

Third Sector Research Centre

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The personalisation agenda: implications for the third sector

Dr Helen Dickinson and Professor Jon Glasby

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The personalisation agenda: Implications for the third sector

Abstract

Personalisation has been identified as being '*a cornerstone of the modernisation of public services*' (Department of Health, 2008: p. 4) and much interest in this concept has arisen recently. However, there is a high degree of confusion over what personalisation is and the types of changes that will be associated with this agenda. There are many ways in which the concept of personalisation might be interpreted, all of which have different implications for service users and service providers, particularly in terms of the mechanisms which have been introduced to try and facilitate these changes. Personalisation has a considerable history and has the potential to offer very different services to those that have been delivered in the past. Moreover, the underpinning philosophy of the personalisation movement is aligned with the types of values which a number of third sector organisations have been advocating for some time. Personalisation is more than a passing political fad and third sector organisations need to think carefully about how they will respond and shape the many changes which have already started to happen and that will increase in momentum over the coming months. This paper sets out the major features of the personalisation agenda and drawing on existing evidence sets out the key research, policy and practice implications of this for the third sector. Personalisation offers the potential for much improvement in terms of the way in which individuals with care needs are supported, but might also potentially mean significant changes for providers involved in the delivery of welfare services. It is important that third sector bodies understand these implications and are able to respond to these appropriately or else risk losing out in this change process.

Keywords

Personalisation, health and social care, personal budgets, individual budgets

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Introduction

'One thing that has emerged strongly from our research is that many third sector organisations are still not fully aware of the implications of this reform and how they should react to it' (Bartlett & Leadbeater, 2008: p. 32)

Personalisation has been identified as being *'a cornerstone of the modernisation of public services'* (Department of Health, 2008: p. 4) and much interest in this concept has arisen recently. However, there is a high degree of confusion over personalisation. There are many ways in which the concept of personalisation might be interpreted, all of which have different implications for service users and service providers, particularly in terms of the mechanisms which have been introduced to try and facilitate these changes. Some of these mechanisms (e.g. direct payments, individual budgets, personal budgets) have provoked controversy as these ultimately represent a different way of delivering welfare services, which can be perceived as threatening to some individuals, organisations and value bases.

Yet, personalisation has a considerable history and has the potential to offer very different services to those that have been delivered in the past. *'Personalisation is about giving people much more choice and control over their lives and goes well beyond simply giving personal budgets to people eligible for council funding'* (Social Care Institute for Excellence, 2009: p. 1). Moreover, the underpinning philosophy of personalisation is aligned with the types of values which a number of third sector organisations have been advocating for some time now (e.g. Blackmore, 2005). Regardless of the specific delivery mechanisms that are used to deliver personalisation, it would appear that this agenda is here to stay, with all the major political parties committed to this vision. Personalisation is more than a passing political fad. Against this background, third sector organisations need to think carefully about how they will respond to the many changes which have already started to happen and shape those that are still yet to develop over the coming months and years.

As the quote from Bartlett and Leadbeater set out above suggests, the concept of personalisation is not always well understood and many third sector organisations are unsure of how they should react in terms of the types of changes associated with this agenda. Writing for the NCVO, Harlock (2009: p. 8), states that *'personalisation is still evolving in terms of policy, implementation and practice and how we can turn the rhetoric of personalisation into an effective reality is as yet unclear'*. This paper sets out the major features of the personalisation agenda and drawing on existing evidence sets out the key implications of this for the third sector and for future research. Personalisation offers the potential for much improvement in terms of the way in which individuals with care needs are supported, but might also potentially mean significant changes for a whole range of different agencies and individuals involved in the design and delivery of welfare services. It is important that third sector bodies understand these implications and are able to respond to these appropriately or else risk losing out in this change process.

This paper has been informed by a number of sources conducted over a five month period that have been brought together to produce the exploratory findings set out in here. Initially, a structured literature review was carried out in order to uncover any peer reviewed literature that might pertain to

this topic. However, from the outset it was acknowledged that the amount of research that would exist in this area would be limited given the relatively early stage that the personalisation agenda is at in terms of health and social care. Therefore we also sought out 'grey' literature that may relate to the personalisation agenda by searching the websites of relevant agencies and organisations and through contacting a range of key stakeholders for any leads that they may have to such resources.

What we are interested in exploring in this paper are the potential implications of the personalisation agenda for the third sector and we have separated these into implications for research, practice and policy. In order to determine these, we could not rely solely on the rather limited evidence that exists in the mainstream peer reviewed literature but also needed to derive the perspectives of a range of different stakeholders.

We conducted stakeholder interviews with ten individuals spanning governmental, third sector, health and social care and academic posts. These semi-structured interviews asked a range of questions about the potential implications of the personalisation agenda for the third sector. In addition to these formal interviews, a series of informal conversations were also held with other stakeholders at variety of different events that relate to personalisation and were held around the country over the research period. These conversations were used to form a long list of the potential implications of the personalisation agenda for the third sector. Not all of these are set out here and there may be many more potential impacts than we have room for within this paper, particularly given the diversity of the third sector. Those reported here are those which appear to be most prominent.

These implications have been generated in order to identify a research agenda relating to third sector organisations that are engaged in delivering public services. The paper ends, therefore, with a set of research questions that TSRC will engage with in terms of its future programme of research.

A brief history of personalisation

Since 1997, disabled people in the UK eligible for adult social care have been able to opt to receive 'direct payments' (a cash sum in lieu of directly provided services). Originally pioneered by disabled people in the US, this way of working was introduced to the UK in the 1980s by disabled people's organisations, promoted by disabled people during the early 1990s, and introduced only after sustained lobbying by disabled people (see Glasby & Littlechild, 2009 for an overview). Subsequently, it has been disabled people who have been most active in providing support to direct payment recipients and in campaigning for further extensions and greater take-up. Almost more than any other current policy, this is a concept developed, implemented and rolled out by disabled people themselves. Moreover, the move towards greater self-directed support and individualised funding is an international phenomenon – with many developed countries experimenting with similar forms of what the US calls 'consumer-directed care' or 'cash and counseling' (see, for example, Alakeson, 2007; Robbins, 2006; Glasby & Littlechild, 2009). From the beginning, the campaign for direct payments was seen as part of a broader struggle for greater choice, control and independent living, with disability re-defined as being the social, cultural and attitudinal barriers to disabled people participating as equal citizens, rather than in terms of individual impairment (e.g. Oliver, 1996). Drawing heavily on thinking from other civil rights movements around race and gender, this

independent living movement has been very successful in challenging traditional attitudes and approaches to disability (e.g. Mercer, 2002).

Described as holding out *'the potential for the most fundamental reorganisation of welfare for half a century'* (Oliver & Sapey, 1999: p. 175), the 1996 Community Care (Direct Payments) Act represented the culmination of a longstanding campaign by disabled people and their allies to give people using social care services access to direct funds with which to design their own support. This Act overturned aspects of the National Assistance Act 1948 that prevented local authorities to provide cash payments to disabled people. Until this time the system of care that had been developed might be described as 'bureau-professional' (Clarke *et al.*, 1994) where disabled people were assessed by professionals and then assigned to services on the basis of availability. Scourfield (2005) argues that this Act was symbolically important as it demonstrated that the government of the time was taking the voice of disabled people seriously. While direct payments can be used to purchase services from a voluntary or private sector agency, many people choose to use the money to employ their own personal assistants (PAs), essentially becoming their own care managers. Initially discretionary, direct payments were soon extended to other user groups (including older people, carers, younger disabled people and people with parental responsibility for a disabled child), became a key performance indicator and were made mandatory (for people who meet the criteria and want to receive a direct payment).

Scourfield and others (e.g. Jack, 1995) have argued that changes such as the Direct Payments Act only represent a *'qualified form of empowerment'* (p. 470) as they do not alter the basic needs-based and means-tested basis of the English welfare system. Therefore, a key limitation of direct payments is that they have often been bolted on to existing traditional systems, where it argued that disproportionately onerous financial monitoring has on occasion reduced the scope for innovation (Glasby & Littlechild, 2009). In some localities, this way of working has also been seen as something of an 'optional extra' – an alternative to current ways of working that co-exists with the traditional system without necessarily challenging previous approaches (see Glasby & Littlechild, 2009 for further summary and discussion of these issues).

In contrast, the more recent advent of personal budgets seems to offer all of the advantages of direct payments, whilst also starting to transform the system as a whole. Personal budgets are a way of working pioneered by In Control. Set up in 2003 by the Department of Health, several local authorities and Mencap, In Control is a national social enterprise which has developed and is rolling out a new system of social care (often called self-directed support). In Control identifies what it considers the seven key steps to self-directed support as:

- **step 1** – Using In Control's resource allocation system (RAS), everyone is told their financial allocation - their personal budget - and they decide what level of control they wish to take over their budget;
- **step 2** - People plan how they will use their personal budget to get the help that is best for them; if they need help to plan, then advocates, brokers or others can support them;
- **step 3** - The local authority helps people to create good support plans, checks they are safe and makes sure that people have any necessary representation. This is a particularly important

part of the safeguarding process, as local authorities retain a duty of care and therefore have a key role to play in signing off support plans;

- **step 4** - People control their personal budget to the extent they want (there are currently six distinct degrees of control: ranging from direct payments at one extreme to local authority control at the other);
- **step 5** - People can use their personal budget flexibly (including for statutory services). Indeed, the only real restriction imposed is that the budget cannot be used on something illegal (as long as people are meeting their eligible needs);
- **step 6** - People can use their personal budget to achieve the outcomes that are important to them in their context of their whole life and their role and contribution within the wider community;
- **step 7** - The authority continues to check people are okay, shares what is being learned and can change things if people are not achieving the outcomes they need to achieve.

Following experience of Direct Payments, the English Government pledged to implement personal budgets across the whole of adult social care (Department of Health, 2008). In a slight complication, initial Department of Health pilots incorporated not only the social care budget (which is the prime focus of In Control), but also a series of additional funding streams, including various social security, housing and employment support funds. As a result, the tendency is now to use the term 'personal budget' to refer to the work of In Control and to innovations in adult social care, and to use the term 'individual budget' to refer to initial Department of Health pilots (which additionally sought to integrate a broader range of funding streams). Box 1 sets out definitions of the key terms which are found in discussions of personalisation. Box 2 provides an overview of In Control as an example of a third sector organisation involved in the design and delivery of personalised services.

Whilst definitions of the main terms used in discussions of personalisation may seem like an academic debate, they are important as a number of these terms have been used synonymously or incorrectly. Personalisation has often been equated with individual budgets, *'which were seen as the key, if not sole and main, route to achieve personalisation'* (Boxall et al., 2009: p. 505). Others have used the terms 'self-directed support' and 'individual budgets' as if they were the same thing, but as this section has demonstrated these are quite different concepts. This paper argues that personalisation is a broad outcome and direct payments, individual budgets and personal budgets are instead means or levers of achieving personalisation. Given the importance of the meaning of the concept of personalisation, it is to the issue of definitions that this paper now turns.

Box 1: Key definitions

Direct payments: introduced formally under 1996 legislation, the individual receives the cash equivalent of a directly provided service. This is available for social care only, and can be used to contract with a private/voluntary sector agency or to become an employer by hiring your own staff - it cannot be used to purchase public sector services.

In Control: national social enterprise, independent from government, which developed the concept of personal budgets and is supporting local authority members to implement this way of working.

Independent Living: a key aim of the disabled people's movement has been to achieve independent living (a situation in which disabled people have as much choice and control over their lives as everyone else). This does not mean doing everything yourself – in practice, no one is truly independent, and we are all interdependent on others to meet our needs as human beings.

Indirect payments: prior to the 1996 Direct Payments Act, many local authorities overcame uncertainties in the legal context by making indirect or third party payments.

Individual/personal budget: new way of working pioneered by In Control. At its most simple, it involves being clear with the person from the outset how much money is available to meet their needs, then allowing them maximum choice over how the money is spent/how much control they want over the money. Initially, the individual budgets developed by In Control were for social care funds only. Subsequently, Department of Health pilots began to explore scope for integrating a series of additional funding sources (and their use of the term 'individual budget' therefore tends to refer to a single pot with the potential to bring together all the various funding available to the individual). This paper follows current policy rhetoric by referring to 'personal budgets' for adult social care funds only, and to 'individual budgets' for more integrated sources of funding.

Self-directed support: the more general term used by In Control to refer to a new system of adult social care, based around In Control's seven steps.

(Glasby and Littlechild, 2009)

Box 2: In control: an example of a third sector organisation delivering personalisation

Building a series of small, local pilots, In Control is now a national membership organisation, with some 122 out of 150 local authorities in England having joined. From the beginning, In Control drew its inspiration from what might be described as an 'inclusion movement' of people with learning difficulties, their families and key allies who had been campaigning for many years to resettle people out of long-stay hospitals and develop more person-centred approaches in ordinary community settings. At its most simple, a personal budget is essentially about being clear with people from day one how much is available to spend on meeting their needs, and ensuring that the person and those close to them have as much control as possible over how this money is spent on their behalf. While a spectrum of support options exists (ranging from receiving the full amount as a direct payment through to having the local authority manage the money), the aim is to make sure that decisions are taken as close to the person as possible. Ideally this will be the person themselves, but could also be someone else who knows the person well and cares about them (for example, a family member or worker) if there are good reasons why the person cannot or does not want to take on this role (for example, if there are concerns about capacity or adult protection). In Control suggests that this amounts to little more than 'sensible delegation' (personal communication), and can free up the time of trained social workers to focus on those who need to most help to plan their support.

What is personalisation?

Personalisation is defined broadly by central government as *'the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive'* (HM Government Policy Review, 2007: p. 7). It is argued that personalised services start with individual service users, rather than the services themselves as the public sector has traditionally done. Leadbeater (2004: pp 18-19) suggests that personalisation is *'a new organising logic for service provision...as influential as privatisation was in the 1980s and 1990s in reshaping service provision'*. Personalisation is becoming a central theme in the reform of health and social care under the New Labour government (Darzi, 2007; Darzi, 2008; Department of Health, 2009; Department of Health, 2007), but is by no means a new concept. Furthermore, as Pykett (2009: p. 393) notes, an interest in personalisation is not confined to England but references to this are made by the other UK governments of Wales, Scotland and Northern Ireland, in addition to Canada, New Zealand, USA, Australia, France and South Africa.

As argued above, for a considerable period of time growing dissatisfaction has been expressed by disabled people about a lack of flexibility and the unreliability of welfare services. Traditional modes of social delivery have been argued to produce the dependency of individuals, rather than promoting independence, and to prevent disabled people from obtaining full citizenship rights (Morris, 2006). Boxall *et al* (2009: p. 504) argue that

'those promoting personalisation often contrast the 'one-size-fits-all' approach of standard services with this more 'personalised' approach where services and supports are tailored

and customised to match the needs and preferences of an individual, offering them 'choice and control'.

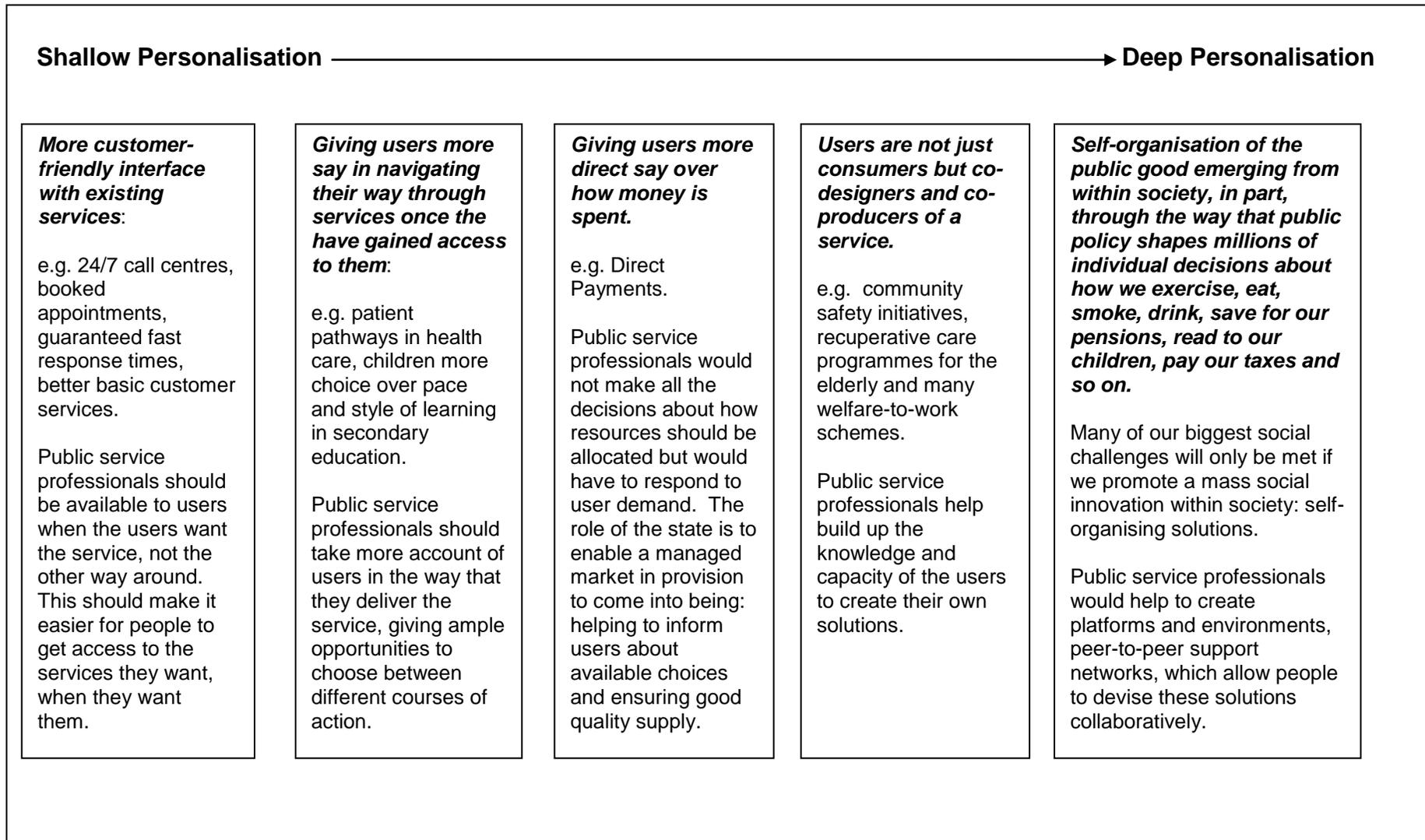
Personalisation is therefore a broad outcome in the sense that it is ultimately about active citizens (as opposed to passive recipients), co-producing services which allows them to live life in a way in which they have determined. However, personalisation is not uncritically accepted as a positive development by all commentators. Ferguson (2007: p. 401) argues that,

'in its uncritical acceptance of the marketization of social work and social care; in its neglect of issues of poverty and inequality; in its flawed conception of the people who use social work services; in its potentially stigmatizing view of welfare dependence; and in its potential for promoting, rather than challenging, the deprofessionalization of social work, the philosophy of personalization is not one that social workers should accept uncritically'.

David Miliband (then Minister of State for School Standards) argued that a personalised approach reflects a *'model of service delivery that overcomes the limitations of both paternalism and consumerism'* (Miliband, 2004: p. 11). What this kind of perspective starts to suggest is that personalisation is more than a set of specific policies but is instead linked to the type of philosophy that underpins the design and delivery of welfare services. As Pykett (2009: p. 375) argues,

'what is at stake within debates on personalisation is a question of the government's duty to ensure the welfare of its citizens weighed up with the personal responsibility of citizens to care and provide for themselves.'

This might, therefore, explain the difficulties in pinning down a precise definition of personalisation (Cutler *et al.*, 2007; Needham, forthcoming). The definition of personalisation employed therefore is crucial in terms of this debate. Although various advocates have argued for the emancipatory potential of the personalisation of welfare services, others have warned that in practice its use may prove primarily rhetorical and deliver very little change in practice or even prove detrimental to service users (e.g. Kestenbaum, 1999; Spandler, 2004).



Based on Leadbeater, 2004: pp. 21-24.

Leadbeater (2004: p. 18) argues that personalisation *is 'a very potent but highly contested idea'*. He goes on to conceptualise personalisation as existing on a continuum, where there is a 'shallow' version at one end and (his favoured) 'deep personalisation' at the other. Box 3 sets out these options on a continuum with detail of what these might entail in practice. Yet, as Cutler *et al* (2007) point out, it is only the final two of these options that offer a different role to service users in shaping their care; one that goes beyond 'paternalism' (p. 849) where individuals choose from a menu of pre-existing options.

Another term which is increasingly gaining salience in welfare services is that of 'co-production'. Co-production has been defined as

'delivering public services in an equal and reciprocal relationship between professional, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change' (Boyle & Harris, 2009: p. 11).

One of the central ideas that underpins co-production is that service users, families and neighbourhoods are all resources and should be engaged in the process of welfare service delivery and only this will fundamentally improve the public sector. Co-production involves a shift in the balance of power, responsibility and resources from professionals to individuals. This type of process, it is argued, should unleash innovation, provide efficiencies and produce the types of services that it is argued that individuals want and need. Such a form of co-production is akin to the type of 'deep' personalisation that Leadbeater advocates, but personalisation and co-production are by no means synonymous.

It is, therefore, important to note that personalisation is not a coherent and simple model; multiple potential interpretations of this term exist. For this reason the definitions of personalisation adopted at local levels are important. However, in practice, a number of the debates surrounding personalisation often become hung-up over the types of mechanisms that might be employed to try and bring about personalisation (e.g. direct payments, individual budgets, personal budgets) and not the outcomes that it is intended to achieve. Personalisation in this context therefore becomes more concerned with the means for bringing about change, rather than in the ends or the outcomes of personalisation.

The 'deep' version of personalisation is very much the type of aim that many third sector organisations have been making a case for and trying to achieve for their constituents for some time. In practice, affording disabled people control over the cash with which to buy and organise their support has been one of the major mechanisms implemented in an attempt to provide more personalised services to individuals in health and social care. However, this should not mean that we mistake these financial levers for the broader outcomes of personalisation. *'Personalisation is not a mechanism for public service reform. Rather, personalised services that meet the needs of the individual service user are one of the key objectives of such reforms'* (Brooks, 2007: p. 10).

The paper now moves on to briefly discuss the evidence base to consider the impact which the types of mechanisms associated with personalisation have demonstrated to date in order to provide some indication of the types of impacts which personalisation might hold for service users and their families.

The evidence base

To date, the evidence suggests that direct payments lead to greater satisfaction, greater continuity of care, fewer unmet needs and more effective use of scarce public resources (e.g. Bornat & Leece, 2006; Glasby & Littlechild, 2009; Hasler *et al.*, 1999; Social Care Institute for Excellence, 2005). Even though new ways of working inevitably incur a series of start-up and management costs, it seems as though direct payment recipients have more of a vested interest than the local authority in ensuring that each pound available is spent as effectively as possible and in designing support that enables them to have greater choice and control over their own lives. While take-up is inconsistent and low compared to the number of people who receive directly provided services, any remaining barriers seem to be the result of the way in which direct payments have been operationalised rather than of the concept itself. Where direct payments have been taken up enthusiastically, the biggest successes have often come where there is a user-led Centre for Independent Living providing advice and peer support. However, Kestenbaum (1999) warns that as English social service departments have limited budgets, mechanisms like direct payments might result in an upper limit being imposed on individual care packages. Moreover, in concentrating on individual service provision, there is a danger that collective service provision might be undermined. In the longer term, research into these issues will be needed in order to fully assess the impact of these changes.

Since 2003, personal budgets have been implemented with around 12,000 people. The evidence suggests that not only do personal budgets seem to be delivering their primary purpose of giving people more control over their own support, they also seem to lead to overall improvements in well-being and to greater efficiency (Poll *et al* 2006; Hatton *et al* 2008). Early pilot work with 60 people in six local authorities demonstrated improved satisfaction, improved efficiency, increased use of community and personalised support, and an improved ability for individuals to make desired changes in their lives (Poll *et al.*, 2006; see also Table 1).

Table 1: Impact of personal budgets (within 1 year)

Desired change	% Achieved
Where I live	76%
Who I live with	81%
What I do with my time	69%
Who supports me	89%

Source: Poll *et al* (2006)

Since In Control's initial 2006 monitoring, additional research has continued to emphasise the potential benefits of personal budgets. In 2008, interviews with 196 people using personal budgets in 17 local authorities once again demonstrated promising results with participants reported improvement in (Hatton *et al*, 2008):

- quality of life (76%);
- choice and control (72%);
- taking part in and contributing to the community (64%);
- personal dignity (59%);
- spending time with people you like (55%);
- health and well-being (47%);
- economic well-being (36%);
- feeling safe and secure at home (29%).

This was followed by the publication of the national evaluation of Department of Health ‘individual budget’ pilots (Glendinning et al., 2008). While this was a complex study, it nevertheless suggested that personal budgets are cost-neutral and can lead to a number of benefits for service users, such as:

- mental health service users reported significantly higher quality of life;
- physically disabled adults reported receiving higher quality care and were more satisfied with the help they received;
- people with learning disabilities were more likely to feel they had control over their daily lives;
- older people reported lower psychological well-being, perhaps because they felt the processes of planning and managing their own support were burdens.

(Glendinning *et al.*, 2008: p. 2)

However, the main exception seems to be for older people, where the history and culture of services may mean that more detailed research is required.

Following these reported successes, personal budgets are now being rolled out rapidly in adult social care, and are being piloted in health care and in children’s services. They have the support of all three main political parties, and broader debates are starting to take place as to whether personalisation could become a more general organising principle for other areas of the welfare state (for example, in community development, when rehabilitating prisoners, in substance misuse services, in education and when working with young people not in education, employment or training). Indeed personalisation is emerging as a central theme in education, children’s services and social security (see, for example, Department for Education and Skills, 2005; Department for Children, 2008; Office for Public Management, 2008; Gregg, 2008; Cabinet Office, 2009).

The third sector

Defining the third sector is far from a simple task; this is not a coherent and bounded sector but instead is diverse in size, scope, scale and form. Indeed, the Third Sector Research Centre (TSRC) has a programme of research dedicated to this task, and has produced a number of papers which aims to achieve precisely this task. Whilst recognising the complexity and diversity of the third sector, the implications discussed in this paper are likely to be significant for the wider sector, and its response to the personalisation agenda.

Central government defines the third sector as comprising *'non governmental organisations that are value driven and which principally invest their surpluses to further social, environmental and cultural objectives'* (Cabinet Office, 2007: p. 5). Government has indicated that the third sector should have a much greater role in the delivery of public services. The Cabinet Office (2006: p. 3) set out a commitment to, *'the principle that where services are commissioned and procured by government, there must be a level playing field for all providers, regardless of sector'*. This interest in the third sector and its role in the delivery of public services is part of a wider focus on the supply side of public services and the role of commissioners in shaping improvements. Hence the focus which TSRC has on the role of third sector organisations in service delivery of which this project is a part.

The implications of personalisation for third sector organisation involved in delivery of services will also have to be considered in the context of the user group in receipt of those services. Much of the extant data surrounding individual and personal budgets is based on data derived from the study of individuals with physical disabilities or learning disabilities, although there is now increasing evidence from older people's services starting to emerge. Individuals in these groups are more likely to have received a direct payment than, for example, older people. Moreover, there is some evidence about how client groups spend their budgets differently. In an analysis of how individuals are presently spending personal budgets, Bartlett (2009: p. 12) finds that older people spent the least on leisure services of all the service user groups that were involved in the research. Bartlett also found that people with learning disabilities were more likely than people with physical impairments and older people to want to change where they live and their opportunities for paid work (p. 19).

However, in practice it may not be as simple as being able to segment service user populations as this: in a truly personalised system individuals would be able to shape their services around their personal needs and wishes. Indeed, one of the complexities of a truly personalised system is that it is quite difficult to predict the desires of service users in advance – these will be personal and thus individual. If individuals in receipt of services are to be involved in the design and co-production of services then this fundamentally changes the nature of welfare services which have traditionally been designed and delivered according to the needs of the 'average' individual.

The third sector is a provider of welfare services throughout a range of different service areas and a number of the implications set out in this paper primarily refer to third sector organisations and the potential changes that the personalisation agenda might entail for these providers. However, the third sector also has a strong role as an advocate and as a campaigner on behalf of individuals and groups. As the previous sections suggest, much that has been achieved so far in terms of changes to health and social care systems has been as a result of user-led advocacy groups that have campaigned for greater independence, control and choice for people with disabilities. Should third sector organisations take on a greater role in the provision of care services then this might have potential impacts on advocacy and campaigning roles (discussed in more detail below). Individual third sector organisations might also actually carry out more than one function and this is where some careful thinking will need to be given to their activities now and for the future.

Implications of the personalisation agenda for the third sector

As already indicated, personalisation is not a simple and straightforward policy or set of policies. Therefore in talking about this agenda some stakeholders did raise fundamental issues about who *should* be delivering public services. Whilst an interesting debate, this is not the primary concern of this paper and is therefore not covered in detail. However, one point that a number of stakeholders did express was a concern that the third sector is not yet 'ready' for the personalisation agenda. Several respondents expressed a fear that third sector providers have not yet sufficiently engaged in the level of debate that is necessary in order to respond effectively to this agenda. As one respondent suggested, '*providers need to step up to the mark or they will lose business*'. Demos suggest that there will be positive impacts for the third sector from the increased use of personal budgets in social care, particularly as much of the innovation, advocacy and campaigning which has resulted in current wider social care reform has its roots in the work of third sector organisations (e.g. user-led Centres for Independent Living) (Bartlett & Leadbeater, 2008). Yet, in being able to respond effectively, the third sector will need to be sufficiently engaged so that it might actively shape this agenda. Arguably, what is more significant than potentially losing business to other sectors is that a lack of understanding of the key debates around the notion of personalisation might mean that third sector organisations are unable to support service users and their carers which might ultimately mean that the form of personalisation that is enacted is closer to Leadbeater's 'shallow' rather than 'deep'

The section discusses a number of themes relating to personalisation and the third sector, including:

- demand;
- finance;
- administration;
- workforce;
- marketing;
- relationships with partners.

In concluding the paper we draw out the main implications into the categories of practice, policy and research. The existing evidence base indicates some changing trends and the longer term impact of the evolution of personalisation will inevitably result in a number of considerations for policy. Given that personalisation agenda is still developing and local areas are still in discussions about how this will be interpreted and implemented locally there are still a number of issues that are unclear and would benefit from additional research. These areas will be of interest to TSRC in taking forward its role in developing the evidence base on, for and with the third sector in the UK.

Demand

One of the main debates that has surrounded the potential implications of personalisation is whether or not this will increase demand on the third sector. There is a range of evidence available to suggest that personalisation has the potential to change the type of demand put on the third sector,

but whether this will mean an *increase* in demand is a more contested issue and one that will likely be determined locally as this agenda evolves over time. Third sector organisations are often characterised by government (and others) as being better able to provide the types of services that people want and need. If this is true, then personalisation could be seen as a huge opportunity for third sector providers to expand their role in the delivery of health and social care services. However, this debate is more complex than it might first appear.

Implications in terms of demand depend on what activities third sector organisations are presently involved in and whether there are plans for this to change significantly in the future. Third sector providers exist at a variety of different scales and a number of large third sector providers currently provide, for example, residential care, in a number of areas. Evidence from the first phase of In Control (Poll, 2006) found that of the 30 people with learning disabilities they worked with across six local authorities, ten were in residential care at the start of the process and all moved out of this setting. Nine of these went into their own homes and one returned to their family. The use of day care also fell from around 4.5 days per person per week on average to 3.5. There was a significant increase in the number of people who employed personal assistants, from eight before the introduction of personal budgets to 22 after.

The increase in numbers of personal assistants was also mirrored in the Department of Health funded evaluation of individual budget pilot sites (the IBSEN review by Glendinning *et al.*, 2008). Although some individuals simply 'converted' their previous care packages into individual budgets, meaning this was predominantly an administrative exercise, others made significant changes to the types of services that they chose to receive. Several service providers reported that people were leaving their services to be supported by personal assistants and some providers were therefore altering the types of services that they offered. This theme of the increase in personal assistants runs across many of the categories identified in the paper and is picked up at a range of points. For now, what is important to note is that existing evidence suggests that where people have been in receipt of individual budgets and direct payments, some have chosen to opt out of existing service providers in preference for employing their own personal assistants or spending their money on different types of services. Moreover, new and different sorts of services can only be delivered if the resource allocation system (RAS) is set at a sufficient level for that local area.

The IBSEN study also found providers generating new opportunities for business or expanding into new service areas. For example, a day centre provider had previously wished to open a domiciliary care service but worried that its higher-quality services would cost more than others and they would struggle to get a contract from the local authority. However, with the introduction of individual budgets this was eventually agreed on because of a perceived willingness of the individual budget holders to pay more for this additional quality (Glendinning *et al.*, 2008: p. 201). The IBSEN review revealed that many of those in receipt of an individual budget still demanded traditional 'mainstream' services, but a large number also spent their budget (or part of it) in very different ways on things like arts materials, skip hire, photography classes, and driving lessons amongst many other examples.

What these more innovative examples demonstrate is that sometimes where individuals control their own budgets they spend it on very different things than services might traditionally have done so.

A number of the third sector stakeholders we spoke to suggested this was a very positive shift but involved careful thought in terms of the implications of these changes. Although a shift towards the micro-commissioning of care was broadly welcomed there are a range of implications which go with this move that need to be considered. Moving towards a truly personalised system will mean that:

- existing providers will need to personalise existing services or else may lose their current service users to other providers;
- providers will need to have a good understanding of the price of individual services;
- demand might change in less predictable ways as service users choose *when* they want to receive their services;
- new opportunities for secondary services might appear as the take up of individual budgets/personal budgets increases; and,
- providers may become involved in different activities such as advocacy and brokerage.

In terms of the final point raised above there may be potential for some very different types of demand to emerge as the personalisation agenda develops. Not everyone wants to manage their own budget and may want a provider that they trust to do this for them and there could be a role for third sector providers here. Similarly, individuals may not wish to recruit and manage personal assistants themselves and there may be a role for third sector organisations to do this. Some third sector organisations may choose not to deliver services but instead act as brokers for individuals where they assist them in designing person-centred care plans. All these roles take very different skills and involve different forms of development. However, what they all have in common is that it is crucial to start entering into dialogue with appropriate partners at this point so that third sector bodies have the chance to engage in discussions about what form personalisation will take locally now and in the future. Finally, whatever form personalisation does eventually take, there will still be a role for the third sector in advocating for service user rights on a wider scale.

Finance

Given the importance of finance in public services and the potential that personalisation holds for altering the status quo, discussions about personalisation often quickly slip into debates about the mechanisms or the levers that are available to try and bring about personalisation. Yet, as we have previously noted, although things like individual budgets, personal budgets and direct payments are important, these are some of the mechanisms for bringing about personalisation in practice. Implementation of these does not necessarily represent personalised services in a broader sense. Therefore, it is crucial that the third sector understands these mechanisms and the potential impact they might have on the financing of public services, but this also needs to be considered within a much wider context.

One of the implications of personalisation that has perhaps received the most attention so far is the potential for modes of funding to change. At one end of the spectrum, cash might be fully devolved to individual service users who act as micro-commissioners. However, there are a range of other potential options for structuring the finance of personalised services. Some individuals might choose not to control the cash themselves and instead nominate a provider or other type of advocate to hold

the money. Others might want to use an independent broker to hold their money and hence act as the contracting body. There are then various options in terms of who holds the money under a personalised system:

- the individual themselves;
- an agent acting on behalf of the individual;
- a provider organisation that is already trusted;
- a trust body that is set up to administer the budget of one or a collective of individuals; or,
- an independent broker.

If a local health and social care community is able to deliver truly personalised services, all of these options may co-exist in an area and it is important that these are therefore understood. Which option is selected in practice will depend on the needs and desires of individuals and their preferences. Each has rather different implications in terms of who it is that does the actual contracting function and the economies of scale that are related to this in terms of a variety of different functions.

It is likely that there will be less block contracting by public sector bodies in the future. If service users are to have truly personalised services then public sector organisations will not simply be able to purchase a bulk of, for example day care places or residential home places, from providers and then slot individuals into these services. The starting point will be different – what services users want, rather than what is available. This might provide new opportunities for *‘small, specialist, niche organisations to engage in service delivery’* (Harlock, 2009: p. 10); however for others this might potentially pose challenges in terms of stability and funding. Richard Gutch (2008) reflects this when he recently interviewed a number of chief executives of third sector organisations. He reports that

‘according to Paul Farmer, chief executive of Mind, personalisation of services is both an opportunity and a threat. The move towards individual budgets...could help disabled and older people live independent lives, but replacing the relative security of block contracts with the vagaries of market demand could be risky’.

The shift from block to spot purchasing might pose some difficulties to those third sector providers who rely on wholesale contracts with local statutory bodies. This does not mean necessarily that these providers will lose service users, but that they will have to contract in different ways. A number of third sector organisations have been arguing against block contracting for some time, therefore this shift should be a welcome move for some parts of the third sector. Most people would not expect a local authority to block contract from a large commercial sector organisation, but instead to understand and respond to the needs of individual customers. Similarly, in a context where there is an expectation that public services should be more responsive to the individual needs and desires of citizens then these modes of block contracting may no longer be appropriate.

In some areas there are already changes underway in terms of how local authorities and service providers are operating contracts. Some local authorities are using Virtual Budgets or Individual Service Funds so that they can divide up block contracts into a series of individual support packages (see, for example, Tyson, 2007). Block contracting will not simply disappear overnight, but it does seem that increasingly health and social care commissioners are moving away from this model. A

major implication of this is that providers need to ensure that they have a clear idea of what their services cost at an individual level. This means that providers need to understand the full costing of the staff, various overheads, infrastructure costs etc. and how these relate to individual services. Whatever form of contracting is employed it is likely that the individual or body contracting with providers will want some form of breakdown of what is to be provided and the price so that the various options available can be compared and contrasted to one another. This could have potential implications for existing service providers that rely for some aspects of their workforce on volunteers. It would be even more important that it is clear just what it is that the volunteers do and that this is not being paid for by commissioners – indeed, there were fears that this kind of situation could lead to fewer volunteers. If people who volunteer feel that their activities are being paid for at least in part by a commissioner then they might be less willing to engage in these activities without payment.

There are also a range of other potential financial implications that the mechanisms of personalisation might also bring about. The IBSEN report also raised an issue in relation to non-payment where some individual budget holders were reported not to have paid the bill for their care. This is a potentially problematic issue and providers might have to ‘chase’ their service user for payment. There was debate amongst the stakeholders we spoke to as to whether a certain degree of non-payment would be inevitable and so would need to be factored into overall costs of services. Regardless of whether third sector providers and their partners decide to factor in these costs or not, what this again reiterates is the importance of having good information over the costs of each service. Another issue that the IBSEN study highlighted was in the potential for the irregular use of services, if for example, an individual had to suddenly go into care. Obviously this is an issue which exists at present, but where local authorities have block contracts there may be some additional capacity that may be drawn on. The situation may look rather different in a personalised system with a multiplicity of provider bodies. Therefore, providers would need to think about how such a scenario would be handled in conjunction with their commissioners.

Administration

Given the implications set out above in terms of potential changes to contracting modes there are a series of knock-on effects that relate to the administrative functions of third sector providers. This might involve greater administrative support, or an increased role for ‘back-office’ functions. However, as also suggested above in terms of modes of contracting; the earlier these issues can be discussed with local statutory bodies the better as there may be some possible resources or capacity building functions that may be accessed and used to develop these types of functions.

At a micro-level this there might be an increase in transaction costs as providers are required to invoice micro-commissioners or local authorities on an individual basis. Providers may also find that they have to more frequently chase non-payments or late payments which might also add to the administrative burden and costs of third sector providers. Again, it is important that these are anticipated from the outset and contingency plans put in place to mitigate any potential impact that these might have on the stability of provider organisations. There are examples of developing technology available that might be able to expedite or simplify some aspects of these processes, such as the shop4support system which has been developed by In Control. This system is designed as a

way of bringing together a range of providers from many sectors and areas of service delivery, thereby playing a role in information giving for budget holders and also creating greater efficiencies through streamlining payment systems.

Where providers are small they may seek greater efficiencies in terms of back office functions by merging these with other providers or contracting aspects out to specialist agencies. Some stakeholders suggested that what we might expect to see in the future is the merger of smaller third sector providers so that they can create greater economies of scale and more stability within a context where public sector finances look like they might become ever tighter. However, where providers wish to maintain their existing identities there may be opportunities to share specific functions to gain efficiencies and these would seem to be an immediate opportunity for this. There is arguably a role here for voluntary service councils and voluntary infrastructure organisations in supporting small third sector organisations in these processes.

As suggested above, the number of personal assistants that are employed looks likely to rise. There may therefore be a space in the market for new providers to arise that specialise in the recruitment and oversight of personal assistants. Individual budget holders could contract with these bodies who would then undertake the employment of personal assistants. There could potentially also be a role for these sorts of bodies to provide some cover in case of illness on the part of personal assistants. Although some individuals may choose to do this themselves, it may prove more efficient to do this as a block function. These agencies would provide more than simply an efficiency saving though and may have a role in shaping the market for personal assistants. There is evidence that one of the aspects that blocked the development of direct payments was a lack of personal assistants (Bartlett, 2009). Given a lack of personal assistants available in the labour market individuals chose not to take direct payments as they were not able to employ someone to replace traditional services and the supply of personal assistants was not there. As these roles become more common then there could be a role for third sector providers in running these types of functions, potentially in the form of user- or staff-led co-operatives. Third sector organisations may be more trusted than existing commercial sector agencies and larger third sector providers may choose to run an arm of their organisation that is purely geared towards recruitment of personal assistants. This would provide piece of mind to individual service users commissioning their own care and offering opportunities for efficiencies through the redeployment of workforce for other third sector provider bodies.

Workforce

A crucial issue for third sector organisations is the potential impact which any changes might have on their workforce and volunteers. As has already been indicated, in a number of the existing studies of the use of individual budgets, a significant proportion of individuals have chosen to employ a personal assistant rather than accessing more traditional services. This potentially poses a problem to third sector providers as they might lose existing staff members as was illustrated by the IBSEN review. One train of argument goes that personalisation might mean that individuals seek to make all the efficiency savings that they can, so rather than go through individual service providers or agencies which have their associated overheads, they might choose to employ individuals directly. The potential cost to third sector providers is not simply in terms of the loss of a member of staff; they may

have given this individual extensive investment in terms of training and this will be lost. However, some studies (e.g. IBSEN) have suggested that the implications of personalisation may mean that it is easier for providers to retain staff as the types of services that these organisations are delivering are more related to what individuals want and need than currently is the case. It is proposed that this offers a more rewarding job than simply providing routine care within existing provider organisations.

What was significant in terms of the IBSEN experience was that the demand for unplanned or short notice care could put stress on the rostering of the workforce. The IBSEN team found that when given the option some individuals 'banked' hours from home service providers so that they could have fewer hours of support over several weeks in order that they might 'save up' for a particular activity (p. 203). Examples of this given were enabling outings for Christmas shopping or trips to the beach. If individuals have more say over the types of services that they want and when they want them to be delivered this might not fit with existing models of care. It is therefore important that there is a clear idea about what service users want from the outset and what providers are able to respond to realistically. In some cases, like Christmas shopping or trips to the beach, these are easier to plan for than a service user deciding on that day that they do (or do not) want a specific aspect of care and expecting a provider to respond to this. Again, the types of shared back office and workforce functions alluded to earlier may facilitate the ability of providers to respond effectively to these types of issues.

Marketing

If third sector organisations are to try and engage service users to purchase their services there may be a stronger role for marketing their services than there have traditionally been. Bartlett and Leadbeater (2008: p. 5) succinctly reflect this argument in arguing that,

'The irony is that reforms towards more personalisation in health care were driven by one part of the third sector, and now could disrupt the business models of other third sector organisations. Although the third sector certainly has the right value base to thrive in a world of personal budgets, they might not always be as good at competing in the market – which may require branding, marketing and customer relationship management – as private sector providers'.

If existing providers of services are to more effectively retain their service users (and potentially attract others) and new providers wish to enter the market to take on any one of a number of functions then they will have to think about marketing their services in a way that has not traditionally been undertaken. It will likely no longer be sufficient simply to be on the preferred supplier list of the local authority to ensure that providers are able to maintain a level of business. Providers will need to go beyond this and seek new forms of marketing, although arguably existing household names may do well in this type of context.

First and foremost, who providers market to will be a primary consideration. Personalisation will not mean that third sector providers are no longer required to market to local authorities. Local authorities and their health partners will still have a role in managing the market as the strategic commissioners of their health and social care communities. Some areas are experimenting with how they might make those listed on their preferred suppliers lists adhere to specific price and quality arrangements, so that only quality providers are included on these lists.

If there is to be increased micro-provision then providers will have to reach micro-commissioners. This is where links to statutory bodies and other partners become important so that providers can reach the groups that they seek to ultimately provide services to in an effective means. It is likely that a range of different approaches to marketing might arise which seek to draw on new technologies as well as more established means. Ultimately creating an effective marketing strategy will depend on having a good understanding of the service users and carers with which third sector organisations are seeking to interact. Little has been said of this facet as yet in this paper, and it is often suggested that third sector organisations are suited to delivering personalised services because they understand their service users better than statutory bodies do. This may be true but it is important that providers ensure that they truly do understand their service user and carer populations and have effective means of incorporating service user voices within their organisations. Taking for granted that third sector organisations are more suited to these types of activities could be a mistake and third sector providers should check at an early stage that they truly understand the needs of their constituent services users and carers.

Relationships with partners

What is clear from a number of the implications set out above is that there will be significant implications on the relationship between third sector organisations and their local public sector partners. Although it might be easy to conceive of this as being a more distant relationship than currently exists – given that statutory sector bodies may no longer be the budget holders – what many of the points addressed above suggest is that third sector bodies may need to form closer relationships with their local partners.

Many of the implications set out above will only become a reality through third sector organisations working together with their local statutory bodies in new and different ways. If health and social care commissioners are to understand what people want in terms of their services then they will need information about what people spend their money on now and also what they are likely to do so in the future (Bartlett, 2009). Only by generating this sort of information will commissioners be able to establish where the gaps are in the market and work with a whole range of providers to establish locally appropriate services. This will likely predominantly happen on a local basis as loans, pump-priming funds are provided to start up particular services or to extend others according to need. There may additionally be scope for voluntary sector infrastructure organisations to offer an entrance point, drawing on more specialist support organisations as appropriate.

Third sector organisations will also need to consider how they might be best supported to share best practice across the wider sector or service areas. Given that there will likely be greater competition between providers will this make them less likely to share innovative practices with other providers? Again there is potentially a role here for voluntary sector infrastructure organisations to continue to facilitate this type of interaction as a number of existing organisations already do. However, in the long term there is an implication in terms of the balance between competition and collaboration that exists within the sector.

Discussion and future research agenda

This paper has covered a number of themes and discussed a series of implications that it is suggested the personalisation agenda might hold for the third sector. In this section the implications for practice and policy are summarised, whilst the implications for further research are also laid out.

Although not exhaustive it would appear that the main practice implications that arise out of this paper include:

- providers need to 'truly personalise' services to appeal to micro-commissioners. This could have a series of implications in terms of where and when services are delivered;
- providers need to have a good understanding of the groups they are aiming to deliver services for and their associated wants and needs;
- providers need to have a good understanding of the costs of their individual services;
- new opportunities for business or expanding into new service area may become available for providers;
- a larger role may develop for managing budgets on behalf of individuals or in terms of brokerage or advocacy;
- providers need to understand the mechanisms to bring about personalisation and their potential impact on the financing of public services;
- reduction in block contracting will mean third sector providers will need to market their services in a different way and to a different audience;
- potential for increased 'back office' costs to contract with and chase funds from micro-commissioners. Smaller providers may wish to consider;
- providers may lose staff who take up roles as personal assistants directly employed by individuals with direct payments;
- providers need to think carefully about how they might effectively secure the 'user voice' within their organisations;
- providers will need to forge close relationships with a range of public and third sector partners.

Whilst these practice implications will no doubt be of importance to those currently involved in the delivery of services and those who plan to move in to this area in the future, there are also a wider set of ramifications that arise out of the personalisation agenda. There are also a range of issues that local and national policy makers will be required to consider as health and social care service delivery mechanisms and processes evolve as a result of personalisation. A series of policy implications also emerge from the discussions set out in this paper, including:

- changes in levels and types of demand placed on third sector providers will need reviewing as a part of market management so that we can understand what individuals want and need in terms of services and support;
- if there is an increased role for third sector organisations in terms of advocacy or brokerage then it is important that this role is appropriately funded and supported;

- the impact of local RAS levels on the ability to deliver personalised services will need to be monitored;
- how can the 'irregular' usage of services be co-ordinated in a multi-provider system?
- how can third sector providers be best supported to deal with the increased administrative costs that may come with personalisation?
- third sector providers will need support in recruiting and retaining high quality staff and there may be a local role in overseeing the local labour market in conjunction with a variety of partners;
- how might third sector organisations be encouraged to share innovation and best practice across the sector?

Finally, this paper is the first stage in informing the future activities of TSRC's service delivery stream of research. The discussions set out in this paper do seem to suggest many more areas for future research activity than it necessarily does answer questions about the nature of personalisation and the third sector. The main research implications that arise out of this paper include:

- how is personalisation being interpreted and implemented locally in different areas and to what effect?
- does personalisation lead to better outcomes for individuals?
- are individuals choosing different services to those which are 'traditionally' provided?
- what will be the long-term impact of the implementation of mechanisms like direct payments, personal budgets and individual budgets?
- how can prices of services be effectively broken down to the individual level?
- does the personalisation of services impact on levels of volunteering for third sector providers?
- how does personalisation impact on the existing workforce?
- how can third sector organisations effectively market their services to local authorities and micro-commissioners?
- how can third sector organisations and local public sector partners work together to effectively manage local markets?
- how can third sector organisations facilitate the sharing of best practice across the sector?

This paper has focused predominantly on the concerns of provider organisations, with rather less mention of commissioner bodies. As the next stage of TSRC's work around personalisation in health and social care, we will focus on the commissioning function - particularly in terms of how third sector organisations can understand and become involved in more effective commissioning processes at the local level. A discussion paper on commissioning is currently under production and this will highlight the gaps in the existing evidence base in more detail, as well as providing case studies of best practice in terms of commissioning.

Conclusions

Personalisation has the potential to deliver services in new and different ways that are nearer to what service users and their carers want and need. However, personalisation is a broad concept and if it is to be implemented in a 'deeper', rather than 'shallower' sense then arguably third sector organisations will play a strong role in supporting the development and implantation of a range of reforms. Personalisation has a significant history and represents what a large amount of the third sector has been advocating on behalf of disabled people and their carers for some time. All the major political parties are signed up to this agenda and it will not simply disappear. If the third sector is to play a role in the shaping, designing and delivery of personalised services in the future then it is important that the full implications of this agenda are understood and thought through at some length.

The changes involved with personalisation will not take place over night, although it is likely that some of the implications outlined in this paper will have some significant implications for the third sector. These factors will have different kinds of implications for different audiences but need careful consideration now and planning for the future. If the third sector does not start engaging with these issues now then there is a danger that not only will there be a potential loss in business opportunities, but also the type of personalisation which is ultimately enacted is not a co-productive form of enterprise but something more akin to current configurations of services.

Resources

In thinking about some of the implications set out in this paper in more detail, the following resources may provide a useful first stage in providing more insight to some of the issues raised.

- More information on In Control can be found at <http://www.in-control.org.uk/site/INCO/Templates/Home.aspx?pageid=1&cc=GB>
- More information about shop4support can be found at <https://www.shop4support.com/S4S/UI/Content/Home.aspx>
- The Social Care Institute for Excellence's rough guide to personalisation gives an overview of the main terms and policy drivers and is available at <http://www.scie.org.uk/publications/reports/report20.pdf>
- Demos has a number of publications describing the history and development of the personalisation agenda, see <http://www.demos.co.uk/>
- The Health Services Management Centre has a research stream orientated around health and social care partnerships and this has a particular focus on individual budgets and personalisation in health and social care, see <http://www.hsmc.bham.ac.uk/work/partnerships.shtml>
- The Department of Health has a personalisation network which has a number of resources for commissioners and providers of health and social care services, see <http://www.dhcarenetworks.org.uk/Personalisation/>
- Documentation relating to the IBSEN evaluation can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_089505
- Community Action Hampshire has a video on their website which provides examples of how several third sector organisations are already adapting their services to meet the challenges and opportunities that personalisation brings, see <http://www.action.hants.org.uk/index.php?id=440>

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About the Centre

The third sector provides support and services to millions of people. Whether providing front-line services, making policy or campaigning for change, good quality research is vital for organisations to achieve the best possible impact. The third sector research centre exists to develop the evidence base on, for and with the third sector in the UK. Working closely with practitioners, policy-makers and other academics, TSRC is undertaking and reviewing research, and making this research widely available. The Centre works in collaboration with the third sector, ensuring its research reflects the realities of those working within it, and helping to build the sector's capacity to use and conduct research.

Third Sector Research Centre, Park House, 40 Edgbaston Park Road,
University of Birmingham, Birmingham, B15 2RT

Tel: 0121 414 3086

Email: info@tsrc.ac.uk

www.tsrc.ac.uk

Service Delivery

From housing, to health, social care or criminal justice, third sector organisations provide an increasing number of public services. Working with policy makers and practitioners to identify key priorities, this work will cut across a number of research streams and cover a series of key issues.

Critical understanding service delivery by the third sector is important to policy making as the third sector now provides a major - and very different - option for public services, which may be more responsive to the needs of citizens and service users. At the same time, there are dangers inherent in the third sector becoming over-dependent on funding from service contracts – particularly in terms of a potential loss of its independence. The centre's research will help to inform the debate on the way in which service delivery is developing, the potential role of the third sector in commissioning as well as contracting, and the implications of different approaches to service delivery on the overall impact of the third sector.

Contact the Author

Helen Dickinson

0121 414 7069

h.dickinson@tsrc.ac.uk

Jon Glasby

0121 414 2260

j.glasby@bham.ac.uk

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