insights

Self-directed support (SDS): preparing for delivery

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Key points

- Self-directed support (SDS) is not the same as personalisation or direct payments (DPs). SDS is a vehicle for personalisation; DPs are one of four options for SDS.

- Base-lines and mechanisms for capturing learning need to be established now, to strengthen the evidence base for practice.

- Social work assessment will require co-production with people seeking support, and will need to be outcomes-based rather than service-led. The Talking Points: Personal Outcomes Approach should be helpful when rolling out SDS.

- The interaction between SDS and adult protection is far from clear and might usefully be addressed via joint training and the development of protocols at a local level.

- Inequalities regarding take-up, costs and outcomes do not necessarily mean personalisation, increased choice and control are more suitable for some groups than others, but that creative approaches need to be developed.

- Practitioner roles will need to shift towards support and brokerage, away from procedural care management.

- User-led support organisations and those providing independent advocacy have critical roles to play and will require sustainable funding.

- Although the implementation of SDS will be affected by funding cuts, personalisation brings challenges regardless of the financial context; cuts bring challenges regardless of the model of social care.

Introduction: what is self-directed support (SDS)?

As the *Social Care (Self-directed Support) (Scotland) Bill* goes through Parliament, it is timely to consider what can be learnt from existing research, related initiatives and experience elsewhere.

According to the Scottish Government's Self-directed Support National Strategy (2010), SDS is:

'a term that describes the ways in which individuals and families can have informed choice about the way support is provided to them. It includes a range of options for exercising those choices. Through a co-production approach to agreeing individual outcomes, options are considered for ways in which available resources can be used so people can have greater levels of control over how their support needs are met, and by whom' (Scottish Government, 2010, p229).

The Bill defines SDS in terms of four options that local authorities will have a duty to offer:

1. the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support

2. the supported person chooses their support and the local authority makes arrangements for the support on behalf of the supported person
3. the local authority selects the appropriate support and makes arrangements for its provision by the local authority
4. a mix of options 1, 2 and 3 for specific aspects of a person's support.

(Self-directed Support Bill: Explanatory notes, section 13, p4, 2012)

Although not everyone will be eligible for direct payments (option 1), if the local authority thinks someone is ineligible they will have to explain why. Option 2 includes 'Individual Service Funds' where the local authority contracts with providers on someone's behalf. If local authorities decide that carers should have support, they too would be offered the four SDS options. The local authority must also provide information and advice so that people who use services can make an informed choice over how their support is to be provided.

SDS has been described as a misunderstood and 'evolving concept', often confused with direct payments (Ridley and colleagues, 2011). However, as the Bill makes clear, direct payments are just one of four options for SDS. Sometimes SDS is understood as the same as 'personalisation', but personalisation is an umbrella term covering a range of approaches to providing individualised services, choice and control. Personalisation can be 'shallow',

tweaking existing services to make them more user-friendly, or 'deep', involving users as co-designers of services (Leadbeater, 2004). SDS requires personalisation of the 'deep' sort.

Background to SDS

As elsewhere, the Scottish public service reform agenda (see *Christie Commission* report) has prioritised the delivery of personalised, reflexive and flexible services, giving individuals greater choice and control over their support. In Scotland, SDS is central to realigning social care along these principles. The approach is reflected in a wide raft of reports and policy initiatives (eg *Changing Lives, Reshaping Care for Older People, National Carers Strategy*).

In some respects, SDS is not a new idea in social care, but builds on earlier developments around personalisation such as person-centred planning and direct payments (Glasby and Littlechild, 2009). In other respects, as SDS becomes the mainstream mechanism for delivering social care, it brings new challenges for organisational culture, systems and the workforce.

The origins of personalisation can be traced back to two sources. One was the work of disability activists in what became the independent living movement. They argued that disabled people should have rights to choice and control over how they are supported to live their lives as equal citizens in the community (Zarb and Nadash, 1994). The second was a pamphlet published by the think-tank Demos (Leadbeater, 2004) which proposed a new 'script' for public services, in the form of 'personalisation through participation'.

The first approach to personalisation could be characterised as rights focused, and the second, as service reform driven. However, the Association of Directors of Social Work (ADSW) report on personalisation captures the tensions at the heart of these developments, tensions likely to increase in a climate of austerity:

> 'One of the significant challenges…is the need to meet ever greater demands for services within limited resources and to do so in a more individualised way'. (ADSW, 2009, p1).

Delivering SDS

Overview
Commentators have suggested that the changes envisaged amount to total system transformation, encompassing all levels of interaction and structures in public services:

> 'Success will depend upon a re-framing of social care and corporate practice, commissioning and service delivery' (ADSW, 2009 p3.)

There are implications for corporate systems and culture, from strategy to delivery. The Scottish Government has allocated a budget of £39.5m over three years to help local authorities, providers and independent support organisations meet the challenges of implementing SDS. The Government also funded three SDS test sites from 2009 to March 2011, which generated useful learning (Ridley and colleagues, 2011). Clearly, as implementation progresses, learning will increase. Baselines and mechanisms for capturing learning need to be established now, to strengthen the evidence base for practice.

In Control has proposed a seven step approach to implementing self-directed support (see http://www.in-control.org.uk). This was piloted in England and tested for applicability and adaptation by the three Scottish SDS test sites (Ridley and colleagues, 2011). It was also replicated separately in a small project in North Lanarkshire (Etherington and colleagues, 2009). However, there have been criticisms of the In Control approach, and even some legal challenges concerning the Resource Allocation System (Duffy and Etherington, 2012).

While procedural models may indeed have a role to play, it will be important to ensure they do not promote too narrow a focus on process, thereby undermining flexibility, innovation and real engagement with people who use services. The principles of co-production, placed firmly at the heart of the SDS strategy in Scotland, emphasise collective input and agreement from users and practitioners at all stages of design and delivery (Scottish Government, 2010). However, despite the mantra of involvement, service users and their organisations have not always felt that they have had much say in shaping or developing personalisation (Beresford, 2009). Moreover, greater empowerment of users does not necessarily mean less red tape. For instance, in the SDS test sites in Scotland, efforts to design support systems for SDS services were felt instead to have increased paperwork associated with assessment and resource allocation, at least in the short-term (Ridley and colleagues, 2011).

Cost and commissioning

The evidence to date is limited, but suggests that SDS will not cost significantly more than conventional social care. The evaluation of the

Individual Budget (IB) pilots in England (where choices similar to SDS were offered) found very little difference in the cost of IBs and conventional social care (Glendinning and colleagues, 2008). Rummery and colleagues (2012) also found no evidence that the resources and costs associated with SDS in Scotland were likely to be significantly greater than those associated with more traditional services, although full costs were difficult to measure and predict. Resource requirements for assessment and monitoring might initially increase, but were likely to decrease as SDS is mainstreamed and systems develop.

Rummery and colleagues also suggested that commissioners, such as local authorities, are likely to continue to play an important role in safeguarding the cost and quality of care (although whether they safeguard or control cost is debatable, as is their role regarding quality). However, the SDS framework brings changes and challenges to commissioning practices. Individual SDS users exercising their choice about service provision will be able to move contracts quickly. Local authorities' cumbersome commissioning practices will have to change to enable a move away from block contracting, accommodate a probable increase in demand for personal assistants (PAs) and for contracting with small, possibly specialist, providers (ADSW, 2009).

The experience of DPs showed that transparent costings for individual users could be developed and that this should encourage greater fairness (Rummery and colleagues, 2012). However, unlike the detailed unit cost requirements of DPs, 'light touch' financial controls are seen as a priority by Scottish Government (Ridley and colleagues, 2011).

Assessment

Central to the SDS system is that assessment is driven by consideration of outcomes identified by the person supported by services themselves (Miller, 2012). Unpaid carers also need to be considered in assessments and support planning.

The Talking Points: Personal Outcomes Approach promoted by the Joint Improvement Team contrasts an outcomes-based with a service-led approach. The latter focuses on what people cannot do, and on doing things to or for them rather than with them (www.jitscotland.org.uk). An outcomes-focused approach, therefore, marks a departure from traditional deficit planning associated with assessment based on need, which is typically professionally led.

While the legal requirement for needs-based assessment remains unaltered by the Bill, in a personalised system an assessment based on a professional's definition of needs becomes an obstacle to individual choice and control (Foster and colleagues, 2006). It means a shift from form

filling and ticking boxes to engaging with people. This is underlined by Rabiee (2012), who argues that for social work practice, it is crucial that assessments and responses are timely, flexible and based on individual circumstances.

The emphasis on co-production is underpinned by the belief that individuals are 'expert' in their own problems, and have assets and skills to bring to bear on resolving them (although they may need support to do this). With this approach, it is not enough for assessments to reflect user views, they must incorporate the user's own assessment (www.jitscotland.co.uk). However, there is a legal duty to carry out social work assessment, and local authorities cannot devolve responsibility for this onto the individual. Nonetheless, the power shift required by co-production has implications for the role and tasks of social work and potentially organisational culture.

Empowerment versus protection

Empowerment and protection have been important policy themes for more than a decade. While SDS focuses on the promotion of greater choice and control for service users, legislation such as the *Adult Protection and Support (Scotland) Act 2007* and *Adults with Incapacity (Scotland) Act 2000* are concerned to ensure that adults deemed 'at risk of harm' are supported and protected. It has been argued that there are inherent tensions between empowerment and protection that are not being addressed (Hunter and Manthorpe, 2012).

The Scottish SDS test site evaluation (Ridley and colleagues, 2011) found little awareness in SDS circles of the implications for adult support and protection concerns, and increased potential for abuse of those managing their own budgets. Lead officers for adult protection seemed to be 'bystanders' in the implementation of SDS, with few system or practice linkages between the two strands of activity (Hunter and Manthorpe, 2012). Yet, clearly, SDS interventions in Scotland

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will have to be informed by legislation concerned with protection – and vice versa. To clarify their interaction, joint training and developing protocols at local level might prove helpful.

Social workers will naturally be concerned to promote positive outcomes and will understandably have concerns about being held accountable should things go wrong. Yet, while ensuring appropriate protection obviously remains important, an overly cautious approach to risk could result in the inappropriate curtailment of user choice and control.

Identifying human rights implications could provide a necessary counterbalance to an over-emphasis on risk management and capacity measurement. Using the FAIR approach to human rights might help practitioners to get that balance right (http://www.scottishhumanrights.com). A human rights focus could also help counteract persistent power imbalances between professionals, users and carers and the dangers of 'too narrow a focus on the system and process changes required to implement the mechanisms of self-directed support' (Chetty and colleagues, 2012, p18). Moreover, it has been argued that plugging the 'human rights deficit' within the personalisation agenda could strengthen the legal, policy and practice dimensions of personalisation and, by implication, SDS (Chetty and colleagues, 2012).

Inequalities

In Scotland, uptake of DPs was slower than in England and concentrated on people with physical impairments (Witcher and colleagues, 2000). Latest statistics show that inequalities across service user groups persist (Scottish Government Statistics, 2012). For example, people with mental health conditions remain significantly under-represented and only a tiny number of recipients came from BME communities. The SDS test sites in Scotland reported that access for those with mental health problems, older people, those with addictions or from black or minority ethnic groups was not addressed during the evaluation period (Ridley and colleagues, 2011).

In the individual budget (IB) pilots in England, average costs were found to vary considerably across user groups (Glendinning and colleagues, 2008). They were lowest for mental health service users and highest for people with learning disabilities. Although some differences in outcomes were indicated between groups, overall they were slightly better for all those on IB, particularly in terms of people feeling more in control of their daily lives. Social care outcomes were cost-effective for all groups except older people, for whom standard care arrangements retained a slight edge. They also felt happier with standard care arrangements. However, interestingly, latest statistics show that a third of DP recipients are now aged 65 or over, compared to just 7% in 2001 (Scottish Government, 2012).

Disabled people have expressed concern over prejudicial attitudes towards some user groups and a perception that they would not be able to manage payments (Ridley and Jones, 2003). Indeed, the *Hidden in plain sight* report (EHRC, 2011) evidences the continuing challenges regarding discrimination, access to resources and institutional prejudice facing disabled people using community resources, if not planned well. Yet, the existence of inequalities does not necessarily indicate that personalisation, increased choice and control are unsuitable for some groups. Instead, they may point to the need for more creative approaches to delivery and support. It will be important to monitor inequalities and ensure that they do not become entrenched with the roll-out of SDS.

More positively, the inherent flexibility of SDS and its DP antecedent has appeared to be beneficial for users in remote parts of Scotland, promoting geographical equality. DPs were initially found to be helpful for people in dispersed rural areas where traditional services have been more limited (Priestley and colleagues, 2010). Recent figures support these findings, revealing the highest rates of DP packages per population head were in two rural local authorities - Scottish Borders and Orkney (Scottish Government, 2012).

Workforce implications

Policy documents both north and south of the border have acknowledged that the reform of public services through personalisation will require a radically altered care workforce (Department of Health, 2008; Scottish Government, 2010). SDS brings implications, not just for roles and skills, but for workforce composition and regulation.

Social workers

From observing changes in England and Wales, Leece and Leece (2011) suggest that the role of social workers in this new personalised system is uncertain, and a number of challenges will emerge. Resistance to change in some areas has been based on concerns from front-line staff over the impact of personalised support on statutory work forces (Priestley and colleagues, 2010).

Since the introduction of DP and community care legislation more broadly, there has been debate about the role of social workers as gatekeepers to services, which in some cases has restricted access to these type of schemes (Priestley and colleagues, 2006). In the current financial climate they risk finding themselves implementing a policy that, despite its positive goals, is perceived as a

device for making cuts (Ferguson, 2012). However, it has been suggested that practitioners will spend less time on assessment and gatekeeping and instead be more involved with support brokerage and advocacy (HM Government, 2007; Department of Health, 2008).

The new approach to assessment will require marked shifts in both the 'expert' culture and mindset of professionals and the commissioning of services, geared to meeting outcomes for people. They will require a 'new script' in order to move out of the technical and procedural patterns of working as care managers (Duffy, 2010a).

Whatever its challenges, personalisation could offer an opportunity for social workers to return to traditional values and ways of working. Duffy (2010b) argues that they should embrace personalisation as consistent with their professional ideologies of self-determination and choice. Overall, how social workers respond, individually and as a profession, is likely to be contingent on the quality of leadership, and the management and training of front-line practitioners.

Providers

SDS also brings significant change for providers, who will be required to design, deliver and market services differently. How they are funded will also change, as block contracts are replaced by separate contracts for services for individuals.

A study of the implications of personalisation for the voluntary sector social care workforce (Cunningham & Nickson, 2011) found general support for the principles of personalisation and associated opportunities to enhance skills. Gaps identified included risk enablement, decision-making and community connecting. As well as these gaps, there were concerns about pressure from local authorities to cut costs, and the subsequent impact on services and training budgets. The study also explored the likely impact on terms and conditions, and expressed concern that pay, pensions and reasonable working hours could be pitted against user demands for flexibility, autonomy and choice.

Directly employed Personal Assistants (PAs)

According to the latest statistics over the last five years the number of people using DPs to purchase care and support has increased, while the number receiving home care services provided or purchased by local authorities has fallen (Scottish Government, 2012). While personal assistants (PAs) account for only a small proportion of the current workforce it is possible that their numbers will increase as SDS becomes mainstreamed.

Although the profile of the directly employed PA workforce was found to be broadly similar to the wider social care workforce, the former are less subject to regulation and have no access to dedicated support (Reid Howie Associates, 2010). In England, Leece and Leece (2011)

highlighted the apparent contradiction between a modernisation agenda that has increased regulation on social care practitioners, and the fact that DP users can employ staff without safeguards. Enforcing Criminal Records Bureau (CRB) checks was seen to undermine the principle of user choice and control. Manthorpe and colleagues (2009) found that almost half of the DP users interviewed had neither undertaken CRB checks for prospective PAs nor taken up references. Likewise in Scotland, Disclosure Scotland clearance will not be mandatory. The implications for responsibilities and risk management are covered in updated guidance on the Protecting Vulnerable Groups (PVG) Scheme and SDS (see www.selfdirectedsupportscotland.org.uk).

This underlines the importance for all concerned of local authorities and support organisations proactively assisting PA employers to develop good employment practice. Reid Howie Associates also recommend that a support service for PAs should be developed, along with occupational standards and associated training (2010). However, it is worth noting that in the majority of cases, the use of PAs was found to be working well.

Support brokerage and advocacy

Brokerage involves providing assistance to procure and manage a support package, drawing on individualised funding (in whatever form). Self-directed support, particularly the likely rise in employment of PAs directly by individuals, increases the importance of support and brokerage on issues such as recruitment and employment law. It has been questioned whether this role should be undertaken by social workers, who are ultimately accountable to statutory agencies. (Barnes and Mercer, 2006). Research has also highlighted some antagonism from users to the idea that support brokers should be part of the social care workforce at all (Dowson and Grieg, 2009). Instead, user-led organisations have been widely accepted as the preferred model of support (although many do not provide advocacy). Local authorities in England and Wales have been encouraged to adopt this approach (Cabinet Office, 2005).

In addition, it is well recognised that those least likely to be able to exercise self-determination are most at risk of having their rights (including human rights) ignored. Unless care managers, advocacy and support organisations play a significant role in enabling people needing support to access appropriate services, it is likely that only the more articulate, well-informed users will be in a stronger position to secure higher quality services at reduced

cost (Rummery and colleagues, 2012). Without advocacy support, inequalities between users could widen, as concluded by a report from the Equality and Human Rights Commission (EHRC, 2009).

In recent years, the role of advocacy has become increasingly important for people requiring access to public services (Donnison, 2009). The SDS Bill's clear focus on individual choice over the type of support prompted calls for independent advocacy to be included as a feature of the Bill. In Scotland, advocacy is free, independent (though often provided by organisations funded by local authorities or the NHS) and operates nationwide. Unfortunately, cuts to third sector resources mean that advocacy provision is likely to become more limited rather than the reverse. Investment in advocacy, as with other support services, is required to ensure that increasing demands do not unfairly land on people who access support or family members.

Looking to the future

A key challenge on the horizon concerns the implications for SDS of health and social care integration. The use of SDS for healthcare purposes has been piloted by NHS Lothian and NHS Fife/Fife Council, with some successful outcomes (Blake Stevenson). The Individual Budget pilots in England combined different funding streams (Glendinning and colleagues, 2008) and this

approach is currently being developed by the 'Right to Control Trailblazers' (http://odi.dwp.gov.uk/odi-projects/right-to-control-trailblazers.php). Although neither included much in the way of healthcare monies, they provide useful learning on the process of integration.

Perhaps the biggest challenge to realising the Scottish Government's goal that SDS should promote choice and empowerment is the need for public spending cuts. Evidence from Europe suggests that the financial crisis has had a significant, detrimental impact on social care provision (eg see DAA News Network, 2011 on the Netherlands). Whatever their support for personalisation, there are fears that cash-strapped local authorities will be obliged to use the introduction of SDS as a vehicle for cuts (notwithstanding their duties under the 1968 Act). Welfare reform will further tighten the financial screws on people who use services and local authorities.

Cuts could adversely skew SDS implementation and outcomes. For example, there is a risk that user empowerment becomes a double-edged sword. The objective might be – or be wrongly perceived as – 'not simply…to improve service quality by "bringing the user in" but also...to cut costs, by making the user do more for themselves' (Bovaird and Loeffler, 2012, p6). The possibility that cost-cutting is at the expense of those who need support

is an issue that has rightly concerned the user and carer movement, as well as some professionals (SCIE, 2009; Ferguson, 2012).

However, there is no causal link between SDS and austerity measures and they should not be conflated. Personalisation raises issues for practice regardless of the financial context. Cuts would be taking place regardless of the model of social care. It will be important not to attribute the negative impact of cuts to flaws in the personalisation agenda, or to lose sight of the evidence that personalisation can make a positive difference to people's lives. Yet, this underlines the fact that the availability of an individual budget is no guarantee of choice and control (Ferguson, 2012). Other factors, including size of budget, the availability of diverse service providers and the existence of advocacy and support, are all critical to success.

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