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Commissioning for personalization: from the fringes to the mainstream

By Catherine Needham
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Afterword by John Tizard, Director,
Centre for Public Service Partnerships

CPSP @ LGiU

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A PMPA/QMUL/CPSP project

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Executive summary

Personalization is the tailoring of public services more closely to their users. Operating both as a philosophy of reform and as a policy agenda, it takes a variety of forms in different services. Usually it involves offering service users more choice and control through an expanded range of providers, including new entrants. This report takes stock of personalization in practice to develop a composite picture of how public services are changing. It draws on interviews with politicians, civil servants, local authority managers, frontline staff, service users, trade union representatives, academics, consultants and staff from private and third sector providers.

The personalization agenda is moving quickly in the UK and has strong political support so the pace can be expected to continue under the new government. This report is vital reading for professionals, analysts, policy-makers and decision-makers involved in delivering public services who need to know how personalization is reshaping the welfare state and the positives, and the pitfalls of its implementation.

Implementation

Personalization is furthest developed in **adult social care**, where there has been strong national direction to increase choice and control for service users through personal budgets, alongside more accessible universal services, more effective spending on preventative services and development of social capital.

In **children's services**, individual budgets are being piloted. Budget-holding lead professional models have been developed to give frontline staff more control over resources for individual families. Family intervention projects are being developed to provide tailored support for 'problem families'.

A number of initiatives are underway to tailor **health** provision around the individual, including choose and book facilities for hospital admission, and expert patient programmes for those with chronic

conditions. Personal health budgets are being piloted.

Employment services are increasingly offering personal adviser models, providing support for the long-term unemployed.

Housing services for those with care needs are being integrated into the broader personalization agenda. For other tenants, initiatives such as choice-based lettings and the local housing allowance are designed to give more control and responsiveness.

In **education** there has been a national guarantee of tailored support for pupils falling behind. Schools and children's trusts are developing pupil-led approaches to building design and teaching.

In **criminal justice**, the Conservatives have promised to link rehabilitation funding more directly to personal outcomes for ex-offenders.

Commissioning

To tailor services more closely to their users, there will need to be radical shift in the ways in which they are commissioned, at the individual, operational and strategic levels. Interviewees highlighted key themes which are shaping and/or inhibiting their practice. Most relate to adult social care, where the agenda is furthest developed, and to personal budgets which is the highest profile aspect of personalization to date.

Individual commissioning. Personalized services must be shaped by and be responsive to users, some of whom will themselves take on a role as service commissioners. Challenges facing existing commissioners in relation to supporting these new commissioning models include:

- Recognizing the diversity of provision involved in person-centred services.
- Broadening communication beyond the service user (involving carers, self-funders, staff and the broader community), and recognizing potential conflicts of interest.

- Effective support planning, so that people know what personal budgets can be spent on, and so that spending choices are linked to outcomes.
- Keeping people safe in a context of reduced professional control.

Operational commissioning. One of the key challenges for existing commissioners will be to take on new roles as market shapers and facilitators. Challenges include:

- Understanding and stimulating local markets to find new providers.
- Supporting and challenging providers, developing framework contracts and managing instability.
- Closing and redesigning services, particularly day centres.
- Costing and pricing services.
- Preparing the workforce for individual commissioning.

Strategic commissioning. Concerns were found, as well as optimism; these focused on:

- Progress on joint working.
- Links between Total Place and personalization.
- Affording personalization in a context of major budget cuts.
- Accountability for spending public money.
- Managing risks of market failure and poor choices.

Mainstreaming. Concerns were discovered about:

- Dual systems needing to run for an extended transition period, raising questions about affordability.
- The risk of system overload, if intensive support planning is required for high numbers of service users.
- Nothing changing because users will choose to continue with traditional models of service provision.

Personalization has the scope to be a radical agenda for public services. But service users, frontline staff and managers are currently operating in an environment of great uncertainty as they build new relationships and agree new contracts. User anxieties (am I allowed to spend money

on that?), provider concern (can I pay staff and run services on an insecure funding base?) and manager worries (can I afford personalization?) indicate the challenges for this agenda as it moves from the margins to the mainstream.

In an afterword, John Tizard sets out the urgent public debate which must be had about how we take forward personalization based on individual budgets. ■

Commissioning for personalization: from the fringes to the mainstream

Catherine Needham

Queen Mary, University of London

Introduction

Personalization is the tailoring of public services more closely to their users. Operating both as a philosophy of reform and as a policy agenda, it requires 'thinking about public services…in an entirely different way—starting with the person rather than the service' (Carr, 2010, p. 67). It takes a variety of forms in different services, but usually it involves offering service users more choice and control through an expanded range of providers, including new entrants. It is an approach furthest developed in social care, where it is particularly associated with personal budgets for service users and with improved access to universal services, investment in preventative services and building users' social capital. It is fast becoming the rationale for reform in health, housing, employment services, education and criminal justice, although exactly what more 'personalized' services mean across all these contexts is sometimes unclear. It is an approach that has cross-party support, as evidenced in all the major parties' manifestos for the 2010 general election.

This report examines how personalization is reshaping public services. It first takes stock of how far the personalization agenda has advanced, highlighting its penetration into a wide range of services and identifying common themes across these sectors. Second, the report reflects on the issues thrown up by the implementation of personalized public services, with a focus on commissioning as a key site of transformation. Much of the discussion here focuses on

personal budgets in social care as the best developed example of new commissioning practices, although with some discussion of the importance of other aspects of personalization (including tailoring universal services and building social capital).

Given the claims that it is a new and potentially radical approach to reforming public services, personalization has attracted a great deal of commentary. Much of the literature reports on the merits (and, less frequently, the limitations) of personalization as a new model of public service delivery, and offers guidance on how it should be implemented. A literature review, highlighting key themes, is available to download from the PMPA (www.pmpa.co.uk).

New research/new ideas

This report does not just replicate the existing literature—it examines personalization in practice to develop a composite picture of how public services are changing. The report draws on 75 interviews conducted by the author. Interviewees were selected using a purposive sample to ensure coverage of the various types of organization and service sector affected by personalization. Participants included politicians, civil servants, local authority managers, frontline staff, service users, trade union representatives, academics, consultants and staff from private and third sector providers.* They were selected to provide reflections from practice: they are neither examples of best practice nor a representative sample. Rather they are accounts of key issues facing people involved in the personalization process, raising themes that can inform formal evaluation and policy planning.

The report focuses on England where personalization is furthest advanced and has had a higher policy profile than in Scotland, Wales and Northern Ireland. The other parts of the UK have lower numbers of social care users on direct payments than England, and are at different stages in developing a fuller agenda of personalization for social care (see, for example, Scottish Government, 2009; In Control Cymru, no date). It is as yet unclear whether the other regions will 'catch up' with England or develop their own version of,

*Interviews were conducted on an off-the-record basis and either tape-recorded and transcribed or written up from notes. The author is very grateful to all those who agreed to be interviewed for the project.

or alternative to, personalization.

By taking stock of the development of personalization in England, part 1 of this report provides a benchmark for future comparative work. Part 2 of the report discusses the challenges facing commissioners in relation to personalization, drawing on the reflections from practice. This will be of value to policy-makers, analysts, managers, and those involved in shaping frontline provision, setting out the benefits, hazards and dilemmas facing those charged with developing personalized public services.

Part 1: Personalizing the welfare state

One of the uncertainties of personalization is how far it has advanced in a range of service sectors. The pace of implementation has been variously described as 'breakneck' and 'glacial'. Part of this ambiguity results from a difficulty in identifying exactly what counts as 'personalization'. As discussed above, personalization in social care has been fairly carefully developed as an agenda which has four core strands (choice and control, social capital, prevention and access to universal services), with a strong emphasis on allowing users to 'self-direct' their support (HM Government, 2007). However, elsewhere personalization has been developed as a broader agenda of tailoring services to users, which may incorporate some degree of state-led tailoring alongside or in place of user-led tailoring (Keohane, 2009).

This section provides a brief overview of public service reforms which have been undertaken under a personalization label or which appear to draw upon the imperative of user-driven or state-driven tailoring of services to the individual. It looks in turn at adult social care, children's services, health, housing, employment services, education and criminal justice.

Adult social care

Personalization has the longest history in adult social care, emerging out of the independent living movement of the 1970s and sharing some of the principles of the community care reforms of the early 1990s. Direct payments for people with physical disabilities were introduced in the mid 1990s, and later extended to include people with learning disabilities, older people, disabled children, mental health service users and carers. In the early 2000s, the social enterprise In Control (see figure 1) worked with local authorities to develop direct payments into individual budgets which integrated funding from a wider range of sources than direct payments and could be spent more creatively. In 2005, the Department of Health piloted individual budgets in 13 councils. Evaluation of the pilots found that the initiative was generally welcomed by participants, who reported feeling they had more control over their daily lives (Glendinning *et al.*, 2008). However, attempts to integrate multiple budget streams were recognized to be problematic, and future implementation has focused on personal budgets for social care.

Figure 1. In Control.

In Control is a social enterprise that has played a key role in making the case for personalization, building the evidence base and convincing policy-makers to incorporate personalized approaches into social care and beyond. It was set up in 2003 with the aim of reforming the social care system on the basis of self-directed support, and was instrumental in encouraging the Department of Health to introduce personal budgets. In Control now operates both as a charity, promoting active citizenship, community development and the reform of the welfare state, and an independent company, providing training and consultancy. It also has international branches, developing self-directed support outside England.

The *Putting People First* concordat (see figure 2) was signed in 2007 between central government, local government and the social care sector marking a new level of commitment to personalizing social care. A three-year transforming social care grant was allocated to local authorities from 2008, to assist in the move to personalized care. National indicator 130—a performance measure introduced by central government—requires local authorities to have 30% of eligible service users on personal budgets by April 2011. The care white paper published in April 2010 called for this to be extended so that all eligible users are offered a budget by 2012 (DH, 2010). There are also a series of milestones which local authorities must reach on the way to these longer-term targets, which include setting up a user-led organization in each local authority, ensuring provision of a universal information and advice service and engaging with service users and the wider community (Putting People First consortium, 2009).

Most local authorities are setting up a resource allocation system (RAS) to calculate the amount of money a service user can receive in a personal budget. Users can choose to manage the money themselves as a direct payment or to have it managed by the local authority or a third party (as an individual service fund). The user (along with their carer, where appropriate) and a support planner (who may be a social worker, another local authority employee or someone from a third party organization) then work to put together a seven-stage support

Figure 2. Putting People First.

Building on a range of initiatives, such as the Department of Health's *Valuing People* white paper (DH, 2001) and the report on *Improving the Life Chances of Disabled People* (Prime Minister's Strategy Unit, 2005), the *Putting People First* concordat has been a key driver for personalization. The concordat widened the personalization agenda within social care, emphasising that it should not just be seen as personal budgets or direct payments (HM Government, 2007). Personalization was to be about choice and control for the individual, with a number of strands including early intervention and prevention (linked to reablement), social capital, and improved access to universal services. The implementation of Putting People First has been overseen by a team including the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA).

plan.* Spending plans must be linked to approved outcomes and signed off by the local authority, but users are encouraged to be creative in how funds are spent. This may be something very different from a traditional package of care services: for example a personal budget holder could buy goods and services from multiple providers in different sectors simultaneously (for examples of spending choices see Bartlett, 2009). The Care Quality Commission are encouraging councils to find creative uses for budgets, so long as they are outcome-based.

Many local authorities are still putting in place their RAS and have only launched personal budgets for a small number of users. Care Quality Commission data published in February 2010 showed that 115,000 adults over 18 in England were receiving a personal budget or direct payment, which represents 6.5% of all adults using services in 2008/09 (CQC, 2010). Many of these will be younger disabled people who were in the vanguard of the movement for more choice and control. The extension of personal budgets to older people, who form the vast majority of eligible social care users, is less well

*The seven stages are: find out how much money I am entitled to; make a plan; get plan agreed; organize money; organize support; live life; see how it worked (see the In Control website, http://www.in-control.org.uk).

advanced. The residential and nursing home care sectors, used mainly by older people, are unlikely to be funded through personal budgets—although people using these services should still have facilities to tailor the services more closely to their needs through personal support planning.

All three major political parties going into the 2010 general election were committed to continuing the roll out of personal budgets, and there is an expectation that the policy will continue in broadly the same direction under the new government. However, the long-term funding of social care—which will shape eligibility for state-funded personal budgets—has been a much more contentious issue, with the major parties divided on how to proceed. It remains to be seen how the proposals for a national care service, set out in pre-election care white paper, will fare under the new government (DH, 2010).

Children's services

Much of the focus on personalization in social care has been on adults, and there is a perception that it is proceeding in a less focused and more *ad hoc* way in children's services. In Control has worked with 22 children's services to explore the potential for personal budgets and the wider personalization agenda for children, young people and families, through the Taking Control programme (Crosby, 2010). In May 2007, the then Department for Education and Skills announced pilots to provide individual budgets for disabled children and their families through the Aiming High programme, which are ongoing (DfES, 2007). At a regional level, Yorkshire and Humber have supported work improving the experiences of young people at the point of transition to adult services, including working with special schools to support person-centred planning (Cowen, 2010).

For children with additional needs, which may include having a physical or learning disability, speaking English as a second language, or being at risk of abuse or neglect, there have been pilots of a budget-holding lead professional (BHLP) model (see figure 3). Preliminary evaluation of the pilots found that the BHLP model helped to create 'a "can-do" culture from the bottom up' (OPM, 2008, p. 34). A national evaluation by researchers at Newcastle University, however, was less positive, finding that frontline staff didn't have the necessary commissioning skills and that budgets from different sources were not

Figure 3. Budget-holding lead professionals.

The budget-holding lead professional (BHLP) model releases resources to the frontline without making users themselves directly responsible for budget management. Staff nominated as a BHLP help to co-ordinate a wide range of services and to work creatively with families and other staff to access resources. The lead professional often commissions services directly, helping to ensure provision is personalized to the needs of the individual and family.

being integrated effectively (Walker *et al.*, 2009).

Much of the experimentation in the children's sector has been driven by the person-centred planning rationale that is reshaping adult social care. However, there are other interventions which involve state-led tailoring of services, such as the family intervention projects which have developed out of the Home Office's anti-social behaviour agenda. These are intensive programmes, offering tailored support for 'problem families' to tackle recurrent problems associated with the co-occurrence of factors such as mental health problems, behavioural disorders, substance abuse, educational underperformance and anti-social behaviour (Department for Children, Families and Schools, 2008). Often run by the third sector, the projects provide a range of intervention strategies, including support in the family home and the provision of specialized short-term housing facilities. Most providers stress the importance of voluntary participation by the families, so that they are committed to collaborating with professionals to improve outcomes, although there are usually sanctions for non-compliance. Evaluation of the initial pilots found positive results, however key elements of the project (small caseloads, well-trained and supported staff) may be hard to maintain as the project is rolled out nationally (White *et al.*, 2008).

Health

Tony Blair made a commitment at the end of 2004 'to change the National Health Service into a personalized health service for each individual'. Part of this agenda was to improve access to health services through NHS Direct and longer opening hours for GP surgeries, and

Figure 4. Personal health budgets.

Personal health budgets, along the lines of personal budgets for social care, had been rejected in a 2006 white paper, for compromising the free at the point of use principles of National Health Service funding. However the Darzi reviews of the NHS, published in 2007 and 2008, revived the idea of individual budgets. The budgets are currently being piloted in a range of services including mental health, maternity, end-of-life care and substance abuse. Patients can opt to manage the money themselves, following new legislation on direct payments in health. Alternatively they can work with health professionals or a third party to identify how to allocate a notional or managed budget.

to expand patient choice through the choose and book system (Darzi, 2007, p. 12). It has also been about providing more tailored support for people with chronic health conditions, such as diabetes and HIV/AIDS, who could become 'expert patients', involved in self-management and peer support (DH, 2004). Everyone with a long-term health condition is expected to have a personal care plan by the end of 2010, setting out a tailored programme of support (DH, 2006).

A more radical approach to personalized health care was launched in 2009 with the piloting of personal health budgets (see figure 4), modelled on those being used in the social care sector. There has been a high level of interest, with 75 primary care trusts (PCTs) involved in pilots, for a range of services. Running alongside the personal health budget pilots is an In Control initiative: 'Staying in Control', which is examining how personalization models developed within social care can best be amended and tested within the NHS.

In the 2010 general election, both the Labour and the Conservative parties promised to extend budgetary control for people with long-term health conditions. The Conservative manifesto indicated that health and care funds would be integrated into a single budget, to be controlled by the individual.

Housing

Personalization is reshaping housing provision in a number of ways. The first is through addressing the housing needs of people in the

social care system, to ensure that accommodation is not left out of the care agenda. As a member of the Department of Health's Putting People First team put it: 'Decent and appropriate housing is also a way of providing more personalized care, giving individuals more control over how they live their lives' (Porteus, 2008). As part of the government's Think Family initiative, oriented at families at risk, housing is one element that can be included in an individual budget (Taylor Knox, 2009, p. 17).

Local authorities can also draw on Supporting People funds, which provide housing support for vulnerable people, to offer personalized support (Audit Commission, 2009a). The government has noted the possibility of using personal budgets to provide options for 'some marginalized groups including the small numbers of people who have slept rough for many years and have, up to now, been unwilling to accept the help on offer' (DH Care Networks, 2009).

For social housing tenants and those in receipt of housing benefit, there have been efforts to make services more personalized over the last 10 years, through initiatives such as choice-based lettings and local housing allowances. Piloted in 1997 during New Labour's first term in office, choice-based letting schemes are expected to be operating nationally by the end of 2010. The schemes are designed to 'enable people to balance their own "felt" need, as measured by the time they felt able to wait, against the availability of the properties they might be able to secure' (DETR, 2000, §9.20).

For people living in private rented accommodation and eligible for housing benefit, local housing allowances have been available nationally since 2008. The allowance is determined on the basis of a local authority rate (taken as a median average of local rental rates), and goes directly to the tenant, rather than the landlord. If tenants are able to secure a cheaper rent they can keep the additional money, or they can top up the rent to access more expensive accommodation (DWP, 2006).

Employment

The JobCentre Plus initiative launched in 2002 incorporates a commitment to personal advisers for jobseekers. However, an ippr report into personal advisers found that the caseloads were too high to deliver effective support to individual clients, and that more training

and career progression was required to raise the status and effectiveness of advisers (McNeil, 2009). Services continued to be delivered on a block contract basis with inadequate differentiation between the different needs of jobseekers.

The Gregg report (2008) introduced the language of 'personalized conditionality' for people out of work, combining holistic personalized support with conditionality to incentivize behaviour change. The Department for Work and Pensions' green paper, *No-one Written Off*, developed this agenda, stating its intention to 'provide support that is tailored to each person's needs and to give everyone the opportunity to develop skills so they can find, and get on in, work' (DWP, 2008, p. 11). A key thrust of this agenda has been the introduction of the Flexible New Deal (see figure 5).

For disabled jobseekers there has been a commitment to provide greater control over the money spent on their behalf—linking up to the broader personalization agenda in social care. Legislation in 2009 introduced Right to Control Trailblazer pilots, which will integrate resources from a range of funds, including Work Choice and Access to Work, aimed at facilitating entry to the workforce for disabled people. Right to Control also supports the integration of funds to make it easier to live independently in the community (such as the Independent Living Fund), expanding its remit beyond labour market entry. The DWP has recently invited tenders for a Personalized Employment Programme, aimed at people on incapacity benefit or in receipt of Employment and Support Allowance, which

Figure 5. Flexible New Deal.

The Flexible New Deal was announced by the Department for Work and Pensions (DWP) in 2008, as part of a commitment to create a more personalized service for people out of work. Private and third sector organizations operate under contract to place people in work, with funding calculated on the basis of how many people are placed in jobs. The initiative does not incorporate plans to give jobseekers more budgetary control, although there is a commitment to be more responsive to user feedback, linking customer satisfaction to performance management.

will be piloted from March 2011 (DWP, 2010). The Conservative party manifesto for the 2010 general election indicated that it would continue with personalized approaches to facilitate entry into the workforce, offering tailored interventions earlier than is currently the case.

Education

Personalized learning was put on the agenda in 2004 by David Miliband when he was Minister for School Standards. He defined it as: 'High expectations of every child, given practical form by high-quality teaching based on a sound knowledge and understanding of each child's needs' (Miliband, 2004). The Children's Plan published by the Department for Children, Schools and Families (DCSF) in 2007, stated: 'Personalized teaching and learning will become the norm in every early years setting and classroom, stretching and challenging the able as well as ensuring no child falls behind' (DCSF, 2007). It announced £1.2 billion over three years to support personalization, including support for children with special educational needs. The 2009 21st-century schools white paper set out a pupil guarantee with an entitlement to personalized support for every child (DCSF, 2009). There is now a national expectation that all schools will have individual learning plans for each pupil, with tailored support for students that fall behind on literacy and numeracy.

However, the personalization learning agenda remains somewhat peripheral at the national level, clashing with a focus on standardized testing to a national curriculum. There is certainly no evidence of the focus or steering from central government that is driving personalization in social care. There is no indication yet that school children (or their parents) will be given real or notional budgets to shape their own learning. A DCSF interviewee confirmed that personalization for children's services was not yet about individualized commissioning, focusing instead on how to encourage schools to commission more creatively and get the third (voluntary) sector more involved. An Office of the Third Sector report noted the valuable role of the third sector in relation to supporting pupils outside mainstream schools and in bringing additional creative skills into schools (McGuire, 2010a). The Specialist Schools and Academies Trust (SSAT) has been very supportive of personalized learning, and

some new academies have experimented with more creative approaches to school buildings and timetabling (SSAT, 2010). Three Kunskapsskolan academies (see figure 6) will open in England next year, funded by the same company that has developed innovative approaches to pupil-led learning in Sweden.

Within further (ages 16–18) and higher (18+) education, there is little evidence of a co-ordinated national agenda to personalize learning provision. In the 16–19 sector, the idea of learning pathways and diversity of provision has a long history (Campbell *et al.*, 2007, p. 145). However devolving budgets to further education students is not currently on the agenda. The experience of Individual Learning Accounts, which were poorly devised and led to widespread fraud, may be a barrier to experimentation in this sector (Committee for Public Accounts, 2003). Within higher education, the Quality Assurance Agency for Higher Education is committed to the increased use of personal development plans for students, describing them as 'a structured and supported process undertaken by a learner to reflect upon their own learning, performance and/or achievement and to plan for their personal, educational and career development' (QAA, 2009). Higher education funding is already more individualized than many other sectors, given that students make a direct and substantial financial contribution. Government ministers have encouraged students to see their tuition fees in terms of a consumer purchase and to demand more control over the quality and format of their education, including the option to undertake intensive two-year degrees and have increased contact time with academic staff (Hurst, 2009).

Figure 6. Kunskapsskolan.

Kunskapsskolan were developed in Sweden with the aim of creating learning environments that were conducive to pupil-led learning. Traditional classrooms are replaced with larger and more flexible learning spaces. Pupils choose to attend classes, although they must work with a personal mentor to ensure that they are meeting their learning aims. The model has been influential in shaping attitudes to new school buildings in the UK.

Criminal justice

Personalization is underdeveloped in the criminal justice system. Indeed, a number of interviewees pointed out that it is a bad fit for a system that has existed to depersonalize the offender. However, there is some interest in how the third sector can be more involved in offering tailored approaches to offender management and reducing reoffending (ACEVO, 2009; Concilium, 2009). An Office of the Third Sector report noted that it may be easier for the third sector to build up trust with ex-offenders than it has been for the probation service (McGuire, 2010b). An interviewee in the Ministry of Justice reported that there may be some scope to devolve budgets to offender managers, on the BHLP model, although there are no immediate plans to do so. He noted: 'Where we're at [with personalization] is we know it's important but we're not sure how it fits and how it works'.

A Conservative party policy paper, *Prisons with a Purpose* (2008, p. 72), suggested that funding for individual prisoners could be disaggregated and paid to a prison and rehabilitation trust, with additional funding available to trusts if they stop prisoners reoffending. However, there are no proposals to involve prisoners and ex-offenders in determining how the money is spent, on the individual budget or BHLP models.

Recasting the welfare state

Personalization has a long reach, driving a common interest in tailored interventions across a range of sectors. It is evident from the breadth of reforms discussed that personalization does not constitute a single model of reform. The promise of choice and control for the users of social care services is rather different to the tailored interventions and 'personalized conditionality' offered by family intervention projects and the Flexible New Deal. Linkages are appearing between some sectors which may mark the beginnings of more holistic, citizen-centric approaches—for example between social care and housing, or social care and health. However, other sectors, particularly education, are pursuing personalization in a way that looks sectorally distinct and disconnected.

Despite these differences, there are some key themes across all services: an assumption that services can and should be more tailored to individual users; a more diverse range of non-state providers; the

disaggregation of budgets to the individual level, whether under the control of the service user or frontline staff. All of these themes constitute major challenges to the conventional post-war welfare state, in which ideas of standardized, state-run services, based on risk pooling across individuals were predominant. All the major parties have signalled their support for more personalized approaches, partly because it builds on a shared commitment to consumer-responsive public services and a mixed market of public, private and third sector providers, and partly because its flexibility provides a lot of latitude in terms of specific policy agendas. It is as yet unclear exactly how radically personalization will recast the welfare state, with suggestions that moves to individual budgets in a range of services could be a step on the way to greater use of co-payment, building on the model of prescription charges or university tuition fees. There has been a high-profile public debate about a version of the state in which local government offers a 'no-frills' minimum, with people purchasing extra services on top.

A more immediate challenge posed by personalization, across all services, is a radical reshaping of the commissioning process, since it is commissioners whose role is likely to change most radically in the shift from standardized to tailored public services. This is the focus of part 2.

Part 2: Commissioning for personalization: reflections from practice

A range of commissioning challenges are emerging as a result of the drive for more personalized approaches to service provision. Commissioning will not be limited to people 'with commissioning in their job title' (DH, 2008), but will be done by service users and staff on behalf of users, drawing on a wider than ever range of providers.

This section explores the challenges of personalization, focusing on forging links between individual, operational and strategic commissioning. Much of the discussion is on social care, since is it here that new patterns of commissioning, and the resultant challenges, are most apparent. Of the various ways in which services can be tailored, attention here centres on personal budgets. It is with respect to such budgets that traditional models of commissioning and service delivery are being most radically challenged, and where the emerging practice base can indicate important changes to the broader welfare state. The patterns discussed here indicate the sorts of issues which other public services will soon have to face as they move towards making services more personal.

Individual commissioning

A key theme of personalization is that services must be shaped by and be responsive to users. Some users will take on the role of service commissioner. Existing commissioners and service managers are being urged to engage users and carers more effectively and also to reach out to the broader community, including potential future users. This requires being responsive to the diverse ways in which users want services to be personalized, with some choosing to manage a budget and others wanting traditional services to be delivered in a more flexible way. Issues raised by interviewees in relation to supporting new commissioners included:

- Recognizing the diversity of provision entailed by person-centred services.
- Communication beyond the service user (with carers, self-funders and the broader community).
- Effective support planning.
- Keeping people safe.

Person-centred services

A key challenge expressed by interviewees was ensuring that services were person-centred, which could mean a wide range of things for different users. Taking a person-centred approach may involve encouraging creativity in the use of resources; interviewees had examples of people spending personal budgets on holidays, laptops, magazine subscriptions, art classes and hair extensions, among other things. However, it may also be about recognizing that sometimes choices will be more conventional: 'One of our service users had signed up to horse-riding course, which you think great. But there were no outcomes. That person ended up going to a private day centre instead, i.e. something quite traditional' (voluntary sector service manager). One social entrepreneur who worked with the Department of Health on personalization indicated frustration that some people reject personalization because they don't think service users want full budgetary control: 'It's quite bizarre when people say personalization won't work for everyone. Actually if it's person-centred it will, because if person-centred to you means stay in my residential care home at the age of 96 for the next 25 years, that is fine'.

One of the key challenges for existing commissioners is to look at the needs of the whole person, rather than just their care or health needs. According to one policy consultant: 'Personalization, unlike consumerism, focuses on life, not on services…There will be lots of services that I need—health, education, employment—which are not paid for by a personal budget, but which need to be personalized'. This requires local authorities to develop system-wide approaches to personalization rather than seeing it as a social care policy. However, one local authority chief executive reported that personalization remained 'ghettoized' in social care. Another interviewee observed: 'Lots of local authorities have used the transforming social care grant to set up a personalization team, and then the rest of the local authority and the rest of the adult social care department leave it to that team to bring about personalization'.

Communication beyond the service user

As well as widening the base of services, local authority commissioners are expected to widen their engagement beyond existing service users. These lines of communication are not yet well established. As one local

authority manager put it: 'Putting People First was supposed to include self-funders, but where is our offer on self-funders? There isn't one'. There is an emphasis on prevention and reablement within personalization to prevent people becoming reliant on state-funded social care. This involves close liaison with health services to identify individuals who might benefit from a reablement scheme, or some other form of preventative support. However, again, there are barriers here, particularly at a time of tight public finances: 'Can we afford to put self-funders through our preventative scheme, when it doesn't save us money?' one local authority manager wondered.

Existing commissioners also need to be responsive to carers, as set out in the cross-government 2008 carers' strategy (HM Government, 2008). Carers are entitled to an assessment, and to 'maintain a balance between their caring responsibilities and a life outside caring', which may become problematic if carer needs do not align with those of service users. Interviewees noted that service user preferences to spend a personal budget on a varied programme of activities may clash with carer needs for support services to be based in a fixed location on a fixed timetable to fit around other work obligations.

Effective support planning

As well as engaging with users and carers, commissioners will need to liaise with social work staff and care managers involved in assessing user needs and with the support planners working with users to design how budgets will be spent. Some interviewees felt that social work staff do not yet have adequate training to work within the new assessment models—'they are trained to think in hours, not prices'. The interviews also revealed that support planners do not always have a clear sense of what may and may not be funded using a personal budget. One support planner expressed her frustration with her local authority employer: 'You ask questions but no one knows the answer'. According to another: 'We need more support on knowing what we should be funding and what not, what people should have a responsibility for paying for themselves'. A manager from a user-led organization for disabled people commented: 'The support planners don't know how to cost things, they don't understand that personal assistants have overheads, like holiday and sick pay'.

There are also concerns around who should fund support

planning (also called 'brokerage'), how conflicts of interest can be avoided, and whether independent brokers are necessary. In some areas, local authority in-house support planning is funded through top-slicing personal budgets. Often it is existing care managers who do the assessments and the support planning, although the Department of Health recommends that these roles be kept separate ('We can't afford to do that', reflected one commissioner). In other areas, third sector organizations such as Centres for Independent Living play a key role in providing support. Some third sector organizations currently fund their own advice and advocacy services and are waiting for clarification about how these services will be funded in the more uncertain financial climate of individual purchasing. Some organizations provide services, such as day centres, alongside advice and advocacy, generating a potential conflict of interest in a context of personal budgets, since there is a financial gain in recommending use of their own services. To minimize this conflict, some third sector organizations are setting up a separate social enterprise arm, which will enable them to sell services in a way that is not possible as a charity. For example, the charity representing micro-providers, NAAPS, has set up a social enterprise arm (Community Catalysts), which will be able to trade with local authorities and other organizations to supply consultancy and other social care support services.

There was little support expressed by interviewees for a new profession of independent broker. One interviewee commented: 'It is hard enough to find out what people are actually commissioning with their personal budgets…Involving external advisors lengthens the information chain back to local authorities as to what current demand is for'. Duffy and Fulton (2009) have argued that service users can best be served by drawing on existing community resources, including families, friends and peers. In part, this reflects a broader concern within the personalization debate about the role that social capital should play alongside funded state support. A key element of personalization within social care has been around helping people to develop networks of support which are based on friendship and reciprocity rather than contract. As one interviewee from a user-led organization for disabled people put it: 'Reviews with service users showed people felt that there isn't enough unpaid involvement in my

life. We're looking at expanding voluntary involvement. People's relationship maps would look bigger and they would have different things to spend money on'. Such peer support approaches may involve commissioners in a co-ordination role, working with users to support consortium arrangements, for example pooling budgets with others to fund small-scale purchases such as swimming lessons, or larger ongoing costs such as shared housing.

Keeping people safe

Safeguarding is a key concern for care services, and the impact that personalization will have on it remains contested. Safeguarding has gained a high public profile following recent child protection cases, and is a key priority for the Care Quality Commission and the General Social Care Council. Interviewees differed in how far they saw personalized commissioning as increasing or decreasing the likelihood of abuse. One director of adult social care noted: 'You've got to strike the balance between keeping people safe versus giving them a better life…We need to make sure managers know what a safe but personalized service will look like'. The relationship between safeguarding and personalization is not yet clear, particularly with regard to financial safeguarding (see, for example, DH, 2009a, p. 5).

Creating a culture in which social workers and other frontline staff feel they can take a positive view of risk will require engagement with the blame culture that has surrounded recent media controversies in the UK over social work interventions. A number of interviewees suggested that it was only a matter of time before a high-profile media story emerges linked to the misuse of personal budgets, and that a robust response would be required to ensure that the broader personalization agenda was not derailed.

Operational commissioning

One of the key challenges for existing commissioners will be to take on new roles as 'operational' commissioners, shaping local markets and supporting users and their advocates in the direct commissioning of services (Care Services Improvement Partnership, 2008). Commissioners are expected to 'develop' the market (SCIE *et al.*, 2009) and to practice 'smart commissioning' (DH, 2008; Duffy, 2008), while recognizing and mitigating the dangers of destabilizing local markets

(DH, 2005, p. 27). They are expected to draw together (and share with providers) intelligence about the state of the local market and demographic data about current and future demand for services.

In relation to market-shaping and new forms of contracting, the interviews showed that the following themes were proving challenging:

- Understanding the market at the local and regional level.
- Supporting providers to meet demand and set up new systems.
- Decommissioning.
- Costing and pricing.
- Developing the workforce.

Understanding the local market

Mapping local markets is one of the first challenges for existing commissioners. There is enormous diversity in existing markets, across and within local authorities. One suggestion has been that local authorities build on the customer-focused market that already exists for self-funders (Tyson, 2007, p. 13). However, in many local areas there is no vibrant self-funder market to draw on—rather, markets are patchy and unresponsive. As one social care manager put it: 'Our sense at the moment is that the market is very dysfunctional. There are few incentives for providers to be innovative. I don't know of any authority that can genuinely say otherwise'. According to another: 'People say to us it's all very well to have direct payments but there's bugger all to buy' (director of adult social care, local authority)

Commissioners are concerned that they don't have the right skills for market-shaping: 'A sophisticated approach is required to manage a market, you need analysis and modelling skills. We don't have that' (local authority social care manager). Another said: 'It is quite difficult to stimulate a market in a context of personalization because there is less security'. One national policy officer in a voluntary organization felt that local authorities lack basic market knowledge: 'You can only stimulate the market if you know what your provider market is, the vast majority of local authorities don't actually know the massive amounts of activity that are going on in their local authority areas anyway'. This may be particularly apt in relation to micro-providers (many of whom do not have any paid staff), who may play a key role in

specialist services for groups, such as black and minority ethnic elders or lesbian, gay, bisexual and transgender mental health service users (NAAPS/DH, 2009).

Some local authorities felt that effective markets could best be developed on a regional or sub-regional basis, particularly since many providers operate across local authority boundaries. However, a Department of Health regional officer did not agree that this was part of the regional office remit, indicating also that some local authorities were resistant to working with the regional office, seeing it as having an enforcement role.

Supporting providers

A key role for commissioners in the context of personalization is working with providers on business development skills, market responsiveness and financial planning. This involves a wide range of providers with very diverse needs—from large-scale private and third sector providers, used to relying on block contracts, to micro-providers and user-led organizations who may provide very different services and have very different financial and organizational needs to the larger providers.

The role of the local authority will involve helping providers to make the transition from 'wholesale to retail' provision. Providers may be asked to take on new roles such as care management, human resources management and support planning. Providers may be offered outcome-focused contracts in place of task- and time-based contracts, designed to assure quality and supply through the pre-selection or validation of providers (DH, 2009a). In domiciliary care in some local authorities, for example, providers have signed up to framework contracts that commit them to providing personalized and flexible services but with no guarantee of demand. Providers and budget holders agree the detail of provision, with the contract setting out broad outcomes. Quality assurance is provided on the basis of Care Quality Commission ratings and user feedback. This contractual arrangement provides much less security for providers, particularly since the Department of Health is keen to affirm that people should be free to purchase services from outside the framework contract should they choose to do so (DH, 2009b).

In this context providers must become more sophisticated at

marketing themselves to service users, carers and support planners, rather than relying on established links with local authority commissioners. Many local authorities have set up provider forums to improve communication with and support for providers in addressing these issues. However, relationships between commissioners and providers have traditionally been adversarial and many continue to be problematic. As one local authority manager put it: '[Providers] want us to tell them what to do. It's a parent-child relationship, we've been their biggest purchaser. The bulk of providers don't even come to our events'. A director of adult social care noted: 'we're not awash with entrepreneurial spirit here really'.

The provider perspective is rather different: 'There's local authorities that I'm aware of that are going out doing these pilot activities and are just not talking to the [third] sector…They come to the provider market and say you've got to do it, it's adapt or die, and that doesn't really work' (national policy officer, voluntary organization). Voluntary sector interviewees complained that too much of the transforming social care grant has been absorbed by the local authority, rather than used to support providers make the transition to personalized services, a concern echoed in a recent report from private sector care providers (English Community Care Association, 2010).

Provider anxieties focus around the unpredictability of organizational financing once more purchasing is done on an individual basis. As one head of a small-scale social care provider said: 'We don't have a finance department or an HR department…I'm not sure the infrastructure is there if everyone managed their own money, to do all the invoices'. The likelihood that back office costs will rise under personalization, and that there may be an increase in late payment and non-payment of invoices, requires organizations to think creatively about how to resource these elements. This will be a particular challenge for small and medium enterprises, and third sector organizations with low capitalization. A number of local authorities have opted for pre-payment cards for service users, which can be loaded up with a direct payment allocation and used to purchase services, avoiding a lengthy invoicing process.

In the face of these challenges, some providers are optimistic: 'If you do what people want they will stay with you. There are some

vulnerabilities in it. But generally people like what we do'. However, others are worried: 'No local authority has thought about the destabilization and closure, and the impact that will have on staff and users' (director, third sector umbrella organization). One director of adult social care noted: 'The bigger providers are trying to get the business model right, lobbying to get secure funding around transition'. Another interviewee reflected on the issues: 'It's going to take a lot of fleetness of foot and commitment from commissioners both local authority and health to make sure you don't idiotically and unintentionally sweep away some really good services' (civil servant, mental health). Some providers may choose to exit the market altogether. A civil servant working on personalization and housing warned: 'Larger providers have made announcements that they are not going for new housing. They are saying that personalization challenges their care and support packages—pensions, employment rights etc.'

Decommissioning

Market-shaping will include the decommissioning of some existing services, delivered on the basis of block or spot contracts. As a civil servant from the mental health sector put it: 'Commissioners worry a lot about commissioning different things, but actually I think in many ways what they've got to do is decommission things rather. The issue is going to be about drawing money out of traditional services to hand to individuals'.

In many areas, progress on this agenda has been slow. Interviewees reported that three or four year block contracts remain common, limiting the scope for personalization to be anything other than a fringe activity. A local authority chief executive reflected on the slow progress of decommissioning: 'Why is the agenda going so slow? It's redundancy costs, it's fear, organizational inertia, not wanting to close down the day centre, or other service. We need to actively manage decommissioning at the same time as giving out budgets'. A local authority social care manager said: 'Personalization doesn't yet link to decommissioning of services because there isn't yet anything to replace it. We would have thought we'd have a major closure programme for day centres but we aren't because we haven't got a viable alternative offer'.

Decommissioning is particularly contentious in relation to day services, which were one of the most divisive issues in the interviews. Described variously as 'comfortable prisons' and 'places you can go to without fear of stigma', their future was hugely emotive. Some people felt that they would continue to be part of local authority provision for years to come, in part because older generations tend to be heavily dependent on them. However, others felt that they should not continue to be subsidised if they did not provide a service that people wanted to buy.

It is anticipated that people with personal budgets might not want to give up day services altogether, but rather to opt in on a more *ad hoc* basis, attending on particular days or for particular events (Duffy, 2010). However, some interviewees were concerned about how accommodation-based services could be sustained on this basis, given the building and staffing costs of keeping a centre open. There were fears that a few service users choosing to withdraw their funding could lead to the closure of a service that was popular with other users. As one third sector provider put it: 'If people want to go to activities like a day centre occasionally, they won't be there. You can't run a day centre on that basis'. One director of adult social care was more bullish: 'We need to demolish the old buildings, cash in their value, and build state-of-the-art facilities for those people who really need them'.

Costing and pricing

In a context of disaggregated commissioning, market development requires accurate costing and pricing of services. A theme that came up repeatedly in the interviews was that costing of in-house services was as yet very underdeveloped. As one third sector provider put it: 'At the moment we can't see the cost of the in-house day centres, so we've got nothing to compare with'. Uncertainty about costing is often internal as well as external, with local authority staff themselves not having access to disaggregated costings for their services (OPM, 2008, p. 40). One interviewee noted that pricing services in advance can be difficult, because the unit cost may depend on how much of that service is purchased, which is hard to predict as service users make individual purchasing decisions. In relation to personal health budgets, another interviewee anticipated a similar problem: 'We don't have a tariff for

community care, so no one knows what a unit for an occupational therapist or a district nurse will cost. We have a tariff for secondary care but not primary care' (researcher, health research organization). In uncertain markets, providers often charge more to cover the risk of low demand, but the head of one umbrella organization for providers indicated that this road was not being held open to them: 'Local authorities are taking stability away and not allowing a notice period, but also won't allow organizations to charge more than they did before'. These issues around pricing need to be addressed if frontline staff and users are to make choices about how to allocate a budget, and to choose between in-house and external services.

There are also problems around ensuring that support plans realistically reflect the costs of external services. As a support planner put it: 'Our local authority panel has set a cost for home care that is not enough to afford it through self-management, it doesn't cover the agency rates…But if people have been assessed as needing a certain amount of home care, that is what they need'. In this context there is a disincentive to take the money as a direct payment, even though this is supposed to be the default option for service users.

Developing the workforce

Personalization will lead to major workforce change, following a period in which the care workforce has already been the focus of much scrutiny and review (DH, 2009c; Social Work Task Force, 2009). Interviewees indicated that they were at an early stage of thinking about these challenges. There have been suggestions that personalization will reinvigorate the caring professions (GSCC, 2008), and most local authority interviewees took that line. As one put it: 'If you speak to social workers, they tend to find personalization quite liberating, that's what they came into the job to do'. However trade unions and other professional bodies expressed concern that personalization will deskill and marginalize an already vulnerable workforce, a point backed up by plans to reduce the number of qualified social workers in some local authorities (Land and Himmelweit, 2010).

As service commissioning passes more to the individual level, it may be difficult to match uncertain and shifting user demand to the provision of skilled staff on an appropriate contractual basis. Training

of care staff, social workers and assessors needs to reflect the new skills required and fair employment practices. Most local authorities indicated that social workers and care managers were being trained in more personalized approaches. However, homecare staff may be further marginalized and casualized in the move to more individual forms of contracting (for a discussion, see Land and Himmelweit, 2010). Decisions need to be made about local accreditation practices for personal assistants and providers; local authority interviewees indicated that they were still consulting locally on whether to create a register of personal assistants. There are particular challenges in rural areas and issues around employment of migrant workers (Bawden, 2009).

Strategic commissioning

As well as supporting individual commissioning, and ensuring effective operational interventions, there is a challenge for local authorities and related bodies to ensure effective strategic commissioning for their localities. Interviewees noted a number of concerns and some optimism about the scope for strategic commissioning, focused around:

- Progress on joint working.
- The potential for Total Place to advance the personalization agenda.
- Affording personalization.
- Accountability.
- Managing risk.

Progress on joint working

A key theme of personalization is that resourcing should be person-centred, not service-centred, recognizing that people approach their lives holistically and get frustrated by government silos. The importance of joint working between local agencies has been emphasised by a number of government initiatives, including local strategic partnerships, local area agreements, and more recently the comprehensive area assessment and the Oneplace website (http://oneplace.direct.gov.uk), which makes it easier for citizens to see the performance of a range of local agencies (Audit Commission, 2009b).

The central imperative at the strategic level appears to be

integrated commissioning between health and social care, involving local authorities and PCTs, but also foundation trusts and a broad range of service providers. The Department of Health's world-class commissioning initiative highlights the scope for commissioning to be transformative rather than merely transactional, and calls for strategic interventions to improve local health outcomes (DH, 2007a). The Joint Strategic Needs Assessment (JSNA) is an existing commitment to joint working, requiring local authorities and PCTs to identify current and future health and wellbeing needs of the local population, and feed that into commissioning priorities (DH, 2007b). Local area agreements can be used to bring partners together under the targets agreed as part of the JSNA. The importance of joint commissioning and funding is particularly evident in sectors which span the health/social care divide, such as services for older people and mental health. In areas with care trusts, local authorities and PCTs already work together to provide care services, through pooled budgets and multi-agency health and social care frontline teams (Allen *et al*., 2009). The Department of Health is currently piloting integrated care approaches in 16 sites, which involve partnerships with social care, secondary care, the voluntary and private sectors in health categories such as urgent care, mental health and children's services (DH, 2009d).

Some of the local authorities approached for the study had restructured their commissioning functions, away from sectorally based units in order to facilitate integrated and strategic approaches, whereas others had yet to make the transition. In many areas joint strategic commissioning between local authorities and PCTs continues to be an aspiration rather than a reality, described as 'embryonic' by one local authority interviewee. According to another: 'Putting People First had lots of signatories, but there's been no joined-up work'. Some interviewees highlighted the difficulties of multi-level integration within a single service (notably the NHS), let alone between services.

One of the barriers to integration may be that other public services have not yet caught up with social care in prioritizing personalization. As personal health budgets become mainstreamed, it may be possible for individual service users to integrate their care in a way that has not been possible at an organizational or strategic level. However,

commissioners will need to work through the complexities of combining means-tested social care monies with health services that are free at the point of use (Audit Commission, 2009c, p. 34). Concerns have been expressed that a move to individualized budgets will signal the introduction of means-testing and topping up within the NHS (Unison, 2009). As one interviewee noted: 'People are not allowed to top up in the NHS. But [with personal health budgets] how do you police that, draw the line, if people just want to pay for a bit more physio?'

Total Place

Local strategic partnerships are leading on the Total Place initiative, aimed at approaching service funding in a more creative and integrated way to remove duplicated funding across different agencies in a locality (see www.localleadership.gov.uk/totalplace). Many interviewees highlighted the coherence between personalization and Total Place, in reimagining local service provision and breaking down traditional service silos to rebuild provision around users. 'Personalization offers an ideal set of technologies to enable a Total Place strategy to work—because it offers a flexible framework for putting resources in the hands of citizens, families and communities. It also enables fresh conversations between citizens and the state about what really needs to be achieved' (Duffy, 2010).

The Total Place initiative is generating a large amount of optimism about more effective ways of spending public money. However, some interviewees expressed concern that silos would remain entrenched as battles for funding become more intense.

Affording personalization

Although commissioners may not have direct responsibility for balancing budgets across a service sector, these are key issues which shape the strategic context within which commissioners operate. Personalization is an agenda that developed in much more auspicious financial context, and is now being modified in anticipation of severe funding cuts ahead. As one local authority social care manager noted: 'The circumstances are very different than when we had the national pilot here for personalization. That was very *laissez faire*, very flexible. It had a lot of money thrown at it. Now for older people,

personalization is costing more and we need to look at that'.

To date, the relationship between personalization and cuts remains unclear. There is some cynicism that personalization is being used as a label to legitimize service changes which are more about cutting budgets than about enhancing choice and control. As one policy consultant put it: 'Local authorities that are cutting everything, that have massive budget issues, use personalization and individual budgets to justify anything that they want to do'.

Retaining the ethos of self-directed support while undertaking swingeing budget cuts will be a key challenge for all local authorities. Short-term pressures for savings may choke those elements of personalization which are likely to deliver longer-term savings, such as prevention, early intervention and reablement. One local authority manager explained the challenge: 'Personalization has got to save us money, we've got no choice…We know we can achieve dramatic savings on individual people. Personalized services will be cheaper in some circumstances, particularly for learning disability and physical disabilities. There's not so much savings to be made on older people because we're stingy to start with'. Another was more upbeat: 'Personalization meets the needs of people in the community and that's a whole lot cheaper for us. At the end of the financial year, we said to people can you return any unspent money to us—we got over £200,000 returned to us. People are much more frugal with their resources than we would be'.

Accounting for public finances

Accountability in the use of public finances is another key issue, including appropriate involvement from audit and regulatory bodies, and engagement from locally elected members. Getting the auditing of direct payments right has been a challenge, as one director of adult social care explains: 'The audit side of direct payments drove everyone mad. It was so bureaucratic. An officer had to go out and look at every single invoice and receipt. We challenged the auditors—which isn't easy—and they now do a sample'. There is also the issue of how far local councillors are engaged in and supportive of the personalization agenda. According to one director: 'I sense from some of the elected members that they feel direct payments diminish their role in deciding what social care spends its money on. What do I get to vote on?' A

number of interviewees raised the question of how far social care budgets should be allocated on a no-strings basis, like other benefits, or how far the state should retain oversight over how money is spent. One director of adult social care felt that this would diminish 'the professional *raison d'être*', whereas another said: 'We aren't bothered what people spend their unemployment or social security on. When people raise concerns about disabled people misusing funds, I just see it as an example of prejudice'.

Managing risk

Personalization requires commissioners, providers and users to encounter new forms of risk, and at a strategic level there is a need to identify and manage this process. For providers, there will be organization and financial risks posed by the new retail model, in which the security of local authority block contracts will disappear. Private and third sector providers need to identify ways to manage this new risk profile, and to work with local authorities to minimize the risk of market failure (perhaps through accessing preferred provider status). Local authorities and other commissioning bodies need to manage the risks of market failure. Some local authorities are anticipating and putting in place contingency funding for market failure—although this may be a big drain on resources. Commissioning organizations will also need to clarify how far they can (or should) divest themselves of legal liability for the spending choices of people with personal budgets, for example if there are legal disputes between direct payment holders and personal assistants, or if people choose to purchase inappropriate support services (ADASS, 2009).

From the fringes to the mainstream

All of the challenges discussed so far will become more pronounced as personalization moves into the mainstream of social care, and expands beyond social care into a range of other services. A number of interviewees reported concerns about the mainstreaming of personalization, focused around:

- Running dual systems for an extended transition period.
- System overload.
- The risk of no change.

Dual systems

A number of local authorities described their current approach as running two systems in parallel:

- Flexible services for people with personal budgets.
- Traditional day services for people on conventional funding streams.

The Department of Health recognizes that local authorities are currently providing two sets of services but expects this to be phased out as personal budget holders become a majority of users (DH, 2009b).

The national programme manager for Putting People First explained that the target of 30% of eligible people on personal budgets by 2011 is expressly designed to move away from this: 'When you have got three or four people on direct payments you can run two systems. We want to ensure self directed support is the main system' (In Control, 2010). The Office of Public Management has noted the importance of 'tipping points' where sufficient levels of participation in new schemes leads to new patterns of contracting and disinvestment (OPM, 2008, p. 38). However, the transitional phase may be a long one. As one interviewee noted: 'In local authorities that have relied on block contracts it may take 10–15 years to implement—although they've only got a three-year transformation grant'. There are clearly questions to be answered about how far dual systems will be affordable at a time of severe budgetary constraint.

System overload

Some interviewees expressed concern that the transformatory spirit of personalization will be lost as it becomes routinized and mainstreamed. Certainly some of the initial creativity and support that has been possible looks hard to support on a mainstream basis. As one local authority support planner explained: 'It is taking a long time to do a support plan, about 25 to 40 hours per person. That includes going out to get quotes for the services they want and bringing back various options. At the moment that time is agreed by the chief executives, but it can't be funded going forward. I can do three or four at a time…Social workers have caseloads of 50 to 60 older people. They haven't got time to do a support plan'.

One difficulty of embedding personalization is that many people approach the local authority—or a related service like a women's refuge—at a point of crisis, where the key thing is to offer a response as quickly as possible. As one interviewee from a refuge asked: 'If a woman's in the middle of a crisis and needs to come now we don't need any kind of barrier in the way, and this is where personalization for us is possibly as issue, because we don't want women having to think, or us having to think, does she have a budget?' A number of interviewees noted that personalized approaches, including budgets, are more appropriate once someone's condition has stabilized, whereas there may be some services, such as mental health, where needs fluctuate significantly.

Risk of no change

Running alongside the risks that personalization will overload public services, a number of interviewees raised a different kind of risk: 'In the first year [of having a personal budget] most people buy the same thing as before. The biggest risk in all this is that nothing will really change' (local authority social care manager). Although the numbers of people on personal budgets are rising there is concern that this is just a rebadging process, with care plans being renamed support plans without the transfer of choice and control to the service user that self-directed support envisages. As one director of adult social care said: 'The question is, is it just a piece of paper saying you have got £100 but nothing has really changed?'

Rather than a radical shift, this interviewee predicted that people would make adjustments at the margins: 'Change will be around the edges for people. They don't want to risk change in their crucial service, like their home care'. But she went on: 'Even if the money is going to the same providers, we want more dialogue between them and service users about what service users want, more flexibility of provision'. Another interviewee said: 'People may only want to tweak services around the edges, but actually those changes may be crucial'.

Conclusions

Personalization has the scope to be a radical agenda for public services. It is premised on a shift of power and a new understanding of the relationship between citizens and the state. A director of social care expressed the aspiration that people with care needs will be removed from the 'ghetto' in which they have been placed: 'Less and less will it be possible to talk of a social care market, because people will spend their money in the same way as other people'. Another social care manager commented: 'We need to stop using the language of commissioning. People won't 'commission' things—they will *buy* them'.

This report has offered a snapshot of the personalization agenda as it currently stands, explaining its relevance to a range of different services, and key themes for commissioners in its implementation. It is an account of how some of the gaps and simplifications in current guidance are being interpreted and having an impact locally, and what some of the future dilemmas and trade-offs of personalization are likely to be.

Much of the discussion here has focused on social care, where the practice-base is best developed. As personalization becomes established in the health sector and beyond, it will be shaped by commissioner–provider relationships that look very different from those in social care. In the health sector, for example, interviewees talked of commissioner and provider relationships not in terms of parent and child, but rather David and Goliath—with large secondary providers, particularly foundation trusts keen to accrue more services, and commissioners having little scope to experiment with new, small-scale initiatives. As one civil servant working in mental health services put it: 'The commissioning bodies simply don't have the teeth or the vehicle to force change, except round the edges'. This is a very different model from the social care market—and it is likely that each sector will bring its own commission-provider relationships and own challenges. These challenges will be particularly intense in services where joint commissioning is expected, as the long history of difficult relationships between health and social care attest.

A key issue which will need to be addressed as personalization moves from the fringes to the mainstream is how to strike a balance between user control, user responsibility and the public interest. To date this issue has been underplayed, as personalization for social care

recipients has focused fairly uncontroversially on giving primacy to user control. However, even within social care, tensions are emerging. For people using mental health services, for example, there may be an expectation that people move back into the labour market. However the organizer of a day service for people with mental health problems soon to be funded out of personal budgets inquired: 'why would anyone chose to pay £26 for a morning session at a day centre so we can tell them they ought to get a job?' These tensions will become more profound as the promise of personalized services is held out to jobseekers, ex-offenders and the homeless. The extent to which services are shaped by user demand or by conditions imposed by government will be a crucial issue if personalization is to make an impact outside of social care.

This point relates to broader issues in the personalization agenda, about how far personalized services will minimize or exacerbate inequalities between service users. Implementation remains too underdeveloped to offer a clear picture, and the vast diversity of practice inhibits generalization. There have been concerns that middle-class service users will be more confident than others in accessing and maximizing the benefits of personalization. Research by Glendinning *et al.* suggested that the increased use of individual budgets may encourage more use of 'top up' services from user's own resources, which may have a negative impact on equity (ESRC/ACEVO, 2009, p. 11). However, Glasby and Littlechild argue that the greater transparency associated with personal budgets has the potential to enhance equity, helping to ensure that 'people with equal needs start to receive equal resources' (2009, p. 154).

All of these issues are in flux, as a new government takes office in the UK, making it risky to predict the future of personalization, although the main uncertainty seems to be around the speed of travel rather than the direction with all parties committed to more personalized public services. Some elements of the future agenda are predictable: severe budget cuts, demographic changes, and enthusiasm for non-state solutions to traditional welfare state problems. Personalization does not offer straightforward win–wins, despite some of the more enthusiastic claims made about it. There will need to be trade-offs and choices. Much of the detail of personalization, as with any major policy change, remains contested,

as local managers, commissioners, frontline staff, users and providers deal with the ambiguities of the agenda. This report has drawn on ongoing practice across local authorities to identify the key uncertainties and dilemmas for commissioners, so that those debates can proceed on an informed basis. In a policy context awash with 'how to' and 'best practice' guides, it reflects the messy interface between a new policy idea and the lived experience of those affected by it. ■

Afterword

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Personalization of public services is here to stay—we have to make it work

This report raises many vital questions for policy-makers and professionals, and signals the need for an urgent public debate about how we take forward personalization based on individual budgets. Personalization of public services is here to stay—even though it will take many forms, including more individual budgets and user-purchasing of some services. Accordingly, further debate should not be around the principle or whether the policy should be pursued. The fact is that it will be—and it should be. Rather, key questions now must be around: how to extend the idea; to what services; in what way; and at what speed?

For many public services—such as social care, child care, managing long-term chronic illness, training, further and higher education and support for those out of work—the model is almost certainly going to be based on the transfer of public monies to individuals to make their own choices and to purchase services from a range of service providers. Easy enough to say, of course, but the consequences of such a policy are profound.

For a start, it will change the relationship between the state and the individual, since the latter and not the former will now decide what service is received and from whom. This will challenge the long-standing monopoly provision within the public sector, and also third and business sector services which previously had been purchased 'on block' by the state. This means greater competition between suppliers, which should lead to innovation, higher quality outcomes and lower prices. However, should there be inadequate regulation, the outcome could be poor quality services, people at risk and higher costs.

Professionals have to stop assuming 'we know best'

The role of many professionals will be challenged too, for the service

user and not they will now be in the driving seat. Professionals will henceforth have to assess need and become advocates and advisors, rather than 'case managers'. They will have to balance their budget responsibilities with their assessment and advisory role. This ought to be seen as a positive change by those professionals—but for many not used to challenge or having to justify their decisions, it will be an uncomfortable journey.

Suppliers have to change too: 'choice and competition' means more suppliers

Providers will have to change their business models from 'wholesale' to 'retail', with all the implications that this implies. Demand risk will move from the public sector commissioner to the suppliers—be they public, business or third sector. This will place big demands on providers. For example, they will need to be sufficiently capitalized to manage their cash flow, and they will need to adopt marketing practices which will, inevitably, prove more costly than dealing with a small number of public sector clients. It is likely that new entrants with retail experience will be attracted into these public service markets and that some existing providers will exit. In addition, given that competition and choice are key drivers for personalization, it will be essential that regulation ensures competitive neutrality.

'Regulation' for the citizen, not the convenience of the provider

Regulation and the 'rules' pertaining to personalization will need to be proportionate to the risks to the user rather than introduced to protect institutional or professional interests. No one should be under any illusion—this is a major culture shift. Public sector strategic commissioning in those service areas where direct payments are introduced will look and feel fundamentally different to what it was before. Now, the core functions for strategic commissioners will be to: identify needs and aspirations in consultation with users and professional staff delivering the services; assess needs where there is no uniform service; allocate finance to service users; and 'finesse' markets to ensure that there is a competitive supply market.

They will also need to regulate their providers for quality assurance, health and safety standards, and other legislative requirements. There are those who will argue that such regulation is

unnecessary, but in services that are so sensitive and critical to the lives of users, and where there is direct contact with vulnerable people, it is inconceivable that there will not be some form of regulation including those relating to workforce issues. We will likely see accreditation of service providers, with service users being made aware of those who are accredited and those who are not—leaving the choice as to whom to engage to the user. In critical and sensitive personal services, there is a case too for direct payments to be only used where the provider meets certain standards and is accredited. Critically, however, such an approach will have to be introduced in such a manner so as not to undermine the principle of personalization or to stifle innovation. There will probably also need to be some national guidance, and each local area will need to have an appeals process in place for suppliers.

New supply markets take time to develop so that, in those services and/or geographic areas where personalization is newly introduced, there will be a case for some phasing in of the extent of its application. Active market engagement and management by strategic commissioners will play a critical role in this market development. That said, its complexity and challenges must not be used as excuses for tardiness in extending personalization—tempting to many though this may be.

'Total Place' lends itself quite naturally to personalization

Service users often require services which are currently provided and/or funded by different public sector agencies. Accordingly, there is a strong case to build on Total Place and introduce personalized 'pooled budgets' with payments funded jointly by agencies, for example health and social care funded payments/budgets for elderly people with care and clinical needs.

Put the citizen in charge, not the state

There is a major and urgent debate to be had about the extent of state control and influence over both the supply markets and the use made of the direct payments by individuals. As with benefit transfer payments, a strong case can be made that there should be no prescription on how monies are to be used, implying that the public audit function should only be interested in the processes up to the

point of payment to the service user.

This also presumes a cash payment, and raises a fundamental question about the rights of the service user if she/he has not spent their 'payment' in accordance with their assessed need and consequently has cause to require access to public services (for example the chronic diabetic who has not followed the prescribed medication and behaviour but now requires emergency NHS treatment).

The right of citizens to make their own, informed choices must be paramount and will lead to a variety of services

This approach also raises fundamental questions about the relationship between the professional adviser and the service user, and about the balance of power, authority and knowledge between them. Users may need to be counselled to take and follow professional advice, and should have access to independent advocacy as necessary. Critically, however, personalization implies that users are regarded as being able to exercise informed choice—rather than the reverse. To avoid the obvious conflicts in such arrangements, this advocacy should not be provided by the bodies responsible for budget control.

Ultimately, personalized budgets are public money. Accordingly, there has to be public debate on these aspects of personalization and a consensual view needs to emerge before decisions are taken. Inevitably, this will result in a robust debate between the purists and the pragmatists, as well as the dogmatic and the idealistic. There will always be a wider public interest to be taken into consideration when public money is spent, and any decisions adopted will have to be robustly defended when there is media, political or challenges from other (sometimes 'vested') interests. However, whatever the outcome of these debates, one must start with the presumption that just as with individual choice, so too the decisions may be different for different services, different user groups and different localities.

Personalization presumes informed service users

Accordingly, there will have to be easily accessible information about:

- Alternative means of addressing needs.
- Comparative information about the potential suppliers including

their services, charges, track record, accreditation (where there is one), workforce practices etc.
- Access to independent advisors, advocates and brokers.

'Strategic commissioners' will need to be clear about their new role and duty

Personalization will fail if people continue to use the same services to the same standards simply because this is what they know. It will also fail if users purchase inappropriate and under-performing services. Strategic commissioners have a key role to play in ensuring that the right range of choice and options are in place, but they cannot and must not act as advocates—the potential conflict of interest is simply too great.

In some extreme cases, users may require protection from their families who may put their financial interests before the needs of the user. Hopefully, this will be rare, but there will need to be safeguards proportionate to the risk. This is a sensitive area, but one in which commissioners must have an awareness and a ready strategy.

'Mutualism' has a role to play

Service users should, where appropriate, be encouraged and supported to form user-controlled mutual organizations to co-ordinate service purchasing through the benefits of market power and to provide advocacy and brokerage services.

Workforces who provide services are key players and need to be involved

There is a serious danger that poorly-regulated personalization could lead to a detrimental impact on the workforce and consequential quality and protection issues for clients. This has to be avoided. Users must be helped to appreciate and understand the terms of employment, the commitment to training and development, and the qualifications and professional status of those whom they may wish to engage; and why these matter for the quality of service and their wellbeing. The state has a right to expect certain workforce standards too. Accordingly, there has to be a debate with trade unions, employees and suppliers about how choice and diversity of supply can be accommodated within the rights and entitlements of staff.

Funding—and who pays for it all

The final points to be made in this short commentary arising from the research study relate to funding.

Public services require a certain level of funding to secure specific outcomes. This applies as much to personally purchased services as it does to those organized by state institutions. If budget pressures reduce the available money, the public sector should openly change eligibility criteria rather than underfund individual payment allocations. There will need to be an honest, public debate in each locality about the appropriateness of service users making a 'top-up' payment or some other form of co-payment. If we are honest, it is clear that co-payments could, if not carefully controlled and regulated, lead to inequity and inequality of provision—core services for all and better services for others. Is this what the public wants? Perhaps it is—but the evidence is not clear that they do. We do know that there is a strong demand for equity and fairness in respect of access to public services, and we do know that there is a demand for greater choice and personal control. There has to be an honest and open debate on this topic.

Also, it has to be acknowledged that the use of vouchers or 'smart card' payment systems may prevent attempts by commissioners to control how the money is spent and with whom. This could be at variance with the principles of personalization but their applicability may be different for different services. When these mechanisms are proposed, we should question why.

This report is principally about personalization through the transfer of money or purchasing power to individuals, but personalization can also be secured in those services which are collectively provided or procured. The service landscape will be very different as it changes over the next few years as a consequence of perhaps up to 50% of services being directly purchased by service users and not the state, and most of the remaining 50% being tailored to individual needs and choice through other mechanisms.

Conclusion: The implications are profound—we need a major debate now

Personalization has the potential to have as radical an impact as the introduction of the collectivist welfare state after the Second World

War. However, the personalization being addressed in this report is a means of securing the delivery of 'collective' provision. There are those who argue for individualism and self-funding but this a different approach to public service provision and finance. It is critical that collectively organized personalization is not confused with individualism, deliberately or otherwise.

In summary, the consequences for service users, providers and commissioners of personalization are going to be profound. This is not a policy area that should be dominated or drowned-out by 'noise' from vested interests or any kind of ideological dogma—from whatever direction.

This report is a genuine attempt to be honest about the direction of travel, to stimulate a debate to get it right, to provide an initial template for that debate, and to point out where some of the challenges lie. This debate and discussion needs to start right now. ■

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