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Article information:

To cite this document:

Michelle Cornes, Bruno Ornelas, Bridget Bennett, Andy Meakin, Karl Mason, James Fuller, Jill Manthorpe, (2018) "Increasing access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion: a theoretically informed case study", Housing, Care and Support, Vol. 21 Issue: 1, pp.1-12, <https://doi.org/10.1108/HCS-09-2017-0022>

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<https://doi.org/10.1108/HCS-09-2017-0022>

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Increasing access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion: a theoretically informed case study

Michelle Cornes, Bruno Ornelas, Bridget Bennett, Andy Meakin, Karl Mason, James Fuller and Jill Manthorpe

Abstract

Purpose – *The purpose of this paper is to present a case study describing the progress that is being made in one city in England to increase access to Care Act 2014 assessments and personal budgets among people with experiences of homelessness and multiple exclusion.*

Design/methodology/approach – *A case study employing a “study group” to describe and reflect on local development work.*

Findings – *The authors focus on the “systems change” activity that was undertaken by one voluntary sector partnership project to address issues of referral and access to adult social care. This included the development of a “Multiple Needs Toolkit” designed to support voluntary sector workers to communicate more effectively with adult social care around the application of the new Care Act 2014 eligibility thresholds. The authors discuss the role of “persistent advocacy” in increasing access to assessments and also the limitations of this as regard the potential for poorer joint working.*

Originality/value – *Throughout, the authors draw on the “ambiguity-conflict” model of policy implementation to assess if the learning from this single case study might be applied elsewhere.*

Keywords *Personalization, Care Act 2014, Eligibility, Ambiguity-conflict model, Homelessness, Hospital discharge, Intermediate care, Medical respite, Transition of care, Realist systematic review, Systems change*

Paper type *Research paper*

The authors affiliations can be found at the end of this article.

Introduction

Integrated care is central to overcoming the problem of fragmented and uncoordinated services. It is of particular importance for excluded groups who may have difficulty in advocating for their own needs (Faculty for Homeless and Health Inclusion, 2013). While government initiatives such as the “Homeless Hospital Discharge Fund” (Department of Health, 2013a) have prioritised ways of improving integration between health and housing sectors, less attention has been paid to the interface with adult social care. It is timely to redress this because a key feature of the Care Act 2014 was removal of reference to “eligible” and “ineligible groups” so that any adult with any level of need for care and support has a right to an assessment.

The Care Act 2014 was introduced in England from 1st April 2015. It rescinds much legislation, including the NHS and Community Act 1990, with the aim, inter alia, of creating a single consistent route to establishing entitlement to publically funded care and support. To make the

The authors are grateful to the Faculty of Social Science and Public Policy at King’s College London for funding this work. The authors also grateful to the Social Work Department at Royal Holloway London and VOICES who hosted events as part of this work. The views expressed are those of the authors and not those of the funders.

law fair and consistent, the government aimed to remove anomalies which treated particular groups of people unjustifiably differently (Department of Health, 2013b, p. 1). As a consequence some people who were frequently passed over by adult social care on the grounds that they did not come within a certain user group as defined in legislation, for example, “homeless people” will no longer be excluded (Mandelstam, 2013, p. 80).

The Care Act 2014 places personalisation on a statutory footing for the first time. It substitutes to some extent individual funding for a system of block commissioning of services from the private and voluntary sectors (Ellis, 2015). Under the Act everyone eligible for non-residential care and support is entitled to a “personal budget”. The guidance stipulates that a “direct payment” (a cash payment in lieu of services) should be the preferred option (Department of Health, 2017, s12.2). However, personal budgets can also take other forms such as an “Individual Service Fund” (ISF). With an ISF the service user can appoint an organisation of their choice to both manage the personal budget and use its own employees to deliver any direct care or support. This model is designed to enable people to exert influence, without having to take on the responsibilities that come with a direct payment such as having to employ staff (Tomlinson *et al.*, 2014) or manage the money. The other option, and the one that remains most commonly used in England for around 95 per cent of service users (Slasberg and Beresford, 2015), is where the local authority manages the personal budget on behalf of the service user, often providing regulated personal and domiciliary care services in much the same way as in the past. This has been described as “phantom personalisation” (Slasberg and Beresford, 2016).

In a review of the implications of the Care Act 2014 for people who are homeless, Comes *et al.* (2016) suggest that homeless organisations need to rapidly increase their knowledge of personalisation as it is conceptualised within the new care and support system. This is because as block contracts and grants for services diminish, negotiating the new “cash for care” system through mechanisms such as ISFs may be key to organisational survival. Importantly, the Care Act 2014 guidance is clear that personal budgets can encompass expenditure on both care and support (and items), including housing and tenancy-related support (Department of Health, 2017, s15.55).

Given these changes, this paper explores the progress that is being made in one city in England to implement the Care Act 2014 with regard to meeting the needs of people with experience of homelessness and exclusion. We begin by describing the method through which the case study was generated. We then explore the wider background to the case study in terms of the voluntary sector’s increasing role in “systems change” and how this can be understood in terms of the wider literature on “managerial domination” in policy implementation processes. The case study then describes the different steps that were implicated in making some scale progress towards increasing access to Care Act 2014 assessments and personal budgets. This encompasses discussion of “persistent advocacy”, the development of a ‘multiple needs toolkit, shared learning and a community of practice. Finally, we explore how transferable this approach may be to other areas in England, mindful of the unique position of this voluntary sector organisation as a charitably funded project rather than a local authority commissioned service.

Method

Because implementation is still in its infancy, there is no formal research reporting on the impact of the Care Act 2014 on the health and wellbeing outcomes of excluded groups. With a view to scoping future research on this topic, the Policy Institute at King’s College London along with social work colleagues from the “Faculty for Homeless and Inclusion Health” convened a series of study group meetings comprising academics, local authority social workers and practitioners working in the field of homelessness and multiple exclusion. Four study group meetings were held across 2016 and 2017. Three sessions were held in London and one in Stoke-in-Trent. In attendance at one or more of the meetings were: four academic researchers, 18 local authority social workers from three local authorities (two in London, one in the North of England), 16 homelessness practitioners from eight homelessness organisations (four from London, one in the south west of England, three from the north of England) and one “expert by experience”.

The case study presented here was generated through these study group meetings. At the first meeting, a presentation was given on the work that was taking place in the case study site. Using a simple “Plan-Do-Study-Act” methodology (Reed and Card, 2015), progress was then tracked

by the study group over a period of one year. This did not constitute any formal evaluation activities such as interviews or focus groups. Rather the study group was used as a “sounding board” for the main stakeholders involved in developing the work. The main stakeholders were the director and senior manager from the voluntary-sector organisation leading the work, along with a senior social worker from the local authority. Alongside the main stakeholders, academic and other members of the group became actively involved in the development work itself. This included making visits to the case study site to learn more about the work or contributing their interdisciplinary knowledge and expertise (e.g. sourcing relevant literature, designing and participating in local training events, and helping with note taking and writing-up activities). The meetings generated over 12 hours of discussion and debate. Permission was secured from participants to report on these discussions. Mason *et al.* (2018) provide more detail about the study group format and an overview of the range of topics that were discussed.

The main limitation of this approach is that the findings presented in this paper are not based on empirical research. There is also the potential for bias towards a more positive view of the work given that all the authors of this paper (albeit to different degrees) were actively involved in designing and delivering the work. Nevertheless, the paper was written to achieve “critical reflexivity” (Girbich, 2017). We also think it is potentially valuable to report this work as it provides early learning which may be useful for other areas developing similar work and also offers recent insights for other researchers interested in scoping this topic.

Challenging “systems failure”

In a critique of personalisation and personal budgets, West (2013) draws attention to the evangelical way in which these concepts are promoted by key policy makers and local authority officials despite the near impossibility of implementing them in “progressive forms” due the current financial climate. She locates these observations in the wider discourse on “managerial domination” suggesting that institutions will seek to efface critique by reiterating the “symbolic frame” through which a situation is to be interpreted (e.g. “making it personal” or “offering choice and control”). In what follows, we further develop this critique of “managerial domination” by drawing on Matland’s (1995) “ambiguity-conflict model” in public policy implementation. In doing so, we want to explore what happens when the voluntary sector takes on a grass roots activist role, not only questioning the “symbolic frame” but also seeking to take some ownership of the transformation or “systems change” process.

Abercrombie *et al.* (2015) have drawn attention to the fact that “systems change” is increasingly being adopted by a range of progressive charities and funders as a means of addressing the root causes of social problems. They conceptualise “systems change” as an intentional process designed to alter the status quo by shifting the function or structure of an identified system with purposeful interventions. They see an important role for charitable and voluntary sector organisations in “challenging systems that don’t work and showcasing better alternatives” (Abercrombie *et al.*, 2015, p. 3) but also caution how:

It is easy to characterise government as the problem – and there are plenty of places where the public sector’s behaviour is frustrating and creates challenges – but voluntary sector actors can sometimes be guilty of a lack of curiosity and empathy with government colleagues, which can, in turn, limit the understanding and ability to engage and influence decisions (p. 29).

In 2013, the Big Lottery launched the “Fulfilling Lives Programme”, investing £112 m over eight years in 12 areas of England with high concentrations of people experiencing multiple needs (Adamson *et al.*, 2015). An individual is said to have “multiple needs” where they have concurrent experience of at least two of the following: experiences of homelessness, reoffending, substance misuse and mental ill health. An important ambition of the “Fulfilling Lives” programme is that it should lead to sustainable changes to the wider systems of services used by people with multiple needs, and that participating projects should evidence new ways of working which will influence the future commissioning of services (Adamson *et al.*, 2015).

In a review of the systems change literature commissioned by the Gateshead Fulfilling Lives Project, Hough (2013, p. 27) identifies personalisation as an example of a “systems failure” and an area where systems change work might usefully be targeted. Referencing Duffy (2014), she

describes how the aspiration for a more flexible system has become distorted by austerity or public sector spending reductions and how, as a result, personalisation has become an “excuse for abandonment”. Seeking to tackle these kinds of exclusionary practices through “innovation in referral and access to services” features as key change objective in the Big Lottery Fulfilling Lives Programme (Moreton *et al.*, 2016, p. 37). We now turn our attention to theorising about the potential for conflict where “systems change” led by the voluntary sector is targeted at flagship government policy, that is the dominant “symbolic frame”.

The ambiguity-conflict model

Matland (1995) hypothesises that when public policy is enacted by government, the task of implementation is to translate symbolic ideas and aspirations (high ambiguity) into clearly specified goals and objectives. This might take the form of detailed policy guidance. The next task for government officials is to design the most appropriate control mechanisms which can secure the compliance of frontline actors. This can be achieved through marketisation and managerialisation and might include, for example, frameworks for quality monitoring and contract compliance or the introduction of a local authority “panel” to review proposed personal budget expenditure plans. As guidelines develop and become more specific, Matland sees the potential for conflict increasing as competing interest groups begin to see more clearly the threat to their own “turf” (p. 159). Thus, “symbolic implementation” is characterised by “high ambiguity/high conflict” whereas “political implementation” is characterised by “low ambiguity/high conflict”.

For Matland, a key attribute of “political implementation” is that it reduces the scope for “street-level bureaucracy” to influence outcomes:

The central principle in political implementation is that implementation outcomes are decided by power [...] The “bottom-up” argument that policies are decided at the micro level fails because it does not take account the considerable forces and power than can be brought to bear upon an issue when it is unambiguously and explicitly formulated (Matland 1995, p. 165).

Ellis (2015) argues that personalisation does not fit neatly into Matland’s characterisation of “political implementation”. This is because prior to the Care Act 2014, personalisation was implemented largely in a legislative vacuum. As result, she suggests that early policy guidance remained highly ambiguous which made it difficult for local authorities to lever sufficient control to close the “enduring spaces for and influence of street-level discretion” (p. 245).

Like West (2013) and Hough (2013), Ellis sees the transformational aspirations of policy on personalisation as having been constrained by the challenge of retaining the ethos of “self-directed support” whilst experiencing severe funding cuts. She suggests that the more social workers are under pressure to manage excessive demand relative to resources, the more social work discretion will be used defensively. Thus, while controls such as new managerialism “have affected a qualitative shift in the governance of front line discretion, the assumptions and practices of paternalism and deservingness appear remarkably impervious to change” (Ellis 2015, p. 251).

In the case study that follows, we explore two questions in particular arising from this theoretical exposition. First, to what extent is the Care Act 2014 reducing ambiguity by filling the legislative vacuum surrounding personalisation? Second, and with regard to the first, what is the role of charitable and voluntary sector “change agency” in mediating between government control and the “professional discretion” of the front line social worker?

Case study – the golden ticket

[Roald Dahl’s writing is characterised] by his anarchic spirit and spikily, gruesomely satisfying resolutions to his problems (Mangan, 2014, p. 1).

VOICES is one of the 12 “Fulfilling Lives” partnership projects and works across one city in England. The overall aim of the project is to empower people with multiple needs to change their lives and to influence services. VOICES employs a team of service coordinators who work intensively to build relationships with customers (the term used in preference to client, service user or user)

and achieve an integrated response to their needs from local services. Coordinators help customers to navigate complicated access points to services, act as persistent advocates in order to secure entitlement to resources, and provide a continuous source of support that is not contingent on behavioural conditions. For example, customers are not excluded from the service if they fail to attend an appointment.

At a more strategic level, VOICES aims to facilitate partnerships across a wide range of local stakeholders. This includes: senior commissioners from the NHS and local authority; representatives from the police; local charities; and people who have lived experience of multiple needs. One of VOICES' key objectives is to:

Seek opportunities for systems change by challenging the ways in which systems of all kinds, such as in commissioning, communities and policy, inadvertently reduce the [life] chances of people with multiple needs (VOICES, 2016, p. 9).

Based on co-production with people with lived experience of multiple needs, VOICES' aspiration for systems change was initially conveyed through Roald Dahl's popular tale "Charlie and the Chocolate Factory". The aim was that the most vulnerable and excluded citizens will have a "Golden Ticket", "The intention is that being accepted as a Golden Ticket holder [a customer of VOICES] will provide registration with a GP and a full health MOT, acknowledgement of vulnerability for social services, housing, health, mental health and criminal justice services" (VOICES, 2013).

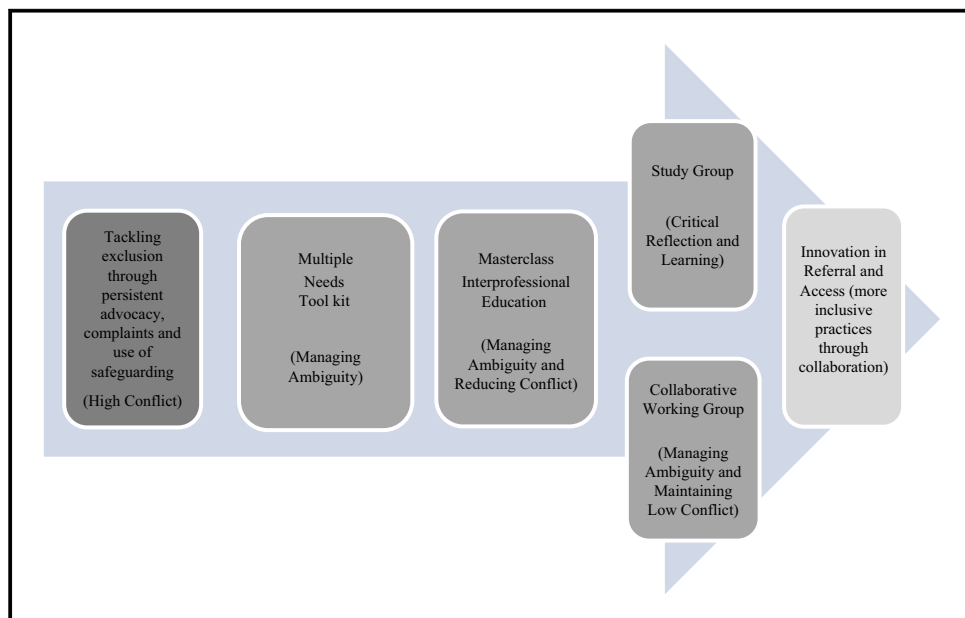
Securing the golden ticket

VOICES' work to lever change with regard to "referral and access" in adult social care emerged iteratively. It can be conceptualised by way of the diagram shown in Figure 1. The diagram highlights the process through which "systems change" was achieved by moving away from "persistent advocacy" (High Conflict) towards a more collegiate or collaborative approach (Low Conflict). The collaborative approach employed shared learning and Communities of Practice as a means of managing the ambiguities inherent in the Care Act 2104.

Persistent advocacy

For the VOICES coordination team, issues quickly came to light as regard access to adult social care. Coordinators found it difficult to negotiate the initial customer services screening processes

Figure 1 Increasing access to Care Act 2014 assessments – from conflict to collaboration



and to secure an assessment for their customers. Situations occasionally arose where coordinators felt that they had no option but to provide care themselves. In one case, a VOICES coordinator reported that she had used her own washing machine to meet the needs of a customer who was disabled and doubly incontinent having failed to secure what she perceived to be the necessary help through adult social care.

In order to improve access to adult social care, the initial approach employed by VOICES coordinators centred on practices which they conceptualised as “assertive” or “persistent advocacy”. This approach is legitimised within the systems change literature on the following grounds:

Practitioners analysis of systemic social problems often emerges from their experience and dissatisfaction, rather than a formal diagnosis or study, and they are likely to agitate for change from within a system (Abercrombie *et al.*, 2015, p. 12).

Persistent advocacy involved VOICES coordinators directly challenging the decisions of social work colleagues where they perceived exclusionary practice. The case study shown in Box 1 illustrates this approach as described from the perspective of a VOICES coordinator. It was recognised that as “unqualified workers”, it was not always easy for VOICES coordinators to challenge “professionals”. However, customers were often appreciate that someone was “on their side”. In turn this enabled VOICES coordinators to build the relational capital that was needed to engage with people previously identified as “hard to engage”.

Persistent advocacy was also sometimes backed-up through management support for the use of formal escalation (and complaints) procedures. Another strategy used by VOICES was to establish interprofessional alliances which invoked medical and professional hierarchies. Typically, this might involve securing a letter of support from a senior NHS doctor in order to challenge the grounds on which particular needs had been deemed ineligible by the local authority. For example, clinical evidence might be introduced to argue that in a particular case, chronic homelessness and alcohol misuse were a result of a brain injury and not poor or unwise lifestyle choices (which as illustrated in the case study was a common argument put forward by the local authority for disputing eligibility).

Box 1: Case study recounting the use of persistent advocacy^a

Steve is in his 50s having been in and out of prison for more than two decades. He has struggled with a heroin addiction and poor mental health for most of his adult life. Steve was in hospital receiving treatment for an infection when he was introduced to VOICES. He was later admitted to a Mental Health Ward for further assessment. Steve informed his VOICES Service Coordinator that he did not want to return to the hostel where he was living. He felt that an environment where heroin was easily accessible was not going to help his recovery.

Steve was supported by VOICES to make a request for a Care Act assessment. However, the outcome of the assessment was that Steve was ineligible for support. This was justified on the grounds that he “had capacity” was therefore “making a ‘lifestyle choice’”. Steve was later discharged from hospital to a B&B. He remained there for 5 weeks.

Steve was readmitted to hospital due to his ongoing physical health problems. A request for another Care Act assessment was put through by a Community Matron. Again, Steve was deemed to be making a “lifestyle choice” and deemed ineligible for care and support. Steve’s physical health was deteriorating and mobility worsening. He became doubly incontinent and unable to address his own care needs.

To secure another Care Act assessment for Steve, the VOICES coordinator visited the local authority in person and refused to leave until she had spoken to a social worker. Following this assessment, Steve was found to be eligible for care and support. He spent ten weeks in a respite facility before moving into his own specially adapted home. Through a “managed personal budget” Steve receives five daily visits from care workers with wider interprofessional input from occupational therapy, community nursing and VOICES.

Note: ^aAnonymised – written by a VOICES coordinator

In terms of delivering systems change, an independent evaluation report of the VOICES initiative (Rice, 2017) identifies assertive advocacy on a casework basis to be a powerful tool for enabling fair access, concluding that:

It may be that part of VOICES legacy is recognition that a small team working flexibly with small caseloads of people is an ongoing need to sustain and progress fair access systems change (p. 8).

However, while improving access to assessment on occasions, this assertive approach was also characterised by “high conflict” and poorer working relationships in which social work colleagues own pressures and organisationally defined roles may have been disregarded. Furthermore, as illustrated in the case study above, “arguing the case” could take place over extended periods of time. This could potentially lead to poor interim outcomes for service users with increased expenditure upstream, including repeat admissions to hospital and the need for potentially more costly care and rehabilitation packages. Thus, while VOICES staff and management recognised the gains from “persistent advocacy” in cases like these there was a clear imperative to move towards more collegiate ways of working (i.e. to lower the conflict level).

Multiple needs tool kit. An early lesson to emerge from VOICES’ work centred around the importance of communicating with adult social care practitioners in their own language. It was recognised that where referrals provided a narrative account of customers’ circumstances (described by one VOICES manager as being comparable with a soap opera storyline) these were rarely acted upon by social workers. What worked from an advocacy perspective, was ensuring that referrals clearly specified how presenting needs mapped onto the new “eligibility regulations” contained in the Care Act 2014. Eligibility is important because it triggers a legal duty for the local authority to meet a person’s needs.

To assist coordinators in their advocacy work, VOICES designed the “Multiple Needs Tool Kit” (Ormelas and Meakin, 2016). This provides a “step by step” guide to working through the Care Act 2014 eligibility regulations. The tool kit is a powerful advocacy aid as it records different viewpoints side by side: that of the person being assessed, that of the support worker (or advocate) and that of the social work assessor. One outcome of presenting information in this way is that it renders any discretionary judgement (both professional and non-professional) explicit and therefore open to much greater scrutiny and challenge. For example, hypothetically, the social work assessor might support the VOICES customer’s perspective that they are managing their “personal hygiene” well, while the view of the coordinator may be that the customer is unkempt and self-neglecting. Here, the social worker might argue the VOICES coordinator is being paternalistic, while the support worker might see the social worker as saving resources by not probing why the customer is declining care and support. The customer meanwhile can potentially find themselves stuck between both these professional judgements which might then be played out in terms of an assessment of his or her capacity. Thus, one limitation of the tool is that while it gives expression to the customer’s perspective, it does not necessarily lead to increased “choice and control”.

Initially, social workers and their managers in the local authority expressed concerns about the tool kit on the basis that it duplicated a “self-assessment” tool that was already being developed. However, VOICES addressed these concerns by making the aims of the tool kit clearer in the introductory section, providing reassurance that it was not intended to replace the formal assessments of professional social workers. This dialogue between the two parties marked a potentially important “first step” in moving towards a more collegiate and less combative relationship. The tool kit’s negotiated aims are:

- to ensure that people with “multiple needs” can record and communicate their needs as effectively as possible;
- to increase confidence among VOICES and other voluntary sector workers in working with the Care Act 2014;
- to support social workers (who may be unfamiliar with this “client group”) to explore how “multiple needs” impact on the need for care and support; and
- to enable relationships and information exchange between these two groups of workers who may not have worked together previously.

How the tool kit was working in practice was then regularly reviewed in a specially convened meeting (a community of practice) which brought together social workers and VOICES co-ordinators. Both VOICES co-ordinators and social workers agreed that the tool kit was helpful. For VOICES co-ordinators its main value was in promoting greater knowledge and understanding of how to work with the complexity inherent in the Care Act 2014 eligibility regulations or thresholds. For social workers who had little previous experience of working with people with multiple needs, it was acknowledged as being helpful in enabling them to ascertain a better understanding of the seriousness and gravity of risks associated with situations such as “rough sleeping”. It was also considered helpful in enabling social workers to understand the impact of fluctuating needs linked to behaviour driven by substance use and mental ill-health. One social work team manager said that it had transformed her own and consequently her team’s understanding of the vulnerabilities and difficulties facing this group of people.

Indeed, the tool kit appeared to be something of a Golden Ticket. This was because when the needs of VOICES’ customers were documented through its “lens” it was nearly always the case that they appeared eligible for care and support. This is because of the close parity between the consequences of “multiple needs” and the eligibility regulations (DH, 2017). For example, a very high proportion of VOICES’ customers have: impairments linked to physical and mental ill-health including substance misuse; associated difficulties with achieving two or more of the outcomes listed in the regulations, especially with regard to maintaining a habitable home environment and those outcomes linked to social inclusion (e.g. making use of necessary facilities or services in the community); and with consequent significant impacts on their wellbeing (e.g. as evidenced through high utilisation of hospital resources). Of the 16 tool kits completed (at the time of writing this paper) all triggered a Care Act 2014 assessment. Outcomes of the assessments were:

- Eight customers receiving a “personal budget”. In all cases these were managed by the local authority. In seven cases the local authority organised regulated services (providing a package of domiciliary (home care) and personal care into customers’ own homes) and in 1 case a Personal Assistant was organised for the customer.
- Six customers being supported in Extra Care sheltered accommodation because of needs requiring residential care.

Masterclass and community of practice

When the Care Act 2014 was implemented in April 2015, VOICES requested that the local authority deliver some introductory training. However, during the session the trainers acknowledged that they could not answer many of the questions the Act raised for VOICES’ customer group as the training was designed with older people and people with learning disabilities in mind. It was therefore recognised that this was uncharted territory, and that a joint training venture or Masterclass might help pave the way. Importantly, the Fulfilling Lives projects have a healthy budget for learning initiatives, while local authorities received few dedicated resources for Care Act 2014 implementation. The Masterclass was delivered as an interprofessional educational initiative in Autumn 2016 and brought together VOICES’ staff with two social work teams. This was followed-up in early 2017, with a session which brought together a wider range of local stakeholders including representative from housing and health. The sessions were led by academics who gave an overview of the policy field and who could also act as independent brokers to facilitate the subsequent discussion. VOICES was able to tap into this academic consultancy because it was linked to a shared study group.

The Masterclasses were well received by participants and generated a strong desire to continue learning together. This led to the formation of a Collaborative Working Group. The group was practitioner-led and adopted a “community of practice” methodology (see Cornes *et al.*, 2013; Hennessy *et al.*, 2013 for an outline of the model employed). Communities of practice are specially facilitated sessions which bring together different groups of people who want to deepen their knowledge and understanding of a particular topic. Through the use of anonymised case studies, the aim was to provide a “safe space” in which to discuss ethically challenging practice issues.

Progress to date

Reflecting back on the work that had taken place in the city around the early implementation of the Care Act 2014, key stakeholders from VOICES and adult social care who were engaged in the study group agreed that working together through the Multiple Needs Toolkit had enabled significant progress to be made with regard to “referral and access”. It was however acknowledged that relationships between VOICES and adult social care had been strained while cases were initially “argued”. Coming together through shared learning and the “community of practice” was seen as having been especially important in managing this conflict by enabling greater understanding of each other’s roles and pressures. While it was recognised that there was still much work to do locally to fully implement the Care Act 2014, there was a sense that this would be taken forward as a shared, collegiate endeavor. The perceived outcomes of working together were summarised in a blog in which was written by the Senior Social Worker involved in the study group. The outcomes were:

- increased knowledge, skills and confidence among social workers when engaging with people with multiple needs;
- increased knowledge, skills and confidence among VOICES coordinators when working within the legislative framework of the Care Act;
- more open sharing of knowledge and increased appreciation of the priorities of other organisations;
- development in working relationships with an increase in joint working between organisations; and
- smoother referral process between organisations leading to less defensive practice and improved outcomes for the individual.

Discussion

This case study lends further weight to Ellis’ (2015) argument that personalisation is an atypical form of “political implementation”. While the Care Act 2014 has closed a number of loop holes, for instance, clarifying the position of “homeless people” with regard to accessing the new care and support system, ambiguity remains high. For example, what constitutes an acceptable level of “personal hygiene” is not defined in the legislation and is therefore open to dispute. According to Mandelstam (2017, p. 17), the Care Act 2014 legislation and guidance contain many “short cuts and escape routes” that will inevitably be used by hard pressed local authorities to constrain customers entitlement to resources.

However, what this case study adds to the understanding of atypical “political implementation” is the importance of exploring not just the relationship between “top-down” and “bottom-up”, but also the interplay that can exist between different kinds of “bottom-up” change agency. In this case study, the interplay between the local authority “street level bureaucrat” and the voluntary sector “advocate-activist” was able to lever some quite significant transformational change. This was with regard to the assumptions and practices of deservingness, leading to innovation in access and referral. These are areas which Ellis (2015) describes as being remarkably resistant to change.

To understand how this “bottom-up” collaborative was able to lever change, two overarching factors seem important. First, VOICES was able to position itself as the “trouble maker” (Hough, 2013) within the systems change process because it was charitably funded and therefore outside the control of the local authority’s finance and contracts management systems. These are recognised as powerful transactional technologies for securing the compliance of “providers” (Ellis, 2015). Indeed, there are questions as to the potency of voluntary-sector change agency that does not have this freedom.

The second factor that seems to have enabled the transformational change is that VOICES put in place strategies for actively managing the “High Ambiguity/High Conflict” dynamic.

Managing high ambiguity

At the outset, social workers could potentially find themselves metaphorically sandwiched between VOICES “bottom-up” activism and the “top-down” managerialist control of their local

authority employer. Through persistent advocacy and the “Multiple Needs Tool kit”, VOICES sought to prevent what they saw as the “misuse” of the Care Act 2014. This effectively closed down older “escape routes” and potentially prevented newer ones from emerging. For example, persistent advocacy successfully challenged the view that the poor outcomes experienced by their customers could be explained by poor life choices. This was achieved by invoking the new Care Act 2014 regulations and making the case interprofessionally (clinically in some cases) that poor outcomes were more likely the result of impairments linked to physical and mental ill-health.

Here, the ambiguity level was not reduced, rather the scope it afforded for professional discretion was exposed and potentially constrained by VOICES through the use of the “Multiple Needs Tool Kit”. Indeed, Ellis (2015) alerts us to the tension between the competing imperatives of transformational technologies designed to lever co-production, and the aforementioned transactional technologies designed to manage the threat this level of self-governance would pose to fiscal control (p. 243).

Reducing the conflict level

Seeking to change the system through “persistent advocacy” and technological means did have some adverse consequences. The tool kit initially engendered a sense of professional protectionism around the issue of ownership of the assessment process. Thereafter “persistent advocacy” accompanied by increased use of escalation (complaints) procedures raised the conflict level leading to poorer collaborative working. This could lead to problems such as unnecessary hospital readmission which were symptomatic of a fragmented health and social care system. Thus moving towards less conflictual and more integrative ways of working became imperative to sustain the transformation process. This was achieved through the Masterclass and the Collaborative Working Group. It is well documented how communities of practice can open-up spaces for shared learning and reflection, leading to more ethical ways of dealing with the practice challenges of being stuck between what has been described as “The rock of increasing demand and the hard place of apparently decreasing resources” (Scanlon and Adlam, 2012, p. 75).

In many respects, the Care Act 2014 provided the ideal window of opportunity in which to initiate this relational and cultural exchange as it marked a “symbolic” break from the past. Indeed, it might be suggested that VOICES was successful in engaging and enthusing social work colleagues, because the enterprise was viewed as a new implementation project and not an intervention in “systems failure”. Under the cover of having to do things differently, it was then possible to renegotiate the street level bureaucracy that had previously impacted negatively on people experiencing multiple needs, and indeed, to secure something akin to a Golden Ticket. This is the “gruesomely satisfying resolution”. Slasberg and Beresford (2016) argue that while the government claims to be creating historic change to social care in England through the Care Act, this is not substantiated in the legislation and guidance. Thus, instead of tackling exclusion, the Care Act 2014 might just have easily been used as a “Smoke screen for the continuation of a system that has served short term political objectives well, but has been anathema to the person-centred system that government claims to want” (Slasberg and Beresford, 2016, p. 4).

Conclusion

Matland (1995) suggests that by studying a policy’s level of ambiguity and conflict, testable predictions can be made as to how an implementation process will unfold. He sees “political implementation” as characterised by “low ambiguity/high conflict”. With “low ambiguity” come clear objectives and the possibility of tight government control. This, he argues, reduces the scope for street level bureaucracy to influence outcomes. In applied terms, the implication is that where a social problem is already impacted by “political implementation” processes then progressive charities and funders would be better off targeting their resources at government officials than grass roots voluntary sector alliances.

However, this case study does not support this hypothesis. First, personalisation is an atypical form of “political implementation” characterised by “high ambiguity”. As Ellis (2015) argues this allows considerable scope for professional social work discretion which in times of austerity

serves to dampen the transformational effect. Second, Matland sees only one source of control over the “street level bureaucrat”, that from the government official above. What this case study illuminates is the potential for the “advocate-activist” to intervene from the “bottom-up”, in this case preventing “misuse” of the eligibility regulations in order to secure improved outcomes for people with multiple needs. Third, while Matland views “high conflict” as largely unproblematic, this case study is testament to the importance of lowering the conflict level and moving towards more collaborative or network based forms of governance in order to prevent fragmentation and other systemic issues from arising. Ultimately, this case study would suggest that where there is “high ambiguity” as in the case of the Care Act 2014, then the key to successful “political implementation” may be to release the grip of managerial domination and to foster a vibrant and well-funded independent charitable and voluntary sector.

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