers who might be employed directly or indirectly by older people. “In some areas you cannot get a mobile phone signal and if you get lost or break down it can be frightening” or a worker might “get an aggressive client – what do you do?” “Direct employment might put the care worker in a difficult situation if there is some row or disagreement” and that some people might be open to exploitation.
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Charging and Paying

The view was expressed that rural older people (but not necessarily attributable to their rurality) were cautious in spending money and that this might affect their attitude to spending on themselves. One community group worker said:

“Older people have a problem with paying; they have difficulties with the value of things, i.e. going out for a drink. Young people will think nothing of spending £50 on a night out; this is an enormous amount for an older person. The cost of services will be a drawback so people will have to be informed so as they understand.”

Information and support agencies were seen as being the key to addressing these issues, as well as older people’s groups that might help to convince some older people that they should take advantage of new opportunities. Older people were thought to need an indication of what they can expect to pay for certain services so that they will know if they are getting a fair deal.

Some participants considered that charging and paying for social care services were enduring and controversial subjects in rural areas. One community-based organisation working around prevention of ill health and loneliness commented that many older people have traditionally not paid for services and so will not pay a realistic fee for any support, and that voluntary organisations do not like to charge for their services. Both older people and voluntary sector groups might need to rethink what they mean by realistic prices and this might require a cultural change. This subject was not necessarily linked with whether older people had low incomes and limited resources but might be a generational matter.

If people had to pay commission or a fee for the management of their own care package this might mean that the older person might become very reliant on that organisation thought one participant. In general, participants thought that these arrangements would need to be clearly spelled out.

Privacy and confidentiality

Some participants raised issues around confidentiality that they thought concerned many older people living in rural areas. These sometimes affected older people’s willingness to accept support or to participate in activities that might demonstrate, for example, that they are getting frail. One community group worker said:

“Older people do not like to admit failings, and would be embarrassed about everyone knowing, so they might not want known persons caring for them”.

Others thought that “small communities tend to know everything” and that there was frequently a “lack of confidentiality” in the countryside. “The lack of anonymity in rural areas and especially in villages means there will be the potential for a loss of privacy” suggested the chair of
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an older people’s group. An advocacy worker said “Familiarity breeds contempt; some people gossip, others find this disdainful, and people who are frail do not like neighbours knowing that they cannot cope or have problems.” Some of these issues were said to be similarly relevant to older people from migrant groups who were said “not to want anyone to know that a family cannot cope.”

Others linked this to their feeling that older people in rural areas were sometimes characterised by a sense of independence. “Rural people are self-reliant; when they start failing there often is a reluctance to ask for help, they do not like bureaucracy and hate filling in forms” said a community group chief officer. One participant, who runs a carers’ group voluntarily, said that many older people like herself “have never asked for anything and do not like asking for help from strangers.” The outcomes of the personalisation of social care might not be as positive as they could be if these matters are not considered.

3 What might be the outcomes of the personalisation of social care for people in rural communities, including older people and those who support them?

In this final section, participants report their views or predictions of the wider implications of the personalisation of social care for rural communities.

Information and advice, including the role of older people’s organisations

An older people’s group representative argued “There is a need for IBs to be publicised and there needs to be better communication around the implications and responsibilities IBs bring.” This person noted the need for sensitivity around such publicity and remarked, “Older people are less likely to discuss financial matters in public and they need and require confidentiality. This means that although here has been an IB pilot area, people who have decided to use IBs are largely invisible.”

A housing association manager considered that many older people “will probably need someone to assist them in accessing the services they require” and some “may well need assistance in understanding what IBs actually mean and what can the money legitimately be spent on.” Others agreed and one added “People in rural areas will need a great deal of support for self direction; like keeping accounts, looking at services, this could be good because this then gives people control.” A voluntary sector umbrella group worker considered that many older people “were not familiar with IT solutions to some of the administration problems like banking online or email to send information to an agency about payroll matters, for example.”

Some of the participants in this study saw new roles for their organisations in this area and some argued that signposting has long been their role. “People need to know where to buy services from – we inform people that are directed or referred to us or that we know about.” The importance of thinking about language and communication resources in rural localities was highlighted by a worker for ethnic minority groups.
Coverage and quality of care

The personalisation of social care was seen by some to create a demand led, user focused service. Therefore, they argued, it would be essential to inform older people that there are (still) eligibility criteria for public services and a person would need to know if he or she would be likely to meet these, and to learn about any other services available. There is a potential danger that those people most in need will not be empowered to take up services and so public funding may still have to provide outreach staff to ameliorate this, argued many groups with experience in this area of work. These outreach services may incur high per capita costs in isolated and sparsely populated areas they warned.

A number of participants were cautious about major change. An older people’s mental health group thought the new system would “need testing or piloting in this area as there are a different lot of upwardly mobile young people who do not get involved in community life” and that staff or volunteers might not be readily available. A care home manager considered that there might be a risk of “unrealistic expectations” that care and other support will always be provided “when in reality they cannot be.”

Many participants were very concerned that “older people are open to exploitation” and that arguments over resources could lead to “neighbours falling out” and “community in-fighting – factions with fall outs” that would be especially difficult in close-knit rural communities.

There were also concerns that long standing problems would not necessarily be resolved by new systems:

- The shortage of employable people would remain.
- Training is expensive and in short supply, and necessitates investment.
- If an older person employs someone they will not necessarily know about training, who pays for it and where it can be accessed.
- There are already difficulties with agency staff who don’t turn up, who may not be flexible, who are unsuitable, who do not get paid for travel time so spend little time with individuals – these may not be resolved.
- There are not enough trained people who understand the needs of people who have problems making decisions, because of problems such as dementia.
- Older people’s houses in rural areas are often far apart and travel can be a problem for staff. Directions are often difficult in remote areas. Care workers do not like travelling in the dark or poor weather conditions. Road surfaces in rural areas often are not looked after, making them potentially dangerous.
Lack of support

There were numerous concerns about the risks of a lack of monitoring arising from changes in local social services practice and the nature of personalised support. Some participants thought that a lot was being expected of family carers. A mental health group worker asked “How are tired and frail people going to handle paperwork, recruitment and managing care for their loved one?” Another thought that there would not be “the people around to see if care is appropriate.” Many participants predicted problems that might arise if people chose to take their personal budgets as ‘cash for care’ models, such as Direct Payments, and commented on the risks of lack of support:

- “My fear is that the new changes could be problematic in that as it is now social services led there is a quick response if there are problems. This could be hampered if people are employed by agencies or by the individual.”
- “Rural areas tend to be more remote and there may be monitoring issues around ensuring money is spent appropriately.”
- “We need to have monitoring and mechanisms in place to help support people, otherwise older people could be exploited.”
- “Lots of people have problems already just managing their day-to-day finances and post. Which organisation (if any) is going to take responsibility for helping people administer IBs?”
- “There needs to be a system in place for when people cannot manage the IB (ill health, stress) and this needs monitoring.”
- “It is onerous for older and often frailer people managing money, and onerous if they have to manage and employ their own carer, this is a huge responsibility.”
- “If a person is left without the care provider they could be at risk over sickness, holiday, emergencies.”

The need for contingency planning for emergencies was raised by some participants. An Age Concern group Director, for example, commented on this risk on the basis of recent experience:

“An old gentleman, who was frail and had Alzheimer’s, had a package of care organised by his nephew – shopping, cooking, cleaning, checking everything was well. The person doing this went on holiday for a month, nothing was put in place. Age Concern was contacted by a neighbour. When we visited, the person was in a poor state. This package was privately arranged with no outside input, no monitoring and no contingency plans, and a crisis was imminent.”
Mistreatment and neglect

More seriously, there were concerns that older people could be placed at greater risk of abuse and neglect. “If relatives are not around to monitor (then older people are) open to abuse” and fears that “Care in the community by the community is open to abuse, with carers not doing what they are supposed to do” that would be exacerbated by personalised care systems. To counter these risks some respondents asked if IBs could free up social workers to take on more traditional social work tasks, perhaps becoming ‘care navigators’ working alongside the customer providing advice and support? Or would social workers be faced with the challenge of reassessing their role? Systems of safeguarding were seen to be jeopardised by the personalisation of social care, such as checks and vetting, criminal record and POVA checks. “Just letting someone from the village or locality do the caring is not good – it is wide open to problems” commented the Director of an Age Concern group. While support organisations could offer a variety of help with such checks, this needed to be readily available at recruitment stage.

4 Will the personalisation of social care affect rural areas differently?

“What is rural?” asked one participant who was not sure that urban:rural divisions were easily compartmentalised and added “even larger towns in rural areas may not have the services that are available in cities.” For some participants there were no real differences arising from the personalisation of social care in rural areas compared to urban areas, apart from the need to overcome greater risks of isolation. “I don’t think that there are many differences in rural areas than in urban areas, (but) this interview has highlighted some of the difficulties, and the need to look more at the implications” said one participant. Others said they would like to think the personalisation of social care will give people in rural communities more choice and promote equity with urban areas. “The expectations of people living in this area are not great; hopefully it will raise expectations and will help quality of life, giving informed choice.” Another believed that:

“I think that changes will affect everyone differently dependant on their perspective on what care should be like. It will take longer for rural communities to take on board the benefits of such payments although they have the most to gain as they currently receive a reduced service because of geographical constraints.”

Some held that there were wide variations between rural areas. A mental health group worker said “I suspect that it will all depend on what is available locally, some rural areas will have more resources than others. Some will have more of a pool of available people and services.” For example, contrary to other areas, one support organisation in an IB site reported very little difficulty in attracting staff to work in care or support roles. A carers’ support worker thought that “older people living in rural settings want to access the same as anyone else: theatres, pictures, restaurants, meeting folk of their own age.”
Others held that there were rural variations. Without regular visits and contact from professionals and limited contact with family, friends and neighbours, older people could easily be forgotten, especially if they live in isolated properties, said a group of older people. The lack of street lighting in rural areas means older people are much less likely to go out after dark and, in winter, this can mean they are confined to their homes for long periods. This was one example of ways in which isolation becomes a risk in rural communities.

Benefits to the wider rural community were considered possible, because current services such as sports, community centres, shops and so on may be used more and made more viable.

Because older people in rural areas are not concentrated in particular areas and are less likely to go out, they tend to be less visible than their counterparts in towns and cities. Many participants argued that they felt that rural older people were often forgotten. They argued that additional investment and effort would be required to achieve greater independence and well being in later life for those living in rural areas.

The development of satellite offices of existing organisations may occur as a means to satisfy the need for localised services and this might benefit community and voluntary groups. Mixed opinions were given about the complex interplay of personalised care and support and other changes in rural areas:

- IBs could lead to greater community involvement or spirit and increased employment opportunities.
- But, it could also mean some services are withdrawn or close.
- Where support comes from could become an issue, e.g. use of volunteers, friends, families rather than professional care-providers could lead to tensions and *vice versa*.
- The private and voluntary sector may be better placed to provide services with fewer restrictions and red tape than the statutory sector but may not be so trusted.
- Travelling times for care providers could be reduced.
- There may be little improvement to the overall levels of income and skills in rural areas.
5 Has your organisation been thinking about the specific implications for people living in rural areas?

This study asked people about the need to develop personalisation of social care differently in rural areas. Those living or working in IB pilot areas had been addressing these issues for nearly two years, although some said that this study proved a welcome opportunity to explore the rural impact of the changes. “We have started a dialogue with the local social services departments especially around issues of protection which we see as a concern if new players are to enter the care and support system with unknown levels of skills, training and professionalism, leading to the potential for the elderly to become prey of unscrupulous providers and individuals” said the chair of an older people’s group.

Even so, in some of the pilot IB areas voluntary groups had mixed views about the development of the personalisation of social care despite two years of local experiences. For example, one group said: “Implementing – as an organisation we have not been involved in any thinking or planning, as said before, we have not yet had any clients who have taken up IBs or who have expressed an interest in doing so. There appears to be very little information out there about when, where and how this is all going to happen. We anticipate advocacy issues around this, perhaps negotiating with IB budget holders, carers and care agencies, perhaps advocating to social services for clients to have IBs. I think we would be concerned about becoming seen as mediators for what is essentially a consumer issue, something that perhaps should be dealt with by the Citizens Advice. As far as I am aware we would not wish to become a broker for the service or administer this.”

From other areas, the key message was that the voluntary sector would ‘need to look at its remit’. Specific measures being considered were:

- “Looking at charging for some services that are now free.”
- “Working on a draft strategy that is keyed into new social care changes.”
- “We need to look at potential outcomes, lots of discussion/meetings looking at plans for the personalisation of social care.”

Some voluntary sector and private providers that had been working on the subject were part of larger confederations or groups (for example, Age Concern). By contrast, many smaller groups had not yet heard of the personalisation of social care agenda. It appeared that rural issues have not been looked at specifically, although there has been a focus on older people generally led by older people’s campaigning groups.
For older people and their supporters

There is a need to improve understanding of the range of systems for personalised support that is available under the title of personal budgets, to both raise the advantages of Direct Payments but also to publicise the availability of other deployment options, including retaining the services of a care manager and of council services. Older people may benefit from contact with support organisations and people with experiences of personalised support. Discussions about the realities of setting up support plans, especially around risk management, will need to be well structured and timely. Equally, careful planning and good communication will be important to allay fears that people will be left unsupported, or that local authorities no longer have a duty of care, and particularly to ensure that there is contingency planning to cover unforeseen gaps in care. This latter point emerged as important in rural settings among several participants who knew that alternatives are often difficult to arrange at short notice. Peer support was valued by many but participants argued that it will need to address matters of confidentiality that may be of importance to older people and minority groups living in rural communities.

The role of Older People’s Forums and other advocacy groups will be an important way of transmitting the values of the personalisation of social care. These groups need to be involved in plans for change and may be able to communicate effectively and persuasively with other older people’s groups that do not have social care as their main focus.

Experiences of self-assessment and support planning need to be passed on to older people who may fear or not understand the jargon of the processes. While some may require support, advice and encouragement just at this stage, support with administration may also be needed in the long term, if the older person chooses this system. Confidence among older people who have community leadership roles will be important to foster since these are important and trusted sources of information in many areas.

This study identified a number of fears that the personalisation of social care would leave people to ‘sink or swim’. The model of Direct Payments dominates current discussion and older people need to be informed of choices of deployment in terms of the different ways of managing personal budgets.

Many older people are well informed about all the myriad of changes taking place under the banner of ‘personalisation’. Some may know more than many professionals. Opportunities for them to share information and to challenge misinformation may be helpful in local communities.
For voluntary and community groups working with older people

This study revealed that the advent of personalisation will impact upon voluntary and community groups for older people at different levels. They will have to consider how the personalisation agenda fits with their values and roles; consult on the implications; and link up locally with others in their areas of interest and speciality. Some will have a vital role in offering opportunities to listen to older people, to provide them and their carers with advice and support, or signposting people to the right place. Others may wish to undertake monitoring of local developments and the ways in which the Department of Health money to support the development of the personalisation of social care (the Transformation Grant) has been spent. They may be important sources of information for public services about threatened changes in local social care markets. Some will see a potential role for themselves in becoming peer support organisations or to become brokers and support personal budget administration. The voluntary and community sector will be also a key group in seeing how far the other policy goals set out in Putting People First are delivered beyond social care.

This study did not reveal much contact between older people’s organisations and Centres for Independent Living. These links may need to be fostered. Older people are also major users and providers of advice and information services and current cuts in some of these services mean that local authorities and their partners who are commissioning advice and information services should take particular care over duplication and gaps. Local sources of information are important and village contact schemes, where people are paid to assist, have been one way of improving access to information services at very local levels (see, for example, Village Agents in Gloucestershire https://www.villageagents.org.uk). Voluntary and community groups may be able to collect data about the impact of changing patterns of provision, including any problems with accessing services over long distances.

Voluntary and community groups in rural areas will also have to address issues of payment and charging. These may be hard to tackle in rural communities, with the stigma of poverty and desires for privacy. Some groups, such as Age Concern Cheshire, have embarked on consultations around this delicate subject for the voluntary sector and the personalisation of social care will likely compel greater discussion around this subject, not least the risk of financial abuse and the practical issues of payments and financial arrangements. Some voluntary groups or carers groups may wish to take on a brokerage role. In many rural areas these possibilities are currently being explored.

At the level of encouraging older people to have greater expectations for their support, a community development model may be particularly appropriate for the voluntary sector. Links with the prevention agenda, such as LinkAge Plus pilots and the pilot Partnership for Older People Projects, may be usefully made. Age Concern Oxfordshire City and County’s recent report (2008) is one model of collecting and listening to the views of older people in rural areas.

This study revealed voluntary sector groups’ concerns about funding, first for meeting expectations that might be higher among older people...
and their families because of greater public discussions about the personalisation of social care and second, whether funding would be sufficient particularly where costs might be higher, as in rural areas. The voluntary and community sector will have a key role in shaping and monitoring change as it affects older people who use their current services especially where these are funded by the public sector.

The change from block contracts, for an activity or places in a service setting, will affect voluntary groups that may have to think afresh about the viability of their activities. Economies of scale may be less evident. Negotiations and discussions with local commissioners in the public sector will need to manage the risks of making changes before alternatives have been secured. If transitional arrangements are to be short-term then this needs to be made explicit.

For private sector providers

We did not come across instances of planning and modelling scenarios in this study, developing business opportunities, collecting market intelligence, but these are clearly occurring. Investigation of local authority commissioning plans would be of value in gaining further understanding of the potential for developing different approaches to market development. Further, the Department of Health funded evaluation of the Individual Budget (IB) pilots due to be published later in 2008 will illuminate some of these issues. Private sector organisations may find it helpful to work with older people’s organisations to learn more about consumer views and how these are changing as well as conducting market research among existing service users and staff. It will be important to learn what older people will want to buy. Managing change, especially the move from block contracts to individual resource allocation, and the management of risk and viability, will need detailed discussion and negotiation with commissioners.
As the private sector is the majority provider of care homes and home care services, this sector will need to be involved in thinking through the implications for residential and home care services in particular. This raises a number of questions? Will there be greater call for short breaks in the countryside, not necessarily from rural older people? Will people wish to relocate to care homes in rural areas using funding from urban councils? Will there be workforce shortages if more people employ their own staff directly, or will home care agencies and care homes be very attractive employers because they will provide training, backup, guarantees of health and safety provision, and continuity of employment? Will social care businesses take on new areas of work to meet older people’s expressed needs? These questions do not only apply to rural care providers but the rural elements provide for highly localised contexts.

For statutory services

This study revealed the need for local councils to work in partnership with outside agencies and to consult with rural interest groups as well as traditional social care service user and carer groups. There are clear needs to be more explicit about how the personalisation of social care will join up with safeguarding and other strategies, and how existing rural strategies might be affected by the changes of personalisation. These apply locally and regionally. Personalisation is about more than social care but social care is likely to be a key to its success as will the availability of accessible and high quality information and advice about what is available. Communication with the public, particularly older people, though a range of methods that are accessible and reach ‘hard to engage’ groups is needed. This study revealed that it takes much time and effort to inform people about changes, particularly while these are evolving. For example, many participants did not recognise that local authorities retained duties of care. The difficulties of decommissioning services that people do not want to use, to manage the transfer from block contracts to individual purchasing, decisions about cost of satellite services versus the efficiencies of centralising services, should not be underestimated. The reality of the implications of enabling choices of support needs to be addressed, because some things will likely go wrong. Monitoring impact over the long term will need to be a commitment, not just to address budgetary implications but to establish if the outcomes of improved quality of life are being achieved.

As noted above, one key message for local councils and their partners, especially where services are integrated, will be to explain that the personalisation of social care is not the enforcement of Direct Payments. Choice and control are main themes of personalisation and the different choices or deployment options need explaining to older people, staff and other stakeholders. Older people may be the very people to do this.
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The personalisation of social care will also have an effect on the social care workforce, as many participants observed. Some were optimistic that new employment opportunities would emerge and saw this as a way to sustain local economies and communities. Others foresaw greater instability and disadvantages for careworkers. Local councils will need to manage these risks with partner organisations and through local needs assessments.
Recommendations

Relationships are crucial. Without good working relationships the adoption of new ideas and new working practices is likely to be problematic. The Commission for Rural Communities will build on existing partnerships with key national stakeholders to take forward the following recommendations to support the effective implementation of personalisation of social care services in rural areas in the three following main areas:

Rural Proofing:

- The Department of Health and partner government departments should continue to ‘rural proof’ its policies and programmes relating to the personalisation of adult social care, to ensure that they take account of rural circumstances and needs to promote equity and equality.
- ‘Rural proofing’ is a mandatory part of the policy process, which means as policies are developed, policy makers should:
  » consider whether their policy is likely to have a different impact in rural areas, because of particular circumstances or needs;
  » make proper assessment of those impacts, if they are likely to be significant; and
  » adjust the policy where appropriate, with solutions to meet rural needs and circumstances.

Within this, the following issues need to be considered as part of rural proofing:

Research and monitoring

- The long-term effects of the personalisation of social care need to be monitored and assessed to ensure equitable outcomes in rural areas and that it is fulfilling its promise of greater independence and well-being for older citizens.
- It will be important to carefully examine the impact of personalisation on rural premiums in social care as part of resource allocations, on service commissioning and at the level of individual resource allocations.
- The effects on the workforce need to be considered both in respect of their current activities but also to consider the effects of personalisation on the rural social care workforce currently and in the future. Who will be able to act as mentors? What will be the effect on social care workers if they do not have the opportunities to build up employment and pension rights?
- Self-assessment and support planning for older people should be examined to see if there are significant urban/rural differences that give rise to inequalities or different outcomes.
- The impact of the personalisation of social care on community structures, businesses and social enterprises needs to be explored, by talking and listening to older people and considering the outcomes of the policy. We need to continue to assess the impact on providers, the workforce and older people’s supporters, such as family, friends and neighbours.
Quantitative and qualitative longitudinal research into take-up and usage of personal budgets, costs of services in different types of area, effects of distance and other geographic factors on service levels, supply and costs will enable a robust evidence base to consider the long term rural impact.

Implementation

- Older People’s forums and other advocacy groups have an important role in transmitting the benefits of and reasons for the personalisation of social care. They need to be included in communication strategies developed by central and local government.
- Information, support and guidance need to be easily accessible to help older people undertake self-assessments and to be engaged in planning their own support.
- It will be important to foster and measure confidence in the benefits and processes of personalisation among older people who have community leadership roles.
- It will be important to explore links with the prevention and early intervention agenda, such as LinkAge Plus pilots, Partnerships for Older People Pilot Projects and housing services at district level.
- Voluntary and community sector groups should have a key role in monitoring the implementation of the personalisation of social care and in listening to and learning from individual older people’s experiences. This will help them design accessible systems.
- Managing change, especially the move from block contracts to individual resource allocation, possible decommissioning of existing services, and the management of risk and viability, will need detailed discussion and negotiation with commissioners.
- The private sector will need to be involved in thinking through the implications for residential services and home care provision, in particular, and in developing new services for new and existing markets.
- Local councils will need to work in partnership with other agencies and to consult with rural interest groups as well as social care service user and carer groups in order to deal with market failure, to help business planning in social enterprises and to communicate the basis for change locally.
- Monitoring impact over the long term will need to be a commitment, not just to address budgetary implications but to establish whether or not the outcomes of improved quality of life are being achieved.
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References


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About this study

The study was commissioned by the Commission for Rural Communities (CRC) as part of its programme of work on rural disadvantage and access to services.

This paper was written for the Commission for Rural Communities by Professor Jill Manthorpe and Dr Martin Stevens from the Social Care Workforce Research Unit at King’s College London. It was supported by the CRC Adult Social Care Group, which included representatives from Age Concern, the Social Care Institute for Excellence, the English Community Care Association, Department for Environment, Food, and Rural Affairs, the Local Government Association and the General Social Care Council.

The study was undertaken by the Social Care Workforce Research Unit at King’s College London between February and May 2008. The study received ethical approval from King’s College London and composed three phases, 1) a review of the literature and policy context, 2) a focus group discussion with lead officers from local councils that have been piloting individual budgets in rural areas, 3) interviews with 33 people working with older people in rural communities, 14 of whom had experiences of individual budgets in their areas and 19 of whom were working in other rural communities (see table 1). All were asked to explore the implications of the personalisation of social care for rural older people. Interview data was analysed by a process of comparison to explore experiences and perceptions of personalisation.

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