How are we doing with Option Two / Individual Service Funds?

July 2022

REPORT BY

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“[option two] feels a bit like a wet bar of soap; you know it’s there but you can’t quite get a hold of it!”

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Background and Scope

In Control Scotland is pleased to present this research, carried out by Lou Close, into the experiences of six Scottish Health and Social Care Partnerships (HSCP's) in implementing option two of self-directed support (SDS).

Under the Social Care (Self-Directed Support) (Scotland) Act 2013, option two is defined as *funding allocated to a provider of choice or other third party.*

When the legislation was published, option two was a new concept designed to bridge the gap between Direct Payments and traditionally arranged services. It is seen by many as the "best of both worlds", where the person has choice and control over how their support budget is used, but without the administration or employment requirements of a Direct Payment.

There are many examples of people living good lives through option two, but there has been little evidence gathered in how HSCP's have made it possible through their processes and practices. The research was designed to fill this gap in the evidence, by speaking to representatives from six HSCPs:

- Aberdeenshire
- East Ayrshire
- Edinburgh
- Falkirk
- Highland
- Scottish Borders

Initially, our research scope included a focus on transitions, as this is a group who are particularly under-represented in the use of option two, and where there is a real opportunity for positive and lasting outcomes. However, we found that the challenges faced during this time of change

meant that uptake was far lower than anticipated, and so we concentrated on a more holistic view of option two. We believe that improving engagement in option two for this group merits a separate piece of work, which we hope to carry out in the future.

Methodology

We spoke to a range of people, including SDS leads; social workers and care managers from Children, Adults, and Transitions teams; commissioning, procurement, transactions, finance, and business support staff; and providers, community groups, advocacy and other organisations involved in the process or delivery of care and support purchased through option two.

We asked them all a series of questions, including how they define option two locally, what the uptake of option two has been, the types of purchases made under option two, how services are commissioned, procured and managed, what mechanisms are in place for people to manage their budget, and what has had to change in order for them to fully embed option two.

Findings and Recommendations

We found that the experiences have been variable, with some excellent solutions and practice in place to overcome sticky issues. This includes providing peer mentoring to frontline workers, commissioning an external provider to enable independent management of option two packages, removing the need for frameworks for option two provision, and a great many examples of holistic and person-centred purchases being made to support the person to live a good life.

However, we also found some common challenges, about how option two is defined, how providers are paid differently across different options which can disincentivize the offer, how true choice and control can be limited through procurement methods, and how assessment and allocation models can lead to stifled creativity.

The report ends with six recommendations:

1.To revisit the definition of option two so that there is a consistent starting point in all areas which matches the expectations of Scottish Government as clearly set out in the SDS Act and Guidance, and to implement mechanisms through the regulation and inspection process to ensure compliance with this.

2. To build support plans around outcomes and not units of time, with a dedicated piece of work initiated at a national level to properly apply the principle of an up-front allocation of resource, which people are fully enabled to choose to spend on meeting their outcomes.

3. To positively and proactively incentivize provider engagement with option two, by working at a national level to understand the barriers to providers fully engaging to manage option two budgets, and then to proactively address this.

4. To agree a national standard in relation to whether ISF's should be held and managed by the local authority.

5. To undertake work at a national level to identify and address the key blockages to real change in the commissioning landscape. This should include a shift in thinking away from frameworks as the default approach for all options to allow for more individualised support across all groups and greater availability of genuine choice, along with support for providers to develop systems for managing option two prior to taking them on.

6. To proactively increase worker autonomy including addressing organizational appetite for risk, through an examination of local policies and procedures to ascertain whether or not these are, as required by the Statutory Guidance, *"flexible enough to allow workers to be autonomous in exercising their professional judgement".*

Introduction

This project was stimulated in part by participants in an In Control Scotland *Working Together for Change* programme, highlighting a lack of implementation and even understanding of option two as one of several areas needing improvement at a national level. Alongside their anecdotal evidence, the findings of both the Care Inspectorate[1] and Audit Scotland[2] found that since the Social Care (Self Directed Support) (Scotland) Act 2013[3] was enacted, Self Directed Support (SDS) has been implemented inconsistently across the country, and whilst some areas have embedded it well, in others there remain significant obstacles to successful change. There are many challenges in fully implementing both the spirit and the letter of the SDS legislation and guidance which are recognised to a lesser or greater degree in different areas, however a lack of progress around option two is almost universal. The Care Inspectorate's Thematic Review into SDS[4] concluded that whilst option one was essentially well-established in the majority of areas across Scotland, option three remained the most commonly utilised in provisioning care and support, with limited examples of either options two or four being routinely used, the latter primarily held up by the lack of progress on the former.

This is perhaps understandable given the context that, prior to the individual / personal budgets piloting of the 2000's and subsequent legislation, options one and three were already available and essentially 'business as usual' for local authorities, whereas option two represented an entirely new way of working that would therefore be far more challenging to implement than the aspirations to ensure that Direct Payments (option one) should become more widely available and less restricted, and commissioned services (option three) should become more person centred and flexible. Pre-SDS, these existing two choices could be said to be at quite opposite ends of a sliding scale, with Direct Payments representing

[1] https://www.careinspectorate.com
[2] https://www.audit-scotland.gov.uk
[3] https://www.legislation.gov.uk/asp/2013/1/contents
[4] https://www.careinspectorate.com/images/documents/5139/Thematic%20review%20of%20self%20directed%20support%20in%20Scotland.pdf

maximum choice and control for the individual coupled with maximum responsibility for arranging and managing their support and maximum accountability for the money, whereas commissioned services kept both control and responsibility firmly within the authority, so that even where such services were of an excellent quality, they would be primarily focused on delivering against a generic specification and highly detailed contract with the purchaser. In theory, option two offered a middle ground between these two extremes and arguably, as has been stated many times throughout this project, *"the best of both worlds"*, giving the individual a high level of choice and control with care and support tailored closely around their needs and outcomes, whilst the budget is held and managed at arms-length from the purchasing authority, enabling the provider/s of service to be creative, flexible and more nimbly responsive to changes. As the most significantly different aspect of the new legislation, it is potentially therefore unsurprising that it has proved the most difficult to implement.

This project sought to explore what success looks like in relation to option two / individual service funds as a key part of ensuring the proper implementation of all four SDS options, and to encourage good practice by articulating exactly what goes into making sustainable change possible. The purpose of the work was to explore and collate learning from a small number of sites who have managed to make ISFs a reality in order to share this with areas where they remain underdeveloped so that option two finally becomes as readily available and easily accessible as options one and three, focussing on debunking myths and simplifying thinking. As there are already many case studies and stories widely available from the perspective of individuals and families who have used option two, our aim with this piece of work has been to dig deeper into the processes, tools, approaches and mechanisms which need to be in place within local authorities, providers and other organisations in order to make these a reality.

Definitions and Terminology

For the purposes of this project, we have taken the following as our working definition of option two / individual service funds (ISFs):

- Under the SDS (Scotland) Act, option two is defined as *funding allocated to a provider of choice or other third party.*

- An individual service fund is defined by In Control Scotland in its ISF Guide[5] as *the practical mechanism that enables people to select option two, enabling them to not only choose who provides their support, but also to work with their chosen support provider to make flexible and creative use of their individual budget.*

- supportmesupportyou.org[6] describes option two thus: *The supported person is in charge of which support providers they use and how their support works. Someone else manages the money for the supported person to pay for this. This third party can be a provider, the local authority (council) or another organisation.*

- supportmesupportyou.org[7] resources available via the CCPS website describes ISFs as when *The supported person is in charge of which support providers they use and how their support works. Someone else manages the money for the supported person to pay for this. This third party can be a provider, the local authority (council) or another organisation.*

Different sites use the term option two or individual service fund (ISF), with some using both interchangeably while others use one or the other, and in some instances there is a subtle difference in meaning, with the predominant usage seeming to be that where the budget is held in house it is referred to as option two and where it is held and managed by a third party it is known as an ISF.

[5] https://www.in-controlscotland.org/_files/ugd/fd9368_1da0f2f772514ad9b5bac06e5263277b.pdf
[6] http://supportmesupportyou.org/
[7] https://www.ccpscotland.org/

Throughout this report we will use the two terms interchangeably to mean the same thing, that being the alternative to a Direct Payment (option one) and a commissioned / contracted service (option three) which was envisaged by the original SDS legislation.

Participating Sites

In Control Scotland made a number of calls for participants in the project, including through its own networks, Scottish Care, The Coalition of Care Providers Scotland (CCPS), Social Work Scotland and through various individual connections.

Sites who expressed an interest in being involved were selected based on being able to demonstrate that they have successfully implemented option two in a system-wide way, so not simply where a small handful of individuals have benefitted as part of a pilot, but where the option is properly embedded throughout the area and generally available across client groups. We anticipated that this would mean that processes, policies and practice demonstrate a clear understanding of and commitment to offering all four options locally, and where uptake figures suggest that this is meaningful and accessible.

The six sites we worked with are:

- Aberdeenshire
- East Ayrshire
- Edinburgh
- Falkirk
- Highland
- Scottish Borders

In each area we sought to focus on the processes behind the successful implementation of option two, beyond the specific detail of what individuals are using it for, which has been covered extensively in anecdotal case studies over the years.

To get a reasonably rounded view of how ISFs work locally, we held meetings and discussions with as many of the following people in each site as we could reasonably speak to within the time parameters of the project:

- Any designated lead/s for the implementation of SDS in general and / or option two in particular.
- Social workers and care managers from Children, Adults and Transitions teams who have been involved in supporting clients who have chosen to use an ISF.
- Commissioning, procurement, transactions, finance and business support personnel who are routinely involved in managing the practical application of option two.
- Any providers / community groups / advocacy or other organisations involved in the process or delivery of care and support purchased through ISFs, including any specific brokerage organisation/s or group/s commissioned to provide advice, guidance or support out-with the HSCP / authority.

The project was focussed on nine key questions and the bulk of the report will be arranged around these, looking at what is working well and what is more problematic, and seeking to draw key learning from across the participating sites. We also include three organisational vignettes at the end of this report to illustrate the variety of approaches to delivering option two which we encountered across the six sites.

Q1: What is the local definition of option two and how does this compare to the nationally recognised definitions above?

Each site had its own definitions, clearly articulated on websites and in literature, all based on the nationally recognised definitions set out at the beginning of this report, but with enough variation to suggest that this starting point may be where the consistent implementation of SDS envisaged by the Scottish Government begins to fall down. Whilst each authority clearly applies its own definition and works within it, the variance between them is evident in practice in terms of how option two is experienced by individuals and families across the six areas and, presumably, across the country. The Scottish Government's SDS Framework of standards[8] published March 2021 states in point 11.6 that *Supported people can have confidence that their agreed personal outcomes will be met in a comparable way to others in similar circumstances across Scotland*, which implies an expectation of more consistency than we have discovered during this project, and begs the question how someone moving from Aberdeenshire to Falkirk or vice versa, for example, would experience continuing to choose an ISF for their care and support. Of the six, these two sites have quite different definitions, with Aberdeenshire stating clearly that people can *"choose to have all or part of your individual budget paid to an Individual Service Fund (ISF) provider"*[9] while Falkirk states that whilst the person chooses *"what support you want and who will provide it, we will arrange and pay for the services you have chosen,"*[10].

Of the other participating sites only one other, Scottish Borders, clearly defines option two as being where the money is managed by a provider, stating that *"The provider will look after your budget for you."*[11] Both Edinburgh and East Ayrshire offer a choice of the budget being managed either by themselves or *"another organisation",* although as we will see in

[8] https://www.gov.scot/publications/self-directed-support-framework-standards-including-practice-statements-core-components/
[9] https://www.aberdeenshire.gov.uk/social-care-and-health/community-care/financial-support/self-directed-support/self-directed-support-option-2/
[10] https://www.falkirk.gov.uk/services/social-care/adults-older-people/self-directed-support.aspx
[11] https://www.scotborders.gov.uk/info/20055/adults_and_older_people/371/self_directed_support/2

practice the picture is quite mixed in Edinburgh, while in East Ayrshire, the default would appear to be that budgets are held by the HSCP. Highland's definition is not at first glance entirely clear; *"The individual budget is paid to a service provider that is currently contracted with NHS Highland who will help the person to arrange their social care and support"*[12], though in practice, personal budgets are managed by the provider on the supported person's behalf via individual bank accounts as required by the authority's tripartite agreement.

Given that how an authority defines the options is likely to be the starting point for any conversation between a worker and a potential service user, it is clear to see from the above examples how quickly the offer under option two begins to diverge in a way that does not happen for option one, where Direct Payments have very clear, nationally recognised and regulated parameters, or option three which is invariably consistent across the piece. Perhaps, therefore, the expectations and guidance on option two which have been provided nationally have allowed too much room for local interpretation, resulting in the variation experienced in reality by individuals and families who use social care and support.

Q2: How many people are accessing ISFs as defined locally, including breakdown by client group?

In addition to the above disparity in defining ISFs across our six sites, we also found that within sites there was sometimes an acknowledged opacity around accounting for option two, with practitioners, business support and also third sector support and advice organisations, many of whom are funded via Support In The Right Direction[13], raising concerns that some of the recording of which option someone has chosen can at times appear arbitrary. Most of the six authorities gave examples of where the options may be recorded inconsistently, such as ticking the option three box because the provider concerned is also an option three provider, even if the person is clearly choosing and organising their support directly with the agency concerned, or conversely ticking option two simply because the

[12] https://www.nhshighland.scot.nhs.uk/Services/ASC/SDS/Pages/welcome.aspx
[13] https://www.inspiringscotland.org.uk/what-we-do/our-funds/sird-2021/

person expressed a preference for a particular provider even if the actual organising and managing of their care sits entirely with the social worker. People also raised concerns about option two being recorded where, in reality, the "choice" of provider was considered to be quite arbitrary because there was no other provision either suitable or available. It is clear that these are issues of misunderstanding rather than by design, but nevertheless it raises the question as to how reliable the figures provided actually are, and each authority is aware of a need to tighten up definitions and recording protocols to be sure that what they are counting is a true reflection of what people are choosing and experiencing on the ground. An example which illustrates this issue includes a worker from an advice and support organisation saying that whilst the numbers state ISFs are being used, in their experience this is mainly because the person can't cope with option one and the service they need or require isn't available under option three, so in effect option two is a least-worst option rather than a positive choice.

On the next page is a table showing the figures for option two in each area we consulted, representing a snapshot in time of the numbers of people accessing care and support under each option, with the figures converted into percentages for ease of comparison. These statistics demonstrate that the uptake of this option remains extremely small, even where a significant amount of work has gone into developing a model for it, and remind us of quite how much work remains to be done, even in these six sites who have had such a clear focus on increasing awareness and uptake of this choice.

As one frustrated worker from a third sector organisation told us, option two...

> *...feels a bit like a wet bar of soap; you know it's there but you can't quite get a hold of it!*

Site	ISFs as a % of overall cases	ISFs broken down by client group, where available
Aberdeenshire	1.25%	Adult autism: 1.52% Children and families: 36.36% Dementia: 0% Drug and alcohol: 3.03% Learning disabilities: 9.09% Mental health: 10.61% Older people : 6.06% Carers: 22.73% Physical disability: 10.61%
East Ayrshire	5.49% option two 7.41 option four, the majority of which include an option two as part of the four	For option two, no figures. For option four: Child with disability: 26.05% Learning disability: 14.71% Mental health: 15.13% Older adult/physical disability: 44.11%
Edinburgh	4.15%	Learning disability: 47.89% Mental health: 5.72% Older people: 34.04% Physical disability: 12.35%
Falkirk	6% (based on figures from 2020/21 due to implementing a new system)	Breakdown unavailable from old system; new system unable to generate at time of writing
Highland	7.5%	Learning disability: 45.45% Mental health: 7.36% Older people: 28.57% Physical disability: 18.61%
Scottish Borders	1.01%	Physical disability: 8.70% Learning disability: 43.48% Mental health: 8.70% Generic: 39.12%

At the start of the project, we had anticipated that a particular focus on young people going through transition might emerge. This is thought to be a group who are particularly under-represented in the use of option two and, in addition to the lack of consistent headway across all client groups, in 2017 the Audit Commission concluded that there was a specific need for authorities to review their SDS processes for supporting young people transitioning into adult services. Learning from our six sites suggests that transition is an excellent time to think about option two, with transition workers in several of the areas sharing their experiences that option one can feel too complex for stressed and stretched families while option three is often too restrictive in terms of meeting a young person's outcomes, and so option two was felt to be the perfect option offering *"the best of both worlds"*. However, others reported that for some families, the shift from Children's services to Adults also meant a change in provider and therefore brought with it the need for relationships and trust to be built up before they might feel comfortable agreeing for the organisation concerned to manage the young person's budget. For most of the children and families and / or transitions workers who contributed to the project therefore, whilst they could see and would highlight the benefits of choosing an ISF, they often found that a Direct Payment would be chosen - or in many cases continued - at least until the support was well-established, with option three only really being seen as appropriate for those who lack capacity as well as engaged family support, who are content with the local authority's provision, or really don't want any input into decisions over their care and support.

Common to most of the six sites was a sense that people's "choice" of option is often less about what they want and more about what is most likely to secure them the care and support they need, and in some instances the organisations who support people with Direct Payments indicated that they felt at least some of the people they worked with who use all of their services (payroll, employment support and third party banking) are perhaps more suitable candidates for an ISF. Similarly common was the sense that a thorough exploration of the four options happening as part of the assessment and support planning process was extremely inconsistent, with some practitioners confidently doing so whilst others were thought to be simply processing people through the system to

whichever option will provide most efficaciously, in the professional's opinion, for their needs. This is a failure in one of the fundamental duties under the Act, to fully inform the person of the options available to them at the time of assessment[14].

Q3: What examples are there of things being purchased or commissioned which demonstrate that the use of option two is creating more choice and control for people who choose to use it, and how do these differ from or compare to use of options one and three locally?

This quote from a Cornerstone worker in Aberdeenshire sums up the generally wide ranging use to which option two is successfully applied across all six sites, to a lesser or greater degree:

> *From yoga to flower arranging to traditional care and support, option two gives the opportunity to find new and personalised ways to meet outcomes and goals.*

Across all the sites there were multiple examples of ISFs being used creatively to meet people's outcomes, including the ability to use part of the ISF to purchase items or equipment and to pay for memberships or activities, so long as these are congruent with the person's identified outcomes, and many of these can be found in case studies shared on the websites of the HSCP and / or their support and information / brokerage services.

The key difference from option three is that those services which fall under commissioned or pre- or block-contracted arrangements are providing

[14] https://www.legislation.gov.uk/asp/2013/1/section/5/enacted

care and support within the restrictions of the contract specification, and whilst there are many examples of this being of a highly person centred nature, there remain issues around the person having to fit into the service rather than the service fitting itself around them. The key difference from option one is simply that people can employ individual staff directly, using the Direct Payments legislation to become employers in their own right, however in several of our sites even this distinction has become less stark, with the HSCP comfortable about people using option two to purchase care or support from self-employed workers, meaning they get the truly person centred input someone would expect from employing their own staff directly without the burden of becoming an employer themselves. One social worker spoke about how option two *"allows clients to accumulate unspent hours which option three doesn't, and it allows them to employ suitable staff without the need to have been okayed by the contracts team,"* both examples of the clear advantages of choosing an ISF.

The acceptance of self-employed workers is a particularly interesting example of inconsistency in approach across our six sites and again, we feel it is reasonable to assume from this that a similar disparity is likely to be mirrored across the whole country. Some of our authorities, such as East Ayrshire, embrace this as offering maximum choice and control to clients, with advice and guidance for both the worker/s and the service user around how to make it as safe and legally compliant an option as possible, while others were adamantly against it. This debate is perhaps revealing of the site's overall appetite for risk, with those who do not allow people to use option two to employ self-employed workers citing concerns raised by a particular case of a self-employed carer being deemed by HMRC to be in actual fact employed by the client concerned, who passed the liability for back taxes and other costs onto the local authority, at significant cost. In one area we were told of a situation in which a provider was supporting someone via a Direct Payment who was struggling to manage it and so agreed to transfer on to an ISF which the provider would hold and manage; some of the individual's Personal Assistants (PAs) already worked for the agency too, so they simply went onto payroll for these additional hours, while those who weren't were transferred onto the staff to enable the individual to keep the same team, as their being self-employed would not have been an option.

A similar discussion and divergence in approach can be seen in relation to small micro enterprises, and in one case the inconsistency was within the same area but between Children's and Adults' services, with the former being comfortable using ISFs to purchase support via small businesses which were said to have *"just sprung up"* in a very rural location in response to the challenges of the larger providers focussing their offer in the larger conurbations, whereas the latter would only allow people to access a similarly small, innovative group via a Direct Payment.

An area of consistency across the six sites is that if there are changes proposed to the care and support being provided under option two, these can be agreed between the individual and the provider without going back to the social worker or care manager so long as the original support plan is open enough, emphasising the need for plans to be focussed on outcomes rather than specific inputs. An example which illustrates how being too prescriptive in the support plan can then constrain someone's ability to use their personal budget flexibly is where a gym membership had gone un-used due to Covid and the person bought a treadmill to use at home instead, but because gym membership was specified they had to go back and get the change approved by the practitioner who then had to raise a new process internally before they could spend the money on the treadmill. Had the support plan specified inputs which enable the person to develop or maintain their physical fitness, such a return to the social work department and the subsequent time spent by them and other departments within the HSCP in adjusting the allowable purchasing from the budget would have been unnecessary. In other cases where specification is wider, perhaps "complementary therapies" or "group activities", there was much more flexibility to do more without going back for approval, so long as the changed cost is under or within existing budget, and this latter approach is clearly more consistent with the spirit of the SDS Act.

In Edinburgh we heard how ISFs are considered to be the best way to manage complex packages of support when someone has a combination of day time and at home support plus respite. Traditionally this would potentially fall under three separate contracts or service specifications, even if all were commissioned from the same provider, whereas option two allows them all to be rolled into "one pot" and used far more flexibly around

the person as a result. In Scottish Borders, a provider told us of how they had been delivering care to an individual via their contracted service – option three – when the gentleman was nearing the end of his life and his daughter found out about and subsequently requested option two; this *"made a massive difference as we were suddenly able to provide a fully tailored package of support around the man and his family's needs"* where previously they had felt *"frustrated and constrained by"* what they described as the *"time and task focus"* of the council contract.

The Scottish Government SDS Framework of Standards provides clear expectations in this area, with point 11.4 stating that there will be *nationally consistent approaches to eligibility criteria; charging and contributions criteria; commissioning; procurement and budget allocation and calculation, including levels of delegated authority for workers and managers*, and point 11.5 stating that there should be *nationally consistent guidelines on what budgets can or cannot be spent on*. Whilst there is ample evidence from all six sites of flexible and creative solutions to people's care and support needs being provisioned via option two, there is very clearly significant divergence between them as to what is and is not possible. In Highland and Edinburgh for example, people can only use a provider who is already contracted to offer services via a framework agreement, in the first case this being the same framework as that for option three, causing some practitioners to wonder what the difference is (and potentially impacting therefore on recording of options as referenced in the question relating to statistics). In comparison, in Aberdeenshire, East Ayrshire, Falkirk and Scottish Borders people can choose any organisation or group to deliver their outcomes regardless of whether that organisation is known to and contracted with the authority or not, though as we have already seen, this does not extend in all cases to self-employed workers.

In its "Myth Buster for the Procurement of Social Care"[15], CCPS challenges the assumption that *"insisting, for self-directed support Option 2, that a service user must chose a provider from a restricted number of organisations appointed through a previous procurement process where the service user wishes to make a direct award to a provider of its own choice may breach obligations under the Act"*, and suggest that *"not affording service users the choice which the 2013*

[15] https://www.ccpscotland.org/wp-content/uploads/2022/06/CCPS_Myths_Buster.pdf

Act sought to provide them with or otherwise failing to use the flexibilities available in procurement law is likely to impact on meeting legal duties under the 2013 Act." It would seem therefore that those HSCPs which choose to continue to operate frameworks or approved lists for ISF providers need to reconsider this approach.

Exploring the disparity between sites on this issue opened an interesting debate about the respective authority's appetite for risk, as invariably where the control over where people can choose to spend their ISF is greater, the reasoning behind this is given as a sense of duty to protect vulnerable people from less scrupulous service providers; in other words, it is a form of risk management. In considering this issue further with our sites, it became clear that most are perceived by their own staff as well as partner organisations to be relatively risk positive at a macro level, although there were more mentions of concerns about risk in those areas where the balance of control leans further in their direction, posing the question of whether these authorities maintain more control because their experience of facilitating social care and support suggests a need for heightened scrutiny in their area, or whether their fear of risk holds them back from being more innovative.

Q4: What is the wider overview of the local approach to commissioning and procurement in general both on and off any frameworks in place, how is this able to flex to allow for individual choice and control across all four options, and how is risk approached and managed?

The Scottish Government SDS Framework of Standards expects that as part of the work to implement the legislation, we will come to a position where:

- (point 7.5) *There is understanding of, and commitment to outcome-focused, collaborative, community and trust based commissioning.*
- (point 7.12) *Commissioning approaches are further developed for Option 2.*

In most of the six sites, there remain block contracts for substantial services such as care at home which individual workers can "call off" in terms of a number of hours for their clients, and whether these services remain in-house or are provided externally, they are invariably paid in arrears and the accounting is entirely based on units of time. In this area of commissioned or pre-contracted services which are now known as option three, little has changed. However, all six sites have changed and developed their approaches to commissioning in recent years in relation to option two, setting up new mechanisms and processes in order to facilitate individuals and families choosing an ISF, though again, there are significant differences across them all which inevitably impact on availability, accessibility and flexibility. Recording varies significantly and, as we have already seen, the former can be somewhat subjective with terminology and definitions applied inconsistently by different workers. Some sites have chosen to incorporate their recording of option two into pre-existing systems, while others, notably Highland and Falkirk, have established entirely new systems to track and manage ISFs, a process which in both cases has been time and energy consuming and remains an evolving work-in-progress, and yet which arguably enables them to be more confident in their accounting for the various options than other areas. In both cases, there is a clear direction of travel towards linking the assessment, support planning and payment of personal budgets together in one seamless process, with Falkirk's approach discussed in more detail in the organisational vignette later in this report.

Some interesting anomalies emerged when we began to discuss costs for providers managing ISFs which will be discussed further later in this report; in Aberdeenshire for example, whilst people are technically able to use an ISF to purchase care or support from a provider on the HSCP framework, it is unlikely anyone would choose to do so because option three would give them this service "for free" without the need for additional management costs, and so the majority of provision under option two is with off-framework organisations who would otherwise not be commissioned to provide support. Interestingly, there has been an increase in the variety and availability of different providers across the area which correlates with the establishment of the area's currently quite unique approach to delivering option two, though there has not been a direct attempt to prove any causal link.

The area also operates a recruitment portal advertising people looking for PAs to support option one employers, which some agencies choose to use in areas where they have capacity to see if they can offer to help any of the people waiting to recruit their own staff.

The largest authority we worked with in terms of population was Edinburgh, and perhaps unsurprisingly they reported inconsistencies across their four localities, both in terms of understanding, promotion and subsequent uptake of option two and also what kinds of things are agreed by team managers in relation to how the budget can be spent. As with the other sites who operate a framework or approved list system for option two providers, professionals from both within the authority and outside it spoke of the option not being delivered *"in the spirit of the Act"*, as whilst the person or family have clearly chosen and are directing their care and support, the authority still holds the funds. This came up in all of the sites where the ISF is held and managed internally but was a particular issue in Edinburgh, where they have very few block contracts, with everything on the option three framework spot purchased and quite tailored to the individual, begging the question of what is materially different. However the providers we connected with conversely felt that under option two, they had a good level of autonomy to work in truly person centred ways not afforded by the more traditional contract approaches, both in the City and elsewhere. Leonard Cheshire for example are now well set up to deal with ISFs and manage the whole budget on behalf of people, finding that it works really well as an option in complex cases requiring lots of creative support. Edinburgh has a separate framework for option two providers, with 30 of the 52 providers included currently holding ISFs. Interestingly, those providers we spoke to had not actually set up the internal systems and processes they need to manage an ISF until they were asked by the HSCP to take on their first one, making this initially laborious, though once established they felt more confident in taking them on.

One major difference in most sites between options two and three is the method of payment. In one area providers are paid monthly under option three and quarterly under two, in another payment is made in advance under two and arrears under three. In all cases the level of choice and control the person and / or family have is cited as the key difference between the options, with individuals able to liaise directly with their

provider about the day to day delivery of care and support, though in some situations this can be problematic, for example in the case of regular respite when families make arrangements directly. This is because whilst under both options the provider will know what the respite budget for the year is, it is only under option two that they have some responsibility for making sure it lasts and are therefore more likely to avoid over-use.

In sites where the budget is retained internally rather than paid over to a provider or third party to manage on the person's behalf, there is a sense that most providers prefer not to have the whole budget for the individual and would rather simply be paid on production of an invoice, however it is unclear whether this is compounded by other issues such as complex contracting arrangements or additional costs, whether real or perceived. This is in contrast to areas where the budget is managed outwith the authority, where providers report being comfortable with the mechanisms in place and indeed in some cases proactively seek to work with option two as a preference. It is therefore notable that HSCPs can incentivise or dis-incentivise providers to work with them on managing ISFs through their processes and policies, even where the authority in question is or has also proactively sought to engage them to do so in practice.

Across the six participating areas there was further disparity in the use of tripartite agreements, which are recommended by CCPS and the members of its Option 2 Agile group and published as freely available templates under the supportmesupportyou website[16]. Important issues to consider are that contracts or agreements relating to option two that enable it to work well need to *"reflect that the individual using support is at the heart of the arrangements"* rather than the primary contractual relationship being between the traditional two parties of purchaser and provider, and also be *"clear, concise and as short as possible"*. East Ayrshire, Edinburgh and Highland all use a version of the CCPS document, while in Aberdeenshire there is a "statement of terms for agencies" which Cornerstone, who act as the third party holder of ISFs in the area, use to work with any organisations that provide care or support to people under option two. It is assumed in this case that individuals will have agreements or contracts directly with

[16] http://supportmesupportyou.org/search-guidance/option-2/template-contract/

provider agencies or other organisations, but the statement of terms is supplied to individuals to use if the agency they are commissioning through their ISF does not.

By far the biggest obstacle to option two however was described in some way by all six sites as being the fact that personal budgets are still worked out based on hourly rates, which social workers and providers alike could see remains a blunt instrument at best and, at worst, a real barrier to ISFs being a vehicle for real choice and control, as clearly it is extremely difficult to translate a number of hours into more creative solutions. In the case of respite, this being worked out in a number of nights per year is a similarly problematic issue that is getting in the way of people being able to use their whole budget holistically to meet their needs as carers or indeed, as a family. Different areas are working around this – rather than changing it - by various means including the creative use of one off payments, as well as allowing people to "top up" their budget to make it work differently for them. This brings us to the final issue which is the source of great difficulty in some areas: discrepancies in hourly rates between different types of provision and / or between different options. For example, we found that day time support can be paid at a different rate to personal care and yet the same person is fulfilling both requirements during the same visit, or the same provider is paid a different amount for the exact same input under a different option. None of our six sites have fully resolved these issues.

Q5: Is there a brokerage or similar function effectively "out-sourcing" the management of ISFs to a specific third party and/or what mechanisms can people choose to manage their money?

The Scottish Government's SDS Framework of Standards states in point 7.1 an expectation that *local approaches to commissioning will take into account strategic commissioning of local needs, including the requirement for specialist supports, and will enable individual commissioning where people opt to manage a personal budget to commission their own supports under Options 1 and 2.*

Aberdeenshire is a clear outlier in relation to this question, with its bespoke approach to delivering option two completely at arms-length in partnership with Cornerstone fully explained in the Organisational Vignette later in this report. In both Edinburgh and Scottish Borders, some providers hold and manage the person's whole ISF budget, sub-contracting and / or arranging activities and / or purchasing items or memberships as appropriate, while others hold an ISF budget purely for their own input, though in all cases this approach and / or the contracting arrangements which support it facilitate a real flexibility of budget use and is characterised by a trusting relationship between the authority and the organisations in question. In both instances there are also other providers who are commissioned under option two but where the HSCP continues to hold the budget. In East Ayrshire there is no out-sourcing of the management of option two, despite the local definition including this, while in both Falkirk and Highland they operate in line with their definitions, with no provision in either area for a third party to hold and manage an ISF.

Apart from Aberdeenshire where the position is entirely clear and unambiguous, all sites reported a variety of efforts to explore alternatives to the authority retaining the money under option two, including engaging with providers and encouraging them to take up ISFs, and this is an area where there is a real inconsistency in terms of the explanation as to why progress is at best patchy and at worst, non-existent. Acknowledging that in recent years the vast majority of provider organisations have been operating in extremely challenging circumstances in terms of meeting demand, making the available funding meet their costs, and huge recruitment and retention issues which are widely known to plague both health and social care, with the SDS Act significantly pre-dating the Covid 19 pandemic, this cannot alone account for the fact that in some areas there are reportedly few or even no provider organisations willing to enter into this model of working. Reasons for this include an assumption that it will be more time consuming, more administratively burdensome, and that the extra costs thus incurred will eat into the already stretched hourly rate. A couple of sites also spoke of how some of their larger and / or longer-standing option three providers are "*quite happy*" simply sending their invoices in and getting them paid, and indeed a manager from one organisation we spoke with as part of the project was quite disparaging of

the model, unable to grasp the need for option two at all and having absolutely no interest in taking on any option two work.

Where providers take on the management of the ISF, however, those we have spoken with report that they find it the most flexible and person centred way of working, with some saying that they find it no more time-consuming than dealing with social work teams and finance departments over every minor discrepancy or difference to agreed hours under option three, and others sharing that they are more than happy to offset the additional administrative time they feel is required against the ability to be more responsive to the individual's needs. We also spoke with a small number of providers who are so satisfied with the model that they are no longer choosing to work under option three, with one saying that they no longer want to "*buy into*" the restrictions and constraints placed upon them both at organisational and individual staff levels by service specifications and / or framework contracts. This wide range of provider views was expressed by only a small handful of organisations who we were able to connect with as part of this project, our efforts to engage with larger numbers of providers via the umbrella bodies of CCPS and Scottish Care being unsuccessful, and so we are unable to draw significant conclusions from these discussions, a point we therefore recommend requires further scrutiny in the final part of this report.

Away from providers themselves, we also spoke with a number of third party organisations who offer advice and information about SDS, brokerage support with planning and organising care and support and / or payroll and employment support input for Direct Payments recipients, and once again, there was a wide spread of views about option two. Some of these groups expressed a real frustration that their respective local authority won't utilise them as a third party for option two, which they would very much like to be, enabling people to have access to option two *"in the ethos intended"* by the legislation and guidance. For those groups who already open and hold third party bank accounts for option one, supporting people with option two would not be dissimilar in the set-up, as they would still open a holding account in trust for the person but instead of payroll processing would process any invoices, transfers of monies and other payments or purchases. Other groups however were quite content with their current

functions supporting people on Direct Payments and had no interest in taking on the ISF model.

With a streamlining of how option three contracts are paid in some areas and a clear and simple process for payment under option two where the budget is retained in house, providers in most of our six areas are able to benefit from rolling payment mechanisms within which they simply report anomalies against the agreed plan and, so long as these even out over the agreed period to remain within the overall budget, this is simply accepted; they are able to provide or enter narrative if the situation is more nuanced or complex, and in most cases a conversation with finance and / or social work teams is only required if they exceed or indeed fail to use the agreed hours on a recurring basis, suggesting that the support plan in place may be in need of review. This is of course the way that option two was envisioned as working, though with provider or a third party holding the money, and in the final part of this report we consider whether this original concept of what option two would look like is therefore potentially in need of revision.

In one of the six areas there had been a negative experience when a third party holding budgets for people was trialled, and this has undoubtedly led to a re-framing of thinking around the efficiency and reliability of keeping the money in-house.

Q6: How is any management cost in relation to option two met, for example as part of the individual's budget, via central council funding or something else?

There is some variation between our six sites in terms of whether a management cost is added to the package when someone chooses option two and, if so, how this is paid for, and it is reasonable to assume that this inconsistency will be replicated across the country:

- In Aberdeenshire this is very simply delivered via a clear contract with Cornerstone to provide a specific ISF management service. This was tendered and commissioned in the early days of the legislation and

has continued since, as detailed in the organisational vignette later in this report.

- In East Ayrshire there is no charge for managing option two in house, but if someone were to choose to have their option two budget managed externally then there would be a charge applied, leading to the somewhat obvious question as to whether this could be a barrier to people choosing to do so.
- In Edinburgh there is provision within the ISF framework agreement for a management charge to be paid, but in practice this is not "*pushed*" and the finance team are aware of only a very small number of providers who charge it, literally two or three. In these cases the charge is added to the person's package as an additional administrative hour or hours, so the person does not lose out on the care or support time available.
- In Falkirk providers do not hold budgets, however the authority does pay management costs for option one managed accounts so envisage this would be the same for option two should the situation arise.
- In Highland some commissioned providers do apply a management fee which is included in the usual payment mechanism.
- In Scottish Borders the management cost is paid via a consolidated hourly rate which was designed to include administration and many providers agreed there was no extra work required in holding and managing option two budgets above what they already do in relation to their option three commissioned services. There have however been a small number of instances where a provider has made a case for a slightly higher rate to meet the management of an ISF, and one organisation charge a flat rate per week as an administration fee when they hold ISFs, which is added to the person's individual budget so that they don't lose out on care or support time.

Clearly with such a range of approaches it cannot be said that there is consistency in how individuals and families access and experience using option two across different areas, and for providers who work regionally or nationally this can present additional problems as they are required to amend their own charges to reflect the policy of the relevant authority.

Q7: Are there any examples of option four being used, given the lack of option two uptake seems to be the main obstacle in the way of this being utilised?

In a study in 2017, Pearson and Ridley[17] it was found that "*option three, direct delivery of services by the Local Authority, remains the dominant SDS provision*". This was reinforced by the Care Inspectorate's thematic review which, as we have already seen, found that whilst option one is generally well established, option three was most easily available and access to options two and four remained limited. For the purposes of this report, we collected the following information from our participating sites, however the aforementioned issues of using old recording mechanisms as well as how different practitioners are counting the various options makes this question difficult to answer with any real confidence.

- Aberdeenshire: Currently ten active option two clients also have some other provision so would be classed as option four, and historically approximately 10% of cases would fall into this category. Interestingly the majority of the current ones are carer packages where the replacement care is for a cared for person who uses a different option.
- East Ayrshire: Statistics indicate there are lots of option fours (162 at the time of writing, or 7.41% of all cases) and these are usually where the person uses option one for PAs or option three for home care, then uses option two for social supports, group activities or miscellaneous purchases.
- Edinburgh: Anecdotally, a higher proportion of option fours in place, mainly a combination of two and three where three is the care at home service and two is used for daytime support and / or respite. Some examples of one and two in combination too but less common, where a PA does the bulk of the care and support, but the person then chooses an agency or other organisation to do specific things such as respite via an option two.

[17] Pearson, C., and Ridley, J. (2017) Is Personalization the Right Plan at the Wrong Time? Re-thinking Cash-for-Care in an Age of Austerity. *Social Policy & Administration*, 51: 1042– 1059. doi: 10.1111/spol.12216.

- Falkirk: The way the system is currently set up options are recorded separately for each type of support and do not convert to option four, but anecdotally we know there are many in place. Some examples are option one, two or three for care at home with a different option for day service support, social support, short breaks / respite. There is a new system coming soon which should address this and provide greater visibility.
- Highland: Reports are that option two is occasionally used as part of a four, usually for really small amounts of companionship type support while the rest is for personal care and is either a one or three.
- Scottish Borders: Not counting and no real sense of combined options being used routinely.

Q8: What has had to change in order to make this a reality?

In its Learning Review of SDS, Social Work Scotland[18] found that there was often a negative impact from local legal, finance, systems, policies and processes on the ability to deliver SDS in general and option two in particular, and our findings in this project would support the assumption that there is a direct correlation between the degree to which these varying roles and functions are aligned with the ethos and vision behind SDS and the success of implementation attempts on the ground.

We have spoken to people from a wide range of departments within our six sites and it is apparent that, in all cases, people are clear about the parameters of their own roles and, crucially, where they fit in relation to the individual and their experience of receiving good quality care and support to meet their outcomes. What was also important was that the people in these key roles had been involved in the planning and roll out of SDS from the very start, leading to a deeper understanding of what was required by their respective teams or departments and a commitment to developing the systems, processes and practice changes that were needed to support this. In contrast, people in these roles in other areas have found themselves in the unfortunate position of playing catch up long after the work was

[18] https://www.gov.scot/publications/developing-national-framework-self-directed-support-learning-review/pages/2/

underway at the front line, which can cause misunderstanding and occasionally protectiveness around the previous ways of working, both significant obstacles to successful implementation of change. Staff turnover is a critical issue here as well; when organisational memory is lost, it is imperative that changes implemented are robust enough to be passed on as the default option, meaning new systems must be properly embedded and both training and guidance on them kept up to date. There was some concern raised by a small number of practitioners in one site that there had been a shift recently towards bringing a member of the finance team into planning meetings, which was felt to be a worrying development as it has a tendency to skew the focus of the discussion away from personal outcomes and more towards best value, although it was also felt to be an understandable move given a context of continually squeezed resources coupled with lower managerial confidence in decision making on the front line. This would seem to indicate that the aspiration for worker autonomy set out in standard 8 of the SDS Framework of Standards, which posits that workers should be *"enabled to exercise professional autonomy in support planning and set personal budgets within agreed delegated parameters"*, is not being entirely met.

The Scottish Government's SDS Framework of Standards recognises in point 7.11 the importance of training being "*developed to support the outcome of getting it right for communities, and is offered to workers from across finance, legal, contracts, and procurement teams*." Our sites all spoke of the need to not only put training in place at the beginning of a programme of change, but to ensure it remains available both as a refresher to those who have been involved from the start and, equally importantly, for newcomers in a sector which is sadly experiencing relatively high levels of staff turnover in recent years. The Care Inspectorate's Thematic Review also focussed on the potentially deleterious impact of not properly engaging all parts of the system within the local authority as a significant factor influencing the unsuccessful implementation of SDS, citing the *"often negative impact that local legal, finance, systems, policies and processes have had on the ability to deliver SDS."* They went on to note that the evidence suggests tensions arise where *"the systems and processes limit the ability to fully implement SDS, resulting in a systems-led approach rather than a focus on outcomes"*, and it seems clear from this project that having

colleagues from all departments clearly sighted on the desired goal and fully cognisant of their own part within that is an essential component of success. Only one of our six sites spoke about any real issues in relation to what are often referred to as back office functions, and this was with a particular procurement team who could be problematic in terms of raising issues around the more unusual things people might want to use an ISF for and being generally somewhat cautious, however these discussions would invariably be resolved with the positive and proactive intervention of the contracts and commissioning team, and don't actually get in the way of provision as far as people who use services see.

This issue of a lack of awareness and understanding came up continually throughout the project, whether in relation to social work practitioners, their managers or the people who use services. Dedicated and on-going training on SDS in general and ISFs in particular is still clearly needed therefore, and has evidently been a key component part of making option two available widely in the areas we worked with. A particular issue which came up several times and is perhaps more worrisome is an apparent lack of awareness in newly qualified social workers, with one practitioner who took part in this piece of work speaking of how one of their colleagues has told them that as the person they were assessing *"doesn't want home care they'll need an SDS assessment"*, revealing a fundamental misunderstanding of SDS.

Another important factor is the effective and widely available provision of clear information and timely advice, leading to a high level of understanding of people's options and rights under SDS, and the evidence from our small study would seem to suggest that this works best where there is a dedicated SDS support team working outside of but in partnership with the council. That is not to say that social work practitioners are not giving good information on an individual basis, however it was clear from all of our sites that this is far from consistent, and dependent on a number of factors such as their own training and subsequent understanding, the expectations of their line manager, their perception of what is likely to be available in reality (and not wanting to raise expectations they cannot fulfil) and their subjective assumptions about what the person or family in question is likely to be able to cope with or want.

These factors do not seem to be as problematic for the workers in the third sector organisations who are commissioned to provide information and advice, though some did mention the last two - potential availability of options and the individual's capacity to manage a budget - as being a worry to them, even if it didn't stop them giving the full information.

Systems are another area where significant change is required not only to support ISFs being properly accessible to people in terms of basic working practices and processes, but also to enable partnerships and councils to properly record, track and account for their budgets. The aspiration is new finance systems which will speak to the social work system so that plans translate into budgets, making payment scheduling really simple, and in Falkirk where they are about to begin using their newly developed system, a Resource Allocation will be generated in real time when a practitioner inputs their assessment, thus prompting them to think in terms of an individual budget from the beginning. The new system should also generate a budget from the support plan as it takes shape, flagging up if what is being planned goes over budget, though the challenge of creating budget lines for everything someone might potentially want to do under option two was not inconsiderable. Highland too have a new system in place, though theirs is spreadsheet based and so involves more manual inputting of data, and they have also recently designed an app for social workers to access via their mobile phones which should allow them to set up, adjust or cancel an ISF from there. Whilst both of these are excellent examples of two of our sites really grappling with what is such a thorny issue for all HSCPs across the country, both remain based on units of an hour of care and set hourly rates, which as previously discussed, is a fundamental challenge to truly person centred, outcome focussed delivery of social care.

All sites spoke of varying degrees of smoothness in the initial set up of option two and all retained some bumps in the process. There were also concerns about a lack of consistency in terms of how different providers track and account for the budgets once they are holding them. Provider portals, which enable agencies to see details of people who are looking for support and to subsequently manage any packages they may take on, are an interesting mechanism either being used or planned by most of the six areas, and these have the potential to make the process of setting up and monitoring ISFs even more seamless.

A clear focus on choice and control as a strategic and operational aim is another key to success which we will speak about under the final question on the importance of leadership, with a need for managers to see increasing option two uptake as an expectation for staff in order to encourage and empower them to use it. Where practitioners were aware of this there was a greater motivation for them to think about ISFs and discuss them with clients, however if it was not being mentioned in supervision or informal case discussions then there was often a corresponding lowering of emphasis on the part of the practitioner. The evidence from our project would also seem to indicate that in every authority there remain at least some small pockets of staff or even particular teams who will simply tend towards option three, with ingrained views that option one is overly complex and option two still something of a mystery, and this is only compounded where there are exacerbating factors such as staff shortages, high demand and a perpetual sense of "fire-fighting", issues which pre-date but have been exacerbated by the Covid 19 pandemic, when workers will perhaps understandably revert to what they know and what is most expedient to get care in place quickly.

In terms of supporting creative use of ISFs, Highland Children's Services spoke about a traffic light system that they found really useful, which has been designed to provide a really simple "do's and don'ts of SDS" guide, while other areas spoke about the importance of good support planning and also trusting relationships with providers and third sector organisations who work together with the social worker and the individual to think through all the potential ways in which their outcomes can be met. Finally, where a site has an SDS specific role within or available to the social work practice team/s, there was invariably both evidence of these people being at least partly responsible for increased uptake of option two, as well as, in some cases, of them being expected or required to take up some of the work involved in setting up and monitoring the ISFs. This suggests both positive and negative impact of these SDS specialist roles remaining in place so long after the implementation of the Act, when most HSCPs had them, as the reality is that the entire approach to assessment and care planning that existed before the SDS Act came into force has had to flex in order to bring the allocation of a budget to the front of the process in order to meet standard 9.7 of the SDS Standards framework, which states that people should be *"told the likely level of the budget available irrespective of the option*

they choose." Given that not everyone is advised of the options at the start of their assessment and that the budget available can actually vary depending on which option they go on to choose, it is clear that this is an area where more change is required.

Q9: What has been the importance of leadership in making this a success locally, where has the drive come from and are there consequences for not getting on board, or are some parts of the area still able to say, "we don't do that here"?

All of our sites agreed that leadership is key to the successful implementation of any change programme and many of the people we spoke to from within the six authorities, as well as from provider and third sector organisations, were able to point to specific individuals, usually senior managers, whose clear vision and regularly articulated expectations were a key motivation in their own ability to focus on what needed to be done. People spoke about the importance of senior leaders publicly and routinely articulating their vision for increased choice and control and being willing to take risks and leaps of faith, and of key decisions made early on in the SDS implementation process being stuck to, including a staunch commitment to embody the spirit and the letter of the legislation and to interpret the authority's duties and responsibilities clearly and robustly. There was a sense that success in implementing their option two models has been motivated in all six sites by an awareness of and focus on their duty under the Act to support people to choose the right option for them, and to make responsible decisions when they do so. Legal teams in particular were mentioned in several cases as having an important role in being really clear that the legislation stresses the HSCP cannot be controlling of how people choose to spend their budgets, leaving no room for practitioners to shy away from more complex or challenging choices about how to use ISFs to meet outcomes.

A provider in Edinburgh told us how they felt the key difference between the City and other areas they work in across Scotland is that the HSCP are

focussed on and driving the move towards increasing option two at the highest levels, and in Aberdeenshire practitioners spoke of how such a level of vision and leadership helped them remain focussed on utilising all the options, with *"no-one being in any doubt what is expected of us."* In other areas where leadership was perhaps less visible, some people spoke about being tired of being a lone voice *"banging on about"* using ISFs or of becoming disheartened at *"being knocked back repeatedly"* when trying to find creative solutions, indicating that where there is little expectation from line managers in particular to be utilising option two, its successful implementation is perilous regardless of what more senior leaders may be saying. In this instance however, practitioners felt that their managers lacked both knowledge and a corresponding expectation from their own managers, so that a lack of incentive to change cascades through the system from any point of leadership where it is given less importance in the same way that the motivation to get behind something does where it is clearly and repeatedly articulated.

Summary and Recommendations

The SDS Framework of Standards point 11.6 asserts that *Supported people can have confidence that their agreed personal outcomes will be met in a comparable way to others in similar circumstances across Scotland*, and it seems clear that whilst there is a lot of very good work going on, this standard cannot be said to be being met in this snapshot of six out of the 32 HSCPs, a situation which we can only presume is replicated in the remaining areas. Whilst it has ever been the case that there are minor differences in approach, provision and available resources from one area to the next, it is our contention that the people of Scotland ought to be able to expect far more consistency in terms of delivery of what is arguably the most important piece of legislation affecting social care in this country in several decades, and though some of the differences might be said to be quite minor, others have far deeper implications.

There is much good practice and many examples of tools, approaches and mechanisms in this report that can be picked out and emulated, along with multiple problematic issues which are likely to be replicated in other areas, however there are key areas which merit a more collaborative approach to seeking solutions that can be applied collectively across the board, with a focus at a national level most likely to be successful.

Recommendation One: Re-affirming the definition of option two / ISFs

It is absolutely clear that the way a site defines option two steers if not entirely dictates the practical implementation of it, and the disparity this causes between our six sites is unquestionably leading to a very different ISF offer and experience in each area, so this is perhaps the most fundamental area in which work at a national level is required if we are not to see a "post-code lottery" in SDS. A question which arises from conversations with participants in the project is whether the definition of option two held within the SDS Act and Guidance should simply be the default across all 32 HSCP areas with no room left for some to offer only a partial compliance with it. Another question might be that, given when option two was defined it was entirely new and therefore untested, perhaps the current experience of all 32 partnerships should be sought on this issue to identify whether a re-definition by the Scottish Government is actually what is required. Either way, it seems clear to us that the subtle changing of the definition is a significant factor in holding back the full realisation of ISFs as a concept.

Arguably areas who deliver option two whilst holding the budget in house are not truly offering the option within the original SDS Act definition, but in lieu of other mechanisms being available – whether by design or neglect – they are at least providing an alternative to options one and three, and doing so, as we have seen, with a high level of positive impact in terms of individual outcomes, despite the fact that many people within these areas have voiced the opinion that this is "*not in the spirit of the legislation / guidance*". This is a potentially contentious issue, as it would be easy to be beguiled into thinking that it is perfectly acceptable for the authority to hold the ISF pot because people have choice over which provider is paid and their option two packages are creative and flexible, but the potential risk of this model is that the person could be less in control of the budget, leading to decisions being made in times of scarcity that in turn lead to less person centred solutions. While we have not found evidence of this, it is a scenario which is far less likely where the budget goes out of their control and into the management of a third party organisation. One final comment on definitions is that the Act defines option three as where the person wants the council to organise and purchase care on their behalf, but importantly,

this is not required to be restricted to commissioned services only, implying that the broadly accepted definition of option three is questionable also.

Our recommendation therefore is to revisit the definition of option two so that there is a consistent starting point in all areas which matches the expectations of the Scottish Government as clearly set out in the SDS Act and Guidance, and to implement mechanisms through the regulation and inspection process to ensure compliance with this.

Recommendation Two: Build support plans around outcomes and not units of time.

In its report SDS Your Choice Your Right, the Centre for Welfare Reform argued in 2017[19] that *"the prevalent methodology used to calculate individual budgets remains outdated and unsympathetic to the values and principles inherent in SDS,"* going on to say that *"using the concepts of 'hours of support' and 'hourly rates' to determine, increase or reduce the size of the budget leads to considerable rigidity, and removes much of the creativity that can take place when people are given an annualised budget that they are encouraged to use flexibly."* The evidence from this project is that timed units of care and support and their attachment to hourly rates remain firmly at the centre of all personal budgets and as such, are a major factor negatively impacting people's ability to use their resource allocation with true flexibility and creativity, with many of the people we spoke to expressing frustration at a lack of progress in this most fundamental issue.

Despite major strides in outcomes focussed conversations at assessment leading to person centred support plans, without indicative budgets being presented early on to help aid decision making on options and with plans being translated immediately into units of time, it is inevitable that we become sucked back into commissioning the bulk of services very much as we always have, with only marginal change for a small number of individuals, as the tiny percentages of option two clients in each participating site indicate.

[19] https://citizen-network.org/uploads/attachment/579/selfdirected-support-your-choice-your-right.pdf

We therefore recommend that a dedicated piece of work be initiated at a national level to properly apply the principle of an up-front allocation of resource, which people are fully enabled to choose to spend on meeting their outcomes, with the number of hours required to do so and the cost of each a discussion point in creatively making the budget work for the person in conjunction with all their other assets, rather than a starting point which effectively closes down options.

Recommendation Three: Proactively increase and positively incentivise provider engagement with ISFs.

During this project we have heard from providers who are keen to take on more option two work and who feel under option three they are drawn into a time and task way of working which goes against their organisational principles to be person centred and flexible and to ensure clients have maximum choice and control over their care and support. At the other end of the scale we have spoken to providers who are content with their business model under option three and have absolutely no interest in moving beyond this. Those who have embraced ISFs say that it is their preferred option because it allows them maximum flexibility and creativity to work in truly person centred ways. However there are a number of disincentives that exist within the different authorities which contradict the stated aim of encouraging providers to engage with option two, including disparities in hourly rates between options and the additional costs involved in managing each person's budget separately within the agency's internal accounting systems, which as we have seen, are approached differently in different sites. It is also important to note that we were told by many people on the commissioning side of the equation that whilst efforts have been made to encourage providers to take on ISFs, the agencies themselves are reportedly reluctant to do so, however our limited contact with providers in this project makes this difficult to extrapolate meaningfully.

We therefore recommend that this issue is revisited at a national level to understand what barriers there are to providers fully engaging to manage option two budgets with individuals and

families and to then proactively address these moving forward, including by raising the profile of their doing so as an expectation against they will be inspected and held accountable.

Recommendation Four: Agree a national standard in relation to whether ISFs should ever be held and managed by the local authority.

It is clear from the legislation that the original concept of option two was that the money would be held not by the individual as in option one, and not by the local authority as in option three, but by a provider or third party of the person's choice, and yet only a small number of sites have actually succeeded in making this the default model, whether due to a lack of organisations willing to take on this role even where encouragement has been given, or a strategic decision to keep the budgets ring-fenced in-house. From the experience of those sites that do have the provision to outsource the management of the ISF, there would seem to be multiple benefits to this, including perhaps most importantly that the level of choice and control is undoubtedly higher than where the authority retains the money and is concurrently responsible for helping the person organise their package.

Barriers to using option two where the money remains technically in the hands of the local authority include the requirement to comply with localised policies, such as only using providers on a framework or the inability to use self-employed workers, as well as the fact that things purchased are subject to VAT, whereas under option one the person's budget is VAT exempt, making the money go further. However there is also a huge amount of good work being done where the budgets remain internal, as is evidenced by this small study. The question of which is more effective at delivering real choice, meaningful control and person centred outcomes remains therefore unanswered, however we feel that the fact that this inconsistency across Scotland of such a fundamental part of SDS delivery is unacceptable, producing a classic "post-code lottery" and potentially causing real difficulty for anyone using social care who might move between areas.

We therefore recommend that this issue be examined urgently at a national level to properly assess which model is most consistent with the letter and the spirit of the SDS Act, and that this decision is then incorporated into the inspection and regulation of local authorities moving forward.

Recommendation Five: Improve strategic commissioning.

It is clear from the response to our questions that the backdrop of commissioning approaches is not conducive to successfully enhancing uptake of option two. There remains a huge amount of work needed to change the whole commissioning environment, and the tiny percentages of ISFs in all six authorities serve to emphasise that options one and three remain far better understood and utilised, with option three predominantly the default "choice". Much work has been done at a national level to set out what a new approach to commissioning might look like and yet it would seem that little has filtered through to the work on the ground.

We therefore recommend that significant work be urgently undertaken at a national level to identify and address the key blockages to real change in the commissioning landscape. This should include a shift in thinking away from frameworks as the default approach for all options, but in particular options one and two, to allow for more individualised support across all groups and greater availability of genuine choice, real support for providers to develop systems for managing ISFs prior to taking them on, a sensible discussion about fairly meeting the costs involved in managing people's budgets for them, a meaningful shift from market management to market facilitation including the use of micro-providers, non-social care organisations and self-employed workers, and a particular focus on transitions.

Recommendation Six: Proactively increase worker autonomy including addressing organisational appetite for risk.

Whilst there is much evidence from our small study of individual workers being creative in enabling their clients to maximise the use of all their available resources to meet their outcomes, including the budget available to them from the local authority, many of the practitioners we spoke to expressed frustration at the lack of flexibility open to them, both in terms of what is literally on offer in the local area and in some cases the restrictions placed upon them by the authority's requirements, specifically to work within frameworks and / or the inability to use self-employed workers. These concerns were echoed by third sector organisations involved in creating and / or implementing support plans with people, and in many instances the local appetite for risk was cited as another barrier to creativity.

We therefore recommend that an examination of local policies and procedures is required to ascertain whether or not these are, as required by the Statutory Guidance, "*flexible enough to allow workers to be autonomous in exercising their professional judgement*", and that where there is found to be a disparity between what is expected and practice on the ground, this is proactively addressed.

In its 2017 paper SDS Your Choice Your Right, the Centre for Welfare Reform found, as we have in this small study, that there was still only limited exploration and expansion of the flexibility afforded by option two, which it considered – as do we – to be the most innovative aspect of the SDS legislation: *"This is in part accounted for by a cautious resistance to change, but is compounded by contractual confusion, anxiety about sub-contracting, and the reticence of public bodies and service providers to trust each other fully."* The evidence from our six sites would suggest that these issues have been if not fully resolved then certainly comprehensively addressed in the areas concerned, with significant progress in terms of models and approaches being established and new ways of thinking and working becoming more

robust, however the statistics from all six authorities bear out the conclusion that option two remains an extremely under-used choice.

Given how many people described ISFs as "*the best of both worlds*" during the many varied and wide-ranging discussions we have had as part of this piece of work, offering individuals who use social care and support real choice and meaningful control, flexibility and creative solutions which meet their desired outcomes, this is clearly a deeply dissatisfying position for us to be in, and one which we hope this report will help to address.

Thank you to everyone who contributed to this research, we are grateful for your time, honesty, passion and patience.

Vignette 1: Aberdeenshire

Aberdeenshire took a decision early on to embrace the challenge and opportunity of the SDS Act definition of option two, that being to allocate the person's personal budget to a provider of choice or other third party. They invited local providers and third sector organisations to come forward with plans to offer a service which would include support planning, holding the fund and working with other providers and organisations to manage the person's care and support plan with them, resulting in Cornerstone, who already provide SDS advice and information locally, being given a separate contract to manage ISFs.

All parties agree that the current system is really robust, being the result of much work from the pre-implementation phase and continuing development over the past couple of years, though far from seamless and continues to be a work in progress as they continue to learn more about what works and what doesn't. Everyone involved is very clear that this is a three way relationship of equal partners: the HSCP, the individual and / or family and Cornerstone ISF.

All departments across the partnership are both supportive of using the model and creative in how they approach ISFs, including care management, finance, legal and other back office functions, and this is felt to be at least in part a result of all of these teams being represented on the original SDS team back at the start, with those individuals going back into their respective teams taking their learning and enthusiasm with them. Training in the SDS pathway in general and options one and two in particular is regular and on-going, again with an expectation that everyone connected to the work of social care needs to participate, not only front line workers.

In the early days, when everyone was getting used to the new model and testing it out, there could be lengthy discussions about any changes or "tweaks" to someone's support plan before agreement was forthcoming, but nowadays care managers tend to be open and accepting of any

changes within packages that come from Cornerstone ISF, and this is testimony to the importance of building robust and trusting relationships between parties. Devolved budgets are also seen as one of the key levers enabling option two to be so well used, with practitioners in adult services and team managers in children's able to agree up to £375.00 per week in Adults and £275.00 in Children's services. A corporate credit card is also in use and facilitates creativity, mainly but not exclusively in the area of short breaks.

It is clear from our study that when using an ISF in Aberdeenshire, clients have a high level of choice and control and that care and support is tailored to their changing needs and preferences, often with small teams flexing around each individual and / or family. Some of the advantages include that people are able to use off-framework agencies and organisations through option two, the ability to creatively mix packages and make one off purchases to complement care and support and / or help meet their outcomes, and people report liking having the flexibility of the budget being controlled outside of the HSCP without them having to take on responsibility for managing it directly. There are also examples where families have been able to negotiate a better rate than the council under an option two. There is a clear sense that individuals and families are more likely to choose an ISF if the practitioner speaks confidently about it, an important reason to ensure that training is kept up to date and that there is an expectation from managers that front line workers will be proactively encouraging the use of this option.

The model is not without its difficulties of course, and there have been experiences of clients waiting many months for a provider or having to bypass Cornerstone ISF at their suggestion and go straight to the care manager with an intractable problem, and there are still occasional "glitches" in the system. There can also be difficulties getting any providers to work in more rural areas, regardless of which option the person chooses. However the overall picture is of a well-designed system working well, and Aberdeenshire's model is perhaps the most "in the spirit" of the Act, to coin a phrase we have heard many times during this small study.

Of particular note is the fact that more social care agencies have moved into the Aberdeenshire area since implementation of the Act, and it does seem as if this is as a result of both options one and two being so well promoted and readily available, so a welcome if unintended consequence of the focus on developing the first two options has been to help develop the market, which is of course, also a duty under the SDS Act. Aberdeenshire has no pre-existing relationships with many of these providers who all remain off-framework, and feel this is both acceptable entirely in keeping with the spirit of the legislation, which seeks to ensure that local authorities are hands-off and not too controlling. This has brought some challenges of course, as relationships develop, but mutual understanding grows over time and with the focus remaining firmly on what is best for the individual service user, any issues are proactively resolved.

Vignette 2: East Ayrshire

There was a strategic decision made approximately a year ago, mainly driven by the Covid-related overstretched nature of home care, that anything other than option three home care would be considered for option one or two, and whilst this was an excellent way of getting the other two options on people's agendas, not everyone had much experience of them, and so the Thinking Differently Team, who work as peer mentors to support the front line teams with SDS, carers, smart support and technology enabled care have been an invaluable resource to front line practitioners. Despite the willingness of some local organisations who have contributed to this report to explore the role of holding and managing ISFs for people, and the fact that a contract for providers to hold ISFs has been developed, neither of these have been utilised and the current model in East Ayrshire is that option two funds are administered internally, ring-fenced for the individual and flexing to be used as creatively as the support plan dictates. Crucially, there is no restriction on what organisations people can use their ISF to commission – no framework for option two providers – and also East Ayrshire is quite relaxed about and supportive of people's choice to use self-employed workers where this is the right fit for delivering their outcomes.

In fact, the authority has been very proactive at getting a group of self-employed support workers accepted as a legitimate use of option two, and now they simply ask for proof of self-employment and PVG and give advice and information to both parties as to what their legal responsibilities are. This group was initially set up to support a particular group of people with dementia as there was no other solution available, however it seems to be spreading, and is evidence of the authority being risk aware rather than risk averse. Despite all of this however, there remains some lack of awareness about option two and some of those who contributed to the project felt some people who ostensibly "choose" option two probably aren't aware they do so.

A collaborative commissioning approach is well established in the area, with contract negotiated rather than tendered to encourage collaboration and learning across providers and to avoid the pitfalls of competitive tendering, and the recent adoption of a Collaborative Commissioning Charter, co-produced with providers of all manner of community services and supports, social enterprises, voluntary organisations and charities which they have all signed up to abide by. This work was supported by Healthcare Improvement Scotland, approved by the Integrated Joint Board in February of this year and rolled out via a series of workshops during March, so is quite new, and viewed as a work in progress. Once again the input of the Thinking Differently Team giving dedicated practice development support has been imperative, along with the proactive engagement of key people in finance and contracts departments.

The fact that the budgets are held in house in East Ayrshire led to a number of conversations about what actually constitutes an option two being chosen by a client, with some people feeling that even where an in house provision is in place, if the client has proactively chosen that then this should be classed as option two, while others feel the fact that if people need care at home, respite or day time support and don't want to use the council's services then they have no choice but to use option two, and that this negates the suggestion that this is an active choice. It is clear from all of these discussions that the true meaning of SDS is a subject of much healthy debate in East Ayrshire, which can only add to a continual heightening of awareness of all the options available to individuals.

Vignette 3: Falkirk

In Falkirk there is a long-established approach of creative commissioning for respite and short breaks in particular which pre-dates the SDS Act and in many ways set the context within which the increased choice and control envisaged by the legislation felt like a natural progression for workers locally. Corporate credit cards have been in use for some twenty years, initially introduced to solve the issue of carers wanting to book guest houses or caravans for short breaks and those small businesses not being in a position to provide an invoice and hold the booking while the council processed it. There is also a voucher scheme which acts like a cheque book and started off as a mental health pilot many years ago which evolved from there; this is similar to a pre-payment card if a little more "old-fashioned" feeling, and Falkirk are currently looking at the practicalities of switching entirely to cards. Organisations have to sign up to accepting the vouchers and sign a contract with the council, meaning this does tend to be used predominantly with social care providers at present, although it has also been used with non-social care organisations such as an art studio and an outdoor centre. The contract is a simple one page contract where the support provider agrees to accept the vouchers as payment from the individual and submit invoices for payment to the Short Break Bureau, with each voucher equating to an hour of input.

There are examples where option two is less a choice than a necessity due to there being no option three framework provision available, and there is an awareness locally that such cases being recorded as an ISF makes it look like the client is choosing when they are perhaps not, or at least, this would not be their first choice if a trusted in house provision was more widely available. However the real difference between options two and three is in terms of service provision, as under two care and support are more flexible and the client has more choice and control over how they use their hours.

There are also now many people using option two to buy or organise things that are not traditionally commissioned services, such as going to an art studio instead of day services, as well as an extremely good take up amongst carers, with a £1000.00 of the agreed respite/short breaks budget being available for a few years now to spend on anything that will facilitate their own wellbeing and down time, such as garden furniture, exercise equipment or technology, where laptops have been purchased, sometimes in conjunction with the Red Cross "Connecting Scotland" scheme which offers two years of broadband. It is a simple matter for the authority to make these purchases or pay these various people and organisations directly, which may well act as a disincentive to seek to out-source the ISF budget to a third party. Falkirk also now have a simple process and two page form to enable people to access one off Direct Payments, and there is some thinking locally that this may reduce the use of option two in some instances as these are being used a lot, especially by carers, to purchase things as opposed to services. This is increasingly being used to replace or reduce use of the corporate credit card, which involves individual workers having to place orders and is therefore quite time-consuming; with the one-off DP, the money is simply passed to the individual to buy direct, and there is no need for a separate bank account as with an on-going DP. The person can use the money to purchase multiple things, within the agreed budget, in any given year.

All providers whether operating under option two or three regular payments are paid using a four-weekly payment schedule through which the provider doesn't have to invoice, but simply advise the authority of any changes due to the person flexing their hours in order for the amount paid to be adjusted. The difference between options two and three here is that under option two, the person chooses the provider or providers and deals directly with them regarding content of care and support whereas under three this would be done by the social care worker.

The main issues Falkirk are grappling with around SDS at present are to do with differing hourly rates across the various provision and top ups from clients making administration from provider's point of view a disincentive to use ISFs. In common with other sites, Falkirk have struggled to make their recording and monitoring IT systems work for them in relation to option

two, and are about to launch a whole new system at the time of this report going to press which should facilitate a seamless process from assessment through support planning to on-going payments, with the indicative (personal) budget identified by the system and pulled through automatically so that care management, support planning and financial management are easily linked.

A key success factor mentioned by individuals who contributed to this project is that all the different departments work as a team with the client's outcomes at heart, summarised by one person who occupies a back office role who said that "*no one feels their job is primarily about anything else*."

This report was produced by

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With the support of

Scottish Government
Riaghaltas na h-Alba
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