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Putting People into Personalisation

Relational approaches to social care and housing

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ResPublica
changing the terms of debate

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Executive Summary

“Older people’s needs are rather far more social and relational, and it is this aspect – not greater choice and individual empowerment – that is in need of greater supply. Older people can be active producers of social capital, rather than simply consumers of public services.”

The governing philosophy of modern public service provision is that of individual empowerment: it is believed that if people have the power to choose, their needs will be met by the services that they select. A whole industry has grown up around this philosophy, but it unfortunately cannot deliver on what people really want and need – other people. The needs of older people in particular, which this paper primarily concerns, cannot wholly be met by enabling them to become more powerful consumers of public services. Their needs are rather far more social and relational, and it is this aspect – not greater choice and individual empowerment – that is in need of greater supply. Older people can be active producers of social capital, rather than simply consumers of public services.

Choice cannot be the organising principle of life. Human beings want and need to organise themselves around the hopes, interests and ambitions for themselves, their family and their community. If they had the choice, people would choose the ‘good life’ above all other things. Older people have a clear vision of what a good life looks like. This includes the opportunity to maintain relationships, build new friendships and to contribute something of value to those around them. Older people themselves and their families are best placed to define and achieve a good life, but they need services to reshape themselves around their goals and to take an ‘asset- or strengths-based’ approach, starting with the question “What can you achieve and contribute?”, not “What do you need?”. Services that do not

think in this way may not only fail in enabling older people to stay safe, well and active: they may inadvertently isolate or disempower the very people they aim to support. Services cannot replace relationships, but they can support people to maintain existing relationships and to develop new ones.

This paper argues that 'demand-side' reforms such as Direct Payments do not on their own result in a change of provision in the care and support market. It asks what 'supply-side' reforms might be needed in order to bring real choice – the choice about the shape of their lives – to those newly 'empowered' 'consumers'. The goals of the care and support sector and its industry of providers might well be radically misaligned with the wishes of older people. Helping individual older people to choose between established offers cannot bridge the gap between what people want and what they are supplied. Furthermore, the goals and wishes of many older people cannot be delivered by services at all. For them, the focus on more empowered consumption of services has entirely missed the point.

If public service provision is currently based on such a model, what can be done to bring older people's real needs back into alignment with what we supply? This paper attempts to put people back into personalisation and explores the various ways in which human

needs can be met and their skills harnessed by existing and new models of support.

We argue that providers of care and support should develop new approaches that are better aligned with people's relationships. Public services must help foster a wider sense of shared responsibility and reciprocity in all that they do. Individual choice and control are vital, but paradoxically, being able to act collectively brings people more real power than acting alone. This paper argues that working at a scale above that of the individual – at a family-sized or micro-scale, of a small group of people – helps to deliver this transformation. This paper gives examples of how even large organisations and systems can think 'micro' (working with small groups) and that a 'micro' ethos can also be spread through creating new kinds of soft infrastructure which resemble franchise arrangements and social networking structures.

The Care and Support White Paper and Care Bill attempt to reframe care and support for older people as preventative, community-based and empowering. However, we conclude by warning that in their commissioning practice and their approach to regulations, public services and councils remain a long way from being to realise this vision.

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1. Introduction:

What are older people looking for from housing?

“For most of us, our home is the most important space in our lives. It is our shelter from the outside world and the place where we accumulate possessions. But much more than that, it is usually the site of our most important relationships.”

When the care and support of older people is considered, housing is too often neglected. There are many papers on how to make houses more age-inclusive and communities more physically accessible, but fewer on ways of offering housing with support as part of strengthening people’s relationships and sense of community.

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Due to our failure as a country to build age-inclusive housing, coupled with a common progression ‘up’ the housing ladder as families grow and the subsequent need to ‘downsize’ in later life, many older people find themselves needing to move out of a longstanding home at a time when the relationships and community which it contains and symbolises are at their most fragile and may already have started to unravel. In place of that home, people may be offered a place which offers few connections into the surrounding community: in some cases, merely a room in which a lifetime of associations and memories are reduced to a few pictures and treasured possessions.

Great housing and care helps older people to maintain and build a sense of self and their important relationships. But the housing, care and support sectors face a multitude of crises: state social care budgets which are projected to bankrupt councils within 20 years; a failure to create the conditions in which people with higher incomes can insure themselves against catastrophic care costs; and a litany of reports highlighting recurrent failures of practice, often linked to over-stretched, underpaid workers and outdated models of care.

Even where well-funded and designed housing and care services provide safe, clean and pleasant physical environments, people relying on services for their contact with other people can remain lonely. Isolation and loneliness are increasingly recognised as major public health and well-being issues for older people and they are challenges which are particularly resistant to service interventions,¹ particularly those interventions which commodify, professionalise or marketise what John McKnight calls our “common capacity to care”.² They are addressed when people are able to spend time with family and friends and not by someone who is paid to be with you. Similarly, feelings of worthlessness are often best tackled by having something genuinely worthwhile to do.

There is considerable evidence that older people – including those with care and support needs – are not just looking for

ways of meeting their support needs, but are also looking for ways of enjoying a range of family and community relationships and of continuing to contribute to the life of their area. Around the fringes of traditional housing and care services, older people are being offered – or creating for themselves – new, more reciprocal relationships in which everyone is seen as having something to offer. These ‘strength-based’ or ‘asset-based’ approaches are often highly cost-effective, because they work with and help sustain contributions from communities and from older people themselves, supporting rather than inadvertently replacing or undermining ‘real’ relationships.

So how do housing and care providers help older people to build an environment which is not only safe and comfortable, but which also enables them to continue to maintain and build relationships and to be valued citizens? This paper suggests that this can only be achieved by drawing on two concepts, mutuality and the ‘micro’ scale, which are more closely interlinked than is sometimes recognised. It sets out how even large organisations and systems can think ‘micro’ and it argues that, whilst establishing individual choice and control is one of the foundations of this approach, achieving a good life involves having responsibilities as well as rights.

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2. Individual choice and control - and its limitation

“The goals of the care and support sector and its industry of providers might be radically misaligned with the wishes of older people, to such an extent that helping individual older people to choose between established offers cannot bridge the gap between demand and supply.”

In examining the challenges and potential solutions to the crises facing the housing, care and support sector, it is important to recognise how far the sector has progressed in a relatively short space of time. Before the 1980s, the sector was characterised by:

- disabled people warehoused in long-stay institutions;
- a medical model of disability and low expectations of people with long term conditions;
- ‘one size fits all’ state social care services, centrally planned and organised.

Reforms to the sector have focused, quite reasonably, on rejecting medical models of disability, which characterised huge numbers

of people according to their condition label, in favour of recognising that people are individuals with specific support needs and the ability, with the right support, to direct their own care. The impact of this has been huge, establishing the human rights of people systematically denied them, but as the following brief history of reform sets out to show, the focus on rights and entitlements to resources has not yet been matched by recognition of people’s needs to form relationships and to feel a sense of responsibility for others. That failure to recognise the importance of inter-dependence, as well as independence, may have been felt most acutely by older people. Becoming more ‘empowered’ as ‘customers’ rather than passive recipients of care has not on its own led to the widespread development of approaches which enable older people to live active and included lives, in contrast to the more noticeable

Individual choice and control - and its limitation

emergence of new markets of provision for younger adults exercising new control over the resources allocated to them.

Institutional care was not the whole story. In the 1970s, community social work took a more holistic view of support, particularly for older people and families under pressure, but this model lost a battle for resources with an increasingly professionalised and specialised model of social care which attempted to compete for status with other professional areas, such as healthcare. Any discussion of social care support needs also to recognise that state-funded social care is a footnote in the history of care provision, which remains dominated, in terms of hours provided and estimated valued, by the care of over six million unpaid family carers, a contribution which is growing rapidly³ but which nevertheless remain poorly recognised and valued by the state.

Community care reforms following the Griffiths Report (1988) and others, led eventually to the closure of many long-stay institutions for people of working age with disabilities and a significant shift of care for people with long term conditions, including mental health problems, into smaller services located in 'community' settings. Services began to be 'outsourced' to voluntary and private sector providers, who are expected over the next few years to provide a great majority of services. 'Person-Centred Planning' and then

'Self-Directed Support' introduced the idea that services should be tailored to individuals' needs and that people could be experts in their own lives.

In 1983, John Evans became the first person whose move out of a care home was funded with local authority money.⁴ At the time, this was technically unlawful. Direct Payments – the right to take the cash equivalent of a social care service offered to you – were enshrined in law in 1996,⁵ but awareness and take-up of Direct Payments remained very low for a number of reasons,⁶ including councils' reluctance to cede purchasing power to individuals and individuals' and family carers' wariness of taking on legal responsibility for state funding, particularly where the service which results from such a change appears little different from the one previously offered.

Putting People First (2007) set out a comprehensive vision for 'personalising' social care, including a universal offer of advice and information to help people make informed choices; a focus on developing inclusive and supportive communities; a focus on investing in preventative services; and introducing individual choice and control through the introduction of personal budgets. Personal budgets are the principle that everyone using a public service should be told how much that service costs to provide to them and given a choice about spending that individual resource

allocation differently. Direct Payments remain one of a number of ways of taking a personal budget, with varying degrees of individual control and commensurate legal responsibility. Direct Payments remain the 'purest' form of individual control over allocated resources,⁷ but whilst councils are progressing rapidly towards being able to claim 100% personal budget uptake (in 2012-13, numbers rose by 40% from 2011-12⁸), the increase in Direct Payment take-up appears to have stalled for the past two years, with around 25% of personal budgets taken as Direct Payments (44% of the money).⁹

Older people appear to be less keen or able to take up Direct Payments and there has been much debate about the possible reasons.¹⁰ Older people's individual budget entitlements are often relatively small, whereas Direct Payments often offer the biggest gain in control where someone has a large enough entitlement to employ and manage their own personal assistant. Whilst the numbers of Direct Payments remains stable, the amount spent increased 30% between 2011 and 2012, suggesting Direct Payments are more popular amongst those with larger budget entitlements. It is also possible that professionals and agencies make assumptions about older people's desire for choice and control, assumptions sometimes backed up by older people or their families expressing the view that they do not want to engage in a complex set of arrangements and to take on new responsibilities, but would prefer

decisions to be made for them. The pre-Baby Boomer generation of older people are often characterised as a generation of deference, which values professional opinions.

However, having responsibility for how money is spent is of little use without a genuine choice of services from which to choose. Whilst assumptions about acceptable housing for disabled adults of working age have changed dramatically, with independent living (often seen as 'a place of my own') being the accepted norm, this huge change in provision has not been apparent in the market of care provision for older people who need housing with support, which is still dominated by residential care in 'homes' of 30, 40 or 50 beds.

Around half a million older people live in care homes in the UK according to a recent Joseph Rowntree Foundation (JRF) report which found that, whilst some care homes are making modest improvements, "[o]lder people are perceived as commodities, not as consumers or citizens with rights, entitlements or purchasing power. Older people who need a lot of support are seen as a burden, with little or no expectation of a fulfilling life. Care homes focus on physical support through decline."¹¹ Many older people make their first social care choice whilst in a crisis, such as at the point of being discharged from an unplanned hospital visit, so it is not perhaps surprising that few wish

to take on the responsibilities of choosing and managing a care package at this time, when none of the services on offer address the wish to remain independent, connected to family and friends, and active.

Whilst the vision for 'personalisation' set out in *Putting People First* had four equal parts, only the moves towards choice and control are strongly evidenced. It was intended that not only should the location of support move to the community, but that community development approaches would prepare the community for this. Five years on from *Putting People First*, July 2012's Care and Support White Paper again set out a vision for addressing the unfinished business of creating a more open, 'universal' offer to people, including information, advice and preventative interventions, alongside a greater focus on relationships, inclusive communities and active citizenship.

So, whilst the lives of a large number of younger disabled adults have been positively transformed through 'demand-side' reforms such as Direct Payments and personal budgets (including thousands employing their own PA), it appears that widespread reform of the provision of care and housing for older people has not been achieved through giving older people the option of controlling state social care resources at an individual level. This should not be surprising: the 170,000¹² older people

who use their own money to pay for care do not routinely report receiving good value, despite paying an average of £609 per person per week in 2009-10.¹³

A number of conclusions could be drawn from this discrepancy between the de-institutionalisation of housing and care for younger adults and the increasing use of care homes of varying quality for older people. It seems that 'demand-side' reforms alone do not result in a change of provision in the care and support market, which raises the question of what 'supply-side' reforms might be needed in order to bring real choice to those newly 'empowered' 'consumers'. Perhaps the goals of the care and support sector and its industry of providers might be radically misaligned with the wishes of older people, to such an extent that helping individual older people to choose between established offers cannot bridge the gap between demand and supply. Perhaps, the goals and wishes of many older people may not be deliverable by services at all, and therefore, for them, the focus on more empowered consumption of services has entirely missed the point.

3. Older people and personalisation: *Inclusion is part of independence*

“This is a view of choice and control which looks beyond rights and entitlements to encompass also people’s desire to have responsibilities and to contribute to those around them. This more holistic version of the personalisation narrative is entirely relevant to older people’s wishes.”

The preceding chapter suggests that the question which is sometimes framed as “How do we help more older people to use personal budgets?” is at risk of assuming that the goal of developing personalisation was to increase personal budget uptake, when in fact the goal of developing personal budgets was to help people to access better services, as one part of living a good life, a life described by older people as much in terms of their relationships with others as in terms of individual entitlements; in what they can contribute, as much as in what support they receive.

This is not to say that personal budgets are not useful for older people. When options are available which are distinctive and particularly well-tailored, older people appear as keen as any other age group to exercise choice and like other groups, would prefer that choice to

be as simple and bureaucracy-free as possible, whereas sometimes personal budget systems can be experienced as having extra layers of form-filling, negotiation, responsibility and even appeals panels. As noted above, having new purchasing power as an individual does not on its own result in new services being developed in an area. ‘Self-funders’ (people who pay for their own means-tested social care) often pay more for a place in a care home than people whose care has been block purchased from the same care home by their council. So, as with services for other age groups, introducing personal budgets can be one element of widening the range of local services for older people, but even if this were achieved, there is no reason to assume that those high quality services would automatically result in those older people living good lives.

JRF's Better Life programme asked older people for their vision of a good life and found that it extended far beyond being safe, comfortable and having their support needs met. The older people's vision included "the importance of belonging, relationships and links with your local or chosen communities; being able to contribute (to family, social, community and communal life) and being valued for what you do".¹⁴ Another report from the same programme found that older people with high support needs shared this vision and the desire to remain active, valued and connected, including through making new friends, not just maintaining existing relationships.¹⁵

Poor quality services can certainly form a barrier to achieving this vision of a good life, as can a lack of services, particularly services such as transport which enable older people to get outside of their own homes. But services as traditionally formulated cannot address social deficits such as loneliness, nor can they create or sustain age-inclusive communities.

This may require deep reform of our social care system, with its reliance upon needs assessments and eligibility criteria, and its tendency to predicate relationships between citizens and the state upon negotiations about money and other scarce resources,¹⁶ ignoring in the process the much more abundant resources of resilience, family care and community which are present or potentially present in many people's lives.

An alternative to the 'gift' model of care provision (i.e. solutions for people with problems are in the gift of experts), is a 'strength-based' (or 'asset-based') approach which looks first for people's strengths, skills and resources first, rather than their needs and vulnerability.¹⁷ Aligned with the social model of disability, a strengths approach rejects labelling people according to their health condition or age group and refuses assumptions about people's potential to contribute or to develop expertise in their own lives. Strength-based thinking tends to see people's connectedness to their family and community as a crucial part of their ability to make and sustain changes in their lives. Some ideas about 'community' see it as being 'out there' somewhere, if only we could find it and capture it. Asset-based community development¹⁸ (ABCD) approaches tend to look for the building blocks of community in people's close relationships.

This is a view of choice and control which looks beyond rights and entitlements to encompass also people's desire to have responsibilities and to contribute to those around them. This more holistic version of the personalisation narrative is entirely relevant to older people's wishes.

4. From personalisation to a 'strengths-based' approach

"The examples in this section of care, support and inclusion, constructed from close personal relationships along a 'networked' model of care, demonstrate that there are models of providing care, support and housing which are not only affordable, but can contribute to the development and strengthening of communities."

If genuine independence and control for older people require approaches to care to become more clearly focused on supporting people's strengths, resilience and relationships, how can this change be put into practice? Strengths-based approaches to care, support and inclusion for older people:

- find ways for everyone involved to contribute something of value (beyond money);
- offer care and support in the context of close personal relationships, in family homes or at a micro-scale;
- involve shared decision making and in some cases formally shared ownership of organisations or enterprises.

This chapter looks at examples of those three characteristics and then at their application to housing and care for older people.

4.1 Everyone can contribute

In Shared Lives, an adult (16+) who needs support and/or accommodation becomes a regular visitor to, or moves in with, a registered Shared Lives carer; together, they share family and community life. In many cases the individual becomes a settled part of a supportive family, although Shared Lives is also used as day support, as breaks for unpaid family carers, as home from hospital care and as a stepping stone for someone to get their own place. Shared Lives carer Jean says: "People say, 'You must be a saint', but I don't

see it like that. It just comes naturally and I think I get as much out of it as she does. She's just one of the family."

Shared Lives is used by people aged from 16 upwards, including increasing numbers of older people with dementia. There are around 8,000 Shared Lives carers in the UK and they are recruited, trained and approved by a local Shared Lives scheme, which is regulated by the government's social care inspectors. Shared Lives is unique in regulated adult support, in that Shared Lives carers and those they care for are matched for compatibility and then develop real relationships, with the carer acting as 'extended family', so that someone can live at the heart of their community in a supportive family setting.

This form of support can provide value for money not matched elsewhere in the care sector. In 2010, England's care inspectors gave 38% of Shared Lives schemes the top rating of excellent (three star). This was double the percentage for care homes for older people. Shared Lives support and membership organisations, Community Catalysts and Shared Lives Plus, estimate that the average saving when someone moves from residential care to Shared Lives is £13,000 per person, per annum.

The Shared Lives sector is growing whilst other social care sectors are shrinking. Whilst government statistics are inconsistent, live-in

Shared Lives usage by older people appears to be growing by up to 14.5% pa.¹⁹ Whilst the numbers of older people living long-term with Shared Lives carers is small and may be limited by the available pool of Shared Lives carers willing to take on the considerable challenges of caring full-time for someone with dementia, there appears to be strong growth in the use of Shared Lives as a short breaks or day support option, in which, for instance, an older person with dementia visits the Shared Lives carer in their family home, rather than visiting a day centre.

ASA Lincolnshire's At Home Day Resource for people with dementia, established with carer's grant funding, provides support from 10am – 3pm, delivered in the Shared Lives carer's home and the local community. The ASA matching process ensures participants are compatible, with one person supporting up to three people at a time, depending on people's needs. Some people use it to maintain skills such as cooking, gardening, or simply eating together and using cutlery. Isolated older people welcome the manageable social experience in a consistent, familiar setting.

One family carer used the time when her mother-in-law was with the Shared Lives carer to change her bed: if her bed was changed whilst she was at home, she thought it was being stripped in readiness for her to leave. Family carers and providers use a

communication book to share information about any issues and to share the clients' activities during the week, which assists conversation when the client returns home. Because the approach is based on building a consistent relationship between individuals, rather than a succession of different workers working to a service specification, people using the service build up a rapport with the Shared Lives carer, which means that support can continue as their dementia progresses, in one case for eight years.

Time banks are well-established in many areas as a way of creating reciprocal peer-support relationships within communities. A volunteer may be susceptible to the problems of 'gift model' thinking, in which one individual has only something to give, and another only something to receive. Someone offering support in the context of a time bank, in contrast, is offered an equivalent amount of another time bank member's time in return, opening up the possibility of everyone finding a way to contribute something of value. Care banks, currently in the early stages of development, apply the principle to offers of care from individuals expect to receive some form of care in return, perhaps many years in the future when they develop care needs in later life. Care banks face a number of challenges, including avoiding monetising and therefore devaluing previously unpaid contributions, and maintaining the value of a

virtual currency over long periods and through many social care policy changes. However, the Care4Care scheme is being piloted on the Isle of Wight, with ambitions to become a national scheme incentivising large numbers of people to 'bank' hours of care provided to be claimed in later life.

4.2 Micro-scale and family-sized

Three quarters of homecare visits in England are 30 minutes or shorter and 10% are 15 minutes, which a third of homecare providers said put the dignity of service users at risk.²⁰ The 2012 Care and Support White Paper set out the government's intention that contracting by the minute for homecare should end and be replaced by contracting for outcomes. However, the economics of providing longer visits and of fitting visits around their clients' needs, which peak at the same times of day, can be challenging for large providers. This has been one of the factors motivating some workers to leave industrial-scale care organisations and set up a 'micro-enterprise' of their own, in which they sell their support directly to a small group of older people as a sole trader or in partnership with a small team.

'Barbara' set up Home Support service three years ago to deliver personal care and domestic support to older people in their own homes, which can include other support such as

helping them with their shopping. Barbara and her three staff provide this support to 23 older people within a rural locality, all of whom receive Direct Payments. Barbara was supported by a specialist micro-enterprise support agency, Community Catalysts which helps the smallest social enterprises achieve sustainability and cope with regulations and commissioning practices often designed with larger providers in mind.

Barbara has a long background of support work in both residential and domiciliary care. She decided to set up her own venture after becoming disillusioned with her employers taking on more care packages than they had capacity for. This sometimes resulted in service users seeing up to 12 different carers in a week. In contrast, Barbara meets with each of the people who use her service at least once a week to discuss any ideas or concerns they may have, and deals promptly with them. Barbara personally delivers the service to a new service user for at least two weeks before introducing them to the member of her staff team she feels is best suited to their needs.

There is a wide variety of enterprises and approaches within the 'micro-enterprise' sector, many falling outside of social care regulation, or outside of what is traditionally seen as 'social care' altogether. But people working on a micro scale appear to be able to draw on or build close relationships. Like Shared Lives, which has

a national infrastructure but is based on care provision on a family-sized scale within ordinary homes, micro-enterprises tend to mix paid and unpaid contributions, with 'workers' not placed under time pressure to achieve through-puts, but having the space within which to construct more positive relationships in which care providers feel they are receiving much more than money.

The Shared Lives 'hub and spoke' approach to provision, in which local services work to a broad national specification, with direct monitoring of support arrangements largely devolved to a local level, points the way towards 'scaling out' 'micro' level approaches, rather than attempting to 'scale them up'. In other words, creating the conditions in which many thousands of individuals can construct broadly similar relationships and interventions in partnership with older people, rather than attempting to commodify and mass-produce such an approach. It might be useful to think in terms of a licensing approach to replication, in comparison to a franchising model which usually takes a very strict approach to conformity.²¹

Shared Lives at its best, when Shared Lives carers involve their family, friends and community connections in helping an older person to build and maintain many informal relationships, is an example of what Vickie Cammack of Tyze Personal Networks has

described as a 'networked model of care'.²² Rather than seeing the informal and formal provision of care or support as two separate realms, which at times compete for a person's time and attention or undermine each other, a networked model of care looks for ways in which a wide range of informal and professional relationships can work alongside and enhance each other. Tyze Personal Networks attempts to foster these kinds of networks by applying social networking technology to the task of maintaining and growing small, real-world supportive networks. Unlike mainstream social network tools such as Facebook, which risk replacing real relationships with numerous virtual 'friends' and in which privacy can be difficult to maintain, Tyze is password-protected and arranged to facilitate shared caring tasks (with a collaborative task list, shared calendar etc.) and the personhood of the person at the centre of the network, through spaces to share photos and stories, and a secure vault for key documents. Social networks, which are decentralised, flexible and build many peer-to-peer connections, have some striking synergies with the concept of a networked model of ('real world') support.

A networked model can be adopted by large organisations and systems who are willing to create the conditions which enable staff and people using their services to act creatively and with autonomy at the micro-scale. Care provider, MacIntyre, worked with Community

Catalysts to bring micro-scale thinking into its large workforce, through a 'Dragon's Den' approach to encouraging MacIntyre's staff to develop and test their ideas for micro-enterprise style approaches to either providing support to a particular group of service users, or to helping service users to establish their own micro-enterprises.

4.3 Shared ownership

Micro enterprise provides a route for older people to use their gifts and skills to support and provide services for other local people. Whilst all successful micro-entrepreneurs take a collaborative approach to creating and continually developing an offer which a small group of older people wish to purchase, some micro-enterprises are formally owned and led by older people themselves or have mutual ownership.

'Harry' and 'George' are men in their 70s who used to work as joiners. They set up an enterprise with support from Community Catalysts to make and sell rocking horses and then began teaching woodworking skills to other older men. They are now joined by between eight and ten people every week who have made new friendships as a result.

'Cathy' and 'Jean' used to work for a big domiciliary care organisation. They didn't like the way they were obliged to work and so

set up a mutual organisation which supports about 15 older people in their own homes. They have been joined by other like-minded people who are equally passionate about personalised, flexible services shaped round the people they support.

The principle of shared ownership poses a challenge to larger care, support and housing organisations. Charities could involve more older people and families on their boards and in decision-making groups and processes. The new Community Rights enshrined in the Localism Act give older people and their families opportunities to assert their right to own or control services which have previously been owned by the state.

30,000 families spent over £500m a year on the huge Southern Cross care home business which failed in 2011. Southern Cross axed 3,000 front line support posts in the process of trying to stay afloat. Whilst the government and sector leaders debated how best to tackle the challenge of one of the largest care home businesses collapsing, the voices of those 30,000 older people and their families were noticeably absent. No older person appears to have been made homeless as a result of the collapse, but arguably they did not receive good value for money for the £20,000 or so each spent annually on their service, raising the question of what else such a large group might have spent their collective resources upon, had

even a small proportion of them been able to act as a group. A users' and families' group might have been able to influence government and the business in decisions which impacted upon their care and security of tenure. By forming a co-operative, a group might have been able to invest their substantial care home fees in building up a business which they jointly owned and controlled and which delivered a very different model of housing and support.

4.4 Communities contributing and benefitting

Working at a micro-scale and building on people's real relationships brings in resources from the community which are not available to service-based interventions or initiatives, even those run by charities, which take place on a larger, more impersonal scale.

In the Stamford Forum approach, piloted in Leeds, individuals are invited to pool their personal budgets with the resources held by some of Leeds' 39 Neighbourhood Networks. Each Neighbourhood Network covers a very small area, is led by older people and receives council support as well as drawing upon volunteering and time banking. Some have established social enterprises which deliver services to older people as alternatives to traditional care. If the Networks and personal budget holders can find more effective and

cheaper ways of including and supporting budget holders (through greater use of volunteers and other community resources for instance), the partners will be able to keep some of the savings to reinvest in the community.

The Leeds experiment demonstrates that there is a false dichotomy between 'the community' and 'vulnerable people'. People who need support or help with housing are one - important - group which make up any local community. Most individuals will move in and out of 'vulnerability' throughout their lives. The Leeds experiment is one of a few examples of genuinely devolved and co-produced commissioning. Most areas have User-led organisations (ULOs), but these are often confined to a consultative role, rather than being able to take on commissioning or service delivery activity. Micro-enterprises show one way in which individuals can pool their purchasing power in order to move from being customers towards being commissioners who shape services, or even create and co-own their own services and enterprises. Given the large amounts of money involved in housing provision and the purchase of care-with-support, a particularly large amount of power is arguably at stake in attempts to move to a model characterised by mutuality.

The examples in this section of care, support and inclusion being constructed from close personal relationships along a 'networked' model

of care, demonstrate that there are models of providing care, support and housing which are not only affordable, but can contribute to the development and strengthening of communities which is so desperately needed if we are to tackle the epidemic of isolation which is afflicting many groups, but older people in particular. The challenge, then, for organisations offering housing with care or support, is to adapt or even radically change their offer so that the focus on 'house' is balanced with an understanding of the wider ramifications of 'home'.

5. Mutuality and micro-thinking in housing and support for older people

“Co-housing combines individual independent living with an intentional community that brings together like-minded people who want to live in a social environment.”

There are already examples of bringing a networked model of care into housing with care and housing support for older people.

Homeshare has some similarities with Shared Lives but operates on a comparatively tiny scale in the UK, despite being highly developed in a number of other countries: the Homeshare scheme in Paris has created over 900 Homeshare matches via 15 branches in less than six years. In Homeshare, someone who needs some help to continue to live independently in their own home is matched with someone who has a housing need and can provide a little support and companionship.

“Householders” are often older people who own or are tenants in their own home but have developed some support needs or have become isolated or anxious about living alone. “Homesharers” are often younger people, students, or key public service workers who cannot afford housing where they work.

The Homesharer agrees to provide an agreed level of help and support to the Householder whilst living in their home for an agreed period of time. Homeshare is not a regulated service and cannot include the provision of personal care. Homesharers are not usually charged rent in UK Homeshare arrangements, but agree to contribute

to household bills and it may be agreed that other costs such as food will be shared.

Homeshare arrangements rely on the successful matching of participants who are both willing and able to bring something of value to the arrangement, beyond the transaction of support in exchange for accommodation. Local Homeshare schemes recruit and assess participants, providing CRB checks for Homesharers. Some recent start-ups are developing variations on the Homeshare model. 'Uniitee', for instance, aims to match older people with large houses with other older people who are in housing which is either becoming unaffordable or unsuitable to their needs. The aspiration is that participants will be able to provide companionship and peer support, whilst also pooling their resources to purchase better quality care and support.

In Cross-Generational Housing,²³ Michael Keith sets out how housing could be designed with multi-generational living in mind, with the aim of houses being able to accommodate the need for shared spaces and privacy of different generations within one family.

The first co-housing projects were developed in the late sixties in Denmark. Co-housing combines individual independent living with an intentional community that brings together like-minded people who want

to live in a social environment. Common facilities and community activities such as dining, gardening, laundry and recreational facilities can be shared without losing the independence and privacy of residents' own homes. Above all, there is an embedded neighbourliness through common interest, social interaction and the pooling of practical requirements for everyday living (collaborative consumption). Intentional communities have fallen out of fashion in the learning disability sector, due to concerns about creating segregation and the wider range of integrated opportunities now on offer to younger adults with learning disabilities. However, the population of 'older people' is large and very diverse and the risks of segregation perhaps therefore lower. There is also arguably a narrower range of alternatives which are well-integrated into wider communities.

Hanover, one of the UK's largest providers of retirement housing, is actively working with five co-housing groups of older people to support and bring together new co-housing projects. The **Hackney Co-housing Project group** has identified a site in Hackney owned by the Local Authority and hope to acquire it for a multi-generational scheme. Hanover is advising the group and, in principle, will finance the site in return for the acquisition of five rented dwellings for older people in a 10 dwelling development.

Hanover Housing is also mapping and developing peer to peer support across its housing and care provision for older people. Residents in Mulbarton shop and run errands for less able residents; residents in Harrogate help those recently admitted to hospital on their return home and a resident in Shepton Mallet receiving training to teach Tai-Chi classes to other residents. The organisation's vision for future housing arrangements is to develop communities that appeal to 'younger older' people in order to create a mix of ages even in age-exclusive communities.

6. A micro and mutual future for older people's homes and housing?

"This paper has set out an argument for the limitations of service interventions in helping older people to build 'good lives', arguing that people and organisations working in this field can and should develop new kinds of relationships between services, professionals, citizens and communities, which are based on shared responsibilities and reciprocity."

The sections above set out an argument for the limitations of service interventions in helping older people to build 'good lives', arguing that people and organisations working in this field can and should develop new kinds of relationships between services, professionals, citizens and communities, which are based on shared responsibilities and reciprocity. This paper argues that working on a family-sized or micro-scale helps to deliver this transformation, but gives examples of how a 'micro' ethos can be applied within large systems and organisations, or can be spread

through creating new kinds of infrastructure which resemble franchise arrangements and social networking structures, more closely than traditional, centralised organisational structures.

This vision raises questions and challenges for the housing with care sector, including the extent to which reciprocal and mutual approaches work alongside service offers, or should aim to replace services where possible. The extent to which micro-scale approaches can supplant large-scale service offers is still unresolved.

Any approaches which seek to draw on community or social capital, need to address the current disparities between the social capital in different kinds of communities, in order to ensure that people in areas with little existing capital are not further disadvantaged, or even abandoned by a model based on the assumptions of more socially affluent areas.

Inherent in the desire to create reciprocity are greater responsibilities for people who might previously have been offered a solution, however imperfect. What should the response be where people reject these approaches in favour of traditional service and would increase uptake of reciprocal and shared-responsibility approaches lead to them becoming expected of people or even mandated?

The Public Services (Social Value) Act 2012 allows for the potential to create social value to be taken into account in some commissioning decisions. It could be argued therefore that some business or ownership models, such as co-operatives, should be favoured if they can demonstrate they are more likely to foster reciprocity.

For a more decentralised and non-standardised model of care to thrive, new approaches to regulation and safeguarding will be needed, as illustrated by the more decentralised regulation model used by the Shared Lives sector which nevertheless has one of the strongest safeguarding records in social care.

For micro solutions to social care to become as common as, say, small independent hairdressers, there is a role for local and national government, but a different role from that of central planner and purchaser. It lies in bringing new providers, including micro-providers, into the market place and bringing them together with people who hold personal budgets or wish to spend their own money. Councils need to nurture support systems for people to make all kinds of contributions, from unpaid family carers to volunteers and community groups. Commissioners will need to recognise that, whereas they may increasingly hand over their procurement role to individuals and small groups, they retain a vital commissioning (market-shaping) role. To carry out this role, commissioners need to build systems which capture information on met and unmet needs from personal budget and Direct Payment holders, as well as self-funders (who pay for their own care). Planners will need to be able to map an area's non-state 'assets', resources and community groups, as well as its needs and state services. Regulators will need to be pragmatic in the application of regulations often designed with large systems and providers in mind.

“The role of local and national government will be in bringing new providers, including micro-providers, into the market place and in matching them with people who hold personal budgets or wish to spend their own money.”

7. Messages for reform: *Conclusions and recommendations*

“This paper makes one simple point: that there needs to be a ‘new normal’ in the delivery of housing and social care for older people.”

This paper has argued that services delivered to older people fail by approaching them as isolated individuals, which will only serve to exacerbate issues such as loneliness and isolation. Two popular models of support, care homes and support in a person’s own home, are in danger of ensuring seclusion as the norm. Care homes remove older people from their known community, and cut them off from wider support networks and the opportunities they offer. On the other hand, support at a person’s own home can be equally if not more isolating. Reduced mobility, medical needs, perceived external dangers and a lack of connection to a local network or relatives can often act as huge barriers to establishing a more relational form of support. Neither model can support the good life.

An alternative approach must now define and shape our public services: whatever the setting or intervention, services for older people must focus on relationships, the wider community and opportunities for older people to become active producers of social capital, rather than passive consumers of care. In sum, this paper makes one simple point: that there needs to be a new normal in the delivery of housing and social care for older people. This ‘new normal’ needs to include the wider and deeper hopes and aspirations that older people have for themselves which almost universally includes their relationships, their families and their communities.

We propose a series of policy recommendations to government, local authorities, providers and commissioners to support this much-needed shift in public service provision:

1. The **Department of Health** should explore ways in which regulations following the Care Bill could use the proposed 'market shaping' duty upon councils, to ensure that opportunities for greater community support and mechanisms, such as budget pooling, are fed into strategic plans.
2. The **Department of Health** should work with councils to end the use of commissioning and regulatory approaches which exclude micro-scale and mutual approaches to housing and care.
3. **The Department of Health and the Cabinet Office's Mutuals Taskforce, working with the co-operative movement and care providers**, should ensure that there is a joined-up approach to encouraging co-operative and mutual models in the development and take-up of personal budgets and explore ways in which individuals and families purchasing housing and care could pool their resources or form co-operatives.
4. **The Cabinet Office** should explore how the Public Services (Social Value) Act could be used in promoting mutuality and reciprocity through the procurement of care, support and housing for older people.
5. **Local authorities** should promote commissioning approaches, such as virtual marketplaces and budget pooling which promote social value and develops new micro enterprises, co-operatives and participatory budgeting with others of similar needs and interests.
6. **Providers and commissioners of housing and care services** should work with older people and their families to design and commission networked models of care, with interventions which straddle or break down the barriers between the formal and the informal; between paid and unpaid care and support.
7. **Providers and commissioners of housing and care services** should explore the ways in which they can offer a greater range and choice of living and housing arrangements to older people and their families, which are more closely based on the choices older people say they would like to make.

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Models and Partnerships for Social Prosperity

This publication is an output of ResPublica's Models and Partnerships for Social Prosperity workstream, one of the three core workstreams of the ResPublica Trust.

To radically change social and economic outcomes, we need to establish hybrid partnerships between communities, businesses and the public sector, which move beyond the state vs. private sector debate and harness the advantages of both. From creative solutions for localised social care and education delivery to the benefits of community-owned energy and community-run housing associations, this workstream looks at innovative models for public service delivery and private enterprise.

Current and forthcoming work will build upon the ideas outlined in our past output which have had a continuing impact on the British policy landscape. Examples of our successes in 2012 include ResPublica's publication on Military Academies, which outlines a new approach to tackling intergenerational disadvantage and ethos in schools, and was endorsed by Labour Party policy, and a paper how the neighbourhood planning process can engender stronger and more cohesive communities, launched by the then Minister for Decentralisation, Greg Clark MP. In 2013 this workstream will encompass our research on housing, community energy provision, health and social care, welfare, education, employment and skills.

About Hanover Housing

Founded in 1963, Hanover Housing have become one of the UK's leading specialist providers of retirement housing and related services. We are a registered provider and manage almost 19,000 properties in over 600 locations, with around 5,000 home ownership properties and 14,000 homes for rent, including 3,000 extra care properties where residents can access 24-hour care on-site.

This paper forms one of a series commissioned to question assumptions, challenge perceptions and consider the principles that underpin much of policy around housing and the ageing population as part of our work to mark our 50th anniversary. To find out more, go to www.hanover50debate.org.uk.



The governing philosophy of modern public service provision is that of individual empowerment: it is believed that if people have the power to choose, their needs will be met by the services that they select. A whole industry has grown up around this philosophy, but it unfortunately cannot deliver on what people really want and need – other people. The needs of older people in particular, which this paper primarily concerns, cannot wholly be met by enabling them to become more powerful consumers of public services. Their needs are rather far more social and relational, and it is this aspect – not greater choice and individual empowerment – that is in need of greater supply. Older people can be active producers of social capital, rather than simply consumers of public services.

If public service provision is currently based on such a model, what can be done to bring older people's real needs back into alignment with what we supply? This paper attempts to put people back into personalisation and explores the various ways in which human needs can be met and their skills harnessed by existing and new models of support.

