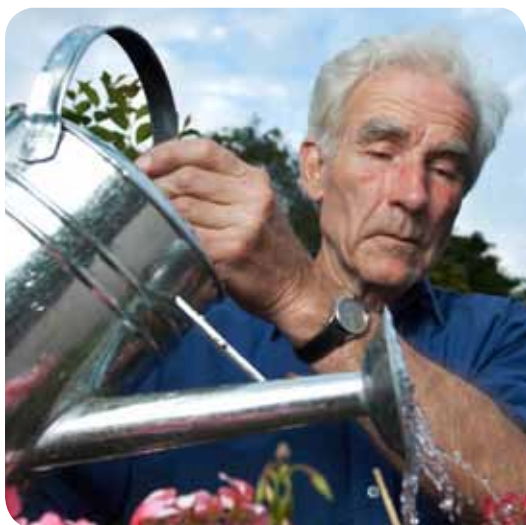
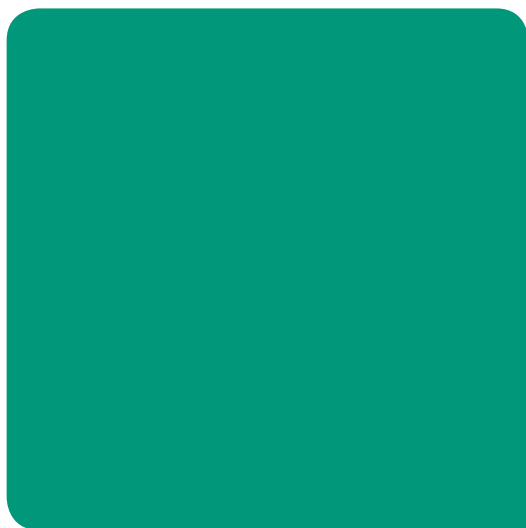




Personalisation: a rough guide



The basics

What is personalisation?

Personalisation means thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. It requires a significant transformation of adult social care so that all systems, processes, staff and services are geared up to put people first.

The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. 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. Personalisation means addressing the needs and aspirations of whole communities to ensure everyone has access to the right information, advice and advocacy to make good decisions about the support they need. It means ensuring that people have wider choice in how their needs are met and are able to access universal services such as transport, leisure and education, housing, health and opportunities for employment, regardless of age or disability.

Personalisation means:

- tailoring support to people's individual needs
- ensuring that people have access to information, advocacy and advice to make informed decisions about their care and support

- finding new collaborative ways of working (sometimes known as co-production) that support people to actively engage in the design, delivery and evaluation of services
- developing local partnerships to co-produce a range of services for people to choose from and opportunities for social inclusion and community development
- developing the right leadership and organisational systems to enable staff to work in creative, person-centred ways
- embedding early intervention, re-ablement and prevention so that people are supported early on and in a way that's right for them
- recognising and supporting carers in their role, while enabling them to maintain a life beyond their caring responsibilities
- ensuring all citizens have access to universal community services and resources – a total system response.

The Department of Health (DH) makes it clear that: 'Importantly, the ability to make choices about how people live their lives should not be restricted to those who live in their own homes. It is about better support, more tailored to individual choices and preferences in all care settings' (DH, 2008a, p 5). This has equal, if not more, resonance for those living in residential care homes and other institutions, where personalised approaches may be less developed. Here, the independent sector has a crucial role to play in delivering personalised solutions for people no longer living in their own homes.

Personalisation is a relatively new term and there are different ideas about what it could mean and how it will work in practice. There are several terms used in association with personalisation or to describe services or activities that reflect the agenda. Some terms are used interchangeably and others are used in relation to particular policies, processes or people who use services. Based on our current understanding, the list below aims at clarifying some of the different examples of personalised approaches:

- **Person-centred planning** was an approach formally introduced in the 2001 *Valuing people* strategy (DH, 2001) for people with learning disabilities. The person-centred planning approach has

similar aims and elements to personalisation, with a focus on supporting individuals to live as independently as possible, have choice and control over the services they use and to access both wider public and community services and employment and education. Rather than fitting people to services, services should fit the person.

- **Person-centred care** has the same meaning as person-centred planning, but is more commonly used in the field of dementia care and services for older people.
- **Person-centred support** is a term being used by some service user groups to describe personalisation.
- **Independent living** is one of the goals of personalisation. It does not mean living on your own or doing things alone, but rather it means 'having choice and control over the assistance and/or equipment needed to go about your daily life; having equal access to housing, transport and mobility, health, employment and education and training opportunities' (Office for Disability Issues, 2008, p 11).
- **Self-directed support** is a term that originated with the in Control project and relates to a variety of approaches to creating personalised social care. in Control sees self-directed support as the route to achieving independent living. It says that the defining characteristics of self-directed support are:
 - the support is controlled by the individual
 - the level of support is agreed in a fair, open and flexible way



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- any additional help needed to plan, specify and find support should be provided by people who are as close to the individual as possible
- the individual should control the financial resources for their support in a way they choose
- all of the practices should be carried out in accordance with an agreed set of ethical principles. (Adapted from Duffy, 2008.)

More about self-directed support

Self-directed support is the mechanism and framework through which personal budgets are being delivered. The Department of Health along with key local authority social care stakeholders have worked on defining what self-directed support is and how it is to be implemented. They say:

Self-directed support involves finding out what is important to people with social care needs and their families and friends, and helping them to plan how to use the available money to achieve these aims. It is about focusing on outcomes and ensuring that people have choice and control over their support arrangements. In practice, implementing self-directed support in social care means ensuring the following elements are in place:

- **Self-directed assessment:** simplified assessment that is led as far as possible by the person, in partnership with the professional and focuses on the outcomes that they want to achieve in meeting their eligible needs. Assessment looks at the individual's circumstances and whole situation and takes account of the situation and needs of carers, family members and others who provide informal support. The council's duty to assess needs can be met through proportionate self-directed assessment and support planning processes, and the council is legally responsible for signing off the assessment and support plan.

- **Up-front (indicative) allocation:** The person has a clear indication at an early stage of the amount of council money (if any) that is likely to be available to achieve these outcomes before support planning takes place. This amount may be adjusted following the development of the support plan.
- **Support planning:** There is advice and support available to help people (no matter where their money comes from) to develop plans that will achieve a desired set of outcomes. Putting People First local government consortium has said that the plan should be 'proportionate and non-prescriptive' – it need not be expressed in units of provision (like hours of care) and can include broader needs and desired outcomes beyond the needs that made the person eligible for support (Putting People First consortium, 2010a). Arrangements should make the most use of any existing social support networks and mainstream services. For those people who will be receiving ongoing council funding (i.e. with a personal budget) to meet their care and support costs, the council must sign off support plans to ensure that eligible needs will be met and any risks managed.
- **Choice and control:** the person should (as far as capacity allows) decide how any council funding should be managed and decide how best to spend it to meet their needs to achieve their agreed outcomes. Decisions should not be constrained by the menu of services currently offered. Councils should not require personal budgets and support plans to be expressed in terms of 'hours of support'. This could reduce flexibility and result in service-led solutions.
- **Review:** The council should have a process for checking whether the outcomes agreed in the support plan are being achieved (adapted from ADASS, 2009a, pp 3–4.)

They continue:

The move towards self-directed support and personal budgets involves comprehensive change – the policy makes it clear self-directed support needs to become the core way of doing business. It is not an 'option'. Implementing self-directed

support is as much about changing culture as about changing systems' (ADASS, 2009a, p 5).

This section addresses some of the questions that people have asked about the different approaches to delivering personalised social care.

What is a personal budget?

In December 2007, *Putting people first* (HM Government, 2007) proposed that all social care users should have access to a personal budget, with the intention that they can use it to exercise choice and control to meet their agreed social care outcomes. In March 2009 the Association of Directors of Adult Social Services (ADASS) reported that 93,000 people were receiving personal budgets (including direct payments) (ADASS, 2009b). The Care Quality Commission (CQC) reported in February 2010 that 115,000 adults over 18 in England were receiving a personal budget or direct payment option, which represents 6.5 per cent of all adults using services in 2008/9 (CQC, 2010). The government expect all 152 councils in England to have made significant steps towards transforming their adult social care services, including having at least 30 per cent of eligible adults on a personal budget, by 2011, with access to information and advice services to support them (and also to support those using their own money to buy care and support).

Personal budgets have been informed both by the experience of direct payments and also by the piloting of individual budgets in 13 English local authorities in 2007–08.

Individual budgets attempted to combine the following funding streams:

- local authority adult social care
- integrated community equipment services
- Disabled Facilities Grants
- Supporting People for housing-related support
- Access to Work
- Independent Living Fund.

Research into the effectiveness of the pilot schemes was conducted by the Individual Budgets Evaluation Network (IBSEN) (Glendinning and others, 2008). The evaluation was promising and showed that people can benefit from having more choice and control over their social care and support services as well as indicating that this could cost no more than traditional services.

However, the research also showed that integrating these funding streams together could not happen without central government changes to some of the legislation and administration rules relating to some of the different funds. The government is currently focusing on using only social care money in the immediate future – this is known as a personal budget. The Department of Health has said that the term individual budget is no longer in use and that the correct term for allocation of social care funding to an eligible adult through self-directed support is personal budget (ADASS, 2009a).

Key to the personal budget approach is giving clear, early understanding of the amount available to the individual, so that they can influence or control how it is spent, in a way which helps them best meet their needs. A personal budget should focus on providing for on-going support and care needs, and should normally be considered only after examination of relevant preventative and re-ablement options (ADASS, 2009a). Personal budgets must be implemented within the framework of self-directed support which involves self-directed assessment; 'up-front' allocation of funds and support planning to promote maximum choice and control (ibid). They are not a crisis intervention option.

ADASS, together with the Department of Health, have issued some useful information about how personalisation, including personal budgets, can be implemented within the current social care legal framework, including the duty of the local authority to assess people in need of social care and support and the right to a direct payment for eligible individuals (ADASS, 2009c).

Several forms of Resource Allocation System (RAS) are in use around the country to determine the size of the personal budget. The majority of these systems are points-based, offering transparency, so that the individual knows at an early stage what

resources are available to them in their personal budget allocation (ADASS, 2009d). In this way, outcomes defined by the person using the service drive the spending. This allocation can be either a full or a partial contribution to social care costs. The person may also choose to pay for additional support on top of the budget. A personal budget may be taken by an eligible person:

- in the form of a direct (cash) payment, held directly by the person or, where they lack capacity, by a 'suitable person'
- by way of an 'account' held and managed by the council in line with the person's wishes, that is to pay for community care services which are commissioned by the council, or as an account placed with a third party (provider) and 'called-off' by the user in direct negotiation with the provider. This 'managed option' includes Individual Service Funds (ISFs) and can be the means by which someone who does not opt for a direct payment can draw on existing or new contracts to suit their needs without taking on direct budget management responsibilities.
- as a mixture of the above
(Adapted from ADASS, 2009a, p 5.)

What is a direct payment?

A direct payment is a means-tested cash payment made in the place of regular social service provision to an individual who has been assessed as needing support. Following a financial assessment, those eligible can choose to take a direct payment and arrange for their own support instead. The money included in a direct payment only applies to social services. A direct payment is one way of taking a personal budget.

As part of self-directed support, the personal budget holder is encouraged to devise a support plan to help them meet their personal outcomes. Assistance in developing this plan can come from care managers, social workers, independent brokerage

agencies and family and friends. Once a plan has been devised support can be purchased from:

- statutory social services
- the private sector
- the voluntary or third sector
- user-led organisations
- community groups
- neighbours, family and friends.

Practice example: Direct payments for lesbian and gay people

The former Commission for Social Care Inspection issued a series of equality and diversity bulletins designed to support providers in addressing the personalisation agenda in social care. The first bulletin looked at providing appropriate services for lesbian, gay, bisexual and transgender people and found that many people valued the choice and control direct payments gave them:

'I am a direct payments user. Yes, it has been a much better option for me as a gay person, no question. I would have been imprisoned with a care agency. Can't stress that too strongly. I live at home supported by people I recruit who I am very clear with who I am. They don't change every week and they are not all straight or gay ... life has been a thousand times better on direct payments, even with its challenges.'

'Staff treated me with respect because I was in control of who was employed and what they did to assist me, both in my home and the wider community. I would not employ someone who decided they would take over my life and decide what was best for me. And I certainly would not employ any person who did not feel comfortable around my lifestyle.'

People can use their budgets to access a wide range of services, including traditional social care, as long as it is legal and meets agreed outcomes.

Personal budgets are a conscious attempt to shift control to consumers. Rather than receiving a fixed range of services and little choice) individuals should be better able to design the services, frequently non-traditional, which best meet their agreed outcomes and agreed care plan. This support plan is periodically reviewed with the person to make sure agreed outcomes are being met and to respond to any changes (Bennett, Cattermole and Sanderson, 2009). Evidence from piloting and early adoption shows that some people will use the new flexibilities to design very different services, whilst others value the ability to adjust more conventional packages to deliver a service more responsive to their own needs (Bartlett, 2009).

More about 'managed' personal budgets

Material from the Department of Health, ADASS, IDeA and LGA (Putting People First consortium, 2010a; Putting People First consortium, 2010b; DH, 2010a) clarifies how local authorities should be implementing the personal budget option for people who do not want a direct payment and would prefer their personal budget to be managed for them. A managed personal budget means either:

- the local authority places an individual's personal budget with a third party so day to day business arrangements are between the service user who has a personal budget and the third party provider (purchasing or commissioning) OR
- the local authority itself holds the personal budget and manages/arranges the services on behalf of the service user (providing in-house owned or managed services).

The managed option should not mean less opportunity for the person using services to exercise choice and control than if they chose to have a direct payment. Whatever the personal budget option, people must know what sum of money is available

to them and be offered genuine choice and control over the services provided. Someone who decides to keep existing service arrangements should be making a positive choice, having been provided with all the support and information they require to make the decision. Having made an informed choice about their care and support people using services should:

- receive a regular statement showing how their personal budget has been spent and the remaining balance
- have easy access to support services that encourage them to think about new ways they can use their personal budget flexibly to get the care and support that is most suitable for their needs.

The provision of personal budgets needs to be consistent with the principles and values of personalisation – personal budgets should maximise choice and control for people using services, their carers and families wherever possible. The Department of Health is clear that local authorities should avoid strategies to 'bolster personal budget numbers at the expense of the wider Putting People First agenda...Without changing internal processes and culture, establishing support services, developing markets and altering commissioning contracts it is highly unlikely that real choice and control will be provided' (Putting People First consortium, 2010b, p 8).

Further developments with choice and control in health and welfare

Personal health budgets

In order to extend the principles of personalisation, choice and control into health, and following positive initial outcomes for personal budgets in social care, the NHS is exploring how personal health budgets could work for people with long term conditions, including mental health problems (The NHS Confederation, 2009a). The Department of Health has initiated a national pilot programme of 75 Primary Care Trusts (PCTs) in 68 sites. Twenty

of these will have been selected for an in-depth study, as part of a wider evaluation exploring the potential of personal health budgets to benefit different groups of people. The pilot programme will run until 2012 (DH, 2009a). The Department of Health have said that:

A personal health budget makes it clear to someone getting support from the NHS and the people who support them how much money is available for their care and lets them agree the best way to spend it. (Department of Health, 2009b, p 4)

They think personal health budgets could work in three ways:

- 1 **Notional budget.** No money changes hands. The person knows how much money is available and talks to their doctor or care manager about the different ways to spend that money on meeting their needs. Then the agreed care is arranged.
- 2 **Real budget held by a third party.** A different organisation or trust holds the money for the person helps them work out their needs and then buys the chosen services.
- 3 **Direct payment.** The person gets the cash to buy the services they and their doctor or care manager decide they need. The person has to show what they have spent it on, but they buy and manage services themselves.

Options 1 and 2 are possible now. The Department of Health have worked to change the law so that direct payments for healthcare in certain circumstances can be tested. The Health Act – which received Royal Assent on 12 November 2009 – extends these options by allowing selected primary care trust sites to pilot direct payments. There is a government consultation on proposals for regulations and guidance to govern how direct payments would work in practice (Department of Health, 2009a).

However, as with personal budgets in social care, it is thought that if 'employed in isolation from other aspects of personalisation, personal health budgets are likely to have minimal impact on the health system' (NHS Confederation, 2009b, p 2).

Right to Control Trailblazers

The Office for Disability Issues has a goal of achieving equality for disabled people by 2025 and is working with disabled people to explore different ways to reach this goal. The Department for Work and Pensions' White Paper *Raising expectations and increasing support: Reforming welfare for the future* (DWP, 2008) set out proposals for the Right to Control. The Right is about empowering disabled people by giving them greater choice and control over public money currently spent on their behalf. This would put disabled people in charge of deciding how their support needs can be best met. The Office for Disability Issues is going to test how the Right to Control will work for disabled adults in a number of local authority areas in England. These will be called Trailblazer sites and the outcome of the Trailblazers will be used to inform any decisions on wider roll-out (ODI, 2009a).

People were consulted on what support should be in the Trailblazers; how disabled people and their organisations will work to develop the Trailblazers; what support disabled people will need to exercise the Right; what Right to Control means for service providers and support services; and views on cost and viability (ODI, 2009a). A feasibility study was also carried out (Purdon et al, 2009) and a Right to Control prospectus for potential Trailblazers has been published outlining more about the initiative (ODI, 2009b).

Trailblazers will explore how disabled people can exercise greater choice and control over the following funding streams (which will still be governed by the existing criteria):

- Work Choice
- Access to Work
- Independent Living Fund (ILF)
- Disabled Facilities Grant (DFG).

Disabled people taking part in the Trailblazers will have a legal right to:

- be told how much money they are eligible to receive
- have choice and control over the support they receive
- be able to choose how they receive the support
- decide and agree the outcomes they want to achieve based on the objectives of the funding stream with the relevant public body.

Disabled people in Trailblazer sites can carry on having existing services if they are happy with them. They can also have the option to take a cash payment to buy equipment and support services themselves or they can have a combination of arranged support and equipment and a cash payment (ODI, 2009b).

Where has personalisation come from?

Although the term personalisation is relatively recent, it has grown from a number of different ideas and influences that are summarised in this section.

Personalisation originates at least in part from **social work values**. Good social work practice has always involved putting the individual first; values such as respect for the individual and self-determination have long been at the heart of social work. In this sense the underlying philosophy of personalisation is familiar. The British Association of Social Workers (BASW) states that social work is committed to the five basic values of human dignity and worth; social justice; service to humanity, integrity and competence (BASW, 2002).



Photo: istock

In terms of **public policy**, personalisation is not just about social care but is a central feature of the government's agenda for public sector reform. The Prime Minister's Strategy Unit report *Building on progress: Public services* (Prime Minister's Strategy Unit, 2007) described it as: 'the process by 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' (p 33). Personalisation has become a key concept for the future of the NHS (DH, 2008d).

Its application to adult social care was announced in *Putting people first: A shared vision and commitment to the transformation of adult social care* (HM Government, 2007) – a ground-breaking concordat between central government, local government and the social care sector. This officially introduced the idea of a personalised adult social care system, where people will have maximum choice and control over the services they receive. It links to wider cross-government strategy including the notion of local authority 'place-shaping' (Lyons, 2007) and the local government White Paper *Strong and prosperous communities* (Department for Communities and Local Government, 2006).

The New Deal outlined in the 2008 Carers' Strategy has integrated and personalised services at its heart. Carers want recognition of their work and expertise, better service coordination, better information, improved joint working between staff and agencies, health and social care. Like Putting People First, the Carers' Strategy has been agreed by several government departments and was the result of a wide consultation. The shared vision is that by 2018 'carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen' (HM Government, 2008, p 7).

The 2010 White Paper *Building the National Care Service* (HM Government, 2010) sets out how personalised social care and support can be delivered and funded in the long term through the development of a National Care Service, developed in response to

2009's Big Care Debate. The aim is to build a social care system that is fairer, simpler and more affordable with clear standards and entitlements. The White Paper outlines the following founding principles for the National Care Service:

- 1 Be universal – supporting all adults with an eligible care need within a framework of national entitlements
- 2 Be free when people need it – based on need, rather than the ability to pay
- 3 Work in partnership – with all the different organisations and people who support individuals with care and support needs day-to-day
- 4 Ensure choice and control – valuing all, treating everyone with dignity, respecting an individual's human rights, personal to every individual's needs and putting people in charge of their lives
- 5 Support family, carers and community life – recognising the vital contribution families, carers and communities play in enabling people to realise their potential
- 6 Be accessible – easy to understand, helping people make the right choices. (HM Government, 2010, p 13)

The White Paper emphasises the importance of jointly provided, joined-up, high quality, flexible services to give people active choice and control over their care and support. The National Care Service is based on these six pillars:

- 1 Prevention and wellbeing services to keep you independent
- 2 Nationally consistent eligibility criteria for social care enshrined in law
- 3 A joined-up assessment
- 4 Information and advice about care and support
- 5 Personalised care and support, through a personal budget
- 6 Fair funding, with a collective, shared responsibility for paying for care and support. (ibid, p 14)

Staying with public policy, personalisation can be seen as echoing many of the themes of the **community care reforms**

that followed the National Health Service and Community Care Act 1990. The aim of these changes was to develop a needs-led approach, in which new arrangements for assessment and care management would lead to individuals receiving tailored packages of care instead of standard, block-contracted services.

In practical terms, a major impetus behind the development of individual or personal budgets has been the experience of **direct payments** which became available, initially to disabled adults of working age in England, as a result of the Community Care (Direct Payments) Act 1996, and have since been extended to other groups. The popularity and success of direct payments has stimulated much of the thinking around individual and personal budgets.

Significantly, direct payments came about and were championed by disabled people themselves. The **service user movement** and the **social model of disability** have been powerful driving forces.

Practice example

Delivering personalisation to black and minority ethnic communities – Oldham Link Team and Language Shop

So that all citizens benefit from personalised care and support, those responsible for planning and providing services need to take steps to ensure that services are accessible and appropriate for people from a range of diverse backgrounds.

The Oldham Link Team and Language Shop is situated within the local authority and works to promote equal access to social care and support via language and community liaison work with black and minority ethnic (BME) people, focusing particularly on assessment and support planning. The team works at strategic and operational as well as frontline delivery level across adult social care.

The aim is to empower individuals, families and communities by providing relevant accessible information and on-going support to people to get the most from the personal

budget option. The team also has a role in developing and strengthening services which take holistic, flexible approaches to support provision which accounts for the family context and cultural needs. This has allowed a wider and more appropriate choice for people from local BME communities and has improved uptake of personal budgets. For instance, one provider can guarantee gender specific support and is able to provide significant flexibility, choice and control to the users of the service who are able to cancel and rearrange scheduled sessions at minimal notice.

The team also works at strategic level with commissioners and service planners within the local authority. As part of their community liaison role, the team can provide intelligence for the strategic commissioning and development of care and support services which are appropriate for the local population. For example, they have recently identified a need for a suitable brokerage service. By offering an analysis of social care assessments which were not successful, the team can potentially identify any patterns and barriers in assessment practice or service provision which may need to be addressed at a strategic level. They have recommended that the assessment process be enhanced by the use of knowledgeable language support workers rather than generic interpreters.

Personalisation has some of its roots in the disability, mental health survivor and service user movements which emerged in the 1970s, where individuals and groups undertook direct action and lobbied for change. Independent living, participation, control, choice and empowerment are key concepts for personalisation and they have their origins in the independent living movement and the social model of disability. The current personalisation policy has been influenced by the practical work of **in Control**, established as a social enterprise in 2003, which has pioneered the use of **self-directed support** and personal budgets as a way to reform the current social care system.

The initial phase of in Control's work was carried out across six local authorities from 2003 to 2005 and focused mainly on people with learning disabilities. It was positively evaluated and led on to a second phase which began to test the model for different people using social care (Poll and others, 2006). The whole evaluation collected information on 196 people in 17 English local authorities. The majority of people reported improvements to their lives since they began using self-directed support (Poll and Duffy, 2008). Now over 100 local authorities are looking towards the in Control self-directed support and personal budget model as a solution to delivering personalised social care services for all adults, and over 3,500 people are directing their own support.

Finally, personalisation has been shaped by the **policy thinking and ideas** of researchers, policy analysts and think tanks. One of the most significant contributors is Charles Leadbeater, whose influential Demos report *Personalisation through participation* (2004b) outlined a potential new script for public services. Drawing heavily on some of the influences highlighted above, he emphasises the direct participation of the people who use services: 'By putting users at the heart of services, by enabling them to become participants in the design and delivery, services will be more effective by mobilising millions of people as co-producers of the public goods they value' (Leadbeater, 2004b, p 19). He argues that personalised public services can have at least five different meanings:

- providing people with customer-friendly versions of existing services
- giving people who use services more say in how they are run, once they have access to them
- giving people who use services a more direct say in how money is spent on services
- turning people who use services into co-designers and co-producers of services
- enabling self-organisation by society (Leadbeater, 2004a, p 1).

The last two meanings are defined as 'deep personalisation', with people who use services working in equal partnership with

providers. This is the type of personalisation that underpins social care transformation. It is not about modifying existing services, but changing whole systems and the way people work together.

Wider views of personalisation

Another term being used in discussions about personalisation is 'co-production'. Co-production is a fairly recent term that is used as a new way of talking about direct participation, community involvement and power and expertise sharing in social care services in the UK. It has also been called 'co-creation' or 'co-design', and can be seen as a way of building social capital.

Putting People First asserts that the transformation of adult social care programme 'seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage' (HM Government, 2007, p 1). In proposals for new ways of organising and delivering social care services, people who use services have suggested that 'service user-controlled organisations can be a site where social workers are employed working alongside service users in a hands-on way' (Shaping Our Lives and others, 2007, p 13). This would seem to encapsulate the essence of co-production in adult social care.

Research on co-production has shown that frontline workers should focus on people's abilities rather than seeing them as problems (Boyle and others, 2006) and should have the right skills to do this. It has also said that developing staff confidence and improving how they feel about themselves and their jobs is very important. Co-production should mean more power and resources being shared with people on the front line – people who use services, carers and frontline workers – so they are empowered to co-produce their own solutions to the difficulties they are best placed to know about. (Boyle and Harris, 2009; HSA and NDTI, 2009; Needham and Carr, 2009) 'Service users should be regarded as an asset encouraged to work alongside professionals as partners in the delivery of services' (Boyle and Harris, 2009, p 15).