

**Implementing Personalisation in
Northcott's Services
A Scoping Paper
June 2010**

Authors: Liz Hopkins, Mel Hughes; Planning and Development Unit
Liz Forsyth, Service Development & Government Relations Manager

CONTENTS

EXECUTIVE SUMMARY	4
BACKGROUND	4
SECTION ONE	
1. OVERVIEW	5
1.1 Personalisation	5
1.2 Definitions	6
1.3 History of Personalisation	7
2. THE INFLUENCE OF INTERNATIONAL PERSONALISATION	8
2.1 Thinkers and Practitioners	8
2.2 Service Providers	8
3. CURRENT PRACTICE	8
3.1 Australian federal and state governments	8
3.1.1 Federal government	8
3.1.2 NSW government	9
3.1.2.1 NSW Opposition – Liberals/National	10
3.1.3 Other states and territories	10
3.2 Australian Third Sector Organisations	11
4. AUSTRALIAN PERSONALISATION	11
4.1. Western Australia	11
4.2 Victoria	12
4.3 Queensland	12
4.4 New South Wales	13
4.5 South Australia	13
5. COMMON IMPLEMENTATION THEMES	13
5.1 Overall systemic change	13
5.2 Whole of government approach	13
5.3 Managerial commitment to systemic change	14
5.4 Structural change	14
5.5 Cultural change	14
5.5.1 Staff adaptation and training / skill development	15
5.5.2 Partnerships, collaboration and ‘co-production’	16
5.5.3 Barriers to cultural change	16
5.5.4 Closing the gap between rhetoric and practice	16
5.5.5 How to evaluate	16
6. HOW PERSONALISED ARE NORTHCOTT SERVICES CURRENTLY	16
6.1 A Criteria for Personalisation	17
6.2 Validity issues with the data	18
6.3 Results	18
6.3.1 Who completed the survey	19
6.3.2 Where are Northcott’s services rated on the scale	20
SECTION TWO	
7. WHAT IS REQUIRED	20
7.1 Developing a deep understanding of personalisation	21
7.2 Changes in organisational structure and processes	21
7.2.1 The development of new systems	22
7.2.1.1 Financial and administrative systems	22
7.2.1.2 Client documentation systems and tools	23
7.2.2 Management structures	23
7.2.3 Innovation	24
7.3 Leadership and managerial commitment	24

7.4 Staff values, attitudes and skills	24
7.4.1 Training	24
7.5 Investment in clients and families	25
8. WHAT ARE THE CHALLENGES AND RISKS?	25
8.1 Financial risks and service viability	26
8.2 Workforce concerns	27
8.2.1 Skill sustainability	27
8.2.2 Labour market conditions	27
8.2.3 Training costs	28
8.3 Risk management issues	28
8.3.1 Duty of care	28
8.3.2 OHS and HR issues	28
8.3.3 Governance	29
8.3.4 Litigious risks	29
8.4 Time and scale of change	30
9. WHAT DECISIONS NEED TO BE MADE	30
10. CONCLUSION	32
11. RECOMMENDATIONS	33
APPENDIX 1	35
APPENDIX 2	36
APPENDIX 3	37
APPENDIX 4	38
APPENDIX 5	39
APPENDIX 6	40
APPENDIX 7	42
APPENDIX 8	44
APPENDIX 9	45
REFERENCE LIST	46

EXECUTIVE SUMMARY

The purpose of this paper is to scope the issue of implementing personalisation in Northcott's services. The paper is intended for distribution to Northcott's Board and Senior Executive for consideration.

The first section of this paper provides a brief overview of personalisation, with definitions of key terms used in the literature. Touching on the history of personalisation, it indicates what current practice is across Australia. A more detailed examination of different models of person centred approaches internationally, and across the respective states and territories of Australia follows. This work focuses on the organisational aspects of personalisation implementation, therefore an analysis of common themes raised by practitioners, academics and governments is provided. Wider political and social implementation themes are touched on before criteria for personalisation of organisations is offered in the form of a self-audit questionnaire tool. Compilation of results from the personalisation questionnaire carried out by selected Northcott managers, coordinators and staff provide a snap shot of Northcott's current personalisation rating.

The second section of the paper specifically addresses the implementation of personalisation in Northcott services, highlighting the key and relevant issues for consideration by Northcott Board members and Senior Executive. Based on the examination of research, literature and current practice, this section focuses on key areas that are required of services to successfully implement personalisation. It looks in more detail about what is required for Northcott to implement personalisation, including developing a deep understanding of personalisation, changes in organisational structures and processes, leadership and managerial commitment, staff values, attitude and skills, and investment in clients and families. What follows is a critical examination of personalisation, highlighting the challenges and risks of Northcott implementing personalisation, including financial risks and service viability, workforce concerns, risk management issues and the time and scale of change required. Finally, the paper concludes by focussing on the key decisions that need to be made if Northcott is to implement personalisation, and offers key recommendations to proceed, including watching the context for change, making a commitment, gathering more information, taking action.

BACKGROUND

A brief report providing an overview of person centred planning (PCP) and self-directed funding (SDF), as well as highlighting some of the key implications for Northcott, was submitted for the March 2010 Board meeting. This scoping paper builds on the information provided in the initial report, and further explores the issue of implementing these approaches across Northcott's services. In order to incorporate both PCP and SDF as part of a broad approach to the individualisation of services, and to allow for variation in the use of terminology, this report focuses on implementing *personalisation* - that is, creating greater choice, voice and control for people with a disability, their families and carers as key partners in the design and delivery of Northcott's services.

Initially the aim of this paper was to explore the different models of personalisation (including individualised funding) and approaches to its implementation, and make

specific recommendations about Northcott's preferred model(s) and approach. However, in the course of researching and exploring these issues, it became apparent that defining a specific model or models of personalisation was not an easy feat, nor a task that could or should be undertaken without first some key issues being highlighted, concerns and challenges raised, and further organisational information gathered, mapped and benchmarked. It also became apparent that making any specific recommendations about the implementation of personalisation requires, in the first instance, strong values based leadership and an explicit commitment to the cause. Furthermore, expecting that the issue of personalisation across the organisation was something that could be fully explored, model developed and implementation plan proposed in a single report minimises the complexity of what is a fundamental shift in thinking about disability service provision. As Routledge, Sanderson & Greig highlight, if decision makers treat personalisation "as simple changes, they are almost guaranteed to fail because they will neglect a careful and well thought-through implementation effort" (ACU, 2008, p.21).

For Northcott to develop workable models of personalisation across the organisation, the topic firstly needs to be fully scoped, key recommendations provided, and subsequent decisions made about commitment to continuing the process of personalisation. As such, this scoping paper is intended to be only the first step on Northcott's personalisation journey.

SECTION ONE

1. OVERVIEW:

1.1. Personalisation

National Disability Services (NDS), the national industry association for disability services, summarises personalisation as "greater choice, voice, and control for people with disability, their families and carers as key partners in the design and delivery of care and support" (NDS, 2010). NDS suggests, equivocally, why organisations like Northcott need to address personalisation:

"Within the next couple of years, every provider within the disability service system can expect to be involved in discussions on the merits, or otherwise, on the various forms of personalisation, and the extent to which there is an evidence base that confirms that this transition delivers better quality of life outcomes for clients" (NDS, 2010)

In the National Disability Agreement (NDA), between the Australian Government and State and Territory Governments, the States have been delegated to focus on "providing a person centred approach to service delivery", with the performance benchmark of: "An increase in the proportion of people with disability accessing services who have an individualised service plan" (COAG, 2009).

The position taken by the Ageing, Disability and Home Care agency of the Department of Human Services NSW (ADHC) is:

"ADHC is committed to the rights and principles of equality, independence, choice and inclusion that underpin a person-centred philosophy. ADHC promotes the implementation of person-centred approaches to planning and practice to support people with disability to

maintain skills and capacities and to have a lifestyle reflecting their goals and aspirations that is valued in the community” (ADHC, 2010).

For this paper, the concept of ‘personalisation’ is deliberately broad reaching and is meant to compass a range of terms, approaches and models including: individualisation, person centred approaches, person centred planning, self-directed funding, self-managed models, individualised funding packages, ‘hosting’ arrangements etc. (some of these terms are further defined below). Essentially, what is at the core of these approaches/models are some fundamental *values* (including respect, choice, individuality, empowerment, independence, inclusion), and an approach that *shifts the power* and places people with a disability at the centre of service planning and delivery. The reason that the concept ‘personalisation’ is used is because there can be many different approaches, planning and service models that encompass and reflect a personalised approach; at this stage of examining the issue, we did not want to rule in or out any specific approaches and models. Rather, the term ‘personalisation’ allows this paper to scope the issues around the many varied ways this could be achieved in Northcott’s services.

1.2. Definitions

This is a field with a multiplicity of terms; here are brief definitions of some key terms:

Person centred approaches:

“Person centred approaches design and deliver services and supports based on what is important to a person. Hence person centred planning can promote person centred approaches” (Government of Scotland, 2007).

Person-centred planning:

Person centred planning is a way of discovering how a person wants to live their life and what is required to make that possible. Person centred planning has its roots in the normalization and independent living movements. It is grounded in a social model of disability and a strengths-based approach. (Centre for Developmental Disability Studies (CDDS), 2004)

“Person centred planning discovers and acts on what is important to a person”.
National Disability Authority (NDA) Ireland, 2008)

“Ideally, the process of person centred planning should begin before an individual makes contact with any particular support service. Services constitute just one aspect of a person’s life”. (Robertson, Emerson, Hatton, Elliott, McIntosh, Swift et al., 2005)

A plan:

“A person centred plan can be helpful in guiding the design and delivery of highly individualised, dynamic support arrangements which are unique to each individual’s needs and preferences” (NDA Ireland, 2008)

A person centred service

A service which is “Provided, organised and designed around what is important to the service user from his or her perspective” (NDA Ireland, 2008)

Self-Directed Funding

“Also known as individualized funding, individualized care packages, personalised budgets, individualised support packages, self managed care and direct funding”. “Individualized funding remains one of the most powerful and enabling means of a greater degree of family empowerment (Harmer, 2000).

Auspice

The term ‘auspice’ is used in DSQ agreements to identify which agency is receiving individual funding on behalf of those funded.

In a wider context, an auspice refers to an arrangement whereby one existing organisation assists a new one to get started (Mamre, 2007)

‘Hosting’ or a ‘Host Arrangement’

“One existing organisation assists an individual or collective of people to develop responses, by entering into an ongoing relationship. The new initiative is not incorporated, hence the need for ongoing ‘hosting’. It receives funding which is transferred from the funding body to the host agency who takes on the legal and fiscal roles required, and is a buffer between the project and the bureaucracy. This bureaucratic buffering is often referred to as a ‘bureaucratic shield’ or a ‘firewall’. The decision making and support arrangements are governed by the individuals or families involved – they are not part of that host agency’s service. The host agency delegates this authority to the initiative. The hosted entity is a semi-autonomous body because of this delegated authority. Host arrangements are intended to be long term. The hosted entity does not need to have the same core business as the host agency, but some alignment with values and philosophy is enormously helpful (Mamre, 2007).

1.3. History of personalisation

From deinstitutionalisation in the 1970s onwards, the approach of ‘normalisation’ as articulated by Wolfensburger (1972), that a person should have a ‘normal life’ like others, gained increasing influence. This evolved into Social Role Valorisation, with the focus on services creating opportunities for meaningful and valued roles in society. Over the past two decades, J & C O’Brien describe a ‘transatlantic community of practice’ with UK and US practitioners moving to numerous personalised models that place the person at the centre of service provision, planning and thinking (O’Brien & O’Brien 2002; Smull, Bourne & Sanderson, 2005; Kendrick, 2009). These models mark a shift in theory, approaches and practice to planning and service delivery for people with a disability. Most current services are reflective of traditional models of service provision for people with a disability, which offer fixed, standard, group based service options, and where decision making is held by professionals and largely determined by organisational priorities and interests. However, around the world there is an increasing rise in services and funding models that reflect a personalised approach to service delivery.

2. THE INFLUENCE OF INTERNATIONAL PERSONALISATION

2.1. Thinkers and Practitioners

The most influential practitioners and commentators on Australian personalisation thinking and practice are from the United Kingdom and the United States. Referred to frequently in the literature is Helen Sanderson, who has developed numerous planning tools, J & C O'Brien (US) who developed some of the Social Role Valorisation foundation work in the 1970s and 80s and Michael Kendrick (US), known for his guidance to organisations on how to become person centred.

An influential organisation from the UK is 'in Control'. Started in 2003 by a group of practitioners, and then parents, it championed the Self-Directed Support model and then trialled Individual Budgets. Now an 'independent charity' it has supported a wealth of initiatives which has resulted in over 30,000 people now having Individual Budgets in the UK (In Control 2010a; 2010b).

2.2. Service Providers

In the UK, adults with disabilities or health needs now have the statutory right to choose to have self managed funding or not. Person centred planning is: "Established as a key component of the provision of social care to all adults" (Department of Health (DoH), 2005). Elsewhere, any mandatory requirement regarding person centred planning seems to revolve around adults with intellectual disabilities. In England this is the case and in the US, many states have mandated the use of PCP. Examples of services which require this are: NY Office of Mental Retardation and Developmental Disabilities, Michigan Mental Health and under 'The Individuals with Disabilities Education Act, all students with disabilities transitioning from high school.

The UK Government's whole of government approach to a 'transformational change' agenda is underpinned by legislation: Valuing People, 2001; Valuing People Now, 2008 (Department of Health 2001, 2009). It has had obvious influences on personalisation implementation in Ireland, Victoria, Australia and New Zealand.

3. CURRENT PRACTICE

3.1. Australian federal and state governments

The shift in the disability system towards a personalisation of services (and funding) is a common theme across the Australian federal and state governments.

3.1.1. Federal Government

The Disability Investment Group (DIG) – established in 2008 by Parliamentary Secretary for Disabilities and Children's Services, the Hon. Bill Shorten MP – was set up to explore innovative funding ideas from the private sector that will help people with a disability and their families access greater support and plan for the future. The DIG report *The Way Forward – A New Disability Policy Framework for Australia* (2009) found that:

"A major drawback of the current disability service system is that the client is not at its centre. While moves to more individualised

packages of care are welcome, there is little opportunity for life course planning for individuals, which involves their families, helps them to meet their aspirations and prepares them for key transitions” (2009, p.2)

Even though some states and territories were trialling individualised care and service packages, they found that the essential issue was that the current disability services system does not have the client at its centre and, at best, services are based on the point-in-time needs of their clients” (2009, p.17). The DIG concluded that “a transformational shift in policy approach and service delivery is needed” and proposed a policy framework which focuses on government and private investment to assist people with a disability to manage their own lives and maximise their independence and contribution to the community (2009, p3).

The DIG recommended a feasibility study into a National Disability Insurance Scheme. The DIG suggest that this scheme “would revolutionise support for people with a disability. It would be person-centred, have genuine whole-of-life focus and maximise independence and participation” (2009, p.2). The Productivity Commission is currently undertaking an inquiry into this issue, the final report of which is to be released in July 2011. The recommendations to come out of this report will no doubt result in a radical overhaul of the disability service system, and incorporate a more flexible, individualised, self-directed and long-term approach to funding and service delivery for people with a disability across the nation. Essentially, it will mark a major move toward personalisation in government funding and policy.

3.1.2. NSW Government

Over the past few years, ADHC has undertaken several initiatives to implement personalisation in disability services in NSW. These include: self-managed options (akin to self-directed individualised funding arrangements) in Community Participation, Life Choices and Active Ageing Programs, and the trial of direct payments in the Attendant Care Program.

ADHC has spent considerable resources on looking at personalisation specifically in the Community Participation Program (CPP). They commissioned a project called ‘Strengthening Person Centred Planning in the Community Participating Program’, which included:

- A literature review through ACU Consortium (2008) titled ‘Person Centred Planning: A review of the Literature – Strengthening person centred planning in the Community Participation Program’.
- The development of practical resource guide for CPP providers in this area, titled ‘Exploring and Implementing Person Centred Approaches – A Guide for NSW Community Participation Program Service Providers’ (ACU, 2009).
- Training for CPP providers on implementing person centred approaches in practice.

ADHC has also piloted the following programs based around a model of individualised self-directed funding (which are part of a participatory action research project called “My Plan, My Choice”):

- *Metro South*: EarlyStart Early Childhood Intervention - 20 families of children aged 0-6 years to use Early Start funds in a more flexible way.
- *Metro North and Hunter*: Extended Family Support Program - 41 families to have flexible use of between \$20,000 and \$60,000.

- *State-wide*: New Day Programs: ‘Life Choices’ and ‘Active Ageing’ (Self Managed) - Targets people with unmet need for day programs offering them \$15,999 for their own individually tailored supports and an alternative to centre based day programs.
- *Northern Region*: Older Parent Carer Program (30 places) - to use up to \$50,000 pa in planning for creative solutions for the future.

ADHC have also established a Person Centred Team at Central office (team of three) to provide support to improve person centred practice across the organisation. In terms of key policy documents that reflect these approaches in ADHC, there is a new Lifestyle Policy & Procedure (draft) for accommodation services, which implements a person centred planning approach and the use of person centred planning tools for residents in ADHC funded accommodation services. ADHC are also working on a position statement on individualised funding; the finalisation of this, any further announcement in this area, is likely to be held off until announcement of second phase of *Stronger Together* is made by the NSW government (due to happen in October 2010).

Stronger Together 2006-2016 points to a commitment to more flexible, individualise and innovative support for people with a disability in NSW. The outcome of phase two of the roll-out of *Stronger Together* will no doubt highlight further advancements in the personalisation and individualisation of funding for NSW disability services.

3.1.2.1. *NSW Opposition – Liberals/Nationals*

A discussion paper by the NSW Liberals/Nationals titled ‘Personalising Service Delivery’ outlines the opposition’s position in relation to personalisation, highlighting that they are committed to a disability service system that increases choice, voice and control for people with a disability and their carers (2009, p.2).

“The NSW Liberals/Nationals do not subscribe to the ‘one size fits all’ approach.....It is well recognised that a trend towards increasing service personalisation has emerged as one approach to improving frontline service delivery. Service delivery must increasingly become personalised, responsive to change and outcomes focussed. For this reason the NSW Liberals/Nationals will aim to tailor services to people’s individual and changing needs through the use of individualised funding packages” (2009, p4).

They acknowledge the challenges involved with personalisation, particularly in relation to the roll out of individualised funding, indicating that the process of implementing individualised funding packages “will take time and require a staged transition that will be disciplined, transparent and consultative. The NSW Government will also be required to provide ongoing and direct financial assistance to service providers during this transition period” (2009, p.1). Their commitment to this approach demonstrates that even if there is a change in government as the result of the 2011 state election, that personalisation will continue to be on the agenda for the NSW disability services system.

3.1.3. Other states and territories

While there are overall commitments to personalisation in state governments responsible for disability service provision and funding across Australia, there is little apparent common practice between them on personalisation. In a couple of states the government has favoured sponsorship of pilot projects in the Third Sector. Victoria

(Vic), New South Wales (NSW) and South Australia (SA) have all piloted some form of individualised funding, but often retaining significant governmental control (In Control, 2009). Western Australia is the originator of the Local Area Coordinator program which evolved into a person centred program and has been emulated by New Zealand, Scotland, Queensland, Northern Territory and the ACT (Bartnik, 2008; Government of Scotland; NZ Ministry of Health, 2010).

3.2. Australian Third Sector Organisations (TSOs)

Similarly, the Third Sector's response to personalisation thus far has been uneven across the states. Sometimes a combination of imaginative managers, Board or family members together with occasional government pilot or seed funding has resulted in innovative new models such as Personalised Lifestyle Solutions in Victoria and Ability Options in New South Wales. Others have innovated without new funding, like Mamre in Queensland and Sunnyfield in New South Wales, who, spurred on by determined families wanting a 'better life' for their family member, have organisationally restructured along person centred lines.

Another interesting trend gathering impetus is parent and advocacy organisations campaigning for a change agenda like In Control, Australia and Centre for Civil Society. An area of future focus will be the extent to which government or third sector supports the emergence of family-initiated services. In WA and Victoria, fledgling family-organised services like the Vela Microboards and Living Distinctive Lives are possible alternatives to conventional services.

Below, details of the differing national approaches and models are given.

4. AUSTRALIAN PERSONALISATION

4.1. Western Australia

Local Area Coordination (LAC):

Eddie Bartnik, Head of the Disability Services Commission (DSA) in Western Australia, has influenced both national and international services with the LAC model that operates within DSA (Bartnik, 2008) Established in 1988 to meet unmet needs of people with disabilities in remote areas, it has evolved to a person centred program, adopted in Queensland in 1999, ten years later in Scotland and is now being rolled out in New Zealand. Its distinctive features are:

- Local Area Coordinators might ask "what constitutes a good life for you?" instead of a more conventional approach of, "What support do you need?"
- A holistic and relationship based approach to working with disabled people and their family, rather than an episodic and funded support focus of work.

Microboards:

'Microboards' are an example from the emergent family-driven personalisation movement. Growing from a Canadian initiative (there are now over 450 in British Columbia) they are: "A small (micro) group of committed family and friends (board) join with a person with challenges to create a non-profit community board. Together this group of people assist the person to plan and achieve their goals and dreams in

an individually tailored way” (Vela Microboards). Vela Microboards, Australia (VMA) was set up in 2007 with seed funding from DSA. In the intervening years:

“The VMA organisational model has evolved, and is neither totally voluntary nor totally commercial in the sense of it being a fee-for-service transaction. It is a collaborative arrangement which is deeply grounded in ideals about citizenship, contribution, social justice, community & family leadership” (Vela Microboards).

4.2. Victoria

The Victorian Government acknowledges the influence of the UK government, In Control and Demos in its approach to create a “whole-of-government and whole-of-community approach to enabling people with a disability” (Department of Human Services (DHS), 2009, 2008). Learning from the UK experience it also acknowledges the risks inherent in changes to self-directed approaches and has identified some future challenges: “workforce design, workforce flexibility and industry sustainability” (DHS, 2009). Whilst, the Victorian Government policies seem to have advanced further than other states in rolling out individualised funding, does the practice match the rhetoric? A study of Victorian self-directed pilots found that the requisite flexibility and individual responsiveness was absent in service delivery (Laragy, 2002). Elsewhere, a high degree of bureaucratic involvement by DHS case managers was observed, which reduced flexibility, control and money available to people with individual budgets. The risk of a whole of government approach is that innovation and flexibility is minimised (Shergold, 2009).

The State Government of Victoria has funded some five small ‘collective’ projects under the umbrella name ‘Personalised Lifestyle Assistance’ (PLA), which is ‘hosted’ through Melba, a third sector disability organisation. PLA’s mission is to work with individuals and families to establish: “Lifestyle options that are natural, typical, and one person at a time responses; influence and self determination over their own lifestyle; the opportunity to govern their own project/arrangements; and sustainability” (Mamre, 2007). Graph depictions of these hosting arrangement models are found in Appendices 1 to 5.

Beginning in 2002, the five collective projects have supported about 25 individuals to develop individualised support arrangements to meet their lifestyle options. Melba also supports a number of people with differing degrees of involvement, charging an administration fee of 10% or a management and admin fee of 20% in what are described as either ‘self-governed’ or ‘family governed’ arrangements (Mamre, 2007).

4.3. Queensland

OLD based TSO Mamre embarked on organisational transformation after young adults and their families were requesting ‘better lives’. After undertaking extensive research in 2007 on personalisation projects, specifically ‘hosting’, initiatives, it developed a comprehensive ‘family managed funds’ model – see Appendix 6 for overview of the model, which is part of Mamre’s *Handbook for Family Managed Funds (December 2009)*. Families are now responsible for the management of governmental funding that Mamre previously received. In exchange, Mamre requires each family to use the funds in accordance with the guidelines, develop a six-monthly Family Support

Plan with a Mamre key worker and account for the expenditure of funds. As families chose the support workers this gives them 'greater choice...greater flexibility...and more control' (Mamre, 2009).

4.4. New South Wales

Ability Options and Lifestyle Solutions are two TSOs that were involved in a two year pilot project called Self Managed Model (SMM), funded by ADHC. They both devised a new framework of policies, procedures, guidelines, training, information-sharing events, seminars, reference groups, intake procedures to facilitate a new way of working with people. However, commitment to the concept of a SMM is not enough; also needed was a belief: "In the intrinsic value, worth and right of the individuals...then commit(ment) to facilitating the support they require" as opposed to the convention of providing a pre-determined 'model or program' (NDS, 2010). Three other key transitional aspects were: the intensity of the administrative processes, the liaison between HR and finance regarding details of individual packages and lastly, training families in elements of industrial relations and OHS.

4.5. South Australia

In Control, Australia reports that the SA government are initiating a pilot project of self-directed funding for 50 people. In Control criticise the amount of control the government retains: people cannot directly employ support workers, nor can they have an independent facilitator (In Control, 2009).

5. COMMON IMPLEMENTATION THEMES

Drawing from international and national literature, some common themes have been identified.

5.1. Overall systemic change

Inherent fundamental systemic change is acknowledged by a wide range of academics, practitioners and activists (ACU, 2008). The UK government's stance is: "Personalisation is about whole system change, not about change at the margins" (DoH, 2008). In 2004, practitioners were advised to implement with caution to reduce the risk of "strong rhetoric and little meaningful action" (CDDS, 2004). This has eventuated to a degree, although using the 'rhetoric gap' to leverage change is advised by a leading UK academic (Mansell, 2004).

5.2. Whole-of-government approach

The uneven, but encouraging implementation in the UK from Valuing People in 2001 has led to a 'second wave' of personalisation with 'Valuing People Now' from the UK government in 2009, which has an explicit 'whole of government approach' to implementation. This was as a result of a conscious understanding that, "without a whole-systems approach, it is possible that PCP will drift into obscurity as previous incarnations of individualised plans have done" (DoH, 2009). It was also recognition of

the challenges of driving significant change: “It will take time. There are significant cultural and organisational barriers to overcome and it cannot be driven from the top down” (DoH, 2008). The pace of change is also important: “It is crucial for the organisation to embark on the cultural and structural change necessary at the same time as some people are being supported to think and plan” (ACU, 2009).

5.3. Managerial commitment to systemic change

The literature on implementation universally emphasises the role of strong leadership: “success is determined... by local leadership, professional culture and the availability of support” (DoH, 2008), and, “the degree of engagement from leadership is the strongest predictor of success (Smull et al., 2009). As with the UK government, experienced US and UK personalisation practitioners now advocate a wider, whole-of-systems approach that encompasses:

1. Training in person centred planning & in person centred thinking.
2. Development and support of coaches in person centred thinking.
3. The sustained engagement of organisational leadership.
4. The sustained engagement of system (government) leadership. (Smull et al., 2009).

5.4. Structural change

Through the literature there are many examples of how organisations have developed structural supports, some commonly identified are:

1. Planning facilitators for individuals who are independent of the services received by the individuals (Robertson, 2005).
2. Cyclical organisational planning which shapes personalisation services and is shaped by the person centred outcomes of individual plans (Robertson, 2005)
3. Internal collaboration between Human Resources, Finance and Administration to develop new effective systems. Leadbeater gives example of collaboration between the personalisation team and finance department to ensure; “Financial systems for allocating budgets were sound and the cost savings were well understood” (Leadbeater, Bartlett, & Gallagher, 2008).
4. Offer a flexible ‘menu’ of services, with transparent costing and fees (In Control, 2009; Melba 2009; Lifestyle Solutions, 2010).
5. Devise robust quality measures to determine that person-centred approaches are being implemented, are equitable and that service has capacity.

5.4.1. Barriers to Structural change:

In the most substantial retrospective UK research on implementation, the barriers to personalisation implementation were widespread particularly in relation to: availability of trained facilitators; availability of services; lack of time and reluctance of people other than paid support staff to engage in the PCP process (Leadbeater et al., 2008; DoH, 2009).

5.5. Cultural change

Changing the culture of organisations to facilitate personalisation is crucial. Swift identifies one of the ‘key supports to PCP’ as “person centred management that

engenders a culture of openness” (Robertson et al., 2005). This type of ‘mind shift’ was experienced by Melbourne based TSO Melba who “needed to shift from seeing themselves as a provider of services to a facilitator of alternative arrangements” (Mamre, 2007). Some ideas for cultural change come from ADHC’s research in personalisation:

“The structure will need to enable good communication and have the capacity for speedy problem solving with others in the organisation, the encouragement of new ideas, and incorporate an effective way of discovering what is not working” (ACU, 2009).

One indication that TSOs might be well positioned for such cultural change comes from the UK research which found that facilitators from a community organisation showed “confidence and flair in helping people make real and positive changes. It was argued that their underlying values appeared to be a strong factor in achieving change with people” (Robertson et al., 2007).

5.5.1. Staff adaptation and training and skill development:

The central cultural change seems to revolve around staff; this has been noted in the UK and in Australia. The UK Government asserts why: “A personalised approach ...has huge implications for the workforce of the future... need to change radically to meet the challenges it will face” (DoH, 2008). This is reflected in independent research by Demos: “One of the key cultural change issues is staff adaptation to the shift of power from professionals to users (clients)” (Leadbeater et al., 2008). The Victorian Government describes the changes:

“People’s relationships with professionals change. Whilst service professionals retain a critical overview of service quality and outcomes, they become more like advisers, counsellors and brokers, guiding people to make choices that meet their needs” (PLA).

How to support such significant skill adaptation? Although, “training is important for all people involved in planning and implementation” (Robertson et al., 2007), it is now acknowledged that training alone is not enough. Smull, Bourne and Sanderson (2009), practitioners of over 20 years agree that:

“Training is not enough – people who attended the training go back with the same culture and same demands; quickly revert back to the problem solving/coping behaviours they used before the training. Coaches are important, but they must have ongoing support – meetings every 6-8 weeks help to transfer skills to habits”.

These practitioners advise coaching for maintaining new habits and new skills, but what about the challenges to existing roles and skills identified by the Victorian experience? “Strong and sophisticated support and supervision” is advised by Hunter and Richie who acknowledge that the shift to “co-production exposes staff to ambiguity, uncertainty, challenge, sources of stress and discomfort” (Hunter & Richie, 2007). This approach is supported by a call for reflective practice: “This is essential to person centred practice and enables learning about how to successfully support people and use your professional expertise effectively and appropriately” (Kilbane & McLean, 2008). The ‘co-production’ mentioned is another cultural change theme, for it highlights the shift for services to partnerships, collaboration and ‘co-production’ of services with other stakeholders.

5.5.2. Partnerships & collaboration and 'co-production':

Research undertaken by Demos in the UK signals that collaboration is the key to success: "Self-directed services will work only as the product of a collaborative innovation involving a variety of players in a community" (Leadbeater et al., 2008). Therefore, TSOs need to turn outward to the community; the O'Briens advise a need for "Good, accurate, comprehensive knowledge of general and community resources to help the planning process" (O'Brien & O'Brien, 2000). Co-production will only happen when clients are integrated "into all aspects of the design, implementation and evaluation" (O'Brien & O'Brien, 2000).

5.5.3. Barriers to cultural change:

Some of the obvious barriers to successful cultural change have been articulated by Shergold: the fear of change, fear of innovation, fear of letting go. He cautions: "It needs to be recognised that too much 'accountability', too much public service process and too much 'professional' expertise kill creativity" (Shergold, 2009). The challenge to be flexible enough to produce 'non-standardised responses' and to develop the capacity to respond to more complex and unpredictable circumstances might overwhelm many organisations. If personalisation becomes mandatory in Australia as in the UK and in some US states, then it will be at the risk of losing its "flexibility and individuality" Shergold (2009) cautions.

5.5.4. Closing the gap between the policy rhetoric and practice:

This is reiterated by Robertson who is fearful of the "serious risk in focussing on achieving plans rather than changing lives" (Robertson et al., 2005). She maintains that, "Person centred planning must never become compulsory for individuals and the completion of large numbers of plans must not be a measure of success for service agencies" (Robertson et al., 2005). The fear of 'shallow personalisation' – 'modest modification of mass-produced standardised services' versus 'deep personalisation' with users becoming co-designers and co-producers of services is identified by other commentators of personalisation (Hunter & Richie, 2007). Instead of being fearful of this gap in rhetoric and practice, another experienced academic asserts that it is essential to mobilise the evidence, maximise the emotive reaction to bad practice and engage those outside the service system in order to close the gap between rhetoric and practice.

5.5.5. How to evaluate:

The final significant cultural issue identified is how organisations will evaluate the effectiveness of their services. Swift highlights the 'radical' challenge to traditional evaluation posed by personalisation, which, based on "individual choice, dreams, wishes, and desires", are "antithetical" to conventional organisational evaluation methods (Robertson et al., 2005). This will be a keen area of interest for TSOs to pursue.

6. HOW PERSONALISED ARE NORTHCOTT SERVICES CURRENTLY?

Part of scoping the issue of implementing personalisation requires an examination of Northcott's current services. That is, in order to place the issue in the context of Northcott's current operations and service delivery models, we need to rate where services currently sit on a personalisation 'scale'.

6.1.A Criteria for Personalisation

There is not set way to measure 'person centred-ness' or how 'personalised' services are, nor any objective criteria for personalisation. Indeed, personalisation is inherently about creating individualised service responses that put the client at the centre of planning and decision making; therefore, measuring the degree of 'personalisation' of a service is relative to the individual concerned. ACU (2008) has however, put together 'A Guide for NSW Community Participation Program Service Providers' on exploring and implementing person centred approaches. Part of this guide includes a reflective exercise that "can be used by organisations to identify the opportunities and constraints to the organisational and cultural change required to embrace person centred approaches and thinking" (ACU, 2008, p.71). Drawing on this resource, a questionnaire has been developed for specific use in mapping where Northcott's services currently sit on a 'scale' of personalisation. A copy of the questionnaire can be found in Appendix 7. This questionnaire was distributed across Northcott services to get a breadth of responses from the following key service areas:

- **Accommodation**
 - Long term
 - Transitional
- **Day Programs**
 - Community Participation Program (CPP)
 - Life Choices and Active Ageing
- **Early Childhood Services**
 - Autism service
 - Early Childhood Support Service (ECSS)
 - EarlyStart Programs – diagnosis support and early intervention
 - Family Resource Links
- **Employment**
 - Jobmatch
 - Transition to Work (TTW)
- **Individual and Family Support**
 - case management programs
 - metro and regional family support services
 - intensive family support services
 - Adult outreach
- **Recreation and Leisure**
 - Leisure Links
 - After school and vacation care programs
- **Respite**
 - Centred based
 - Flexible respite programs
- **Specialist Services**
 - Paediatric Spinal Outreach Service (PSOS)
 - Leaving Care Program – Mentoring Service
 - National Disability Coordination Officer program (NDCO)
 - Computer Assistive Technology Service (CATS)
- **Therapy Services**

6.2. Validity issues with data

Before the results can be analysed, there are some validity issues with the data which must be outlined. First, it is likely that many services have overestimated the degree of personalisation they currently have in their program, based on a belief that they already practice (to some degree) from an individualised and person centred approach. This is reflective of the tendency to simplify what personalisation really means, and research has certainly found that many people tend to treat it as a simple approach that can be easily incorporated into existing services, either because ‘we already do it’ or because it aligns with staff and organisational values (ACU, 2008. p.21-22). Second, some programs have a wide client group – for example, Individual and Family Support (IFS) programs provide a service to children and their families, as well as to individual adults. This made it difficult for these programs to generalise responses for such a varied client group. Additionally, in the context of providing support to children *and* their families, these services found it difficult to identify who was the ‘client’ when responding to client specific questions. Third, most staff are likely to only have a limited understanding of the concept of personalisation, person centred approaches and other terminology used in the questionnaire. Time was not spent educating staff about these core concepts, nor were any definitions provided, therefore responses will be reflective of individual interpretations and understandings of these terms. Finally, not all services completed the questionnaire, and representation from all locations and regions for each service was also not provided. This means the results will not be reflective of full data based on every program and service in Northcott. Essentially this was not the purpose of this questionnaire; rather, the focus was on trying to only provide a snap shot of the scale of personalisation for different services across the broad key service areas (outlined above).

6.3. Results

Respondents were asked to rate each question/statement on a scale of ‘agree’ to ‘disagree’, and these were reflected in numbers 1 to 5. Based on this methodology, the results are measured using the premise that the lower the score = the higher the level of ‘personalisation’ within the service.

Based on responding to the 35 questions, a score of 35 reflects the highest level of personalisation; a score of 105 reflects middle level personalisation; and a score of 175 is the lowest level of personalisation. Therefore, the range of responses could be:

Score Range	Level of Personalisation
35 – 70	High
70 – 105	Medium-High
105 – 140	Medium-Low
140 – 175	Low

Some respondents did not answer certain questions because they were not relevant for the service and/or they were missed by the respondent. To ensure the data is reliable and the ‘total’ scores for each service are based answering the same number of questions, these services have been allocated a middle response rating of ‘3’ (a neutral rating that does neither agree nor disagree) for those incomplete questions.

6.3.1. Who completed the questionnaire?

54 staff members completed the questionnaire, representing 45 services/programs at different locations/outlets. Full results of all completed questionnaires can be found in Appendix 8.

Some services had more than one person complete the questionnaire in the same location (that is, for the same service outlet). This meant that some services would be overrepresented in the broad key service areas (by having numerous responses factored into the results). Additionally, this made it difficult to examine the separate ratings of each service, as there were differing responses from each staff within the same service at the same location (based on different understandings of personalisation). For those services with more than one response for the same location/outlet, the *average* score was used. The following tables outline the services where there was more than one response per location, and what the average score is for the service:

Computer Assistive Technology Service (CATS) - State wide	
Response 1	84
Response 2	86
Response average	85

Early Childhood Support Service (ECSS) - Metro	
Response 1	90
Response 2	63
Response average	76.5

Metropolitan Family Support - Metro	
Response 1	87
Response 2	86
Response average	86.5

Northcott Early Childhood Autism Service (NECAS) - Metro	
Response 1	106
Response 2	104
Response 3	77
Response 4	69
Response 5	54
Response 6	51
Response average	76.8

Support Coordination Program - Queanbeyan	
Response 1	49
Response 2	43
Response average	46

Only the *response average* score for these specific abovementioned services was used when collating the results in the section below and comparing results across services.

6.3.2. Where are Northcott's services rated on the scale?

Results by service area – these results are based on calculating the *average* score from responses of all services that fall under each broad key service area.

Recreation & Leisure	62.3
Early Childhood Services	67.6
Individual and Family Support	68.9
Day Programs	74.3
Specialist Services	74.8
Respite	82.4
Employment	83
Accommodation	85
Therapy services	88.5

For full breakdown of the results of all services by key service area, and to see the details of where specific services were categorised, see Appendix 9.

Top 10 services - highest 'personalisation' ratings:

Service	Location	Score
Support Coordination Program	Queanbeyan	46*
Community Participation Program (CPP) – indiv.	Cumberland/Prospect	50
Northcott Early Childhood and Family Support service (NECAFS) – Early Start - Early Intervention	Illawarra	51
Teen After School & Vacation Care	Campbelltown	52
Flexible Respite	Parramatta	54
Individual & Family Support Program (IFS)	Wagga	54
Northcott Early Start Diagnosis Support (NEDS)	Ballina	55
Leaving Care Program Mentoring service	Illawarra/Sth Highlands	57
Individual & Family Support Program (IFS)	Dubbo	58
Teen After School & Vacation Care	Wagga Wagga	58

*based on *average* as more than one response for same service in same location

For full breakdown of the results of all services, see Appendix 8.

SECTION TWO:

7. WHAT IS REQUIRED?

A review of national and international literature, and examination of implementation experiences from other organisations, points to key areas that are required of services if they are to successfully implement personalisation. Results from the questionnaire indicate that Northcott has a way to go in implementing personalisation across services. If personalisation is to be achieved, attention needs to be paid to:

- Developing a deep understanding of the complexities of personalisation
- Fundamentally changing organisational structures and processes

- Ensuring strong leadership to support the development of personalised approaches
- Ensuring that people with disabilities, families and staff are well supported and educated
- Ensuring that systems and practices are in place to achieve the implementation of personalised service initiatives
- Developing commitment, leadership, and support at a systemic level to facilitate personalised service development by the service sector and community. (ACU 2008, p. 34-35)

In order to learn from the experience of other organisations, Northcott should consider these issues and carefully examine what is required from Northcott and our current organisational and service structure and culture. This is explored below.

7.1. Developing a deep understanding of personalisation

As the core concepts and values of personalisation (such as respect, control, choice etc.) make sense to professionals in the disability sector, and can unequivocally be seen as fundamental rights for people with a disability, there can be a tendency to treat it as a simple process; when understood in this way, all that is learnt is the *rhetoric* of personalisation (ACU, 2008, p. 22). It is much easier for organisations to adopt the language of personalisation as an alternative to actually practicing it. Surface understanding of personalisation can also result in staff and organisations believing they already undertake personalised service delivery, without critically examining this and reflected on the complexities that this approach brings to practice. If Northcott treats personalisation as a simple approach that can be easily incorporated into our existing services (either because ‘we already do it’ or because it aligns with our organisational values), we will be almost guaranteed to fail (ACU, 2008, p. 21). Developing a deep understanding of personalisation will require all levels of staff and management to participate in meaningful, values based training that develops critical thinking skills and encourages constant reflection. It also requires a fundamental culture shift and strong leadership and management that owns the values of personalisation (ACU, 2008, p. 23).

7.2. Changes in organisational structures and processes

Organisational structures play a vital role in whether or not personalisation is effective:

“Personalisation is a philosophy and process that requires fundamental organisational change because it will come into conflict with existing practices and cannot just be added on to existing organisational practices”. (ACU, 2008, p. 23)

For Northcott, personalisation requires a change in practices, including: resource allocation, operational procedures, staff priorities and strategic planning. As personalisation needs to be embedded in our organisational process in order for it to be successful, it “requires a radical and complex review and redesign of service delivery if real shifts in power are to occur” (ACU, 2008, p. 23). However, radical review and redesign of Northcott’s organisational structures and processes will take time and resources. If Northcott wants to commit to personalisation, we must not try and just incorporate the approach into our existing structure and processes, but rather set up new structures and processes that sit alongside our existing services. The use of personalisation ‘pilot projects/initiatives’ within those existing services which already

rate high on our 'personalisation scale', will enable Northcott to start to develop new structures and processes. Some pilot projects have already begun at Northcott, including: implementing person-centred planning for a client at Beverley Park and expanding self-directed funding for some clients in the Individual Community Participation Program. These should be further explored and expanded.

7.2.1. The development of new systems:

A key part of what will be required of Northcott to undergo changes in organisational structures and processes will be the development of new systems.

7.2.1.1. *Financial and administrative systems*

If Northcott is to implement a personalised approach to services which includes mechanisms for individualised and/or self-directed funding models, fundamental re-development of financial and accompanying administrative systems must ensue. Currently Northcott's financial systems support service level budgets, even though some programs (such as Community Participation Program and Flexible Respite) may be allocated as a 'package' of funding per client. In order to personalise services and enable staff and clients the freedom to design individually tailored arrangements, Northcott must have effective financial systems enabling devolved budgets (Mansell et al., 2004, p.9). These financial systems must be able to track individual clients' service budgets and provide regular financial reports to clients on expenditure in their budgets. One such way Northcott could approach this would be to have individual cost centre numbers for each client with an individual funding package. Historically, clients in the Individual Community Participation Program used to have their own cost centre number; Northcott needs to examine the practicalities of this and consider returning to a similar financial system where appropriate. In developing new financial and administrative systems to support personalisation, specifically individualised and self-directed funding models, Northcott must not just develop new accounting systems but also consider the accompanying financial reporting and audit requirements. Northcott needs to develop processes and systems that demonstrate fiscal responsibility for the expenditure of public money without being administratively complex and time-consuming (NDS, 2008, p.12).

When thinking about the re-development of financial and administrative systems, Northcott also has to consider the possibility of providing 'hosting' arrangements (see section 4.2 and Appendices 1-6 for more detail). Northcott has already been approached by Supported Living Network to engage in a 'partnership' which could involve a hosting arrangement if funding was secured. Without sufficient financial and administrative systems to support this arrangement, and without a depth of understanding as to how this model of service could operate for Northcott, such a partnership is not feasible at this point in time. Northcott needs to look at which hosting models would be suitable and viable for the organisation and the financial systems that would need to accompany them.

Laragy's (2002) study on implementation of individualised funding in Victoria found that infrastructure within government and service providers remained focussed on group activities as it was difficult to cost and administer individual programs that differed from the norm. As government funding is "processed around annual service agreements and computer technology was designed for bulk payments and not individual flexibility" (Laragy, 2002 p. 275), the development of individualised budgets and supporting financial systems in Northcott needs further exploration and careful consideration. In order to undertake such a radical system redesign, Northcott first

needs to map the unit costs of each service type and benchmark the costs of services and what different supports and services clients may be able to 'purchase'.

7.2.1.2. *Client documentation systems and tools*

Much of the rhetoric in Northcott around personalisation has been the idea that each client will only ever have 'one plan' even if accessing numerous services; this plan should outline the client's aspirations and goals for their ideal life, as well as their support needs, and how formal services and informal supports can help the client achieve the life they want. While personalisation supports the client only having one plan, focussing on 'the plan' as the desired result, rather than the outcomes through implementing the plan, falls into the trap of the rhetoric and not the action of personalisation. Focussing on developing a 'one client – one plan' system across the organisation places too much emphasis on *making the plans*, without significant investment in cultural change to ensure the planning process and plans are in fact reflective of an individualised and personalised approach. Moreover, if personalisation is "adopted in a prescriptive manner that mandates that everyone must have a person centred plan", this undermines the values of personalisation which are respect for individuality and choice (ACU, 2008, p.31).

Northcott will certainly have to develop client documentation systems and tools that support person centred planning and support the development of individualised approaches to service delivery. These systems and tools will also have to be accompanied by processes and procedures that reflect individualised responses and that place the client at the centre of the planning and decision making process. Issues that Northcott needs to consider in developing these systems include: How we plan? Who does the planning? Who has authority to 'sign-off' on plans? How do we document plans? How do we review plans and their implementation?

There are many existing person centred tool and planning approaches (Essential Lifestyle Planning, MAPS, PATHS etc.) that could be used as part of a personalised approach in Northcott. Northcott needs to consider how these existing tools could be incorporated into a new personalised and flexible client documentation system. The development of accompanying electronic client management systems is another issue that is relevant for Northcott to consider.

7.2.2. Management structures:

Personalisation requires a fundamental shift in power, whereby clients and their families should have the central decision making power over their lives and the services and supports they require and receive. This means control not just over the planning but also the use of the resources and supports to implement these plans. Introducing individualised and self-directed funding as part of personalisation necessitates the hand over of financial decision-making to clients and their families. The "bureaucratisation of management processes and the reservation of funding decision to higher-level managers removed for direct contact with service users" are impediments to effective personalisation (ACU, 2008, p. 24). In order to implement personalisation, Northcott needs to review the management and decision-making structure in services. Northcott needs to "to devolve authority and resources to service users and staff" and needs to develop non-hierarchical and lateral management systems (ACU, 2008, p. 24). Issues of delegation and how to maintain accountability in such management structures is something Northcott needs to further examine.

7.2.3. Innovation:

Another core organisational change that is required for the successful implementation of personalisation is the importance of “introducing innovation at all levels and areas of organisation”; however, it should be introduced gradually (ACU, 2008, p. 23). For Northcott, this means encouraging critical thinking to develop new and *creative* responses to meeting clients’ needs and aspirations. Practically, it requires committing resources in new and different ways to support the fulfilment of clients’ individual plans and goals.

7.3. Leadership and managerial commitment

All the research on implementing personalisation points to the fundamental determinant of success being strong values-based leadership and management commitment (Kendrick 2009, p.47; ACU, 2008, p.26). The capacity of staff to deliver creative and individualised strategies (as they move away from traditional care models) need to be developed and encouraged by strong leadership (ACU, 2008, p. 26). To implement personalisation across the organisation, Northcott needs positive leadership on the issue at all levels of management. If its implementation is to succeed, Northcott also needs to make an explicit commitment to personalisation and set it as an official organisational goal and priority.

7.4. Staff values, attitude and skills

For Northcott to effectively implement personalisation, there needs to be a shift in the values and attitudes of staff (ACU, 2008, p. 21). If person centred value bases are not integrated into services, through staff who support and espouse these values, then personalisation in Northcott will not succeed. The values that underpin personalisation (such as empowerment, choice, respect, control, individualisation etc.) are certainly not in conflict with Northcott’s values, and it would seem that our existing staff would support these values. Perhaps the shift for Northcott staff may be more about changing their attitude, particularly to their role and issues of power and decision making. In order to effectively personalise Northcott services, staff need to “relinquish their roles as ‘expert’ and ‘fixer’ and move to role of using expertise to work with the individual and individual’s supports” (ACU, 2008, p. 27). For some Northcott staff (such as social workers and family support workers) this notion will not be new and is in fact foundational to their working relationships with clients. However, for other professions based around a medical-model, such as some Therapists, this shift in attitude and power will be more challenging.

7.4.1. Training:

If personalisation is an approach that is not to be simplified, and one that requires a depth of understanding in order to be meaningful in practice, training is a core requirement for its implementation. Competent and skilled staff are essential to support the development and implementation of personalised plans for Northcott’s clients. Research indicates that limitations in implementing personalised plans that actually result in real changes in lives of people with a disability, is partly the result of the relationship between goal setting and the skills of staff providing support to this process (Mansell et al., 2004, p.10). As the whole organisation needs to develop a depth of understanding about personalisation, training needs to be provided for all Northcott staff and management, including the Board.

Training needs to emphasise the importance of values, actions and creativity, and not just focus on the systems associated with personalisation and person centred planning. Training must focus on way of facilitating real change for people instead of on individual planning systems (Mansell et al., 2004, p.14); it must emphasise actions that make a difference in lives of people, rather than focussing on the planning system itself; and it must “address critical thinking skills to enlist non-traditional supports and things beyond discipline-specific or institutionally available solutions” (ACU, 2008, p.27).

Training in personalisation is not just a one-off short course, but needs to be a thoughtful and intensive education and training program that is followed up with ongoing supports and strategies (such as role-playing and mentoring over extended period of time), to support staff implementing the approach in their daily work (ACU, 2008, p. 27). Once staff are trained, Northcott needs to implement a process of continuous learning whereby supervision and monitoring of the support provided by staff focuses on achieving real changes in everyday life for clients, rather than addressing compliance with plans and adhering to a specific planning process and documentation (Mansell et al., 2004, p. 10). Northcott will also need to consider providing training to staff in particular roles to develop new skills. For example, case management staff may need skills in brokerage if supporting clients with individualised funding packages to purchase a range of supports; direct care workers will need to develop personal care skills in the context of an *active support* model (teaching the task rather than just doing it for the client).

7.5. Investment in clients and families

Personalisation shifts the planning power and decision making to the client and their families. Particularly in self-directed funding models, it shifts the purchasing power and requires clients to act as consumers in a market-place. The knowledge and skills required to take up these roles should not be underestimated. Research in Canada found that “individualised funding became more complex to administer and many families did not have the knowledge or means to apply this type of funding in the personalised and innovations ways that were possible.....there were few resources to assist families in thinking creatively or in managing the complexity of individualised funding” (Rouget, 2009, p. 2). If Northcott is to effectively implement personalisation, particularly if including models of individualised funding, Northcott needs to invest in clients and their families. In practice this would mean supporting clients and their families to access the training Northcott staff receive; it also means providing resources to support planning, decision making and compliance with financial and administrative requirements. Essentially, Northcott needs to be committed to providing opportunities for clients and families to be empowered and build their knowledge and skills.

8. WHAT ARE THE CHALLENGES AND RISKS?

There are many important considerations for Northcott when looking at what is required to implement personalisation across the organisation. A full scoping of the issue would not be complete without examining what are the challenges and risks of implementing personalisation across Northcott services.

8.1. Financial risks and service viability

Undoubtedly, the major concern that organisations have when considering the impact of personalisation is the issue of financial risk and service viability. Shifting to a market-based approach to disability service provision and the move to individualised funding has financial and cash-flow implications for organisations. With individualised funding packages, clients can move easily across programs and between services, which reduces income predictability; as NDS posits: “The management of uneven cash flow requires service providers to have sophisticated financial skills and take on increased risk” (NDS, 2008, p.6). In the context of self-directed funding where clients essentially purchase services from the organisation, in order to mitigate some of these risks Northcott would have to put in place arrangements to manage ‘bad debt’ and develop contracts with clients that stipulate consideration of “length of notice periods required for termination of services being provided” (NDS, 2008, p.6). Not only is there a risk of unpredictable income and uneven cash flow, there are likely to be increased costs associated with reporting and accountability, including invoice and processing payments, reporting to individuals and governments, and monitoring of increased number or service agreements and cost centres etc. (NDS, 2008, p. 12).

Another important consideration here is who sets the price of services. In a market-based system, price mechanisms are based on supply and demand; however, “in Australian approaches to individualised funding, governments have retained their role as price setters” (NDS, 2008, p. 6). The question here is if government retain their role as prices setters, will they set prices that cover the full and reasonable cost of service delivery, with appropriate indexation? Unfortunately this is not necessarily the current experience of service providers (NDS, 2008, p. 6), and will be an issue that the organisation will need to lobby government on.

The other major financial risk that individualised funding poses is how fixed costs will be serviced – that is, how to maintain infrastructure and administrative functions within a demand-driven model? If individualised self-direct funding packages are rolled out by government, or a result of a new national disability insurance scheme, how will Northcott address infrastructure needs and sustainability without block funding? Block funding also provides flexibility to manage crisis and changing circumstances – how do we allow for crisis management, on an individual level, within individual packages and service plans? There are also clearly some pricing implications here for families and clients, as infrastructure costs may need to be recovered from individual packages.

Another financial risk is whether or not the shift to funding individuals (and not organisations), will impact on public fundraising donations for organisations. With personalisation also comes increased support provided to people within their local community and by informal community networks; this is a model that will have an increased requirement for community development work – how is this funded under individualised funding arrangements? (NDS, 2008, p. 8). There is also a danger in this system that by focussing on natural and informal supports this may mask the “social costs of insufficient public expenditure of supports for people with disabilities” (ACU, 2008, p. 30).

With increasing financial risk, decreasing income stability and a demand driven system, the concern for service viability is well-founded. Portable, individualised

funding could lead to sudden loss of people attending traditional services or specific organisations; some services may no longer be viable, thereby the amount of choices available to people with disabilities may actually be diminished (Laragy, 2002, p.265-267). Review of implementation of self-directed funding in the UK system found that in some instances the demand for traditional services will decline and that there will be closure and consolidation of services; however, this will be gradual rather than revolutionary (Leadbeater et al. 2008, p. 59). It is also more likely to have more impact on smaller organisations who, due to their size, may have an increased risk of viability issues.

While these financial risks and viability issues may only be of real concern if government implements individualised self-directed funding packages across the disability service system, it is important to consider these broad financial risks that personalisation will have for Northcott. Northcott also needs to start thinking now about beginning the process of personalisation, so that service costs, financial models and viability issues are well thought out before any major individualised funding program is implemented by government.

8.2. Workforce concerns

Another major concern with the advent of personalisation, especially individualised funding and the shift to focussing on informal care and supports, is the challenge this may pose to professional staff in the disability sector. Personalisation and a person centred approach specifically embraces the idea that informal care is important and possibly even preferable to formal service provision. If an increasing number of clients choose support from informal networks over formal staff there could be a de-professionalisation of the workforce supporting people with disabilities. That is, if family and friends are the key partners and providers in terms of planning and *delivery* of services (Laragy, 2002, p. 265), clients will rely less and less on skilled and trained disability sector staff. This raises several concerns:

8.2.1. Skill sustainability

The experience of personalisation of the disability service sector in the US was that “movements to empower consumers have occurred at the cost of or without substantial consideration of broader implications for skill sustainability” (NDS, 2008, p.7). There has been little research into the impact that this has had on the direct care / personal care industry. However, it is fair to conclude that the shift to employing family, friends, neighbours and local community members (as is common and encouraged in personalised approaches, especially with self-directed funding packages), means a greater use of unskilled labour.

8.2.2. Labour market conditions

With personalisation, supports and staffing arrangements should be focussed around the needs and desire of the person with a disability, rather than on organisational concerns regarding rostering and compliance with conditions in workplace agreements and awards. As clients can choose to move around and purchase a range of services under a personalised approach, the predictability of employment of staff (with regular shifts) may be compromised. With increasing demand for flexibility in shifts and working conditions, there is likely to be a greater demand for and use of casualised labour. Moreover, increasing reliance on informal supports, and employment of family and friends, may mean that services are being provided by people without the

regulatory requirements (training and safety) that apply to formal sector (Burton & Kagan, 2006, p. 308).

8.2.3. Training costs

In models of individualised and self-directed funding, there is also a concern that staff training is not supported:

“Even if individual budgets have a training component built in, there remains a concern about whether this will be sufficient to address the issue of minimum standards that most agencies will probably wish to ensure in their staff” (Dowson & Salisbury cited in NDS, 2008, p.7)

The concern is how organisations can access the funding required to continue to train staff, both in terms of core job skills and knowledge as well as offering opportunities for professional development.

8.3. Risk management issues

When considering a radical shift in organisational structures and processes, and contemplating systemic fundamental change to how disability services may be funded, there are some key risk management issues that Northcott must consider. The following risk management issues are of particular relevance when considering implementing self-directed funding models that could include ‘hosting’ arrangements (see section 4.2 and Appendices 1-6 for more detail on these arrangements).

8.3.1. Duty of care:

There is a tension between organisational versus individual planning that may result in conflict between achieving person centred goals and managing duty of care (ACU, 2008, p. 25). If personalisation is about putting the individual client at the centre of planning and delivery of supports, how does an organisation prioritise differences in clients’ goals and needs and the allocation of resources? How can Northcott manage duty of care across clients, when the goals or plan for a client conflicts with what other clients may desire or need (ACU, 2008, p. 25) or even put the safety and wellbeing of other clients at risk? Moreover, the de-professionalisation of workforce (through the increasing use of family, friends etc. as key partners and providers in the planning and delivery of services), removes the safeguards previously provided by professional involvement, which may leave people for “subservient to the wishes of their parents/carers” (Laragy, 2002, p. 265). In this instance, what is duty of care for clients when plan is oversighted by Northcott but includes informal supports? Does the use of self-directed supports and de-centralised governance arrangements in hosting models (for example, when a family is responsible for recruiting and supervising direct care staff) affect the organisation’s liability in relation to duty of care? Essentially, personalisation raises the question of where the responsibility lies for duty of care in arrangements that are informal and de-professionalised.

8.3.2. OHS & HR issues:

A major risk management issue that is often raised when discussing the implementation of personalisation, in particular of self-directed funding and hosting arrangements, are concerns regarding liability with workers compensation, occupational health and safety (OHS) and other related human resources issues. This is of particular importance in ‘hosting’ arrangements whereby de-centralised governance models shift responsibilities for recruitment and supervision of staff to the

client and/or their family. Clients/families are reluctant, and at times unable due to governments restricting funding to organisations, to take responsibility for employment contracts and compliance with industrial relations legislation and business and tax law. Families also often lack the infrastructure, financial and administrative support and knowledge to take on this responsibility. In these instances, the organisation retains the responsibility for legal employment contracts with individuals; however, the recruitment, selection, training and supervision of staff is often the responsibility of clients and their families (the argument being they are best placed to know the client's needs and the governance arrangements reflecting de-centralised decision-making and control). The risk to Northcott in such arrangements is how to ensure compliance with legislation, safe working environments and reasonable working conditions without having the day to day supervision of staff. Other organisations providing 'hosting' arrangements, such as Mamre in QLD, have developed clear contracts with families and staff, and a comprehensive handbook detailing expectations, roles and responsibilities for families in these arrangements. Northcott would need to consider these safeguards if exploring hosting arrangements in order to ensure liabilities are met.

8.3.3. Governance:

As personalisation requires the client to be at the centre of planning and decision making, what are the risks of governance arrangements that reflect de-centralised power and decision-making? With a shift in the delegation of authority to (or as close as possible to) clients, how does Northcott ensure plans and services comply with relevant legislation and policy directives? How can Northcott maintain a governance structure that ensures legal and financial accountability without compromising the decision-making power of clients and the creativity of service planning and design necessitated by personalisation?

8.3.4. Litigious risks:

There is understandable concern from Boards and Senior Management about the appropriate level of risk personalisation should expose the organisation to. The concern is how organisations are expected to retain a risk management role and responsibility if decisions about service planning, design and delivery are shifted to the clients and their families. However, any fixation on risk as a major challenge to implementing personalisation seems to be misplaced. There does not appear to be any litigation happening in disability service systems as a result of personalisation; through researching this topic no information referenced any legal matter or significant risk management problem facing government or non-government disability service providers operating within a personalised approach. In fact, research on the implementation of personalisation in the UK has found that when people were given the freedom to design their own care packages and support plans, they actually took very little risks; by engaging people in managing their own risk, people made sensible choices that improved quality of life and kept them safe (Leadbeater et al., 2008, p.33-34). Research regarding the UK system also found that individualised self-directed funding and personal budgets does not actually relieve the organisation of an overall risk management role, as they still retained a level of responsibility to approve plans (Leadbeater et al., 2008, p 33-34). Essentially, a personalised approach requires an increase risk *sharing*, which can actually result in a decrease in risk.

8.4. Time and scale of change

When examining what is required to implement personalisation in Northcott, the tendency is to view the process in totality across the organisation. However, “large scale change is always difficult, requiring considerable investment in staff training, new information technology and new accounting systems” (Laragy, 2002, p. 275). Just because personalisation may require a comprehensive shift in service delivery, it doesn’t mean that the response is a comprehensive approach to personalisation that is implemented quickly and on a large scale. Laragy (2002, p. 264) argues that personalisation, in particular the development of individualised funding models, “should be implemented incrementally and cautiously”. The challenge for Northcott is to think about how to make fundamental changes in culture, structures and process, without being reductionist.

When thinking about personalisation, there is also the tendency to view self-directed individualised funding packages as the culmination of a personalised service. The risk here is to think about individualised self-directed funding as the answer to how to make service personalised. However:

“Individualised funding is only a financing method and the critical factor in achieving innovation lies in relationships between people and in the potential of staff to be responsive and creative”. (Laragy, 2002, p. 276).

The challenge here is to create a flexible service system that “accommodates those who want to manage their own funds as well as those who want a well-defined service” (Laragy, 2002, p. 276).

The other challenge is that implementing personalisation, in particular implementing self-directed individualised funding models and innovative and creative solutions to traditional care models, may seem particularly difficult and redundant in a system that is still based around block funding and traditional service models. However, experience from other organisations has been that “there has been no need to ‘wait’ for the whole system to change to create small pockets of innovation” (Rouget 2003 cited in ACU, 2008, p.26). The lesson here is that Northcott needs to start small and being the process of implementing personalisation in a considered manner.

9. WHAT DECISIONS NEED TO BE MADE

This paper has so far raised many issues to consider and things to think about, and clearly there is much more work for Northcott to do to implement personalisation. It would be easy at this point to conclude that the issue has been scoped, that more work needs to be done, but that the magnitude of implementing personalisation across Northcott is a barrier to proceeding. However, as the research and experience of other organisations has shown, personalisation is about starting small and making meaningful changes towards an organisational culture, structure and processes that reflect an individualised and person centred approach that sits alongside traditional services. So, what are the key decisions that need to be made at this stage in order for Northcott to proceed on this journey of personalisation?

Based on research and experiences of personalisation across many organisations, Michael Kendrick has developed a set of key decisions that will help organisations “start a process of systematic individualisation of service options” (Kendrick, 2008,

p.2). The recommendations he makes (outlined below) serve as a guide and “food for thought” rather than a checklist, and some will evoke robust and contentious discussions as their implications for Northcott are fully considered:

1. **Setting the goal as an official agency priority**
2. **Cease expanding group/fixed model of service as of a given date** – it is counter productive to continue to expand group or fixed models of service if the aim is to generate more individual options, as group models are essentially contrary to individualised services in that they are based on groups rather than built as “one person at a time” arrangements of support.
3. **Assign key organisational leadership responsibility** – if there are not key staff and board members specifically authorised to lead an effort at personalisation, there then is always the chance the effort will be leaderless.
4. **Create specific organisational component(s) to shepherd personalisation** – if the effort at personalisation does not have a distinct organisational “home”, then the general culture, management system and practice that preceded it could act to hold back progress. By assigning the agenda to its own organisational sphere of authority and leadership, it’s more likely that those involved can move more quickly in getting the personalisation effort underway.
5. **Not ‘backfilling’ group models** – it only serves to delay the individualisation of services and personalisation process by reinforcing group models. However, there will be a temporary burden for the organisation to absorb this added cost while gradually reducing the numbers in the group setting.
6. **Make the components of individualised support options negotiable person-by-person** – advise clients precisely what service, administrative and financial features the organisation has designed to be potentially negotiable. Empower client and their families to have the authority to negotiate service design and implementation.
7. **Evaluate and improve upon previous agency attempts at personalisation**
8. **Learn from other organisations who have been notably successful with personalisation** – to assess properly what other organisations have achieved, carefully work out what Northcott means by quality in personalisation and then vigorously apply this criterion.
9. **Create nominal internal individualised funding accounts for each person supported in individualised arrangements** – internal individual funding accounts where each client is nominally allocated a unique budget based upon their personal needs and the resources available. This process can be largely independent of whatever system of accounts funding bodies require and need not be actual accounts, so much as a means by which individuals can plan, negotiate and track the details of their personalised support arrangements.
10. **Engage and support service users to explore their dreams and potential** – give clients ongoing support to continue to ‘imagine better’ in their lives.
11. **Proactively reach out and partner with key funders and external bureaucracies** – educate as to what efforts are being undertaken regarding personalisation and seek cooperation with these.
12. **Define what are the dimensions of quality in regards to personalisation** – identify what quality might mean in terms of ‘quality supports’

13. **Select the right people to support quality in personalisation** – place the best possible people into central roles in terms of supporting individuals with their lives.
14. **Ongoing investments in values based learning and reflections** – take stock of whether behaviours and values diverge in practice and whether they will need strengthening and better application in the work of the organisation.
15. **Start small and emphasises depth and quality** – ensure the organisation does not prematurely move onto expanding individualisation to all clients when much remains to be done in terms of quality for the small number of clients who may have started the process.
16. **Right from the beginning invest in self-conscious renewal** – keep the organisation and its people continuously renewed and revitalised in the face of many challenges that come with attempting an ambitious process.
(Kendrick 2008)

In addition to Kendrick's set of key decisions, some other specific key questions that need to be answered for Northcott are:

- Is there a commitment to making personalisation of Northcott's services a priority?
- What models would work for Northcott?
- What elements will be key indicators of quality in terms of Northcott's models of personalised service provision?
- What can we build on in terms of a personalised approach and practice in existing services?
- Who do we need to build relationships with to further the personalisation of our services?
- What resources do we have available? What resources can we use to focus on personalisation and further develop Northcott's models?
- What do we need to further develop to support personalisation of Northcott services? What do we need to cease doing?

10. CONCLUSION:

This paper has addressed the issue of personalisation and attempted to scope what the implementation of personalisation might mean for Northcott's services. Drawing on Australian and international experiences of personalisation, broad common implementation themes were identified. From scoping current practice and common themes of personalisation, a questionnaire was developed to assess how personalised and person centred Northcott's services currently are. The results of this questionnaire across the breadth of Northcott services highlighted the key services areas that rate higher on the personalisation scale (the top three being Recreation & Leisure, Early Childhood and Individual & Family Support). This questionnaire also scoped the top ten services that rated 'high' in terms of personalisation.

A more detailed exploration of what implementation of personalisation would specifically mean for Northcott then followed. This highlighted key and relevant issues for consideration in relation to three key questions: 1. What is required for Northcott to implement personalisation? 2. What are the challenges and risks of implementing personalisation across Northcott services? 3. What key decisions need to be made if Northcott is to implement personalisation?

Clearly a lot of information has been provided about the implications of implementing personalisation; what has not yet been addressed is what the implications of *not* personalising Northcott's services are. Perhaps this question can best be answered by focussing on the core reasons for personalisation. First, there is clearly political impetus for personalisation – there is funding and policy directions which point to, and are starting to move services towards, personalisation in the disability service system. Moreover, there are existing government funded pilot projects reflecting a personalised and individual funding model approach to service delivery, which could likely be rolled out more broadly over time. Second, there is the current Productivity Inquiry into the funding structure for long term care and support in the disability service system, particularly focussing on the introduction of a National Disability Insurance Scheme. This radical overhaul of the disability system could result in a market-based model where clients 'purchase' services through individualised funding packages. As this is what the future will likely look like, Northcott needs to start thinking about how to restructure the organisation so as to be responsive to and competitive in the new disability service market-place. Third, other non-government disability organisations have already travelled well down the path of personalisation, including undertaking person centred planning, individualised self-directed funding and 'hosting' arrangements. In order for Northcott to keep up with changes in good practice and provide comparable services for clients, a shift to personalisation needs to happen. Finally, and most importantly, personalisation results in quality outcomes for clients – shifting the power and decision making to those people whose lives it fundamentally affects, means that Northcott will be much more responsive and creative in delivering services, and the people with a disability we support can stop planning *for* and start living the life they want.

So, the question is not whether we personalise services but how we implement personalisation across Northcott's services. In considering implementation, the focus needs to be on how to *start* personalisation rather than how to *finish* with personalisation across the organisation. The following are some key recommendations about how Northcott can start on the journey of personalisation.

11. RECOMMENDATIONS:

1. Watch the context for change:

- 1.1. Watch the outcome of the second phase of *Stronger Together*.
- 1.2. Watch the outcome of the Productivity Commission Inquiry into a national disability insurance scheme.

2. Make a commitment:

- 2.1. Commit to personalisation and support this with strong values based leadership.
- 2.2. Set a clear vision and goals for personalisation in Northcott.
- 2.3. Develop Northcott's position statement / policy position on personalisation.
- 2.4. Consider a time-specific commitment to reduce fixed / group models of services.

3. Gather more information:

- 3.1. Benchmark service costs and map unit costs across all programs.
- 3.2. Look at the cost of each Northcott service:

Scoping Paper on Implementing Personalisation – June 2010

- What do clients get?
 - What organisational infrastructure is needed?
 - Can clients pick and choose?
- 3.3. Undertake more work on developing Northcott's models of personalisation – benchmarking quality and what makes a service 'individualised'.
- 3.4. Develop and cost different models of personalisation and individualised funding and map the financial systems management implications.

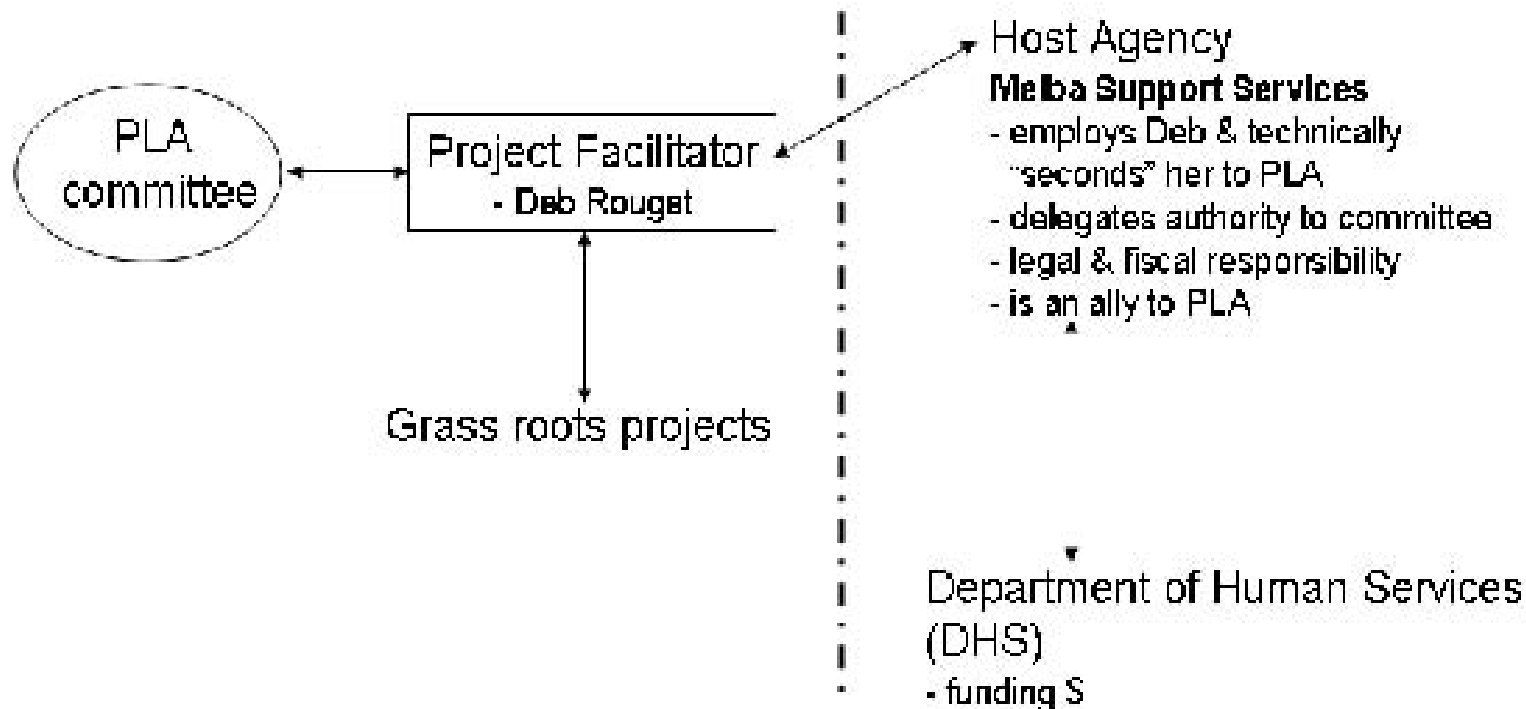
4. Take action - pilot personalised approaches:

- 4.1. Continue to support current personalisation pilot projects in Northcott.
- 4.2. Start small – focus on those programs that scored the highest 'personalisation rating' and look at developing them further to increase their personalised model of service delivery.
- 4.3. Explore the option of using individual cost centre numbers for individual clients who have a package of funding to use (eg. CPP and Flexible Respite).
- 4.4. Investigate the Local Area Coordinator model pioneered in Western Australia – particularly examining whether it is an appropriate model to adapt for support in our regional and remote locations in NSW.

APPENDIX 1

(Victoria) *Personalised Lifestyle Assistance Project (PLA)*
Host Arrangement

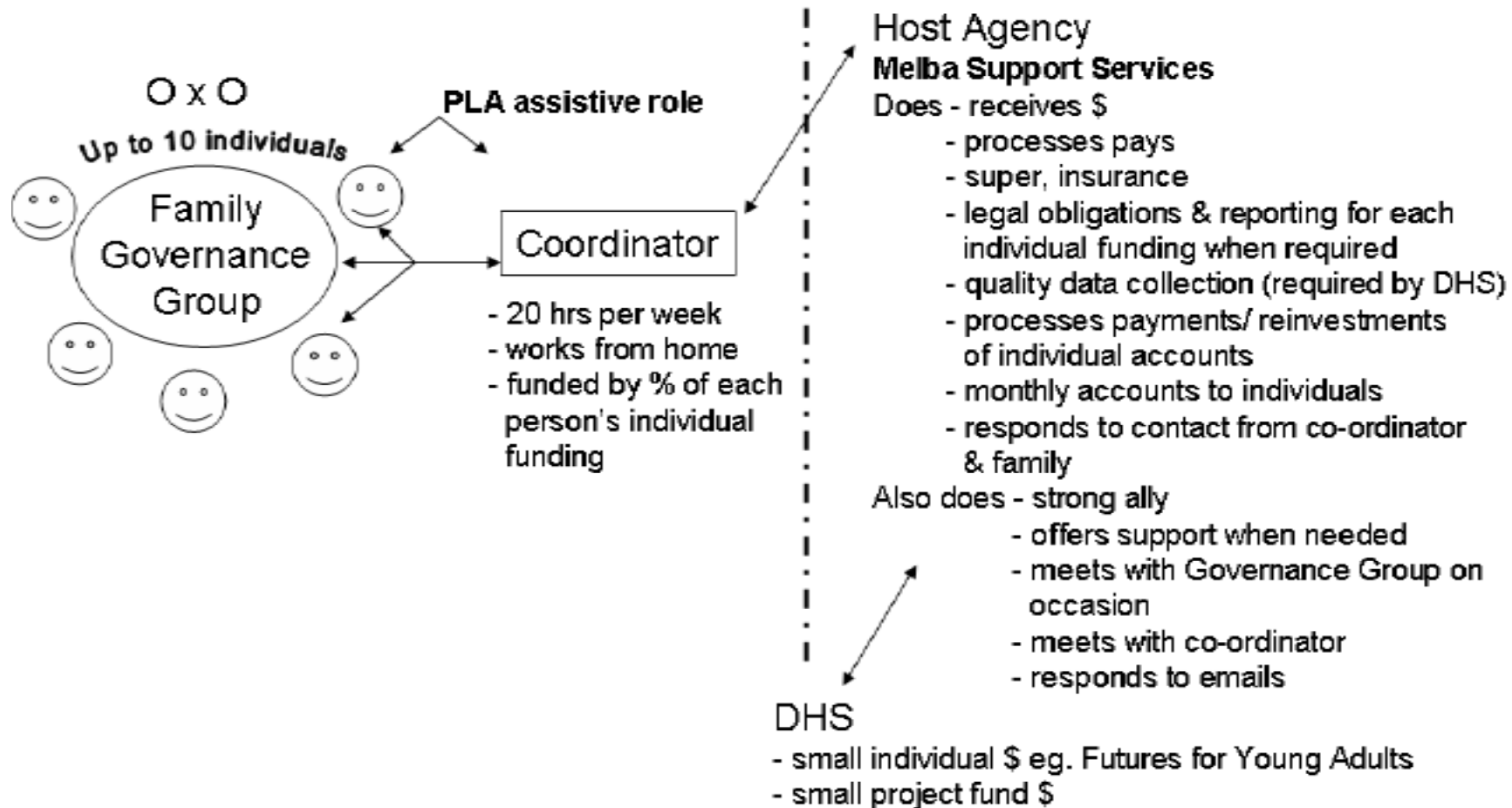
Throughout Victoria, PLA supports the development of small individual grass roots projects, designed created & governed by the people who use them. It assists with vision, planning, submissions, principles, agreements, ongoing guidance, evaluation & renewal. PLA also supports the project members to present at conferences etc. PLA started in 02/03



APPENDIX 2

(Melbourne) *One by One* (O x O)
Host Arrangement

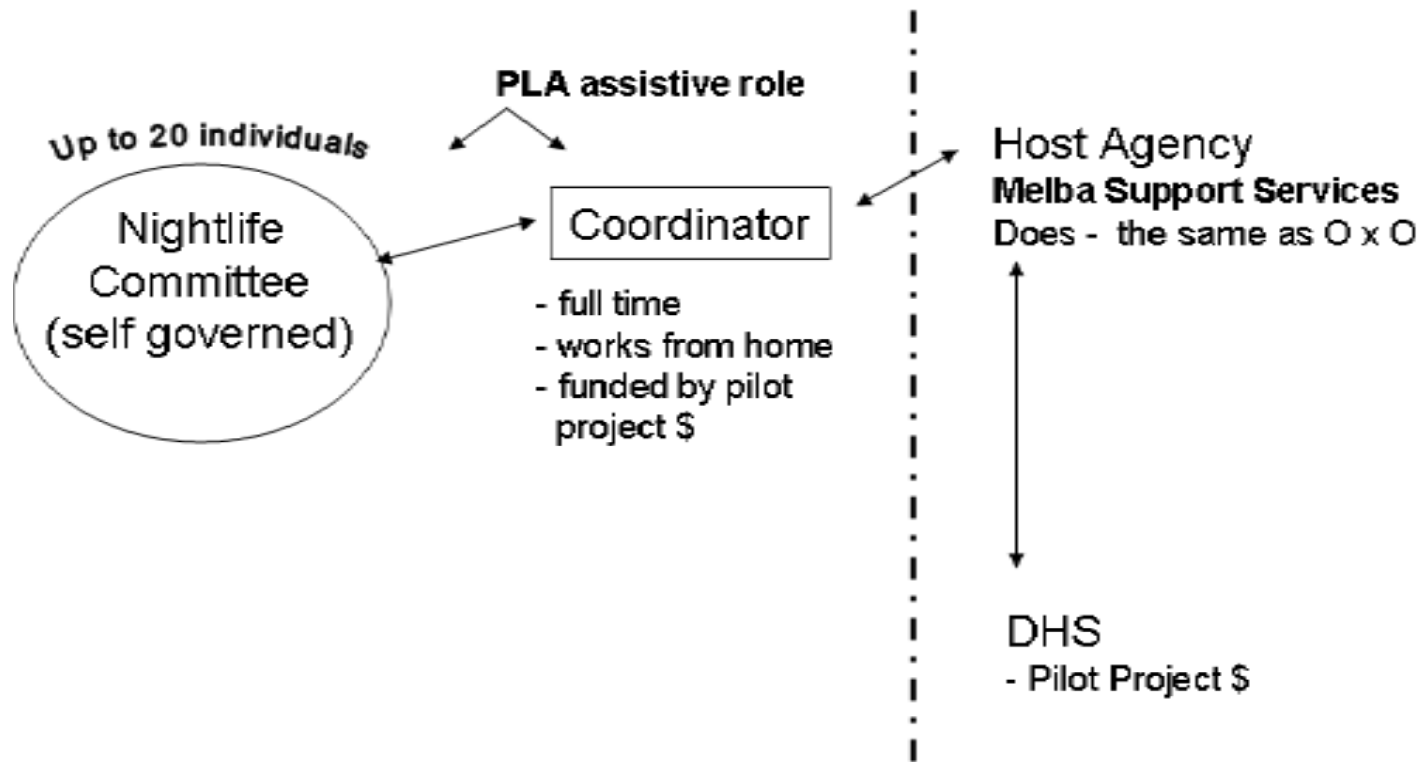
One by One started in 02/03. It creates highly tailored personalised support arrangements around each of their daughters so they can follow natural pathways eg. work, recreate, study and friendships in the community. It supports people as individuals rather than members of a group.



APPENDIX 3

(Melbourne) *NightLife*
Host Arrangement

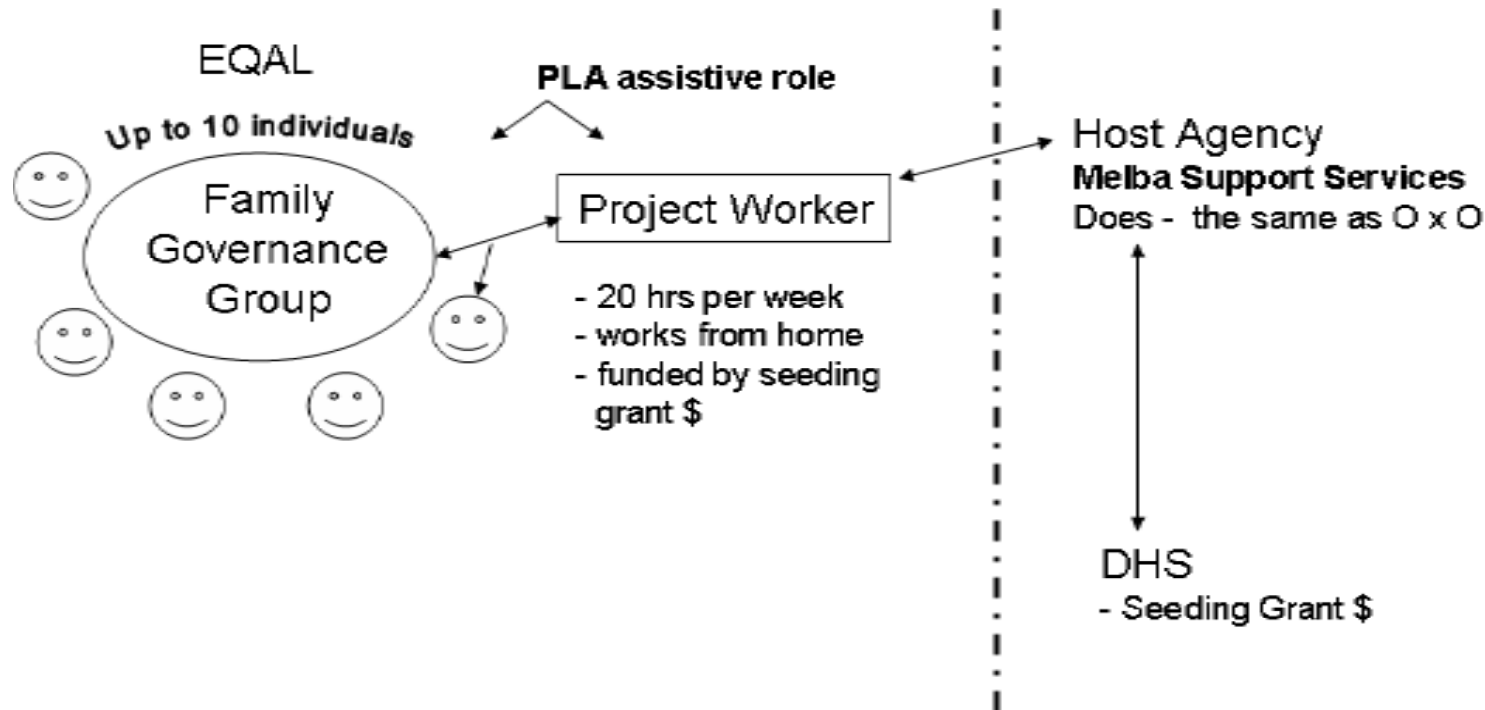
NightLife aims to provide a flexible night time service for people with physical disabilities living in their own homes. People supported by *NightLife* will be able to ring mobile support workers and obtain support between 8pm – 6am, 7 days per week, 52 weeks of the year, without pre-booking support. Support will be varied and could be called upon several times per night. Support will be for brief periods of ½ hr so the mobile support workers are available to others. *NightLife* began in 06.



APPENDIX 4

**(Melbourne) EQAL – Empowerment of Quality Active Lifestyles
Host Arrangement**

EQAL was designed to identify & facilitate uniquely tailored business, lifestyle & social opportunities in the community around each person supported & their unique passions and abilities. It was initiated by two families whose sons have quite complex needs. EQAL began in 05.

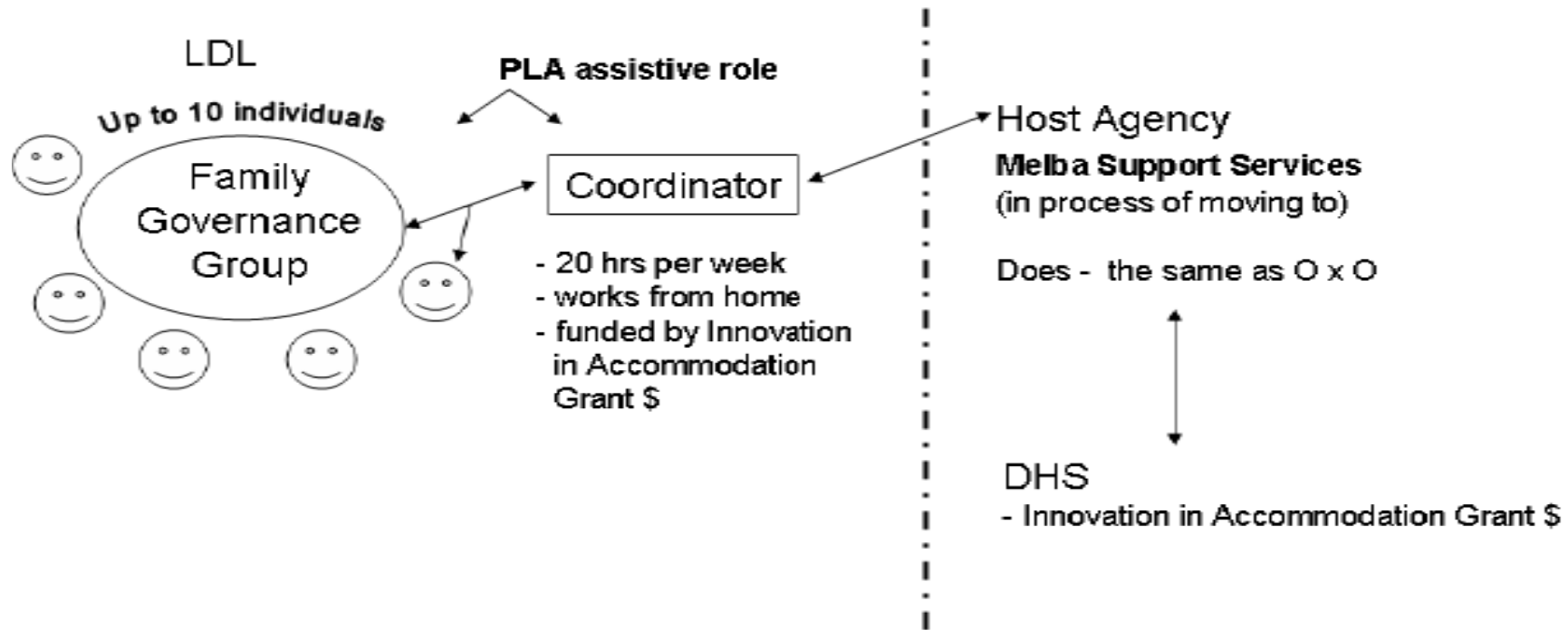


APPENDIX 5

(Melbourne) LDL – *Living Distinct Lives*
Host Arrangement

Living Distinct Lives families are each building their own visions for a good life for their son or daughter, including moving into their own place & pursuing a unique lifestyle in the community.

In 05 families began by establishing circles of support around their sons & daughters.



APPENDIX 6

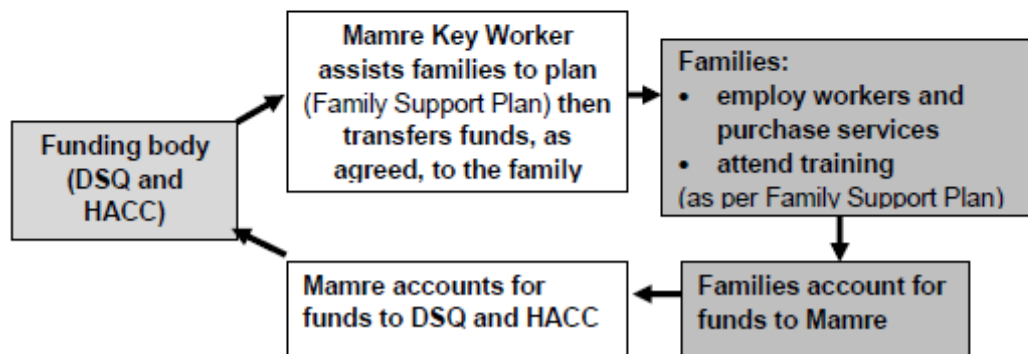
Mamre Association Inc
Handbook for Family Managed Funds – Family Support

1. What are Family Managed Funds?

Family Managed Funds is a shared management arrangement where Mamre and the family work together within an agreed plan.

1.1 Where does the money come from?

Family Managed Funds are funds from Disability Services Queensland (DSQ) and Home and Community Care (HACC) Program which are transferred from Mamre to families with a family member with a disability.



Mamre delegates the responsibility for the management of all or part of the funds to families. Mamre requires each family to:

1. use the funds in accordance with the guidelines of DSQ and/or HACC and the six-monthly Family Support Plan.
2. account for the expenditure of the funds in accordance with their Family Support Plan and this Handbook.

1.2 How can the funds be used?

Generally, funds can be used for:

1. paid support in the home
2. paid support to go out shopping, to events etc
3. paying another family to care for your family member for, say, the weekend
4. support for the family member on a weekend or holiday away from the family
5. support for the family member during the family holiday
6. approved goods and services
7. other support as negotiated with the key worker.

Some funding programs are more specific. *The key worker will advise families regarding their particular funding program guidelines.*

The family and the key worker develop a family support plan which is reviewed at least every six months. The team leader will approve the plan.

1.3 Who is eligible for Family Managed Funds

Mamre asks families to respect the Charter, values and principles of Mamre and comply with its Policy and Procedures.

Mamre assumes families want to manage their funds; however, the family can withdraw from the agreement if it no longer works for them. Similarly, if the family does not comply with the guidelines, Mamre will cease payments. As an alternative, Mamre will offer to manage the funds for the family. This may incur an extra cost.

1.4 What are the benefits of Family Managed Funds?

Families benefit because they:

- may avoid organisational costs that agencies charge
- have greater choice over who works for them
- have greater flexibility in the types of support they use
- have more control over how and when workers provide support.

1.5 What are the responsibilities of Family Managed Funds?

Families are required to:

- make the time and effort to manage the funds
- take responsibility for the service provided, including:
 - engaging workers (Key workers can offer advice and support.)
 - directing the support provided
 - providing a safe work environment
 - ensuring adequate insurance is in place
- meet the requirements as outlined in this Handbook
- be accountable for the funds and forward all documentation to Mamre.

1.6 What are the assumptions underpinning Family Managed Funds?

Mamre believes:

- Families have the best interests for their family member with a disability at heart and can be trusted to account for the funds as agreed in their family support plan.
- Families are best able to identify the level, type and quality of support they need to ensure a rich and full life for their family member with a disability and for themselves.
- Families are the experts in their family member's care and have the knowledge to provide training for support staff. (*note: workers may require professional training to meet particular needs of the person.*)
- Families are best placed to identify, build and maintain their natural networks and to show paid workers how they can complement and support these networks.
- Family Managed Funds should take as little administrative time as possible and be as flexible and responsive to each family's individual needs as possible.

For more information see [Chapter 6 - What families need to do.](#)

APPENDIX 7

Assessment on Northcott’s Person Centred-ness

Northcott’s Board would like to know how person centred Northcott’s existing services and programs are. Please take some time to respond to the statements below, thinking of the program/service that you manage or work in and the clients that you work with. Your answers are confidential and your individual response will not be identified. Please answer as to where you rate ***your specific program / service*** on the “agree / disagree” scale against the below statements.

Program/service name: _____ Metro / Regional

Beliefs and values about an inclusive society and inclusive lives.	Agree	Disagree
The lives and roles of people accessing this program mirror those of other people in the community	1 2 3 4 5	
Clients in the program pursue individual interests in ordinary community groups in ordinary facilities.	1 2 3 4 5	
Support provided in the program does not reinforce stereotypical beliefs about people with disability (e.g. they always need support, need specialist services)	1 2 3 4 5	
Program staff understand the importance of social inclusion and valued roles in society.	1 2 3 4 5	
Clients and their families understand the importance of social inclusion and valued roles in society.	1 2 3 4 5	
Program staff believe that social inclusion is possible and desirable.	1 2 3 4 5	
The program is structured to facilitate and enable social inclusion.	1 2 3 4 5	
Investment in people with disability and families	Agree	Disagree
Program staff and management understand the barriers that people face in being able to develop a ‘positive vision for the future’.	1 2 3 4 5	
Program staff assist people and families understand the benefits of genuine inclusion and valued roles.	1 2 3 4 5	
Program staff and management are committed to sponsoring and supporting people and families to attend workshops, conferences and events where families and people tell inspirational stories of change.	1 2 3 4 5	
Authority, control and power	Agree	Disagree
People with disability and families are supported and encouraged to drive their own plans for a desirable future.	1 2 3 4 5	
The behaviour of the clients and their families reflect their belief that they are in a power sharing relationship with the organisation (e.g. families are confident to put forward ideas for an inclusive future)	1 2 3 4 5	
A client’s support arrangements reflect their individual cultural context, aspirations and values.	1 2 3 4 5	
The program’s policies, procedures, newsletters and other communication mechanisms reflect and enable authority, power and control to be shared with clients and their families.	1 2 3 4 5	

Scoping Paper on Implementing Personalisation – June 2010

Partnership with people and families	Agree	Disagree
There is frequent dialogue and relationship building between the program management and staff and clients and families.	1 2 3 4 5	
Program staff invite clients and families to participate in key strategic planning, reviews and evaluations.	1 2 3 4 5	
Planning with clients and their families is conducted by workers who are not connected to the program.	1 2 3 4 5	
Any planning or support arrangements respond with flexibility to the cultural and linguistic background of people and families.	1 2 3 4 5	
Planning happens at a time and location that suits clients and families and includes all those people and agencies the client wants involved.	1 2 3 4 5	
Clients speak highly of how the program is a person centred service that responds with flexibility to an individual's needs.	1 2 3 4 5	
Tailoring support to the person	Agree	Disagree
The program provides a service which is unique to each person.	1 2 3 4 5	
The program's administrative and financial processes can track individual expenditure and provide regular reports to individuals.	1 2 3 4 5	
Program staff are recruited to work with a specific individual, based on desirable characteristics such as shared interests.	1 2 3 4 5	
Staff rosters (if used in program) are shaped around individuals, with high degrees of flexibility	1 2 3 4 5	
Ordinary community resources are identified and used to support a Northcott client in this program.	1 2 3 4 5	
Staff work to empower people and do not develop dependent relationships.	1 2 3 4 5	
The program can provide flexible support when people need it.	1 2 3 4 5	
The program has minimised the amount of bureaucratic paperwork that clients and staff have to complete.	1 2 3 4 5	
Staff take a holistic approach by asking a client, 'what makes for a good life for you?' rather than 'what support do you need'	1 2 3 4 5	
The program and staff accepts that plans change, people make mistakes, some plans will fail and they can change flexibly, without negative consequences.	1 2 3 4 5	
Dealing with structural and cultural barriers to change	Agree	Disagree
Staff have a good understanding of what person centred approaches means to providing services to people with disability.	1 2 3 4 5	
Clients and families have the capacity to work in person centred ways.	1 2 3 4 5	
Staff have got the capacity to work in person centred ways.	1 2 3 4 5	
Staff will partner with families and individuals to meet the individual needs in people's plans.	1 2 3 4 5	
Program management will get involved in knowing about the real change made by individuals in their plans.	1 2 3 4 5	

(With acknowledgements to 'Exploring and Implementing Person Centred Approaches' by ACU & ADHC)

REFERENCE LIST:

Australian Catholic University (ACU), Ellis MacRae & Associates and Sherwin & Associates (2009), *Exploring and Implementing Person Centred Approaches – A Guide for NSW Community Participation Program Service Providers*, NSW Department of Ageing, Disability and Home Care.

ACU Consortium (2008), *Person Centred Planning: A review of the literature*, NSW Department of Ageing, Disability and Home Care.

Ageing, Disability and Home Care (ADHC) (2010), *Lifestyle Planning Policy and Practice Guidelines*, Accommodation Policy and Development, ADHC, Department of Human Services NSW.

Bartnik , E. (2008), '*Making disability supports and services more personal , local and accountable: An international perspective on Local Area Coordination as a new "front end" of the disability system*', Keynote address to National Needs Assessment and Service Coordination Conference held in Christchurch New Zealand, 2nd December 2008, Disability Services Commission, Western Australian Government.

Burton, M & Kagan, C. (2006), 'Decoding Valuing People', *Disability & Society*, Vol. 21, Routledge, UK.

Harmer, M. (2000), '*Self-directed approaches - Supporting people with a disability to direct their own supports*', Case Management Action Group, accessed on 28.11.09 at:

<http://www.cmag.org.au/about/projects/Regional-Planning-Framework-Project/resources-and-publications.html>

Centre for Developmental Disability Studies (CDDS) (2004), *Client participation in the Individual Planning Process*, NSW Department of Ageing, Disability and Home Care.

Council of Australian Governments (COAG) (2009), National Disability Agreement, accessed at:

http://www.fahcsia.gov.au/sa/disability/progserv/govtint/Pages/policy-disability_agreement.aspx

Department of Health (DoH) (2009), 'Executive Summary', *Valuing People Now: A New Three-Year Strategy for people with learning disabilities - 'Making it happen for everyone'*, UK Department of Health, accessed on 28.11.09, at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377

Department of Health (DoH) (2008), Transforming Social Care, Local Authority Circular 1, accessed on 28.11.09 at:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082139.pdf

Department of Health (DoH) (2005), *Independence, well-being and choice: our vision for the future of social care for adults in England*, UK Department of Health.

Department of Health (DoH) (2001), *Valuing People: a strategy for learning disability services in the 21st century* (No. Cm 5086), UK Department of Health.

Department of Human Services (DHS) (2009), *Individual Support Packages*, State Government of Victoria, Department of Human Services, Disability Services, accessed on 05.06.10 at:
http://www.dhs.vic.gov.au/disability/supports_for_people/individualsupportpackages#changes

Department of Human Services (DHS) (2008), *Support Your Way – A self-directed approach for Victorians with a disability*, State Government of Victoria, Department of Human Services, Disability Services, accessed on 29.11.09 at:
http://www.dhs.vic.gov.au/data/assets/pdf_file/0019/323407/cis_supportyourwaybrochure_pdf_0209.pdf

Disability Investment Group (2009), *The Way Forward – A New Disability Policy Framework for Australia*, Report of the Disability Investment Group, Commonwealth of Australia.

Government of Scotland, *Evaluation of the Implementation of Local Area Co-ordination in Scotland*, The Government of Scotland, accessed on 30.05.10 at: <http://www.scotland.gov.uk/Publications/2007/03/28152325/3>

In Control (2010a), *'A brief history of in Control'*, In Control UK, accessed on 02.06.10, at:
<http://www.in-control.org.uk/site/INCO/Templates/General.aspx?pageid=90&cc=GB>

In Control (2010b), *A report on In Control's Third Phase - Evaluation and learning 2008-2009*, In Control UK.

In Control Australia (2009), Newsletter, November 2009, accessed on 03.06.10 at: http://www.in-control.org.au/documents/40125.5486342593_In%20Control%20Aus%20News%20Nov%2009.doc

Kendrick, M. J. (2009), 'Some lessons concerning agency transformation towards personalised services', *The International Journal of Leadership in Public Service*, Vol 5, Issue 1, Pavilion Journals (Brighton), UK.

Kendrick, M. J. (2008), 'Key Initial Decisions Community Agencies Need to Make If They Are To Individualise Supports', *Frontline of Learning Disability*, Issue 72, Dublin.

Kilbane, J., McLean, T. (2008), 'Exploring the History of Person-centred Practice' in Thompson, J., Kilbane, J., Sanderson., H., (Eds.) *Person-centred Practice for Professionals*, Open University Press Maidenhead.

Laragy, C, (2002), 'Individualised Funding in Disability Services', in Eardley, T. and Bradbury, B. (Eds), *Competing Visions: Refereed Proceedings of the National Social Policy Conference 2001*, SPRC Report 1/02, Social Policy Research Centre, University of New South Wales, Sydney.

Leadbeater, C., Bartlett, J., & Gallagher, N. (2008), *Making It Personal*, Demos, UK.

Lifestyle Solutions (2010), *Ability Options: The Self Managed Experience presentation*, Presented at NSW Annual State NDS Conference 2010, access at: <http://www.nds.org.au/presentation/article/16>

Mamre (2009), *Handbook for Family Managed Funds - Family Support*, Mamre Association Inc., QLD.

Mamre (2007), *Research related to 'Hosting' a family governed or community governed service for adults who have been supported previously by Mamre - Report to Mamre Management Committee and Mamre Director by T. Murdoch*, Mamre Association Inc, QLD.

Mansell, J. & Beadle-Brown, J. (2004), 'Person-centred planning or person-centred action? Policy and practice in intellectual disability services', *Journal of Applied Research in Intellectual Disabilities*, Vol. 17.

Melba (2009), *Melba Support Services presentation*, presented at In Control Forum 24 November 2009, accessed at: <http://www.melbasupport.com.au>

National Disability Authority (NDA) (2008), *Guidelines on Person Centred Planning in the Provision of Services for People with Disabilities in Ireland*, National Disability Authority, Ireland.

National Disability Services (NDS) (2010) 'Personalisation Research and Resource Library', NDS (Australia), accessed on 20.05.10 at: <http://www.nds.org.au/projects/article/48>

National Disability Services (NDS) (2008), *Individualised Funding: what it requires to work*, NDS, Canberra.

NSW Liberals/Nationals (2009), *Personalising Service Delivery – A discussion paper*, NSW Liberal Party / The Nationals, NSW.

NZ Ministry of Health (2010), [Report on the review of Local Area Co-ordination-type processes](http://www.moh.govt.nz/moh.nsf/pagesmh/5362/$File/local-area-coordination-paper-mar2010.pdf), Government of New Zealand, accessed on 29.05.10 at: [http://www.moh.govt.nz/moh.nsf/pagesmh/5362/\\$File/local-area-coordination-paper-mar2010.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/5362/$File/local-area-coordination-paper-mar2010.pdf)

O'Brien, C., O'Brien, J., (2002), 'The Origins of Person Centered Planning: A Community of Practice Perspective', in Holburn, S., Vietz, P.M., (Eds.) *Person Centered Planning: Research, Practice, and Future Directions*, Paul H. Brookes, Baltimore.

Personalised Lifestyle Assistance (PLA), accessed at:
http://www.melbasupport.com.au/main/page_our_services_hosted_arrangements_personalised_lifestyle_assistance.html

Robertson, J. Emerson, E., Hatton, C., Elliott, J., McIntosh B., Swift, P., et al. (2007), 'Person-centred planning: factors associated with successful outcomes for people with intellectual disabilities', *Journal of Intellectual Disability Research*, Vol 51, Part 3, pp 232 – 242.

Robertson, J., Emerson, E., Hatton, C., Elliott, J., McIntosh B., Swift, P., et al. (2005) *The Impact of PCP*, Institute for Health Research, Lancaster University, UK.

Rouget, D. (2009), 'Editorial – Individualisation of resources for people who have a disability', in *Thinking about Individualised Funding*, Periodical of PLA, Issue 1, Victoria.

Shergold, P. (2009), 'Been there, done that, still hoping for more', *Griffith Review*, Edition 24: Participation Society, Griffith University.

Smull, M.W, Bourne, M.L., & Sanderson, H (2009) *Becoming a Person Centered System – A brief overview of what we are learning in the USA and UK*, March 2009, accessed at:
<http://www.nasdds.org/pdf/BecomingaPersonCenteredSystem-ABriefOverview.pdf>

Vela Microboards Australia (VLA), accessed at:
<http://www.microboard.org.au/page/2007>

Wolfensberger, W. (1972). *The principle of normalization in human services*. Downsvew, ON: National Institute on Mental Retardation.

Resources:

Centre for Civil Society: <http://www.civilsociety.org.au/>

In Control UK: <http://www.in-control.org.uk>

In Control, Australia: <http://www.in-control.org.au/>

Helen Sanderson Associates: <http://helensandersonassociates.co.uk/>