



Care Management and Self-Directed Support

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ABSTRACT

Care management is a central part of the current health and social care system, but the development of Self-Directed Support raises significant questions about the future of this function. Moreover, if the current design of the care management function is to change, then this will raise significant challenges and opportunities for those professionals who currently act as care managers. These changes may even allow social workers to return to a way of working that fits better with their professional ethos.

KEYWORDS: CARE MANAGEMENT; CASE MANAGEMENT; SELF-DIRECTED SUPPORT; SOCIAL WORK PRACTICE; HEALTH AND SOCIAL CARE; INDIVIDUAL BUDGET

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Introduction

Self-Directed Support is the name for the whole-system change of the current social care system to a system where people are put in as much control of their own support as possible (Poll *et al*, 2006). There are different versions of Self-Directed Support in different countries, but this article will focus exclusively on recent developments in England, and in particular on the impact of Self-Directed Support on care management.

It is important to begin by setting out a clear account of care management as it currently functions, in order to examine the changes implied by the implementation of Self-Directed Support. The article then reviews the meaning of these

changes to people currently involved in the care management function, in particular social workers.

Care management

Care management is an innovation in social care that began to be tested in the 1970s. The explicit rationale for care management was to provide an effective mechanism for individualisation of care, development of more home-based support solutions and stimulation of greater choice in service provision. The influential Griffiths Report stated:

At the local level the role of social services authorities should be reorientated towards ensuring that the needs of individuals within specified groups are identified, packages of care are devised and services coordinated, and where appropriate a specific care manager is assigned. The type of services to be provided would be derived from analysis of the individual care needs; the responsibility of social services authorities is to ensure that the services are provided within the appropriate budgets by the public or private sector according to where they can be provided most economically and efficiently. The onus in all cases should be on social services authorities to show that the private sector is being fully stimulated and encouraged and that competitive tenders, or other means of testing the market, are being taken. (Griffiths, 1989 pvii).

The report went on to propose that there was a new job role to be created to underpin this new approach.



In cases where a significant level of resources are involved a "care manager" should be nominated from within the social services authority's staff to oversee the assessment and re-assessment function and manage the resulting action. Where care is already being effectively managed, this proposal will amount to little more than making existing roles explicit. (Griffiths, 1989 p14)

Although there are many local versions of care management, the role has now become a near-universal feature of local systems. The *Caring for People* White Paper (DoH, 1989) provides an effective summary of the intended system.

Case management provides an effective method of targeting resources and planning services to meet specific needs of individual clients... To be effective case management systems should include:

- Identification of people in need, including systems for referral*
- Assessment of care needs*
- Planning and securing the delivery of care*
- Monitoring the quality of care provided*
- Review of client needs...*

The government also sees advantage in linking case management with delegated responsibility for budgetary management. This need not be pursued down to the level of the individual client in all cases, but – used flexibly – is an important way of enabling those closest to the identification of client needs to make the best possible use of the resources available. (DoH, 1989 p21–2)

Note that, in the passage quoted above, the term 'case manager' is preferred to 'care manager' and, for a period, both terms were used. Eventually 'case manager' fell out of use and the Department of Health and most local authorities now use the term 'care manager'. In reality, the model of service delivery described above has become an important template, shaping local practice, although some local authorities have continued to resist the use of the term care manager as a job title.

Like many good ideas, care management has evolved as it has been implemented and as it has been affected by other changes in policy and local systems. However, there appears to be a growing sense that, whatever the achievements of local authorities and those care managers who are trying hard to make this system work, there are deep problems. One well-respected observer has noted that:

... systems of care management seen in most parts of the country today [...] under-developed, under-supported by information systems, without devolved budgets, overly bureaucratic, unresponsive to user preference, of unproven effectiveness and cost effectiveness (Knapp, in Blewett et al, 2007).

This article does not aim in any way to evaluate the success of care management or to deny its value. Instead its aim is to explore the potential impact of changing the system within which care managers have to work towards a system of Self-Directed Support where resources and control are designed to be much closer to the person who needs support.

To begin with we can identify a number of constraints in the current system that have a significant impact on how care managers have to work. In particular there are three features of the current system that bear examination:

- the inflexibility of the resources that can be identified and used to meet needs
- the disguised nature of the rationing system by which resources are assigned
- the professionally dominated process of planning and organising support.

These factors seem to constrain how care management has been delivered in practice. The next section examines each factor in more detail.

Constraints on care management

Flexibility of resources

It is implicit in the early definitions of care



management that the resources that care managers have at their disposal would be flexible and could be shaped to meet the needs of the individual most effectively. However, care managers tend to find that the reality is quite different. Most resources are pre-committed to particular services and, given current commissioning practices, cannot easily be individualised. For example, a recent report on services for people with learning difficulties concluded that:

over 70% of the money spent by councils in 2005–06 was used to fund traditional building-based services,

and that councils are tied into:

long-term commitments to pay for care that is expensive and cannot easily be changed as a person's needs change (CSIP, 2007).

This means that care managers are often restricted by local commissioning practices to finding a 'place' for someone within a block contract or an in-house service. This is not a flaw in care management; it is a consequence of the current system which, as I have argued elsewhere, is:

structurally wasteful, because resources are directed towards services instead of towards people (Duffy, 2007).

Disguised rationing

The second key constraint on care managers is the need to ration resources, but without an explicit framework for rationing. Care managers are expected to work 'within the appropriate budgets' (Griffiths, 1989) but without any clear or explicit set of principles by which to govern their rationing decisions (or the decisions of their managers). Rationing exists, but it is disguised rationing.

Even when central government has tried to provide a framework for rationing, it is clear that

the central rationing questions remain obscure. Under *Fair Access to Care Services* (DoH, 2002) eligibility for support is determined by level of need, but there is no clarity about what level of resources is appropriate for what level of need. Instead a vague formula off-loads the real problem of rationing back on to local authorities.

Councils are also reminded that they may take their resources into account when drawing up their eligibility criteria against which they assess individuals' needs, and when deciding which services will be provided to meet those needs. (Department of Health, 2002)

Some believe that it is the rationing function played by care managers that makes their role incompatible with their other role as 'care planners' (Dowson, 2002). On this analysis there is a 'conflict of interest' between trying to balance the books of the local authority and trying to find the right way of meeting someone's needs. However, this may not be quite the right way of understanding the fundamental problem.

Certainly many care managers do not feel that their primary purpose is to ration resources; they believe that their role is to advocate for services on behalf of their clients in the context of scarcity. This means that success in identifying resources for 'clients' is highly dependent on a number of factors: skill in advocating a case, the state of the budget, the urgency of the case, effective pressure from the person or their representatives. Overall it is at least plausible that this process of competitive advocacy, in the absence of any explicit framework for rationing, will have the following consequences.

- People with the same level of need will receive very different levels of funding. For example, in Control's work on resource allocation has revealed that there is a very weak correlation between the level of need and the level of resources received, even when the conception of need is defined by local practitioners (Duffy, 2007).



- There will be increased emphasis on the assessment process in order to justify the case for resources. For example, it is striking that work on how care managers use their time suggests that 45% of the functional time of care managers is spent on gathering assessment information (see below). If 15% of the £19 billion social care budget in England is spent on assessment and care management, then about £1.2 billion is spent on getting social care recipients to provide information to the social care system (National Statistics, 2005).
- There will be more expensive services that are focused on people in crisis. For example, CSCI has reported that expenditure for adults in 2005–2006 increased by four per cent in real terms without any increase in the number of people served (CSCI, 2006).
- There will be continued emphasis on purchasing ‘professional’ services that have high legitimacy, rather than more innovative services. For example, the ADSS report on learning disability expenditure noted that, despite rhetorical and policy demands for more innovative forms of support:

use of higher cost services such as residential care, nursing care, and private hospitals has increased rapidly over the last 10 years (ADSS, 2005).

These consequences occur despite the fact that most care managers are well-motivated to work responsively and efficiently to organise good community-based support, distribute resources fairly, and prevent crises and institutional service provision. Arguably, these problems exist not because of rationing (which is an inevitable feature of any real-world system), but because the current system disguises the need for rationing. What replaces formal and principled rationing is a process that encourages a form of competitive ‘advocacy for service’. On this analysis, care managers do not have a ‘conflict of interest’; rather, in pursuing the interests of those they serve, they are forced to play by the inappropriate rules of the current system.

Professional domination

The third constraint on care managers concerns their professional duties. In general, care managers are expected to assess everyone, develop care plans for everyone and organise support for everyone. The system is not sensitive to the capacities and gifts of those who must use it, not because care managers themselves hold negative views of the capacities of those they serve – quite the opposite. For example, in the following exercise care managers were asked who they believed would be the best person to develop support plans for real people on their present caseload. This gave rise to the distribution shown in *Figure 1*, opposite.

The same group were then asked to consider who would be the best people to manage or co-ordinate the support to the same people on their caseloads (*Figure 2*, opposite).

This data, which has been aggregated from several sessions, has been provided by approximately 100 care managers, considering a total of 800 cases. The majority, but not all, of those care managers were specialist care managers for people with learning difficulties. This makes the findings particularly interesting, given the inherent complexity and the higher degree of social isolation experienced by people with learning difficulties. The data is also interesting because it shows judgements made by care managers about their own roles and, while it may not be objective, it makes the actual result even more striking.

In summary, the structures of power and control within which care managers are asked to work seem to be having a significant negative impact on the ability of care management to achieve its original objectives. It is difficult for care managers to deliver flexible, personalised and cost-effective support services when the system cannot provide a fair and flexible level of funding that can be controlled by the most appropriate person.

Self-Directed Support

The most recent attempt to reform the care management system in England is the work being



done to promote Self-Directed Support by in Control (www.in-control.org.uk) and the Department of Health's Individual Budget Pilot

Programme (www.individualbudgets.csip.org.uk). Both these initiatives have built on much earlier innovations, in particular the development of the

Figure 1: WHO IS THE BEST PERSON TO DEVELOP THE SUPPORT PLAN? CARE MANAGERS' VIEW

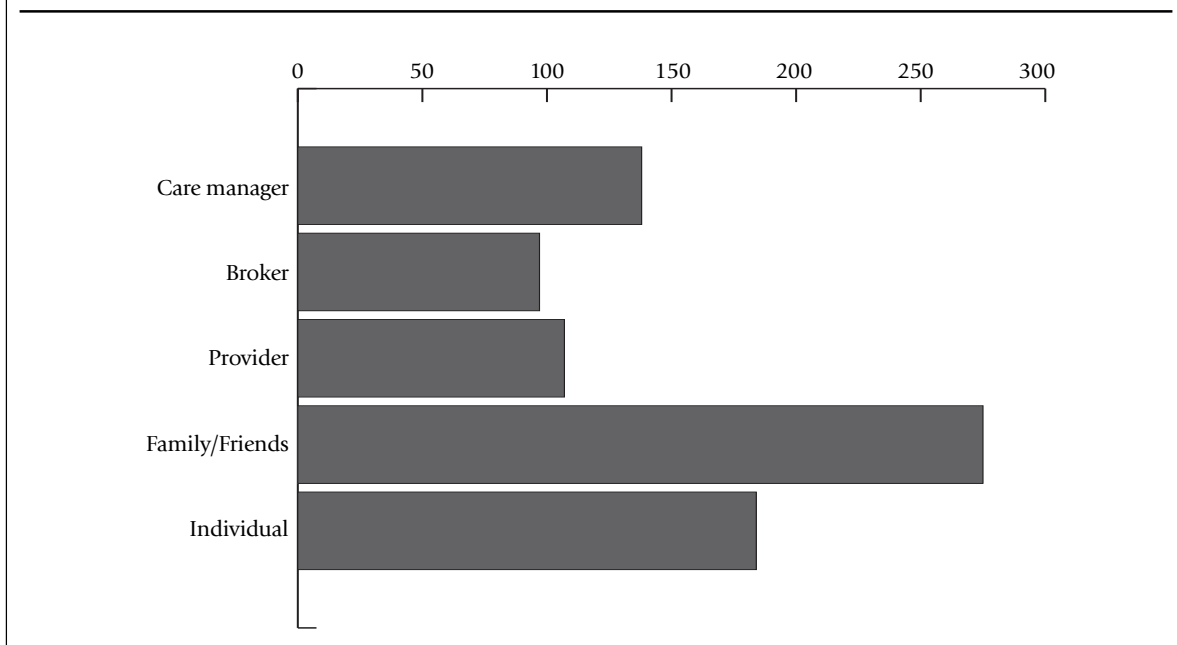
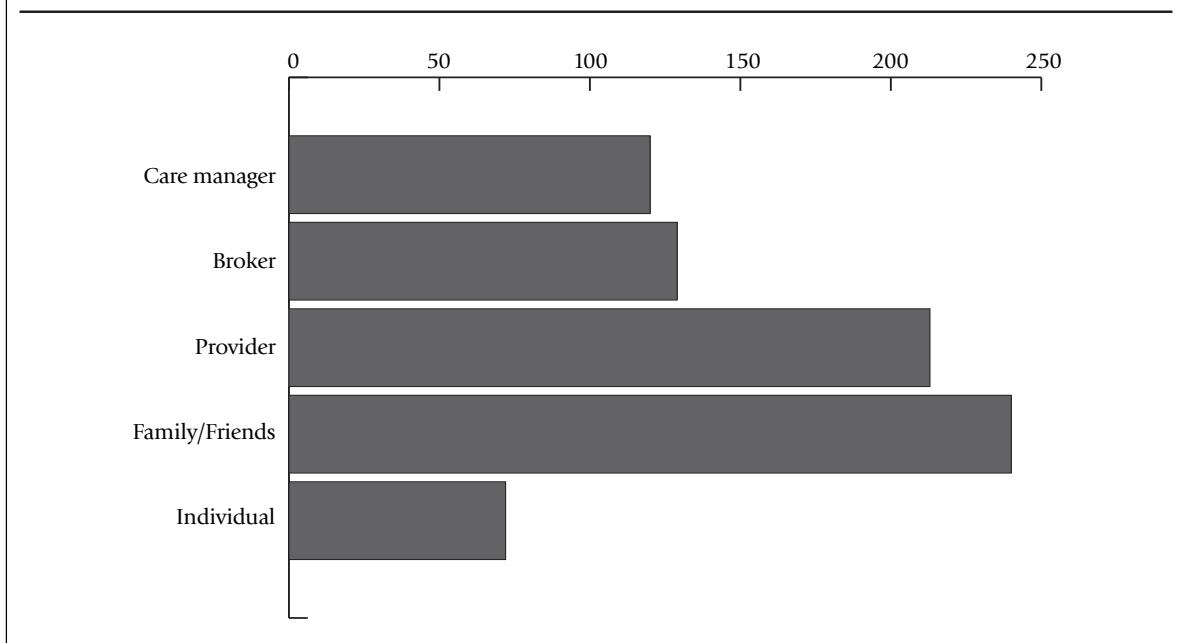


Figure 2: WHO IS THE BEST PERSON TO ORGANISE THE SUPPORT? CARE MANAGERS' VIEW





Independent Living Fund (ILF) and then the Direct Payments system, both of which also provide funds that can be controlled directly by disabled people.

While the ILF and Direct Payments have clearly been successful in their primary goal of improving the lives of disabled people, they are often implemented at one remove from the existing care management system. The ILF system is run by a UK-wide independent trust with its own staff, administration and rules, even though it cannot provide funding unless the local authority's care manager has also carried out an assessment and agreed to provide an appropriate service (Henwood & Hudson, 2007). Direct Payments, on the other hand, are provided directly by local authorities, but are usually delivered by a specialist unit that makes allocations following a care manager's assessment and care plan. It is rare to find a local authority that has thoroughly integrated Direct Payments into the care management process (CSCI, 2004).

Thus, in contrast to the ILF and Direct Payments, Self-Directed Support can be understood as an attempt to achieve the same goals, but by reforming the whole system in which the care manager operates. There are many elements to Self-Directed Support, but focusing on those which most directly affect the care manager helps identify the following key innovations.

Rules-based rationing

The current system of rationing is by professional judgement; there are no explicit rules for determining how much funding people should receive. Instead one or more people decide how much is fair on the basis of their judgement of the needs of the individual and what is available in the overall funding pot.

This is not the only way of rationing scarce resources. It is also possible to identify explicit rules setting out what is a fair allocation. In fact it is often the case that we expect a fair system to be able to identify the rules which determine the distribution of resources. Currently most of the work to develop an explicit rationing system for

resources has been carried out by local authorities that are members of In Control. The approach that has been developed seems to be able to offer a method which is both fairer and more affordable. The name for this new system is the Resource Allocation System (RAS) (Duffy, 2005).

Fundamentally this is a shift towards a system of transparent entitlements, in which people have a right to support and are clear about how much support they can reasonably expect to receive. Arguably this will radically alter the power balance within social care.

Support planning

The primary reason for moving towards a rules-based approach is that it changes the way in which planning is carried out. In the current system the assessment process leads straight into the development of a care plan. This care plan is then used to advocate for resources, so the care manager must control the care plan. In effect, the current rationing system encourages the care planning process to be more professionally dominated than necessary.

Implementation of the RAS can change this process. There must still be an initial evaluation of needs, but because it is focused solely on identifying the key needs that determine the fair allocation, it can be carried out much more quickly. In fact it is even possible to use a self-assessment questionnaire to enable people to identify their own Individual Budget directly.

Once people know their own budget, they are expected to produce their own support plan. (The term 'support plan' is preferred to 'care plan' because the word 'care' implies passivity on the part of the person who is 'cared for'.) Critically, this requires the local authority to be explicit about the criteria for successful support planning. In Control's model of good practice (in Control, 2006) suggests the following seven criteria for a successful support plan.

- Be person-centred.
- Set clear outcomes.



- Describe the planned support.
- Keep the person healthy and safe.
- Maximise self-determination.
- Show clear management.
- Be in budget.

This does not mean that everyone can produce a support plan unaided, but it does mean that autonomous support planning is the default option. Whoever produces the support plan, it remains the role of the care manager to check and approve it; this is surely a more sensible use of the skills of a care manager. It is not reasonable to expect a care manager to know the details of someone's life and community sufficiently well to produce the optimal support plan, but an experienced professional is in a good position to interrogate, challenge or help improve a support plan.

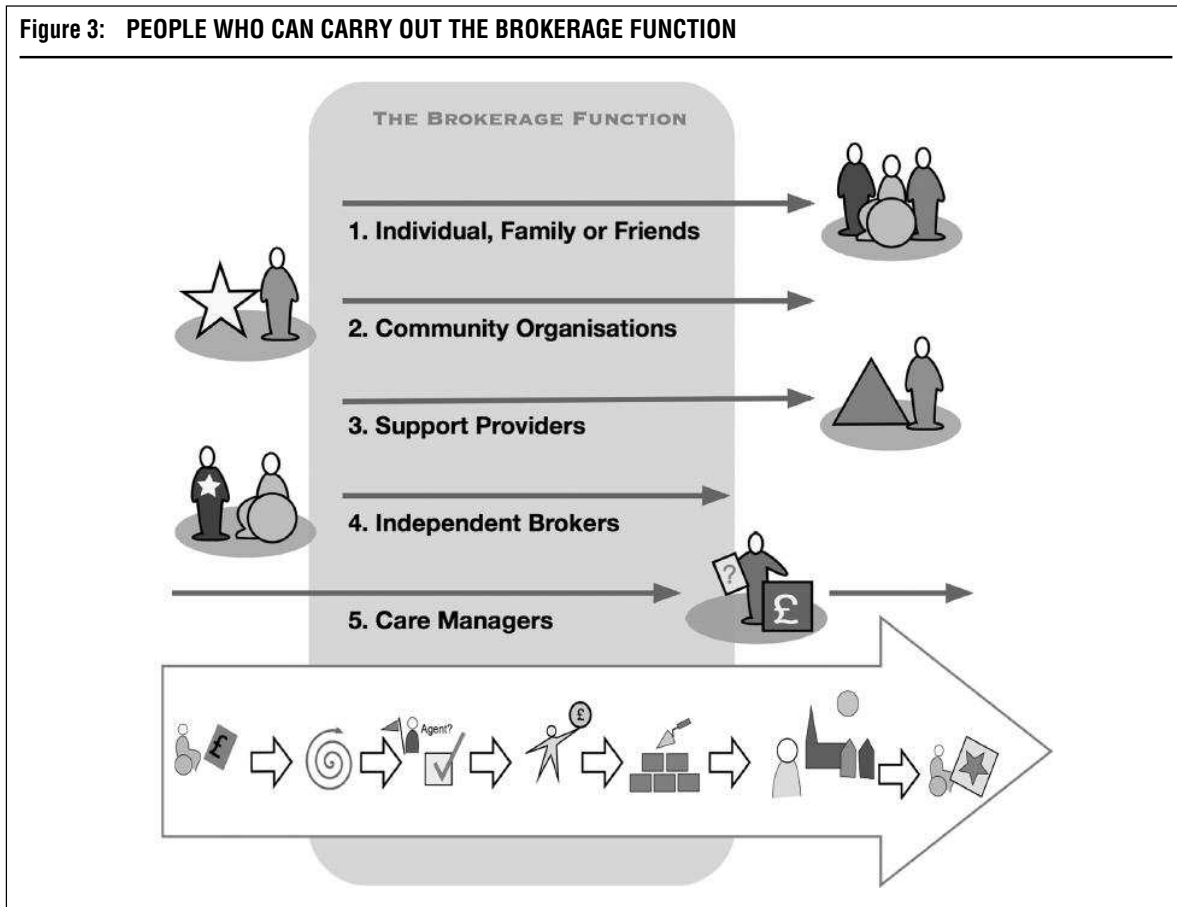
Support planning enables a shift to what we might call co-produced self-assessments: people leading the development of their own support plan, but within a framework of support, information and challenge.

Support brokerage

Support brokerage is the process of sorting out the necessary plans, arrangements and practical support. It is a function that can be carried out by many different people and it is not necessarily one discrete function; different people can take on different parts of it. In Control has identified at least five different people who can do some or all of the brokerage function (*Figure 3*, below).

It is important to note that in the current version of Self-Directed Support the care manager may have a dual role at this point:

Figure 3: PEOPLE WHO CAN CARRY OUT THE BROKERAGE FUNCTION





- facilitating brokerage – helping people to think through how much help, if any, they require to plan and organise their support plan, and helping people find the necessary help
- doing brokerage – providing brokerage support directly, helping people to plan and organise their support package.

The figures quoted earlier suggest that approximately 20% of cases might need direct brokerage by the care manager. However, particularly in the early days of Self-Directed Support, it is likely that care managers will tend to under-estimate what people can do for themselves or find it difficult to mobilise other resources to provide the brokerage function. This raises important practical questions about how best to enable people to be their own brokers, how best to stimulate brokerage by others, and when care managers should intervene and act as brokers themselves. Moreover it will be important for local authorities to determine to what extent people can be allowed to pay for the brokerage function from within their own personalised budget; this approach seems more consistent with Self-Directed Support, but to date services of that kind are usually commissioned and controlled by the authority directly.

Degrees of control

Currently, systems like Direct Payments which give people direct control of their own support funding are almost inevitably ‘partial’ systems that focus on those who are ready, willing and able to take control of their own support. Yet a universal system of reform needs to be able to include:

- people who do not want direct control of their own budget
- people who cannot manage their own budget
- people who shouldn’t manage their own budget.

Currently, people who fall into any of these categories will usually be excluded from Direct Payments, and inevitably this will tend to exclude a large sector of the social care population, among

them people with dementia, serious mental health problems or significant cognitive impairments. Currently in Control recommends two distinct methods for overcoming this problem, ensuring that everyone has the maximum level of control appropriate to their situation.

- Appoint an agent; if someone needs support to agree the support plan with their local authority, the authority will need to appoint a willing agent to act as the person’s representative in the initial negotiations (West Sussex, 2005).
- Use a budget controller; there are actually a number of other ways in which people can control an individual budget, besides using a Direct Payment (including use of a representative, a Trust, a brokerage agency or a provider agency, and of course continued use of the care manager to commission services) (in Control, 2006).

In practice, it is interesting to note that, while Self-Directed Support is a universal system that allows ‘conservative’ choices, this does not seem to slow down the move to Direct Payments (although this may change if other services improve and become more responsive). In the initial piloting of Self-Directed Support, in Control found that more than 50% chose to manage their budget as a Direct Payment (Poll *et al*, 2006).

Outcome-focused reviews

The review process is integral to care management, although in practice many local authorities have started to develop review teams which employ staff who are not professionally qualified. It seems that the review part of the care management process has been downgraded and the assessment process has become increasingly prioritised.

However, the logic of Self-Directed Support implies that this should be reversed, and that in future the review should become the most important aspect of the whole care management process. The test of success in care management will be whether a particular arrangement is working, that good outcomes are being achieved. This cannot



be evaluated properly at the beginning of the assessment process, but it can be evaluated as the individual or their representative begins to make real decisions about how to use their funding.

This is a fundamental shift in thinking, from a 'static placement' focus to a 'dynamic outcomes' focus. Currently, because services are treated as fixed slots into which people are placed, the general approach to quality control emphasises making the right initial assessment decision and then regulating quality by setting standards and making inspections. But if people are in control of their own funding, this approach to quality will be quite inappropriate.

Self-Directed Support means that someone can change their minds, change their service, learn and adapt quickly and flexibly. The primary question for the person will be whether a particular service is helping them meet their needs in a way that works for them. In its turn, the local authority will need to shift its attention to finding out whether people are meeting their needs and achieving good outcomes. If not, the arrangement will have to be changed, and ultimately the local authority will need to change who is acting as the primary controller of the budget. If the arrangement is working well, then the local authority should be sharing what is being learnt, what innovations or successes are being achieved, with the wider population.

Overall, Self-Directed Support is not a way by which a local authority weakens its duty of care – quite the opposite. It is actually a way in which the local authority fulfils its duty of care better by making sure the right person controls the right budget, with the maximum possible degree of flexibility. In time it may be seen that it is a failure of a duty of care for authorities to control a resource that others can control more effectively, or to fetter the discretion of those controlling the resource with unreasonable rules and restrictions.

Professional impact of self-directed support

It is important to consider the likely impact of Self-Directed Support on the various professional

groups that currently fulfil the care management function, in particular the impact that Self-Directed Support will have on social workers.

One of the most encouraging side-effects of the early implementation of Self-Directed Support is that many social workers have been enthusiastic about this new approach and see it as connecting well with the reasons for which they originally chose to join the social work profession. For example, the Project Manager for Individual Budgets in West Sussex, where they are applying Self-Directed Support to older people's services, wrote:

Generally speaking, the introduction of IBs has been met with considerable enthusiasm and commitment by practitioners (once the RAS is agreed), principally because of the focus on user empowerment and creativity in support planning. Many practitioners and Team Managers feel that this is 'what real social work is about... it's what I trained for...'. Those sites that have started to pilot IBs are gaining confidence and are keen to continue (Goldingham, 2007).

This strong congruence between Self-Directed Support and the real values of social work is not surprising. For instance, the code of practice for social care workers issued by the General Social Care Council says:

As a social care worker, you must protect the rights and promote the interests of service users and carers. This includes (1.1) treating each person as an individual, (1.2) respecting and, where appropriate, promoting the individual views and wishes of both service users and carers, (1.3) supporting service users' rights to control their lives and make informed choices about the services they receive... (GSCC, 2002).

Clearly these ethical principles are hard to meet meaningfully in the current system. Only a shift to something like Self-Directed Support will enable



social care workers, and social workers in particular, to give people the necessary choice and control to make these principles real. But even if the theoretical congruence between social work and Self-Directed Support is high, there are still a significant number of challenges for social workers and the other professionals involved in care management.

Time management

One of the most significant challenges will be the very different use of time that will be required of social workers in a system of Self-Directed Support. For instance, a recent report broke down the activities of care managers into a large number of different tasks (Weinberg *et al*, 2003). If these tasks are mapped back on to the core care management functions, we can get some sense of how care managers currently balance their time between these functions (*Table 1*, below). The discounted figure is based on extracting travel and merely administrative functions.

Taking this analysis as a starting point and reflecting on the consequences of Self-Directed Support, we might speculate that, in future, care managers might spend:

- much less time on gathering assessment information for everyone
- much less time on support planning for some people
- much more time on support planning for some people
- much more time on the review function for everyone.

Table 1: HOW CARE MANAGERS USE THEIR TIME

Functions	Actual	Discounted
First point of contact	6.8%	11.4%
Assessment information	27.0%	45.4%
Planning support	2.4%	4.0%
Developing support	7.6%	12.8%
Problem-solving	11.3%	19.0%
Reviewing	4.4%	7.4%
Organisational functions	40.6%	
TOTAL	100.1%	100.0%

In other words, the care management function may need to be radically rebalanced, both away from assessments and towards reviews, and away from limited care planning for everybody and towards intensive support to some. In practice, such rebalancing is always difficult; practitioners often find it easy to identify new work they should be doing, but much harder to do less work.

Performance management systems

A more distant challenge will be that many of the current central systems for controlling care managers and encouraging better performance have not really been synchronised with Self-Directed Support. In particular, there are particular difficulties in trying to make sense of the single assessment process (SAP) and the Department of Health’s monitoring system Referrals, Assessments and Packages of Care Project (RAP). These systems were developed to drive forward performance improvements in the old system; it is unlikely that, without thoughtful interpretation, they will be sensitive to the dynamics of the new system.

This is not because Self-Directed Support is inefficient – quite the opposite. An approach which makes better use of the energies and capacities of ordinary citizens and which is driven by their decisions is likely to be more efficient. Moreover, Self-Directed Support allows greater activity in parallel rather than in series, which promotes increased overall responsiveness and efficiency.

Cultural resistance

A further challenge will be cultural resistance to change. Even though Self-Directed Support is more congruent with social work values, people do not like change, and in particular they do not like to have change imposed on them. It will be very important that those who lead the implementation of Self-Directed Support do not repeat the mistakes made when care management was implemented in the 1990s. These changes were imposed on the professions by central government in a way which would have been impossible with more powerful



professions. (It is unimaginable that doctors, lawyers or nurses would have allowed government to make such radical changes to their patterns of professional practice without greater consensus.)

Deficit thinking

Perhaps an even bigger challenge will be to overcome the long-standing practice of seeing older people, disabled people and their 'carers' as fundamentally needy, to focus on the deficit and to miss the many capacities and gifts that people bring. Such deficit thinking will make it very hard for social workers to enable people to take more control; instead there will be a tendency to get over-involved and to do more than is really necessary. This is not only wasteful but, more important, it fosters undue dependence. The following story helps identify the challenge.

Peter is someone with a learning difficulty who lives at home with his family. His local authority was experimenting with Self-Directed Support, and when Peter complained about the day centre that he did not want to attend, his care manager went to see him. Peter had been chosen to be part of the Self-Directed Support programme, so when the care manager went to see him and his family, instead of doing a long assessment she told the family that, as Peter was using a service that currently cost £10,000 per year, plus £20,000 of ILF that he was already receiving, he could begin planning to use that money differently – to suit his needs better. The family got together that weekend, Peter, Mum, Dad, brother, sister-in-law, and came up with a plan. By the following week they had presented the support plan to the care manager, who admitted that it would have taken her months to get to that same point. The plan was agreed, and within a few weeks Peter had made the changes he wanted.

Now this is a positive story about an ordinary family who showed that they had the capacity to do something that the professional involved would have normally expected to do herself. It took great self-discipline on the part of the care manager not to get more involved, and to allow the family to do

the planning. Given the institutional and paternalistic history of social care services, it is going to be very difficult for professionals to let go and let others plan and organise support.

What is likely to help local practitioners is to see the development of a framework of helpful resources that make it easier for people and families to lead their own planning. These are likely to include:

- easy-to-use planning tools
- guides and sources of information about support
- peer support and the existence of user-led organisations
- direct training and education for citizens.

New skills and a new focus

Arguably, one of the areas to which social workers will need to give more emphasis is support to people whose needs are particularly complex or who may be behaving in ways that are challenging and risky. Since the original community care reforms, a growing number of people have been placed in expensive institutional placements, often with a diagnosis of 'challenging behaviour'.

One reason for this trend might be that, as the care management process has become more standardised, it has been harder to invest the necessary time in those people who really need support to develop appropriate, personalised support services. Often the key to developing such services is developing a relationship of trust with the person in order to begin the process of helping the person slowly take control of their life. Self-Directed Support provides the necessary tools for this approach, but care managers will need to be given the time to apply these tools and to practise the appropriate skills.

Conclusion

This is only a partial survey of the impact of Self-Directed Support on the care management system, and much of it is still speculative. There are now more than 2,000 people using Self-Directed Support, but the full impact on care managers will be clear only when the numbers are much higher.



Overall there are significant reasons to be positive about how these professional roles will develop. Self-Directed Support offers opportunities for professionals to focus their skills on those who need them most and to increase their ability to make a good impact on people's lives by enabling people to do more for themselves and to get support that is more personalised and appropriate.

But there are two fundamental challenges. First, local leaders must ensure that the skill and energy of care managers are not wasted and are refocused effectively. This may mean challenging some long-standing ways of working. Second, professional groups, particularly social workers, will need to take control of their own destiny and begin to define good professional practice in Self-Directed Support. For those social workers who still resist the term care management, it may even be time to offer a different account of what it means to be a social worker, an account which is consistent with the right of older people and disabled people to get support and to control their own support.

If we are to avoid the fate of social work in the 1990s, the social work profession itself must lead the process of change. It must not only actively help bring about the new system of Self-Directed Support, but also begin to redefine its own role and standards and ensure that it is genuinely accountable for achieving real and positive change for individuals and communities. Only by exercising leadership will the profession be able to shape its own destiny.

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