Emerging Practice in Self-Directed Support Option 3

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for In Control Scotland
November 2023

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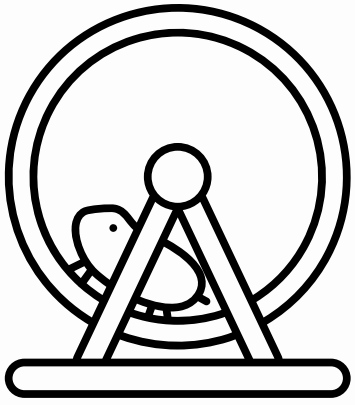
“You’re like a hamster on a wheel, constantly in motion but going nowhere”



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Executive Summary

Self-Directed Support is Scotland's national policy for social care. It is founded on a set of values and principles that prioritise choice, flexibility, and human rights, that aims to put people using social care in control of the way their support is arranged. Through the four options people can choose a level of control that suits them and their family, with the options ranging from full control over the budget through a direct payment, to placing their trust in the local authority to manage on their behalf through option 3. The legislation and supporting guidance are clear that for the vast majority of people self-directed support is the way that social care is delivered, regardless of which option is selected.

Scotland has been on a programme of transformational change in social care for over a decade and, thirteen years after the vision was first shared [1], much of the learning so far has focused on options one and two – the direct payment option and the individual service fund (ISF) option – with this mainly coming from the experiences of people and families and the impact that being in control has made to their lives. Recognising the lack of evidence in how local authorities had made change happen, In Control Scotland published our own case study research into ISF's last year, but, while learning in option two has been rare, the evidence base for transformational change in option 3 is almost entirely absent. This report has sought to begin to fill this gap with examples of flexible use of option 3, but perhaps more than that it seeks to start a conversation about flexibility within social work managed services.

Option 3 is often the way that the highest volume services, like home care, is delivered, often via in-house services. It is invariably the quickest and easiest of all options to set up, and represents the biggest

proportion of people using social care. Common perceptions of option 3 as “traditional services” – which often broadly translates as “the way things used to be” – suggest that transformational change has not yet filtered through all options equally. We asked for examples of practice in option 3 which match the spirit of the SDS legislation, insofar as they are as flexible as they can be within the limitations of these high-volume services, and we did find some – which are examples of innovative commissioning or pilot projects rather than wholescale system-wide change - but they are rare and feel anomalous against the broader social care landscape across Scotland.

The values and principles of our national social care policy must be applied to all of our social care, without exception. We hope that the learning from this report will create some momentum for conversations on option 3, on how we can ensure that transformational change does not start and end at options one and two.

Introduction

The Social Care (Self- directed Support) (Scotland) Act, 2013 Guidance [2] states that whilst option 3 "differs from option 2 in that the local authority provides or arranges services on the supported person's behalf", which means that the "supported person does not have direct, on-going or day-to-day responsibility for planning and controlling how the available resource is used … Nevertheless, under option 3 the principles of choice and control, collaboration and involvement should continue to apply. The authority, through its approach to commissioning and procurement of services, should seek to ensure that the services provided are as flexible as possible, are sufficiently personalised and are ready to adapt to the desires of the individuals who use them."

This project sought to understand where the approach to commissioning and providing care under option 3 has shifted in line with this aspiration; what has been required to enable this shift and what can be learned, shared and scaled up to ensure that people living across Scotland can expect a similar level of flexibility and person-centred support, even when they choose option 3. We sought sites to work with who could demonstrate that they have successfully changed or are changing the way they commission care and support under option 3 in a system-wide way., ideally where the new approach is embedded and generally available, sites who have been piloting at a small scale, were also welcomed to participate. In actuality, we did not find any sites where the changes to option 3 services went far beyond the pilot or test of change stage apart from a small number which, as will be explored in the report, now have well-established new models in place for a particular client group or type of support. This means that from what we have learned in this piece of work, we cannot say that provision of care and support via option 3 has changed significantly since the implementation of the Act.

In order to seek good practice examples in relation to option 3, we cast our net wide, inviting Health and Social Care Partnerships (HSCPs) and Councils (via our networks and connections) to participate and share what they have achieved, and what they are still learning about how to move away from what are often considered “traditional services” towards ensuring that the spirit and values of the Self-Directed Support (SDS) Act are firmly at the heart of all that they commission, regardless of the option. Interestingly, a significant proportion of people who responded did so to say that they have so far made little or no progress in this area but were beginning to think about doing so and would therefore be really interested in what we discovered. We heard many times how the emphasis since the implementation of the Act has very much been on development of options 1 and 2, with far less exploration or even in some cases any attention at all, on what SDS means for option 3. Indeed, it was not uncommon to hear that in the minds of many practitioners and other professionals working in HSCPs, SDS basically equates to options 1 or 2, with comments such as “option 3 isn’t really SDS” or “traditional services (referring to care at home, supported living, day services and other traditionally in-house or block-contracted services) don’t come under SDS” sadly quite widespread.

Perhaps more prosaically, there was an almost overwhelming sense in a significant proportion of areas that none of the options are really a choice at all, with the simple reality of what is available on the ground dictating which option people receive their care and support under. We were told of examples in several areas where people are waiting for an option 3 provider but in the meantime are seeking to recruit Personal Assistants (PAs) through option 1, and basically end up “choosing” whichever turns up first. This seems to be a significant issue in remote and rural locations, which as we shall see throughout the report, would appear to be struggling more than their more urban counterparts when it comes to shifting the dial on SDS in general, and option 3 in particular.

In theory of course, if option 3 services are of a high quality and provide just as much flexibility and creativity as can be gained by using options 1 or 2, then this option really should be seen as a perfectly reasonable, proactive and positive choice for people to make. If we are having good quality, person-centred conversations from the first point of contact and within the assessment process, developing outcomes-focussed, strengths-based support plans with people, and commissioning for outcomes, then any option should in theory be able to fit with someone's needs and aspirations, with the only choice being how they want to manage it; the one caveat to this being that if someone would like to employ their own staff then they would need to choose option 1.

Section 19 of the Act states that "for the purpose of making available to supported persons a wide range of support when choosing options for self-directed support, a local authority must, in so far as is reasonably practicable, promote— (a) a variety of providers of support, and; (b) the variety of support provided by it, and other providers." This section of the Act makes clear the expectation that commissioning authorities should make changes to the way they plan and purchase care and support across all four options, a concept often referred to as "market facilitation", which is intended to ensure that every aspect of how care and support is commissioned and provided reflects the values at the heart of the legislation. As we shall see later in the report, different authorities have taken a very different approach to this aspect of their responsibilities under the legislation, with some actively choosing not to go down this route at all but rather to keep all of a particular service, such as care at home, in-house, and thus essentially being delivered by one provider.

Our working definition of option 3

In talking about option 3 during this project, we have used the following three overlapping definitions to inform our thinking and discussions, as well as a general terminology around block contracted and / or in-house services which most people working in social care recognise as being option 3.

- Under the SDS Act, option 3 is defined as “the selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority and, where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.”
- The Social Work Scotland’s National Framework for Self-Directed Support Learning Review [3] describes option 3 as where “local authorities decide the budget available and following discussion with the individual, chooses and arrange the support.”
- supportmesupportyou [4] describes it as when the local authority selects and arranges the support for the person based on their needs and outcomes; “I let the council decide how to spend the money.”

Participating sites and who we spoke to

The HSCPs and Councils listed below participated in the project on a scale from simply sharing details of and insights from a pilot undertaken or underway around their option 3 services, to a full exploration of what they have done and are doing to really invest in changing their offer at scale. Four sites also feature as vignettes at the end of the report.

- Aberdeen City.
- Aberdeenshire.
- Angus (Childrens' Services).
- Dumfries and Galloway.
- East Ayrshire.
- East Lothian.
- Falkirk.
- Fife.
- Moray.
- South Ayrshire.
- Leeds (a guest appearance from south of the border).

In exploring the experiences of each site, we spoke to several different people including:

- any designated lead/s for the implementation of SDS in general and / or option 3 in particular;
- social workers and care managers who are regularly supporting clients to choose to use option 3;
- commissioning, procurement and / or finance personnel who are routinely involved in managing the practical application of option 3;
- providers, community groups, advocacy or other organisations involved in the planning or delivery of care and support purchased through option 3, including any specific brokerage organisation/s or group/s commissioned to provide advice, guidance or support out-with the authority;

In all cases we sought to focus on what is behind and has enabled any successful shift in focus for care and support provided under option 3; what levers can authorities and their partner organisations activate in order to move away from option 3 being seen as “traditional services” or even “business as usual” while the work of delivering the heart and soul of the SDS legislation is left to rest wholly on options 1 and 2.

To create similar parameters around our discussions with each area, we based our explorations around nine questions which follow here, along with details of what we learned as we focussed our thinking on option 3.

Question one: What is your local definition of option 3 and how does this compare to the nationally recognised definitions we are using for the purposes of this project?

These were simply taken from the websites of the participating sites, though it is worth noting that in the majority of cases, the definitions are not obvious or easily available, due to the fact that SDS itself is often several clicks away from where someone seeking social care support is likely to begin. Most HSCP and Council websites have a separate section for self-directed support within or linked from the health and social care pages, suggesting to the uninitiated that it is simply one of a variety of things they might be able to access if they have social care needs. In a small number of cases it was necessary to go quite proactively hunting for it, one example being a click on well-being from the home page, then another on social care and health, followed by still another on support available, where we find eleven different things to choose from, including SDS but also things like “day care for older people’”, ”support for a learning disability” and ”care and support at home”. SDS is admittedly the first tab on this screen, however the fact that it is separate implies that it is a whole different thing to the rest, and yet the intention of the legislation is quite clearly that any care and support provided by social care is now facilitated through the SDS values, principles and processes. In other cases, unless a specific search is made for self-directed support it is difficult to find it at all; it doesn’t even come up when you follow tabs for “care at home”, ”disability support”, “learning disabilities” etc.

Once you do find the right place on the website, the way option 3 is described varies from statements such as “you can ask for your support to be arranged by us and provided either directly by us or by someone else on our behalf” [5] (Dumfries and Galloway), to “you choose to let the Local Authority decide how best to meet your agreed personal outcomes and arrange support for you” [6] (East Ayrshire), or “you wish for us to arrange and manage your support for you entirely” [7] (East Lothian).

This subtle difference in language is actually quite powerful, the difference between “asking”, “choosing” or ”letting” being not insignificant in terms of the message that someone reading the definitions might receive.

In some cases there are useful reassurances such as from Aberdeen City, whose website states that “by choosing Option 3 you have not lost choice and control over your support. Your practitioner will still support and engage with you about how you would like your support to be delivered to meet your agreed outcomes and will monitor these arrangements appropriately.” [8] However, this assurance of choice remaining with the person using services is perhaps less clear in other places, where option 3 is described as the option “where your social worker chooses the right provision of support for you, and arranges it on your behalf. You may choose this option if you would prefer your Social Worker to choose your support package following a discussion with them” [9] (Moray).

If, as can be reasonably presumed, delivery of option 3 services is shaped by the way it is defined locally, it would seem that my choice could vary from which option will be preferable to me in terms of managing my care and support to which option actually provides me with any choice at all, very much depending on where in the country I happen to live. More worryingly, from this exercise alone it would seem clear that far from now being the machinery underpinning all social care and support delivered to people in communities, SDS remains a somewhat niche part of a far bigger picture of provision, much of which would appear to have been wholly unaffected by this significant piece of legislative change to the health and social care landscape.

Question two: How many people are accessing option 3 as defined locally, including breakdown by client group, and what percentage of the overall population of people supported does this constitute?

It was more difficult than anticipated to answer this question, and most local authorities found it tricky to define this in any great detail. The anecdotal response to this question was invariably that the vast majority of social care service users overall would be accessing their care and support via option 3, whether by active choice or simple necessity, though where an area is described as having made a major shift in a particular client group or type of provision, such as in the case of care at home for people in Aberdeen City or Fife, this number is of course much higher for that particular service area.

For the areas who were able to provide data, the proportion of supported people using option 3 ranged from 47% (Aberdeenshire) to 79% (Dumfries and Galloway), with service areas such as physical disability and learning disability leaning the most heavily on this option. There is learning to be gleaned from this difficulty in pinpointing statistical data on option 3, as it suggests these services do not currently fit into the systems used in the same way as those commissioned via options 1 or 2.

Question three: Can you provide an overview of how option 3 services are commissioned, for example as part of a framework, block contract and/or in-house provision?

Standard 7 of the SDS Framework of Standards [10] says that the approach should be one of "flexible and outcome-focused commissioning" where "people and commissioners work together to plan, design, and quality-assure flexible local supports, to ensure that people have choice and control over what matters to them." The intention behind this standard is that all social care services and associated supports are "planned, commissioned and procured in a way that involves people and offers them real choice and flexibility in how they meet their personal outcomes", and this means not only via options 1 and 2 where this is clearly visible on an individual basis, but also via option 3 where the authority arguably has far more influence over the shape and feel of services through its directly commissioned contracts. As we will see, in those areas where pilots have been trialled, or new ways of commissioning specific services have taken shape, people and families have been involved to a lesser or greater degree in evolving plans; however where care and support commissioned under option 3 remains un-changed, these on-going contracts tend to be re-tendered when needed with limited if any input from the people who use them.

An excellent example of a new way of commissioning care at home can be found in Aberdeen City, where the Granite Care Consortium (GCC) [11] works across all client groups throughout the different localities of the city, and this is highlighted in the vignette later in this report. The Consortium grew organically from a process of engagement between the authority and its existing providers, where commissioners shared their vision for the future improvement of the service and listened carefully to what contracted partners had to say. Whilst there are ten different provider organisations represented by the Consortium, the authority only has one contract per locality, with GCC, making their internal

processes far more streamlined, which of course represents a cost saving, and enabling the provision of care and support on the ground to be delivered in the most efficient and effective way for individuals. A similar model known as the Care at Home Collaborative [12] has been in place for nearly a year in Dumfries and Galloway, where it is a vehicle to enable providers to work together in partnership with Home Teams (a multi-disciplinary team with social work, community waiting times team and care and support at home operational staff) for a more efficient and responsive delivery of care and support at home. This enables hand over, changes in hours, swapping hours or even combining "runs" where useful or preferable for the client.

In Aberdeenshire, a number of supported living schemes for people with learning disabilities which operate under option 3 are currently moving to their weekly budget formula, which has been shown to encourage more creativity and flexibility under option 2, where it is already in place. In this model the aggregated budget is paid to the service rather than being split per person, and they then create support plans with the individuals being supported using the discreet hours notionally allocated but not distinctly prescribed for them. Two of the agencies who have been involved reported at a recent provider forum that this is working well for them and, crucially, for the people they support too. Both this and the consortium / collaboration models move towards the ideal where each person's budget is paid in advance as a whole number of hours which the provider then works with them to agree how and when to deliver, with room to flex these hours not only for each individual, but also across or between individuals if circumstances need this. Flexing in this way – often referred to during our discussions as "stepping up or down" – allows providers to quickly respond to crises or changes of circumstance, simply reporting back to the social worker or care manager what has happened if these changes appear to need to become permanent for an individual, rather than having to agree every single change with them in advance, which delays responsiveness and both stifles creativity and hampers flexibility.

In Moray however, all new contracts for option 3 services are designed with people with carers' or guardians' involvement, including on interview panels, and when contracts come up for renewal. Whilst this is clearly driving up quality as well as satisfaction with new packages, they also spoke of the challenges of bringing legacy services up to speed, where culture and practice can sometimes remain fixed in how things have always been done. They have had a couple of instances where the person and the provider agreed to move to an option 2 for greater flexibility, which they realise suggests that there remains room for improvement within their option 3 services.

Throughout our discussions in relation to how option 3 services are commissioned there was recognition of the fact that payment systems and processes can be a major limiting factor to progress, as they are invariably predicated on time and task reporting which allows little to no room for creative or flexible service delivery. Other complicating factors included more than one example of where organisations appear on frameworks for both options 2 and 3 but the hourly rate associated with each is different, meaning that option 2 clients have to top up their budgets whilst the same providers are simply paid their full hourly rate by the partnership, if they deliver the care or support under option 3. Clearly this creates a perverse incentive for people to choose option 3 as well as for providers to prefer it, as it saves them the administrative burden of invoicing clients directly for their share of the cost.

A number of the sites we worked with are using or planning to move towards using Scotland Excel's flexible framework [13] or a version thereof. None have utilised their new models for more than one aspect of their offer to people using social care support, though scaling up and out to include all option 3 services is very much a next step for those where a new approach is now in place for one, such as supported living in Aberdeenshire or care at home in Fife.

There is a clear recognition, shared by most of the sites spoken to, that a cultural shift is required to move away from support plans detailing specified tasks to be delivered at set times, compounded by the fact that there are of course situations where a certain thing does have to be done at a certain time, such as catheter care for example, or medication prompting.

Question four: How does your approach to market facilitation lead to more creative, flexible, and person-centred care and support being provided via option 3?

The Independent Review of Adult Social Care in Scotland [14] concluded that "the requirements for arranging and buying services should include investment in improving the quality of care, and in staff terms and conditions – and in improving the choices and quality of care. We heard that the way services are planned and paid for makes unhelpful competition. This makes the process focus on cost. We want it to focus on working together for high quality, person-centred care and support. The focus on costs causes poor terms and conditions, including pay, for the social care staff." It is well understood in any sector that when staff are happier, they stay in post for longer and generally do a better job, and this is acutely important in social care where supported people continually struggle with inconsistency of carers, and staff themselves feel frustrated by the constraints on what they can and can't do for and with the people they support. This is something that HSCPs can influence directly through all options, but through commissioning for option 3 services in particular.

The clear aspiration is to move to a place where staff are freed from the restrictions of care plans which specify only certain tasks to be performed in arbitrarily defined units of time, so there is no need for them to "work with one eye on the clock" (as multiple carers report) as they can be trusted to do the work required within a reasonable amount of time. The certainty of a set salary regardless of whether one client needs or wants less care on a given day or week, is, as we will see repeatedly in this report, a major factor in creating the breathing space within which good, person-centred working practice can flourish. Another key consideration is that when the uncertainty of whether there will be enough work is removed, this encourages both individual workers

and the agencies who employ them to actively work to reduce people's packages where appropriate, whether through reablement, helping people learn new skills or creating connections with freely available community facilities. The reassurance of continual supply of work that block contracts offer is one of the levers that are being deployed in a number of areas for shifting the dial in this way towards more creative, personalised support; if a number of hours per week are allocated to a given provider or consortia of providers in a given area, and then clients are slotted in to utilise these with the assurance that there will always be more clients to come, then providers are far more likely to work in this way.

Some interesting learning has been gleaned in this area from south of the border. The report compiled by Leeds university looking into the authority's Community Wellbeing Pilot (CWBP) [15] – see vignette – concluded that this model demonstrated that "a better community home care system is possible", marking "a radical change to the current model of care delivery: time and task [which has] created a system that places emphasis on organisational need, process and managing risks." By contrast, the CWBP offered new ways of working based on principles of co-produced, person-centred care which is flexible and adaptable, including a commitment by staff throughout the system to actively encourage and enable community support networks. The evaluation highlighted both improved outcomes for service users and carers and increased job satisfaction for home care workers, leading of course, to improved recruitment and retention – the "holy grail" for a sustainable and high-quality social care system.

Care at home services remain one of the most intransigent areas to change in those areas who have not as yet proactively and robustly addressed them. Often what has worked at pilot scale in a discrete area of provision, such as learning disability supported living services where there is relatively stable 24/7 care and support, proves too complex to simply transfer to these much higher volume and turnover sectors.

Outcome-focussed commissioning, where people have access to 24-hour support on a shared basis, is reportedly far simpler to manage than in the more dynamic field of visiting / outreach services or care at home. A good example of this comes from East Ayrshire, where people we spoke to shared with us how their best value review into older people's care at home three years ago had concluded that quality, responsiveness, and flexibility were key issues which needed to be improved. The conclusion was that these improvements could only be achieved by making the service 100% in-house, and this work began pre-Covid when the split was 70% in-house and 30% independent sector; it is now at 89/11, though recently momentum has slowed due to the knock-on effects of the pandemic.

One of the people responsible for driving change in Dumfries and Galloway spoke about the fact that whilst work around developing option 3 is still in its infancy, early evidence would seem to indicate that practitioners and providers are thinking differently about the way care and support are planned and delivered. Their in-house care at home provider has 20% of the market while the remainder is delivered by private providers, so in theory there is choice for service users, but the reality on the ground is often that it depends on who is actually available and has capacity in your area when you need help. This led to a discussion about whether variety of provider agencies is necessarily the correct focus; after all, what is the point in having a choice of multiple providers if they all offer the self-same time and task driven input? So, the focus locally is more on making sure that whichever provider someone gets, their choice is about what kind of care and support they receive, with the emphasis on being person-centred and outcome-focussed rather than driven by time and task focussed packages. This in turn means a shift in emphasis for social work practitioners, and support has been needed for them to encourage moving away from using support plans to proscribe specific things providers must do at specific times, which inevitably restrict and constrain them from delivering the personalised service we all wish to see, and instead simply detailing the

need to be met and the budget available and leaving the provider and the person to work out how best to make the two blend in their individual circumstances.

Several people spoke of how part of market shaping includes a focus on communities and engaging groups such as churches, charities and social housing providers as well as unrelated businesses and amenities such as pubs, cafes and leisure facilities, and how this work remains highly aspirational when most front-line workers are fully engaged in simply managing the high levels of demand they encounter on a day-to-day basis. This kind of thinking can only really gain traction when there is a sense of collective responsibility for social care support, when people locally can see the value to all concerned of supporting each other informally, and when time is proactively created for people to build the connections and relationships needed to make this a robust reality.

Question five: Have you allowed "funding, support, and time for a process of disinvestment in order to reinvest in more personalised supports," as directed by the SDS Framework of Standards, which states the expectation that this investment "is based on a thorough understanding of the social care market, local geographic factors and unmet needs." What changes has this process led to?

In Children's Services in Angus, there had been a focus on encouraging options 1 and 2 as the in-house provision was "bursting at the seams", and there was a keenness to avoid expansion, however with virtually no independent providers available locally, the team turned their attention instead to improving the council's own offer. This has paid off significantly in terms of service improvement, staff, client and family satisfaction with the in-house option 3 service, with investment in training and support to encourage staff engagement resulting in a positivity towards change. As an endorsement of all the team's hard work, in October 2023, the short breaks service became a finalist in the Scottish Social Services Awards for Outstanding Residential Care Service. Time has also been given to review, update and simplify SDS processes and systems.

By contrast when speaking to the majority of participants about Adult Services, there was a sense that whilst small scale pilots have had the headroom to develop with other client groups, there is simply not enough breathing space in older people's services to even begin to explore ideas, as they seem to be constantly fire-fighting. One practitioner gave the analogy of being a hamster on a wheel, "constantly in motion but going nowhere". People could see the need to create time for professionals to work on planning and learning from pilots in order to scale up successes, but several practitioners also spoke of the need to create space in the right parts of an individual's pathway into social care, explaining how so much time is absorbed by the care manager chasing providers for whatever hours of care they have free means the time for

whole-hearted, person-centred working with people when they first present to the authority is severely squeezed, and this is only compounded by the sheer volume of referrals coming through. One social worker seemed to speak for many when they said that we need to "turn everything on its head and get it right at assessment and care planning, which is where it often goes wrong".

A commissioner in another area spoke of how it can sometimes feel as if they are purely operating in survival mode, with providers handing contacts back due to lack of staffing, an issue which blights a sector where staff routinely report feeling under-valued and know they can earn as much if not more working in hospitality or retail, where there is also often far more job security. As we have already seen, this issue is only compounded by the challenges of rurality, with not enough hours to sustain services and zero hours contracts meaning staff understandably won't agree to work only minimal hours.

In Aberdeenshire, there has recently been some early exploration of ideas for capacity building in older people's services, examining how the concept of aggregated or bundled hours, which came out of a "Deep Dive" into option 2 following the HSCPs involvement in our project on Individual Service Funds (ISFs) last year [16]. They have identified an area for a small scale, geographically based test of change to address known unmet need in a rural part of the patch, using some of the principles of the Buurtzorg Model [17] to encourage more staff autonomy and flexibility. In 2021, the authority moved away from focussed providers for care groups and now have a single framework for "support at home", however this aspiration - which is a sensible solution in the most rural locations - falls foul of the fact that many providers are only registered to work with a specific client group and / or in specific delivery models, so this restricts them from responding to the new way of contracting that is being offered. There has been a lot of work from care managers and commissioners to encourage providers to try and coordinate their runs for rural areas, and this works for a while before they start to struggle to

maintain staff levels, at which point pressure comes back onto the in-house homecare team – “the service of last resort”. A manager from within this service described this as a “spiral of despair”, as whilst constantly picking up the pieces in this way there is no time to focus on improvement or even begin to think differently about the work that they do with individuals; “demand always outstrips supply and we are forever chasing our tails.” There is also an issue in that, while a given provider may work across client groups, care managers do not, and this means an older people’s care manager for example would not think of asking a learning disability provider to pick up a package for them, even if the need is for personal care which the organisation is on framework to offer.

Recruitment and retention of staff across the social care sector came up time and again as the number one reason for a lack of a market to shape. Falkirk are engaged at present in a process of exploring how Care Inspectorate (CI) registration can impact on ability to provide support across multiple groups. This may have a particularly disproportionate impact in remote and rural settings, where there may not be enough hours to offer a specialist learning disability, mental health or over-65s service exclusively, but where combined together all three would create enough of a pool of hours to make one provider’s presence viable, as long as they could meet the agreed outcomes for all clients.

East Ayrshire are currently in the middle of a best value review of option 3 services for learning disability, mental health and drug and alcohol services to inform new contracts to begin in April next year, and whilst they want to focus this on increasingly personalised responses, they know already key issues that will come up are rurality, recruitment, retention and hourly rates, all of which have a huge impact on the provider’s ability to be flexible and creative. They are also in the process of exploring a new commodity strategy with a collaborative, flexible approach, aspiring to provide stability and growth alongside helping to build local market choice. In East Lothian meanwhile, a local MSP

recently called a meeting to look at recruitment and retention of social care staff locally as it is such well-known local issue. They, like other areas, have been focused on thinking about how they can use the lever of commissioning practice to enable the stability providers need in order to be able to improve terms and conditions for staff, such as block contracting to enable salaried roles whereby the worker is paid for a full shift regardless of exact contact hours, and other incentives such as making electric pool cars available to staff who do not wish or are unable to use their own car for work.

Several areas we spoke with are testing out or have versions of the Coalition of Care Providers Scotland (CCPS) three-way contract and ethical commissioning framework [18], and many are examining their internal systems and processes to see where these slow down or even present barriers to more outcomes-focussed commissioning. However, whilst the majority of people from all areas recognised the need to disinvest in spending time feeding systems and engaged in processes that drain the budget without adding to the quality of someone's service provision, it is these same systems and processes they must feed in order to ensure people receive care and providers are paid, meaning they feel a frustrating lack of "wriggle room" to work differently. These problems were widely reported by both authorities and providers equally in all participating sites to one extent or another, though many have still managed to find or create space in which to innovate, albeit often at small scale.

Question six: Are you able to confirm that people are "told the likely level of the budget available irrespective of the option they choose," as directed by the SDS Framework of Standards, which states that people should be "told the likely level of the budget available irrespective of the option they choose"?

In all participating sites there would seem to be a disparity between the intention to do this, which is clearly articulated on most of their websites, and the reality in practice. Several people spoke of how in theory, supported people are advised of their indicative budget as a result of their assessment or at the start of the support planning process, regardless of which option they are likely to choose, in reality the budget is really more of a focus for options 1 and 2, and many practitioners themselves did not see the relevance in the case of option 3; as one said, "we're paying for it anyway". In Aberdeenshire for example, this is something which is actively promoted in training, and although they don't gather data on it, anecdotally it would seem that it is not always happening. Often practitioners report a fear that individuals will spend every penny of a budget if they know what it is and it is something the SDS team say they are regularly supporting staff to overcome. This anxiety about individuals focussing on the money rather than the outcomes they need to achieve is something which has dogged person-centred working since the dawn of Direct Payments (now option 1) and seems quite persistent in the face of continual and repeated guidance and training across the country to redress it. A key issue underlying this is a fundamental lack of trust between all parties, something that most people comment on when one scratches the surface of these kinds of concerns.

Perhaps an even bigger issue is that conversations around support planning in many areas are not strengths or asset-based. The indicative budget, where it is known, is looked to first and foremost and assumed

to be there to cover everything, rather than seeking to maximise all of a person's natural and community assets to move them towards their outcomes first, before looking to the budget to fill any gaps. This is at the heart of person-centred planning models and indeed, has been the focus of many "good conversations" trainings over recent years, training which is reportedly on-going in many areas. While we continue to describe a person's presenting issue from the first point of contact in terms of their deficits and what traditional services they might already be being streamed into, our chances of breaking into more person-centred ways of commissioning the services these same people eventually receive seem tenuous at best.

This issue is only compounded by the fact that many HSCPs still do not have a reliable model for working out an indicative budget for people, with significant variation across the country as we know around how this is done. Of those we spoke to, some were using a form of Resource Allocation System (RAS) [19] but most some sort of an equivalency model, where the budget allocated to a person after assessment is equal to the cost which a traditional response to their assessment would have been prior to SDS. No site seemed entirely at ease with their approach to indicative budget setting, and it is difficult to see in these circumstances how meaningful support planning can take place in the spirit of the legislation, which anticipates transparency in this area leading to more honest and equal conversations about provision to support outcomes.

Question seven: What changes have you made to in-house / block-contracted (option 3) services to ensure that these aspire to match options 1 and 2 in terms of choice and control over their day-to-day care and support, for people who choose to let the authority commission it on their behalf?

The SDS Framework of Standards expects a shift in commissioning practice "from approaches based on time and task activities and towards the commissioning of support to meet individual outcomes" and whilst we as a sector have been talking about working in more outcome-focussed ways for many years now, this remains one of the hardest nuts to crack in terms of realising the full potential of SDS. It would seem that even where assessment and care planning have shifted to being more person-centred and outcome-focussed, the very processes involved in actually paying for care and support remain wedded to systems which demand to be fed a number of hours in order to generate a payment, and this quite obviously then drives practice to meet this demand. This has the result of pulling the attention of social workers and care managers as well as provider agencies constantly back to units of time, however much they strive to focus on outcomes.

As we have seen so far in the report and contained within the vignettes, there are pockets of difference across Scotland whereby payments are aggregated and made in advance and providers are trusted to adjust their input as reasonably required by the changing needs and wishes of their clients, freeing them up to be far more creative and flexible in their work with individuals as is the intention of the SDS Act. Examples like the Granite Care Consortium in Aberdeen City and the weekly budget model in Aberdeenshire demonstrate how well this can work for all parties concerned, however even within these areas they remain the exception rather than the rule until fully scaled up to cover all option 3 provision, and this will require whole-system change. Creating temporary

pathways through existing processes and procedures or allowing for exceptions to support pilot projects or tests of change are a lot simpler than addressing the entire complexity of the whole system, but until such time as whole system change is achieved, it seems doubtful that we will see the level of scaling across all of social care provision that was envisaged by the legislation.

In many areas what we heard was that, outside of pilots or tests of change, much of the care and support delivered under option 3 remains of a fairly traditional nature, not only wedded to the time and task model but also arguably towards the end of the spectrum which could be described as institutionalised. People spoke of old habits being hard to break and how the continuation of old practice simply reinforces it. An example which came up a lot in many areas was that of practitioners still routinely going into “standard” situations, especially hospital discharge, with a preconceived idea that four home care visits per day will be the solution, and in these cases they may not even go through all the four options at all, simply placing people into care at home under option 3 instead of looking with them at level of need, level of budget, and how to make best use of the latter to creatively meet the former. An almost universal justification for this was the volume and nature of referrals, with practitioners explaining that they simply do not have time to work in more person-centred ways, and even where their intention is to pick up a more nuanced conversation about outcomes and assets with the person at review, by then often the package is set and the person does not want to change it.

In areas where tests of change have focussed largely on learning disability services – which is not uncommon – people spoke of how these services have been focussed on person-centred thinking and working for so long that commissioning differently is “like pushing on an open door”, whereas conversely, the thinking around older people in particular needing time and task focussed input is so ingrained it requires an enormous effort for people involved in its planning or provision to think

any differently. We heard on several occasions how the admirable policy of free personal care [20] actually compounds this, an unintended consequence of a highly acclaimed piece of legislation being to skew thinking towards all that can be delivered for free.

Again, rurality was mentioned as one of the barriers to achieving improvements in this area, with a lack of staff for providers to employ mirrored by a lack of people wanting to work as PAs in remote and rural communities, meaning what is available is often pared to the bone or even struggling to deliver even the most basic of services. The way we tender for care services arguably plays into this, with providers in theory able to tender for more than one "lot" (client group or type of support) but in practice this can require them to have multiple registrations with the Care Inspectorate. An example which illustrates this very point was provided by Falkirk, where a short break service for under 65s needed to request a variation in their registration to take someone over 65, as the person would have been left with nothing otherwise.

In Moray where, as is common, their largest option 3 service is care at home, they now work to a partnership model whereby it is delivered entirely by the in-house team working with one specific provider in partnership; all other providers operating locally are therefore de facto option 2 providers. Whilst this was intended to enable a focus on quality and a shift of focus as required by the principles of SDS, in practice it seems some practitioners think of this option 3 service as effectively "pre-commissioned" and are therefore restricting themselves and therefore their clients to the partnership framework providers; despite the partnership model, there is the potential to use option 3 for other organisations if people choose, but this rarely happens.

People involved in leading SDS in South Ayrshire spoke of the fact that in learning disability services options 1 and 2 are quite widely understood, promoted and thus utilised, and echoed what we had heard from many other sites, that it is far easier to be creative when you are working with

a person and their family over time and therefore have longer to plan, as tends to be more the norm with this client group. They spoke of how, in their Core and Cluster models of housing within learning disabilities, “we are using SDS option 2 to support some service users to share resources, which is promoting friendships and interests jointly. This then enables an innovative approach to sharing hours and ensures that the service users get so much more from their social support hours.” In one particular locality a senior manager led a project on option 2 for older people to try and encourage take-up, and whilst this had the impact of reducing demand for the option 3 service, it was not felt that this had created the conditions within which thinking could be done about changing the way option 3 is delivered.

Question eight: Can you give a variety of examples of things being purchased or commissioned via option 3, to demonstrate that the use of the option is creating more choice and control for people who choose to use it than may have been available to those using in-house / block-contracted services prior to the implementation of the Act?

The SDS Framework of Standards states that "the authority should view its commissioning role as being a facilitator of choice. This involves both providing information about choices and commissioning and procurement processes that allow people to have a real choice of provider and type of support." The user and carer information and advice service, supportmesupportyou explains further that this expectation means there needs to be a major shift away from "current approaches [which] do not maximise control for the individual and may restrict choice through the use of restrictive frameworks and over specified contracts", and this would seem to remain a stumbling block to creative use of option 3 budgets in many places. It was hard for people to find examples where option 3 is used to purchase anything other than what we might consider standard or traditional services, such as care at home, day or residential care, and those that did commission something other than a service off framework for option 3 felt that this is often hampered by contracts and commissioning requirements. As one practitioner explained, "if it's a really small service or one-off purchase we just use option 1, otherwise it feels like using a sledgehammer to crack a nut."

The children's short break, respite and outreach service in Angus previously mentioned was recently rated "excellent" by the Care Inspectorate, affirming the decision to focus efforts on improving the in-house offer when the lack of providers and PAs locally frustrated efforts to increase uptake of options 1 and 2 and thus reduce reliance on this service. During Covid the service had been given more capacity, making

it more flexible and able to open 24 hours a day, seven days a week, which it had not done previously. The service works in demonstrably person-centred ways, using one-page profiles for example to ensure each young person is fully "seen" and supported as an individual. A notable example of their creativity as an option 3 service was the organising of a Prom, as while there is no specialist school provision in Angus, many young people with additional support needs were struggling to engage with these events. They held a graduation event for those youngsters who were going through transition to celebrate them moving on to adult services, with the Director of Children's Services and other senior staff in attendance lending weight to the importance of this for young people and families. Young people and families are very happy with this service, but this does not mean the authority are complacent, and whilst proactively supporting continuous improvement within this option 3 service, they would also like to develop more option 1 and 2 provision to complement it. Meanwhile mainstream children's homes in Angus are looking to emulate the good practice seen at the specialist short breaks service around person-centred working, use of one-page profiles etc, so the good practice commended by the Care Inspectorate is being shared across the wider department.

In East Lothian, where they have an extremely high number of 15 minute calls at 30% of all care at home inputs, they are reviewing the assessment process, moving away from the time and task model and trying to create more flexibility to enable improved practice and subsequently outcomes for people. Lots of these short calls are for medication prompting, and so one piece of work has been looking at how these can be addressed differently for example by using telecare, an area where they already have a good team in place who provide advice and information really well. They are also exploring the use of smart tech systems with a possible trial in some learning disability services with a view to scaling up and out if successful. East Ayrshire have also invested energies into expanding the use of smart supports to support independent living. They have recently launched a new "Smart Hub" for

people to find out more about what is on offer, including a flat which is kitted out with a wide range of technology, much of which is ordinary consumer tech based on systems such as Alexa, rather than specialist disability equipment. The Hub is open to workers and the public alike, so that they can see the technology in action.

Another major area of option 3 provision across Scotland is day services for people with learning disabilities, and in East Lothian they have recently developed a Resource Coordinator role, working with people to get them out of the day centres and involved in more appropriate, person-centred activities which move them closer to the outcomes they wish to achieve in their lives. The intention is that this will result in a shift for day centres which will become more specialised services responding to clients with the most complex needs, however at present day centres are still running at mostly the same cost despite the decreasing numbers of people accessing them, so there is little saving, and this is set against considerably more expenditure on those who have moved on.

Staying with learning disability services, in Moray there is another good example of innovation in option 3 provision where a house of multiple occupation is run under what is known as a “skeleton contract”, with the fine detail in the individual service designs around each person. This means – in contrast with the model being trialled in Aberdeenshire - that there is no longer a generic contract for three people sharing in place for this house, instead there are now individual contracts which are designed around each person and can therefore - in theory – be lifted out of the service and placed elsewhere, should the person choose to move house or provider. The provider involved is extremely positive about this way of working, as it means they can truly tailor their support around people as necessary and make best use of any shared time as appropriate. In theory, this structure should allow for a house of multiple occupancy where each of the people living there have their care and support needs met using different options or even different providers, though this is yet to be tested.

Question nine: What has had to change in order to make this a reality? We anticipate this will include the following but not exhaustive list: paperwork, including policies and procedures, systems, training, partnership working, decision making, culture, and practice.

Different people across the sites involved in this project highlighted different items listed in the question as either having changed, or needing to do so, to support the innovative practice and emerging models for delivering care and support under option 3, and as we have seen in the preceding discussion as well as in the vignettes, all of these levers must be used in synchronicity for tests of change to grow into business as usual for all client groups and across all service types. It is far simpler to create an aside or adjunct system or process to enable a side-step for a pilot project than it is to make the whole system change required to make the move to common practice, and the pull of the old ways of working – or perhaps simply the ease and comfort of the known and familiar – was clearly seen to act as a brake on progress by many of the people we spoke to.

With regard to the universally reported issue of recruitment and retention of care workers across the sector, the nationally recognised lack of decent pay and conditions coupled with a general under-valuing of the work done in social care were acknowledged as major factors mostly outwith the control of individual HSCPs to change. However, the new ways of commissioning and working explored in this report are bearing fruit in terms of acting as enablers for providers to offer more stability to their staff, and this in turn is creating more reliable, sustainable services which are able to offer the consistency of carers as well as the flexibility of care that service users rightly demand.

Another universally reported stumbling block to progress was that of mindsets, a term that was used routinely in relation to practitioners,

providers, contracts and commissioning officers, and essentially everyone else who has a part to play in the health and social care system. Leadership was seen as key here, with those areas able to point to a clearly articulated vision from senior management also reporting higher levels of engagement and development in terms of thinking across colleagues. People from Aberdeen City talked about how leadership, shared vision and drive came from a culture of collaboration which was already in place, with the push to change coming from providers as well as from authority, and in Angus a key driver of success was seen to be how senior leaders are demonstrably keen to support front-line staff, letting them direct how to do things and being open to their ideas and suggestions, opening the door for system-wide change.

It would seem however that mindsets are another aspect of the system which can be subject to intransigence and even to back-sliding; if early successes in pilot schemes fail to scale up or remain in some sort of enclave within the wider “business as usual”, then people quickly become disheartened and can revert to old ways, not only sucking life out of the original pilots but also hampering efforts to widen their reach into more areas of the authority’s work. Interestingly, Leeds found that the people who use services themselves can fall foul of this obstacle too, with one Citizen Panel finding a large number still wedded to time as the key measure of service delivery, despite a real shift in focus to outcomes and quality on the part of all the professionals they engaged with. A further development of this conversation around mindsets was the evolving understanding that delivering real choice and control for people who use services requires careful and on-going negotiation between care and support workers and the cared-for person to ensure maximum flexibility with minimal detrimental impact to either party.

Conclusions

The Independent Review of Adult Social Care, 2021, sets a clear expectation around what needs to be different moving forward if SDS is to become a lived reality for people using social care support; "We want to see an end to this emphasis on price and competition and to see the establishment of a more collaborative, participative and ethical commissioning framework for adult social care services and supports, squarely focused on achieving better outcomes for people using these services." Examples shared throughout this report demonstrate not only that this is possible using option 3 as well as 1 and 2, and at scale, but also that where the time and energy required is invested in developing these new models and ways of working, the benefits are significant for people who use, commission and provide services.

However, success is slow and held back by a multitude of obstacles. Mindsets are often stuck, and time is gobbled up just servicing the current demand – if you are operating on that hamster wheel invoked by a practitioner earlier in the report, then there is no time to think, be creative, or experiment. Recruitment and retention of care workers remains a massive hurdle, but attitudes and expectations of everyone within the system also continue to present significant barriers to the full realisation of the SDS principles and values across all options but perhaps most tellingly in option 3.

In its conclusions, the independent Feeley Review into social care highlighted that services need to be commissioned for public good instead of just being good for budgets. In direct response to Feeley, the Scottish Government's National Care Service (Scotland) Bill [21] includes provisions on ethical commissioning and ethical procurement, and much work has been done by iHub and CCPS amongst others to help HSCPs

and Councils to apply this thinking to their approaches to delivering social care. However, as the CCPS paper Commissioning for Outcomes [22] describes, “the promise of person centred, outcome focused partnership working offered by national commissions, legislation and standards has been repeatedly spurned in favour of process-led, resource-intensive, system-focused commissioning and procurement practice. Structures and processes seem easier to plan, measure and account for than outcomes, so the wrong thing keeps getting done, only ‘righter’.” This sadly feels all too familiar still, again most visibly in relation to making real changes to services commissioned using option 3.

We anticipated that the processes, policies, and practice visible in participating sites around option 3 would demonstrate a clear understanding of and commitment to offering all four options locally, and to shifting the way that in-house and / or block-contracted services are commissioned and delivered to ensure these are meaningfully different to how they were prior to the implementation of the Act. However, throughout the project, option 3 was repeatedly described as a quick fix in urgent or crisis situations, the default option for high-volume services such as care at home, and the service of last resort in all cases, and unfortunately was frequently equated by those who commission and provide these services as falling short of the person-centred, outcome-focussed goals we are all seeking to achieve. This was routinely further clarified as being a particular problem in the provision of care and support for older people, where demand is said to constantly outstrip supply and care managers are described as “swamped” with referrals. Plans to go back and review someone’s package and choice of option once the crisis has settled or the discharge from hospital is effected often don’t come to fruition, because the worker is onto helping the next person in crisis, and meanwhile the first person gets used to what is in place.

We found the excellent examples of progress detailed in this report and lots of evidence of practitioners, commissioners and providers thinking differently about what used to be known as in-house or block-contracted services, so that those who choose to use them can be sure of increasingly personalised support. However, we were also told repeatedly that option 3 hasn't really changed much and that people still talk about SDS as being options 1 and 2, with comments such as "option 3 isn't really SDS" or "I'm not using SDS" when they are, in fact, using option 3 services. Until this changes, it is difficult to see how the good practice examples highlighted by this report will gain enough traction to become the norm, rather than as at present, very much the exception.

Recommendations

Recommendation one: Make it clear that SDS is business as usual.

The Act clearly envisages a shift from the way social care was delivered previously to SDS as the new vehicle to be used in all cases, and yet what we see and hear on the ground and even at higher levels within the sector, is that SDS is still seen as something in addition to what we have always offered. So, we see lists under the heading social care on HSCP and Council websites which include SDS as one amongst many services on offer, whereas it is intended to be the system behind them all. It is difficult to envisage options 1 and 2 growing to rival option 3 in terms of usage, or option 3 services becoming truly person-centred and outcome focussed, while this current, widely reported misunderstanding persists to pervasively.

Recommendation two: Invest real time at all levels across the sector in breaking out of our silos.

As we have seen repeatedly throughout this project, restricting our tendering, contracts, registrations and indeed our assessment, thinking and planning by client group or type of support needed, does nothing to encourage innovation and actually constrains us in proactively addressing lack of provision, particularly in remote and rural areas. Far more work needs to be done to learn from and capitalise on the examples shared in this report and elsewhere of individual or consortia of providers operating across client groups and types of care.

Recommendation three: Re-frame thinking around free personal care.

We need to move to a place where someone's personal care needs are seen as simply one constituent part of their overall life, rather than allow the free personal care policy to continue to skew how we assess for, plan, and deliver services. It is clear from this project that free personal care has narrowed the bandwidth available for us to think about and deliver care and support; it drives our assessment, care planning and commissioning, creating unhelpful complexity when people have multiple or overlapping needs and wishes and creating the potential for a focus on getting tasks done in a vacuum where the equally important need for those tasks to be done in relationship with the person is lost.

Recommendation four: Let go of the hourly unit of care.

Payment systems must move away from their current reliance on units of time and instead properly connect payment to the effective delivery of outcome-focussed person-centred support plans; it is of little use commissioning for outcomes if the way we pay those who deliver them remains wedded to hours.

Recommendation five: Revise eligibility criteria.

These are widely recognised as keeping social care provision in crisis response mode as people do not reach the threshold for intervention until they are desperate, by which time they will inevitably require far more care and support both in terms of volume and complexity than may have served them well for many years, had we become involved sooner. Eligibility creates a further barrier by making no allowance for the value of relationships that need to form around the care tasks being delivered, meaning that it is the task itself rather than the importance of that task being delivered by someone known and trusted by the cared-for person, that drives provision, to the detriment of both parties.

Vignette one: Weekly Budgets in Aberdeenshire

In Aberdeenshire, Learning Disability supported living schemes are currently being moved to a new model within option 3, known locally as the weekly budget, to enable and encourage more creativity and flexibility in service delivery. The budget is paid to the service as a whole amount, not disaggregated per person, and the provider works with the individual and their family to create the support plan using the discreet hours allocated but not prescribed for them. Two of the providers involved reported back at a recent provider forum that this is working really well for them, their staff and most importantly, the people they support.

Weekly budget planning looks at which parts of a person's care and support are flexible and which are non-negotiable, with hours aggregated and an anticipatory way of working allowing them to flex up or down as required. This means in practice there are often different amounts of time spent with individuals from one week to the next as the staff team work with the person and their family to respond to the fluctuations which are a reality of a full and busy life, whilst maintaining the basics at all times. New services will commence on the weekly budget model as administrative processes are now in place, though it is assumed that legacy services will take time to migrate to new system.

Key messages which came from providers working on the initial test of change for the weekly budget model are:

- It works and is a win-win-win for the provider, the client and the commissioning authority, in the words of one: *"There are huge benefits to all parties."* Because it has been so successful, the providers themselves are now keen to see all their services shifted to

this model, meaning they are now a lever for change as they push back against social workers or care managers who come to them with prescribed time and task rather than outcome focussed care plans.

- It enables providers to give staff the safety net of knowing their hours are guaranteed even if a service user's hours decrease or someone leaves. This means staff relax and flourish more in their roles, taking more responsibility and initiative which inevitably benefits the people they support. As a result staff are far more likely to actively seek things to engage clients or help them regain or develop new skills, and this in turn has removed some burden from managers who used to be the ones expected to source activities. Staff now proactively pull themselves back where they can see this will be appropriate, whereas before this, making space for a client to regain or develop independence would have been hampered by the worker's fear of losing hours and therefore pay.
- Focus of payment, evaluation and contract review by outcomes achieved rather than hours delivered for individuals, is both easier and more effective in terms of working out if the service is providing high quality care and support.
- Trust between all parties is massively improved, which means the quality of these relationships is significantly more equal and positive.

"There are huge benefits to this model"

Vignette two: Fife Care at Home Collaborative

The care at home collaborative covers all adult client groups receiving personal care support, though the majority are over 65s. It consists of just under 30 provider agencies, most of which are independent although there are small number of third sector organisations too, working on flexible framework. The three cornerstones of the Fife Collaborative are their Terms of Reference, Memorandum of Understanding and Data Sharing Impact Assessment, which together underpin the collegiate way of working that is evolving locally to the benefit of all.

Working together in this way, the HSCP and the Collaborative have been able to invest in raising the wages of carers to above and beyond the Scottish national living wage, both in order to be competitive with other markets like hospitality and other significant local employers, and also to give a clear message that the work of being a carer is highly valued. Valuing Fair Work Principles has been a sharp focus of Collaborative Members. Close working with the Fife HSCP through a series of Tests of Change and engagement and participation of evaluation with frontline workforce has led to a series of improvements including; enhanced weekend rates of pay, interim cost of living payments, provision of branded clothing, leadership coaching and other supported interventions. The result is that staff self-reported motivation and commitment levels have gone up, sickness absence has fallen and retention is far stronger, so recruitment costs are considerably down. Staff also report higher job satisfaction as they are allowed time to build and nurture relationships with their clients, not just get in, do the task and get out again with one eye always on the clock. Service users and families are happier and complaints are down.

Senior leadership in collaboration with their Care Inspectorate link

inspector are signed up to the concept of an hour's 'bandwidth' to be delivered flexibly as required across multiple visits, giving staff more time to respond sensitively and in real time to the subtle shifts in the needs and wishes of their clients. Pre-collaborative and post, the commissioning of time continues to focus on outcomes but, like elsewhere in Scotland, calculations of support operate on multiples of 15 minutes to gauge how to logistically plan for support, including travel and where required more than one care worker. The model of bandwidth management of care already promotes supporting a caseload approach as the commissioning of care already takes account of paying providers on planned care time. This enables Providers to plan for recruitment and deployment of staff knowing that the commissioned rate is already known and payment, terms and conditions guaranteed. This is in contrast to the risks whereby Commissioned care is paid on actual time, creating a position of uncertainty for Organisations on financial planning, not knowing how many staff to recruit in context.

The system works on "Pin Point", a GPS system that maps all care at home needed or being delivered across the area, along with each Provider, including the internal service of Fife Council. The visibility and proximity of packages of care to be sourced, makes it a highly interactive system, and for provider organisations, there is also a Microsoft Teams site coinciding with this which speaks to all providers and can be used to reach out to other agencies. The principle purpose is about it being live, or as good as, updating every hour. Capacity and Allocation Meetings take place each week to explore offers of service with providers collectively and discuss opportunities for partnered working or potential realignment of brokered care; all of this helps to maximise the response levels for people awaiting care.

A care home collaborative and co-operative, developed in partnership with providers in that sector and following a similar model, is soon to go live, and there is a current tender open for the future delivery of supported living. Consideration as to how a Collaborative arrangement could or would enhance arrangements is being considered.

Vignette three: Granite Care Consortium

Aberdeen City have taken an innovative approach to care at home services under option 3, coming away from a standard spot-purchase framework to develop one block contract for all care at home support, across client groups and across the City. This move to a patch based model without client group silos was agreed with providers during a number of engagement events, where commissioners worked with them to understand their concerns and fears about this agenda, and this collaborative approach led to the emergence of a consortium of ten providers wanting to bid for the contract as one entity: Granite Care Consortium (GCC).

Initial motivation to engage with this model from provider's point of view was both to improve, as they could see the flaws in the system only too clearly, but also to survive, as the old competition structure simply wasn't sustainable enough for them to recruit and retain staff, offer a decent service and crucially, be confident of being able to continue to do so even when a staff member moved on. The partnership worked at pace because of the high motivation and commitment from all parties to change away from the time and task focused model that was clearly not working for anyone.

So now there is a block amount paid to the consortium monthly in advance, within which individual packages of care and support can flex up or down in response to changing needs or circumstances, and crucially this is discussed and agreed between the provider and the individual, with no need to revert to the social worker for authorisation. One senior social work manager described how finding care "used to be a free for all" but is now so much simpler and more reliable; the Care Management Resource Coordinators meet daily with GCC to discuss

what is coming through and agree together how to prioritise packages. Not only the care and support delivered but the whole system around it now feels more person-centred and outcome focussed, and crucially, there is a culture and atmosphere of genuine trust between all parties.

GCC currently supports approximately 1200 clients, around 10% of whom have complex needs and require support from 2 care workers (double-up) at each visit, delivering more than 11,800 hours of care and support each week, with the empowerment to step up or down, share across or switch between providers an intrinsic reason for the success they've seen. A good example of how this works in practice is that of an individual being supported by a specialist Learning Disability provider who became injured and was in need of additional support for personal care while recovering. This was discussed with the GCC central team and they were able to secure another provider from the consortium to step in to add some hours to the package whilst needed. The package was then stepped down again when the client regained independence with personal care tasks. While care management were notified of this change, there was no need for approval or lengthy discussions. The shared goal is always to meet the client's outcomes and this was achieved.

Finding care "used to be a free for all" but is now much simpler

The GCC model has been in place for three years now and has demonstrably improved sustainability of services, with no care package being handed back in that time because there is no single point of failure; if one provider cannot manage to work with a particular client then the rest work together to pick up the care, all pulling together now

they are no longer in competition. This in turn has given stability to the ten providers involved and by extension, to their staff, with the five year term of the contract allowing for improved recruitment and retention. The contract reflects ethical commissioning principles which supports salaried staffing not zero hours contracting, though different providers have different Terms and Conditions for their staff and not all are paying a salary for set hours regardless of contact time as yet, which is the aspiration. Part of the block contract amount is intended to support the consortium model by funding the central administration team to coordinate it all, which is hosted by one of the ten providers but entirely independent of all.

Each provider is still inspected individually and how many have 5s from Care Inspectorate, which supports the general feeling and anecdotal evidence that quality of care and support is continuing to improve under the model. Providers and commissioners both agree that the main keys to success have been a shared vision between partners and clear leadership, and all spoke of how the removal of competition has led to increased sharing of good practice as well as pooling of resources to meet client needs.

Vignette four: Leeds Community Health and Well-Being Service

The new service was conceived following a decision to create space to focus on a radical change to what was clearly a failing part of the adult social care system, with the absolute goals of making care at home more personalised for all adults and more rewarding for the staff working within it. Competition with the retail and hospitality sector meant that turnover in the home care sector was high and it was proving increasingly difficult to provide continuity of care worker, something that citizens understandably place a high value on.

The initial pilot during 2020-21 focussed on developing small neighbourhood-based teams, with WhatsApp groups for carers to communicate directly with each other in real time enabling things like quick resolution of issues or even simply someone to pop back in on a client later in the day to check on them if required. Staff teams are encouraged to be self-organising and proactive measures were taken to increase worker autonomy – key aspects of shifting away from a time and task focus. Prior to the pilot, turnover in the participating provider organisations was at 36%, and this dropped to 18% during the course of the year.

The authority signed up to Unison and GMB's ethical care charters and, as a result of incremental increases over an eight year period, have now reached the point where it is paying more to ensure a real living wage for carers. With a shift allowance being added into the hourly rate, home care workers are paid for whole shifts apart from breaks, even if they have 'down time' between calls. The expectation is that such down time will be used creatively by workers to help build on an individual's support plan, connecting with local community and services for example or

supporting someone to attend new activities while they get settled or gain confidence. Providers can increase input by up to 3.5 hours per week and decrease as much as they like; this is reviewed every four weeks and if a new pattern has emerged then the package will be adjusted to reflect this.

The new service is commissioned in partnership with community health services, and this has enabled home care workers to be skilled up to undertake delegated health care tasks, meaning that input from an individual carer is more holistic and the experience of service user is less fragmented. There are increased costs such as the shift allowance and trusted assessor role premium, but the working assumption is of long term savings, based on anecdotally reported experience in another area in England and one in Wales, both of which demonstrate that proactive reablement and regular light touch review lead to reduction in care, so that people always have the right size package to suit their current needs.

> “There is a slow shifting away from social work being a mostly transactional interaction”

Although at present a time and task model is used to generate an indicative personal budget for an individual, at the point of support planning this is reviewed, with the acknowledgement that everyone’s needs are different, for example one person’s shower may need 20 minutes and another twice that. With the care agency involved in support planning with the individual and the social worker, there is a far more personalised conversation about delivery of support from the beginning.

There is also now a slow shifting away from social work being a mostly transactional interaction, with far more personalised relationships developing between practitioners and providers as well as between all professionals and people who draw on care and support.

An independent evaluation of the Phase 1 pilot by Leeds Beckett University, whole system savings and efficiencies as well as the following key outcomes have been clearly identified:

- Improved outcomes for service users and carers.
- Increased job satisfaction for Home Care Workers leading to improved recruitment and retention.
- Improved efficiencies and savings.
- Wraparound support in a person's home reducing avoidable hospital admissions.
- More responsive service enabling faster hospital discharge.
- Third sector role enhanced to complement services and support a person's wellbeing.
- Fewer complaints and requests for change as service users receive a flexible and consistent service.
- Streamlining internal processes including payments, charges and contract management.
- Efficiencies for providers in lower staff turnover and reduced travel time.

The evaluation highlights the significantly improved outcomes for service users and carers, *"who report that the flexible model of care provision has met their needs and fits into their life seamlessly. Bespoke adaptations to care packages have made sensitive care needs feel as if they are delivered by personal friends and family rather than a distant community care organisation. This positive experience for service users and carers has been matched in staff satisfaction for [home care workers] who have reported greater autonomy and satisfaction with their practice."*

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This report was produced by

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With the support of

The Scottish Government
Riaghaltas na h-Alba