Chapter 4
When is Personalisation Considered a Form of Co-production? The Case of Personal Budgets Reform in English Social Care

Enrico Bracci and Danny Chow

4.1 Introduction

In recent times, co-production has become an all-embracing term applied in different contexts and with several meanings. Broadly speaking, co-production can be considered any "regular, long-term relationships between professionalized service providers and service users" (Bovaird 2007, p. 847). Osborne and Strokosch (2013) differentiated co-production into three categories: operational, strategy and service. Although some of these categories may overlap, the focus of the present chapter is on the operational model of co-production.

In particular, this chapter considers how the personalisation policy of social care in England was translated in practice and if it can be considered a form of co-production. In the mid-2000s, Individual Budgets (IB), and its related programme Personal Budgets (PB), represented a suite of reform programmes underpinned by accounting-centric notions of personalised co-production of public services. These programmes, with PB at the centre, reflected the government's drive to transform public services through personalisation. The basic rationale is that by giving 'clients' (users of public services in receipt of social support) control over the money used to fund their social care, it is implicitly assumed that this will facilitate the alignment between the care received and the clients' needs and preferences (Duffy 2007).

Although this chapter is the joint effort of both authors, the sections can be attributed as follows: Sects. 4.1, 4.2, 4.3 and 4.6 to Enrico Bracci, Sects. 4.4 and 4.5 to Danny Chow.

E. Bracci (✉)
University of Ferrara, Ferrara, Italy
e-mail: enrico.bracci@unife.it

D. Chow
Durham University, Durham, UK

M. Fugini et al. (eds.), *Co-production in the Public Sector*,
PoliMI SpringerBriefs, DOI 10.1007/978-3-319-30558-5_4

In contrast, the traditional approach to social care delivery relied on services delivered by local authorities (LAs) within a public administration paradigm (Osborne 2006). Under this approach (which is still practiced in many LAs), social care managers were solely responsible for assigning services to clients. The introduction of PB was intended to encourage LAs to adopt more flexible and creative ways of providing social care through the joint and pro-active involvement of service users (Wilberforce et al. 2011). Under PB, the care budget is devolved to the user, based on the level of need. The responsibility to assign a personal budget to the customised services/goods is placed at the user level through the mediating role of care manager (Needham 2011).

The PB concept is thus more in line with recent innovations in public service delivery, which extends beyond traditional service planning and management towards the co-production of public services (Fotaki 2009). The introduction of personalisation in social care affects the overall governance of power and responsibility, specifically from central government to LAs, and from care managers to service users (Duffy 2007). An attempt at conceptualising the trend of personalisation in social care then is to view it as an operational form of co-production (Osborne and Strokosch 2013). From this perspective, the service user is expected to engage with, and is engaged by, professionals in the design of the service. The dynamics of the engagement is then said to empower the service user, aligning expectations with their experience of service delivery. The on-going debate is on whether personalisation as a concept, and the personal budget as a core technology, can be construed as a type of co-production. This chapter aims to address this unresolved issue of definition.

The rest of the chapter is structured as follows: Sects. 4.2 and 4.3 review the literature on co-production in social care. Section 4.4 is a description of reforms centred on personalisation in England and its main features. Section 4.5 describes the structure and use of personalisation process and a personal budget, and presents the analysis of personalisation and co-production as a shared responsibility. Section 4.6 concludes the chapter.

4.2 Co-production in Social Care: Literature Review

In public services, and in social care services in particular, the active participation of and inputs from users have always been considered key determinants of effective outcomes. Users of social services already make contributions at the different stage of the process: from assessment to planning, from commissioning to implementation and so forth (Hunter and Ritchie 2007). However, the concept of co-production, despite being first mooted in the 1970s, faded away and fell into disused in the 1980s. The main reason was the increasing popularity of New Public Management (NPM) then, in which rational concepts of reorganising the public sector (embodied in ideas such as efficiency and effectiveness) and the wider use of quasi-market tools (e.g., competitive tendering and vouchers) envisaged users as individual consumers.

In social care, co-production then was marginalised by two competing organising philosophies of welfarism-professionalism and consumerism-managerialism (Pestoff 2009). Welfarism and professionalism conceived of a strong role for the State in designing, planning implementing and reviewing the social services, leaving no room for users' involvement. On the other end of the scale, consumerism promoted the creation of market mechanisms with users behaving as customers. As a consequence, users who are unsatisfied with services received are expected to rely mainly on exit mechanisms (like the notional consumer) by choosing a different provider available in the market. In such situations, co-production was not considered as a solution to improve efficiency and effectiveness of the social services.

However, the failure of reform programmes operating under the NPM banner to deliver all of its promises has led to the revival of co-production as a principle for the reorganisation of public services. Perceived inadequacies of NPM has also led academics to shift towards a New Public Governance (NPG) mode (Osborne and Strokosch 2013; Osborne 2006). As previously noted, the genesis of co-production is not new. In the 1990s, some scholars have suggested that the management of social care should replace managerial theories derived from the manufacturing industry with the co-production framework (Wilson 1994).

The return of co-production in debates around the management and organisation of social care discussion can be attributed to the following reasons (Needham et al. 2012, pp. 2–3):

- A reduced faith in target-based and market process.
- An increased call for devolution of power up to the users/citizens.
- A pressure to increase efficiency and reduce public spending.
- The growing awareness of the importance of the knowledge generated via the user interaction.
- An increased determination to make social care more personal, increasing the effective participation of users.

As a delivery mechanism for social care services, co-production is not new, given that the interaction between users and social workers has always been critical to achieving a successful outcome. However, the ways in which co-production may take place can be several and with different characteristics. Needham et al. (2012, pp. 9–10) suggested at least three types of co-production in social care:

(1) *Compliant (or descriptive) co-production*: this is the most basic form of co-production. Social services can only be delivered if the user takes part in the process. The process can highlight compliant of procedures without the necessary deep engagement in bringing about meaningful change. Under this form of co-production, the service provider and the user agree on the definition of the problem, and the design and implementation of the possible solution. This type of engagement is not set up to significantly change users' lives.

(2) *Supportive (or intermediate) co-production*: this form involves wider recognition of the diversity and importance of roles around the user. More responsibilities are given to the users in defining outcomes and in direct problem solving of complex issues.
(3) *Transformative co-production*: it has the potential to create additional relationships between the users and social workers that support them. Users are given a more pro-active role in shaping the services and the social workers alike. At this stage, all opportunities given by co-production are exploited and social care becomes more attentive to the variation in needs of individuals and to the wider context of social care.

Indeed, co-production in social care aims to have a transformative role, affecting not only the provision of public services, but also users' lives (Realpe and Wallace 2010). It recognises the active role and contribution in the successful delivery of social care, while at the same time the empowerment of social workers when dealing with the users. Wilson (1994) explains that the extent to which social care can be co-produced depends on several issues:

(a) *Normative*: laws and regulations may define some limitations and/or obligations in the use of forms of co-production. This may be due to the risk involved (i.e., mental illness), or the need to control funding.
(b) *Ethical*: co-production may involve choices considered valuable for the user but not necessarily for society as a whole. Consider, for instance, the case of a user buying a seasonal football ticket to increase his or her autonomy and assimilation with other members of the society—Would this be universally considered social care? Questions can also be raised as to its appropriateness as a use of public funds.
(c) *Equity*: co-producing means also to design and implement services specifically tailored for a single user or a small group. Such a situation may lead to unfair differentiation and access to resources.
(d) *Technical*: co-production requires adequate staff in both quantity and expertise, as it can be time-consuming and challenging to implement, mainly because staff expertise has to be built through training and experience.
(e) *Organisational*: co-production may challenge the efficacy of existing systems of service delivery and threaten the organisational hierarchy. Existing modes of public sector operations are seen to be less efficient and more paternalistic compared to co-production, leaving them vulnerable to downsizing or even to closure.
(f) *Financial*: co-production requires an additional and secure source of funding in order to sustain the process, alongside current spending on social care, which could be challenging in austere periods for the public sector.

It is not surprising that the Social Care Institute for Excellence (2013) foresaw four areas of change needed in order to implement a co-production model in social care:

- *Culture*: in terms of individual and/or organisational beliefs, values and principles at work.
- *Structure*: the organisational patterns, the way resources are allocated.
- *Practice*: the way co-production is carried out by the organisation, in terms of processes and technologies used.
- *Review*: controlling and evaluating the results achieved and learning how to improve what went wrong.

There are many scenarios where co-production is an appropriate mode of social care delivery. Co-production can be used with different people in disparate social contexts and conditions. Co-production can benefit from the users' knowledge in creating value and improving the services and foster the development of peer-support mechanism between users. Through the continuous interaction between the actors involved, new knowledge is then created and new outcomes for public services will be defined, potentially leading to improvements in value for money. Overall, co-production could nurture the development of social capital in the community, through networking and self-support among individuals and associations.

In the context of social care, it is important to distinguish between different types of services under co-production, ranging from long-term care to short-term interventions. In the former case, like care for the elderly and the frail people, users and social workers are formally linked to each other for extended periods, for which voice is the only governance option if users are disgruntled with the service received. The salience—meaning the scale of relative importance of the services to the individual user—of this type of services is high and co-production may support the creation of public value. The concept of public value has many definitions and proposals and has been equated with many things, however using Moore (1995) public value can be defined as: "A framework that helps us connect what we believe is valuable and requires public resources, with improved ways of understanding what our 'publics' value and how we connect to them".

At the other extreme, the second case of short-term services, such as home-based care, allows users to exercise exit strategies in case of complaints over the quantity and quality of services. Pestoff (2012), in combining the salience of social services and the ease of involvement of users, proposed a two-by-two matrix (Table 4.1) to frame co-production opportunities.

It is not surprising that access to participation is key to determining the opportunities for co-production, with users being able to transit from passive client to active consumer. The extent to which involvement is possible depends not only

Table 4.1 Citizen involvement in social service co-production

Salience	Accessibility and engagement	
	Low	High
Greater	Active consumer	Active co-producer
Less	Passive client	Ad hoc participant

Source Adapted from Pestoff (2012, p. 25)

on the type of services, but mainly on the regulatory conditions and the organisational choices made by each public sector organisation. As Pestoff (2012) stressed, both NPM and traditional public administration logics tend to reduce access to participation, with the former advocating a consumerist approach that actively exercises choice amongst a variety of service providers, whilst the latter mandating users passively receive services assigned to them.

4.3 Conceptualising Co-production

The previous sections and the introductory chapter earlier in this book have illustrated some of the complexity and challenges in trying to define and conceptualise what co-production is or is not. We draw on Pestoff's proposed concepts, which argue that the salience, or importance of a particular service to the user, and the accessibility and engagement of the service with the user, forms the basis for understanding the relationship between personalisation and co-production. This is also Brandsen and Honingh's (2015) starting point, which overlaps with Pestoff's concepts. Brandsen and Honingh (2015) considered two main variables:

(1) The degree of involvement of users both at the design and implementation stage;
(2) The closeness between the core service of the public service organisation and the tasks performed by the users.

In combining the above variables, four possible case-situations are possible:

- *Complementary co-production in service design and implementation*. When users perform tasks that are complementary to those of the public service organisation, but co-produce both the design and implementation. As an example, an elderly group organising cultural activities at the local museum. In such cases, users are not involved in the core activities of the organisation.
- *Complementary co-production in implementation*. In this situation, users are not involved in the design of complementary activities, but co-produce the actual implementation. As an example, handicapped users helping social workers in preparing a theatrical production.
- *Co-production in the design and implementation of core-services*. It occurs when users are involved in both the design and implementation of activities representing the core mission of the organisation. As an example, a user with mental health issues defining the psychological and/or behavioural improvements and the activities to be implemented in order to achieve them.
- *Co-production in the implementation of core services*. It occurs when users are involved not in the design, but only in the implementation of the organisation's core activities. In such activities, users' involvement and participation in the implementation phase are crucial for outcomes, but these are framed within the context of professionally determined solutions.

4.4 Personalisation Agenda in England and Co-production

The etymology of 'personalisation', as applied to public services, is as ambiguous as co-production itself. It is often used in relation to different things and describing different policy decisions. Personalisation is sometimes linked to the transference of risk and responsibilities to the users, or as a new mode of engaging users.

In England, the debate on personalisation can be dated back to the beginning of the new century, within the modernisation manifesto of the Labour Government (Ferguson 2007; Gardner 2011; Glendinning 2008). Social movements such as "In Control" and "Independent Living" provided the initial drive to improve social care and social work through personalisation initiatives (Duffy 2007; Leadbeater 2004). Table 4.2 summarises the main policy documents that were produced to implement personalisation as a new mode of planning, designing, delivering and assessing social care, but also healthcare and education. From the 2006 white paper "Our health, our care, our say: a new direction for community services", to the 2011 Think Local Act Personal (TLAP) agreement, the discussion in England was centred on how social care can be personalised in order to meet wider public sector objectives using resources more efficiently and improving the care outcomes.

Personalisation is a social care approach described by the Department of Health as meaning that "Giving people greater choice and control over the services they use, we also need to ensure that everyone in society has a voice that is heard. When people get involved and use their voice they can shape improvements in provision and contribute to greater fairness in service use" (Department of Health 2006, p. 165). Personalisation is primarily a way of thinking about services and those who

Table 4.2 The personalisation policy in England: a retrospective view

Year	Act/document	Content
2006	White paper "Our health, our care, our say: a new direction for community services"	Users should have a bigger voice over the care they receive Introduced the individual budget as the means to achieve personalisation
2007	White paper "Putting people first"	Increased choice and control in adult social care, focusing in prevention, enablement and high quality of personally tailored services
2010	White paper "Equity and Excellence"	Strengthened the potential of personal budgets to improve outcomes
2010	DH paper "A vision for Social Care"	Confirmed a greater rollout of personal budgets and direct payments to increase choice and control Stresses the role of community action to increase the social capital
2011	Think Local, Act Personal (TLAP)	Sector led approach to improving personalisation and building community capacity

use them, rather than being a worked out set of policy prescriptions. Carr (2010, p. 67) argued how personalisation requires 'thinking about public services in an entirely different way—starting with the person rather than the service'. It also encompasses the provision of improved information and advice on care and support for families, investment in preventive services to reduce or delay people's need for care and the promotion of independence and self-reliance among individuals and communities (Carr and Robbins 2009).

Such policies subsequently formed part of a broader debate that has linked public service reform more generally with the role of the citizen, 'co-production' processes, and a 'double devolution' of power away from state bureaucrats towards LAs, and to frontline professionals and end-users (Needham 2011). Power and responsibility to choose the service is shared between users and providers, within the budget and the care plan assigned by the professionals (Bracci 2014). In this sense, the user co-designs and co-produces a personalised type of care, based on his/her needs. Professionals, under this scheme, supervise and control the outputs and outcomes achieved through the care received.

The outcomes/consequences of the personalization agenda are still under debate and show a mixed picture. Some research showed that early PB adopters experienced improved autonomy and control over their daily lives (Glendinning et al. 2008). Others outlined negative consequences in terms of diluted public accountability when risks and responsibilities are devolved (Bovaird 2007), and/or the de-professionalization of social care that marginalizes the role of social workers (Ellis 2015).

Despite the criticisms, PB is in line with the overall tendency to go beyond the traditional conception of service planning and management, "where public officials are exclusively charged with the responsibility for designing and providing services to citizens, who in turn only demand, consumes and evaluate them" (Pestoff 2006, p. 506), towards more co-production of public services. However, it is important to differentiate between the delivery mechanism (the budget), and the approach (personalised care, person-centred support). For example, the process of assigning a budget to a user is not co-production per se, but it may become co-production in relation to the support methods adopted, the social networks built and the overall availability of quality services in the market.

Indeed, co-production does not only involve the choice of the provider of a service, but also the co-planning and co-delivery of what is ought to satisfy the user's need (Pestoff et al. 2006; Pestoff 2006). Pestoff (2006) argued that co-production qualifies when a mix of activities occurs involving both public services agents and citizens to the provision of public services. Co-production refers to the active involvement and empowerment of users, as well as the community as a whole, in designing, delivering and consuming public services (Brudney and England 1983). In this sense, personalisation means a move from "one best way" of doing things to a repertoire of possible choices. Individual personalisation is considered particularly relevant in case of so called "soft" public services (Brudney and England 1983) like education as well as welfare services. In particular, within the different patterns in which co-production can occur, reference is made to the

concept of consumer co-production (Osborne and Strokosch 2013). In a consumer co-production type, the aim is to empower users by engaging them at the operational stage of service production in order to balance expectations and experience of the service (Osborne and Strokosch 2013).

4.5 Personalisation and Co-production as a Shared Responsibility

Personalisation and personal budgets are, thus, two distinct but linked features of social care provision in England. Although the up-take of PB in 2013 involved some 30 % of all eligible users, the government is committed to widening the reach and scope of personalisation. The changes, compared to the previous systems, are numerous, particularly in terms of distribution of responsibility and accountability. In fact, a concern raised by the introduction of co-production is the potential dilution of public accountability (Bovaird 2007). Indeed, personalisation of social care involves the devolution of responsibility and power down the line to the individual user (often referred to as the 'client' by our interviewees at the local authority). This user/client is now being institutionally reconstituted as an 'accountable' person (Bracci 2014).

Table 4.3 summarises the main changes brought about by the introduction of personal budget in particular.

Users become responsible not just for the use of money available, but most of all for the choice and design of the services in order to achieve the desired outcome. By agreeing to manage a personal budget, the user become accountable for its use and the results achieved. Higher up the organisational chain, care managers share responsibility for the design of services needed within the mechanism of the users' support plan. The expectation is that users who are also PB holders and their care managers should be involved in a continuous process of dialogue in order to shape the most suitable choice of services that can fulfil the expected outcomes.

It is important to note that whilst the role of social workers is not being diminished with the advent of PB, there is a recognition of the significant shifts in skills required to deliver and manage social care, which ranges from emotional labour, implementing statutory mandates, to financial planning and management. For example, social workers are now expected, as part of the wider redefinition of care delivery under PB, to be aware of the need to manage well the mix between budget finances and service procurement. Carr (2010) identified the new skills needed as being the following:

- Decision-making—helping service users decide whether a direct payment or council-managed personal budget is right for them.
- Needs assessment and resource allocation—assessing service users' needs, or supporting them to assess their own needs, and allocating a budget to meet them, based on a resource allocation system.

Table 4.3 Responsibility and accountability changes through PB

Actor	Before PB	Under PB
Clients	Limited or absent responsibility for the choice of the services	Responsible for the choice of the services and the outcomes to be achieved (Support Plan)
	Not relevant or accountable on the use of money (if direct payment)	Accountable on the use of money and the outcome achieved
Care managers	Responsible for the type of services provided to clients	Co-responsible for the choice of the services and the outcomes to be achieved (Support Plan)
	Accountable for achieving financial target and performance measures (star systems)	Accountable on the use of money and the outcome achieved, as well as other performance measures (star system)
Local authority	Responsible for the provision of services and the financial targets	Responsible for the creation of the market place (commissioning) and the achievement of performance targets on IB and financial targets
	Accountable under the performance assessment and indicators	Accountable under the performance assessment and indicators

Source Bracci (2014)

- Reviewing the size of a personal budget—in case that a person's personal budget is insufficient to meet his/her needs, the social worker would take the case to a LA funding panel.
- Support planning and brokerage—drawing up a support plan in partnership with the service user and their family, and brokerage, i.e., providing information on or sourcing services to implement the support plan (see Fig. 4.2 as an example).

The complexity of the tasks resulting from a shift to PB implies that the personalisation of social care in England is more constitutive of a process involving not just socio-psychological needs assessments, but also financial budgeting and managerial skills in managing the out-sourced procurement of services. Figure 4.1, based on our observations of PB implementation at an anonymous English local authority, sketches the main phases of a personalised care within this processual outlook. The case organization is a medium size local authority in a large conurbation in northern England that provides a whole range of social care services, such as elderly home and residential care, adult social care and child social care.

Within the PB scheme, the work of social workers starts with the contact assessment, during which the user asks for support for his/her own needs. The process makes it clear that personalisation is embedded within the system from the very beginning. Users are required to fill a Needs Assessment Questionnaire (NAQ), or a Resource Allocation System (RAS) as it is called in some other LAs, which is designed to individually configure the requirements of users. The self-assessment data, in simple cases, leads to the quantification of the indicative budget allowed to the user. In more complex cases, the NAQ is then fed to an expert panel, composed by social workers, responsible for setting an indicative budget

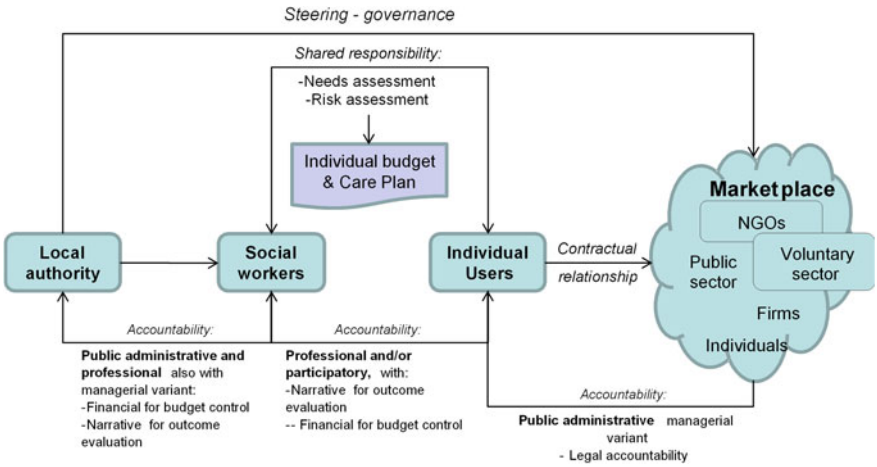


Fig. 4.1 Personalisation: the responsibility/accountability relations in the new governance

based on an assessment of the level of support needed, which is further mediated by the social worker's professional evaluations. In this phase, the expert group can focus on the level of risk involved (for instance if the eligible user has a drug addiction problem), or on other issues which requires a specific assessment. Before a user is eligible to manage their own PB, he/she is further assessed for the potential risk of abuse, safety and freedom from harm and discrimination.

Upon conclusion of the assessment, users will then be notified of their eligibility for a PB as well as the indicative budget awarded. Subsequent to approval, the user, in collaboration with the care manager, sets out to develop a personal support plan, describing the way the money will be spent and the outcomes to be achieved. In this phase the user, together with the social worker, has to estimate the cost of the services he/she would like to buy with the PB. The support plan will periodically be subjected to scrutiny of actual monies used and outcomes achieved. This happens when the support plan is referred to the Board and Administration (B&A) of the local authority. As an example, the NAQ (or RAS) is intended to give users some level of power, control and responsibility over their needs.

The support plan and the outcome matrix represented important technologies that had a dual use—planning and control on the one hand and financial accountability on the other (Bracci 2014). This reveals a process of sharing/delegating responsibility between the local authority and the user. The number of actors involved in the delivery of PB expands as the need of governing and coordinating mechanisms increases. In a governance network, the relations can be interpreted in terms of the vertical and horizontal nature of relationships between actors. In particular, it is relevant to assert "to whom" and "from who" and by "which means" accountability is being rendered (Bardach and Lesser 1996).

As depicted in Fig. 4.1, the actors involved in the process of governing and delivering PBs are the followings:

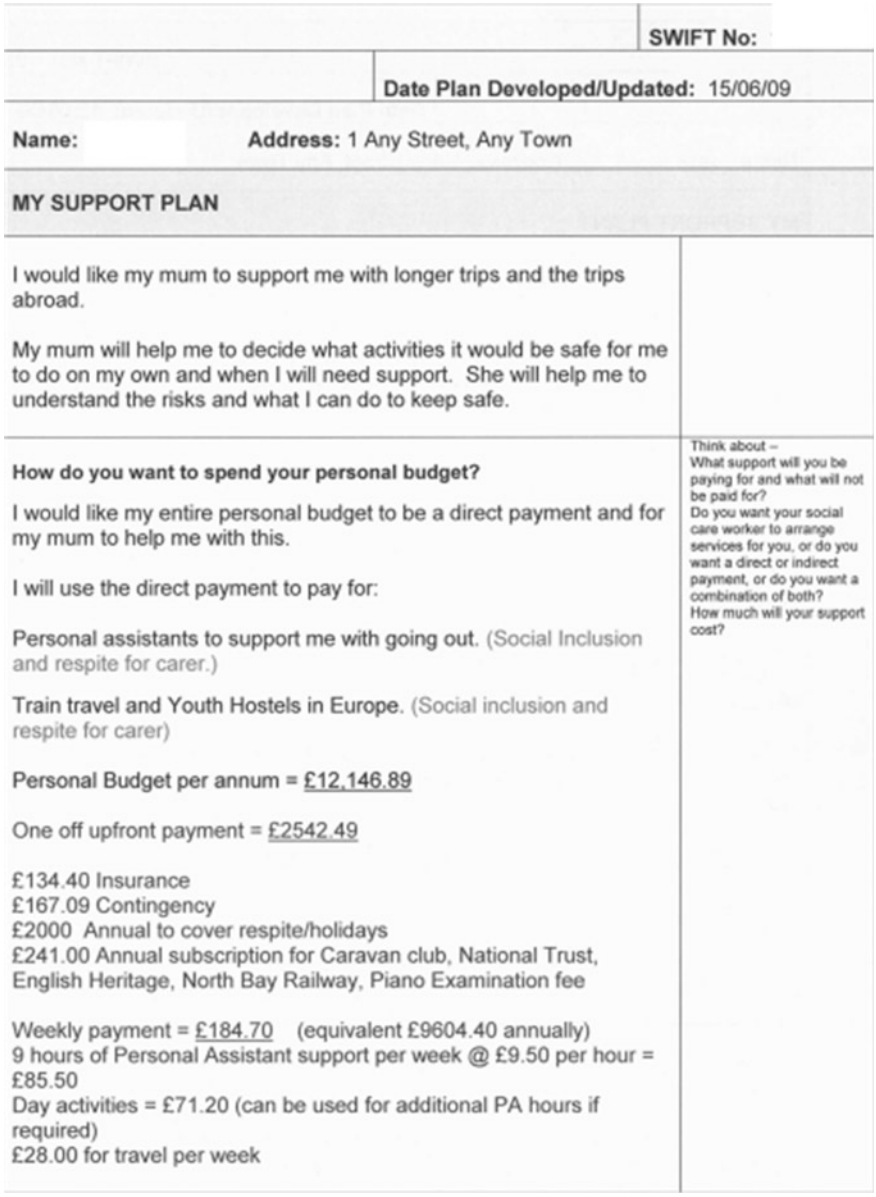
- The local authority steering and governing the market place for PB provision of supply services and organising the social service provision;
- The social workers responsible to assign PB within a care plan toward a stated outcome, to support users in the design and implementation of the support plan;
- The individual user responsible for the design and implementation of the support plan and of the use of PB within a care plan and to achieve the stated outcome;
- The market place "enrolled" to provide the services required by the individual user.

The user and the social worker, after the indicative budget is set, start a process of co-planning. During this phase, the plan will describe the user's assessed needs and expected/desired outcomes, the ways in which this can be met through the procurement of services, the cost of services required and agree on how the outcomes will be evaluated. The aim is to hand over more power, control and responsibility to the user (Bovaird 2007). Indeed, under PBs the user is left free to choose, for example, what type of care and how often to receive the support, within the total amount assigned and the care plan arranged. This process can appear creative in some cases, as user involvement means that original and sometimes even unusual approaches to working out care solutions are not uncommon. There are safeguards to the amount of creativity allowed, as ultimately social workers will have to vet PB plans and service delivery. In this respect, PB is more than a change in the way social care is delivered; it is also a cultural change both for professionals and for users.

In Fig. 4.2, the policy of the (anonymous) local authority observed is to empower users by giving them the freedom to come up with their ideas about how to spend the PBs, rather than imposing a schedule of 'allowable choices'. From the LA's perspective, the control is to be explicit upfront over activities and/or services that are disallowed, but otherwise granting freedom and trust to the user to choose the service most relevant. Once the support plan (also called *care plan*) has been drawn up, it is subjected to scrutiny by an internal panel made up of care managers and other social workers. Subsequent to the approval of the plan, the social worker and user share joint responsibility for its implementation and other associated risks.

Personalisation therefore differs notably from traditional means of delivering public services, where the full responsibility and risk over the choices made to satisfy the citizens' needs are borne by the government alone (Pestoff 2006). In the context of PBs, the active participation of users is intended, by design, to reduce the government and professionals' responsibilities (Ackerman 2004) by devolving part of the risks of decisions made and day-to-day management to the user. This shift of responsibilities through joint determination is differentiated from a NPM-oriented approach, in which users are given money to "buy" the services available from the marketplace.

Figure 4.2 illustrates a typical support plan. As previously explained, a user, with the support of the social workers, would set out the type of support he/she thinks will need. Time and other expenses are also quantified. The budget is given



SWIFT No:

Date Plan Developed/Updated: 15/06/09

Name: **Address:** 1 Any Street, Any Town

MY SUPPORT PLAN

I would like my mum to support me with longer trips and the trips abroad.

My mum will help me to decide what activities it would be safe for me to do on my own and when I will need support. She will help me to understand the risks and what I can do to keep safe.

How do you want to spend your personal budget?

I would like my entire personal budget to be a direct payment and for my mum to help me with this.

I will use the direct payment to pay for:

Personal assistants to support me with going out. (Social Inclusion and respite for carer.)

Train travel and Youth Hostels in Europe. (Social inclusion and respite for carer)

Personal Budget per annum = £12,146.89

One off upfront payment = £2542.49

£134.40 Insurance
£167.09 Contingency
£2000 Annual to cover respite/holidays
£241.00 Annual subscription for Caravan club, National Trust, English Heritage, North Bay Railway, Piano Examination fee

Weekly payment = £184.70 (equivalent £9604.40 annually)
9 hours of Personal Assistant support per week @ £9.50 per hour = £85.50
Day activities = £71.20 (can be used for additional PA hours if required)
£28.00 for travel per week

Think about –
What support will you be paying for and what will not be paid for?
Do you want your social care worker to arrange services for you, or do you want a direct or indirect payment, or do you want a combination of both?
How much will your support cost?

Fig. 4.2 The individual support plan: extract

directly to the user, or to a broker appointed by the user or managed as a virtual budget by a social worker. In the first case, the user is required to account for the actual use of the money and, through an annual review, to evaluate the outcomes achieved. The support plan, as illustrated in Fig. 4.2, used plain English that is free

of any technical jargon, in order to ensure that users are comfortable with the process, regardless of their language and communication skills.

The support plan is a technology designed to actively engage the user into a reflective dialogue with his/her social worker through the construction of objectives, action points, timelines and budget allocations. The support plan in Fig. 4.2 exemplifies how co-production could materialise within a Personal Budget scheme, as the user together with his/her social worker iteratively revise the support plan until they come to an agreement. The process of co-production ends when the care/support plan is approved and allocated a budget. The next stage of the personalisation process, which extends beyond co-production, is the implementation phase of the designed service and of the accountability process. In presenting the support plan, the user takes full responsibility over the way public money is to be spent and for what purpose. Users are made aware that, in case of abuse (e.g., unauthorised used of funds), the PB will be suspended indefinitely. The social worker also shares responsibility in signing off the PB support plan.

Co-production, and, therefore, trust between social workers and users are based on co-decision and co-planning of the support plan. Whilst ironically some social workers compared this joint decision making process to traditional paternalistic roles of social services under the welfarism-professionalism mode, a key differentiator is that user self-determination is at the very heart of social work practice. This notion of self-determination supports the claim that personalisation is a return to 'true' social work, through the nurturing of vulnerable or marginalised users' independence and the wider societal inclusion that managing a budget and being in charge of one's own treatment can bring (Leadbeater 2004). However, there are no guarantees that the personalisation process and the personal budget will lead to more substantive engagement between users to co-produce the service. The low level of PB uptake, when compared with the Government's target, suggests that there is still a way to go before the full-expected benefits of cultural and policy change can be realised.

4.6 Discussion and Final Reflections

The aim of this chapter was to understand the policy-oriented shift towards personalisation in social care, and address the issue of whether personalisation can be considered a type of co-production. It is important to separate the concept of personalisation from the process of applying personal budgets to adult social care in England. While the latter can be considered the means through which personalisation happens, the former is the rationalisation to make care more tailored to the individual. In other words, personalisation is a process of designing and implementing a social care plan, which is then put into practice using instruments such as PBs.

In order to establish whether the personalisation of care through the use of PB can be considered a means of co-production, users need to be supported by public

organisations to develop the social networks necessary to support co-production. Users must be given an active role, pooling their resources with those of the public and social workers.

As Table 4.4 stresses, personalisation may only be considered as co-production if it is implemented within a citizenship model oriented to social justice and inclusion. If personalisation is reduced simply to the transfer of money and responsibility to purchase services in the open market, the joint decision making process that underpins co-production would cease to exist. In such situations, local authorities are thus relegated to the role of gatekeepers, responsible only for assessing PB eligibility and maintaining a market place for users to purchase services required. This would not be co-production, but instead represent a consumerist view of social care with a passive role for the users and where public sector organisations are absolved of joint responsibility for the decision, provision and active management of care delivery.

It is clear that personalisation cannot deliver co-production in every single case, since co-production involves an active role by both parties and the pooling of resources. As some research on the evaluation of PB showed (Hatton and Waters 2013), users may not even know how their PB are being used, and/or don't have the proper information and knowledge on how to use it. At the institutional level, some authors argued that the implementation of PB by local authorities can be seen as a cynical way to devolve risk and responsibilities to budget holders (Ferguson 2007; Junne and Huber 2014), especially during periods of austerity with decreasing levels of public funding (Bracci and Chow 2015).

In reflecting back on the conceptual framework, personalisation can potentially be considered as a non-complementary form of co-production in the design and in the implementation of core and no-core service. Under PB, the process of constructing the support plan can lead to the design of a core service, pooling knowledge and resources from both sides. At the same time, the actual implementation of core services designed through the support plan could conceive of a more active and involved role for users and carers working towards mutually agreed

Table 4.4 Citizenship model and co-production

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

Source Adapted from I&DeA (2009, p. 43)

outcomes. In this process, additional non-core services can be considered in both the design and the implementation of core services.

Personalisation can, thus, be considered as a co-production only if the relationship between the social worker and user starts from the design and following implementation of both core and non-core complementary services. Plans devised solely by local authority and/or the social workers at the implementation stage cannot be considered personalised care.

Overall, personalisation, by its very nature, entails the design and the implementation of care involving substantive input from all actors within the wider community. Only when this condition is met can personalisation be considered a form of co-production and be in a position to deliver the claimed benefits in terms of value for money. Such a view is consistent with Duffy's (2007), in that there is no guarantee that every individual PB programme will involve co-production. The latter can be considered as a desired aim of personalisation, but it should not be taken for granted. Only if the essential elements described above are present, real co-production is possible; otherwise personalisation is a façade for other political agendas both at the central and local government level. These socio-political dynamics are understudied, and needs to be taken into considerations by scholars both from a public management and accounting perspective in future research on the development of personalisation in social care.

References

J. Ackerman, Co-governance for accountability: beyond "exit" and "voice". World Dev. **32**, 447–463 (2004). doi:10.1016/j.worlddev.2003.06.015

E. Bardach, C. Lesser, Accountability in human services collaboratives-for what? and to whom? J. Public Adm. Res. Theory **6**, 197–224 (1996). doi:10.1093/oxfordjournals.jpart.a024307

T. Bovaird, Beyond engagement and participation: user and community co-production of public services. Public Adm. Rev. **67**, 846–860 (2007)

E. Bracci, Accountability and governance in social care: the impact of personalisation. Qual. Res. Account. Manag. **11**, 111–128 (2014)

E. Bracci, D.S.L. Chow, Personalised adult social care in England and boundary management: the role of accounting, in *IRSPM*, ed. XIX IRSPM Conference, 2015. Shaping the Future: Transforming Public Management—Re-Invention or "Revolution"? 30 March–1 April, (Birmingham, 2015)

T. Brandsen, M. Honingh. Distinguishing different types of coproduction: a conceptual analysis based on the classical definitions. Public Adm. Rev. (2015 in press). doi:10.1111/puar.12465

J. Brudney, R.E. England, Toward a definition coproduction concept. Public Adm. Rev. **43**, 59–65 (1983)

S. Carr, *Personalisation: A Rough Guide*, 2nd edn. (Social Care Institute for Excellence, London, 2010)

S. Carr, D. Robbins, *The Implementation of Individual Budget Schemes in Adult Social Care* (Social Care Institute for Excellence, London, 2009)

Department of Health, *Our Health, Our Care, Our Say* (2006)

S. Duffy, The economics of self-directed support. J. Integr. Care **15**, 26–37 (2007). doi:10.1108/14769018200700012

K. Ellis, Personalisation, ambiguity and conflict: Matland's model of policy implementation and the "transformation" of adult social care in England. Policy Polit. **43**, 239–254 (2015). doi:10.1332/030557312X655828
I. Ferguson, Increasing user choice or privatizing risk? The antinomies of personalization. Br. J. Soc. Work **37**, 387–403 (2007). doi:10.1093/bjsw/bcm016
M. Fotaki, Are all consumers the same? Choice in health, social care and education in England and elsewhere. Public Money Manag. **29**, 87–94 (2009). doi:10.1080/09540960902767956
A. Gardner, *Personalisation in Social Service* (London, 2011)
C. Glendinning, Increasing choice and control for older and disabled people: a critical review of new developments in England. Soc. Policy Adm. **42**, 451–469 (2008). doi:10.1111/j.1467-9515.2008.00617.x
C. Glendinning et al. *Evaluation of the Individual Budgets Pilot Programme Final Report*. (York, 2008)
C. Hatton, J. Waters, *The Second POET Survey of Personal Budget Holders and Carers 2013* (Think Local Act Personal, London, 2013)
S. Hunter, P. Ritchie, *Co-production and Personalisation in Social Care: Changing Relationships in the Provision of Social Care* (2007)
I&DeA, *Transforming Adult Social Care: Access to Information, Advice and Advocacy* (London, 2009)
J. Junne, C. Huber, The risk of users' choice: exploring the case of direct payments in German social care. Health Risk Soc. **16**, 631–648 (2014). doi:10.1080/13698575.2014.973836
C. Leadbeater, *Personalisation Through Participation: A New Script for Public Services* (London, 2004)
M.H. Moore, *Creating Public Value: Strategic Management in Government* (Harvard University Press, Cambridge MA, 1995)
C. Needham, Personalization: from story-line to practice. Soc. Policy Adm. **45**, 54–68 (2011). doi:10.1111/j.1467-9515.2010.00753.x
C. Needham, Q. Mary, S. Carr, *Emerging Evidence Base for Adult Social Care Transformation* (SCIE Res, Brief, 2012). 31
S.P. Osborne, The new public governance? Public Manag. Rev. **8**, 377–387 (2006). doi:10.1080/14719030600853022
S.P. Osborne, K. Strokosch, It takes two to tango? understanding the co-production of public services by integrating the services management and public administration perspectives. Br. J. Manag. **24**, S31–S47 (2013). doi:10.1111/1467-8551.12010
V. Pestoff, Citizens and co-production of welfare services. Public Manag. Rev. **8**, 503–519 (2006). doi:10.1080/14719030601022882
V. Pestoff, Towards a paradigm of democratic participation: citizen participation and co-production of personal social services in Sweden. Ann. Public Coop. Econ. **80**, 197–224 (2009). doi:10.1111/j.1467-8292.2009.00384.x
V. Pestoff, Co-production and Third Sector Social Services in Europe, in *New Public Governance, the Third Sector and Co-production*, ed. by V. Pestoff, T. Brandsen, B. Verschuere (Routledge, New York, 2012)
V. Pestoff et al., Patterns of co-production in public services. 37–41 (2006)
A. Realpe, L.M. Wallace, What is co-production? London (2010). doi:10.2805/87863
Social Care Institute for Excellence, *Co-production in Social Care: What it is and How to do it* (2013)
M. Wilberforce et al., Implementing consumer choice in long-term care: the impact of individual budgets on social care providers in England. Soc. Policy Adm. (2011). doi:10.1111/j.1467-9515.2011.00788.x
G. Wilson, Co-production and self-care: new approached to managing community care services for older people. Soc. Policy Adm. **28**, 236–250 (1994)