



**Stockport Self Directed Support Pilot in  
Mental Health**

**Final Report of the Evaluation of  
the Self Directed Support Pilot**

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**Dr C. East-Telling  
Faculty of Health and Social Care**



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## Executive Summary

In recent years personalisation and the individualisation of health and social care have become key drivers of change. The process was initiated by the previous Labour government, and the new Coalition government has sought to accelerate the shift through policy documents, continued consultation and practical guides [1-7].

Personalisation in learning and physical disability services is becoming well established, however mental health services have been slow to take up the agenda and offer Personal Budgets to service users. Stockport Metropolitan Borough Council (SMBC), together with Pennine Health Care NHS Trust, are working to address this and implemented a pilot study to explore the possibilities for self directed support and Personal Budgets within Stockport mental health services.

This report presents the findings of the evaluation of Stockport Council's Self Directed Support pilot in mental health services. The pilot has been in place for eighteen months, and this report covers the evaluation of the implementation.

The purpose of the evaluation is to better understand the experiences of people with mental health problems who access the Stockport Self Directed Support service, together with those of staff responsible for implementing the pilot. As part of the service users will receive some, or all, of their care budget as a Personal Budget. The impact these budgets have on user's lives in relation to inclusion, choice and autonomy is being explored.

In addition the evaluation aims to bring greater understanding to the most effective ways of delivering brokerage and individual support planning, particularly the merits of external, internal, peer and self led brokerage.

The specific aims of the evaluation are to:

- Understand the experiences and satisfaction of staff and users accessing the Self Directed Support pilot
- Explore the characteristics of different brokerage systems
- Investigate the processes of brokerage
- Map where and how users spend their resources
- Highlight the implications for future implementation of Self Directed Support services

This report explores the introduction of Stockport's Self Directed Support pilot with respect to each of the aims outlined above, before going on to discuss some of the key commissioning and organisational themes which are impacted by the introduction of Personal Budgets.

## Key Findings from the Evaluation

### *Experiences of service users*

- ❖ Service users have been very positive about the move towards personalisation within Stockport mental health services. The aim of the pilot was to achieve 60 service users taking up a Personal Budget in the first year. This was far exceeded with 94 service users on the pilot in the first year rising to 179 by the end of the complete eighteen month period. This shows the popularity of the scheme amongst service users
- ❖ Support plans have been creative and outcome focussed, drawing on resources including those not normally accessible through traditional services.
- ❖ There have been many positive stories from service users regarding the outcomes they have achieved within the SDS pilot.
- ❖ Service users have built capacity in all key areas to increase their citizenship and community involvement, both of which are strong indicators of recovery. These areas include greater authority to be in control of their life, having a direction or purpose in life, having the resources to improve life, having a place to belong, having the right support and being involved in community life by giving back to others. Through this service users have gained self esteem, and hope for the future.
- ❖ There is a need for clear communication with service users regarding the ethos and outcome based approach embedded in SDS. Service users were not always clear as to what they could expect to achieve through their Personal Budget or how to build their support plans to meet their needs.
- ❖ Service users requested more information about how the process worked, more guidance on what could be included in their plans, and documentation to point them in the right direction when looking for services or support, e.g. where to find a personal assistant or gym to join. This needs to be developed in a comprehensive way to avoid piecemeal advice, which may not always be suitable
- ❖ In some cases there were unacceptable time delays during the process, particularly in the first year. This was exacerbated by the lack of communication between staff and service users as to what was happening with their application, in part due to uncertainty by staff. Clarity as to the process, and expected time frame would be welcomed by service users, perhaps as a handbook or electronic guide.

### *Experiences of Care Practitioners*

- ❖ Care practitioners generally felt that the ethos of SDS was a very positive development in mental health services and felt that the large majority of people who had been through the process had benefitted considerably from being on the pilot.
- ❖ Many of the care practitioners were very positive regarding personalisation, but the professional gift model was still very evident amongst a significant minority. There is still work to be done to move towards a citizenship model and co-production, where practitioner and service user are seen as equals in a partnership to bring about the best outcomes for the individual.
- ❖ There was a recognition that SDS would bring a huge culture change, which would take drive and commitment to implement. However, practitioners wanted management to acknowledge that some of the new ways of working were already part of the practitioner's traditional role, and that communications around the changes should be positively framed as building on existing skills, rather than damming current practice.
- ❖ Practitioners felt they did not have sufficient training in SDS,: many of them had been on some sort of training course but they felt this did not target their needs for information. Some suggested that practical training or working through real life examples would have helped. Additionally training on the review process was considered insufficient, and ongoing training as the pilot progressed would have been welcomed.
- ❖ Practitioners were under pressure due to the additional paperwork and time needed to implement SDS, along with the current CPA approach. Streamlining the system was considered a necessity if SDS was to be expanded into the future. This is currently being explored in Stockport using 'wellbeing care plans' to help bring the two systems together.
- ❖ The need for better communication of the inevitable process changes which took place during the pilot was highlighted. Lack of communication to all practitioners sometimes led to an unnecessary increase in work load, as they had to negotiate new processes and forms and redo some of the paperwork. Additionally it led to delays for service users, because practitioners were unclear as to how to proceed with the process, delays and mistakes were sometimes made.
- ❖ Lack of resources or commitment to the pilot sometimes led practitioners to hand over the support planning process to the external broker. This must not be allowed to happen, as ultimately the care practitioner will have



responsibility for the service user and support plans developed, and will need to take on board the ethos to ensure positive outcomes.

- ❖ There was a consensus that changes to service user culture would be needed to highlight the fact that clients could no longer expect to be in services for life if they did not need them. Establishing a suitable review process, which included how service users could move on and out of services, but still maintain the positive outcomes they had achieved, was considered important.
- ❖ Some care practitioners are still acting as gatekeepers to the process, both in terms of who is offered SDS, and as to the routes which service users can take to develop their support plans.
- ❖ There were concerns that provision of the service was not equitable, and was only being used by articulate service users with low level need. Yet some practitioners were only offering the service to users who had less complex needs, and simplest support plans as these involved the least amount of work. Thus a self perpetuating bias was created.
- ❖ Some care practitioners were keen to take on the role of support planning with their clients. This is an option which should be offered to service users as some clients like the fact that they know their care practitioner, and there are no new people involved in the process. But for others it is important that they are able to work with someone from outside services who does not necessarily know their previous background before the application begins, and is therefore neutral in the process.
- ❖ There is a recognised need to empower service users to complete some, or all, of their own support plan where possible. It is not feasible for care practitioners to do all the research into a support plan for more than a few service users. By empowering service users who have the capacity to take more responsibility for their plan, whilst providing just enough support for them, care practitioners can be freed up to concentrate and spend time on more complex cases.
- ❖ There were issues around risk and safeguarding for service users due the traditionally risk averse culture in mental health services, and because SDS promotes a more balanced assessment of risk with joint responsibility between service providers and service users. However, the authority worked hard to allay fears and put in place risk enablement panel which was welcomed by care practitioners.

- ❖ A major concern arising from the findings was the poor working relationship between care practitioners and the peer brokers from the user led organisation. Care practitioners were not working with the ULO, and many still harboured prejudice and preconceived ideas about both ULO's in general and the ULO chosen to be a part of the pilot. This is a major concern to the progression of Personal Budgets and is an issue which must be addressed urgently.

### **Exploration of Brokerage Routes**

#### **External broker**

- ❖ The external broker worked within CMHT teams to build capacity, and with service users to develop support plans. In addition the external broker worked with the peer brokers from the ULO to develop capacity for peer support.
- ❖ The external broker was key in the early stages of the pilot for bringing experience, knowledge and confidence to the process and CMHT teams.
- ❖ Creative and unique support plans were developed through this route, which would not have been developed by internal staff at this early stage.
- ❖ The relative independence of the role enabled the broker to act as an advocate for service users, without the constraints of the internal culture.
- ❖ Although this role was independent to a point, placement within the CMHT teams did lead to more involvement in the politics and decision making processes than would be expected of an external broker.
- ❖ Initially the external brokerage option was applied equitably amongst service users, mainly due to lack of other brokerage options available. As the pilot progressed there was less equity due to the lack of resources and the growing number of people on the pilot. This balance should be re-established moving forward.
- ❖ The peer broker role was established and strongly supported by the external broker. Building ULO capacity and skills, and the provision of a pathway for referral were vital elements.
- ❖ There were a number of issues in moving forward with this role, which must be addressed, including:
  - Funding for the external broker service – should this be paid for by the authority or by the service user out of their Personal Budget.

- To ensure the external brokerage function does not add an extra layer of complexity in SDS. The service must be simple to use and keep care practitioners 'in the loop'.
- There is currently no regulation in the brokerage function, and concerns about safeguarding and possible risk to service users should be explored.

#### Internal broker

- ❖ This was a new role established towards the end of the first year of the pilot. Three care practitioners trained to act as internal brokers within the CMHT teams, and maintained their care practitioner roles in parallel with the internal broker role.
- ❖ The internal brokers have worked well within the CMHT teams they support, and the support plans they are developing are effective.
- ❖ Due to the workload of the internal brokers, from both their care practitioner and broker roles, they are under increasing pressure at times to fulfil both commitments.
- ❖ As the SDS service expands the draws on their time will increase, and they may find it more difficult to give the time and focus needed to each service user to ensure successful outcomes. For this reason it should be considered whether this role would be better as a stand alone function across all teams. This could enable greater capacity and focus from the internal brokers.
- ❖ Currently the role of the internal broker is to build capacity among other care practitioners and to develop support plans. The internal brokers are aiming to train practitioners and hand much of the support planning over to them once they have the skills. However there is a question as to whether practitioners or the broker have the time and resources, in the current structure, to complete numerous support plans effectively.
- ❖ The internal broker role is not independent from the culture and processes of the mental health service, and this can be a double edged sword. The broker has knowledge of the politics and pressures care practitioners are working under, and how the system works. However, they are unable to be as independent in their decisions and support to service users, as they are aware of this context.
- ❖ Due to the stresses and pressures of both advocating for the service users and working for the authority, the internal brokers need a route to their own support. A source of expertise and experience, preferably external to service,

would allow them to offload and discuss any issues which may be difficult to explore within their work context.

- ❖ The internal brokers must improve interaction with the other brokerage functions, they had not worked with the peer brokers, nor had any established routes for interacting with them. This is a fundamental oversight within the pilot.

### Peer brokers

- ❖ The peer brokers were very enthusiastic about SDS, and could see the clear benefits it could bring to service users.
- ❖ The peer brokers have a unique set of skills to offer, and grass roots experience of navigating mental health services from a service user and carer perspective.
- ❖ This role suffered from a faltering start, but is now up and running and able to offer support planning to service users. Due to nature of ULO's it can be difficult to fit working styles and patterns with big organisations, and this had a major impact on setting up the peer brokerage route.
- ❖ The ULO was given help and support by the external broker to become established, and this proved critical to the progression of this role. However, now the external broker has moved on from the project the ULO needs another champion to push the peer support agenda forward.
- ❖ The peer support group felt they were not viewed as equal partners in the SDS process, have experienced prejudice and exclusion by practitioners. Clearly this is not an acceptable situation, and ways of working together must be sought.
- ❖ There is currently no mechanism for referring service users to the peer brokerage service and they have not received any new referrals, since the external broker moved on from the project. This situation must be addressed to allow service users the option of using the peer brokers, and to enable the ULO to be able to build their capacity further.
- ❖ Peer brokers were not involved in the training or setting up of the pilot, and as such have been severely limited in their opportunities to interact with care practitioners or internal brokers. They felt if they had more contact with practitioners they could begin to break down the barriers of prejudice against them, travel the journey of learning together and be able to be more active partners in the process.

- ❖ There were some questions from practitioners as to whether the ULO chosen was the right one to support their service users. Regardless of the legitimacy of this concern, it highlights the fact that there may need to be more than one ULO offered to meet the wide ranging needs of service users mental health services.

#### Self brokerage and community links

- ❖ There were insufficient records of self brokerage in the SDS pilot to enable this option to be evaluated. There were some service users who took this route, either fully or partially, but they were recorded on the database as being led by a care practitioner and none gave any feedback at this stage. Nevertheless it is important to understand the experiences of this group, and as, if expected, it becomes a more established route to Personal Budgets feedback and understanding should be sought.
- ❖ Also within this pilot links with community groups and networks were not explored as alternative routes for brokerage. There are a wealth of untapped resources within these areas, and these must be built on to establish community links within SDS and consolidate the social capital these networks can provide.

The evaluation has shown that no one brokerage route can meet the needs of all service users. Therefore it is recommended that users are universally offered the full range of brokerage options upfront, with an explanation of the pros and cons of each. The ultimate choice as to which option to use should be made by the service user, with support if necessary, once they have been given all the relevant information and time to make the decision.

#### SDS Database

User spending was mapped via the database collated by Pennine Care during the pilot. This has shown that the 179 service users on the SDS pilot have come from across the range of adult mental health sectors, and cover a wide age range (18 to 79 years).

The median spend for each service user was £3, 976 in the first year dropping to £2,989 in the second. This was partly due to the reduction in price point year on year, and compares to the median spend found in the national IBSEN report [8] of £4,800 for mental health service users and £6,610 for all Personal Budgets holders.

The key areas on which service users spent their Personal Budgets included:

- Leisure activities / holidays (38%)
- Assistance with everyday tasks (29%)
- Home improvements / cleaning services (23%)
- Access to the gym or other sporting activities (21%)
- Computing and other electronic equipment (13%)
- Help to increase socialising (11%)
- Transport (11%)
- Education courses (9%)

Support plans have been developed to find creative ways of meeting user's needs, increase citizenship and bring them towards greater integration into society, a positive indicator for recovery.

### *Commissioning and organisational issues*

- ❖ Continue to work on strengthening links between health and social care staff within the team, in line with coalition government thinking [2], and ensure common focus and priority of SDS.
- ❖ Stress the importance of moving forward with SDS, as it is no longer a pilot and the drive is to implement wider, do not allow practitioners to slip back into old ways of working once initial focus wanes.
- ❖ Commissioning must be flexible, but needs to balance requirements for traditional services with those for new often smaller providers. There will also be a greater focus on co-production of services with users and community.
- ❖ Non-service support should be fostered and promoted to consolidate social capital. This includes building a role for ULO's:
  - Invest in capacity building and support
  - Make processes more accessible
  - Demonstrate backing and confidence in ULO; tackle prejudice and gate keeping by practitioners
  - Publicise ULO services
  - Include ULO's in training and other 'team building' activities
- ❖ Continue to work on safeguarding, and enable the balance of risk and protection to be achieved [6, 9].

- ❖ Encourage staff to believe in service user's capacity and to provide 'just enough' support to empower them.
- ❖ Support staff in taking on new ethos, and back them at every opportunity.
- ❖ Information networks need building both within the care practitioner function and for service users
- ❖ Ensure equity in offering SDS and brokerage routes to all
- ❖ Establish a robust review process to continue gathering evidence and stories relating to the success of SDS.
- ❖ Start to build community links, and support self brokerage (either full or partial) wherever possible.

## Conclusions

The overall findings show that the Self Directed Support pilot has created an exciting opportunity for change in adult mental health services in Stockport. Despite the challenges faced in its implementation and execution, and the need for further development and consolidation, it can be seen as a huge positive step towards achieving the goals of personalisation which are a key thrust in social care.

Service users have been able to build support plans which have created inspiring outcomes, and changed their lives. The plans have enabled them to reconnect with their communities, build self esteem, self image and hope for the future, and ultimately supported them to move towards recovery.

## 1. Introduction

This report is an account of the introduction of the Stockport Self Directed Support pilot in mental health services. The pilot has been in place for eighteen months, and this report covers the evaluation of the implementation. An evolving methodology, utilising a range of techniques, has been employed to build a rich picture of the impact of SDS on those involved. The evaluation can be viewed as a jigsaw built from service user, care practitioner and broker perspectives, and the findings are presented within this framework.

The pilot was based on the standard model of allocation of budgets and involved the completion of a self assessment questionnaire (SAQ) followed by a resource allocation process using a resource allocation system (RAS). Points are allocated to service users based on their level of need, and their Personal Budget is calculated according to their number of points. Once this allocation has been made up front, a support plan is developed, either with or without brokerage assistance, to show how the budget will be used in practice, and expected outcomes [10].

## 2. Aims

The aim of the evaluation is to better understand the experiences of people with mental health problems who access the Stockport Self Directed Support (SDS) service, and of those who are responsible for implementing the pilot.

As part of SDS users will receive some, or all, of their care budget as a Personal Budget. The impact these budgets have on user's lives in relation to inclusion, choice and autonomy is being explored.

In addition the evaluation aims to bring greater understanding to the most effective ways of delivering brokerage and individual support planning, particularly the merits of self, external, internal and peer led brokerage.



## Specific Research Aims

The specific aims of the evaluation are to:

- Understand the experiences and satisfaction of staff and users accessing the Self Directed Support pilot.
- Explore the characteristics of different brokerage systems.
- Investigate the processes of brokerage.
- Map where and how users spend their resources.
- Highlight the implications for future implementation of Self Directed Support services.

## 3. Background

In recent years there has been a marked shift towards personalisation and individualisation of health and social care [11, 12], in part due to user dissatisfaction with public services on offer, and the desire for more choice and autonomy in our lives. Changing demographics have also played an important role in the move towards personalisation, as we become an older and more diverse society with widely differing needs and wants. Personalisation is now considered to be the major driving force in public sector welfare reform in the UK [13]. It creates care and support services which begin by putting the individual at the heart of process, and recognising that they are a person with their own unique strengths, weaknesses, preferences and aspirations. Personalisation reinforces the idea that the individual is best placed to know what they need and how those needs can best be met [14].

Whilst health and social care have both taken on board the personalisation agenda, the speed and extent to which this has taken place varies widely. Social care has pioneered the approach, and is further down the road of personalisation than health care, due to a number of factors which are discussed later.

The transformation of social care has been supported by a number of key policy guidance documents from the Department of Health. The green paper

Independence, Well-being and Choice [15] signalled the first move towards personalisation, which was later reinforced through the white paper our Health, Our Care, Our Say [16]. In 2007 the government produced its groundbreaking Putting People First Concordat [17]. The core of this framework is a commitment to support independent living through an increased focus on individualised care [18]. It agrees a shared responsibility to create a high quality personalised system, which involves input and cooperation between councils and independent, voluntary and community organisations, and works beyond the boundaries of adult social services alone [19]. Joint approaches to commissioning, which were introduced in the 1999 Health Act [20] and consolidated in the National Health Service Act 2006 [21], were again reemphasised.

It has been possible to provide service users in adult social care all, or part, of their funding as a Direct Payment since 1996, when the Community Care (Direct Payments) Act came into force [22]. This was initially aimed at disabled adults of working age, but has since been extended to other groups. In 2001, through the Health and Social Care Act [23], it was made mandatory for local authorities to offer Direct Payments to eligible individuals: those are people who are able to receive social care services who consent to and are able to manage payments. Direct Payments are one way to increase personalisation in social care, in that they allow users to apply for money to buy specific items or services pertinent to them. Direct Payments have proved to be popular with over 66,800 people accessing the payments by the end of 2008 [24, 25], although the proportion of people with mental health needs using the payments has been very small [26, 27]. Nevertheless, the number of people with mental health needs using Direct Payments has seen the biggest rise in any sector, from 50 in 2007 to 3,373 in 2008, a rise of 62 percent [28]. This would suggest that there is a large potential to increase Direct Payments to mental health service users, and to implement Self Directed Support to this sector. The main delivery tool in Self Directed Support is the Personal or Individual Budget. This can be seen as an expansion of the Direct Payment, in that both Direct Payments and Personal Budgets provide money given individually to the service user to spend on their needs. However, a Direct Payment is usually a one off, or series of smaller payments for a specific use, made up entirely of money from social services.

Both Personal and Individual Budgets focus on the wider picture which sets an overall budget for a person's care, which they are told about up front. Individuals can design and purchase their own support from the public, private or voluntary sectors [29] and can combine money from a number of sources, including:

- Local authority adult social care
- Disabled facilities grants
- Supporting people
- Access to work
- Independent living fund
- Integrated community equipment services

A Personal Budget is the term used to describe a budget made up with money only from a single source, e.g. social care sources, and an Individual Budget refers to one which is designed to access money across a range of sources. However, in the early days of personalisation the term Individual Budget was often used interchangeably with Personal Budget. The Stockport pilot utilises only social care funding and thus the money service users are receiving is a Personal Budget.

There are a number of key features which can be considered to define Personal Budgets [30]. They should be:

**Transparent** - Personal Budgets must be clear and up-front, letting the person who needs support know what they can expect to receive so that they can plan and organise their support in a way that suits them best.

**Flexible** - Personal Budgets must be flexible, allowing the person who needs support to meet their needs in the most effective way possible.

**Fair** - Personal Budgets should be allocated in a way that is fair and which provides people a budget that is adequate to meet their needs and without imposing unreasonable financial burdens on people who need support.

**Easy to Use** - Personal Budgets should be easy to use and widely supported.

**Outcome-focused** - Personal Budgets should serve to help people positive outcomes in their lives and any monitoring or regulation of people's management must be primarily focused on the outcomes people achieve.

The use of Fair Access to Care Services (FACS) eligibility criteria, and completion of a Resource Allocation System (RAS) assessment can help to ensure all service users are treated equally, and the allocation of money is fair and open. There have nevertheless been some difficulties where people have been receiving traditional funding, despite not fulfilling FACS criteria, i.e. FACS criteria have not been applied correctly in the past, and these issues need to be addressed when taking forward SDS and Personal Budgets.

Personal Budgets can be delivered and managed in a number of flexible ways to best suit the service user [31]. These include:

- Direct Payment to the individual
- Payment to be managed by a representative of the individual
- Payment to a trust acting on behalf of the person
- Payment and management through an intermediary agent
- Management by a service provider, using an individual service fund
- Management by the council commissioning on the individual's behalf

A national pilot of Individual Budgets (mostly made up of Personal Budgets) took place in 2005 across 13 local authorities including all groups of disabled and older people [8, 32]. The number of sites including mental health service users in their sample was low (four sites and 14 per cent of service users overall), nevertheless, findings indicate that this group had very positive outcomes in terms of well being, and a strong tendency for better psychological health. However, there are a number of obstacles specific to this care group which must be addressed in order to widen participation. Many of these issues have been well documented in the paper 'A voice and a choice' [33], and include issues of mental capacity, the tension between relinquishing control and managing risk, fit with the care plan approach, and misuse of money. A further key issue has been the huge shift in culture, roles and responsibilities needed to implement Self Directed Support and Personal Budgets.

There is still an institutional legacy in social care which treats service users as recipients of care rather than as citizens who can take control over their own support. Support is seen as a 'gift' which is given to people on the basis of a professional assessment of their needs, rather than something they are entitled to claim. Some practitioners have welcomed the shift needed to implement SDS as a reinvigoration of social work values, and are keen to work more closely with service users to achieve better outcomes. However, there are some concerns that care management may become fragmented, professional skills devalued and that crisis intervention might come to dominate social work [34].

In 1999 the Government published The National Service Framework for Mental Health, a comprehensive 10 year plan covering the future of mental health care in the UK [35]. This drove a shift in social care services around new types of teams with functional roles, which aimed to provide more effective social care through assertive outreach, crisis and home treatment and early intervention [13]. Ten years on the Government updated the plan under the banner, New Horizons [36], which aimed to continue and build on the agenda set out in the original plan. As such the new plan continued to emphasise the role of personalisation in the mental health arena, and to broaden its remit.

There has been much discussion regarding the use of Personal Budgets in Health Care [37, 38], and their integration with Social Care funding [39]. In the white paper *Our Health, Our Care, Our Say* [16] it was clearly stated that offering Personal Budgets to NHS patients "would compromise the founding principle of the NHS that care should be free at the point of need". Nevertheless, the outcome of the IBSEN evaluation in social care and the debate that followed has served to change this point of view. By the time the NHS next stage review led by Lord Darzi [40] was published in 2008 the perspective was that the potential of Personal Budgets "should be explored to give individual patients greater control over the services they receive".

Following on from this the Department of Health initiated a three year national pilot of Personal Budgets in health care [41, 42] which started in 2009/2010. This mirrors

the progress made in social care, and will enable service users to buy some of their health care using their own budget. However the majority of health care provision will still remain outside the Personal Budget remit, being deemed unsuitable for inclusion, e.g. in patient hospital care. It has been recognised that the health pilot should acknowledge and build on the social care experience and use this to help inform their journey, as opposed to starting with a blank sheet. In the second stage report published in November 2010 [43] the health budget pilot was showing many similar findings and challenges to those in social care Personal Budgets.

Nevertheless, there are still questions regarding the appropriateness of developing individual health budgets in parallel with social care budgets, rather than integrating them into one holistic Personal Budget. For service users with wide ranging or complex needs it can be difficult to distinguish between what is health care and what is social care, for example physiotherapy services, or complementary therapies. In some cases people have used their social care Personal Budget to employ a personal assistant who is then providing health care services, such as medicine management [8]. This clearly blurs the boundaries of health and social care, and as Personal Budgets become more widespread this issue will grow in complexity. Some social care leaders have expressed the view that unless social care funding can access some of the health care funding provided within Personal Budgets, new artificial boundaries will be created between health and social care; precisely the kind of difficulties the flexibilities introduced in the 1999 Health Act were designed to ameliorate. This is particularly concerning in mental health services where health and social care elements are so tightly bound [44].

It is recognised that Personal Budgets have had a lower position on the health care agenda than on the social care agenda. This, in part, is due to the perceived notion that the NHS is more professionalised, and also because in social care there is a clear indication that personalisation is a strategic thrust in the delivery of their services [44, 45]. However it can cause tension within joint agreements, and reduce the effectiveness of care provided. Increasing the prominence of personalisation in health will go some way towards unifying the goals of the two areas, but until closer integration of funding can be achieved it will be difficult to provide care as a whole

package. Some authorities, e.g. Yorkshire and Humber, are now starting to explore ways to integrate health and social care funding more fully, although these projects are currently at the very early stages of development, but will hopefully provide insights over time [46, 47].

Stockport Metropolitan Borough Council and Pennine Health Care set up a pilot study to introduce Self Directed Support services and Personal Budgets to adult mental health service users. Initially the pilot was set up to run for twelve months, later extended to eighteen months, and aimed to bring 60 service users onto the pilot scheme by the end of year one. The pilot originally focussed on the Early Intervention Team (EIT), as this was often young users first contact with adult mental health services, and was considered to be a pivotal point where there would be an opportunity to intervene with the new initiative. However, during the initial set up period it became evident that service users in the EIT remit were in fact less likely to interact with mental health service providers. They were often at a stage where they wanted to keep official interaction with mental health teams to a minimum, and still felt they had their health under control. Therefore as the number of potential pilot service users in EIT was lower than expected, it was decided to open up the pilot to other mental health teams across the entire spectrum. Thus after the initial period the pilot was broadened out to include all mental health teams from EIT to Older Persons Services (OPS).

The team involved in the implementation of the pilot was assembled in partnership across health and social care, as were the senior managers responsible for leading the project. Most of the care practitioners came from Pennine Care NHS Trust and those driving the agenda from Stockport MBC.

## 4. Methodology

An evolving reflexive methodology has been used to gather feedback from those people affected by the new ways of working, and a number of different techniques were explored in order to collect feedback from service users, care practitioners and brokers [48]. These methods are explored below.

### 4.1 Service User Feedback

Data collection from service users proved to be a challenge, and number of different methods were implemented throughout the period of evaluation to try and gather information from this group.

#### 4.1.1 Diary

Initially a diary study was proposed to evaluate service users' experiences of using the Self Directed Support service in Stockport. This was selected as a method for collecting data over a three month time period, which would tap into people's changing experiences and perspectives as their budget evolved. The diary asked users to complete details of their Self Directed Support plan as it was developed and also once it was in place. It also sought to ascertain how people's thoughts and feelings changed over the course of using the Self Directed Support service, and how their lives had been affected by receiving the Personal Budget and being part of the Self Directed Support pilot.

In the first instance the diary was developed as a paper based document, however because this project was initially aimed at users of the early intervention team, the diary was also developed as an electronic document which could be filled in and emailed back to the researcher over the three month course of the study. The electronic diary was considered to be more appropriate to the younger users, under the care of EIT, who were more familiar with computer technology in their everyday lives.

Both versions of the diary, the paper based and the electronic, included a short questionnaire at the front to gather general demographic information, data on the



actual process of applying for a Personal Budget and an overview of the type of support given during the development of their Budget.

This was followed by a section to be completed each month, for a total of three months. This section used a person centred planning approach to better understand what had gone well, or not so well that month, and what had been learned over the course of the month.

The final section was a general overview of what things were important to users, what made a good day for them and what made a bad day for them. This was included to provide a means of recording which factors the users felt were important to incorporate in their support plan.

#### Recruitment process

Users were asked to fill in the diary over a three month period and mail the completed document back. A £20 high street gift voucher was offered as an incentive for the return of the completed diary.

A flyer asking for participants in the diary study was sent to care coordinators electronically, and a paper version distributed by one of the team leaders to all participants using the Self Directed Support service. The care coordinators were asked to discuss the evaluation diary with their service users, and ascertain if they would be willing to take part.

The response was very limited to the initial flyer, with few users expressing interest, and none agreeing to take part. Therefore the researcher made telephone calls to all the care teams to reiterate the aims of the evaluation, and again ask them to discuss with their clients whether they would be willing to take part in the study. Most of the care coordinators agreed they would raise the idea with their users again. However, the response was still low: two users agreed to take part in the study, but they did not return their diaries.

#### **4.1.2 Service User Day**

As the response to the diary study was low it was decided to try and reach service users via a Service User Day. The aim of this day was to bring service users together over lunch to discuss with each other how the Self Directed Support service had impacted on their lives. There was an opportunity to talk over any issues and highlights the journey had produced, and the users were asked to fill in two short questionnaires around their experiences of applying for a Personal Budget. In addition service users were invited to take part in the diary study and complete a diary for three months.

The external broker (Step by Step), two representatives from the peer support group (All Together Positive formerly known as Accentuate the Positive) and two members of Chester University were present to help answer any questions, and to join in the discussions where appropriate.

Two service users completed the questionnaires on the day, and two service users agreed to complete a diary for the study. One diary was returned, however the user was still awaiting payment of his Personal Budget. Therefore the entries focus mainly on the user's hopes for the future and his anguish at waiting for his budget to be implemented.

#### **4.1.3 Service User Narratives**

Due to the challenges faced in gathering a meaningful amount of user feedback from the proposed data collection methods above, it was decided that a selected number of service users would be interviewed by a member of the Stockport Mental Health service. One of the care coordinator's mailed service users to ask for their involvement, and followed up with phone calls to recruit service users. Ultimately, eleven SDS pilot service users were visited and their stories and experiences recorded in their own words. These narratives were then analysed using Max QDA to explore themes and issues which had arisen whilst the participants' were on the SDS pilot.

## **4.2 Care Practitioner Feedback**

Care practitioner feedback was an important part of the picture in terms of understanding the successes and challenges of the pilot. Therefore feedback was sought from as wide a range of care coordinators and support workers as possible. This involved distribution of feedback forms at training days, the development of a short questionnaire to be distributed to practitioners and a discussion group run with a number of people involved in delivering the SDS pilot to service users.

### **4.2.1 Care practitioner feedback forms and questionnaire**

Two feedback forms were developed to elicit information from care practitioners regarding their experiences of being involved in the Self Directed Support Service. The first form focussed on care practitioners' experiences of implementing the Personal Budget service, and the second gathered information relating to how care practitioners who had actually been through the process felt about it.

These feedback forms were distributed to attendees on a day course in September 2009, aimed at re-launching the SDS pilot, and giving care practitioners more information about what was involved in the SDS process.

An additional feedback form was provided by Stockport Council to gather general issues raised on the day. The data collected from these forms was integrated with that from the evaluation feedback forms to provide as much depth to the data as possible.

It was further agreed that the evaluation forms would be distributed at all future care co-ordinator training days, and this additional feedback would be incorporated into the findings as and when it became available. To date no further forms have been received.

Towards the end of the pilot a short questionnaire was developed to be sent to care practitioners regarding their experience of implementing the pilot, over the full eighteen month period. However, this questionnaire was not used in the final evaluation as it was decided the timescales did not allow for its distribution and

return. Nevertheless, it will serve as a useful tool for data collection should this be required in the future.

#### **4.2.2 Care practitioner discussion group**

A discussion group was set up to capture the experiences of care practitioners and staff who had been instrumental in delivering the SDS pilot programme to service users. The discussion group consisted of twelve staff from the Pennine Care Foundation Trust who encompassed a range of experiences, including those implementing SDS at the point of delivery, through team managers responsible for staff who were implementing SDS, to SDS champions from within the organisation. For the first part of the discussion two members of staff from the external broker service, Step by Step, were present. However they left the group for the latter part of the meeting to enable staff to have a free and open discussion of their experiences of working with the external broker.

The aims of the focus group were to understand staff experiences of implementing the pilot, and the positives and challenges encountered to date, specifically:

- To understand the impact of the self directed support pilot on care practitioners and other staff responsible for implementing the pilot.
- To understand the experiences of care practitioners whilst introducing SDS to their service users.
- To gather feedback on the positives and challenges of implementing SDS.
- To generate ideas for improvements in future implantation.

The discussion group took place on 16<sup>th</sup> September 2010, in Stockport at a neutral venue.

#### **4.3 Broker Feedback**

At the outset of the pilot it was hoped that there would be a number of different brokerage routes available to service users taking part in the SDS pilot. Namely external brokerage, internal brokerage, peer brokerage and self brokerage.

However, although there have been a small number of service users who have completed their own support plans, there has been no feedback to date from this group as to their experiences.

In the first year of the pilot some care practitioners took on a brokerage role, with or without support from the external broker, nevertheless, the majority of service users completed their support plan with the help of the external broker, who was experienced in support planning. This was in part due to the fact that the process was new and unfamiliar to care practitioners, but also a reflection of delays in developing alternative brokerage routes. In the second year of the pilot the range of brokerage options available expanded, including the establishment of internal brokerage and peer brokerage options, although the peer brokerage role was not as fully developed as was hoped by this stage. In the latter part of the pilot the majority of service users undertook support planning with their care coordinator alone, or with help from one of the internal brokers.

#### **4.3.1 Development of External Brokerage Role**

Two interviews were undertaken with the external, or independent, broker to discuss this role in the project and experiences of performing the brokerage role. The first meeting took place in October 2009, once the project was becoming established, and the second meeting took place in December 2009, as the project remit evolved.

A final report written by the staff from Step by Step was produced in September 2010 and distributed in October 2010 [49]. This report was a reflection of the external broker's experiences of implementing the SDS pilot in Stockport and key aspects of the report are incorporated into this final evaluation report where appropriate.

#### **4.3.2 Development of Internal Brokerage Role**

In December 2009 a decision was taken to resource three internal brokers in the CMHT teams. These brokers received additional training with respect to developing support plans, and worked along side the external broker taking on clients from

some of the sectors. The internal brokers were interviewed in August 2010, to capture their experiences of implementing the function and to explore the maturation of the role.

### **4.3.3 Development of Peer Brokerage Role**

As already stated, the development of the peer brokerage role was slower than initially planned. However, a number of staff from All Together Positive (ATP, formerly known as Accentuate The Positive) received training in support planning, and began to take on a brokerage role for some service users in the second year of the pilot.

Peer brokers from ATP were interviewed in August 2010 to better understand their experiences of being part of the SDS pilot study, and to explore facilitators and barriers to their inclusion in the brokerage services being offered.

### **4.4 Data Collection via SDS Pilot Database**

A database containing the details of all service users taking part in the SDS pilot has been maintained by Pennine Care Foundation Trust, throughout the pilot study. This database recorded details of service users who were on the pilot scheme together with information about their Personal Budget, and how they spent the money. The database has been used to better understand the participants on the pilot, and to track their progress and the outcomes of their application. The database is still being populated as the pilot progresses beyond the initial phase, but for the purposes of this report a cut off point of August 2010 was used for analyses of the content.

## 5. Findings and discussion

### 5.1 Feedback from Service Users

There have been fundamental issues around how to gain access to service users, and in particular how to encourage care practitioners to become enablers in this process within the SDS pilot. It has been a challenge to gather feedback from service users and gauge their response to SDS. Nevertheless, where contact has been made there has been a strong desire by service users and their carers to talk about the process, and their experiences of being involved in SDS. This serves to reinforce the belief that the service users have important stories to tell, which can help guide the future development of SDS

#### **5.1.1 Feedback from service user day in year 1 of the pilot study**

The feedback from the service user day was positive despite some challenges and frustrations along the way. One carer whose husband was able to employ their son as a personal assistant highlighted that often it is the unexpected outcomes of the support plan that are the most important, and have the most impact on a person's life:

*“My husband is able to be more involved in conversations now (between her and her son), you can see it in his face that he is taking an interest in what is being said, and trying to join in. That alone is worth all the waiting and difficulty in getting the money. I feel I have my husband back”*

She also took the view that this had only happened because they had been able to employ her son, who had a lifetime of knowledge regarding his father, his background and his situation. The outcome would not have been the same, she felt, had an unknown carer or carers come in to help with the day to day needs of the family.

It was clear from talking to the service users that there were a number of issues which needed to be addressed in the SDS process including:

- Time taken to complete the SDS process. Some of the users had experienced unacceptable delays during the process of applying for a Personal Budget. This needed to be addressed and times reduced considerably, as it is was major hurdle and de-motivator for the service users
- Time taken to receive money. A number of service users were unsure about when, or even if, they would receive their money. For some there had been a false hope of quick resolution; this was caused in some instances by a lack of clear information about when the money would arrive, and in others by ill informed advice from care coordinators, who themselves lacked the necessary clarity. A more transparent indication of when, or indeed if, the money will arrive would help service users to put their expectations and anxiety into perspective.
- Many service users did not have clarity regarding the process involved in applying for a Personal Budget. A clear plan of what happens at each stage of the process, and how long each part of the process is expected to take, would help service users (and care practitioners) to understand what is needed at different stages of the application.
- There was also some confusion at this stage amongst service users and care coordinators about what Personal Budget money could be used for. In line with the principles of Self Directed Support and Personal Budgets, the money provided can be used for any purpose as long as it is legal and helps the user to remain healthy, safe and well. With time and experience it is becoming easier and clearer to understand the kind of things people can and cannot use their money to buy.
- Some service users found it difficult to understand that the money they would be provided with could only be used to fulfil the wishes outlined on their support plan. The money could not be used for other purposes once it had been earmarked on the plan e.g. money provided to redecorate and improve surroundings could not be used to buy a new television set, if this



did not lead to the agreed outcomes. This requires clarity on the part of the broker / care coordinator to make sure the service user understands the situation at the outset, and careful monitoring to ensure the money is spent only on agreed support needs.

- Availability of the broker was an issue in year 1, which was probably due, in part, to the high workload of the external broker, who was working on numerous support plans at any one time. However, it is important that service users feel they have adequate support during the development of their Personal Budgets and beyond, and capacity must be monitored to ensure service users are not experiencing long delays, or unavailability of suitable support to complete their plans.

One key point to make here is that despite the difficulties and delays experienced by these service users interviewed in year 1, none of them actually stopped the process or withdrew from the pilot. They were all positive about the idea of Self Directed Support and Personal Budgets, and would go through the process again (although without all the anguish they had been through this time) if it meant being able to receive their money as in Personal Budget.

The feedback (albeit from a small sample) indicates that they felt their support plans:

- reflected what was important to them
- reflected their needs
- took into account their choices
- the service users also indicated that the process had improved their life a little or a lot.

### **5.1.2 Service user narratives**

During the second year of the pilot eleven service user stories were recorded by Stockport staff. These gave a rich picture of service user experiences and built on the findings from the service user day which took place in year one.

Narrative methodologies are widely used within healthcare settings offering a means to capture data rich in personal experience [50]. The service user narratives, analysed using Max QDA, highlighted a number of themes, some of which had been picked up at the service user day and others which were supplementary

The narratives were overwhelmingly positive in their reports of service user involvement in the SDS pilot. This may in part be because the interviewees were self selecting, and were under no obligation to tell their stories, therefore more likely to be those who felt they had something to tell. Nevertheless it is a reasonable assumption that if there had been those with wholly negative experiences of the pilot they too would feel they had strong stories to tell.

The service user narratives have been analysed within the frameworks of personalisation and the keys to citizenship proposed by Duffy [51, 52]. The dimensions of personalisation proposed by Duffy relate to the resources that need to be in place in order to enable a person to live a good life, and the keys to citizenship are the outcomes which can be achieved if the right resources and community connections are available.



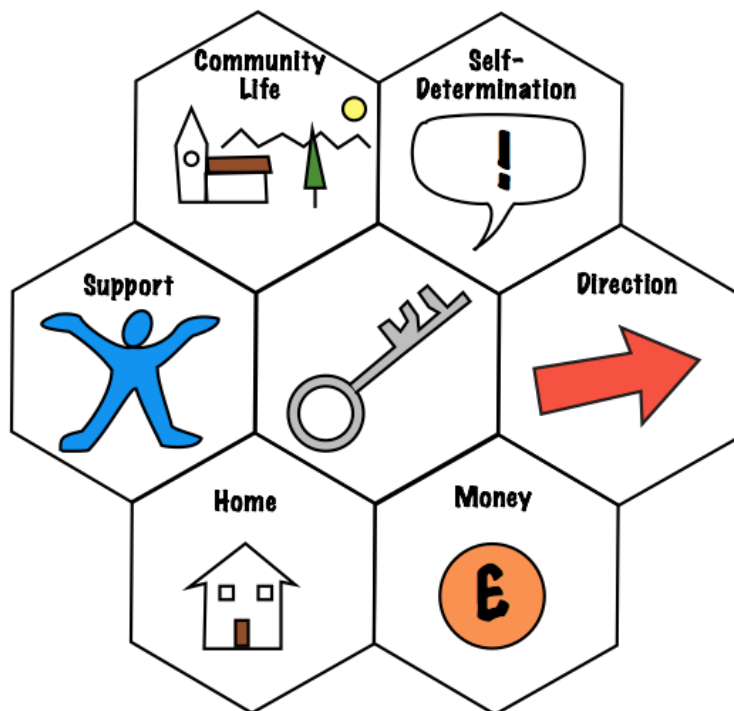
**Figure I: The Dimensions of Personalisation**

There are five dimensions in this model:

1. Capacities – an individual’s skills, strengths and needs
2. Connections – a person’s family friends and community connections
3. Access – having the opportunity to use community resources and public services
4. Control – the resources and assets that enable us to control our lives
5. Resilience – the inner strength that enables us to utilise and build on these resources

People with mental health issues often find that their ability to be fully contributing citizens within society has been curtailed due to a number of reasons, e.g. through stigmatisation, isolation or self imposed exclusion from society. This can be a self perpetuating situation; if suitable support and resources are not available it can be difficult to make the transition back into society and on to the road a recovery. Self directed support is a key pillar to ensuring that personalisation is achievable, and helping to provide enablers to increase a person’s feeling of citizenship. Feeding directly into the areas described above, SDS is facilitating service users to look at their own strengths and needs, to have control over what they think will help them to recover, the means to access services and resources they feel will be beneficial and ultimately to build on community connections which can help them to reintegrate into society more fully.

Linking into this, Duffy has proposed that in order to become a more integrated part of society it is important that any interventions in service user’s lives provide benefits in a number of areas [53], as shown in the diagram below. If outcomes can be achieved which build capacity in all these areas, a strong framework to promote recovery and social inclusion can be achieved.



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**Figure 2: Keys to citizenship**

The six keys to citizenship Duffy proposed are:

1. Self Determination (Authority) - the ability to be in control of your life
2. Direction - having a distinct purpose and meaning to your life
3. Money - having enough resources to direct your own life
4. Home - having a place where you belong
5. Support - needing other people, giving value to the lives of others
6. Community Life (Contribution) - giving to others through family and community

Service user narratives have provided a rich picture of users experiences of being on the SDS pilot, and the outcomes they have achieved. The feedback shows that SDS has contributed to building capacity in all the areas of the model, as will be discussed in more detail below. In accordance with the Nursing and Midwifery Council Code (2008), names have been changed to ensure anonymity.

## Authority

Service users provided many references to the fact that the control they had over their support plan, what should be included, and the flexibility afforded by SDS, was liberating

*“I like the flexibility that Self Directed Support gives you as I feel it is important to be able to use different approaches and ideas with different people which is unlike traditional services. “*

(Martin)

*“I never would have used traditional services and feel that the flexible approach that Self Directed Support gives suits me.”*

(Richard)

*“I have never really used any of the mental health services as I feel that they did not fit my needs and also especially as I find it difficult to go out.....The Self Directed Support has given me the opportunity to try new experiences that would not have been as accessible to me.”*

(Martin)

*“I also used to receive support from traditional services, which, although was excellent, didn't fit my needs as adequately as we would have liked.”*

(Andrew)

Other service users praised the fact that they had the authority to choose who they employed to support them. This enabled service users to feel comfortable with the support they implemented, and to feel in control of the situation.

*“Being able to choose where the support was from was perfect for us as our son knows me well of course and knows me as his dad rather than seeing a person with communication difficulties.”*

(Andrew)

*“I found it really important that I could choose who I had to support me with the garden.”*

(Stephen)

There were also a number of references to the fact that completing the SDS and going through the process had been a beneficial experience through which service users felt they had learned a lot. This gave them confidence and a new self belief in their own authority to run their life.

*“I’ve realised that not everyone is judgemental and I feel that I am more accepted in the community. I still get stressed sometimes and hear voices but I think I’m coping with them better. “*

(Joanne)

*“I’m quite shy and was able to choose someone I already knew from the allotment group which worked really well as I already knew them and had built my confidence up with them.*

*I am now able to plan, prepare and initiate something. I can visualise how things will develop and my motivation has increased. I also feel I now have the confidence to accept mistakes and to learn from them.*

*My increased motivation and confidence has helped me realise that I can do anything I want to as long as I put my mind to it.”*

(Stephen)

*“It has helped raise my confidence and feel that I have gained a lot of knowledge”*

(Andrew)

*“This now means that I am more confident and in a far better place ready for my discharge.”*

(Mathew)

*“I was looking at asking for funding for a support worker to help and encourage me to use buses but I don’t need that now as I feel more confident and motivated and I’m using public transport on my own now independently.”*

(Simon)

### Direction

The new direction many service users felt they had in their life since beginning the SDS process was highlighted, as was the feeling of motivation they had gained through having a purpose and goals:

*“The SDS has helped me to start doing the things I wanted to achieve; things I want out of life. It’s nice that I have things I’m working towards and sometimes when I’m feeling low, it’s nice to know that I am making changes and I’ve got goals that I want and can achieve.”*

(Scott)

*“I’m doing something that shows results and I’m doing something constructive with my life.”*

(Stephen)

*“I have enjoyed my computer course and have used the internet to look into future courses and job prospects.”*

(Mathew)

*“At the last consultant’s appointment, before I got my SDS funding, I told my Psychiatrist that I felt like I was lost in a black hole. At my last review I was able to tell him how things had changed and that I’m happy now.”*

(Mark)

*“It has changed my focus; I had voices and couldn’t go out and felt I had nothing positive to do. It gives me something to work around. Now I’m doing art it gets me out and gives me motivation to do things that in the past I had tried to avoid.”*

(Richard)

*“I think my biggest accomplishment is that I get myself there on a Wednesday by bus. I struggle to catch buses on my own as I can get quite anxious but I needed to overcome these fears if I wanted to go horse riding and I’ve managed it. It was hard catching the bus on my own at the beginning but I wanted desperately to go riding so I had a massive incentive to do it.”*

(Joanne)

*“The Self Directed Support scheme has helped me to explore my interest further. I was offered some garden space at Redcroft and received funding through Self Directed Support for a shed, gardening tools, seeds, plants and compost”*

(Stephen)

*“I feel more motivated now and have begun to attend the gym regularly.”*

(Simon)

### Money

The money provided to service users through the Personal Budgets was mentioned, but mainly in the context of what it could be used for. The fact that it was being provided to fund whatever the service user felt would be most beneficial to them, and that this was such a change from traditional services was applauded. However the majority of narratives relating to money were in fact referring to the resources and services which had been purchased with the allocated money.

*“I used the SDS money to buy a computer and enrolled on a course at Learn Direct. (Rachel) helped me to look for the one which suited me best. I didn’t want to go into a college at this stage because I still felt that I “stuck out like a sore thumb”.”*

(Mathew)

*“I also have problems with phobias and have a strong phobia around using public transport so I also got a vehicle to help me get around. I used to have a car but it was very unreliable and I was always anxious that it would break down when I was out and would be worried about how I was going to get back home. Now I feel I’m not prevented for going anywhere.”*

(Martin)



*“I didn’t enjoy school very much and don’t feel that I learned much there but I really want to be able to read. I think it will give me more independence and freedom. I think that’s why I want to learn to drive as well – I have anxieties about using public transport and have to rely on other people to give me lifts so if I could drive then I could go where I wanted when I wanted.”*

(Scott)

*“I also applied for SDS funding towards a holiday. I haven’t been on holiday for nine years and I used to love to travel and see different places. I’ve been to America and Asia as well as living in Sydney, Australia for seven years where I gained my Diploma in Community Services (Mental Health) and got a job at a Mental Health Day Centre. I feel that studying different places and different cultures inspires me to write and I’ve also applied for money for a camera as I love the stimulation you get from visual arts like photography. Also one of the units that I’m going to be doing at university is travel writing and I have applied for funding to pay for some of my modules at university and some materials that I’ll need for the course.”*

(Margaret)

*“I also bought exercise equipment including weights which I feel helps lift my mood and makes me feel better. The money also went towards driving lessons for my wife. Being able to go out in a car gives me freedom. I have to choose my environment as I don’t like the hustle and bustle of busy places.”*

(Richard)

*“I was able to purchase the equipment I needed for horse riding and it has paid for me to have riding lessons twice a week. I used to ride horses when I was young but I hadn’t been for a long time as I felt that things were preventing me from doing it, the main issues being finances and confidence”*

(Joanne)

*“I wanted ....to be able to pick my youngest daughter up from school. I have struggled in the past to do this and haven’t had the money to do it. I have had to*

*rely on friends and neighbours but I felt that this wasn't right as I was their mother and wanted to do these things for them."*

(Nicola)

### Home

Many of the service users reported that they used their money to improve their home or environment. This is a key area for citizenship and for creating a sense of belonging. A positive home environment serves as a strong base from which confidence and motivation to achieve in other areas can grow:

*"I split up from my husband about three years ago. It was quite an abusive relationship...this time in my life was hard and the condition of my flat went downhill quite badly...It took time for me but, with the help of others, I managed to start sorting my head out.....The only thing I was struggling to sort out was my flat. It had painful memories about my husband and how he used to treat me. One thing he used to do was to throw devil bangers (very small explosives wrapped in paper) against the bedroom wall to get my attention when he was in bed and wanted me to make him a drink. The bangers made marks on the wall and every time I saw them, it was a reminder of those bad times but I had left it so long that it was in quite a bad condition. I didn't have any money to decorate or sort out the carpets which were quite stained and threadbare and I found it difficult to motivate myself to sort out my stuff as I was still not feeling 100% and I knew that the marks on the wall would still be there.*

*I found out about SDS from my Support Worker. We discussed what I felt would help me to feel better. I decided almost immediately that I would like to use it on decorating and re-carpeting my flat...I was in control of everything and I think this helped me feel that it was my flat again."*

(Rachel)

*"(Steve) and I applied for new flats and I am now settled into a nice flat not far from where my family live but far enough away for me to be independent."*

(Mathew)

*“I applied to SDS for funding for a fridge freezer, a microwave and a tumble dryer. Both food and personal hygiene are very important to me and the white goods I have at present are about at the end of their life. Even when I’m ill I feel that hygiene is important and I always try to attain high standards and especially so having a reliable fridge freezer, as I realise the importance of not keeping food at the correct temperatures.”*

(Margaret)

*“I feel happier in the flat and I think we are both really proud of it now. I think before it was done up it was a place to live, but now it’s our home.”*

(Rachel)

### Support

Support was a significant aspect in many of the narratives, whether this was formal support in terms of developing and implementing support plans, or informal support from family, friends and community. Support is seen to be a key enabler in positive outcomes from the SDS process.

Help in developing the support plan was identified by several service users:

*“(The external broker) got to know me, learnt about my background, which I think is important, as well as getting to know your likes and dislikes....I think you need to get the holistic picture of a person and think outside the box to find out what people would like and what would be best to suit their needs”*

(Martin)

*“I met (the external broker) who helped me complete my support plan. I felt that (the external broker) really listened.”*

(Rachel)

*“My support worker helped me to decide what I was going to spend the funding on. We went to different garden centres and priced things up and she supported me to order them. I was supported to decide what to spend the money on but I made all the decisions. I think it was good that I received this support because I was worried about making the right choices with the money I was given. “*

(Stephen)

And also support in implementing the plans:

*“I also now have a tutor who is helping me with my literacy. I enjoy doing this and my tutor says that I’m doing well.”*

(Scott)

*“I did a creative writing course at the local college and wrote a narrative about someone with schizophrenia which the tutor said was fantastic. I didn’t have much confidence in my abilities but am now beginning to realise that I am good.”*

(Margaret)

Further, there were numerous references to informal support from family, friends and community:

*“Through my payment I received funding to join a tennis club. I now play 5 – 7 times a week and find that it keeps me stable as I have built up a routine with it. I get to meet new people and I’m feeling part of my community.”*

(Martin)

*“I was also given funding for a laptop. I really enjoy using the laptop and am now involved in different forums. I chat to people with similar experiences to me and share knowledge and I find it very supportive. I find it helps to speak to people in a similar position to me using a medium which fits my lifestyle and needs better than traditional services.”*

(Martin)

*“I have also applied for a computer as mine doesn’t work anymore. I used to be able to speak to my friends in Australia using my computer. I have one particular friend who is very supportive and I miss being able to contact her so readily now that I don’t have my computer”*

(Margaret)

*“Going to the stables has helped me to form relationships with new people. I’ve got issues around people and I find it very hard to get to know others and trust them. The riding lessons have really helped with this as I usually see the same people each week when I go riding and I’m beginning to get to know them in an informal unpressurised way. “*

(Joanne)

*“I got a mountain bike. I enjoy having a bike and use it to go out with friends to places like Reddish Vale. I think it’s a good social thing and I think it’s fun and I like being out in the fresh air.”*

(Simon)

*“I’ve had drug problems in the past and due to this and other issues I lost contact with my family. I used to go fishing with my dad and I used to enjoy it. I decided I needed to do something about my life so I got in touch with my dad.”*

(Mark)

### Contribution

Many of the narratives made reference to the fact that the SDS pilot had enabled the service user to more fully contribute to society, and to invest some of their skills and expertise in their families and communities.

*“I think my favourite change is her bedroom; it was lovely to do something nice for her...I feel a lot more confident and it’s really good that my daughter can now have friends to stay.”*

(Rachel)

*“I struggle to get out due to my mental health issues and it causes a lot of anxieties but I wanted to be able to do more for my children.....Being independent is very important to me and being able to get out more and do things for my children and myself has definitely helped.”*

(Nicola)

*“I didn’t feel valued before but now I feel I’m part of something and feel confident enough now to look at putting something back into the community. I have a lot of ideas and I am looking at becoming a personal coach to help others.”*

(Martin)

*“I now feel more confident and motivated to do other things and I have started to go to the local community allotment society and am getting to know people who live in my area outside of mental health services.”*

(Stephen)

### Serendipitous outcomes

One further area meriting exploration is that of serendipitous outcomes, and unexpected consequences from receiving Personal Budgets. Almost every case documented revealed that by having a Personal Budget there have been knock on effects in other areas of the service user’s life. Thus it can be seen that building capacity in all areas of the model, citizenship can be increased both by design and often coincidentally. This is being realised through SDS and many service users can be seen to be taking a more active role in their communities.

*“I now also attend college and am doing accountancy. It may not seem that learning about gardening is linked to going to college but it is.”*

(Stephen)

*“The next stage is that we are hopefully going to go on holiday with my family soon, something that I feel I couldn’t do before.”*

(Martin)

*“My daughter loves her bedroom and we have managed to get into a routine with her chores and homework..... I feel a lot more confident and it’s really good that my daughter can now have friends to stay.”*

(Rachel)

*“Because I’ve lost weight and going out more due to my bike, I’m beginning to feel more confident and less anxious about things.”*

(Simon)

*“For example I’m planning to go to London in June to look at the art galleries which I don’t think I could have done before. I think I will still feel anxious but having the ability to go by car has decreased the anxieties somewhat and I don’t think that I would have done that before. I used to wonder what people thought of me; being unemployed with a diagnosis of schizophrenia but now I can tell them that I am an artist.”*

(Richard)

*“The (horse riding) club gets busy on Friday evenings which is one of the times that I go but I’m getting used to it now and I think it has helped me cope with other busy places as well.”*

(Joanne)

*“Also, I didn’t know how my children were getting on at school and wasn’t able to when someone else was picking them up. I am now able to do this and I now have the chance to speak to my child’s teacher after school when I’m picking her up.”*

(Nicola)

*“This SDS payment seems to have been a catalyst in my life. I began to go fishing with my dad. Dad then introduced me to his friend’s daughter and we have started going out together. I usually don’t do anything at Christmas but last Christmas I decided to go for a Christmas meal at the local pub. I got chatting to the landlord and landlady who asked me to go to their house for Christmas Day and Boxing Day with their family. I had a lovely time and have found good friends in them. .... I’m*

*sure most people (including myself) couldn't see a connection with receiving £350 and completely turning my life around but it has."*

(Mark)

The findings from the narratives serve to highlight how SDS and Personal Budgets have often been instrumental in bringing about change in people's life and have led to further recovery or integration into society, which can act as a spring board to improve many other wider aspects of their life. By providing the necessary framework to increase citizenship, service users are able to move along the road to recovery [54, 55]. Giving personal control and opportunities to service users, and by showing interest and belief in their skills, abilities and needs has helped to build self esteem, self image and provide hope for the future.

## **5.2 Feedback from Care Coordinators**

The findings from the care coordinators feedback are presented below. They are a combination of the feedback taken from:

- The evaluation feedback sheets, distributed at the re-launch day in September 2009
- The Stockport Council feedback forms distributed at the re-launch day in September 2009.
- The care practitioner discussion group held in September 2010

Feedback from the re-launch day in September 2009 highlighted a number of issues and discussion points which had arisen during the first few months of the pilot. At this stage many of the care coordinators and practitioners had yet to complete an SDS application, or were just starting out with the process. However, a number of the themes which arose at the re-launch day were still considered to be pertinent when the discussion group took place at the end of the pilot in September 2010, indicating that they were still salient to practitioners. There were some additional areas highlighted in the discussion group, which had become important over the course of the pilot, and these are also discussed in this section.



## Outcomes

There was a general consensus that SDS was a very positive development in mental health services and that the large majority of people who had been through the process had benefitted considerably from being on the pilot.

*“I would suggest that 95% of things have been brilliant. It’s been a fantastic scheme, for the first time ever Social Workers and Nurses have had access to funds to do an individual care package. So lots of people have had computers which has given them social access. It’s given them confidence. It’s given them communication. It’s helped them with their skills. It’s been fantastic.... We’ve actually got this bit of money...bang, bang, bang, bang, bang... And for years we’ve had to apply for £20 here and £30 here to try and pull things together and it’s great to have £300 a week to really affect somebody’s life and those ones are by far the majority...”*

Support plans were being developed in creative ways, with a wide range of items and activities included to help recovery. There were numerous positive outcomes, and the increase in social inclusion many had achieved through SDS proved to be a spring board to kick-start their life again, and move along the road to recovery.

There were some great stories of how support plans had affected people’s lives:

*“One case I’ve been involved with...it’s been a really positive thing that the person’s been out of hospital for a year and they haven’t had to have a re-admission so that’s been excellent, but their level of need is huge and they have a huge package of care but they’ve been able to stay within their family unit and not be admitted so that’s been a positive thing.”*

*“One girl has got a really complex high needs. She’s only overdosed once and ended up at the hospital...She’s written a book and it’s been published and that’s been a great thing for her because she feels that she’s helping other people. Her relationship with her son’s improved because they’ve been able to do activities*

*together. I mean, she's still got massive needs and all sorts of support but she's sort of...and doing a de-sensitising programme as well and taking her out but because she's had this other thing added on she comes out now and can actually ask for something across a counter which she wouldn't have done a year ago, eighteen months ago."*

*"Another client's now got a dual diagnosis but that's there because as well as a mental illness she doesn't communicate with anyone, but because she's had a camera and things, she can express herself in other ways by photography and doing other things and that's improved her life."*

*"Socialisation and more independence and they're free to choose what they want to do and you know...there's especially one girl that I'm working with. She has a very big issue about her weight and lost her confidence and so she's attending the gym and she's got a personal trainer. She's having her weight monitored which is all helping with her physical health as well, yeah. And her self-esteem's growing, she's socialising now with social circle groups and just lots of positives..."*

*"I had a young chap who had fishing tackle and it's built his relationship up with his Dad, that's inevitably led to his brothers and sisters back (in his life) again and he's met a partner through one of his brothers and he's now moving out of creative support housing to independent living and it's just all started from £350 fishing tackle and it's unbelievable the way it's escalated, yeah, yeah. And he's aware and he knows that all this has kick started his life back. He says he feels like he's got his life back together."*

*"The term recovery is very individual and I think if you spoke to a lot of these individuals, they don't say "we have recovered" but what they would say is, "it has helped us on our journey to recovery"."*

*"They've had new experiences that they probably wouldn't have had before this SDS ever come along."*

*“I’ve noticed with another client of mine as well, he used to have creative support...and he was always cancelling his support, just not bothered. When I did the SDS with him I said, you’ve got to give notice to cancel, otherwise you’ll be charged and when we review you next year I’d have to look at how many times you’d cancelled because you don’t need the service. He’s engaging far more now than he ever did before because he’s taken responsibility, because it’s the support he needs and he in effect is paying for it, so he’s just not cancelling.”*

*“It’s the social inclusion. People are actually connected much more than they were before...the thing is, the things that cost the least seem to have the most effect.”*

*“Yeah, it’s true.”*

*“I like the fishing rod one. £350 which is a pound a day for a year if you like and the impact that had and you know. “*

*“One person I’ve just done one for’s really ill. He has lots of symptoms. He does nothing. He meets nobody except his family, but by going through this process he’s going to make a difference to his quality of life. It’s not a lot of money that he’s asking for and he doesn’t want support workers. He can’t go to day centres and things because of the way it makes him feel ‘cause he thinks people read his thoughts all the time and he feels uncomfortable.”*

*“Every single one of these packages has made people happier, OK. Every single one of them has made people’s quality of life better.”*

*“In (the early intervention team)...they’ve used it to fund say training or getting computers that have got specialist graphics and stuff and it’s helped them then to be able to get the skills that they can then move on to go into employment.... And I suppose from early interventions point of view we’ve looked at it that it potentially in the short term has been quite expensive because of the things that we’re able to support...plan with people they would never have got because there was no main stream way of accessing those things for people...weren’t entitled to it, but the fact*

*that we have been able to do those things with people now, a longer term benefit is that we hope now that they won't need a service in future."*

*"You're able to work more imaginatively"*

Nevertheless, there was a degree of disquiet that some of the requests being put into support plans were perceived as luxuries rather than solutions to fulfil need:

*"I think people were led to believe it was basically Woolworths...I think there's no clear definition between want and need...I'm still unclear about want and need because you can say my mental well being will be improved if I have...and you can put anything in that box. The number of people who want restaurant meals as part of their mental well being...horse riding lessons...it's er...someone gets something..."ooh ahh" you know. And that's not need that's, you know, "ooh I quite fancy that".*

*"What they said though (in the presentation to service users) was...if this thing makes you feel better that's meeting a need. Well a holiday in Tunisia would make us all feel better, you know."*

In response however, one practitioner explained:

*"In defence, a couple of my clients have had holidays... it's an ongoing process of changing their life, having holidays. Socialising with people...having new people around them 'cause they're frightened. One that I've just done, this gentleman's not been away for 16 years. He has no social contact. He's lonely, he can't mix with main stream services because of his voices and his thoughts, and he only feels safe with his family so having a one week holiday with them is fantastic really. It's like winning the lottery for him."*

This shows that many of the practitioners have taken on board the ethos of SDS and are focussing on the outcomes of the support plan rather than the means by which

those outcomes are achieved. This is an ethos which needs to be embraced to move the SDS agenda forward.

Despite the general agreement that SDS was a very positive move within social care, there were issues and concerns expressed by the practitioners. This is to be expected as SDS is a new concept within the area of mental health, and this was a pilot scheme which was evolving and developing as the scheme progressed. Below are the main findings from the discussion group, which merit further discussion.

### Organisational Issues: systems, processes and resources

#### *Introduction of SDS and practitioner training*

Most of the care practitioners were introduced to SDS either through a training day on personalisation, or via word of mouth from their colleagues. In general the introduction of SDS was viewed as a positive progression in the service although there were a number of concerns, and a significant amount of uncertainty about the pilot.

*“I did the five day training with Happy Associates, so before I went really I knew absolutely nothing about it but as I did the training I realised obviously it’s fantastic, or it can be fantastic for people but I think it’s people’s expectations of what they can have is quite different than what we may think will help them”*

*“My first concern was that it was running alongside CPA as a pilot and as practitioners the amount of work and paperwork in those two systems running alongside each other was going to be problematic.”*

*“Yeah, certainly all the practitioners in my team were saying yes it sounds like a very good idea and obviously it’s going to be very beneficial for the service users, some service users but again the amount of paperwork on top of the existing paperwork was going to make them feel more stressed really.”*

*“I just thought it was another new fashionable thing that’s coming in and then it’ll all be finished by...when something else replaces it, to be honest.”*

*“I think some of the concepts are really good but there was a concern about it being sort of maybe not equitable and how the money would actually be used.”*

As with any new introduction there are inevitably concerns and some apprehension because the scheme is new and unknown, and in general the idea of SDS was well received. However the fact that initial concerns were still being echoed a year later indicates that they are of importance to care practitioners, and in some cases have still not been addressed satisfactorily.

The amount of training the care coordinators received varied considerably, with some receiving tailored training within their team, and others picking up the process on the job as they went along:

*“I think initially Early Intervention were approached as being a pilot site so training has sort of focussed around the Early Intervention team, and also there were champions encouraged to come from each of the sector teams and other teams. So some people in service got quite a bit of training and other people got none thinking about it. Made it up as they’ve gone along.”*

*“I think it’s been quite inequitable with the rest of the local authority as well ‘cause I think the local authorities learnt from what happened here ‘cause this is where it started and all the teams throughout Learning Disability and Physical Disabilities get half a day on process and a full day on support planning before they even start working on any of this.”*

There was a general consensus that the training provided at the beginning of the pilot was not sufficient. However during the course of the discussion group it became evident that the issue was not with the amount of training offered, but with the focus of the training.

*“I have delivered quite a lot of training and I know all the way through pilot I’ve said do you want us to provide more training and the feedback I’ve got is “We are sick*

*of training” we’ve had you’ve coming round the sectors, we’ve had you delivering training... we’ve had an Away Day at Holdsworth Mill, please don’t deliver any other training! So I think that’s a very mixed message to what I’m hearing today.”*

One of the independent brokerage team also highlighted this issue:

*“I think that through the early days, because we were introduced on the early intervention team there were two clear issues at the time: its what was the information that staff had about the whole scheme and their intended role within that, that was really unclear and I think the second bit was then how do you do the process, how does it work and I don’t think those two at the time were given the kind of focus needed.”*

It was the area of process and systems where practitioners felt they did not have enough training or support. This was exacerbated by the fact that it was a pilot project, and both process and paperwork changed throughout the course of the pilot on more than one occasion:

*“The training with Step by Step, the Away Day which was kind of like erm...well it was an overview of things really. I suppose the bit that we didn’t do was actually trying to put it into practice. I think I’ve got most of that from (the external broker) who came to see me a couple of times.”*

*“Exactly the same. I don’t feel that it was adequate though. I felt that it would have been more beneficial if we could have actually had a more hands-on, you know, have gone through the process, you know. I would have felt a lot more confident. “*

*“Yeah, I mean, I think we had, in fairness, our team had a lot more training than a lot of other people but I think the initial training we got before the project started was very much about person-centred approaches which the team itself didn’t find that useful ‘cause we were already doing a lot of that stuff anyway and it didn’t really link that well to SDS so we actually approached (the external brokers) and*

*requested to do some specific SDS sort of personalisation training which they put in for our team as part of an Away Day that we already had planned. So we have had sort of extra training, I think, to a lot of other teams, but even with that in mind I think it's better said that, you know, my colleagues have all still found it quite difficult and I think part of that is because the process is very much changed and developed. “*

*“I did the two training .....the initial....but it was very much about person centred planning which...I did that as part of my training to be a social worker really and like you said, we were working in that way anyway with limited availability to resources, that was the difficulty. What I thought...it was about the systems. It was about how things worked in practice and the systems of getting the paperwork through and then getting the payments for the people and that, you know. It was all those things that I really wanted training in and somebody to sit down and go, these are the steps that you have to take.”*

### *Communication*

There was acknowledgment that since this was a pilot scheme things would change and develop over time, but there were issues around communication of the changes to the practitioners themselves. There were concerns about increased time and paperwork on cases because people had been ill informed about changes to the process or documents and had therefore completed the wrong forms, which then had to be completed again. In other cases there was confusion as to sequence of steps in the process, and sometimes applications were left or 'hidden' because the practitioner didn't know what to do with them, or how to get the necessary support to move forward. Consequentially, this led to service users being left in the dark as to how their application was progressing, and caused frustration all round.

*“I think sometimes it was about the system and knowing the system. I do think that that did get missed a lot of the time off the training. Was actually knowing how, you know, physically...once you've started this what is the process. Where do the forms go to? Who signs what, where? Who can sign what and where? And I think the other thing was because it was a pilot and things frequently changed. I*



*mean the RAS Form changed on numerous occasions. Who signed off your direct payments form? Whether you had Shaw Trust involvement. A lot of those things changed throughout the project and I think there was a lot of difficulty with that information then getting on passed on.”*

*“Very confused because sometimes you were just getting to grips with this and thought you knew what you were dealing with it, and then you found that actually you should have sent this paperwork to that person.”*

*“And that you’ve missed something out completely that you should have done weeks ago and I think for lots of practitioners it became very time consuming and I think also for clients it seemed to go on for weeks and weeks and weeks without getting any kind of confirmation of when this was going to be up and running because of people’s confusion and I think we were...and I think they were quite poor at times at passing, you know, updates...”*

*“I think I felt it was a pilot so there was a lot of uncertainty over whether it would continue and it’s just kind of continued without any training or any update from anybody.”*

As the pilot has progressed this issue eased somewhat, as practitioners became more familiar with the process and paperwork.

*“Cause it was evolving wasn’t it? It was a new project. It was changing all the time so it was quite difficult at first. It feels easier now.”*

Nevertheless, as new changes are introduced going forward with the SDS service it is an issue which needs to be addressed to ensure smooth transitions wherever possible.

There was also some discussion about communication with the service users themselves. Some practitioners felt that SDS had been introduced to service users ‘as an opportunity to use social care money to buy whatever they wanted’. There

was a concern that not enough clarity about the ethos and rationale behind SDS had been given, and that it had just been seen as a 'free for all'. This was felt to undermine the practitioners, as some service users were not engaging in the process of defining outcomes that would enable their recovery, but were coming with a wish list of things they wanted. It was also felt by a minority that there were a number of service users actively encouraging others to make outrageous requests. Although this was tempered by the majority in the group who felt most people were moderate in their requests, and did embrace the process.

Whilst it is important to ensure that service users are properly informed and good communication is put in place, this finding may also be an indication of the fact that practitioners were feeling overwhelmed, under supported and underprepared to fulfil their role in the process. It is vital therefore to ensure that practitioners feel they have the tools and support from their employing organisation to be able to explain the SDS process to service users and implement it successfully.

#### *Resource availability and workload*

Resource availability was a big concern to practitioners. There was disquiet that too much was being expected of too few practitioners, also that some practitioners had been thrown in at the deep end and expected to swim.

*“From my experience within my team, I think practitioners are very motivated again but they’re just weighed down with all the other demands that are placed on them and I think the expectations again are far too high with the resources that we’ve got and the capacity within the team. I don’t think that’s taken into account.”*

Another area of tension mentioned by practitioners, which exacerbates that of resource availability, was duplication. The SDS pilot has been introduced alongside the existing CPA (Care Programme Approach). There were concerns raised that this was merely adding to the workload and paperwork practitioners were expected to complete, and actually restricted their availability to implement the SDS approach. Adding another layer to the systems already present within social care increases complexity and bureaucracy, in direct contrast to the aims of SDS.

*“Well, if it’s going through. If it’s no longer a pilot then the CPA has to be streamlined with the support plan process. You can’t still have the expectation of having a traditional care plan, you know, and a support plan and a CPA Assessment. Under the self-assessment questionnaire, they have to all be linked in together so you’ve got one combined process.”*

There have been a number of discussions regarding the parallel running of CPA and SDS [56, 57], and some authorities are trying to address this by looking at combining or simplifying documentation for both [46]. This is also starting to be addressed within Stockport, exploring the use of ‘wellbeing care plans’ to help bring the two systems together.

### *Changing roles*

It was agreed that SDS would impact on the roles and responsibilities of practitioners, and there was a range of responses to this aspect of the pilot. Some viewed the change as a threat, and they sought to minimise the impact this new way of working would have on their role. A minority of practitioners disengaged with the process and handed over the responsibility to one of the brokers, with minimal input when necessary. This will be discussed later in the report, however this action does nothing challenge practitioners’ points of view or motivate them to take on the new ways of working. For others this new working style brought with it opportunities to work creatively, and actually reengage their ‘traditional’ social work skills of person centred planning. Whereas the CPA has focussed more on managerial skills, SDS allows for grass roots social work skills to be employed.

Nevertheless, for some of the practitioners this focus on the culture shift needed within the service was considered to have been delivered in a patronising way. They felt aggrieved at the suggestion that they did not already work in this way.

*“I think that I went along to the recovery network day and I was told they’d found this brand new thing called treating people as individuals and sort of working with them with respect and courtesy and some of us felt we’d been working that way for*

*quite a long time already.....I think the other thing of concern was it was a local authority project and that we were directed to do it – there was not a great deal of discussion. We are now doing this.”*

*“It did feel like that because we do treat all our clients as individuals and you do try and find sources but before there was only the main stream services out there so we could only...it was tick...a lot of them were tick box services that we’ve had before this so you could only direct them in that way. There wasn’t the money there or the ethos to do different things so you are ultimately tied.”*

Again this is as much about communication as it is about willingness to change. It should be viewed as a positive that practitioners already feel they have the necessary skills to implement SDS, but it is important to communicate this change in culture in a way which will energise the work force rather than devalue, and demoralise them.

There will of course be changes in the role of the practitioner in SDS, but if implemented properly these changes can be reinvigorating and enable creativity to flourish[58-60]. They should allow for more community focused, empowering and facilitative social work to be practiced [61], although this is not the experience of many practitioners to date.

*“At the Away Day, the large day for SDS, Terry Dafter did a speech and he did a pilot about the social workers in the local authority. They’re now spending 18% of their time in face to face contact with people and the rest of the time is being spent on paperwork. And that really...that unbalances there and it needs to be shifted because...it’s scandalous, you know.”*

In order to bring about the necessary changes practitioners need time and space to think and discuss the implementation of SDS, and they need support to make the changes. This was also highlighted by the fact that a number of practitioner forums and meetings had been set up to allow people to come and discuss any issues or experiences they wanted to share with other practitioners. However, as some of the practitioners explained:

*“They had the monthly forum that A was talking about, that everybody could come to at any time and there was a weekly forum that people could come to for help and advice, and I think that it’s down to the time pressures. When you’ve got...*

*I was going to say that. There’s lots of Forums that happen.....*

*It’s not that they’re not there.*

You haven’t got time to go to them all.

*But you know, if you can’t get time to get there...’cause we set up that monthly forum and it was same people coming every time and they’ve really developed. There’s a weekly meeting that everybody can go to.”*

This exemplifies the fact that there are many competing demands on the practitioners’ time. SDS needs to be given a greater focus, and people given the message that this is important, and that going to the forums is a legitimate use of their time.

Another area which proved fruitful in the discussion group was that of the changes which would need to take place within the service user community, as SDS was implemented. There was agreement that many service users believed once they were in mental health services they were there for life, and it was felt that this assumption needed to be challenged.

*“I think the culture within services is having to change because historically people have come into mental health services and they have stayed in mental health services until they die and that’s...and the culture is changing that people come into service, we look at what they need, we meet the need and then they move on and that’s been a big culture shift for people. It’s been a big culture shift for service users but it’s also been a big culture shift for staff within the service. ”*

*“Yeah, and that’s the culture shift isn’t it that you are no longer going to be in the mental health services for life. You are moving forward and the aim is to move you out of service and that is really frightening. It’s really frightening for practitioners and it’s frightening for service users.”*

There was a second area related to this which was uncovered, which was that practitioners felt in the main they were not seeing a reduction in traditional services for people using SDS. This was surprising, however it became clear that some people were seeing SDS and Personal Budgets as an add-on to their traditional services.

*“They’ve had add-ons which there’s no doubt about it, it’s improved their lives, but it hasn’t reduced the traditional services that happen.”*

Nevertheless, this is only part of the story because practitioners acknowledged that they were able to use SDS creatively and ask for things that could not have been provided by traditional services:

*“Because what we’re identifying is things that the traditional services don’t do. So therefore it’s an add-on to what they’re getting already.”*

As the scheme progresses it would be hoped to see a reduction in traditional services as people are using the SDS to fulfil their needs, and move along the path to recovery. However it is an area practitioners may need to look at more closely when they implement support plans, to ask whether the service user actually needs traditional service in addition to the SDS, or at least if SDS can be used as a means to reduce the need for traditional services in the future. Again this may be part of a culture shift for practitioners and service users, and indeed some are already taking this on board:

*“There are some people who’ve come off. (Sarah’s) come off. She doesn’t get a traditional support package anymore.”*

*“And we produced a package for somebody else who had a lot of support time but it’s been...the traditional service has been replaced by...he still gets the same service but it’s not provided by us.”*

*“...a couple of mine don’t get traditional services.”*

### Putting SDS into practice

Practitioners have worked hard to implement SDS and ensure positive outcomes for their service users. However, there was still a feeling amongst some practitioners that a minority of service users were not ‘on board’ with the ethos of the scheme, and expectations of what they would be able to receive were not realistic. There was a great deal of discussion as to how to temper service user’s expectations, and there was concern that service users were talking to each other, discussing what Personal Budgets could be used for and how to get themselves the best ‘deals’ :

*“The amount of phone calls we’ve had as a team off people who’ve said “Oh I know Joe Bloggs who’s had a car or a holiday so I want a car and I want a holiday” and that’s been the difficulty. It’s the constant battle we’re...that balancing...what people assess their own needs to be and what they need to be able to live their lives.”*

*“Like in my team, all of a sudden, out of the blue, quite a big group of people suddenly discovered their mental health needs required horse riding lessons, spontaneously. I mean, I know, ‘cause somebody said “Oh I’ve got horse riding lessons” “Oh I quite fancy that” and so I think people have been...I think there’s no clear definition between want and need. There isn’t and then that means that the social workers and the nurses are put in a terrible position of being the bad guy”*

This however must be put in the context of the pilot as a whole, where the majority of people have made very moderate requests, and where the small number of controversial ‘luxury’ items requested have gained an almost mythical status. Further, as one of the other practitioners pointed out, working with service users to identify

what can and cannot be achieved through services has always been a part of their role:

*“I have a bit of an issue about the need and want thing ‘cause I think that’s what we’re doing anyway. Our role is to assess need and I think we’ve always defined...we’ve always been in the position of having to say to people well, actually, we don’t feel we would meet that need and so I feel as qualified practitioners that we do that anyway.”*

In addition within the ethos of SDS the distinction between need and want is more blurred than within the current system. If a need has been identified in a service user’s plan, then the way in which this need is met should come from the user themselves. So for example if a need to meet more people has been identified, and going horse riding will mean that the person meets people at the stables, then this is a legitimate means of fulfilling the need. In SDS it is the outcome which should be the focus of the plan, not the means by which it is achieved, and thus why it is important to understand the reasoning behind requests and support plans, rather than looking solely at the ‘want’ list. This also highlights the need to document reasoning when developing support plans, so that if someone else were to look at the plan, rather than seeing it as an extensive ‘want’ list they are able to see the rationale behind the requests, and understand why they have been included. Recording this information is also important for practitioners, as there will be times when service users and practitioners may not agree on a level of need, and clarity in reasoning can help to reduce conflict:

In some cases there was uncertainty and fear about what service users could apply for. As this was a new process for all involved there was a need for clear communication to service users as to how the SDS process worked, in that it wasn’t just a wish list of items to be purchased, but instead a comprehensive support plan looking at all aspects of need and how to fulfil these to produce positive outcomes.

*“If you think about you know, at the beginning, what we were talking about, people’s expectations and...and I don’t think that is always properly addressed*



*when the application's first made. And it's about obviously the ideas. It's about...to try and aid your recovery and it's not something that will be available indefinitely. Obviously people's needs change. "*

Further practitioners needed to feel confident in their ability to help service users plan for good outcomes, and also to know that the organisational support required to make tough decisions was available.

*"Some experiences it's been a bit...for some people it's been like 'points make prizes', you know. And filling in that form I've had sort of carers sat there sort of clearly wanting things marked up higher and then you end up with a disagreement about order of need and then it makes it feels like you are withholding something from them and that they're entitled to it. It becomes a bit like filling in like a DLA questionnaire where you're preventing them from having the monies to actually have these things and a lot of these people don't actually have an awful lot. So it puts you in a really difficult position."*

*"That's the culture shift, you know, and I think that's where the organisation has to support us as practitioners in saying to people no you don't...because inevitably complaints will come in, you know. Service users will complain that we are not giving them what they perceive they need so that's where the organisation has to support us and say well, as practitioners you've done the assessment, you know, there's a disagreement there. If you can justify why you're saying this person hasn't got that need then the organisation needs to support us to be able to say that."*

*"And it is hard getting that, you know, being able to say to people I disagree. I don't feel you have that need...You know, I'm not agreeing with you. You know, you say that you need five hours of support a day. You don't, you know. And it is a big...you have to have a very good relationship with people to be able to challenge them in that way."*

As the process becomes more familiar and established, some of these decisions and difficulties should ease on both sides. Although, a number of the comments serve to

emphasise how important is to move away from the professional gift model proposed by Duffy [51] to the more challenging co-production model, fundamental to the success of SDS [62]. There needs to be a shift from the professional deciding what is best for the service user to a new relationship of co-production, where the service user and practitioner work together to establish needs and develop support plans to effect successful outcomes. Nevertheless, there are practitioners starting to work in this way, and it is a progressive change as confidence builds and people see others successfully working with service users.

*“It’s working with a client and saying this is what you could have but let’s see if you really need it and that’s how I approach it.”*

This leads on to some of the possible changes in practitioner role afforded by SDS. There is still much discussion as to the role of practitioners in the future of SDS [61, 63, 64], but one of the key challenges will be the move towards enabling service users to be an active part of their own support plan where the capacity exists. The majority of service users have the capacity to take on the larger role in developing and implementing their own support plan. There is a natural desire by practitioners to want to improve the lives of their service users, and sometimes to step in to help before help is really needed. In some cases this can be counterproductive, taking away service user’s skills and capacity and leading to further dependency on services. Service users need to be challenged to take an active role in their recovery, and to be responsible for their own well being wherever possible, and practitioners need to step back and allow service users to take more control. Although this can be very difficult on both sides, and is not an option for some service users, it can ultimately lead to greater empowerment. There are practitioners within the service who are bringing this thinking into their work:

*“My service users have done their own support plan. Without the broker or without my influence completely but that’s taken time again, working with them and working out their needs because self-directed support, that’s what I’ve...I’ve gone and...you know, I’ve used the label self-directed support...it’s yours...Encouraged them and spoke to them and worked with them.”*

*“...what my experience is, that sometimes people need a bit of guidance because often they think of it as items that they are requiring rather than looking at it in a sort of way of what’s useful, what’s going to enable them, what courses will enhance things, rather than a television, you know, you know what I mean? It’s sometimes trying to guide people isn’t it?”*

*“...and we’ve had probably about three or four where the client’s actually done them and we, I suppose looked and made sure that it’s covered the things that it needed to in order for us to be able to sign off. But predominantly they’ve done them themselves.”*

However for a lot of other practitioners this is not the case:

*“...because when this came into force I was as new as anybody else...is that I didn’t anticipate, not the support planning and not writing the support plan, but I think I didn’t look at walking people through the process and the amount of time that...forget support plan, forget the SAQ but finding the service, gauging the service, walking the service user along, the service then breaks down from the other end, you’re policing it and that on top of, like you say, everything else, you’ve then got a service user ringing up who’s saying “I got that support worker and they’ve not been turning up” and then you’ve got to respond that. So I think I was personally very naïve in thinking that the bulk of the time would be in the support planning and doing the RAS? And not realising that there’s a whole raft of other work that then follows it, that it is a pilot.”*

*“I mean I spent an afternoon on and off the phone to agencies talking about costings, about how much...what can you give me for this much and if I give, you know, if we do this with you and we do this other bit with somebody else, how will that work and I’m not an accountant. I’m a social worker and I spent a whole afternoon on...trying...a broker...and trying to barter with agencies to get the best deal and I can barely manage my own finances (laughing). We’re being asked to manage...to try and help all these people organising these vast amounts of money.”*

It is not feasible to expect practitioners to work in this way and to be able to introduce SDS a large number of service users:

*“To be able to spend the time needed, to do these really, you know, positive pieces of work and seeing people moving forward out of service...but then I would need a caseload of about five as a full time practitioner to be...you know, to give the amount of time needed. That just isn’t possible.”*

This is where further support is needed, both in terms of process and practice to deliver SDS. Moving forward SDS should look to strengthen community ties and build up capacity amongst other relevant groups to enable practitioners to do less of the leg work involved in bringing a support plan to fruition. This would also have an impact on practitioners freeing up their time and enabling them to focus on cases which needed more input and support.

As part of the pilot it had been expected that a database of service providers would be set up, which would enable practitioners to recommend service providers to clients if requested, but by the end of the pilot this had not yet happened. It was felt that this would be very useful for practitioners in reducing the amount of time spent trawling round for services:

*“I think the things like finding services, I think are very time consuming and... when we were first approached as doing a pilot...part of it would be that, you know, over this pilot year we’re going to build up this database and you’ll be able to just dip into that and know where to go...there is no database, you know, that’s never happened. I suppose as a team you’ve started...if you get sort of similar things, people are sort of saying “oh well, I went there” or you know “this person went to that”.”*

*“There is a database, it just isn’t put together. Like, you know, so it’s like I think so and so set their own??...it’s that sort of...so it’s all there somewhere but no-one’s put it together so you’re starting from scratch each time I think.*

As a result of the time pressures and lack of information practitioners are having to make short cuts to find services:

*“As an individual practitioner you think well I’ve used that agency before so I’ve got a bit of a relationship so I’ll go with them.”*

*“So you use it again.”*

*“And it might...in all honesty, it might not be the best thing but it’s because...”*

*“Quickest...”*

*“You know you’ve got those links into that agency or that service or...”*

There was however, some recognition that this was not a satisfactory way of working:

*And it’s almost...you go to people and I think if this chose...’cause I go to people, they say “I want a PA” and I say “Well, we’ve used these” but it’s not them (service users) doing the research themselves or having as much input into it as you would want somebody to have and having real choice because I know, at one stage, people were ringing me up saying “The independent providers we’ve got? They’re full. Where do we go?”*

Another aspect to this has been the realisation by practitioners that the way in which they have implemented SDS can lead to the creation of a dependency. There were concerns that some people were requesting items or services which they themselves could have sourced, and by taking on these requests practitioners were de-skilling and disempowering service users:

*“And it is creating that dependency. Like, one of the issues that I have with it is, one of the symptoms of schizophrenia, they have...people have negative symptoms and they’re unmotivated for example to clean their house. So what we’ve tried to do is maybe put supportive...to work with them to help them...to try and*

*motivate...suddenly we're putting cleaners in for everybody to go in and clean their houses."*

Teams were starting recognize that service users could and should take some of the burden and responsibility of sourcing contacts etc. themselves where possible, so as not to be entirely dependent on practitioners or brokers to do the work for them. Some teams were also looking at reducing long term dependency on the service and starting to talk to service users at the support planning stage as to how they would build on and continue the progress they made on SDS, once they were no longer receiving authority funding. This helped to quash any false expectations by service users that they might stay on SDS for the rest of their life, even if they did not need the support.

*"I think that one of the things that we as a team have started to look at much more, which I think we didn't do so much of when we first started, we looked at how people were going to kind of manage their package and things like that. But I think what we, as we've got used to doing them, we've started to kind of ask the question at the beginning of, you know, "If this goes then and hopefully you've met your outcomes, then how are you going to kind of keep some of this going if this is gone?" because I think that's something people need to consider because budget...because effectively if something meets somebody's outcome and that needs resolved then it isn't going to be there next year. So if we're putting things in, like for example, the horse riding to sort of get somebody out and sort of social activity and things like that then we need to be considering that, you know, OK that's fine but if that meets that outcome how would you then continue to fulfil that for yourself and I think as a team we've started to kind of look at that a bit earlier because didn't we first started doing these, the emphasis wasn't so much on that bit of it."*

Other teams now need to build this kind of thinking into their support plans to empower service users to use SDS as springboard to continue their recovery journey as far as they are able.

## Risk

Risk assessment was considered to be an important part of the practitioner's role [9], and there were concerns that SDS did not take risk seriously enough. This was more of an issue at the beginning of the pilot, when care practitioners were concerned that service users could present a risk if allowed to define their own support needs, and manage a Personal Budget. At the re-launch day in 2009 there was a discussion regarding the fact that risk aversion had been a big part of the care practitioners' role, and that both the coroner and public attitudes to risk may not align with what was perceived to be the riskier strategy being taken in the SDS pilot. The prevalent risk adverse culture traditionally found in both mental health services and the local foundation trust has impacted heavily on this point of view.

There was also some concern that if service users had less contact with formal services then it would be more difficult to identify risks as they emerged. Care practitioners were worried that they would only be called in once a crisis point had been reached, whereas if they had been in more regular contact with the service user they could have avoided a crisis situation before it arose. However, it was recognised that care practitioners still had a duty of care to their service users, and therefore could not be 'written out of the loop completely':

*"We have a statutory duty to raise the issue of risk and yet when you do it's not...it's sort of...you're sort of being the awkward person, you know."*

The local authority worked hard to challenge this perception of risk being too high in SDS by taking legal advice, and also by enlisting the support of experts in personalisation and senior management to push the SDS agenda forward. Practitioners were given the message that as long as requests helped to ensure service users were healthy, safe and legal then they were acceptable. Also that a crisis plan should be developed with the service user when support planning, as safeguarding measure. Practitioners were further reassured by the creation of the risk enablement panel, which could be used to discuss support plans where additional expertise was needed. Initially the risk enablement panel was not well understood, and some practitioners were unsure as to how it worked. However, as

the pilot has progressed more clarity has emerged, and the panel is now appreciated as a useful tool in the SDS process:

*“This risk enablement panel is really good you can actually take the...and have a discussion and sometimes the discussion goes one way and sometimes it goes the other way and I think that’s quite good, and there is more of that.”*

*“I think that’s a part I think we deal with really, really well because of this risk enablement panel. So when you’re presented with a thing and you think you know, it’s a bit hard, you can decline to sign it and then it goes to a panel and it’s actually quite...I’ve been a couple of times ‘cause I’ve refused quite a few of them and you go there and it’s quite a sensible discussion. I think it works quite well.”*

Although the risk enablement panel is clearly a source of support to practitioners, it must be ensured that the panel is utilised effectively, and used only for the small minority of cases where further discussion is merited. Currently this is the case, but it would be prudent to monitor the situation to ensure that practitioners don’t fall into the habit of taking all plans to the risk panel as a ‘vetting procedure’ to provide a safety net. If this were allowed to happen it would risk the creativity of plans and the independence of service users to meet their needs however they feel appropriate.

### *Equity*

There were practitioners who felt that SDS did not provide equity for service users within the pilot:

*“...the resentment is there with the practitioners because you’ve got a load of people on low level support receiving computers and horse riding lessons and all these sorts of things when we’re struggling to get money for people to have a house that’s habitable, to have hot water, to have those basic life...”*

*“...the day I had to sign the horse riding, facials and restaurant meals package we had a client whose house was fire bombed and was being threatened by the neighbours and she needed some money to get to Kent to stay with family and we*



*had no way of doing it. We ended up collecting the petty cash from different offices to pay for her transport to Kent and you're thinking hang on, this person's at risk of life and death...our emphasis seems to be the more well people and there are very ill people don't get a look in. "*

*"I mean I think, you know, there's loads of wider issues... There's lots of unrest, you know. There's issues around you know, some people are having all these wish lists granted and other people go into hospital for months on end and in really poor conditions you know and you just think, I'm sorry but you know this is the whole the picture and it makes you feel really frustrated and torn, you know what I mean."*

There is a clear focus here on the perceived level of inequality within mental health services, although this has always been the case. Nevertheless some practitioners did feel uncomfortable praising SDS in front of other colleagues for this reason.

Conversely, it can be argued that by helping those with less severe mental illness on the road to recovery sooner in their illness, they are actually avoiding a further decline in health and the need for more costly and more complex services at a later date.

There was also clear inequity in the way in which service users were being offered the chance to take part in the SDS scheme. In some teams all cases were discussed by the practitioners and considered for SDS, and in others there were criteria which practitioners applied to determine those offered the service:

*"Really, who do we cherry pick or...for SDS. It's not equitable because we don't have the time to do it or offer it to all our clients, I don't."*

*"I think at the moment it's those people that you know you're going to be pretty much in agreement about their level of need. I think the people who aren't being offered it at the moment are those people where there's big differences and it's a constant challenge and you're constantly in that debate about people's level of need."*

In some ways this feeds in to the inequity reported above, in that if the people being offered SDS are selected to be the easier more straightforward cases then it can be no surprise that people with perceived low levels of need are forming the majority of the SDS cohort. It would be hoped that as SDS becomes more firmly established and proven that it will be offered to a wider range of people with more complex needs and the inequities may be reduced somewhat. However there is always the risk that SDS will be marginalised and offered only to those service users whose cases are considered 'easy', and this must be monitored. It should also be noted that there were a small number of instances reported where service users were offered, but rejected SDS. Currently it is still the service user's choice as to whether to take part in SDS and to receive a Personal Budget:

*"Yeah, you know, some have turned it down. We've got as far as completing the support plan and then, "oh no I can't take this, I don't deserve it and what's it, is it going to be means tested?" and just frightened of it, have turned it down."*

*"In early intervention...we've got some people where the young person just doesn't want to manage it. They don't want to and then you know you've got somebody like Mum and Dad saying "Well I'll do it for them" and you're thinking "Oooh no" because it's making more of a dependency."*

Another unfortunate aspect relating to equity which was picked up on was the reduction in monies available to service users over the course of the SDS pilot. The original price point set in the pilot was reduced as it became clear that this was not sustainable. As this was a pilot and there was no national guidance on using a RAS (resource allocation system) within the mental health services there was no clear benchmark from which to start. Therefore it has been an ongoing process to find the acceptable price point for this scheme, and has resulted in some people who applied for the budget in Year 1 having their budget cut when they reapplied in Year 2. This has been uncomfortable for the practitioners:

*"I did one of the first...as you say it's quite a big package, and when they were reviewed...the needs hadn't changed, and this person is as well as they're going to*

*be, but there was £12,000 less in the budget and I'd had to scrape and scrape and scrape. This person's needs hadn't changed... I've been told, next year the budget will be cut even more. His needs aren't going to change. He has a family... So how do you justify that to that person? He's still the same but we can't give you the same level of care."*

It is not an ideal situation but since this was a pilot, and in the prevailing economic conditions, it might have been considered inevitable. Nevertheless, it was important that practitioners and service users alike were fully informed at the outset that it was a pilot and there may be changes in the scheme as the pilot progressed.

A further area of discussion revolved around the issues of reviews and dependency within the service. The review process is one that has evolved as the pilot has run its course:

*"Lots of things, I think, weren't thought about at the time that training was delivered. So things, for example, like review training and reviewing a package."*

However, there is still a lot of uncertainty about the review process, and some practitioners were concerned that there was no mechanism for discharging people on SDS from the service. Service users may have recovered sufficiently to need only minimal support or a yearly review, but it meant they still had to have access to a CMHT. This was felt to be counterproductive to what they were trying to achieve and creating a block within the system pathway.

*"We have created a small cohort of people that almost like to see themselves as dependent for life because they don't want to give up all the things they're getting...so...and you can't discharge them."*

This is an area which needs to be addressed and one practitioner suggested that a review team might be the answer:

*"We've got people who are very stable. Their package is really going to remain as*

*it is for a very long period of time but we have to keep them open because they need a review and if we had a reviewing team...you know, like, in local authority like, in the other teams like learning disability, physical disability, they do have reviewing officers..."*

The review process has gained some clarity over the course of the pilot, and there are now established review procedures in place. These need to be consolidated and communicated effectively to practitioners to enable them to complete the process correctly and on time, and there is still room for improvement in this aspect of the pilot as it moves forward.

### Working with the brokers

#### *External brokerage*

Some of the practitioners in the discussion group had experience of working with the external broker during the SDS pilot implementation. The degree and type of involvement varied considerably, including:

- Handing over the support planning responsibility entirely to the broker
- Accompanying the broker as they completed the process
- Shadowing, where the broker went out and followed the practitioner closely through the whole process,
- Contact with the broker only for advice and clarity during the process.

The amount of involvement with the broker also changed through the course of the pilot, as practitioners became more confident in their own abilities to conduct the 'brokerage' role.

Feedback from the care practitioner training day in 2009 indicated that those care practitioners who had worked with the external broker were appreciative of the support they had received:

*"The broker was invaluable and prepared the support plan"*

*“The broker was very helpful to enable me to understand the process”*

*“Although I put a lot of time in, (the broker) must have put much more time in”*

*“After a joint meeting the broker produced support plan with client”*

However most of the feedback at this stage indicated that the broker had taken on the support planning, and it was not a joint activity with the care coordinator. As the pilot had progressed practitioners have become more confident to be an equal partner in the support planning process and there has been less reliance on the external broker to complete the support plans.

This same pattern emerged in the discussion group, as the relationship between practitioners and the external broker developed. There were contrasting experiences of working with the broker, with some of the practitioners feeling that *“At the very beginning the brokers were very evangelical”*. One practitioner went further:

*“The external broker. Yeah, very. And everything was, you know, should be agreed and supported so people could enhance their...and if you questioned anything or raised doubts or raised issues as this, you were a sort of ‘non-believer’. It very much felt like that and that caused a lot of anxiety and of course the service users were picking this up as well. I think there was a degree of...almost conflict built into it because the social worker or the nurse, by the nature of the profession, you have got to raise things like this. It’s your professional duty, you know, and that was quite an imposition. I think there was an undermining of professionals from the very beginning.”*

And another:

*“I do think it’s been...quite a little bit idealistic, I’ve felt and it doesn’t totally reflect what’s actually going on in practice, well it doesn’t at all actually.”*

*I think it sometimes leaves aside the accountability that we do have because as care co-ordinators we are assessing risk and we are constantly living with that “What if something happens?” and I don’t necessarily think that always came from the brokers.”*

Although these are legitimate concerns they must be put in the context of the role of the broker, which was to build capacity within the mental health teams and to support service users in planning. At turns this has required challenging, informing and inspiring practitioners. There was some confusion as to the role of the broker within the pilot, and this ambiguity was exacerbated by the fluidity of the brokerage role. The development of the brokerage functions are discussed in more detail later in this report.

Some practitioners felt that the independent broker acted as an advocate for the service user, and implied that this was not part of their role.

*“It is, they did what they did very, very well. Very, very, well. Very, very helpful. However, they did not act as brokers. They acted as...the client talked to them and they did what the client said and so therefore if you did have? It was two against one. Yeah, the broker didn’t broker....they acted as advocate”*

*“...description of an advocate, yeah, because in my experience I’ve worked with (the external broker), I think similar to you. I’ve found it very useful, very beneficial, she’s very motivational as well but when you said that it was, it was the client actually telling (the external broker) what would enhance their life etc and then that would go on the support plan.”*

However, some would argue that this is one of the key aspects of brokerage, and that listening to service user’s views and translating them into the support plan was an essential part of co-production.

The majority of practitioners who had worked with the external broker were very positive about the experience.

*“The first two I did on the pilot I did with (the external broker) and we did it together and it was a positive experience for me ‘cause they were both...’cause I didn’t know the process either it was difficult. They were both quite difficult people, not difficult people the clients but they’d got very complex needs in different ways. I do my own now because I know the clients and I feel...I do it with them.”*

*“I have done (worked with the broker) but mainly when I’ve become a bit unstuck, I’ve then phoned up (the external broker) and said I don’t know what I’m doing with this, more complex ones and it’s tended to be about trying to look at the budgets really. And I’m still in the process of things, so, I can only tell you from where I’m up to but that’s been quite useful really. I’ve felt like “Oh, well there is a light at the end of the tunnel”. Or there could be, you know.”*

There were some concerns that in a small number of cases the external broker had developed a support plan without input from the practitioner, and then delivered the plan to be signed off by the practitioner without any discussion. In a few of these cases this was because the practitioner did not want to be involved in the process, and in others the case had been handed over to the broker due to lack of time.

*“I also have issues with that with care co-ordinators not having input into the support planning process with the supported living team and that you’ve been presented with an SDS package that as a care co-ordinator, ultimately I have to take responsibility for that client and I haven’t been part of that SDS. How can somebody I’m care co-ordinator for, how can their care be planned without any involvement with me? I know some care co-ordinators refuse to come to reviews and things but...”*

*“I was going to add to that because I think a key point as well, attached to that is because obviously there is pressure within the teams, we have had situations where the care co-ordinator hasn’t been able to or hasn’t been available and we’re under pressure to provide a package of care. An SDS has to be done so there has been*

*one or two where it's gone to a broker...It's not ideal, are you with me? It's not an ideal situation but that is the only way that we've been able to do..."*

This merely highlights the fact that the practitioners should be involved in the process, even when they work with the broker because they will be responsible for the plan once the broker hands it over. It is clear that practitioners are under a lot of pressure, but as one practitioner stated:

*'How can their care plan be planned without any involvement with me?'*

There was also some discussion, particularly at the feedback day in 2009, about the development of a specialised brokerage role within the care practitioner teams. Steps in this area were taken with the introduction of the 'Internal Brokerage' role in December 2009, which is discussed later in this report.

#### *Peer brokerage*

When discussing working with brokers, it was disconcerting to find that the peer to peer support group All Together Positive was not mentioned by anyone. When this area was probed it became clear that practitioners were not really viewing this as a viable brokerage option. None had worked with the peer support group, and most of the practitioners seemed unclear as to their involvement in the project, as exemplified by this exchange:

*"Who?"*

*"All Together Positive. They're a peer to peer support group."*

*"No. I've not used them."*

*"Yeah, is that the group that's called funny Stuff, it's emerged from, yeah, yeah I know what you mean."*

And another practitioner reported:



*“One of the concerns I have is that I know people who are part of that are part of the cohort, service users who spread the word that basically you could have anything and my concern is...I don't want to come across as sort of this...this professional who wants to take control of everybody's life and well you know, but as a care co-ordinator I am accountable of managing risk and if something happens to that person I will be called to justify the work that I have done with people and so a peer to peer support brokerage is really good as long as it doesn't become a battle, you know and they're advocates like, you know, and it is about working towards but recognising there isn't a want list, it's a need list and you know and that's been my concern about using them. I have to be honest.”*

Some of the practitioners felt that the peer to peer support group employed to develop brokerage did not fit the needs of their service users.

*“It didn't seem to us as though it was kind of opened out to anybody else because it came from Stuff sort of setting up another in-house group, and certainly for our clients who are a younger age group, it didn't seem like peer support because...do you know what I mean? Because it didn't represent them at all and they had nothing in common and in some respects seemed quite frightening because it was made for people who have been in service for, you know, pretty much all their life”*

*“Well I think there's the assumption that stuff represents service users and I don't think they do necessarily, I have to be honest. I don't have any...everybody in my client list at the moment doesn't have any involvement with stuff and they don't like them as an organisation so that is off putting thing. I have to be honest.”*

This is a serious concern for the SDS pilot, as peer support is one of the key tenets of personalisation, and building capacity in this area should be seen as a priority. It has been reported that the most successful personalisation programmes have come from those areas where community capacity and peer support have been built in as an integral part of the service [65], and communities can help to fill needs that traditional services cannot. Therefore building up good working relationships with

peer organisations and community sectors, which can provide alternative support is vital to the continued success of SDS. Moving forward it would seem prudent to focus on these areas, to ensure appropriate peer support groups are available to service users, and to legitimise their involvement in the service. This is discussed in more detail later in the report.

### 5.3 Feedback from brokers

The brokerage role within self directed support is one which has generated considerable discussion, and there are contrasting views as to who should fulfil this role in support planning, and how they should work within the scheme. Early literature emphasised the need to provide independent brokers to support service users; this would ensure that the support planner was independent from the local authority and therefore less inclined to bias or constraints when support planning for users [66]. More recently there has been discussion as to whether this is the best way to proceed, as independent brokers are not a profession, not regulated, can be costly and can add complexity to SDS [63, 67]. However, amongst service users there is some unease at the idea that professionals from within the system may provide brokerage, as they are bound by the system and politics involved in delivering SDS, and in many ways hold a degree of power over the service user as to their funding [64].

Brokerage has a wide remit, and what constitutes brokerage is still being defined [68]. However a number of the key areas which could be offered by a broker include:

- finding out what is available
- exploring what is possible
- providing information (signposting)
- giving technical advice
- encouraging and developing informal supports
- coordinating supports and resources
- assisting the person to manage their obligations and responsibilities in relation to their budget
- facilitating to enable things to happen

- helping with support planning and person centred planning
- helping the person speak up for themselves or where necessary to speak up on their behalf.

It is unlikely that any one brokerage function can fulfil all the above roles, but the list shows the diversity of possible interactions with service users.

CSIP has proposed that brokerage can be developed through five separate, but interlinked areas [68]:



- Independent or external brokers who are paid to provide support
- Care practitioners and other key staff within the system.
- User led organisations, e.g. peer support
- Community and neighbourhood networks
- The person and their family

**Figure 3: Routes to brokerage**

This framework has been utilised to present the findings from the brokerage functions with the SDS pilot.

### 5.3.1 Feedback from external / independent brokers

The external brokerage role was established at the outset of the project with three main aims. The first was to develop personal support plans with individuals in on the SDS pilot; the second to build capacity within the CMHT teams to enable them to take on the changes SDS would bring, which could include support planning, and

thirdly to support the peer brokerage providers, All Together Positive, in building their capacity to provide a brokerage service.

#### *Definition of the external brokerage role*

The external broker had considerable experience in support planning, albeit outside mental health, as this is such new area in which expertise is being built as projects progress. Although the broker was nominally called an “Independent Broker” the role was not as clearly defined as the title suggests. The role of the independent broker has by necessity had to be flexible, and at times there has not been complete clarity about where the role of the external broker should start and end.

The broker was positioned within the CMHT teams to enable capacity building, but this led to both positive and negative experiences. The closeness of the relationship facilitated communication and made it easier to share learnings. However, the independence of the broker was sometimes challenged due to this close working relationship. The broker became more involved in the politics, strategic direction and system changes needed to make SDS a reality than perhaps would have been expected from an external broker. Nevertheless due to the threefold nature of the role this blurring of boundaries was more inevitable than if it had been an independent or external brokerage role only. An entirely independent broker would not have been involved in the day to day running of the pilot, or the process in place to implement it.

#### *Developing support plans*

In terms of support planning, initially the external broker offered the only viable alternative to care practitioners undertaking the support planning themselves. As the project and processes were new to all involved, some care practitioners felt unable or unwilling to offer support planning themselves at this stage. Therefore almost all the support plans involved some input from the external broker, and without this input at the early stages the SDS pilot is unlikely to have become as established.

#### *Independence of the external broker*

The external broker was able to retain enough independence from the authority to ensure that support plans could be developed which were creative, different and

completely service user led. The external broker's experience in this area meant that they were confident to include sometimes controversial aspects to support plans. However, due to the initial cautiousness of care practitioners and members of the local authority, the broker by necessity became a strong advocate for some service users, who it was felt would need support to defend their plans in the face of robust questioning. This meant that the broker was sometimes asked to justify and rationalise service user's support plans out of context at meetings where there was little knowledge or understanding of the service user's situation or experiences.

There was sometimes tension between the broker and care practitioners, and the broker felt pressure to conform to more traditional ways of working. However, this tension between roles can be beneficial, as it is only by breaking the established ethos and ways of working that new ideas can be introduced and integrated into the culture of a workforce.

#### *Overreliance on 'the expert'*

There was a danger that the external broker was seen as 'the expert' who employed the only 'correct way' to support plan, and that this would deter others from trying. It was important not to rely solely on the external broker to understand the ethos, process and practice of implementing SDS, as future growth and understanding by care practitioners could be stymied. Nevertheless, it has become apparent that care practitioners are moving forward with this agenda themselves, and beginning to take on the support planning role, with or without help from other brokerage routes, such as the internal brokers. This is reflected in the data from the SDS database, discussed later in this report, which shows that the brokerage route used by service users has become more diverse over the course of the pilot. At the end of the pilot the external broker moved on from the project, and is no longer providing external brokerage at this point.

### 5.3.2 Feedback from internal brokers

The internal brokerage role, which was established towards the end of the first year, has continued to grow over the remainder of the pilot, and has now become a viable alternative to the external brokerage route. The three internal brokers work within the CMHT teams, with two initially each supporting one of the teams and the third providing extra capacity where needed. The third CMHT was supported through the external broker and the peer brokers, although this is evolving over time, as the external broker involvement in the project has come to an end.

#### *Working with care teams*

The care practitioners who have taken on the internal broker role have been through additional in-depth support plan training with Happy Associates, to build their expertise in the area. The support they provided was very welcome to care practitioners, even more so as the external broker's involvement in the project ended. However, as would be expected the internal brokers have encountered a variety of attitudes when working with care practitioners:

*“Some are very much for it, and some are very resistant. This is still the case, we’re still not there yet”*

The internal brokerage function operates in a range of ways with care practitioners, from answering questions on the phone when practitioners need a little extra support, through to taking on the full support planning role, with little input from the care practitioner. In this way their role is mirroring that of the external broker. They are also continuing to build capacity within the care practitioners:

*“I go out with the care coordinator. Maybe go out once or twice, then hope they will take on the role. “You do it now, and I’ll support”, that would be the plan because they learn it then...’cos that’s the way forward”*

However, moving forward there are a number of areas which need to be explored in consolidating the role.

### *Dual role of internal brokers*

Currently the internal broker position has been implemented as an additional responsibility to the care practitioner role, rather than as a standalone function, and all the internal brokers work both roles simultaneously. This can lead to tensions within the role, and finding the time to support plan can be difficult:

*“I enjoy doing it, I enjoy meeting people. If I only had one it would be a pleasure, but it’s when you have loads it becomes stressful.”*

Although the internal brokers are aiming to build capacity within care practitioners, there is still a question as to whether staff, both care practitioners and internal brokers, have enough time and autonomy to support plan as creatively and effectively as they would like. There is a danger that if support planning cannot be given the space and freedom needed to build successful outcomes, practitioners and internal brokers may revert to more traditional ways of working out of necessity.

One option would be to make the role of the internal broker more distinct, and form a separate function or hub of brokers. This would have the benefit of allowing the brokers to focus on building their capacity, and enable them to support more service users in building support plans. It would also free care coordinators from support planning in cases where there is a low level of need, and allow them to focus on more complex cases within their workload.

### *Route to support for internal brokers*

It is important to ensure that there is an established route for providing support for internal brokers. Their dual responsibility in the process can mean that they feel pressure from both practitioners and management to develop support plans which conform to more standard expectations of care provision, and to moderate the voice of the service user. In order to ensure internal politics and pressures do not constrain and distort the role of the internal brokers an independent source of support should be made available.

### *Interaction with other brokerage functions*

A key area of importance is that there has been little or no interaction between the internal brokers and the external broker, or the peer brokers. This is an area where it would be prudent to build links to establish a wider brokerage function, and to better understand how each other works. Each of these functions has much to offer, and it is only by learning from each other, and building on the wide range of experiences encountered, that a stronger brokerage function, however this is delivered, can be built.

The internal brokerage function is one which is evolving as SDS becomes established within mental health services in Stockport. Looking to the future the role must be given sufficient time, space and focus to develop and ensure it is not 'swallowed up', by the ever competing demands placed on care practitioners and in particular internal brokers.

### **5.3.3 Feedback from peer brokers**

The peer brokerage role is one that developed slowly over the course of the pilot. All Together Positive were already an established independent training and advocacy organisation, but had not undertaken support planning in the context of SDS.

### *Clarity regarding ULO involvement in SDS*

Due to the evolving nature of the pilot there was uncertainty on both sides as to the type and extent of services which would be offered by the user led organisation. There were several false starts and plans which did not come to fruition, and which served to highlight the challenges working with user led organisations can bring. They are not within the remit of the local authority and they have their own agendas and time scales which may not fit in with those specified by the authority. This can create a tension in the relationship. However, building community capacity is a fundamental tenet of the success of SDS, as peer groups can offer unique perspectives and support to service users. Therefore it is important to find ways of working together to produce successful outcomes.



The external broker provided support and advice to ATP throughout the pilot, to enable them to build their brokerage capacity within SDS. By the end of the pilot ATP had undertaken several training courses in personalisation and support planning to build their expertise and were in a position to offer support to service users and care practitioners. However, there are a number of ongoing challenges which need to be addressed as the scheme continues, since they are blocking peer involvement and support in the pilot and beyond.

### *Equality with other staff*

ATP felt there were issues regarding their status within the pilot, because although they were service providers they were also service users themselves at times:

*“...they would see us not as service users and carers, but as people with vast experience and expertise, and we would be getting more familiar with them.”*

There was a perception within ATP that they were not equal partners in the process, and they were not always a fully integrated part of the pilot study

*“We’re not involved with care coordinators and other people going through the same process as us. If we could go back and do the training together ATP would spring to mind, whereas currently we don’t do anything together so how would they know?”*

*“Do they see you more as outsiders?”*

*“They **don’t** see us, when do we actually come in to contact?”*

This makes it difficult for a group to contribute and grow with the pilot to provide relevant services to users.

In addition the pathway by which referrals are made to ATP is not clear either to care practitioners or the peer group themselves. Within the pilot referrals to ATP came through the external broker, who worked with the peer group to identify

support plans they could assist with. However as the pilot has drawn to a close it has become apparent that referrals are not being made directly to the peer group to broker support plans. Consequentially a lower than expected referral rate to the peer brokers has resulted and must be addressed. This may be a reflection of some care practitioners acting as 'gatekeepers' and deciding who should provide planning support for their clients. It is much easier for care practitioners to work within the system they are familiar with, and have easy access to, i.e. the internal broker or themselves, to develop support plans, even if this is not necessarily the best option for their client. Working with the peer brokers can challenge care practitioners thinking and ways of working since peer brokers may develop support plans in different ways and timescales. However, it is vital that service users are afforded the option to use peer brokers if so desired, as their 'ground roots' understanding and experience cannot be replicated elsewhere. Further peer brokers can often give service users more time, flexibility and focus than practitioners are able, as they are not working under the same time constraints.

#### *Reflecting the needs of service users*

There were some concerns voiced by the care practitioners that the peer support organisation chosen to provide brokerage did not reflect the needs and experiences of their client group. This was especially true of sectors such as EIT, who felt that it could be off putting to their service users if the peer group did not reflect their experiences or understand their culture. This highlights the importance of ensuring the right peer support is available to service users, and that there may need to be a range of user led organisations available to provide brokerage and support to meet the diverse needs of service users.

However there were other care practitioners who had not actually worked with the peer brokers, yet who felt they were not the right people to provide this service. This is a deeply concerning issue, as it serves to highlight some care practitioner's preconceived prejudice against the ULO and the fact that the practitioners are acting as gatekeepers, deciding who should have access to which information and services even before the support plan has been written. Again there is a lack of communication between the professional practitioners and the user led organisation,

and there was concern within ATP that they were not being allowed to work together with care practitioners to break down some of the barriers of discrimination which were in place.

Nevertheless, ATP were overwhelmingly positive about SDS, and their involvement in the project:

*“We are at the coalface, at ground level with service users...we have a wealth of experience...so coming together on this project we thought was just fantastic, but it hasn't really evolved in that way as much as we would have liked it to.”*

Peer brokerage is fundamental to the success of SDS, and suitable peer brokers must be nurtured and championed to ensure they can fulfil their potential in providing support and guidance to other service users in SDS.

#### **5.3.4 Alternative brokerage options**

This leads onto the other areas of brokerage proposed by the in-control model, i.e. self brokerage and community support.

##### *Self brokerage*

As highlighted earlier in the report there were only a very small number of service users who opted to complete their own support plan, and none of these chose to provide feedback of their involvement in the pilot. Therefore we have very limited understanding of how the self brokerage route was experienced, and this may need to be picked up later if and when this route becomes more established. Self brokerage may increase over time after the pilot, as service users gain confidence and knowledge about building support plans, although the majority of service users utilised some kind of brokerage or support within the pilot. Moving forward there should be a greater emphasis on service users taking on more of the responsibility of implementing their own support plan. Where the mental capacity exists service users should be encouraged to take an active role in planning, sourcing and

implementing their support plan, thus building their confidence and ownership of outcomes.

### *Community support*

In addition increased involvement of community support and neighbourhood networks should be encouraged, to provide both formal and informal brokerage and support to service users where appropriate. This is an area which was not explored extensively in the SDS pilot, but which is important in building strong inclusive communities[69, 70], and should be a focus for future developments within the service.

### **5.3.5 Future of brokerage**

In terms of the future of brokerage within SDS, it is clear that no one option can meet the needs of all service users. A range of brokerage options need to be in place, including external, internal, peer and self brokerage, and there needs to be genuine choice as to which option the service user can employ. Ensuring the availability and equitable promotion of the range of brokerage options in place provides the best possible chance of effective support planning and successful service user outcomes.

### **5.4 Analysis of the SDS pilot database**

The following data and charts give an overview of the key points of the database findings to the end of August 2010, and can help to illuminate the reach and effectiveness of the service. As the database is still in progress and not all entries have been completed fully it must be noted that the figures may change as more information is gathered. However it is considered unlikely that the overall findings will significantly change once the database is fully populated, therefore confidence in the findings is still high.

At the end of the pilot in August 2010 there were 179 applications for a Personal Budget, this comprised of 94 in the first 12 months and 85 in the second six months.

At the outset of the pilot the aim was to recruit 60 service users to the SDS scheme. The data clearly shows that service users were keen to be a part of the pilot, and the numbers achieved far exceeded the target set.

A total indicative budget of £1,082,826 was nominally allocated to the SDS pilot over the 18month period; of this a maximum of £642,400 was allocated in the first year and so far a maximum of £440,426 in the second year. These figures were calculated from the maximum estimated indicative budget, where available. By comparison the traditional budget was estimated to be £407,187, however this figure is considered unreliable due to insufficient information in the spreadsheet, and also because some of the service users receiving SDS were not claiming traditional services, as has been discussed earlier.

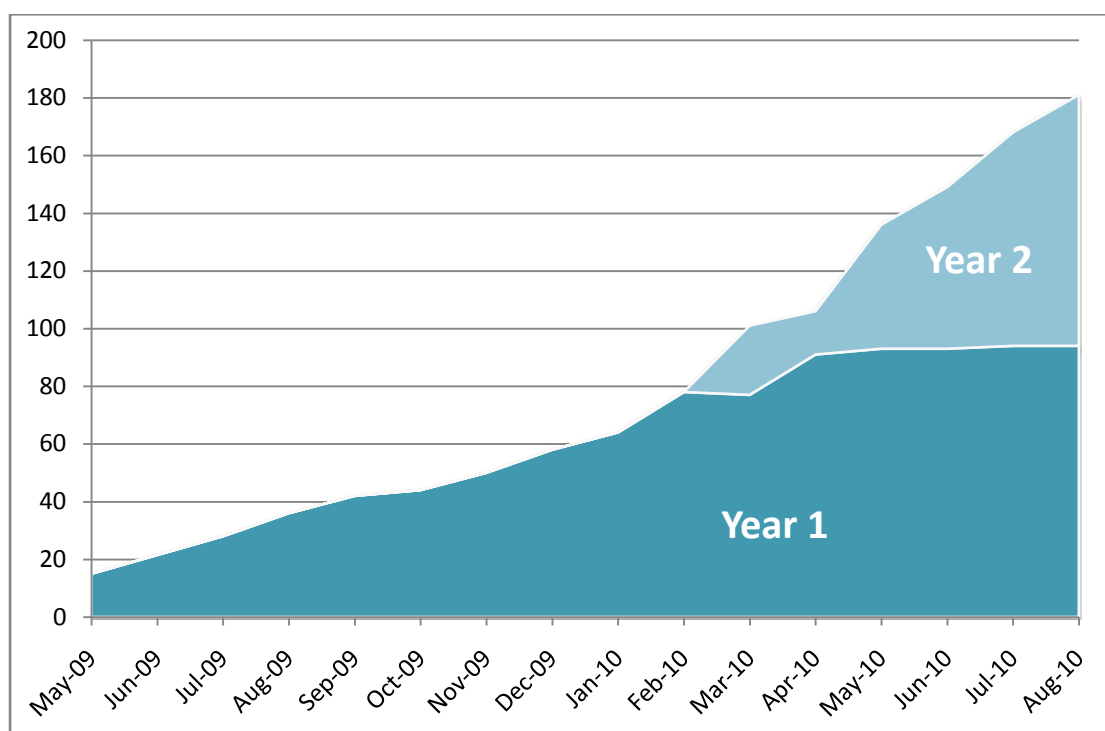
The total funding allocated to date via Direct payments and invoices has been £476,746, with £394,021 being allocated in the first twelve months and £82,724 to date in the following 6 months.

The average spend on each client was £5,813 (median £3,394) over the course of the pilot, with an average of £6,156 in year one (median £3,976) and £4598 in year two (median £2,989). This incorporated the fact that there were a few very large Personal Budgets in the database, but the majority were relatively modest in size. These findings are broadly in line with those of the IBSEN report [8] which reported the average spend for mental health service users in the study was £5,530 (median £4,800), compared to an average of £11,450 (median £6,610) for all Personal Budgets holders.

It can be seen that the spending levels reduced from year 1 to year 2, although there is still missing data to be entered into the spreadsheet for year 2, which has skewed the allocation figures. This was due in part to the reductions in price point introduced over the course of the pilot, and also practitioners increasing familiarity with completing the assessment tools as the pilot progressed.

There has been a steady rise in the number of service users being offered and taking part in the SDS pilot, as can be seen in figure 4. This would indicate that care

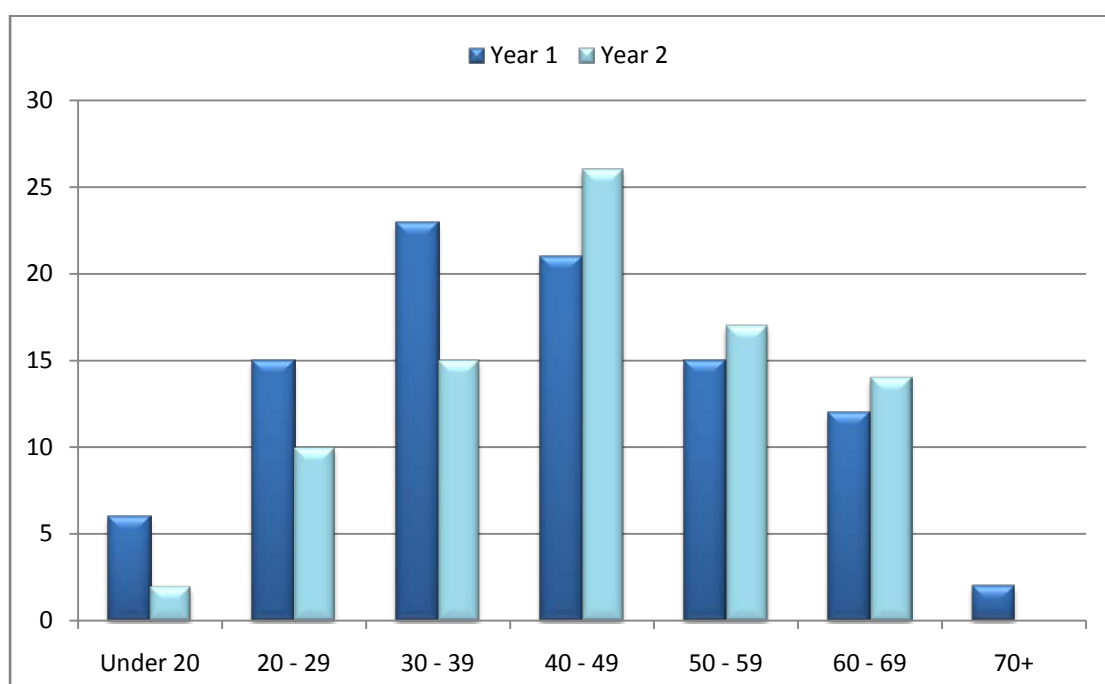
practitioners have become more aware of this new way of working, and are increasingly confident and willing to promote the service to their clients. They may have seen how the process works, and the possible outcomes of using Self Directed Support, and therefore feel more comfortable with the process. In addition service users have become more aware of the availability of SDS, and the benefits it can provide, and therefore more inclined to take part. As awareness of the possibilities afforded by SDS continues to grow, so does the number of people taking up a Personal Budget.



**Figure 4: Number of service users on SDS pilot study**

As the number of service users on the pilot grew, there was also a slight increase in the number of cases on hold. This is to be expected, as there will always be a proportion of service users who for one reason or another do not feel confident in taking forward their application at a particular time, others were waiting for information and assistance to help them progress further, and a small number were unable to continue with their application because they fell outside the given criteria. Nevertheless, the number of people whose case is on hold is still small, and the large majority continue with the process to its conclusion.

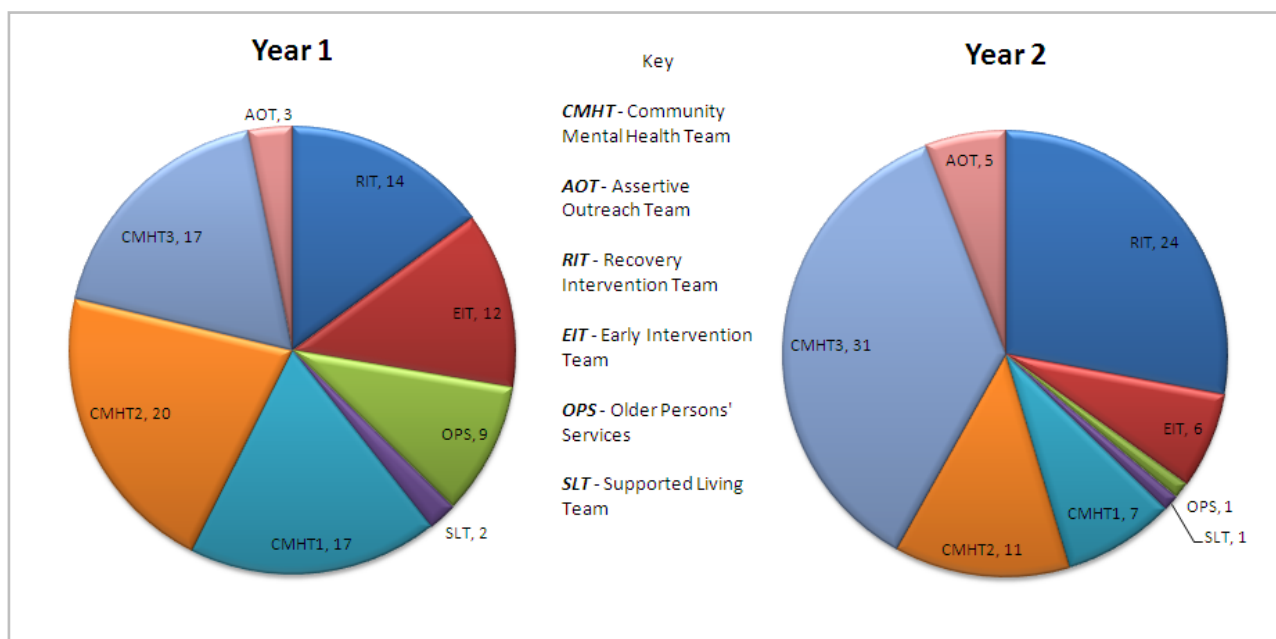
The age range of service users covered a wide spectrum (see figure 5) with the youngest user being 18 and the oldest 79 years. The median age of service users in the first year was 40.5 years, and those in the second year 46.5 years. This data refutes the initial view that EIT would be able to access more users as they entered services for the first time, and instead gives weight to the idea that younger people are actually less likely to access SDS or for that matter any other service, as they are still at the stage in their journey where they want to keep formal contact with services to a minimum. The figures do however indicate that the pilot became more main stream in year two, since the median age of service users rose by six years. Older service users have potentially been within the system longer and are therefore familiar with and used to accessing traditional services. Since they are now being included on the pilot more frequently this suggests that SDS is being seen as more acceptable to a wider range of service users.



**Figure 5: Age of SDS service users**

Referrals to the pilot have come from all sectors within the mental health service, as shown in figure 6. In the first year Community Mental Health Teams, Early Intervention Team, Recovery Intervention Team and Older Person's Services all referred similar numbers of service users, with the biggest number of referrals coming from CMHT2. However in the second year there has been a shift and the

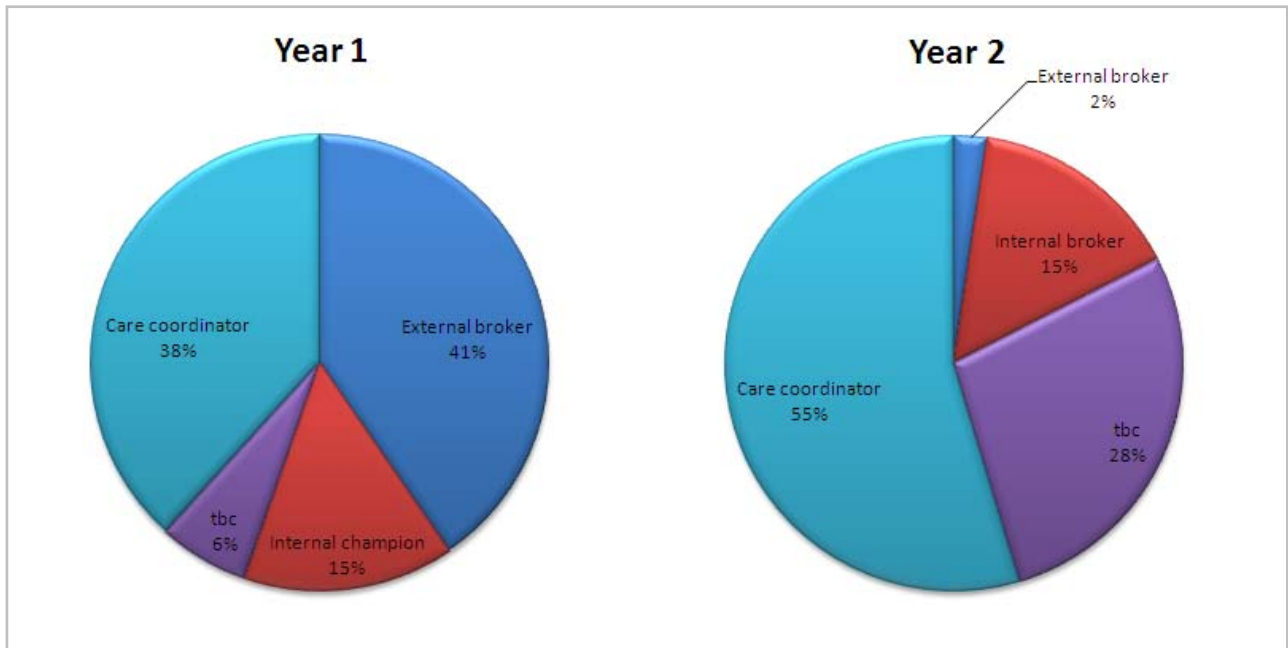
majority of cases have been referred by CMHT3. The Supported Living Team and the Assertive Outreach Team have referred smaller numbers of users, as would be expected. However, there have been some challenges with the Older Person's Services referrals around FACS criteria and some applications were put on hold or withdrawn in year 1, this is reflected in the smaller number of cases being referred from the OPS in year 2.



**Figure 6: Source of service user referrals**

In the first year of the pilot the largest proportion of referrals were supported by the external broker, as can be seen in Figure 7. This was in part due to the fact that the process was new, and both practitioners and service users were looking to the experienced external broker to provide support and guidance. However in addition alternative brokerage routes were not well established at this stage. The internal brokerage role was being fulfilled by a number of champions, selected care practitioners within each team, who were providing support and assistance to other less experienced care practitioners.

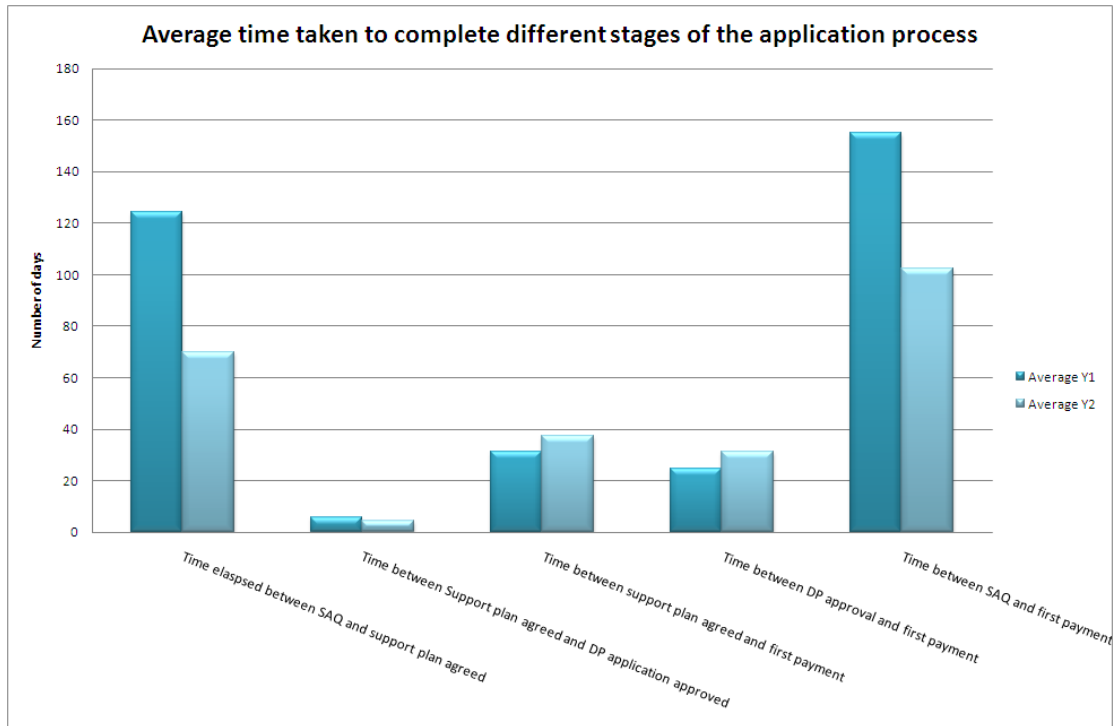




**Figure 7: Brokerage route on SDS pilot**

By the second year of the pilot the range of brokerage options had expanded, and the internal brokers had effectively superseded the champions as brokers within the mental health teams. Many more care practitioners were also taking on the brokerage role themselves, as they became more confident and knowledgeable about the process.

The peer brokerage function had developed sufficiently in the second year to take on service users, and they indicated that they were in the process of completing six support plans. This does not show up on the above chart, but is probably included in the large number of support plans where the brokerage route has not yet been identified, i.e. tbc. Further the database does not indicate how many service users acted as their own broker and completed their support plans. The responsible care practitioner is recorded in the database as the ‘broker’ and therefore there is no distinction made between those who are self brokering and those where the practitioner acted as broker.



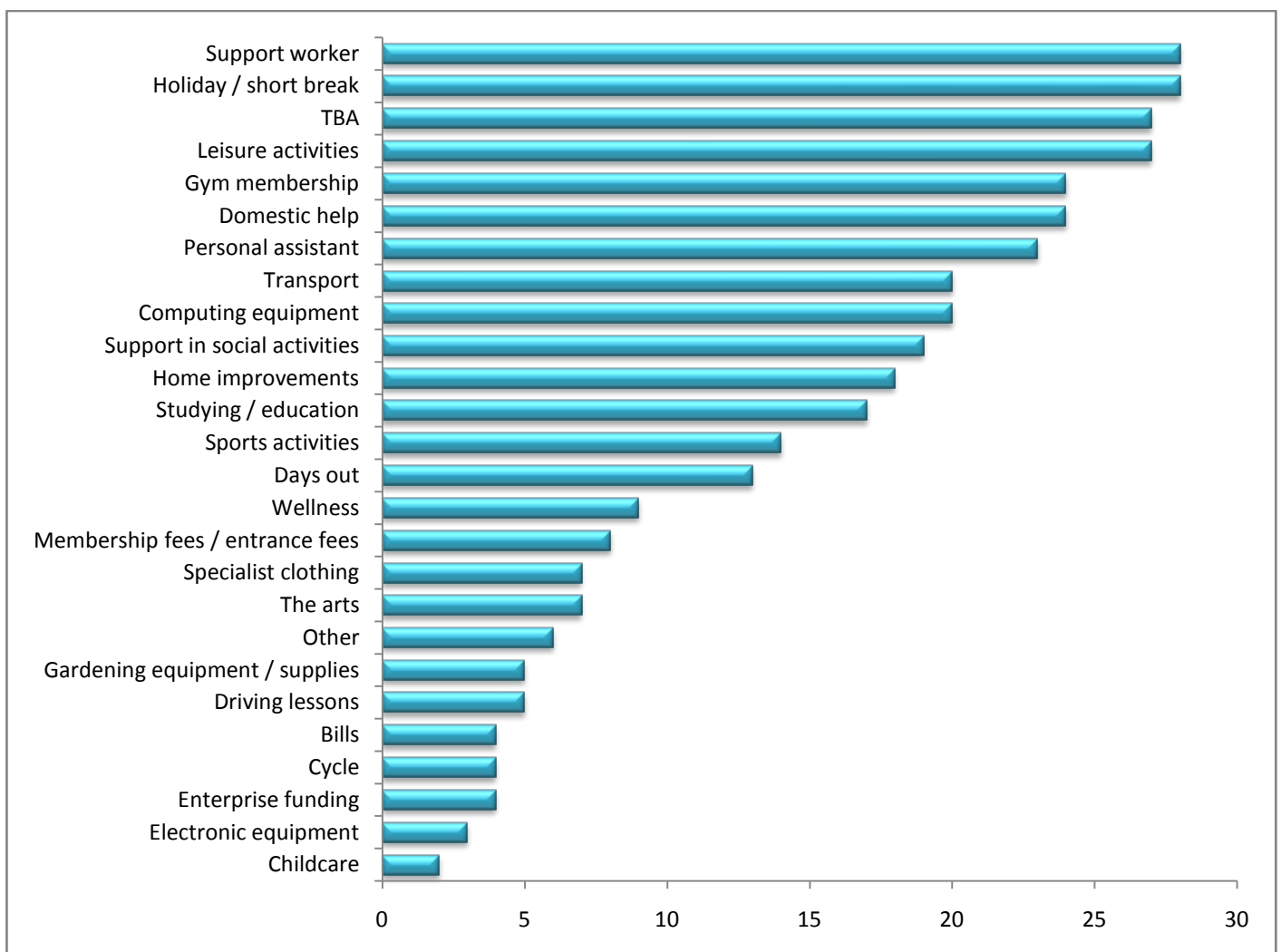
**Figure 8: Breakdown of time taken between SAQ and first payment**

Figure 8 shows the time elapsed between the stages of the SDS process. Service users and practitioners highlighted challenges around the time taken to complete support plans and implement Personal Budgets. This was particularly the case in the first year, and some service users experienced unacceptably long delays. These delays were evidently caused by the lack of clarity and understanding amongst practitioners as they were becoming familiar with the process, and also the time taken to establish suitable criteria for use in the SDS pilot. However, for the service user these delays were de-motivating and unacceptable in the context of SDS. Nevertheless, in the second year the overall time taken between completing the initial Self Assessment Questionnaire (SAQ) and receiving the money was significantly reduced compared to year one. This was mainly due to a significant drop in the time taken between completing the SAQ and getting the support plan agreed, and indicates that as the practitioners and managers became more familiar and confident with the process, and more assured as to what could be included in support plans, the process quickened. The chart shows there were slight rises in the time taken to complete other aspects of the process, i.e. time between support plan agreed and first payment, and time between direct payment (DP) approval and first

payment, but these were not significant, and may have been due to the increase in numbers of people on the pilot.

As was highlighted in the service user feedback, these delays were not always unwelcome and some people appreciated the breathing space to reassess other areas of their life, or prepare for the changes the budget would bring. Service users were willing to accept there may be delays in the process, and provided there was transparency with regard to the reasons and timescales for these delays they did not appear to cause an issue.

The following chart 9, illustrates how service users have spent or are planning to spend their Personal Budget money.



**Figure 9: How the Personal Budget money was spent**

The scope of activities and items proposed is wide ranging and diverse, and many people are using the money in a number of different ways (hence the chart totals sum to more than the total number of people on the pilot). This data illustrates the findings from the service user narratives, showing how people are using the money to build capacity and expertise in many key aspects of their lives.

By far the biggest area of budget spend is the purchase of assistance with everyday tasks, either through a support worker (16%) or personal assistant (13%). The range of tasks incorporated in these categories includes help with eating, dressing, reading communicating and organisational skills.

There are also a large number of service users spending their budget on assistance with socialising, or attending social events (11%). This may be in terms of practical support or emotional support, or both. The reintegration with society which can be achieved through physical or emotional support, and the desire to lead as 'normal a life as possible' are cornerstones to facilitating recovery [55].

Many people used their money for holidays (16%), day trips (7%) or leisure activities such as cinema visits or eating out (15%). These activities can provide benefits not only through respite from everyday life, but also by introducing new experiences and reconnecting service users with normal activities in the wider community, which can improve recovery prospects.

Other common uses of budget money included carrying out home improvements (10%), or employing domestic help in the home or garden (13%). This indicates that people are using their budgets to enhance their environment, which can foster a sense of pride and a feeling of being 'at home' in their home. Improved well being and in some cases social interaction, either directly through increased wellbeing or by providing a place where social activities can take place, can thus be achieved.

Access to sporting activities was important to some, and a number of people used their money to purchase gym access (13%), or other sporting hobbies such as horse

riding (8%). These aspirations have dual benefits in that they provide a health benefit, but also in many cases increase social interaction and inclusion.

A number of service users spent their money on purchasing computing (11%) or other electronic equipment (2%), variously to maintain contact with the outside world, support their hobbies or to facilitate furthering their education. Others enrolled on educational courses to achieve this aim (9%). Ultimately, this can lead to greater fulfilment of ambitions, including facilitating access to work and society, and provide a sense of purpose and enrichment in people's lives.

A further area of focus was on providing transport of one sort or another (11%). Taxis, bus fares or vehicle hire were covered, and one family used their budget to buy a car. This proved controversial at the time but embodied the ethos of self directed care in providing a means to achieve many of the goals this particular user had, including transport, a place to be alone and safe, and an opportunity to provide respite and time apart for the family.

## **6. Summary and conclusions**

This report detailed the evaluation of the Self Directed Support (SDS) pilot project in Stockport, which was run over an eighteen month period between March 2009 and August 2010. The pilot has provided opportunities for service users to develop creative and wide ranging support plans, which would not have been possible under the traditional Care Plan Approach (CPA), and which are generating positive outcomes in people's lives.

The overall aim of the evaluation was to better understand the experiences of people both who accessed the SDS service, and those who were key in its delivery and implementation. Specific research aims were:

- Understanding the experiences and satisfaction of staff and users accessing the Self Directed Support pilot

- Exploring the characteristics of different brokerage systems
- Investigating the processes of brokerage
- Mapping where and how users spend their resources
- Highlighting the implications for future implementation of Self Directed Support services

Each of these aims was addressed individually, before key commissioning and organisational issues were discussed. A summary of the findings is presented below.

The experiences of implementing SDS were explored from the perspective of service users receiving a Personal Budget and practitioners responsible for implementing the pilot:

#### *Service users*

In general both staff and service users have welcomed the introduction of SDS in Stockport, and it is seen as an opportunity for positive change in the social care sector. Service users in particular have hailed the pilot as a life changing opportunity, and there were many illustrations of the huge changes taking part in the pilot that have been afforded.

SDS has been shown to facilitate improvements in all the key areas of citizenship:

- Self Determination (Authority)
- Direction
- Money
- Home
- Support
- Community Life (Contribution)

Service users have reported greater confidence and authority over their life and an increased sense of purpose and direction. There have been opportunities for people to widen their social interaction and in some cases try new experiences which they would not have been able to achieve through traditional funding. In addition there has been a shift towards more participation in and contribution to community, as

defined by the service users. In a number of cases people felt they had built strong enough community connections and gained sufficient confidence in their skills to be able to “give something back” to their community and help others in their lives.

The flexibility to spend Personal Budget money in ways service users felt would best support them to achieve their agreed outcomes, was considered crucial to the success of the project. Also key was the support and guidance offered by brokers and care coordinators, especially in the early stages of the project, to navigate the system, which could sometimes be complicated and time consuming.

#### Key findings and recommendations for future focus

- Service users must be offered access to a full range of support options, to assist them in completing their SDS application, including external, internal and peer brokers, and the opportunity to self broker if appropriate.
- It is essential that there is good communication with service users as to their expectations of what a Personal Budget can be used to achieve, this is both in terms of over and under expectation.
- Clarity of the SDS process and transparency in progress and timescales for application must be ensured. Clear documentation as to the process and timeframe which can be expected from the SDS application which will allow the service user to feel more in control of the process.
- Strong information networks must be built to enable easy access to information regarding products and services available to fulfil support plans, e.g. personal assistants, leisure facilities. These may be paper based, online, or via the telephone, and would allow service users to take on more responsibility for implementing their own support plan.
- Delays must be kept to a minimum, to ensure service users are not demotivated by the application process, and that solutions can be implemented in a timely manner.

### *Care practitioners*

Whilst there were many care practitioners who were very positive about the introduction of SDS, and who were implementing the ethos in their work, there were still a significant number who had not fully embraced the approach, and were less facilitative of the process. Those who had engaged with the pilot had often seen the huge changes made to people's life after receiving a Personal Budget, and this spurred them to continue the work and become greater advocates of the approach. There were challenges to overcome, as in any new implementation, but the outlook of individual care practitioners was seen to determine whether these were viewed as insurmountable obstructions and a reason not to participate in the pilot, or simply the teething problems associated with implementing a new process. In general care practitioners were becoming more confident in their ability to implement SDS, and more willing to offer service users the option of a Personal Budget.

#### Key findings and areas for further focus

- The culture shift needed to implement SDS has, and will increasingly have, an impact on the role and responsibilities of the care practitioners. Whilst many care practitioners welcome the changes, and view the implementation as a positive force for transformation, there are others who are resistant and are waiting for the 'storm to blow over' so they can go back to their traditional ways of working. Since emerging coalition government policy has embraced personalisation and self directed support, and has strongly indicated that it will push for a much wider roll out of the service [2], this is not acceptable. The message that SDS is here to stay, and will become a much bigger part of care practitioners' work should be reiterated and emphasised to care practitioners.
- Lack of appropriate training was felt to be an issue. There was a call for more practical experience and guidance, delivered through discussions of real life cases, and the experiences of others who had already been through the process. Also training around the systems in place, and how and when these were to be used would have been welcomed. In addition ongoing training was requested, as the pilot progressed and activities such as the review process became more pertinent.



- There is a need to ensure that practitioners focus on the outcomes of a plan, rather than the list of items requested. For this reason it is important to document the reasoning behind support plans, so others can understand thinking that has led to a particular request..
- Good communication between management and care practitioners was not always achieved. Changes to the pilot were not cascaded in a timely manner to all care practitioners, and this led to frustration and sometimes duplication of work. Good communication is essential to keep care practitioners informed and up to date with any changes in the process.
- Resource availability and high workload were major challenges to the implementation of the SDS pilot. Care practitioners sometimes felt they were unable to give their full attention to the SDS process as it was time consuming and they had too many other demands on their time. However, as the importance of the personalisation agenda continues to increase, SDS will become more central to practitioners' roles, and capacity will need to be found. Practitioners need to be given time and space to take on board the new ways of working, and legitimacy to spend time discussing problems or questions they have, i.e. at SDS forums or meetings. Nevertheless, a considerable amount of time is often taken up in investigating services and possibilities to fulfil support plans, and this could in some cases be taken on by service users themselves, brokers or community groups. Opportunities must also be sought to streamline the paperwork and processes wherever possible. As personalisation will be an ongoing theme for many years to come, it is important to ensure duplication between this and other systems in operation, such as the CPA, is minimised. Stockport are starting to address this by exploring 'wellbeing care plans'.
- Moving beyond the professional gift model which has been dominant in social care in the past, to a citizenship model, where coproduction between staff and service users is seen as the norm is still proving challenging. In some cases staff are continuing to act as gatekeepers, either to the process itself, through deciding who should be offered SDS, and which brokerage options

service users are informed about, or by taking on the role of support planner and influencing the development and implementation of plans.

- Risk reduction is still a big part of care practitioners' role, and some felt uncomfortable with the devolution of risk to service users which is a fundamental part of SDS. Risk aversion is engrained in the service, and has been encouraged in the past. However, the introduction of SDS has brought changes in the assessment of risk, and encouraged more flexibility. Although risk will always be present, this must be balanced against service user's abilities to direct and manage their own care. Staff need to feel supported if they are to achieve this goal, and the local authority has worked hard to allay fears of blame and prosecution if the management of risk is relinquished. The setting up of a risk enablement panel has been well received amongst staff, and as long as it is used only for the very small minority of cases which need to be looked at in more depth, it is a positive addition to the tools available during the process. Nevertheless to maintain progress in this area, and ensure control is not taken back by services at the first opportunity, the message regarding risk must continue to be stressed.
  
- There is continuing unease amongst some staff regarding the equity of SDS. This can be broken down into two main areas.
  - The fact that Personal Budgets are being used by people with low level need, when it is perceived that the money could be used better elsewhere. This aspect must be looked at in context, since early intervention is more effective and cost efficient than waiting for higher level need to develop, and is a key thrust in new government documentation [1]. Nevertheless, it is important that those practitioners who have taken on the ethos of personalisation and SDS are not made to feel that their service users are 'unworthy' and taking funds from other more needy people.

- Staff inequity in offering Personal Budgets to service users is evident in some teams, and this exacerbates the view that only low level need amongst articulate service users is being met by the scheme. This will be a self fulfilling prophecy; if SDS is being offered only to those cases considered easy to manage through SDS, then they will be the only service users on the scheme. However, again if we look to the coalition government thinking in this area, they have expressed the expectation that all eligible service users are to be offered a Personal Budget by 2013 [2], thus the current position of some staff is untenable. Although more complex cases will require more support and time to ensure successful outcomes, these are the cases where care practitioners can make a real difference. It is possible that cases where there is a lower level of need can be managed more efficiently by service users themselves, or with support from within their communities.
  
- The final point above leads on to the area of service users' capacity in developing their own plans. Staff are moving towards the recognition that they do not have sufficient time to implement all support plans, and in many cases there are other people who can take on the responsibility for 'bringing the plan to life'. There are a large number of service users who could take on some or all of the responsibility to research and implement their support plan, and it should be assumed that service users have this capacity unless otherwise evident. That is not to say they do not need support, but that there should be a culture co production where service users and care practitioners work together to ensure positive outcomes. Empowering service users to enable their own support plans, with or without support brokerage from other sources, e.g. family, friends or community, should be a fundamental goal of the process since over support can be as damaging as under support.
  
- There has been good progress on developing creative support plans, as experience of the process has increased, and confidence has grown. This has also

been attributable to the external broker who due to past experience in the area and relative independence from the authority was able to show what could be achieved through support planning. This helped to guide practitioners, and give them self-assurance about what could be included in support plans. In order to consolidate this it is important to maintain a culture supportive of 'thinking outside the box' into the future, particularly since the external broker has now moved on from this project.

- One of the most important issues reported was the lack of interaction between the care practitioners and the peer brokerage service. This is a major concern with the pilot, as it reinforces the view that some care practitioners acting as gatekeepers and deciding what is best for their clients. It also highlights prejudices within the service, both in terms of the services being offered to clients and the opportunities being offered to peer brokers. This is discussed in more detail below, but it is an area which must be addressed urgently, as without community or peer involvement in SDS it is less likely to be a self-perpetuating system, where service users can become reintegrated in their communities and move on the path to recovery.

#### *Brokerage routes*

This leads into the following aims of the evaluation which were to explore the characteristics of different brokerage systems and investigate the process of brokerage. The brokerage options available to service users were very limited in the first year, due to delays in setting up both an internal broker role and the peer broker role. Therefore all service users who were assisted in writing their support plan either received help from the external broker, their own care practitioner or one of the champions from within the care practitioner teams. This has limited the amount of feedback and comparison that can be made between the brokerage options, as each was at a different stage of development. However an overview of each of the routes is included, together with recommendations for the future of the brokerage role.

It was not possible at this stage to gather meaningful evidence as to the experiences of service users who self brokered their support plans; however this is a route which should be explored going forward with the service. It is expected that this will become a much more frequent route to SDS in the future as service users are encouraged to take on a greater role in the development of their support plans, and their well being. It would be prudent to follow up the experiences of this group, once a viable number of service users have adopted self brokerage, to build understanding as they navigate through the SDS application and implement their support plan, and ensure their experiences are not lost in the system.

### External broker

The external broker was crucial to the early stages of this pilot, as the experience and expertise this role brought to the process was invaluable. The presence of the external broker was welcomed by care practitioners and has served to build up capacity within the mental health teams effectively. The external broker worked with care practitioners in a range of ways, from offering advice and support, through leading practitioners along the process, to taking on the support planning responsibility entirely for some service users.

### Key findings and recommendations for future focus

- The external broker offered experience and an outside perspective on what could be achieved. This gave confidence and encouragement to the care practitioners in the initial stages of the pilot, to see what was achievable through SDS.
- The relative independence of this role enabled the broker to look at support planning from a different perspective, and also to act as an advocate for service users if necessary. This was a unique aspect of the external brokerage route.
- The broker was sited within the CMHT teams which facilitated good communication and helped in the aim of building capacity within the practitioner teams. However it also meant that the role was not as fully

independent as might have been expected. Insight into the politics and processes within the teams was beneficial to understanding the context in which practitioners worked, but could also be a hindrance in terms of being too involved in the decision making process.

- A small number of care practitioners withdrew from the support planning process entirely and handed responsibility over to the external broker. In some cases this was because of a fundamental mistrust of SDS, and in others due to time pressures. However, in doing this they did not gain any personal understanding of building support plans or how to move forward with SDS.
- There was a risk that care practitioners would come to rely on the external broker too heavily to influence what could be included in support plans, i.e. to view the external broker perspective as the expert perspective. Whilst this may have been expected at the outset of the pilot, it is important in the future, when using an external broker to help plan, to reassure practitioners that there is no right or wrong way to achieve positive outcomes. It is the service user who must be the focus of the process, not the process itself.
- The external brokerage route was not offered universally in this project, in part due to capacity issues as the pilot expanded, but also because some care practitioners were acting as gatekeepers. After the initial period referrals only came through one CMHT. However, it is important to allow the service users to decide (with support if needed) which brokerage route to adopt, once the options have been explained,
- The external broker offered extensive support to the peer broker organisation, both in formalising their own offering and in supporting them to build their expertise. This was invaluable in helping to provide a voice for the user led organisation (ULO), who found it difficult to find a route to be able to contribute to the process in an effective way. Without the support of the external broker it is unlikely the ULO would have progressed as far as they have, or developed the confidence to fully contribute to SDS.

- There are some concerns that introducing an external broker adds further complexity to the SDS process, and brings with it funding challenges. Also due to the unregulated nature of the function there are worries with respect to safeguarding service users [67]. Nevertheless, the external broker can offer a different perspective on SDS and due to their independence from the decision making process are able to act as strong advocates for their client if needed.
- The external brokerage option should be available to all service users as required, as it can offer an offer an independent perspective on support planning, and ensure impartiality in the SDS process.

### Internal brokers

The internal broker role was set up at the end of the first year of the pilot, and as such is still evolving in its scope and remit. As with the external brokerage service it has been well received by care practitioners and used for a range of activities from answering one off questions, through helping to support plan with other practitioners, to completing support plans for care practitioners.

### Key findings and recommendations for future focus

- As the internal brokers are care practitioners themselves, they have a good understanding of the culture and pressures which care practitioners operate under. This enables them to understand the SDS process fully and work well with their colleagues. However, this also means that they are not independent of the decision making and funding process, and may at times find it more difficult to advocate for their clients. In addition whilst the close working relationship with other care practitioners can afford greater background knowledge of the client they are working with, this can sometimes be a double edged sword, as it can lead to preconceived ideas about the person and the kind of support plan they need.
- The internal broker role has been implemented as an add-on responsibility, as opposed to a stand alone role. Therefore the brokers can be under pressure

to complete their own work, whilst taking on support planning activities for other care coordinators. This situation is manageable if the number of referrals to the service remains relatively low, however it cannot be sustained if this brokerage route is adopted by a larger number of service users. There is a danger that if the workload becomes too high the internal brokers will not be able to give the necessary time or focus to each support plan, and care practitioners may revert to traditional ways of working to save time.

- Internal brokers should be protected as far as possible from the inevitable tensions and politics which arise with any new implementation, as this can influence their brokerage role. There must be a recognition that this role needs to be as independent as possible, although it can be a challenge to remain uninfluenced by organisational factors.
- As a counterbalance to these dangers it is advisable that internal brokers are provided with an external source of support, where they can discuss their role and any issues which arise.
- A major concern was that the internal brokers were not working with the peer support group in any way. As with the care coordinators, they had very little interaction with the ULO, and were not aware of either their capabilities or strengths. This is a key area which must be addressed moving forward with the SDS scheme, and ways of working together more effectively must be explored.

### Peer brokers

The peer brokers have been very enthusiastic about SDS, and view it as a hugely positive move forward in services. Their role has developed as the pilot has progressed, and there have been several false starts and set backs in establishing this as a realistic brokerage route. However, working with user led organisations (ULO's), who may have different time frames and goals to established services, necessitates creative ways of working together to achieve positive outcomes.



The peer brokers have been through extensive training and this route is now a viable option. Nevertheless concerns still remain in this area as to nature of their involvement in the SDS structure and how to effectively utilise their skills

#### Key findings and recommendations for future focus

- The peer brokerage route can provide a unique perspective on SDS and support planning. They have grass roots experience of living with mental illness, and negotiating mental health services, and have a wealth of expertise and understanding to offer.
- There are clear barriers to the ULO's progression within SDS, in part due to prejudice and misunderstandings on the part of care practitioners.
- They were helped considerably by the external broker, who supported and nurtured them to develop their role. However as the external broker has now moved on from the project it is vital that they are provided this support from else where.
- It can be very difficult for small ULO's to work with the local authority, to have their voice heard and to understand where they can fit into the process if they are not party to the 'full picture'. It is vital that these opportunities are opened up to the ULO's, particularly as research has shown that peer support is a key factor in the continued success of SDS, and a major thrust in the coalition government's plans for the future of personalisation [3].
- The peer brokerage option is not being offered universally within SDS, and referrals have only arisen due to intervention and support from the external broker, Moving forward the peer brokerage option must be offered to all SDS participants, and an effective referral route established,
- Integration of the ULO in training and discussion sessions would facilitate greater understanding between all those involved in implementing SDS,

improve relationships and help to break down barriers to the inclusion of peer support in the range of brokerage options provided to service users.

- There was some question amongst care practitioners as to whether this ULO was the right one to be offering peer support to all service users. Some of this arises from care practitioner preconception, and should be challenged. However it does raise a valid point that service users have different needs for peer support, and that a range of options or links to other groups would be beneficial in this area.

### Community groups

There is a wealth of untapped support and expertise in local community groups and organisations which has not been explored during the SDS pilot, but is an area where links should be established in the future. Building strong communities is in line with the current thinking on 'The Big Society' [71], and capacity within these sectors should be tapped into where possible.

The next aim of the project was to map where and how users spend their resources.

### Database mapping

The 179 service users on the SDS pilot covered a wide age range from 18 to 79, with a median age of 40.5 in year 1 and 46.5 in year 2. The aim of the pilot was to recruit 60 service users to take up a Personal Budget in the first year; however the scheme proved so popular that by the end of year 1 over 90 people had joined.

The median spend for each service user was £3,976 in the first year, dropping to £2,989 in the second year as price point reductions were implemented (note the figures for year 2 were not complete when analysis was conducted and therefore may change). This compared favourably to the findings of the IBSEN study [8], which reported the median national spend on Personal Budgets in mental health services was £4,800. It is difficult to compare SDS spending with traditional service costs, as some of the people and services involved in Personal Budgets were not available

through other routes. However, it is unlikely that costs will have reduced significantly, in part because Personal Budgets are providing novel solutions to service users. Nevertheless, the positive outcomes achieved through SDS must be taken into consideration when looking at 'costs', as these can be seen as an investment in the future. By investing early in service user's well being and possibly arresting future decline in health there is a positive impact on further costs. Further by increasing community involvement and citizenship, the need for traditional services may start to decline more rapidly over time.

Mapping where and how users spend their resources, through the Pennine Care database, has enabled a picture to be built of where Personal Budgets can make differences to people's lives. The key areas include:

- Leisure activities / holidays (38%)
- Assistance with everyday tasks (29%)
- Home improvements / cleaning services (23%)
- Access to the gym or other sporting activities (21%)
- Computing and other electronic equipment (13%)
- Help to increase socialising (11%)
- Transport (11%)
- Education courses (9%)

Support plans have been developed to find creative ways of meeting user's needs, increase citizenship and bring them towards greater integration into society, a positive indicator for recovery.

#### *Commissioning and organisational issues*

There were a number of areas which arose from the research regarding commissioning and organisational issues within the SDS pilot, and these are highlighted below, together with recommendations for the future:

- The team involved in the SDS pilot were made up of health and social care staff under the joint agreement act, however, it was evident that at some

points in the pilot there was tension at the interface of the two organisations. The priority of SDS was not always aligned as this was a key thrust in social care, but was lower on the health care agenda. Levels of risk and flexibility of working styles also created some uneasiness in the teams, and management worked hard to ensure the team were successful in their outcomes. There were also some concerns from health staff that this new initiative had been thrust on them by social care, hence they were not fully on board with the pilot at the outset. This could be improved by better communication between health and social care functions to promote greater understanding of the ethos and culture in each.

- In addition the coalition government has strongly backed a move towards more integrated care for a number of reasons: to reduce costs, decrease duplication, enable early intervention and preventative care to be more effective and to increase personalisation of services [72]. Documentation indicates that the removal of barriers to working in a more integrated way will be facilitated, enabling a whole system approach to be embraced[2]. This fits well with personalisation in mental health services, where it can be particularly unclear to service users what falls under health care and what is social care. This may help to facilitate even closer working links between health and social care teams, although past experience has shown that integration at any level is not easy and must be worked at [47, 57, 73].
- SDS will bring about changes in the services commissioned by the local authority, including a possible reduction in block contracts for traditional services as clients move away from these areas. Although this has not been the case over the course of the pilot it is sensible to assume that personalisation will lead to a more diverse need for service providers and eventually a reduction in block services. This brings with it the need to ensure the right balance between services, and highlights the challenges in ensuring traditional services are still available for those who want them, whilst dealing with the complexity of working with many more smaller

providers [74]. Co-production of service requirements with service users, carers and communities will become more prevalent [5, 62].

- Commissioning should serve to foster and promote non-service supports, including families and friends, user led organisations, and community networks[46]. These links are key to consolidating social capital and building strong communities.
  - Build links with service users and carers to ensure co-production of support plans and services.
  - Help to develop and support user led organisations[65]. This is especially important now as the independent broker is no longer working on the project:
    - ULO's are often small with limited resources and incomes, and may just be starting out as an independent enterprise thus in the process of building their business management skills. Invest in capacity building and support business development.
    - Processes and goals must be made more accessible to partner ULO's, and simplify routes to inclusion.
    - Demonstrate backing and confidence in ULO, recognising the unique contribution they can make. Tackle prejudice and gate keeping by care practitioners.
    - Help to publicise the ULO and push the service – raise awareness amongst service users and practitioners.
    - Include ULO's in training and other staff activities to build bridges

- Ensure a clear focus on outcomes, not processes. Challenge and refocus where this is not the case.
- Ensure ongoing monitoring and review of services and outcomes to ensure service user needs are being met.
- Work with staff to nurture and support them in their implementation of SDS, in particular:
  - Continue work on safeguarding – support care practitioners to balance freedom and choice against risk and protection [6].
  - Support and encourage staff to believe in service user capacity and to give users ‘just enough’ support which neither abandons them, nor dis-empowers them from taking control of their own life.
  - Support staff to embrace the new culture, take risks, and be more equitable etc. (and not be afraid to talk about SDS).
  - Ensure good communication with all staff regarding the process and any changes to it – to foster high morale and facilitate connection with SDS.
  - Discourage gate keeping practices and prejudice amongst staff.
  - Encourage practitioners to offer SDS to all and to offer all routes to support planning – support practitioners by providing information and contacts.
- Strengthen information networks – develop database of available services and support. This is an area which is being addressed through the implementation of the Quickhart web based application which is being developed for social care service users in the local authority. However, this is beyond the scope

of the current evaluation, but it must be ensured that it can meet the needs of both service users and practitioners in providing pertinent information for SDS.

The Stockport SDS pilot has generated some inspiring stories of the changes service users have been able to make in their lives through Personal Budgets. Service users are positive about the move towards personalisation in the mental health services, and the expansion of SDS within the service is likely to be well received. However, as with any new implementation there are many challenges and new ways of working to adapt to, and these have caused some of the key frustrations within the project.

### **Conclusions**

The overall findings show that the Self Directed Support pilot has created an exciting opportunity for change in adult mental health services in Stockport. Despite the challenges faced in its implementation and execution, and the need for further development and consolidation, it can be seen as a huge positive step towards achieving the goals of personalisation which are a key thrust in social care.

The coalition government has consolidated its own investment in personalisation and indicated moves to expand the ethos within social care with the directive that all eligible service users should be offered a Personal Budget by 2013 [2].

There are already many care practitioners who have seen the benefits of Personal Budgets and are energised to push forward the agenda.

*“I think we have to move away from that traditional service. It hasn’t worked and it has kept people in services for years.”*

*“But at least we’re at the beginning and we’re trying. I think that that for me is what’s kept me going is, we’re at the beginning. Yes I made mistakes as everybody did at the beginning. There were things that were very, very unhelpful but at least we’re starting to look at it”*

The time is now right to embed Self Directed Support and Personalisation into all Care Practitioner thinking, and consolidate the commendable work started in the pilot.

Service users have been able to build support plans which have created inspiring outcomes, and changed their lives. The plans have enabled them to reconnect with their communities, build self esteem, self image and hope for the future and ultimately this has supported them in their move towards recovery.



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