CIPFA The Chartered Institute of Public Finance & Accountancy

Self-directed Support Resource Implications

Workshop Discussions October 2015

The Scottish Government sponsored a number of workshops to promote application of commissioned CIPFA guidance on the resource implications of Self-directed Support (SDS). The notes below are intended to reflect some of the areas and views raised by participants during the workshops. Inclusion below

- *does not represent endorsement or support of the comments by CIPFA or any other organisation*
- *does not necessarily represent unanimous agreement by participants*
- *is not guaranteed to be exhaustive. Other aspects and comments may have been discussed.*

1. Promotion of Service and Provider Options

The requirement to promote a broad range of different services has implications for authorities and providers.

One challenge is whether to seek to transform services to 'shape' or encourage demand or to wait for demand from supported people to change in order to inform the transformation. This is linked to the expectation that Integrated Partnerships are required to develop Market Facilitation strategies. Changing services for existing clients is a particular challenge.

Small providers may find it harder to adapt and broaden services, especially in the current climate. Some councils indicated that providers were withdrawing in some areas.

Low pay in social care sector is affecting the ability to recruit & provide services and the changes to minimum and living wage levels is making this more acute as are other employment requirements – pension rights etc.

Community support (eg neighbours / community spirit) should be a key element in securing a range of support, including informal networks.

Possible hurdles to overcome include: Cultural change; geography & client group factors; 'change resistance'; redirecting resources invested in existing services; expectation of continuity of service for existing clients; requirement for a 'safety' level of service to be maintained; collaboration (some stakeholders may benefit from engagement strategies).

2. Commissioning

More choice can lead to uncertainty in demand for any particular service or provider. This may affect the ability of service providers (incl authorities) to invest in set up costs for new services.

All service providers may need to consider potential decommissioning / withdrawal options available if demand for a particular service is not as great as anticipated.

The potential increase in uncertainty regarding the level of demand and income for external providers (& authority provided services) is a challenge. For example the shift from block contracts to spot purchase creates some more cash flow uncertainty which may affect provider ability to rely on credit facilities / bank overdrafts.

The 'lead time' to effect change through commissioning will probably be measured in years.

It was suggested that SDS and Procurement requirements are not fully in alignment and may in some respects counteract each other.

Outcomes-based support planning should probably be the key focus and most significant driver for change

Some providers are unlikely to be able to support short home visits (eg 15 minutes) as being viable

3. Support for Social Care Staff

SDS implementation requires front line staff decision making to be supported. For instance: permission to make decisions (including committing resources) and be innovative; further development to increase confidence in making decisions; management and political support for front line decisions.

Front line staff can be expected to need more support as direct responsibility for use of public resources needs to be demonstrated and evidenced (with key focus on outcomes achieved). .

Front line staff may appreciate further development support on how to communicate difficult decisions (eg where a review means less public resource input).

Reviewing and updating the Statutory Guidance was suggested. Lessons learned to date (eg re employment law) could be reflected.

4. Integration

Integration is currently requiring significant management and political focus. SDS profile within this change will need to be maintained, for instance specific reference in the Strategic Plan. NHS staff involvement in SDS groups may help.

Integration should assist to promote more alignment of NHS and social care services for the individual.

Integration should reinforce relationships and the formal requirement to engage and consult with a wide range of stakeholders

Structural changes under integration will take time to embed as will roles and responsibilities, with some uncertainty for a period.

The number of different policy changes (eg re carers) can be challenging to deal with and may overlap or contradict in some details.

5. Relevant Amount Determination

More initial emphasis on the existing available resources for a supported person and on the desired outcomes may help support SDS outcomes, and avoid a focus on the Relevant Amount calculation.

Comparison of support between individual cases should be carefully approached since circumstances, preferences and outcomes will differ based on SDS values and principles.

Each authority has its own approach to Relevant Amount determination. There is not currently a 'perfect' Relevant Amount methodology suitable for all councils but this may develop as authorities share their experiences. Not all local authorities are using a points based resource allocation model.

The issue of when the supported person should be advised of the Relevant Amount was raised. While guidance may suggest detailed calculations are desirable as early as possible, initial calculations are indicative rather than set, and councils seek to provide clarity in this respect.'

Some councils noted that the Relevant Amount could be indicated as the same amount for each option (i.e. the same for option 1,2,3 & 4) even though the primary legislation does not specify or require this.

Front line social care staff input to the Relevant Amount determination is important for SDS principles. It is however important to understand the factors that may affect front line social care staff amendment of the indicated Relevant Amount – for example deprivation in some geographical areas could be a factor that requires amendments.

It was suggested that SDS had increased equity and clarity by moving towards a more consistent approach, which may place an increasing focus on fairness.

Relevant Amount determination may arguably need to take consideration of the lead time to amend the support plan. The fairness of this may be debated as those with more flexible arrangements would see quicker changes to their Relevant Amount and support plan.

Two councils have apparently requested QC opinion on the legislation in Scotland relating to the Relevant Amount determination in terms of whether there is a 'ceiling' to the support plan / Relevant Amount requirements.

6. Charging Policies

The existing charging policy framework at a national level is difficult to apply with SDS legislation. The split between chargeable and non-chargeable services may potentially cause sub-optimal SDS outcomes – for example someone receiving Free Personal Care may be able to request that family provide FPC support so that they can use authority support for other (potentially chargeable) services. Under the current arrangements they may not take up this opportunity to maximise their outcomes as they may not wish to start paying a contribution towards their care.

Councils are considering moving (or already have) towards a 'support contribution' approach (eg based on the Relevant Amount for chargeable services). Stakeholders and supported people may be resistant to seeing existing service users charged for services currently provided for no charge, even where the new charging policy may be 'fairer' and more in line with SDS policy and principles. Most councils appeared to adopt transition arrangements for existing clients.

It was suggested that the national charging policies and frameworks, including Free Personal Care, could helpfully be reviewed. The bill for the waiving of charges for carers was noted.

Variations of charging policy between councils could be regarded as 'postcode democracy' rather than a 'postcode lottery'

7. Eligibility Criteria

The current Eligibility Criteria may tend to restrict the focus on preventative expenditure.

One council indicated it was considering a 'whole needs' approach with a split between statutory (criteria met) requirements and preventative (discretionary) needs

Comments on 'fairness'

- The framework will not apply directly to all groups receiving SDS so fairness difficult to assess
- Reference to "Cutting the Cake Fairly" (Commission for Social Care Inspection, 2008) which noted issues with the English eligibility approach
- There is a potential 'cliff edge' approach to support (i.e. someone just above the criteria will receive support, someone just below may receive no support)
- Existing clients may fall below the specified 'eligibility criteria' when support is reviewed and/or council changes level of criteria to be met.
- the current framework does act as a (partially) objective safety mechanism, which also helped to clarify expectations. On this basis amendment rather than removal would be preferable.

The current eligibility framework and assessment process may tend to perpetuate a 'deficit' model approach (eg scoring of inability). This tends to place an emphasis on what a supported person cannot do rather than what they can.

Positive risk management guidance would be a significant assistance

Shropshire went through significant transformation. Acting within the English legislation the implementation of the 'fair access to care services (FACS)' criteria for care was moved to a 'strength based' approach at first point of contact:

- First point of contact is gathering information generally by phone
- Second stage is either a 'fast track' to team support or a multi-discipline group. Home visits have been reduced by asking for attendance at a local centre (eg GP clinic) where possible
- Review undertaken after 2 and 6 weeks with number of re-visits / support interventions occurring after 6 months also used as an indicator
- Process helps focus resources on higher needs
- This was achieved within a 'mutual' / ALEO structure with more permissions and flexibility for front line staff decisions (big culture change) including peer to peer support and political support

8. Option 2

All authorities appear to operate a contract agreement for option 2 arrangements but practices differ, including:

- 'bipartite' arrangements between the authority and the relevant external provider
- 'tripartite' arrangements signed by the authority, the relevant provider and the supported person
- A combination of bipartite contracts / agreements to act as the framework
    - authority & provider (re high level service spec)
    - authority & supported person (the support plan agreement)
    - provider & supported person (detailed spec of the services)

Agreements will need to differentiate between regulated providers and non-regulated providers

Option 2 is not all that widely used at present. Early adopters may encourage increasing change over time.

There is debate on whether Option 2 should or does sit closer to option 3 (therefore supported by similar Framework contracts which may mean restriction to choice) or whether it sits closer to Option 1 with the Local Authority directly or indirectly paying the provider on behalf of the individual.

Option 2 may be seen by some as preferable to taking on 'employer' responsibilities for assistants or as a way of specifying a 'non-contracted' provider.

Not all support may be open to 'creative' or 'innovative' solutions (eg assisting someone to get out of bed is always likely to involve a task / time based approach).

It would be helpful for authorities to record why Option 2 has been chosen by a supported person. This may identify factors that should influence market shaping / service provision.

CIPFA 9 November 2015