social care
institute for excellence

nef
economics as if people
and the planet mattered

Budgets and Beyond: Interim Report

A review of the literature on personalisation and a framework for understanding co-production in the 'Budgets and Beyond' project

Contents

Executive Summary

Introduction to the project

The aim of this project is to find out how to realise the ambitions of personalisation when public funds are increasingly scarce, without exacerbating adverse effects for those intended to benefit from social care. A more personalised approach to supporting people can genuinely help to improve individuals' autonomy and self-determination, as well as the quality of their lives. But personal budgets on their own will rarely be enough to ensure that people have the opportunity and support to achieve the outcomes they want. There is a risk that personalisation could leave individuals feeling isolated and taking atomised decisions that disempower them and their service workers, and fail to improve well-being. These risks may be intensified as funding is reduced for social care, if personal budgets are cut, or if support for budget holders is reduced or withdrawn.

The project has three stages:

1. A review of current policy and practice of personalisation and an analysis of the potential of co-production to improve outcomes for individuals;

2. Dialogue with people receiving support, practitioners, carers, policy makers, and experts in professional and everyday practice. A series of workshops will explore how different groups of people – including budget holders, self-funders, carers and staff - experience services. The groups will collectively produce recommendations for policy and practice. This phase of the project will also explore how personalised services are being evaluated, what the key principles for evaluation are, and what other methods might improve our understanding of personalisation.

3. Preparing to test practical change: working with contacts developed throughout the project to identify opportunities for practical experimentation and draft up recommendations for practical work to develop the gaps and opportunities identified in stages one and two.

This report is the key output from stage 1 of the project, and includes: a methodology for the review, the review of literature on personalisation; an outline of the theory of coproduction; an outline framework of how co-production might be applied to personalisation; and a series of case studies showing how co-production can be applied to personalised services. A full bibliography can be found at the end of the report.

Summary of findings

In this first stage of this project we conducted an indicative review of the literature on personalisation in social care and, where information is available, for health care; the aim was to review the key information that would show the impact on outcomes and costs that personalisation is currently having, and what challenges have emerged in practice. We analysed the major evaluations of personalisation, key policy documents, academic and unpublished literature. This information has been synthesised to focus on key themes: the policy guidance and political context; outcomes achieved through personalisation; costs and benefits; and areas where personalisation is perceived to have gaps or weaknesses. Alongside this literature review we held initial meetings with members of the advisory group to explore their insights, experiences, recommendations for further literature and contacts who would be able to support this project.

The second part of this report provides a framework for analysing what value and benefits co-production might bring to those intended to benefit from more personalised services. We describe the key features of co-production, and explore how personalised services might be co-produced through a set of case studies.

We have found that:

- As a term, personalisation is still somewhat amorphous and it can mean many different things when applied in practice. It is not a value neutral term, and can be used to signal a variety of different policy intentions, from transferring risk and responsibility away from the state, to a new model of social citizenship. This ambiguity has implications for how for easily we can interpret and evaluate the concept in practice.[1]

- Despite aggressive targets to move people onto budgets, personalisation is still new and under-developed in the social care sector, and only at an early pilot stage in the health sector. As such, most literature describes the theory and practice of personalisation, with many case studies and qualitative insights into the benefits; there is an overwhelming lack of long-term, reflective or quantitative evaluations or economic analyses.

- The vision for personalisation was set out under the last Government by Putting People First, and outlined four key domains for transformation: Choice and Control, Universal Services, Social Capital and Early Intervention and Prevention. Though PPF has been superseded by the partnership Think Local Act Personal (TLAP), these domains still represent an important part of the guiding vision for personalisation. PPF also had programmes of work dedicated to Building Community Capacity and Co-production, but these aspects have proved far more difficult to implement in practice, and have often been marginalised at the local level in favour of a focus on PBs.

- The vision and values of personalisation are often conflated with the preferred delivery mechanism of personalisation – personal budgets. This features strongly throughout the literature, and is reflected in the focus of the evaluations, which have isolated the process and outcomes of budget-holding and purchasing as the subject of evaluation.

- The focus on PBs as the key indicator of success may have detracted from attention to personalising residential and agency home care.

- Process is as important as outcomes when understanding how personalisation can improve people's well-being. Recent research from SCIE has shown that PBs can improve the experience of social care for

elderly people, and those with mental health conditions, but that the right support was needed.[2] This research shows that how things are done is as important as the end result.

- Evaluations so far indicate that PBs have resulted in marginally improved outcomes across a across a range of different groups. There is a degree of variation among these groups though: people with learning disabilities and mental health conditions have shown the most improvement (though those with mental health conditions are least likely to be offered a PB), while older people have reported the lowest level of improvement in outcomes; in one or two areas they have seen a negative drop in outcomes when compared with control groups.

- Common outcomes identified in the literature include improved quality of life, improved choice and control, improved health and well-being including psychological well-being, and improved satisfaction with services.

- Some evaluations have also shown a small reduction in the overall costs of services, but this is not consistent and often fails to factor in start-up or transitional costs. As with outcomes, the balance of costs and benefits varies depending on the service user group and no firm conclusions can be drawn yet.

- Evaluations have not yet been able to track long-term changes (that is, over five or more years) in outcomes or costs. The preventative impact of personalisation is not yet understood, despite this being a critical indicator of the value of personalisation. What's more, very few evaluations are tracking whether or not personalisation is having a preventative impact.

- The amount of choice that people have over the support they receive may not change just as a result of more direct commissioning through personal budgets. The factors shaping people's ability to exercise genuine choice and control are structural, and include their access to social networks and advocates, the level of information they have, the amount of peer support, the diversity of local provision, and the vision and perception of their support workers. The IBSEN evaluation showed that 59 per cent of budget holders spent their budget on mainstream services; the lack of genuine alternatives to mainstream support is cited as a frequent barrier to choice and control throughout the literature.[3]

- Common challenges to developing personalisation (as distinct from budget-holding) include: changing commissioning to support personalisation, sharing power and control with service users and carers, addressing the implications of personalisation for the care workforce, changing the culture of services beyond the allocation of budgets, and developing appropriate processes and systems to support the transition.

- The backdrop of public sector austerity is seen by some as a major barrier to implementing personalisation. A Community Care survey highlighted that 83 per cent of those staff surveyed thought cuts to adult social care budgets would ''impede'' personalisation in their area.[4] The issue of funding was also highlighted by 48 per cent of respondents to the same survey thought that the value of PBs was insufficient to help users meet their needs.[5]

- Co-production may be applied to personalisation in four main ways to benefit people using services, and to create value for the individual, the provider and the state:

- Re-considering the approaches to creating personalised services, and moving beyond delivery mechanisms such as personal budgets to consider how the relationship between people using services and staff might be more **equal and reciprocal.**
- Re-thinking **the capacity and assets** that social and health care services can utilise to support personalised services, including people's time, knowledge, skills and experience.
- Shifting the emphasis of personalisation from treating people who are supported as passive consumers, to treating them as **citizens with an active role** to play in designing and delivering public services.
- Considering new models and structures that might help to develop **more mutual and collaborative approaches** to personalisation.

Terms used throughout this report

Personalisation

We understand personalisation to be the Government's policy for transforming services in social care and increasingly in other sectors, such as health and education. The term encompasses a number of different principles, but tends to mean that services should be tailored to people's own circumstances, and give people more control – sometimes through the allocation of an individual budget. It includes those who are supported by the state, and self-funders.[6] The vision that originally underpinned personalisation also included a focus on promoting choice and control, building social resources, improving access to 'universal services' such as leisure and transport, universal access to information and advice on care, and focusing on early intervention and prevention.

Self-directed support

Self-directed support (SDS) is a modified version of care planning, reformed to support people in a more personalised way. It was introduced by the Health and Community Care Act 1990. It describes an approach that gives individuals real power and control over their support, and is a way of administering personal budgets and approaching support planning in a person centred, user led, way.

Personal budgets

A personal budget is one way of approaching personalisation. A sum of money assessed according to means and needs, allocated to an individual to cover their support. This can be managed indirectly through the local authority, a third party, an individual budget, or taken as a direct payment which is a cash sum paid to the individual so they can directly purchase support and services.

Coproduction

We describe co-production throughout this report as a way of designing and delivering services in an equal and reciprocal relationship between staff, people who use services, and their families, friends and neighbours. There is a particular focus on the active role that people can play in the service. Co-production can also be used to describe activities that are shared by people who need care and support, with carers and family members, who work collaboratively, pooling their time, skills and knowledge to develop support and services alongside professional support and resources.

Well-being

We have used **nef**'s dynamic model to understand well-being.[7] The model describes how an individual's external conditions – such as their income, employment status, housing and social context – act together with their personal resources – such as their health, resilience and optimism – to

allow them to function well in their interactions with the world and therefore experience positive emotions. When a person is feeling good and is functioning positively (in terms of good relationships, autonomy, competence and other factors), they can be considered to have high well-being – to be flourishing.

Outcomes

We understand outcomes to be the medium to long term change that occurs as a result of a specific activity. For example, an activity involving distributing information on the effects of smoking might lead to an outcome of a reduced number of smokers in a certain area.

Service user

A service user is someone who receives support and care from statutory, voluntary or private providers. Those who fund their own support are often referred to as ‘self – funders’, although they use services in much the same way as those who are state funded. In this report we refer to service users more often as ‘people who receive support and care’.

Carer

A carer is someone who provides unpaid support to a member of their family, or friends, who could not manage without their support. They can be any age, and be supporting an individual with any type of support.

Methodology

Aim

The aim of this project was to conduct an indicative review of the literature on personalisation, and set out a framework for analysing what benefits co-production might bring for individuals receiving personalised care and support. The review is designed to help us explore what co-production may offer to people who are intended to benefit from personalised care and support; specifically, to explore potential benefits in the outcomes achieved, and the costs of support and care. To this end, the focus of the review was on understanding what literature is that explores the outcome and cost implications of personalisation. The analysis of co-production is illustrated by a number of case studies showing how the approach could be applied to personalised care.

The review included a range of literature, including the major evaluations which have been completed or are still under way, as well as smaller evaluation pieces, action research, government research and other commissioned work, and academic literature. In total we read through over 75 articles, evaluations, books and reports. A full bibliography is listed at the end of the report.

We also reviewed the policy on personalisation over the past decade and less extensively we reviewed literature on commissioning and personalisation, market development and the implications for the workforce.

The research was largely desk based, using key terms on internet search engines and reviewing the databases of a range of relevant websites. A list of these sites and terms is provided below. We also analysed the bibliographies of Needham (2011)and Carr (2009) to get a list of relevant documents that described the development and key ideas behind personalisation.

In addition to web searches we spoke to five leading individuals who have all written extensively, or been involved in evaluating, personalised services, personal budgets, and health and social care reform more broadly. We asked each for their recommendations on literature that would be relevant to our search. Once a draft version of this report had been written we shared it with an external reference group who also made recommendations on additional literature that would strengthen the review, and we acted upon these recommendations. The external reference group is made up of 10 people including service user researchers, academics, sector leaders and carers.

Further references

This was not a systematic review, and we do not attempt to summarise in any depth the literature on what personalisation is, how it is applied in practice, or where the idea has come from. Several excellent guides and

reports to this information do exist, including Carr (2009), In Control, OPM, and the Building Community Capacity website.

Definitions

We felt it was important to define some of the key terms in use throughout this report. These are listed on pages 4 and 5, and include definitions for; Personalisation, Self-directed support, Personal budgets, Co-production, Well-being, Outcomes, Service User and Carer.

Search Sites

The key sites we used for this review were:

- The Social Care Institute for Excellence (SCIE)
- The Department of Health
- The Joseph Rowntree Foundation website
- The Office for Public Management (OPM) website
- The Association for Directors of Adult Social Care (ADASS) website
- The Centre for Welfare Reform website
- In Control's website
- The York and LSE PSSRU websites
- Think Local Act Personal (TLAP site)
- The Community Care website
- Social Care Online

Search terms

1. 'Personalisation'
2. 'Direct payments, costs, benefits'
3. 'Direct payments, outcomes'
4. 'Personalisation Evaluations'
5. 'Personalisation, outcomes'
6. 'Personalisation, costs'
7. 'Personal Budgets Literature Review'
8. 'Individual Budgets Literature Review'
9. 'Personalisation Statistics"
10. ''Personalisation data''

Policy and Context: England

The call for care services to be 'personalised' has gathered strength over the last two decades and is a major policy objective of the Coalition Government. The central idea is that services will be provided in ways that empower individuals, and enable them to take more control over their care and support. The concept of personalisation has been driven forward with particular vigour in the social care sector, although is also being trialled in health, special educational needs and substance misuse. Some of the ideas around choice and control are being tested out for other funding streams in the DWP Right to Control Trailblaizers.[8] The policies developed under the banner of personalisation ten to imply a shift in services so that they can be individually tailored to support people's needs and circumstances. It is intended to put people at the heart of services, and enable them to have greater choice over what services they receive and when, and greater control in deciding how to direct their care and support.

There are a range of definitions of personalisation, and we consider three of them below to help frame the project;

1. SCIE's definition

''At the heart of personalisation is the commitment to giving more choice and control to people using social care services. This may mean exploring personal budget options but it could also mean working with individuals in residential settings to ensure that their personal needs and preferences are identified and met. It is about self-directed support and enabling people to make their own decisions about what care and support they require to lead a full and independent life''.[9,*]

2. Peter Beresford

"Personalisation is a new big jargon word that the government is using in health and social care. It is a made-up word which I think they use to mean person centred support. When they first used it, they seemed to use it really just to mean individual budgets … but more recently, key government spokespersons seem to have used the term personalisation to mean a different more person centred approach to all kinds of services, including residential provision''.[10]

3. The Putting People First definition

In 2007 the Government launched Putting People First (PPF). The Department of Health devised a diagram with four quadrants to describe the broader meaning of personalisation. These quadrants were Choice and

---

[*] A comprehensive account of the origins of the concept and its various meanings and values can be found in SCIE's *Personalisation, A Rough Guide.*.

Control, Social Capital, Universal Services and Early Intervention and Prevention.

Personalisation in social care has thus not sprung fully-formed, but has emerged gradually, in large part out of the movement for more user control over care for those with learning disabilities and through the Independent Living Movement centred on people with physical disabilities.[11] The movement, armed with research showing the potential cost-savings of direct payments, persuaded the Conservative Government in 1996 to give local authorities the power to make direct payments in some circumstances.

The 2006 White Paper *Our health, our care, our say: a new direction for community services* had a noticeable focus on individuals as the subject of personalisation, expressing a desire to "give customers a bigger voice over the care they receive".[12, †] The shift in tone from users of services to customers of services is significant, and implies a policy change directed at consumers rather than active citizens – a theme we will explore in more depth later in this report. Facilitating choice for care users is its dominant theme of the White Paper, with a promise to increase take-up of direct payments and to pilot the introduction of individual budgets, whereby separate funding streams are brought together and held on behalf of the user, to be spent as they see fit. A second priority in the White Paper was the provision of information explicitly as an enabler of user choice.

The White Paper goes furthest in its vision for personalisation in considering care for those with complex and long-term needs. It promises to extend the Expert Patients Programme, which makes use of community resources by offering training from people who have personal experience of living with a long-term illness. It also envisages a greater role for technology, allocating £80 million to local authorities to be spent on measures such as remote monitoring to keep people in constant contact with the health and care system even if they generally live alone, for example, with periodic measurements of blood pressure, glucose, and heart rate.

Two themes of the 2006 White Paper's vision for care for those with complex needs are expanded in the Health and Social Care Concordat between leading sector partners, agreed the same year. This calls for a "universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding''.[13,14]

In 2007 P*utting People First* was established, described as a "ministerial concordat" that "sets out the shared aims and values which will guide the transformation of adult social care". It declares an aim of a "mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services... we want people to have maximum choice, control and power over the support services they receive". Because much funding for individuals who use social care is decided and allocated at the local authority level, several milestones were set for local authorities to help them through the transformation needed by spring 2011. These milestones, set jointly by the Association of Directors of Adult Social

---

† The description of people who use care and health services has consistently been described as a relationship based on consumption, and so people are frequently described as customers, clients or consumers. This is not a distinction we want to perpetuate, and so only use the term here where we are quoting other sources.

Services (ADASS), the Local Government Association (LGA) and the Department of Health, were described as progress measures:

- That the transformation of adult social care has been developed in partnership with existing service users (both public and private), their carers and other citizens who are interested in these services.
- That a process is in place to ensure that all those eligible for council funded adult social care support will receive a personal budget via a suitable assessment process.
- That partners are investing in cost effective preventative interventions, which reduce the demand for social care and health services.
- That citizens have access to information and advice regarding how to identify and access options available in their communities to meet their care and support needs.
- That service users are experiencing a broadening of choice and improvement in quality of care and support service supply, built upon involvement of key stakeholders (Councils, Primary Care Trusts, service users, providers, 3rd sector organisations etc), that can meet the aspirations of all local people (whether council or self-funded) wanting to procure social care services.[15]

Each of these priorities was underpinned by milestones spread out through 2009, 2010 and 2011. For example, for the first priority of involving people in developing the agenda, the establishment of a local user-led organisation (ULO) is a milestone. For self-directed support and personal budgets, at least 30 per cent of eligible people should have a personal budget. For prevention, the key milestone was that by April 2011 there would be evidence that preventative strategies have been employed and demonstrated cashable savings.

While the 2006 White Paper discussed prevention and community resources separately, *Putting People First* draws an explicit link between them in the context of personalisation. It suggests that communities can help keep people in their homes for longer, preventing the need to move into a care home. It calls for the use of "all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm...The alleviation of loneliness and isolation to be a major priority''.

The last years of the Labour Government saw a growing preoccupation with how care would actually be funded. Nevertheless both the 2008 *Putting People First* interim statement, and the 2009 Green Paper *Shaping the Future of Care Together* reiterated the principles of choice and prevention, along with less well-defined commitments to expanded community action and wider use of telecare.

The Coalition Government's 2010 White Paper *Equity and Excellence* establishes its commitment to choice in health and social care saying that personal budgets have "much potential to help improve outcomes, transform NHS culture by putting patients in control, and enable integration across health and social care." Its take on personalisation is clearly spelled out in the Department of Health's 2010 paper *A Vision for Social Care*. This reaffirms the previous government's commitments to preventive action, greater roll-out of personal budgets and direct payments to increase user choice. Its chapter on personalisation repeatedly cites choice and control as an aim; it emphasises the importance of information and universal services so that "the 'hassle costs' of choice [are] reduced as far as possible[16]." It also devotes an entire chapter to plurality and provision,

discussing how to build a market in flexible social care, removed from the inflexible block contacting of the past.

A Vision for Social Care also re-establishes a link between prevention and community action, mentioning the "need to inspire neighbourhoods to come together to look out for those who need support" and "unlocking the potential of local support networks to reduce isolation and vulnerability". It commits the Government to training 5,000 new community organisers "to help build community capacity, particularly in areas with less social capital" and goes on to profile both timebanks and the pooling of budgets as examples of community action improving social care. The principles underpinning *A Vision for Social Care* are reflected in the sector-wide agreement *Think Local, Act Personal,* published in 2010 and signed by sector partners in 2011. TLAP is a sector led improvement approach to personalisation and building community capacity which has taken over the PPF programme.

The speed and scale at which personalisation is projected to expand is ambitious. By 2013 personal budgets are supposed to extend to all eligible social care recipients, preferably as direct payments.[17] A key milestone for local authorities was to have 30 per cent of social care recipients using budgets by Spring 2011. This seems to have been met, although a note of caution is urged; very little of the increased number of budget holders have been supported into receiving direct payments, and there is a concern among some sector leaders that the recent increase in PBs may instead be re-labelled care packages.[18]

The political will behind personalisation is apparent. It is now being extended beyond health and social care to young people, and being explored as an approach in the fields of criminal justice, and welfare to work. The basic approach to personalisation changed little between the Labour and Coalition governments, but the context has changed considerably. Fiscal austerity and reduced public sector funding are likely to have a strong influence on the way personalisation develops in practice. It is this context which is vital when considering the existing challenges of personalisation.

Many local authorities are reducing their social care budgets by increasing the needs criteria for social care, and restricting services to those who may have only critical, or substantial care needs. This implies a reduction in low level preventative and community based interventions that enable people to live independently of services and may increase the need for more acute and costly interventions further downstream.

Furthermore, the current political focus on diversifying the provider base of care and support may impact on quality and inequality, especially as public funds are increasingly withdrawn. It is questionable whether the principles of the original vision of personalisation are at odds with an increasingly marketised and individualised political vision.

The arrival of a White Paper in social care, due out in Spring 2012 will add further detail to the government's plans for personalisation. The impact of the changes to social care funding and services at a local level may become more apparent over the coming year.

Key points to take away

- The vision of personalisation is much broader than the allocation and use of personal budgets and targets for local authorities that focus on numbers of personal budgets has compounded the narrow focus on this aspect of personalisation. Personalisation as envisaged by key sector

partnerships such as TLAP, and by agreements such as PPF, encompasses a shift towards person-centred planning, building social resources, ensuring access to ‘universal services’ and preventing needs arising.

- Personalisation is a strong political narrative, but many of the detailed practical milestones for implementation have not been achieved, and there has not been enough attention paid to what we might lose through a transition to personalisation – for example, a collectivisation of risk.
- Little support or guidance has been available to support the culture change required to ensure personalisation is successful.
- The scale of transformation expected over the next two years is unprecedented: strong political will to extend personal budgets accompanies a period of fiscal austerity, and it is this fiscal context which is one of the determining factors in shaping personalisation.

The Development of Personalisation: Outcomes

In this section we explore the emerging evidence of how personalisation is impacting on people's lives and what outcomes are being achieved, which we have summarised into four common high level outcomes that come through across the evaluations. We briefly review the evaluation methods in use, and document the key findings.

Note on the scope of the literature

Where evaluations are being conducted, they have tended to focus on the experience of *budget holding*, as opposed to the overall experience and processes of *personalised services*, including aspects such as self-directed support and person centred planning. This distinction makes it difficult to understand the importance of supporting people in a personalised way, and to differentiate between the delivery mechanism (the budget), and the approach (person-centred support, or self-directed support). This reflects the increasing focus of many local authorities and providers on allocating budgets as a key indicator of success in personalisation. It is the methods and practices that sit around and beyond budgets that represent the cultural shift needed in services to realise the vision of personalisation, and which reflect the value base at the heart of it. The conflation of personal budget-holding and personalisation is problematic. It risks reducing the aspirations of personalisation to a quest for choice and consumption, while the original vision for personalisation stresses that other factors more linked to active citizenship - such as support methods, both from professionals and social networks, and the quality of services available - are vital for the success of the project. A more nuanced assessment of personalisation will recognises that it is about more than simply giving people money.

Personalisation is still in early stages of development and few major evaluations of it have been conducted.[19] All the major evaluations have focussed on the outcomes associated with budget holding, with very little insight into the processes and relationships supporting personalised care. The recent PHB forth evaluation report does provide a good insight into the care planning and support process, as does the IBSEN evaluation reports. SCIE report 40 is a more recent addition to the learning on how people who are elderly or have mental health conditions experience personalisation. There is even less learning and evaluation on what self-funders' experiences of personalised care are, and knowledge about this group, and how they fare in the care market, is limited.

An additional problem with much of the literature is the infrequent involvement of people using services in the evaluation process, specifically in developing user defined outcomes as part or all of the evaluation framework. The importance and value of working with people using services to define outcomes has been highlighted by some researchers, including Rose, Evans, Sweeny and Wykes.[20] Their assertion that the

dominant method of evaluation is that ‘’a ‘good’ outcome is framed from the perspective of clinicians and researchers’’ reminds us of the barriers that still exist in finding appropriate and meaningful evaluation methods.[21]

Our review of the literature revealed that evaluative material suggests people’s experiences of budget holding to date have been largely positive, with improvements to outcomes recorded across pilot sites, and with a variety of different groups. This is supported by a recent TLAP report, *Personal Budgets: Taking Stock, Moving Forward*.

The notable exception to this is the very inconsistent evidence on the experience and outcomes of individuals who are older, and those with mental health conditions. One hypothesis is that budget amounts for older people tend to be much lower than for some other groups. An Age UK report showed that the average allocated to older people was £53 a week, compared to £78 per week for younger service users.[22] Social or leisure activities which might enhance quality of life and well-being outcomes are often simply not viable once personal care needs are met, or residential places are paid for.

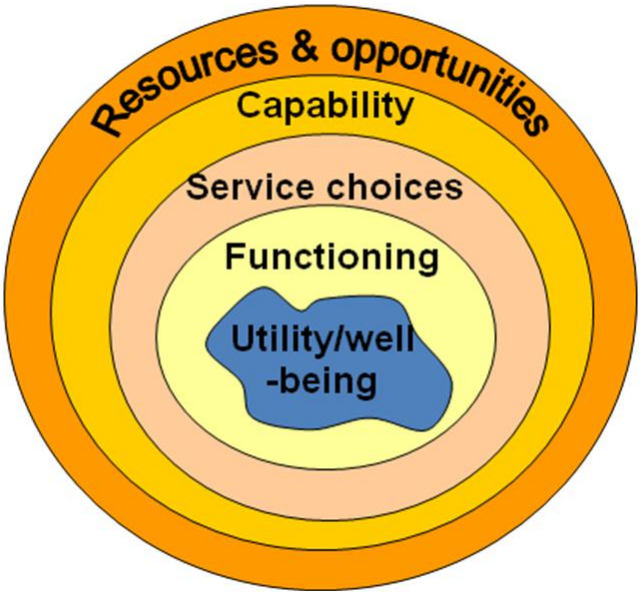
One further nuance within the broadly positive findings is the variation in outcomes data recorded from the In Control personal budgets survey. This showed that people who had direct payments were more likely to experience positive outcomes across 8 of the 14 POET domains, and those with council managed budgets reporting less positive outcomes across four of the domains.[23] This should be seen in the context of the dominant increase in type over the last year being in ‘managed’ personal budgets rather than direct payments according to recent surveys from ADASS.[24]

The findings of the review

The three most significant evaluation reports have been from the Individual Budgets Evaluation Network (IBSEN) ; the Office for Public Management (OPM) which studied the impact of personal budgets in Essex; and In Control, which conducted a survey completed by over 2,000 personal budget holders and carers. All three focus on outcomes measurements and differ in two key ways from more traditional ‘output’ evaluations. Firstly, they are based primarily on individual, subjective measures; secondly, they are designed so that they can measure changes over time.

Outcomes assessments require some conception of what outcomes are and their relative importance to people who are supported. The University of Kent’s Personal and Social Services Research Unit (PSSRU) have produced the following ‘onion’ diagram to broadly categorise the different areas across which outcomes can be tracked.

Figure 1: Tracking outcomes



25

Loosely based on Sen's 'Capabilities Approach', this framework underpins much of the research that has taken place to date. PSSRU's ASCOT (Adult Social Care Outcomes Toolkit) and In Control's POET (Personal Budgets Outcomes Evaluation Tool) take a broadly similar approach. Well-being indicators and outcomes have become especially prominent in evaluations of personalised services; outcomes that are more specific to social care, such as personal safety and dignity, are explored by the ASCOT tool, and have the benefit of assessing the relative value of services to the individual.[26]

This short case study of In Control's latest survey below shows how outcomes measures can be tracked and presented.

Case Study 1: In Control personal budgets survey – Third Phase

Of the major evaluations, the most extensive is In Control's survey of 1,114 budget holders. Using their POET framework, the survey divides its focus into 14 outcome domains which together can track the changes in quality of life entailed by a move to personal budgets. The record is positive on the whole, particularly in the areas relating to the functioning of personal budgets (being supported with dignity; getting the support you need; being in control of support; and being as independent as you want). However, the survey found little impact on the ability to choose where and with whom to live and on volunteering and community help, and there was almost no impact on the ability to get and keep a job.

The survey is broken down by care group. In line with other evaluations, older adults report below-average outcomes in almost all the domains. While the picture is positive across most of the domains and for most groups, it is worth flagging up that personalisation seems to be having a slightly negative net impact on young adults with mental health conditions in terms of their employment prospects and status.

Most evaluations on personalisation use different outcomes frameworks.

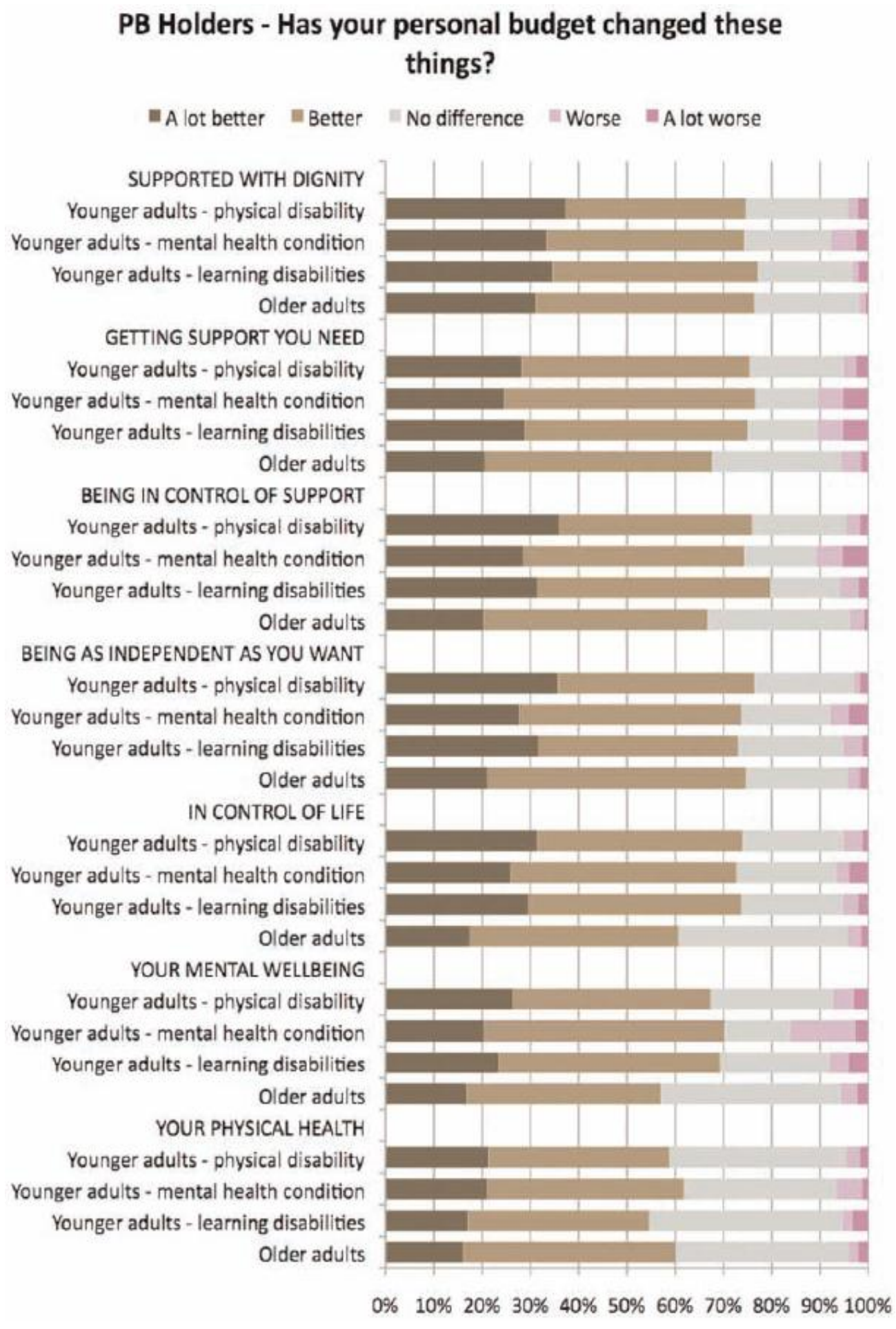
With the rest of the literature it is difficult to find common indicators and make direct comparisons. What does emerge can roughly be synthesised as follows:

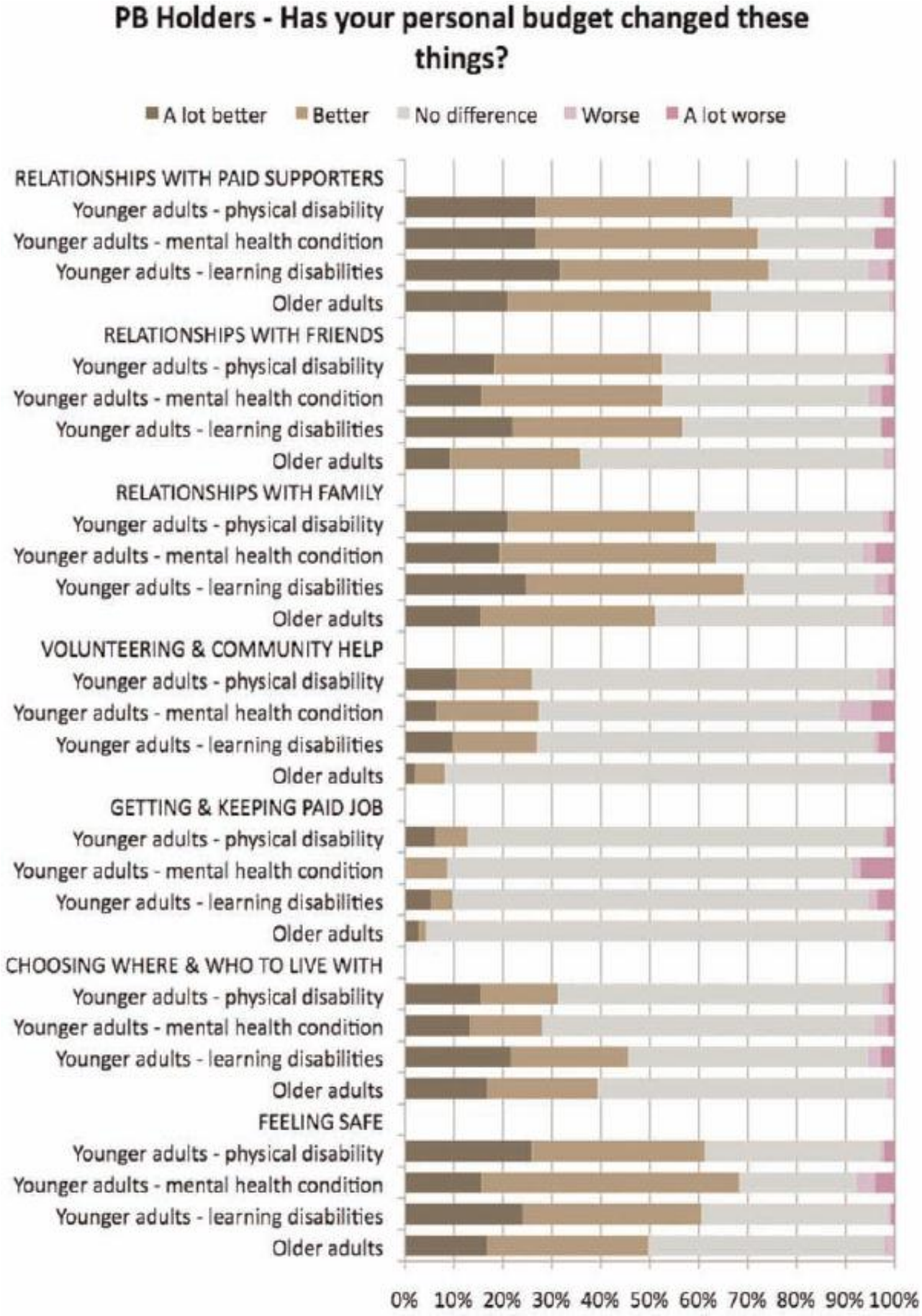
1. Quality of life outcomes
2. Health and well-being outcomes
3. Quality and satisfaction with care
4. Choice and control over care and support

Box 1: Making personalisation work for older people, and those with mental health problems

The national evaluation for the DH individual budget pilots argued that the experience of personalisation for elderly people, and those with mental health problem, was varied, and often significantly different from other groups; this included these groups having less perceived choice and control, and decreased psychological well-being.[27] SCIE has recently commissioned a practice based research project which showed that personalisation can work well for these two groups, but the processes underpinning the PB system, and the relationships between people being supported and staff, were critical success factors. Having a consistent relationship with support staff, enough time to discuss options thoroughly, and advance information about PBs, different types of support, and who they could get help from were all highly valued parts of the process.[28]

Figure 1. In Control 2011 Personal budgets survey




PB Holders - Has your personal budget changed these things?
A lot better
Better
No difference
Worse
A lot worse
RELATIONSHIPS WITH PAID SUPPORTERS
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
RELATIONSHIPS WITH FRIENDS
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
RELATIONSHIPS WITH FAMILY
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
VOLUNTEERING & COMMUNITY HELP
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
GETTING & KEEPING PAID JOB
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
CHOOSING WHERE & WHO TO LIVE WITH
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
FEELING SAFE
Younger adults - physical disability
Younger adults - mental health condition
Younger adults - learning disabilities
Older adults
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

1. Quality of Life outcomes

Self-evaluation tools are widely used in studies on personalisation, especially where studies relate specifically to health and well-being. The tools can broadly be summarised as quality of life measures, but actually vary a great deal in terms of their make-up and level of depth. Many questions within the evaluation questionnaires include an indicator called 'quality of life', although there is no definition or break down of this term so it is left to open interpretation by respondents. The IBSEN evaluation measured quality of life with a seven-point life satisfaction scale: a more nuanced measure that is commonly used in surveys to measure people's life satisfaction.

Quality of life outcomes were found to have increased across the main pilot sites and evaluations. While the quality of life measure appears to tell a fundamentally positive story, it is worth noting that the data are patchy, and different categories of users experience personalisation in different ways.

Key Results:

- A University of Lancaster study analysed data from 196 personal budget users across 17 local authorities and found that 77 per cent of respondents reported improved **quality of life**, while only 1 per cent stated that their quality of life had deteriorated. 55 per cent of respondents reported spending more time with people they like, while 3 per cent reported the contrary.[29]
- By contrast, the IBSEN evaluation found no great difference in quality of life scores between the control group and the individual budget holders group. However, when looking at differences between groups of budget holders, the report found that people with **mental health** problems who were in receipt of IBs reported significantly higher quality of life scores than those in the comparison group, particularly when the PB was taken as a direct payment.[30]
- Increased **social interaction** was one of individuals' major motivations for switching to personal budgets in the OPM study in Essex; this was also one of the benefits most commonly reported.[31]
- The OPM / Essex County Council 2010 study documented improved outcomes including increased feelings of **independence, confidence and dignity.**
- The IBSEN evaluations found that 47 per cent of those who received an individual budget reported that their views about what they could achieve had 'changed a lot' and a further 19 per cent reported that it had 'changed a little'.[32] Once again, this effect was weakest among **older people**. Most interviewees who reported these **increased aspirations** expressed satisfaction with the individual budget system, particularly stressing the greater freedom and choice they felt they had over their own individualised care and a greater recognition that non-care related activities can contribute towards greater well-being. The PSSRU report showed improvements in personal health budget users in terms of **self-confidence, self-esteem and sense of purpose**.[33]
- A study by MIND on people's views of personalisation found positive responses in terms of accessing '**ordinary activities'** – and '**universal services'**, a feature commonly under-evaluated and poorly understood.[34]
- A Demos report highlighted one evaluation that showed 63 per cent of respondents stating that they take more part in community life after the implementation of personal budgets while 2 per cent of people stated the contrary.[35] In contrast, the In Control 2011 study showed very few

people felt their personal budget had led to an increase in civic and community participation, and the majority of respondents felt the budget had made no difference in this respect.

An interesting point when comparing different evaluations' use of quality of life data is that people often expressed improved quality of life when asked to compare their current situation with their previous one. Yet when the IBSEN report asked a group of individual budget holders and a control group to rate their current quality of life and subsequently compared the two, it found very little difference. This may be because people – when asked to judge whether or not their situation has improved - find it difficult to recall how they felt before, or to make a direct comparison. The results in this case do indicate a broadly positive feeling about how people's lives are now. However, using "before and after" measurements of well-being or quality of life might help to pinpoint more accurately the improvement affected by a particular intervention.

2. Health and Well-being outcomes

Health and well-being are two of the key outcome indicators included across the major evaluations, yet there is a lack of clarity over how this is defined. IBSEN used universal measures of well-being and the 12 item general health questionnaire (GHQ) which include aspects of psychological well-being and self-reported health outcomes. In Control divided well-being into mental and emotional, but have no further definition.

The extent to which health and well-being outcomes improved as a result of personalisation varies between groups of people: in the IBSEN report older people on individual budgets reported lower levels of well-being than the control group. More recent research commissioned by SCIE has explored the experiences of older people, and those with mental health problems, in more detail and shown that PBs and the processes underpinning it can work for these groups if they have the right kind of help and support.[36]

Key Results:

- The Lancaster University report showed 47 per cent of people reported improved health, while 5 per cent reported deteriorating health.[37] These findings broadly reflect those in local case studies conducted by In Control.[38]
- The IBSEN evaluation measured well-being outcomes (through a GHQ 12-question scale). Differences between groups of budget holders showed a general improvement across users, except that **older people** reported lower levels of psychological well-being. [39]
- The IBSEN evaluation also reported that among people with **learning disabilities**, self-perceived health was considerably lower among the group with individual budgets than in the comparison group: either those who refused individual budgets had significantly better health before the trials or individual budgets lead to poorer perceptions of health among people with learning disabilities.[40]

In the data however, 'health' is not broken down into more specific categories so once again it is difficult to speculate about the exact causes of any change. It could be due to improvements in the provision of care, or due to the increased well-being that control over one's own life can bring.

3. Quality and Satisfaction with Care

The IBSEN pilots (among others) have used the ASCOT framework as part of their evaluation. This tool is designed to reveal specific outcomes that are the goals of social care interventions. The seven domains include; Personal care/comfort; Social participation and involvement; Control over daily life; Meals and nutrition; Safety; Accommodation cleanliness and comfort; Occupation and employment.

The evaluations we reviewed reported increases in people's perception of the quality of care, and their satisfaction with it. Anecdotal evidence has suggested that this is directly influenced by the choice and control people are able to exert: for example, whom they hire as a PA and the type of support received.

Key Results:

- The IBSEN report found that those in the individual budget group were **more satisfied with their care** than those in the comparison group (49 per cent compared with 43 per cent) – although this difference is small.[41]
- A survey of personal budget holders in Essex found that "those who were purchasing services with their payments (both service users and their family members) tended to express satisfaction with the services they were purchasing and noted examples of positive impact as a result, including a feeling of being treated with greater dignity and feeling a reduced sense of loneliness as a result of increased opportunities for social interaction."[42] Significantly, this perception was evident across different categories of budget holders.
- The IBSEN report found that **young people with physical disabilities using PBs** were more likely to report good quality of care than their counterparts in the comparison group, but this result is not applicable across other categories of individual budget holders.[43]
- OPM's survey reported that people with **physical disabilities** were more satisfied with the care they received, and felt it was of a higher quality.[44]

4. Choice and Control over care and support

The evaluations indicate that personalisation has been positive for people's sense of control over their lives. One sub-theme is a sense among budget holders that they are treated with greater dignity as they have more power to choose the individual who cares for them. In interviews with budget holders this has been articulated in terms of being treated as a 'normal customer' in that they can choose to take their custom elsewhere.[45]

Key Results:

- The IBSEN evaluation found that 47 per cent of budget holders reported that their views about what they could achieve had 'changed a lot' and a further 19 per cent reported that it had 'changed a little'.[46] This effect was **least evident among older people**. Most interviewees who reported these increased aspirations expressed satisfaction with the IB system, particularly stressing the greater freedom and choice over their own individualised care and also a greater recognition that non-care related activities can contribute towards greater well-being.
- Furthermore, people in the IB group were significantly more likely to report feeling in control of their daily lives.[47] This effect was also found specifically for people with **learning difficulties**.[48]

- The Lancaster study found that 72 per cent of respondents reported feeling more in control and able to make choices about their care and their lives, compared to one per cent who reported feeling less in control.[49]
- The OPM report also notes that the major outcome cited was people feeling they were more in control of their lives, particularly those with **learning difficulties**.[50]
- A 2006 evaluation of a small sample of people with **learning difficulties** who used personal budgets to employ personal assistants found that every single respondent said they were more satisfied with the new arrangements. The main reason for this response was greater control over care arrangements. The respondents stressed that before personal budgets they had to live their lives to the social workers' timetables, but their ability to employ personal assistants changed this power relationship.[51]
- A recent SCIE report documented the challenges of having choice and control over care for those with mental health problems, who were less likely to be offered the option of a direct payment.[52]

Greater choice and control has always been central to the philosophy of personalisation and the ability and opportunity to match one's care to one's needs is one of its key goals. The literature has primarily been concerned with the extent to which personalisation *improves choice*, rather than analysing *the effect of choice on people's lives*. This ignores significant concerns over how choice affects equity.

Much could be learned from focusing evaluation on the effects of choice, rather than the extent of it. For example, it is worth considering the broad range of activities on which mental health service users in Stockport spent their personal budgets:

- Leisure activities / holidays (38 per cent)
- Assistance with everyday tasks (29 per cent)
- Home improvements / cleaning services (23 per cent)
- Access to the gym or other sporting activities (21 per cent)
- Computing and other electronic equipment (13 per cent)
- Help to increase socialising (11 per cent)
- Transport (11 per cent)
- Education courses (9 per cent).[53]

This wide-ranging and diverse use of personal budgets clearly goes beyond traditional care and includes a number of things, such as holidays and leisure activities, which provide respite from everyday life but may also help reconnect the budget holder to their local community and a more 'normal' lifestyle. What appears to matter to budget holders in Stockport is not only that they are able to exercise choice and control, but also that they are doing so in a range of ways that they think will benefit their lives as a whole. Detailed evaluation and analysis is needed across other projects to improve the quality of understanding about the differential effects of increased choice and control.

Box 2: The personal health budgets evaluation

Personal health budgets are being trialled across the UK, and an in-depth evaluation is being conducted in 20 sites. A second interim report released in November 2010 stated that implementation was still at an early stage, and the interviews were hypothesising on what potential personal budgets might have on improving their outcomes.[54] The emerging findings on barriers and facilitators are similar to those found in the social care pilots indicating that process may be key to their success.

A third interim report was published in July 2011 which set out the projected set up costs for Personal Health Budgets to health authorities, but did not document further evaluation insights into the outcomes being tracked by the evaluation.

A fourth interim report was published in November 2011 and explored in more detail people's experience of the care and support planning process. The findings seem mixed, with many people reporting positive experiences of greater choice and control, but also continued confusion around the budget holding process, a lack of clarity over allocated amounts and permissible spending.[55] Three quarters of budget holders were not aware they had a choice in how their budget would be managed.[56] Very early indications of outcomes were showing many people were able to access equipment or support which was leading to direct improvements in their health and well-being, such as acupuncture, or a new wheelchair. However, a majority of people expressed some anxiety over the budget process, including how it would be managed, where they might find care or support, and whether their support plans would be approved or turned down.

The final report of the PHB evaluation will include a full analysis of the costs and benefits, and be able to document emerging outcomes in greater depth. This report was published in October 2012.

Key points to consider

- Broadly speaking, quality of life, health and well-being, satisfaction with care and people's level of choice and control have improved, although not across all groups and with significant variations for elderly people and those with mental health conditions.
- The data on how personal budgets affect people's access to employment, volunteering and to universal services are not showing a notable improvement and more needs to be done to explore why this is the case.
- Choice per se is not an outcome if it does not confer benefits from a greater selection of activities from which to choose, as shown in the Stockport example.
- Though there is a small improvement in the IBSEN study of how satisfied people are with their care, the results still showed that 22 per cent of people receiving personal budgets were neutral, or fairly/very/extremely dissatisfied with their care.

The Development of Personalisation: Value for money

This section examines the existing evidence on the value for money that personalisation offers, and what the current debates and projections on cost suggests. It also reviews some of the broader questions and debates around long-term cost reduction, and highlights gaps in the existing knowledge base.

It is important to note the significant limitations on evidence regarding cost effectiveness and value for money. Personalisation is still in very early stages of implementation and it is impossible to have a clear view on how the social care landscape will change, and what impact on costs that will have. There is very little economic analysis on the cost benefits of personalisation, often a neglect of evaluating the net economic benefits which can arise from increased employment and social participation by those who use services. No longitudinal studies have yet documented any consistent findings.

For a detailed breakdown of the current evidence on the efficiency and cost implications of personalisation see SCIE briefing number 37.[57]

In this section we try to distinguish between interlocking concepts: the cost of support or services that people are purchasing; the costs to the state of allocating money to individuals in a personal budget as opposed to contracting themselves; the value that personalisation creates in economic terms; and the longer term preventative impact of personalisation that is seen as a key driver in cost reduction arguments.

In terms of defining the terms 'cost effectiveness' and 'value for money' we looked to SCIE's report on Productivity and Efficiency:

> *''The term 'efficiency' encompasses issues of cost reduction, cost neutrality and waste reduction ('efficiency gains' are achieved where costs are reduced and outcomes maintained or improved). A service can be described as offering 'value for money' where there is an optimum balance between three factors – relatively low cost, high productivity and successful outcomes''.[58]*

Though in this report we have divided the sections on outcomes, and cost, we consider the two to be inextricable when thinking about the effectiveness of services and support.

Much of the early narrative around personalisation focussed on its potential to reduce social care costs, with projects suggesting savings of up to 30 per cent could be made.[59] One study in area of Richmond suggested a 23 per cent cost reduction when comparing costs of direct payments to

conventional services.[60] However, evidence from the literature on costs suggests that this assertion is contested. The Audit Commission has stated that personal budgets are likely to be cost-neutral and that councils should not expect to achieve large cost savings from personal budgets. They have indicated that self-directed support may allow savings in individual, high-cost cases where commissioning has previously been poor. Understanding whether this is playing out on the ground is problematic however, because most evaluations do not analyse methods or approaches for supporting people.[61]

Reports of efficiency and cost savings thus vary widely and it is difficult to identify any consistency across the studies. A study of 102 service users across ten counties before and after the implementation of personal budgets showed that for thirteen users in Northamptonshire there were savings of nearly 20 per cent while two users in Newham had personal budgets which were just under 35 per cent *more expensive* than previous arrangements. On average the study revealed approximately 10 per cent cost savings with improved social care outcomes, and, although the sample size is very small, similar figures have been found elsewhere.[62] [63]

Outside the main pilot sites, evidence on efficiency and personalisation is "relatively underdeveloped, fragmented and inconclusive".[64] As the body of knowledge on the cost effectiveness of personalisation is still young, we don't yet understand the preventative potential of personalisation. Also, while we know how much people are being allocated in their budget, there is very little information, outside the IBSEN study, on the costs of support they are purchasing, and so it is difficult to compare the disaggregated costs people are incurring with more conventionally commissioned services: while people may be given similar pots of money to those spent by the local authorities on conventional services, this does not mean they will get the same amount or level of support.

One feature of the economic cost/benefit case which is given little attention is the potential net economic gain from supporting people to play a more equal role in society, specifically in the workplace. Some work has been done in the areas of mental health and physical disabilities to estimate the loss of economic output from those with mental health problems who are prevented from entering the labour market (1 per cent of national income), and the possible benefits to be gained through income substitution and tax revenue for those with physical disabilities.[65]

Key findings: the IBSEN evaluation

The IBSEN evaluation described cost effectiveness as ''the balance between outcomes experienced by IB holders and the costs of achieving them'' as compared to more conventional arrangements.[66]

- In a survey of 268 individual budget holders, the report found that there are overall very small savings (about 6 per cent) associated with individual budgets in comparison with traditionally provided services.
- ''For the costs incurred, IBs produced better social care outcomes than conventional services, but not better psychological outcomes''.[67]
- The user group that displays the most cost-effectiveness are mental health service users, in terms of both outcomes and well-being.
- On the other hand, for older people there is no evidence that individual budgets are more cost-effective.[68]

Case Study 2: Zarb and Nadash direct payments cost analysis

One other early study was conducted by Zarb and Nadash in 1994. Using data from local authorities and from individual service users, the study compared unit costs of services for those with some form of direct payments or indirect payments – payments administered by a third party such as a local disability organisation – to those provided directly. They found that on average, services bought through direct payments were 30-40 per cent cheaper and cited administrative overheads as the main factor behind this disparity. They also found through qualitative analysis that not only were services cheaper but were of higher quality in terms of user satisfaction.[69]

Other evaluations tend to agree that direct payments are more efficient in spending scarce resources but there is much argument over whether they entail less money being spent or merely better quality services for the same amount.[70]

Key findings: In Control evaluations:

- The first In Control evaluation, in 2006, examined 60 personal budget holders and found cost savings of at least 12 per cent.[71] The sample size was small though, and the evaluation was conducted on learning disability care packages which tend to be higher in cost, and lower in volume. The same findings would therefore not necessarily be reflected with other groups, such as older people.
- The second, in 2008, found that, of a sample of 104, there were average savings of 9 per cent.[72]

A SCIE report from 2009 stressed that in most evaluations to date, start-up costs have not been taken into account and projections for long-term savings are largely speculative.[73] One rough indication is that implementing personal budgets will cost local authorities about £270,000 in the first year and between £140,000 and £170,000 in the second year: these costs vary enormously depending upon size, location and level of service need in the user group.[74] Furthermore, the SCIE report warned that "virtually every analogous scheme in the EU has been based on an underestimate of costs, at least partly due to unpredicted demand and previously undetected or unmet needs."[75]

There is insufficient knowledge to date about other factors that may influence costs and value for money. These include the preventive impact, the importance of market development, and the possible effects of reversing economies of scale and the levels of reliance on current 'community' infrastructure currently provided by the third sector but which faces funding threats.

Prevention

One of the major challenges in realising the full cost benefits of personalisation is shifting support towards a more preventative model. The ADASS/LGA/DH milestone for growing the evidence base to demonstrate savings through prevention has not been realised. The IBSEN pilots don't yet show the preventative savings associated with budgets, or whether people are being supported in ways that provide support 'upstream', thus preventing more acute and costly needs arising.[76] In the current context of increasing needs and means eligibility criteria for state funded care, it is likely that less support will go into upstream care and potentially negate some of these benefits.

Market development

Greater competition in the social care sector was one area projected to drive down prices and thus costs. This, the Audit Commission has warned, is dependent on local authorities' conception of competition. Will competition be on quality, or will it be on price? If it's the latter, evidence suggests costs will be reduced but often at the expense of quality. [77] [78] A 2006 report prepared for the Audit Commission argued that local authorities did not have the expertise to understand how competitive markets develop and it is not yet clear how the market for social care will develop, and how this will impact on either quality or costs.[79] There is also a question over how easy – or not, it may be for small and micro providers to navigate local authority requirements disproportionately benefitting larger providers.

Reversing economies of scale

Some have projected that prices may in fact rise as the economies of scale achieved through block contracting are lost and providers seek to recover these benefits. The loss of block-bought contracts could lead providers to close or end specific services which don't have enough demand to achieve the cost-benefits of scale. Older people are one group whose services tend to be lower cost and higher in volume, which may adversely affect them once services are disaggregated and shifted away from block contracting. This has a significant implication for service users: the minimum demand for a service needed by providers could be quite high, resulting in services being denied to those who want them because they are no longer financially viable to operate. This works against the ambition of achieving *real* choice for those intended to benefit from personalised services.[80]

A final point to make is that the process of switching from conventionally provided services to personalisation may well imply a rise in costs initially as the impact on reduced economies of scale becomes evident. As more people are moved onto personal budgets and choose to withdraw from block bought provision, the unit cost of the latter will rise, essentially meaning local authorities will have to pay twice.

Time to rethink efficiency and cost?

Given that the cost projections of personalisation seem so unpredictable, and the potential gains in well-being and quality of life for service users are often perceived as unquantifiable in monetary terms, a more innovative way of evaluating costs and benefits may be required, and a broader concept of service effectiveness and efficiency is needed. It is necessary to start thinking of value in terms of individual and societal benefits that go beyond narrower concepts of cost-effectiveness.

One way of doing this is through Social Return on Investment (SROI), a tool which takes social and environmental impacts into account as well as narrower financial considerations. In the case of personalisation, an SROI analysis would examine not only the outcomes set out above, but also the 'value-added' from involving users in their care decisions and in doing so begin to focus more on the processes as well as the outcomes of particular activities. As noted above, this has been cited as a potential reason for apparent cost savings in some accounts of personal budgets. Other methods, such as well-being evaluations which evaluate 'before and after' data, and longitudinal studies tracking outcomes over time could be used.

Another tool that can be used to assess cost effectiveness based on outcomes is the ASCOT tool. This tool can be used to shift cost benefit analysis from needs based to outcomes based, comparing ratios for outcomes over cost for different interventions or services.[81]

A report commissioned by the ODI also showed the importance of assessing the very real and practical economic impact of improved methods of supporting people through a comprehensive cost benefit analysis. Their work uses an expansive framework of cost and benefits at the individual, service and exchequer level. Their research demonstrated the economic benefits of supporting people to play an active role in society has an impact on employment, affecting earnings and tax revenues, and decreasing costs to the family. This multi-stakeholder analysis helps develop a more nuanced picture of how benefits and costs are accrued.

Key points to take away

- We don't yet have a clear idea of how personalisation can help to bring about a long term shift in service provision to become more preventative, and realise savings through reducing acute (and costly) interventions.
- The current context of reduced social care funding threatens any potential gains there might be from prevention.

The Development of Personalisation: Challenges and Weaknesses

Here we consider the gaps and tensions emerging in the implementation of personalisation. In the next section we explore what co-production might bring to personalisation in more detail, building on the needs and gaps identified here.

Personalisation in an era of austerity?

The social care system has been the subject of much attention recently, and some of that has been focussed on the perceived inadequacies of funding and the lack of clarity over personal funding of care.[82] Personalisation in its broadest sense is not just about the allocation of funding through personal budgets, and it requires investment in relationships, staff skills and new systems and processes. The current austerity measures place personalisation in a new context within which the costs of care, and eligibility of those who are entitled to state funding care, are central. Since 2006 there has been a 22 per cent increase of the local authorities who only fund those whose needs are 'substantial' and 'critical', marking a significant contraction of the population who are eligible for council support, and a direct response to the cuts which local authorities are making at the moment.[83] There is also anecdotal evidence that the funding being allocated to each individual is decreasing, at a time when the cost of living is rising and there are suggestions that care costs may rise in the short to medium term as block contracts are disaggregated and more individual support packages are priced up. If people's budgets go down theory suggests that providers' competition on quality may improve quality, but competition on cost reduces quality and as people have less funding it may be cost they look towards to make their money go further.

Just a personal budget?

What does personalisation look like when it doesn't involve a personal budget? Do we expect the same services, and the same cultural practices to continue for those who are self funders? Earlier in this report we described the vision of personalisation, which was originally one that implied a root and branch transformation of the social care sector. Yet one of the challenges of personalisation identified in the literature has been the focus on individual budgets as an isolated indicator of success in personalisation. This does not give sufficient consideration to the wider changes needed in supporting people across all the aspects of personalisation. Much attention has been given to the need to transform the culture of services, broadly understood as the daily practices of staff, and the management and business systems and processes that underpin front line activities. The relationship envisaged by many proponents of self-directed support was one of shared involvement, accountability, ownership and decision making. They envisaged a fundamental shift along the entire

care support process, from assessment through to evaluation. The approach and values of self-directed support have not been extended to other areas of elderly care, mental health, long term health conditions and certainly not to other sectors, such as education.

The *approach* to delivering personalised services has been marginalised in many of the major national evaluations. The IBSEN, In Control and OPM studies focussed on the practice of budget holding – which is primarily a delivery mechanism. Most did not consider whether the cultural shift in practice was also happening, and if so, what role it played in improving outcomes.

Recent work done by the partnership TLAP has reinstated a broader framework for understanding and implementing personalised, community based care. This includes an emphasis on changing working culture and practices in social care, focussing on people's capabilities, interests and skills, utilising peer support, developing preventative support and providing good information, advice and guidance.[84] This framework recognises there is much to do beyond allocating people budgets in order to develop personalisation.

Social Justice or Consumerism?

An important critical debate has emerged on personalisation which questions whether it encourages a consumerist role for those who receive support, or a role based on citizenship and social inclusion.[85] The consumerist model, outlined below, has an essentially passive view of those who receive support; they become clients, or customers, who through holding a personal budget are able to exercise choice within an open market of goods and services. This view holds a positive vision of the market, and makes a number of assumptions about its functioning, including perfect information, competition, the role of supply and demand and purchaser choice and power.

The critical debate has focussed instead on the role of state funded social care as one which is active in encouraging people's inclusion into society as active citizens, and is based on principles of social justice such as equality and reciprocity. Duffy's 'Citizenship model' outlines this distinction, as does the table below, produced by the IDeA.[86]

A social justice model of personalisation recognises the limits of solely re-distributing purchasing power to people who receive support, and highlights the need for statutory bodies and providers to develop social networks, encourage mutual support and co-production, and actively support people to play a role within their community. The distinction is particularly important in light of the current cuts to local authority social care budgets. While the

Source: IDeA

Social justice and inclusion	Consumerist
Family/friend/partner/relationships	Cash for care
Neighbourliness	Shop for care
Looking out for each other	Marketplace principles
Social capacity and capital	Trading standards
Co-production	Buyer beware
Inclusivity of community activities and services	Citizen/social networking/user posed information
Outreach	
Regulation or accreditation	

consumerist model encourages local authorities to develop a market and looks to providers to develop the right kind of social care goods, the social justice model implies a much stronger role for the state and providers in regulating provision, developing links and support among and between people, and involve people as active participants in day to day activities.

More information is needed

A key concern expressed in much of the literature was that there was not enough information provided about what personal budgets can be used for, and what it was possible to achieve under self-directed support. What information does exist was cited by some as 'confusing'.[87] This information gap was present for users, carers and support staff and is serious enough to undermine progress in personalisation. Varying degrees of knowledge and experience of supporting budget holders were reported: this may also lead to an unequal distribution of opportunity and innovation in how people are able to use their budgets. Many people are also unclear about the financial logistics of budget holding: the most recent In Control survey found that nearly 10 per cent of older people using personal budgets did not know how their personal budget was managed.[88] The ambition of having locally provided information, advice and guidance services that are universally available has not yet been achieved in many parts of England.

This lack of information exacerbates other weaknesses of personalisation, including the tension between risk and safeguarding and, most importantly, equity issues. Those who have less social support are likely to gain least from a system in which information is patchy and unevenly distributed. A recent TLAP report, 'Personal Budgets: Taking Stock, Moving Forward', highlighted the need for much better information and advice if personalisation is to work well for users and carers.

Market development

Market development should aim to encompass many types of support from both providers, local support infrastructure, ULOs, advocacy and peer support, information and advice, and private and voluntary sector provision. Some evidence suggests that local authority commissioning practices have not yet facilitated the depth of market development and diversification that would be required for the best use of personal budgets and to achieve genuine choice in provision.[89] For example, the Essex personal budget pilot scheme reported that budget holders' power as consumers is undermined by a lack of affordable alternatives.[90] In order to make informed decisions, budget holders have to rely on personal or professional recommendations which privilege those with wider social and support networks. Those without such help are largely forced to make a 'stab in the dark'.[91] This issue is intertwined with the concerns about information set out above: it is questionable how far people are able to use information to make informed decisions over social care. The transition costs of moving between different providers of social services, particularly carers employed by the user, are likely to be significant and thus the cost of a poor choice is relatively high. The idea of driving up quality by trial-and-error purchasing by inadequately informed customers does not seem appropriate in social care.

Exploitation in the care sector

There is a real tension between the choice and control that budget holders have, and the rights of staff, laid down through appropriate terms and conditions of employment. Concerns about the unregulated nature of the relationship between budget holders and employed carers or PAs were raised in the UNISON report, 'Who Cares, Who Pays?'. It suggested that there was a risk that staff may have little or no opportunities for training, as well as reduced job security, and lower wages. The problems inherent in

the current system of unstable work with little or no career structure seem likely to be exacerbated within the personalised system. The paper for UNISON raises concerns that this situation could deteriorate if not enough attention is paid to the working conditions and pay of the carers.[92]

More recently, the DH has published guidelines on personal assistants for people who are supported, and the Skills for Care website with a number of resources for social care staff on personalisation and self-directed support skills.

Devolution of Risk

Personalisation necessarily involves a re-consideration of how providers and front line workers negotiate, manage and assess risk when supporting people.[93] The Office for Public Management (OPM) has argued that the successful implementation of personalisation may be impeded by professional resistance to devolving choice, risk and responsibility to budget holders.[94] This is a particular worry in the sphere of mental health where perceptions of 'risky behaviour' are more pronounced than in other areas of health and social care.[95] However, one study in a London borough showed that, despite some reservations about the organisation of the new system, most social workers were positive about the results of personalisation. They felt that helping people to be independent reflected their ideal of social work that attracted them to the job in the first place.[96]

Recommendations from SCIE's report on Risk in Personalisation include promoting risk enablement approaches which are person focused, ensuring people have informed choice, and adapting organisational systems to support a culture of risk taking.[97]

Equality of choice and control

The issue of equality is frequently raised in the literature and there are concerns that not everyone will be equally able to realise the full benefits of choice and control. This may be because some groups are perceived as particularly 'needy' or 'vulnerable', or because some people have better support networks, and access to better information which informs the choices they make. This has been the experience of some older people in the Essex pilots, and for people with mental health conditions. Opportunities for individuals to be innovative with their personal budget are also unequally spread, and can depend on the views and experience of their support worker. Social workers in one study were concerned that personal budgets would benefit the most articulate and assertive. They also felt that some people tend to underestimate their own needs, and in doing so may disadvantage themselves – particularly where outcomes are being self-evaluated.[98]

> *"This emphasises the importance of ensuring frontline staff are not only confident in explaining the principles underpinning self-directed support, but that they are clear about what choice and control means at a practical level at each stage of the process of delivering cash payments."*[99]

One study has tentatively concluded that the level of take-up of personal budgets (where take-up is optional) can be most accurately predicted by the level of confidence of the individual concerned.[100] This confidence is largely based on their knowledge of their own rights, their skills and their access to networks of support. For older service users in particular, family support is crucial in determining whether they opt for personal budgets.[101]

As we have seen, choice has been positioned as a positive outcome of personalisation. Yet the factors determining someone's ability to choose

have been given less attention, and recent academic work has begun to paint a critique of the normative assumptions made about choice.[102] The positive vision of personalisation is underpinned by the assumption that choice will lead to a better allocation of resources, reflecting people's own desires and choices. It has been argued, however, that policies promoting choice ''favour people with existing financial and social capital'', and that these resources are unequally distributed[103].

Infrastructure and physical space

One gap in our current knowledge of personalisation is in the long term changes to resources and infrastructure. All current evaluations of personalisation have been conducted with existing social care infrastructure in place – mapping a new model of social care on to existing provision. We don't yet know what will happen when services and centres are de-commissioned and closed down, replaced by the commissioning decisions of individuals with personal budgets. It may entail moving away from place-based services, and reduce opportunities for budget-holders to meet and socialise with others. As block services are de-commissioned, physical spaces such as day centres may become fewer and further between – the results of which are currently unknown.[104]

The cultural shift towards personalised practice

If personalisation is about more than the allocation of personal budgets, then many other aspects need to change, including methods of support, the focus of services, and processes and systems that support the front line. Recent research from the Joseph Rowntree Foundation's 'Standards We Expect' project highlighted the fact that development of person centred support is inhibited by a continuing culture of social care that works against the philosophies and values of person centred support. One of the roots of this culture is the training that social work staff receive: personalisation is still not a core theme in some teaching institutions.

The processes and systems that support staff to work in certain ways have also played a role in delaying the shift towards personalisation. Throughout the literature the issue of the budgeting process has been raised as a barrier to people making the most of their budget. The In Control evaluation found extremely high numbers of comments about the assessment process, the times frames involved, the clarity of information, and restrictions on how the budget could be used.[105] The same study found that ''comments concerning relationships with staff and the 'system' were also mainly negative, showing that much of the change needed beyond the allocation of budgets has not occurred.''[106] The OPM study of budget holding in Essex also revealed that staff played an important role in determining how much choice and control people had, and that they could identify groups who were better able to manage a budget.

Both the health and social care sectors have a history of being risk adverse and paternalistic. Such qualities are at odds with the values and vision guiding personalisation. Furthermore, these call for a whole-systems approach to empower individuals and improve outcomes, which has not been achieved. While In Control has developed and continues to advocate self-directed support, this approach is not yes common place and is almost unheard of in many areas of health and social care.

Key points to take away

- We need to understand what change towards personalisation is happening in services beyond personal budgets and how far other aspects of the transformation agenda are being realised

- In particular, universal information, advice and guidance is under-developed at a local level and are consistently referred to as a barrier towards personalisation across the literature
- Although people are largely positive about the benefits of personal budgets, their reflections on the process and on professionals guiding the budgeting process are often negative, highlighting again the cultural barriers to successful implementation

What is co-production, and what does it mean for personalisation?

This section considers the various meanings of co-production and uses a case study approach to explore how co-production might change existing approaches to personalisation in health and social care. It develops a framework for analysing what co-production can offer personalisation and where it might address some of the gaps and weaknesses outlined in the previous section.

Coproduction is a way of working which involves people and professionals working together to design and deliver services in an equal and reciprocal relationship. Where services are coproduced people become active agents in decision making and practical activities. There are strong intellectual and practical links between co-production and other asset based approaches such as the Independent Living Movement, time banking and Asset Based Community Development. These approaches view individuals as experts in their own experiences, possessing talents and skills that are needed as a critical part of the 'workforce' that makes positive change possible for people and places. It is important also to note the difference between co-production and 'self-organised' provision of support. Co-production requires a contribution in terms of time and resources from public service professionals as well as from people who 'use' services. The way in which their time and resources are contributed may well look different from more traditional service provision but they are nevertheless essential. Co-production is not a camouflage for withdrawing professionals entirely from services.

There are many different definitions of co-production. The three below show some of this variety. It can be seen as;

- 'The provision of public services … through a regular long term relationship between state agencies and organised groups of citizens, where both make substantial resource contributions' (A Joshi, 2004)
- '[A] partnership between citizens and public services to achieve a valued outcome' (Horne and Shirley 2009)
- '[T]he process by which inputs used to produce a good or service are contributed by individuals who are not 'in' the same organisation' (Elinor Ostrom).

The commonality across all these definitions is in the *input into services by individuals and groups of experience, insight, time and skills*. In the UK, the term is usually applied to co-production between people and state funded institutions that are delivering public outcomes. Co-production can also apply to the collective and collaborative models of delivery, such as

mutuals, co-operatives, and collective approaches to identifying and purchasing support, by or in partnership with professionals.

nef has worked to develop the following definition of co-production:

> *"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."*[107]

This definition is underpinned by six common features of co-production:

- **Recognising people as assets:** transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal partners in designing and delivering services.
- **Building on peoples existing capabilities**: altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use with individuals and communities
- **Mutuality and reciprocity**: offering people a range of incentives to engage which enable us to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.
- **Peer support networks**: engaging peer and personal networks alongside professionals as the best way of transferring knowledge and supporting change.
- **Breaking down barriers:** dissolving the distinctions between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.
- **Facilitating rather than delivering:** enabling public service agencies to become catalysts and facilitators of change rather than central providers of services themselves.

These features are all in place to some extent across co-produced services, and the approach can be applied across a range of sectors. **nef** has worked with practitioners in areas including health, social care, youth services, housing, employment and criminal justice.

Often, it is easier to explain co-production by describing what it is not. Though it builds on a history of asset based approaches, and is similar in values to community development, user voice, time banking and self-directed support, it remains a distinct concept in its own right. For clarity, we often outline the following list of what co-production is not;

- *Volunteering*: volunteering relies on people giving their time to support other people, or organisations. However, volunteering is often a one way transaction with people who are 'able' supporting people who are considered 'needy' or 'vulnerable'; co-production requires give and take, and actively engages both parties in giving and receiving help from one another. Co-production often involves incentive or reward mechanisms to value people's contribution.
- *User Led Organisations*: ULOs represent an important body of experience, knowledge and capacity. However, they represent only one side of the user/professional constituency, and on their own do not necessarily engage in co-production. It is not appropriate for the

responsibility for co-production to sit with ULOs as they require professionals and service users to also be active partners in this relationship. Many ULOs do however work alongside statutory bodies and public sector staff in a co-produced way.

- *User voice or representation*: user voice on its own is not co-production, as it can often be ignored, and representation on governance boards or recruitment panels that can be tokenistic. Where services are coproduced, people become very active participants alongside professionals in the delivery of key activities, not just as participants in user forums, on boards or recruitment panels. In order to move towards genuine co-production this tokenism needs to be openly addressed and forums or groups that include people using services need to agree the activities they will be involved in, and be supported to have an equal say alongside professionals.
- *Replacing professionals with service users*: co-production recognises the vital importance of making an equal contribution but it also recognises that different people are needed to make different contributions. People with lived experience are each able to offer a unique set of personal resources but professionals with their skills and training are also vital. Within co-production it is likely that the way in which professionals contribute will look different, more as catalysts and less as fixers, but they *are* needed.
- *A personal budget*: giving people a personal budget does not necessarily change their relationship with people who support them. Too often the process focuses on people's deficits and problems and fails to engage with their assets, skills and wider resources like their support networks and friends. At its narrowest a personal budget leave people isolated, and atomised, without the peer and support networks that define co-production. Budgets are also the expression of an entitlement through a cash sum, and are financial transactions. By comparison, co-production is about relationships and the methods and approaches that define the relationships between professionals and people. The quality of self-directed support and the processes surrounding the allocation and spending of a PB are vital in moving PBs beyond a purely administrative function.
- *Joint evaluation, commissioning or design of services*: it is important that people who use services are involved in designing, jointly commissioning, and evaluating how effective the service is. Often in co-produced services, people will be involved in all these aspects. Yet if people are only involved in one aspect of this, then it is likely they will not also be working alongside professionals day to day. A service can be co-designed, bringing in the insight of people using services, but the service may still involve professionals 'doing to' people and not effect change in the *delivery* of services.
- *Community development*: the values and practices used in community development work are similar to co-production. But where community development has become – all too often – a discrete job operating in a silo away from mainstream services, coproduction is an approach which is applied within existing services, and to be adopted by all professionals.

These distinctions are important as co-production is a term which is used and applied to many different areas of practice, and it risks becoming an amorphous concept. Needham and Carr's distinction between different levels of co-production is also helpful in understanding how distinct the concept can be when applied in practice, and in how limited, or transformative the concept can be. At its most basic, co-production can be used as a conception of public services whereby people's action is intrinsic

to the outcome, for example, in putting out their rubbish for collection, or taking medication. This conception applies the lens of co-production to existing systems and practice in an attempt to define the relationship between citizen and state, but fails to recognise its ''transformative'' potential.[108] An ''intermediate'' level of co-production involves a more active recognition of what people using services – and their wider support networks, can offer services. This level might include ''involved, responsible users'' who might be involved or have a voice. This level still fails to address power imbalances, change relationships between people and professionals or have people involved in day to day delivery activities.[109] The third ''transformative'' level is the conception **nef** understands as co-production, which is the transformation of power and control, and the active involvement of citizens in many aspects of designing, commissioning and delivering services.[110]

The series of short case studies below have been taken from **nef**'s previous work on co-production and show how co-production can be used as an approach across a range of public services. We have tried to focus on including examples which show co-production at its most transformative, although as with all examples of good practice, there are always ways to improve it.

Co-production is, at its heart, a simple concept of bringing state and citizen together to pool resources and work alongside each other to design and deliver services. In the social care sector co-production has a particular role

Case Study 3: Merevale House.111

Merevale House is a private residential home for people living with dementia, which believes in and supports 'person centred care'. The philosophy that underpins their work helps make co-production a reality by recognising that 'service' isn't always a one way delivery, but a collaborative endeavour. In a very practical way, residents are active agents in supporting the day to day activities within the home, from preparing meals to recruiting staff and gardening. The give and take relationship between staff and residents allows residents to take control over their lives and fosters a collaborative and empowering sense of community. This is seen in very basic ways, for example people set the tables and eat meals together, rather than 'staff' servicing 'residents'.

Though the people resident at Merevale House would sometimes be described as 'vulnerable' adults, this does not prohibit them from being able to contribute to daily activities, and sets the ethos for the home as one that is based on an equal relationship of active participation.112

Case Study 4: Elderplan Member to Member Scheme, Brooklyn USA

Elderplan, a health insurance provider, originally launched their Member to Member scheme as a way of enabling their members to support others who were slightly more infirm, so that they could stay in their own homes for longer. People earn 'time dollars' for the hours of effort they put in, and they can redeem these from somebody else in the system when they need it. The ethos of "one credit equals another" helps to reward the effort everyone puts in, and opens it up to a wider membership – beyond older people - bringing in a range of community skills and assets. Elderplan members are also allowed to pay a quarter of their health insurance insurance premiums with the credits they earn helping neighbours.

in supporting people who use social care services to exercise citizenship, and positions personalisation as an approach which develops the citizenship model over the consumerist model we described earlier. Having considered the literature on personalisation, and the evaluations documenting its impact on outcomes and costs, as well as the gaps and challenges that have emerged, it is clear that there are specific aspects of the personalisation agenda that could be better met if co-production were adopted as an approach.

Coproduction offers a route away from a passive consumerist model of personalisation and towards one of active citizenship, equality, and mutual support. It mitigates the inherent inequality of a market based approach to services and narrow conceptions of how choice and control might be given to people as a natural by-product of holding a budget. It offers an opportunity to re-introduce the three quadrants of Social Capital, Early Intervention and Prevention, and Universal Services into the practice of personalised services, as well as creating the conditions and structures through which people can exercise genuine choice and control.

Below, we consider a number of different ways in which co-production, applied to personalised services, may improve outcomes for people, and improve the value for money and cost effectiveness that personalisation can offer individuals and the state.

Enabling informed choice

Individual choice and control have become the key ideas driving government policy on personalisation, and are expected to be achieved through the delivery mechanism of a personal budget. But many barriers to genuine choice have been highlighted in the literature: there may not be enough diversity in local provision to enable a wide choice of services, people with stronger social networks may be able to advocate for greater choice and control over their care, and personal budgets may be managed by other parties in such a way that the individual has very little say or choice over their care. Individuals from ethnic minority backgrounds or LGBT groups have been shown to experience additional difficulties in accessing services.[113] Some argue that the institutions of social care have been built up to work against choice, and that dismantling and rebuilding provision is the only way to change this. This also means that the historic lack of choice puts people at a disadvantage, without the knowledge and experience of what other methods of support might be available.

Critical perspectives in academic literature have also shown that the concept of choice is ambiguous and contested, and people's ability to chose may be affected by structural factors and external conditions that they do not have choice over. Clarke has identified three 'antagonisms of choice' including choice and power relations, choice and equity, and choice and the public nature of decisions.[114]

Co-production can bring people together to share their experiences and recommendations, and in doing so improve people's knowledge of and access to a wide variety of support and services. Transferring knowledge through peer networks about what support people are purchasing, and from where, is a critical step in improving people's ability to make informed choices and will also highlight gaps in the market. This collective approach also enables people to explore routes to achieve their outcomes that don't require a 'paid-for' service, for example enabling people to develop genuine friendship groups, rather than rely on paid time from a befriender. Peer networks provide a valuable forum for independent discussion and debate away from professionals and services.

Case Study 5: The Norfolk Coalition of Disabled People

Summary

The NCODP is a network of 49 user led member groups across Norfolk, representing a cross section of disabled people in the county. Their work is a mixture of advocacy, direct service provision, information, advice and guidance, and campaigning. Through a co-designed and co-produced approach, one IAG (information, advice and guidance) service which provides support planning for people with personal budgets has shown how important peer knowledge and support is in helping others make an informed choice on how they manage their personal or individual budget.

What does the NCODP do?

Norfolk county council commission the NCODP to help people identify the support they want, and support them through the process of applying for personal budgets. The NCODP approach has many of the features of co-production. It is asset based, and so they ask people what's working well, and what's not working well in their life – not what the hourly or financial assessment of need is. They then begin to explore what some solutions might be. They discuss what's important to that individual, and through this approach have observed a significant impact on long lasting well-being outcomes. They provide personal insight into how budget-holding and direct payments work.

Of all the people they have supported almost all have gone on to opt for a direct payment; by contrast, only 20 per cent of those supported by the council went on to get a direct payment, instead of a personal budget. The approach and personal expertise provided by the NCODP team is vital to how people are enabled to take on and manage a direct payment.

Why is this co-production

The expertise and personal insight of people within the NCODP is used to support the delivery of social care services with a support planning function that is outsourced by the local authority, who also have a strategic partnership with the NCODP. It is a good example of how professional and user knowledge can come together, and the impact that peer support can have.

One example of how co-production can enable greater choice is shown in case study 5, from the Norfolk Coalition of Disabled People.

Developing Personalisation Beyond Choice and Control

At we described in the introduction, the early outline of personalisation in Putting People First had a useful conceptualisation of personalisation which included 'choice and control', 'universal services', 'early intervention and prevention', and 'social capital'. This conception was intended to encompass a more complete personalisation of services, and was not limited to the allocation of personal budgets and direct payments. A full transformation to personalised services would see all of these aspects incorporated into every aspect of support. Co-production is particularly effective in developing social capital, and introducing a preventative element to services.[115]

Co-production has been shown to improve people's personal networks through taking a social approach to services that seeks to develop links within, among and across different communities. For example, the use of time banks in GP surgeries means that people whose needs are social

rather than medical in origin – such as isolation - can be referred to a time bank, developing their links with others who live locally, and engaging the wider community's time and skills in mutual support.

Where services are effectively co-produced they often prevent more acute needs arising. Often, this is because they actively build up people's skills and capabilities as a core element of services. For example, the nurse family partnership programme in the U.S. saw nurses working closely alongside first time mothers to build their knowledge and skills in a range of areas, including nutrition, literacy, relationship advice and employment. The evaluations have shown that this method of support reduced demand in a range of areas, including criminal justice, welfare and health, as well as dramatically improving outcomes for the mothers and children. [116]

Utilising the full resources within the core economy – the skills, care, knowledge, and experience of people, can also prevent more acute needs arising by providing a stronger network of support within and among local groups. Professional support is expensive and staff are often highly constrained by demands on their time. Bringing in peer support and community based support is a highly effective means of supporting people outside services, helping people to maintain their independence and reduce their need of services.

Pooling resources, time, knowledge and skills rather than shifting resources from state to individual

A key feature emerging from the literature on personalisation is a perceived shift in commissioning power and decision making from the state to individuals, as personal budgets are rolled out. There has been little focus on how the resources of both parties can be *combined* to develop more effective support. These resources are vital, particularly in the current context of reduced funding for social care and public services. They include the time, knowledge, experience and skills of professionals, people 'using' services, their carers and wider network. The current debate lends itself to an either / or situation which positions LA commissioning and control on one side, and independent and individual control on the other. The reality is that the middle ground of joining these two constituencies together and combining their resources will generate more effective services.

The increasing individualism of personalisation has masked the potential opportunity to develop a more collective and collaborative system of social care which has mutual aid and reciprocity at its heart. In practice, this could mean working out which assets people and state have, or developing more collective structures to support decision making and purchasing, such as co-operative bodies that include individuals and support staff.

An example of how pooling resources and collectively purchasing support has aspects of co-production is shown in case study 6..

Utilising the assets within the core economy

Though the early vision of self-directed support was to support people to become active members of their community, there was less focus on how support and activities might be woven into the existing community infrastructure. Co-production has at its heart an explicit focus on using the infrastructure and resources in the core economy (that is, uncommodified human and social resources) to strengthen and support public services. It includes all the time, experience, skill, wisdom and caring that goes on among people, families and communities. If nurtured, the core economy has the potential to be grown and supported to deliver positive social and economic outcomes.

Case Study 6: The up2us project

Project Summary

up2us was designed by the Housing Action Charity (HACT) in response to the personalisation agenda. The aim of the project is to develop and test approaches that encourage people with personal budgets and other funding to jointly purchase the care and support that they want, facilitated by housing organisations.

More about the project

There are six pilot sites which were set up to help people with personal budgets and other resources to act collectively to pool their money and purchase care and support. The hope is that this will help drive up service quality, stimulate growth of new services and ensure that individuals have a stronger voice in the new social care and support market place. It can also support people to have more choice and feel more in control of their lives.

The projects and activities vary across the pilot sites. In some areas groups of people have been brought together in an informal way to share their experience and think about support and activities they might like to purchase together. This has led to people collectively purchasing some gym equipment, and in other locations a rage of social activities for people. In one area a formal co-operative board has been set up to guide the activities of a wider network of people who are pooling their funds.

Why is this co-production?

Up2us brings people together so they can meet others and pool their resources. Though they do not all involve a relationship of co-production between people and professionals, they are developing collective and collaborative models of support that enable people to pool their financial, personal and social resources, and to support each other and share their experience and knowledge of different support methods.

We have already described the benefits of combining the resources of people and state. This has a positive impact on the outcomes of a service, as well as on its capacity. The value for money that services can bring has a direct relationship with how well they work with the core economy.

This doesn't imply a withdrawal of the state, or replacing professionals with volunteers, but instead an integration of the public sector into the existing efforts of the core economy, with public service workers developing new roles as facilitators, brokers, enablers and mediators, rather than merely providers. In a number of cases this has been shown to improve the capacity and value for money that people get from the state.

An example of how this can be done in practice is shown in case study 7.

However, in many local authority assessment processes people's use of the core economy – for example where they receive support from their family and tick a box marked ''I receive all the support I need'', is seen as negating the financial obligations of the state. This may have the adverse consequence of placing more pressure on the family, reducing their long term capacity for caring and support and increasing the risk of acute and high cost interventions when this critical resource is worn down.[117]

Case Study 7: Flexicare at the Holy Cross Centre Trust

Summary

Timebanking is a give and take model that supports informal exchange of skills between people in and around services: each time someone gives an hour of time, they receive a credit for an hour of time, which they can exchange for other activities and services on offer within the time bank. Much timebanking has relied on charitable funding to support the administration of their activities. This can make them insecure.

HCCT in Camden extends an existing time bank at the Centre to incorporate the provision of a 'flexicare' service, which supports people to stay independent in their own homes by providing low level care and support. This care is provided by time bank members who are working towards social care qualifications: they are able to apply their skills and earn credits for their work. Bringing in the trainees to the flexicare service ensures a certain quality and consistency of support for people.

More about the project

Many of the people supported through the flexicare service receive personal budgets from which they can choose what support and care to purchase. These can provide a source of funds to cover vital core costs, such as staff wages, while members have access to further support through the use of time credits earned by helping one another through the time bank. So, for example, while £30 a week from someone's personal budget might usually buy only three hours' worth of formal support, additional capacity can be provided through time credits. Support workers build links for the individual, enabling them to contribute in a range of ways, and so earn more credits to build up their support package.

Using this funding model, HCCT are able to build the capacity of the flexicare service. People who don't qualify for a means-tested personal budget can still gain access to support by earning and redeeming time credits.

The activities created through the time bank don't replace services, but can complement and extend existing provision, building the vital social networks and capacity that support people within their communities. It also brings a crucial preventative focus to services.

A major advantage of this model is the flexibility it offers in support and care; many existing streams of funding, such as Supporting People, are restricted to specific activities and outputs. HCCT's flexicare model means people can be supported with their actual living needs, to achieve outcomes that they determine are important to them, rather than being limited to support provided for their perceived or assumed needs. It also means being able to move away from the abstract assumptions underpinning the social care system , such as restricted support based on expected 'recovery' times. The HCCT model means that people's eligibility for support and care does not end after a defined period of time, nor is it subjected to recurring needs assessments. People who have their own savings to spend (self-funders) may also be joining the scheme in future.

Why is this co-production?

Members of the time bank – including those usually seen as 'users' or 'beneficiaries' of the service, are able to support each other through the time bank. Their active involvement is critical to building up the capacity of the service, and its ability to offer flexible, personalised, social care support. People are directly involved in the running of activities and can offer to exchange their time helping others to earn credits for themselves.

A more equal relationship

One of the key ideas within the original plans for personalisation was how professionals might play a more supporting role, facilitating individuals to identify their own support needs and commission support that works for them. This vision speaks to the role of the professional in co-producing services, where they are working alongside, no longer 'doing to', people to find the most effective support and outcomes possible.

Refreshing this aspect of personalisation is vital, but is particularly difficult to change when many of the processes underpinning personalisation are based on a deficit model of support, looking solely at people's needs. Changing professional roles and practice is a key component of the cultural change that is needed to move towards genuinely personalised services. It provides the opportunity to improve professionals' experience of personalisation and to enable them to carry out skilled professional functions while working equally alongside the intended beneficiaries.

When services are co-produced, the traditional perception of users as 'needy' recipients of services is rejected in favour of one that sees them as assets to the service. People are encouraged to contribute alongside professionals. In practice, this can mean specific activities are jointly planned or led, that people are given resources and responsibility, or that the structure of the organisation is changed into a co-operative or mutual model.

A new social contract based on citizenship rather than *consumption*

Recent policy papers have set the direction of travel for personalisation towards consumption, not participation. This highlights a dichotomy at the heart of the transformation agenda: how people can become active participants in services rather than passive consumers.

Co-production offers a positive vision of how people can contribute to the design and delivery of services and there are numerous examples of how this works in practice. The Skillnet Group case study (below) shows how personalised support can have citizenship at its heart: the role of the provider becomes one of brokering relationships between people and the community, having a specific focus on supporting people to 'do' things, whether that's enterprise, employment, dramatic arts or training.

Case Study 8: Skillnet Group (www.skillnetgroup.co.uk)

This case study shows how the Skillnet Group, a Community Interest Company, has developed personalisation in their organization, and how many of the features of co-production are embedded in their approach. In particular, it shows the importance of changing the way that people and staff work together to set up projects, and how personalised support is developed jointly with staff and the people they support.

The Skillnet Group was co-founded by Jo Kidd, her husband, and a group of people with learning difficulties. It supports people with and without learning difficulties to work together equally to make a difference.Their aim is to support people with learning difficulties to make independent and informed choices about their lives, and they work together with staff to develop projects and support networks which build on people's own interests, skills and capabilities. Their approach to personalisation is one where services are coproduced alongside people who are supported and to identify, value and build on their skills, interests and ambitions.

People are supported in the way that suits them best. Those with learning difficulties are involved in planning and developing projects and support approaches from the outset. Individuals can choose from a 'menu' of different options (which are always evolving) or can choose to develop something new themselves - with others or individually, with support. These activities are many and varied, but include peer brokerage networks, arts and drama, and co-developing training courses on environmental and ethical issues.

One of their projects is called Risky Business, an arts and drama group and emerging social firm, where people are paid for their work and performances. Meetings are held each Friday in Sittingbourne, Kent. There are three members of staff (two of whom have learning difficulties themselves), and around fifteen group members who have come for the morning. They are currently working on sketch performances to be shown at national conferences for which they're being paid. Another, the 'Swale Mates' community connecting project, is a peer mentoring and befriending scheme that works with members of the local community. Yet another is Eco Shed, an enterprise run with three people who have disabilities who are employed, making environmentally friendly products to sell commercially.

Many people whom Skillnet supports are eager and excited about developing their skills, looking for paid employment in a 'ordinary' job, living independently, socialising with one another and being able to be seen as people, citizens and campaigners, not service users, clients or residents. Skillnet supports people with personal budgets and some who are 'self funders', through a variety of means.

The value of co-production: outcomes and savings

This section explores some of the benefits to co-production, and is framed in terms of the outcomes it helps achieve, and the economic and social value it creates.

The immediate and long term cost implications of personalisation are still unclear. As shown, early evaluations indicate minor reductions in the amount spent in an individual budget, as opposed to conventionally contracted services. Whether outcomes will be better and longer lasting, or whether acute (and more costly) interventions will be reduced is still not known.

As part of this project, we want to explore what impact co-production might have on the value (costs and benefits) of personalisation. Throughout this section we look at how different examples of co-produced services generate specific outcomes. We also look at the implications for costs and value. We have particularly focussed on **whole** value, and on the preventative impact of activities. When we use the term whole value, we mean the full economic, social and environmental costs and benefits of specific activities. An activity can be measured to show, for example, the positive environmental effects of a targeted intervention, or the additional social value for different stakeholders (neighbours, local businesses, budget holders themselves) that is generated by the co-produced services.

Improved outcomes for the individual

Evidence from the literature on co-production has shown that working in this way improves outcomes for individuals, often making changes to their lives which are long term, are concerned with their well-being, and build up their skills and capacity in the process. Depending on the activity, service and sector, co-production has been shown to:

- Improve well-being
- Improve social networks
- Improve employability
- Improve social inclusion
- Improve mental and physical health
- Reduce offending rates
- Reduce anti-social behaviour
- Reduce use of acute services

- Increase participation in community activities and civic life.‡

People involved in co-production often report improved outcomes across multiple areas of their life as they are supported to find solutions to *their own* needs, rather than those perceived and determined by specific services. Individuals who are supported by many different services often see the highest benefits from co-production; those seen as 'high risk' or as 'vulnerable' are often supported to become socially included, and active participants in civic life. People involved in co-production often also report a sense of being 'valued'. Meanwhile, those who are seldom in direct contact with services (sometimes referred to as the 'wider community') are given a route into supporting others locally, and participating in the activities of the public sector.

Where services are co-produced, support can often be provided beyond the limits of a professional's role and capacity. For example, where a professional may only be able to spend a few hours with an individual each week, community resources and peer support can 'fill the gaps' and provide a more consistent helping hand to those who need support.

The outcomes achieved through co-production vary depending on the sector and service, but are often social in nature, and describe broad changes in people's lives, and in their ability to participate in the community and in the labour market. There has been much discussion over whether these outcomes can be shown to have a monetary impact. We have not associated any direct financial proxies here, but indicate where social benefits and value are being created.

Below, we describe the economic and social value associated with co-production.

Economic benefits

There are economic benefits to co-production. By this, we mean that as a result of services being co-produced (as compared to conventional models of public services) the costs to the state, at organisational, local authority and central level, and to the individual, are reduced in the short and long term. The evidence on this is persuasive but not consistent, and more rigorous evaluations are needed to show exactly what and how these benefits might accrue on a greater scale. The existing evidence does, however, point to economic benefits in four key areas;

- *Additional capacity*. Much of the value in co-producing services is the additional capacity that is brought into services to support and sustain public agencies in their efforts. This consists of the time that people bring into supporting the service, the value of their experience and skills, and the increased scope and scale of various activities. For example, the flexicare service at the Holy Cross Centre Trust (pp 33 - 34) complements the social care support purchased by people with time based exchanges, allowing them to increase the amount of support they're able to access. The time bank also involves over 600 time bankers throughout Camden, and these contributions to the activities of HCCT was valued at £137,119 by a recent **nef** SROI evaluation.[118]

---

‡ Detailed data on these outcomes can be found in *Public Services Inside Out* (2010, **nef**, NESTA), *Reciprocal Exchange: a review of the evidence in reciprocal exchange systems*, unpublished (**nef**), An unpublished SROI analysis of the Holy Cross Centre Trust, (**nef**), and evaluations conducted on Spice, LAC, Nurse Family Partnerships, Shared Lives, KeyRing, Richmond Fellowship, and the Rushey Green Time Bank.

- *Prevention.* Co-production is one important aspect of prevention. Where support is co-produced, it can prevent more acute needs arising as it actively seeks community based solutions and supports people to build up their capacity, remain independent, and take an active role in community life; the effect is often to reduce their need for services in future. For example, the Washington Youth time court has used many features of co-production in its support, and has reduced re-offending rates significantly below those of the state and national averages.[119] Similarly, the Local Area Co-ordination programme in Western Australia has demonstrated a significant reduction in the need for acute residential care.[120]
- *Cross sector benefits.* Many of the benefits that are a result of co-production accrue to sectors outside those where the service or activity takes place. For example, the Holy Cross Centre in Camden is a mental health centre, but has also demonstrated its impact on social inclusion, improved employability and reduced demand for acute health services. These cross sector benefits have a major impact on reducing the demand for services, and on increasing economic contributions to the state in the form of tax revenues, or reduced benefits, if people are supported into work. Yet we currently have neither a public accounting system, nor a means of allocating public funds, that accurately capture or encourage these benefits.
- *Economies of scale.* One aspect of value that has been explored in this report is the positive gains that individuals can make through pooling their resources (whether individual budgets, or otherwise) and collectively accessing support and services. For individuals in the up2us project this may mean being able to negotiate a group discount for people who want to purchase the same thing, and drawing down some of the benefits that economies of scale have tended to offer provider organisation.

The three detailed case studies below (9, 10 and 11) explore some of the value of co-production in more detail.

We have described the way in which co-production can add social value, bring in new capacity, and reduce acute costs in social and health care settings. It also improves social outcomes for people who use services, and helps them to gain access to greater economic resources.

More evaluations are needed to begin to document the outcomes and value created by co-production, and more work needs to be done to promote cross sector, preventative evaluation methods that can show how value is created and accrued across service areas, and in the medium to long term

Key points to take away

- Better value for money relies on increasing the available resource base in social care
- Long term cost reductions are possible if services explicitly focus on early intervention, consistent support, and operate across sectors or geographical areas; more knowledge is needed on how this might happen at scale

Case Study 9: Holy Cross Centre Trust (HCCT): measuring social outcomes (Commissioned by the EHRC)

About HCCT

HCCT is a Camden based charity that works with socially excluded groups, including those with mental health issues, homeless people and refugees and asylum seekers, to co-produce services that improve their lives in the local community. They do this in large part through their time banking model.

Evaluation Methods

In order to gain a fuller picture of the beneficial outcomes accrued through the HCCT service, in addition to the core mental health outcomes, **nef** undertook a social return on investment (SROI) evaluation for the 2009/10 year, focusing on equalities based outcomes. This tool seeks to add a financial value to outcomes that are not easily monetised and so rarely appreciated. This is helpful in demonstrating the approximate value of those services which do not always show obvious cost savings, but still provide excellent value for money, once the true value of the service is taken into consideration. SROI is a multi-stakeholder analysis, taking into consideration users, providers, local authorities and families.

The following table details the outcomes framework used to evaluate the benefits accruing to service users. From this table broad outcomes have been divided into more specific indicators of success, which tell us to what extent an outcome has been achieved, in order to attribute an approximate value.

Value

The total contract value of the mental health day service over three years was £2,011,591 including £689,515 for the year of 2009/2010. In addition to this investment of funding from Camden Council, the service relies on service users and time bank members investing their time and energy which have been valued by the London Living Wage campaign to total £137,119 over one year alone. Therefore the value of the total input included in the model is £826,634 and this was used by **nef** to calculate the SROI ratio. Over 2009/2010 the providers generated over £4,700,000 in social value. With an investment of £826,634, this is a social return on investment of approximately £5.75 for every £1 invested.

nef also looked at how much social value was generated for each of the key stakeholders, including for service users, volunteers, the community and the state. The latter is of particular interest given rapidly shrinking public budgets. **nef** determined that more than £2,000,000 of social value was generated for the state in 2009/2010 by the mental health day service provided by the Consortium. Nearly half (or just over a million) of this value comes from cost savings associated with the mental health and employability outcomes of service users. The rest of the value is related to outcomes relating to social networks, reducing stigma and discrimination for participants, and community cohesion. Isolating the value from the investment of Camden gives a return on investment (ROI) to the state of more than £3.40 for every £1 invested.

Case Study 10: Local Area Coordination (LAC), Western Australia. [121]

Local area co-ordination is an approach to support developed in Australia that has a personalised way of working and has many features of co-production. LAC involves a local area co-ordinator supporting between 50 and 60 individuals with disabilities. Co-ordinators work with each individual to identify existing local networks and resources, such as a church group, library or local timebank, and introduces them to other people, integrating them into existing local networks rather than allocating them to a specialist group according to their condition. Funding and support can be devolved to individuals and attention is paid to maintaining existing support networks, such as the family, friends and neighbours".[122]

Evaluation Outcomes

Evaluations of the LAC service showed:

- High levels of user-satisfaction: users, families and the coordinators all scored the service highly in surveys conducted. These were further backed up by in-depth conversations.
- Responsive and flexible service provision: the service has proven a strong ability to adapt with the changing needs of the service 'users'
- Good value for money: "the LAC model provides value-for-money outcomes not matched by any other areas of disability service delivery (in Australia)… LAC provides more supports to more people, with a high level of satisfaction, at a cost that is more likely to be able to be afforded by (the Australian) Government".[123]

Significantly, "Evaluations of the LAC service in Australia have demonstrated a 30 per cent reduction in costs as part of a move towards a preventative service with much lower levels of acute interventions and much higher levels of participation and enthusiasm from the people who use the service."[124] This is costed on the basis that the LAC model keeps people from using costly, specialised state services by using more light touch and informal forms of support.

The following table demonstrates the benefits of LAC compared to more traditional residential and non-residential alternatives.

Table 2: Comparison of National and State Service Uptake, Consumer Satisfaction and Cost per Service User Data Across State Output Areas

Table 1: Comparison of National and State Service Uptake, Consumer Satisfaction and Cost per Service User Data Across State Output Areas

	Service Uptake (per 1000 people)		Consumer Satisfaction		Cost per Service User	
	Australia	Western Australia	Australia	Western Australia	Australia	Western Australia
Residential Services	22	25	85%	87%	N/A	$61,944
Non-Residential Services	57	103	71%	78%	N/A	$3,899
Individual Coordination (LAC)	3	14	65%	77%	N/A	$3,316

However, LAC has been applied in the UK with more ambiguous conclusions. Informal conversations with one individual connected to the UK pilots has suggested that the co-ordinator role was not applied in the same way as in Australia, with less focus on the specific (and very different) professional role and skills needed to support people.

Case Study 11: Shared Lives: an evaluation of South East of England.[125]

Background

Shared Lives (formerly adult placement) is an organisation and network providing support services to vulnerable adults. The service is provided by individuals and families who are trained and paid as Shared Lives carers to offer short and long term support, accommodation and rehabilitation. Crucially, Shared Lives carers take on an extended kinship role; welcoming people into their home as part of their family.

How is this co-production?

Shared Lives shows how the assets within the core economy – people's time, skills and empathy, can be used to support the delivery of services. People are able to provide support to individuals within their own homes with training and support from professional agencies.

"There are approximately 130 Shared Lives schemes in England…they vary widely in numbers of service users supported and most have mixed user groups. People with learning difficulties make up the largest user group, but Shared Lives services also support older people or those with mental health disorders, physical disabilities, sensory impairments, acquired brain damage, dementia, autism, alcohol and drugs misuse, or who are parents with disabilities".[126]

Evaluation outcomes

The Shared Lives evaluation reported the following benefits:

- Increased control and choice for 'users'
- Developed 'user' confidence, self-esteem, skills and independence
- Developing stronger reciprocal relationships with others, widening social networks and integrating better into local communities
- Physical and emotional wellbeing
- Reduced likelihood of abuse
- Increased community awareness and involvement

A more cost-effective service

Shared Lives has managed to demonstrate excellent value for money, and also significant cost savings when measuring unit costs against alternative service models – as the following table demonstrates.

Type of care or support	Amount	Unit
Potential savings for a person in Shared Lives instead of LD residential care	£640	per week
Potential savings for a person in Shared Lives instead of OP residential care	£46	per week
Potential savings for a person in Shared Lives instead of PD residential care	£361	per week
Potential savings for a person in Shared Lives instead of MH residential care	£183	per week
Potential savings for a person in Shared Lives, instead of LD supported living	£995	per week
Potential savings for a person in Shared Lives instead of LD daytime support	<£35	per day
Potential savings for a person in Shared Lives instead of OP daytime support	< £5	per day
Potential savings for a person in Shared Lives instead of PD daytime support	< £33	per day
Potential savings for a person in Shared Lives instead of MH daytime support	< £10	per day
Potential savings for a person in Shared Lives instead of Home Care	< £57	per day
Potential savings for a person in Shared Lives instead of Family Support worker	< £93	per day
Potential savings for a person in Shared Lives instead of floating/outreach support	< £31	per day

Overall, it appears there may be a marginal increase in cost-effectiveness of between 5 and 10 per cent. A range of possible sources of cost benefits have been identified in the literature including:

- reduced overhead cost reduction;
- better outcomes;
- directing support more effectively through self-directed support (SDS);
- preventing more acute needs arising;
- getting the support planning and brokerage right (rather than using front line workers for this);
- joint commissioning of health, housing and social care thus also accounting for the cross sector savings which may be happening at present, but are not accurately captured in evaluations.[127]

Other cost benefits which have been suggested, but not yet documented in the evidence include:

- economies of scale through collective purchasing;
- the value of individual, family and community time, support and knowledge;
- supporting people to live independently and reducing in house care through community based support;
- the importance and impact of SDS and coproduction as methods and ways of working which may not result in specific outcomes, but are valuable in and of themselves.

Box 3: Vela Microboards (www.velamicroboardsni.org.uk/)

Microboards are an innovative model of learning disability support developed in Canada and being replicated in Australia, New Zealand and other countries. A Vela Microboard is a small group of committed family and friends who support a person with disabilities to create a non-profit organisation. This Microboard addresses the person's planning and support needs in a personalised and flexible way. They provide a structure so that all family and friends who support an individual can be involved and recognised for their support. Local authorities can commission providers to support and develop Vela Microboards among the support networks of individuals they work with.

Cost and value proxies

The value of supporting families to take a lead role in supporting and co-ordinating the care of someone is equivalent to well over £800 per year per family – based on the alternative costs of providing a family support worker.

.

Summary conclusions and next steps

The material we have reviewed in this report shows that transformation to personalisation is at a very early stage. It is apparent that the terms 'personalisation' and 'personal budget-holding' are often conflated, and evaluations have tended to focus on the latter, rather than on issues such as self-directed support.

Though **outcomes** seem to broadly improve across a number of areas where people have personal budgets, this is not consistent across different groups. More work is needed to achieve a thorough understanding of how personalisation can work to positively improve outcomes for specific groups, such as older people.

There is no clear picture yet on how personalisation will affect the unit **costs** of services, and the **value** of support, in terms of preventing needs arising, providing more effective care and improving well-being. Early indications suggest a slight reduction in direct costs per person, but this is variable, and rarely takes into account start up and transition costs. Furthermore, current evaluations have been conducted with the existing social care infrastructure in place: we don't know how much of this will change.

We have described co-production as an approach to designing and delivering services, and explored where it might have value for people intended to benefit from personalised services. These ideas will be developed and discussed with a wide range of stakeholders in the next phase of this project.

The next step is a series of workshops with people who use services, those who have personal budgets, and those who don't, people's carers, support staff, and some self-funders. These workshops will support people to share their experience of different types of services and funding mechanisms, including services which are co-produced, and others which are more conventional. Participants will make recommendations for policy and practice, and their comments will be incorporated into a report documenting their recommendations.

Phase 2 also includes a set of semi structured interviews with evaluation specialists to explore and document the key principles and approaches to evaluating personalisation. Based on the findings of this report, we will be exploring how evaluations can better understand the impact of the approach to services that is used, how more detail about the variances in choice and control can be taken into account, and how evaluations can consider the impact of support or interventions across other areas of someone's life, preventative costs and values associated with personalisation – not just personal budgets.

Bibliography

ADASS (2011) Press Release: 'ADASS urges Government to include findings of the Commission on the Funding of Care and Support in its review of NHS legislation', May 11th. Available at: http://www.adass.org.uk/index.php?option=com_content&view=article&id=732:adass-urges-government-to-include-findings-of-the-commission-on-the-funding-of-care-and-support-in-its-review-of-nhs-legislation&catid=146:press-releases-2011&Itemid=447

Age UK, 'Care in Crisis: Causes and Solutions', May 2010

Alakeson V (2010) *Quality, Innovation, Productivity and Prevention (QIPP) and Personal Health Budgets* (London: In Control)

Audit Commission (2010) *Financial Management of Personal budgets* (London: Audit Commission)

Bartlett, J, *At Your Service: navigating the future market in health and social care*, Demos, (2009)

Beresford, P in *Power to the People*, http://www.spn.org.uk/fileadmin/spn/user/*.pdf/Papers/SPN_Papers/SPN_Personalisation_Publication_W.pdf

Beresford, P. *Whose Personalisation?*, (2008)

Brewis, R. *A Voice and a Choice: self-directed support by people with mental health problems'*, In Control, (September 2007)

Cabinet Office (2005) *Improving the Life Chances of Disabled People* (London: Prime Minister's Strategy Unit)

Caiels, J., Forder, J., Netten, A., Malley, J. and Windle, K. (2010) Measuring the outcomes of low-level services: Final report, Discussion Paper 2699, PSSRU, University of Kent, Canterbury.

Carr, S. (2008) *Personalisation: A Rough Guide*. SCIE report 20 (London: Social Care Institute for Excellence)

Carr S (2010a) *Enabling risk, ensuring safety: Self-directed support and personal budgets: Adult Services SCIE Report 36* (London: Social Care Institute for Excellence)

Carr S (2010b) *Personalisation, Productivity and Efficiency: Adult Services SCIE Report 37* (London: Social Care Institute for Excellence)

Carr S, Robbins D (2009) *The Implementation of Individual Budget Schemes in Adult Social Care, SCIE Research Briefing 20* (London: Social Care Institute for Excellence)

Cooper Z, Gibbons S, Jones S, McGuire A (2010) 'Does Hospital Competition Save Lives? Evidence from the English NHS Choice Reform' *LSE Health Working Paper 16/2010* (London: LSE)

Cutler, T et al, 'A new epoch of individualisation? Problems with the personalisation of public sector services', *Public Management* (2007)

Department of Health website: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm

Department of Health, *Personal Health Budgets: first steps*, (2009)

DH, 'Personal Health Budgets: Early Experiences of Budget Holders', Fourth Interim Report (October 2011)

Department of Health, *Carers and Personalisation: Improving outcomes* (November 2010)

Duffy S (2010) 'The Citizenship Theory of Social Justice: exploring the meaning of personalisation for social workers' *Journal of Social Work Practice* **24:** 253-267

Duffy S, Gillespie J (2009) *Personalisation and Safeguarding: version 1.1.* (London: In Control)

Duffy. S, Waters. J, Glasby. J, *Personalisation and the social care 'revolution': future options for the reform of public services*, HSMC Policy Paper 3, (January 2010)

Duffy, S. 'The Future of Personalisation: Implications for Welfare Reform', *Journal of Care Service Management*, (2010)

Dunning, J, Social Workers Say Personalisation Will Fail Most Service Users', Community Care Website http://www.communitycare.co.uk/Articles/25/05/2011/116868/social-workers-losing-faith-in-personalisation.htm. Last accessed 29/09/2011

Eost-Telling C (2010) *Stockport Self Directed Support Pilot in Mental Health* (Chester: University of Chester Faculty of Health and Social Care)

Forder, J. Measuring outcomes in adult social care (presentation slides), PSSRU, University of Kent

Frontier Economics (2006) *Choice in the delivery of local government services: A report prepared for the Audit Commission* (London: Frontier Economics)

Glasby J, Ham C, Littlechild R, McKay S (2010) *The Case for Social Care Reform – the wider economic and social benefits* (Birmingham: University of Birmingham Health Services Management Centre/Institute of Applied Social Studies)

Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40

Glendinning C, Challis D, Fernandez J-L, Jacobs S, Jones K, Knapp M, Manthorpe J, Moran N, Netten A, Stevens M, Wilberforce, M (2008) *IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report* (York: Social Policy Research Unit)

Grapevine, 'Connections That Matter', 2011

Hatton C, Waters J (2011) *Think Local, Act Personal: The National Personal Budget Survey* (University of Lancaster & In Control)

Hatton C, Waters J, Duffy S, Senker J, Crosby N, Poll C, Tyson A, O'Brien J, Towell D (2008) *A Report on In Control's Second Phase: Evaluation and Learning 2005-2007* (London: In Control)

Hudson, B and Henwood, M (2008) *Prevention, Personalisation and Prioritisation in Social Care: Squaring the Circle*, London: Commission for Social Care Inspection

Hudson, B and Henwood, M, *People who fund their own care and support*, (October 2009)

IDeA, 'Transforming Adult Social Care: access to information, advice and advocacy'

Ipsos MORI, 'Users of Social Care Personal Budgets', July 2011

Jones K, Welch E, Caiels J, Windle K, Forder J, Davidson J, Dolan P, Glendinning C, Irvine A, King D (2010) *Experiences of implementing personal health budgets: 2nd interim report* (Canterbury: University of Kent Personal Social Services Research Unit)

JRF, *Transforming Social Care: sustaining person centred support* (Beresford et al). 2011

Land H, Himmelweit S (2010) *Who Cares: Who Pays? A report on personalisation in social care prepared for UNISON* (London: UNISON)

Lawlor E, Nicholls J, Neitzert E (2009) *Seven principles for measuring what matters: A guide to effective public policy-making* (London: **nef**)

Le Grand J (2009) 'Choice and competition in publicly funded health care' *Health Economics, Policy and Law* **4**: 479-488

Le Grand J (2007) *The Other Invisible Hand: delivering public services through choice and competition* (Princeton: Princeton University Press)

Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS)

MacIntyre, 'Great Interactions', 2011

Mind (2009) *Personalisation in Mental Health: A review of the evidence* (London: Mind)

Mind (2009) *Personalisation in Mental Health: Creating a vision, views of personalisation from people who use mental health services* (London: Mind)

National Audit Office, 'Oversight of user choice and provider competition in care markets', September 2011

NCVO, *Personalisation: From Rhetoric to Reality*, (2009)

NDTI Insights, 'Independent Living Strategy: Support Planning and Brokerage', (2011)

NDTI Insights, 'Increasing the Voice, Choice and Control of Older People with High Support Needs: lessons from SERI' (2011)

Needham, C, 'Personalised Care Services: Individual, Group or Collective Co-production?', unpublished paper, 2011

Needham C (2011) 'Personalisation: From Story-line to Practice', *Social Policy and Administration* **45:** 54-68

Needham, C. 'Commissioning for personalisation: from the fringes to the mainstream', PMPA, July 2010

Needham, C and Carr, S, 'SCIE Research Briefing 31: Co-production: an emerging evidence base for social care transformation' (March 2009)

Newbronner L, Chamberlain R, Bosanquet K, Bartlett C, Sass B, Glendinning C (2011) *Keeping Personal budgets Personal: Learning from the experiences of older people, people with mental health problems and their carers* (London: Social Care Institute for Excellence)

NHS Confederation (2010) Shaping *Personal Health Budgets: A view from the top* (London: NHS Confederation)

ODI, *The costs and benefits of independent living*, (2007)

OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management)

OPM (2010) Public Interest Seminar: Personalisation and the Future of Health and Social Care, Available at: http://www.scribd.com/doc/33954206/Personalisation-and-the-future-of-health-and-social-care

Poll C, Duffy S, Hatton C, Sanderson H, Routledge M (2006) *A Report on In Control's First Phase: 2003-2005* (London: In Control)

Prabhakar, M (2010) *Individual Budget Pilot Programme for Families with Disabled Children: Evaluation and Challenge/Support: FINAL Quarterly Report* (SQW) Available at: http://www.sqw.co.uk

Putting People First (2010) *Personal budgets: Checking the Results*

Rabiee P, Moran N, Glendinning C (2009) 'Individual Budgets: Lessons from Individual Users' Experiences'. *British Journal of Social Work* **39:** 918-935

Rose D, Evans J, Sweeney A and Wykes T., 'A model for developing outcome measures from the perspectives of mental health service users'. *International Review of Psychiatry*, (2011), Vol. 23, No. 1 , Pages 41-46

Royal College of General Practitioner. 'Care Planning: Improving the Lives of People with Long Term Conditions, (2011)

Shared Lives Business case (2009:pp8) http://www.communitycatalysts.co.uk/wp-content/uploads/2011/06/Derby-County-Council-Shared-Lives-for-Local-Authorities.pdf

Skills for Support Team (2006) *'It's about respect': People with learning difficulties and personal assistants* (Bristol: Norah Fry Research Centre)

Skills for Care, 'Personalisation and Partnership', (October 2010)

Sowerby D (2010) 'What sort of helping relationships are needed to make personalisation happen and how can organisations be developed to support this?' *Journal of Social Work Practice* **24**: 269-282

Stevens M, Glendinning C, Jacobs S, Moran N, Challis D, Manthorpe J, Fernandez J-L, Jones K, Knapp M, Netten A, Wilberforce M (2011) 'Assessing the Role of Increasing Choice in English Social Care Services' *Journal of Social Policy* **40**: 257-274

Stockton S and Cattermole M (2011) Personal budgets: Checking the Results, Putting People First

Think Local Act Personal, 'Making it Real: marking progress towards personalised, community based support'

Tyson A, Brewism R, Crosby N, Hatton C, Stansfield J, Tomlinson C, Waters J, Wood A (2010) *A Report on In Control's Third Phase: Evaluations and Learning 2008-2009* (London: In Control)

Williams B, Tyson A (2010) 'Self-direction, place and community: Re-discovering the emotional depths: a conversation with social workers in a London borough', *Journal of Social Work Practice* **24**: 319-333

Zarb G, Nadash P (1994) *Cashing in on Independence: Comparing the costs and benefits of cash & services* (Somercotes: The British Council of Organisations of Disabled People)

Endnotes

[1] Needham, C, 'Personalised Care Services: Individual, Group or Collective Co-production?', unpublished paper, 2011

[2] Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40

[3] Glendinning C et al. (2008) *IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report* (York: Social Policy Research Unit), p55

[4] Dunning, J, Social Workers Say Personalisation Will Fail Most Service Users', Community Care Website http://www.communitycare.co.uk/Articles/25/05/2011/116868/social-workers-losing-faith-in-personalisation.htm. Last accessed 29/09/2011

[5] Dunning, J, Social Workers Say Personalisation Will Fail Most Service Users', Community Care Website http://www.communitycare.co.uk/Articles/25/05/2011/116868/social-workers-losing-faith-in-personalisation.htm. Last accessed 29/09/2011

[6] Department of Health website: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm

[7] http://www.neweconomics.org/publications/five-ways-well-being-evidence

[8] http://odi.dwp.gov.uk/odi-projects/right-to-control-trailblazers.php

[9] http://www.scie.org.uk/publications/elearning/person/person01/resource/html/object/object1_4.htm#slide1d last accessed on June 8th 2011

[10] Beresford, P in *Power to the People*, p. 9 http://www.spn.org.uk/fileadmin/spn/user/*.pdf/Papers/SPN_Papers/SPN_Personalisation_Publication_W.pdf

[11] Needham, 2011

[12] 2006 White Paper *Our health, our care, our say: a new direction for community services*

[13] 2006 White Paper *Our health, our care, our say: a new direction for community services*

[14] Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40

[15] Putting People First, *Progress measures for the delivery of transforming adult social care services*, p2 Available at: http://www.adass.org.uk/images/stories/Milestones per cent20for per cent20PPF per cent20- per cent20Final per cent209.9.09.pdf

[16] DH, White Paper *Equity and Excellence – liberating the NHS* (2010)

[17] Think Local Act Personal press release, 22nd June 2011. http://www.google.co.uk/search?source=ig&hl=en&rlz=1G1ACAW_ENUK436&q=personal+budgets+in+social+care%2C+2013%2C+local+authorities&aq=f&aqi=&aql=&oq

[18] See http://www.thinklocalactpersonal.org.uk/News/PersonalisationNewsItem/?cid=8981

[19] Sowerby D (2010) 'What sort of helping relationships are needed to make personalisation happen and how can organisations be developed to support this?' *Journal of Social Work Practice* **24**: 269-282, p270

[20] Rose D, Evans J, Sweeney A and Wykes T., 'A model for developing outcome measures from the perspectives of mental health service users'. *International Review of Psychiatry*, (2011), Vol. 23, No. 1 , Pages 41-46

[21] Rose D, Evans J, Sweeney A and Wykes T., 'A model for developing outcome measures from the perspectives of mental health service users'. *International Review of Psychiatry*, (2011), Vol. 23, No. 1 , Pages 41-46 p. 14

[22] Age UK, 'Care in Crisis, May 2010, and NAO, 'Oversight of user choice and provider competition in care markets', September 2011'

[23] In Control, 'National Personal Budget Survey Report', p. 27

[24] ADASS Personal Budgets Survey: http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/2011/ADASS_Survey_March_2011_Summary_Results__29_6_11.pdf

[25] Julien Forder, Measuring outcomes in adult social care (presentation slides), PSSRU, University of Kent

[26] Caiels, J., Forder, J., Netten, A., Malley, J. and Windle, K. (2010) Measuring the outcomes of low-level services: Final report, Discussion Paper 2699, PSSRU, University of Kent, Canterbury.

[27] Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40 p. 9

[28] Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40 p. 11

[29] Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS), p33

[30] Glendinning C et al. (2008) *IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report* (York: Social Policy Research Unit), p71

[31] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p4

[32] Glendinning C et al. (2008) *IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report* (York: Social Policy Research Unit), p67

[33] Jones K et al. (2010) *Experiences of implementing personal health budgets: 2nd interim report* (Canterbury: University of Kent Personal Social Services Research Unit), p15

[34] Mind (2009) *Personalisation in Mental Health: Creating a vision, views of personalisation from people who use mental health services* (London: Mind), p5

[35] Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS), p34

[37] Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS), p33

[38] Tyson A et al. (2010) *A Report on In Control's Third Phase: Evaluations and Learning 2008-2009* (London: In Control), pp144-154

[39] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p3

[40] Glendinning C et al. (2008) *(2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report* (York: Social Policy Research Unit), pp71-2

[41] Glendinning C et al. (2008) *IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report* (York: Social Policy Research Unit), p78

[42] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p2

[43] Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), pp79-80

[44] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p3

[45] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p3

[46] Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), p67

[47] Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), p74

[48] Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), p75

[49] Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS), p33

[50] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p3

[51] Skills for Support Team (2006) *'It's about respect': People with learning difficulties and personal assistants* (Bristol: Norah Fry Research Centre), p3

[52] Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40 p. 9

[53] Eost-Telling C (2010) *Stockport Self Directed Support Pilot in Mental Health* (Chester: University of Chester Faculty of Health and Social Care), p14

[5454] Jones, K et al, *Experiences of Implementing Personal Health Budgets: 2nd interim report* (November 2010)

[55] DH, 'Personal Health Budgets: Early Experiences of Budget Holders', Fourth Interim Report (October 2011)

[56] DH, 'Personal Health Budgets: Early Experiences of Budget Holders', Fourth Interim Report (October 2011) p. 22

[57] Carr, S (2010) *SCIE Report 37: Personalisation, Productivity and Efficiency*, London: Social Care Institute for Excellence

[58] Carr, SSCIE report 37, Personalisation, Productivity and Efficiency p. 6.

[60] ODI, *The costs and benefits of independent living*, (2007) p. 40

[61] Audit Commission (2010) *Financial Management of Personal budgets* (London: Audit Commission), p4

[62] See Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS), p37

[63] See Leadbeater C, Bartlett J, Gallagher N (2008) *Making It Personal* (London: DEMOS), pp91-95

[64] Carr, S (2010) *SCIE Report 37: Personalisation, Productivity and Efficiency*, London: Social Care Institute for Excellence, p4

[65] ODI, *The costs and benefits of independent living*, (2007) p. 36, pp 43 – 44

[66] Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), p89

[67] Glendinning, C: 'Personalisation and personal budgets. What works? What doesn't work? What do we still not know?' Presentation at Coventry University, 15th July 2011, slide 5

[68] Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), p111

[69] Zarb G and Nadash P (1994) *Cashing in on Independence: Comparing the costs and benefits of cash & services* (Somercotes: The British Council of Organisations of Disabled People), pp145-169

[70] Glasby J et al. (2010) *The Case for Social Care Reform – the wider economic and social benefits* (Birmingham: University of Birmingham Health Services Management Centre/Institute of Applied Social Studies), p48

[71] Poll C, Duffy S, Hatton C, Sanderson H, Routledge M (2006) *A Report on In Control's First Phase: 2003-2005* (London: In Control)

[72] Hatton C et al. (2008) *A Report on In Control's Second Phase: Evaluation and Learning 2005-2007* (London: In Control)

[73] Carr S, Robbins D (2009) *The Implementation of Individual Budget Schemes in Adult Social Care, SCIE Research Briefing 20* (London: Social Care Institute for Excellence), pp15-16

[74] Carr, S (2010) *SCIE Report 37: Personalisation, Productivity and Efficiency*, London: Social Care Institute for Excellence, p27

[75] Carr S, Robbins D (2009) *The Implementation of Individual Budget Schemes in Adult Social Care, SCIE Research Briefing 20* (London: Social Care Institute for Excellence), p14

[76] Carr S, Robbins D (2009) *The Implementation of Individual Budget Schemes in Adult Social Care, SCIE Research Briefing 20* (London: Social Care Institute for Excellence), p14

[77] Cooper Z, Gibbons S, Jones S, McGuire A (2010) 'Does Hospital Competition Save Lives? Evidence from the English NHS Choice Reform' *LSE Health Working Paper 16/2010* (London: LSE), pp30-1

[78] Le Grand J (2009) 'Choice and competition in publicly funded health care' *Health Economics, Policy and Law* **4**: 479-488

[79] Frontier Economics (2006) *Choice in the delivery of local government services: A report prepared for the Audit Commission* (London: Frontier Economics), p4

[80] Land H, Himmelweit S (2010) *Who Cares: Who Pays? A report on personalisation in social care prepared for UNISON* (London: UNISON), pp27-8

[81] Caiels, J., Forder, J., Netten, A., Malley, J. and Windle, K. (2010) Measuring the outcomes of low-level services: Final report, Discussion Paper 2699, PSSRU, University of Kent, Canterbury pp. 66 - 67

[82] JRF, *Transforming Social Care: sustaining person centred support* (Beresford et al). 2011

[83] National Audit Office, 'Oversight of user choice and provider competition in care markets', September 2011 p. 16

[84] Think Local Act Personal, 'Making it Real: marking progress towards personalised, community based support'

[85] Duffy S (2010) 'The Citizenship Theory of Social Justice: exploring the meaning of personalisation for social workers' *Journal of Social Work Practice* **24:** 253-267

[86] IDeA, 'Transforming Adult Social Care: access to information, advice and advocacy, p. 41

[87] Eost-Telling C (2010) *Stockport Self Directed Support Pilot in Mental Health* (Chester: University of Chester Faculty of Health and Social Care), p7; Glendinning C et al. (2008) IBSEN: Evaluation of the Individual Budgets Pilot Programme, Final Report (York: Social Policy Research Unit), p145

[88] Hatton C, Waters J (2011) *Think Local, Act Personal: The National Personal Budget Survey* (University of Lancaster & In Control), p14

[89] Carr S (2010b) Personalisation*, Productivity and Efficiency: Adult Services SCIE Report 37* (London: Social Care Institute for Excellence), p10

[90] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p3

[91] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p5

[92] Land H, Himmelweit S (2010) *Who Cares: Who Pays? A report on personalisation in social care prepared for UNISON* (London: UNISON)

[93] Carr, S. 'SCIE Report 36, 'Enabling Risk, Ensuring Safety', November 2010

[94] OPM (2010) Public Interest Seminar: Personalisation and the Future of Health and Social Care, Available at: http://www.scribd.com/doc/33954206/Personalisation-and-the-future-of-health-and-social-care, p3

[95] Mind (2009) *Personalisation in Mental Health: A review of the evidence* (London: Mind), p4

[96] Williams B, Tyson A (2010) 'Self-direction, place and community: Re-discovering the emotional depths: a conversation with social workers in a London borough', *Journal of Social Work Practice* **24**: 319-333, p330

[97] Carr, S. 'SCIE Report 36, 'Enabling Risk, Ensuring Safety', November 2010 pp. vi - vii

[98] Williams B, Tyson A (2010) 'Self-direction, place and community: Re-discovering the emotional depths: a conversation with social workers in a London borough', *Journal of Social Work Practice* **24**: 319-333, p.326

[99] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p9

[100] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p8

[101] OPM (2010) *Delivering personal budgets for adult social care: Reflections from Essex* (London: Office for Public Management), p8

[102] Clarke et al quoted in Stevens et al. (2011) 'Assessing the Role of Increasing Choice in English Social Care Services' *Journal of Social Policy* **40**: 257-274, p262

[103] Stevens et al. (2011) 'Assessing the Role of Increasing Choice in English Social Care Services' *Journal of Social Policy* **40**: 257-274, p262

[104] Needham, C. '*Commissioning for personalisation: from the fringes to the mainstream'*, PMPA, July 2010

[105] In Control, The National Personal Budget Survey, June 2011, In Control p. 20

[106] In Control, The National Personal Budget Survey, June 2011, In Control p. 24

[107] Boyle, Coote, Sherwood, Slay *Right Here Right Now,* **nef**, NESTA (2010)

[108] Needham, C and Carr, S. 'SCIE research briefing 31: co-production: an emerging evidence base for adult social care transformation. (March 2009), p. 5

[109] Needham, C and Carr, S. 'SCIE research briefing 31: co-production: an emerging evidence base for adult social care transformation. (March 2009), p. 6

[110] Needham, C and Carr, S. 'SCIE research briefing 31: co-production: an emerging evidence base for adult social care transformation. (March 2009), p. 6

[111] http://merevalehouse.co.uk/

[112] Boyle, Stephens, Slay *Public Services Inside Out,,* **nef**, NESTA (2010)

[113] Glendinning et al (2011) *Keeping Personal Budgets personal: learning from the experiences of older people, people with mental health problems, and their carers*. SCIE report 40

[114] http://php.york.ac.uk/inst/spru/pubs/1874/

[115] Boyle, Stehpens, Slay *Public Services Inside Out,,* **nef**, NESTA (2010)

[116] http://www.nursefamilypartnership.org/

[117] Clements, L. '*Social Care Law Developments* Elder Law Volume 1, (2011) p. 3

[118] Unpublished SROI study on the Holy Cross time bank, (nef), commissioned by the EHRC

[119] http://www.tdyc.org/

[120]http://www.disability.wa.gov.au/dscwr/_assets/main/report/documents/pdf/final_report_lac_review1_(id_369_ver_1.0.2).pdf

121121

http://www.disability.wa.gov.au/dscwr/_assets/main/report/documents/pdf/final_report_lac_review1_per cent28id_369_ver_1.0.2 per cent29.pdf

[122] Right Here, Right Now http://www.nesta.org.uk/library/documents/coproduction_right_here_right_now.pdf

[123] Right Here, Right Now http://www.nesta.org.uk/library/documents/coproduction_right_here_right_now.pdf from http://www.disability.wa.gov.au/dscwr/_assets/main/report/documents/pdf/final_report_lac_review1_(id_369_ver_1.0.2).pdf

[124]http://www.disability.wa.gov.au/dscwr/_assets/main/report/documents/pdf/final_report_lac_review1_(id_369_ver_1.0.2).pdf

[125] *http://www.naaps.org.uk/en/services/*

http://coproductionnetwork.com/page/measurement-and-evaluation

[126] Shared Lives Business case (2009:pp8) http://www.communitycatalysts.co.uk/wp-content/uploads/2011/06/Derby-County-Council-Shared-Lives-for-Local-Authorities.pdf

[127] Carr, S. Personalisation, *Productivity and Efficiency, SCIE report 37*, December 2010 Carr S (2010b) Personalisation*, Productivity and Efficiency: Adult Services SCIE Report 37* (London: Social Care Institute for Excellence), pp*viii - ix*

Written by: Julia Slay

Contact: Julia.slay@neweconomics.org

new economics foundation
3 Jonathan Street
London SE11 5NH
United Kingdom

Telephone: +44 (0)20 7822 6300
Facsimile: +44 (0)2078206301
www.neweconomics.org

Registered charity number 1055254