Health and Social Care – Together is Better

Personalising a block contract

Research Report

Liz Wands-Murray

With contribution from:

Justine Pearce

Acknowledgements

We would like to acknowledge firstly the input into the report from the Supporting People Manager and the Mental Health commissioner, Together, the care co-ordinator and the service user in terms of their vital contribution to give a wider view of the challenges and positive outcomes from the work.

We would more importantly like to acknowledge and thank all the staff and service users from the provider, the commissioners that led the work, the mental health teams, and the management, as well as staff within commissioning and the Self Directed Support team, without whom the completion of the work would not have been possible. The focus has always remained the improvement of outcomes for individuals, but the cultural shift and work around processes is not to be underestimated, and without the dedication and enthusiasm of staff and those directly affected by the changes, then we would not have made the progress that we have.

Lastly, we would like to give a particular thanks to Together, for embracing the change in the light of potentially reducing their income through the lack of guaranteed block contracting in the vein of improving people's lives, and improving their role in supporting people effectively. Most of all, we would like to say thank you to them for keeping smiles on their faces through some very difficult times!

The People in Control (PiC) Programme is working to develop and create an environment where individuals can access information, products and services that meet their needs and a system of support where the citizen has choice and control of how they will live an independent life in Barnsley.
PiC has four projects which are Universal Information & Advice, The Barnsley Telehealthcare Centre, The Pathways Project and People Development & Social Response . These are designed to combine and deliver a system which supports people to be independent, in control and empowered to maximise their own health and well being.

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Background

Initially, as part of the transformation work in Adult Social Services, BMBC had employed a part time project manager to work specifically in the area of Mental Health and Self Directed Support. Although Barnsley had been part of the pilot and had been using individual budgets and developing personalisation to a high level for several years, there had been limited work done in the Mental Health arena, and it was identified that a dedicated officer would enable some focussed training, exploration of the challenges and barriers of working across the Local Authority and the NHS, and an increase in a personalised approach to delivery of services.

The initial results of this specific work resulted in a slow but steady increase in people using self directed support, and saw a rise from 15% to 30% of social care users in mental health services directing their own support within the first year of the officer being in post.
It became clear that in order to really move forward with this work and take it to the next level, it would be necessary to look at the assessment being used, look at the specific needs that people have, and at ways that real choice and control could be offered to a larger number of people. The obvious way to do that was to consider the large block contracts that were held with the largest provider in the area, and how it would be possible to encourage a change in the delivery of support for people.

It has been recognised that as part of the process used by care co-ordinators to put support packages in place, there has been possible tendencies to place people in potentially inappropriate services rather than those people have no service at all. Often there has been limited information given about the expectations of the support and there has been a lack of 'outcome focused' intervention and guidance from staff. Historically, there has been a lack of onus on care co-ordinators to put outcome focused support planning in place with a focus on recovery. Lack of information about available alternatives, lack of ability to be creative within the process and lack of funding for non traditional/statutory services and support has previously limited individuals and care co-ordinators in terms of options for planning packages with people. Linked to this there has been a lack of feedback from providers around working towards and achieving individual's outcomes, and a lack of demand for this information from commissioners. However, the system of self directed support and Individual Budgets allows this creativity, flexibility, and a focus on outcomes, and therefore offers a more progressive system for individuals

The provider that had the largest number of service users traditionally provided community based floating support through two block contracts. The project was based on unpicking the two block contracts that JCU held with **Together**, a community based mental health provider in Barnsley.
The contracts were split into a Partnership in Action contract, and a Supporting People contract. In total there were 91 units (89 people) utilising around 380 hours per week of support across these two contracts.
There were a small amount of these people (approx 15) who already had an Individual Budget in place (virtual) which included the hours in their package of support.

Plan & Objectives

As mentioned previously, the project was based on unpicking two block contracts with the provider. The work would assist in looking at the financial stability of both sources of funding over the coming financial period. As a result of the cuts in funding, there was a demand to make savings on both block contract spends, and it was hoped that this work would enable the choice and control for service users without reducing the quality of support, or a reduction in support for those who needed these levels of support on an ongoing basis.

Objectives

The project was expected to achieve the following objectives:

- Transfer the majority of service users onto an Individual Budget
- Remove the need for the large block contract
- Ensure outcome focused packages of support to be in place
- Give clarity to the provider around the nature of their support
- Give wider choice and control to service users
- Enable commissioning to consider funding directions/reductions
- Enable clarity around appropriate funding stream for service users
- Give evidence of financial forecast for service user group
- Develop working methods for Individual Service Funds
- Develop a single joint Mental Health Community Support contract
- Develop an appropriate Virtual Budget agreement
- Develop joint specifications for a single joint Mental Health Community Support contract
- Develop fit for purpose payment processes
- Develop monitoring and reporting processes focused on outcomes and recovery

The long term aim of the project was to ensure that the service users have the maximum choice and control over their package of support, and that the provider has enough information and guidance to work in an outcome focused way with service users. This in turn should potentially minimise the amount of time needed in service, and achieve better outcomes for people. The result of that will be a higher throughput of service users gaining independence and promoting social inclusion.

The other main long term aim is for commissioning to be contracting services in a more individualised way, moving away from large block contracts.

In order for this to happen there were several other pieces of work that need to be completed:

- Working methods for Individual Service Funds
- Single joint Mental Health Community Support contract and specifications
- Virtual Budget agreement
- Payment process
- Monitoring and reporting processes
- Joint contract review process

The project was then separated into four work streams:

- Paperwork
- Contract Management
- Process
- Consultation

As this was designed as a project, adhering to Prince2 project management principles in line with the Local Authority approach to project work, it was recognised that each work stream would have work packages within it, and each work package would have a person responsible for ensuring the work was completed in a satisfactory manner. There were dependencies between the work streams, and these would be discussed at regular intervals through the project governances. There was also a high dependence on Mental Health professionals completing work with service users in order to ensure that we were able to reach our project targets. The support and motivation needed for implementation would be part of the work the project would need to pick up, and monitor.

It was also identified early on in the planning stage that BMBC was to be part of the trailblazer for Right to Control, and it was vital that this project worked collaboratively with the integration work being done as part of Right to Control and jointly funded budgets.

Methodology

Designing an Integrated Assessment and Resource Allocation

The integrated assessment was based on the format of the original assessment being used which was for Social Care funding, & focussed on FACS eligibility. Through consultation with Supporting People, Social Care and Mental Health staff, it was expanded to include area's that were felt to be lacking in the original assessment or were needed to be expanded to include housing related need. It also covered the eligibility issue. Supporting People funding is not a FACS eligible funding stream, and caters for those who would traditionally fall into 'Low' and 'Moderate' categories within FACS, so would not be eligible for support funded through Social Services. A resource allocation system was then designed to accompany the assessment and used the original RAS, taking into consideration the cost of Supporting People funded services currently available in the market, and the level of support needed to meet particular needs around housing related support. These extra allocations were attached to the additional domains within the integrated assessment. In some domains the need could be either Social Care, Housing related, or a combination of both, and clear guidance was also produced to guide practitioners in how to allocate appropriately at the point of calculating indicative allocations.

Through the integrated assessment and the RAS, it was possible to identify needs in specific area's, and assign the correct funding stream to each. Obviously there was some cross over, and a section after each domain asked for information about the nature of the need, and the current support given in the specific area, in order to ascertain whether it was Social Care, Supporting People, or a combination of the two. If the information was not sufficient to make this judgement, further information would then be sought from the individual and the worker involved in the assessment.

When looking at the amount of support needed, and comparing that to the cost of providing that support (calculated on an average of the charges providers in the area made for the support), the decision was taken that the price per point for Supporting People would come in line with the current price per point given for Social Care Funding. As an added bonus, this also helped to ensure that there was not confusion when calculating the Indicative Allocation for each individual.

Data Analysis

There was a wealth of information available about the services currently provided through the block contracts in terms of hours delivered. However, there were some discrepancies in terms of review timetables, and a lack of personalised approach to the support delivered. This was due to various factors, including the provider not being given copies of an individual's care plan, the individual having received the service for a long period of time, review's being overdue, a lack of motivation from both the service user and staff to put packages in place with an outcome focus, or not being based on a recovery model.

However, Together were extremely motivated to adapt their business model to provide a more flexible service, and to be able to work with people with Individual Budgets, whether that be virtual budgets, direct payments, or individual service funds. Together were also aware from the start of the process that there was a likelihood that they would lose some service users to other providers as well as through natural turnover, and that there would be a reduction in income for them in the immediate follow on from the work. However, this would have been the case anyway, as the reduction in the contract amounts coincided with this work as part of the budget cuts, and this would have had an impact on the amount of money within the contracts.

As packages of support for people were and are constantly changing, a snapshot of what was being delivered at the beginning of the year was taken, and this is now used to give a comparison to the changing landscape following the project work.

Moving forward

Firstly a pilot of the integrated assessment was carried out, and subsequent training sessions with the staff on completing the adapted assessment were delivered.

A session was then arranged with staff, presented by the Project Lead, the Mental Health Commissioner, and the Supporting People Lead to explain the intentions, breakdown the work involved, clarify the responsibility for work packages, and the intended outcome of the work. It described why the work was to be undertaken to help build sponsorship and ownership of the work within staff teams – focussing on the positive outcomes for service users as the main directive. It was also stressed at this point what it was ***not*** about, and that it would be vital to maintain levels of service appropriately, not withdrawing any service where a genuine need was identified.

It was known that all those who currently part of the two block contracts would need to be assessed using the integrated assessment which would ensure we had a clear picture of each individual's specific needs, appropriate funding streams, and the package of support being lead by the individuals themselves. It was also identified that there was a possibility that not all of the individuals receiving service would be able to complete the assessment, as due to the nature of mental health illness they may be in crisis, or too ill to complete the assessment, but they would still have the need to receive ongoing support. This would potentially be an issue in the future in terms of providing support at short notice to those in crisis who are new to service. An initial 3 month period was given as the timeframe for completing the assessments and plans for the people who would move into directing their own support.

It was then ascertained that people were falling into one of four categories:

Individual Service Fund	*People who completed the integrated assessment, and used their IB to purchase support from any provider based on an Individual Service Fund model*
Virtual Budget	*People who completed the integrated assessment, and used their IB to purchase support from any provider based on a virtual budget, where Social Services continue to manage the financial side of the budget*
Inactive Virtual Budget	*People who completed the integrated assessment, but were not able to write an entire support plan in timeframe, so were given information about their allocation, given choice and control over how the money was used to purchase support, and the changes would be reflected in their care plan until they were able to write a support plan*
Block Contract	*People who would not currently be able to complete an integrated assessment, so it would not be possible to ascertain specific needs, or related funding streams at this point. They would continue to receive service, with long term intention of completing an assessment and moving over to an IB as soon as was feasible. Also a provision for those coming in to service who had an immediate need for support prior to being assessed, and who would switch over to an IB as soon as the necessary process had been worked through.*

There were a proportion of people who were part of the last group where the issue was around the timeframe available for completing an assessment and a support plan, and it was felt that it would be preferable to have a longer timeframe available to work through the process with them, meaning that they would move fairly quickly from one category to another in the months following the initial piece of work.

Other factors

As well as the nature of changing packages, there were several other factors that affected the number of packages of support/individuals being delivered.

These included the Right to Control Pilot, which would potentially result in more service users being identified for eligibility for both Social Care funding and Supporting People funding, putting a further demand on the funding for those who had community based floating support identified as their appropriate service.

Secondly, as part of the Local Authority drive to deliver equity across all service user groups, a piece of work had commenced within the Fairer Contributions team to look at all those in Mental Health that could be liable for contributing towards their support but were not doing so at the current time. There was a recognition that this may result in a number of people withdrawing from service due to not wishing to contribute towards packages, and this needed to be monitored through other avenues, but was analysed regularly in relation to this piece of work. It was identified however that it would only affect a small amount of people, as those who are Section 117 would not be liable to contribute towards their package.

There was a recognition that the reduction in the budget itself, combined with the very real possibility that people would withdraw from service due to fairer contributions would mean that there was likely to be less people drawing on the funding by the end of the work than at the beginning of the project.

Assessment & Planning

Following the session with staff, a timetable was drawn up for assessment and planning for all those currently receiving service on the block contract. The staff embarked on these assessments, and regular support was provided through the project officer while these assessments were carried out. The project worker also assisted in terms of completing the resource allocation following assessment to ensure that the funding was being distributed appropriately to the person according to their needs.

It was expected that a large number of people were likely to select the same or very similar packages of support as the ones they were receiving currently. The staff, and the provider were given some guidance on how to help people think about what they wanted from their support as part of the planning process, whether that be with the same provider or an alternative one.

The vast majority of service users chose to have their care co-ordinator complete their assessment with them, and the same for writing their support plan. A small number chose for the provider to support them with both parts of the process, and the care co-ordinator was involved from a professional point of view.

A timeframe of 3 months was given to assess and plan with the majority of service users. This was a large piece of work for care co-ordinators and the Mental Health teams, and was also timed to coincide with a review of all services delivered from the Purchasing Budget so that people would not be subject to more than one review in the 6 month period, and this would, for most people, tie in with when they would be due for review anyway, or would have been reviewed as part of the budget review.

There were also a portion of people that were receiving service through the Supporting People contract, and had been discharged or stepped down from Mental Health Services previously. This meant that they had not been subject to the 6 monthly review timetable, and some had not been reviewed for some time. As some of these were not now part of Mental health services (although they had been in the past), review of those people was undertaken via the provider. Ordinarily, Supporting People contracts would only be reviewed in terms of reviewing the provider rather than the individuals, so it was normal practice for the provider to oversee the review process for the individuals. As a result of the re-assessment of all the service users, there were two who were identified as needing referring back into mental health services as their needs had increased since their discharge from service. The subsequent planning for those individuals was then undertaken by the assigned care co-ordinator.

As part of the normal process for approving and reviewing packages, a Resource Allocation Panel is held every 2 weeks in Mental Health. The panel at that time included NHS staff such as Mental Health Team leaders, the Lead OT, and staff from Social Services including the Mental Health commissioner, the Project lead, and Head of Mental Health Services. Most of the packages that were part of the project came through this process, the majority of them between 3 and 5 months into the project. This included those that were to remain part of the block contract at that time, as they were part of the normal review schedule.

Once the vast majority had been through the reassessment, written a support plan or had their care plan expanded to be more outcome focussed, and then subsequently been through the Resource Allocation Panel, it was then known what packages would be provided via Individual Budgets.

As the block contracts had been paid through ordinary payment processes within the Local Authority, and those that had Individual Budgets already in place were paid via invoicing direct from the provider, a more uniform system was needed to ensure that payment was simplified and transparent. It was decided that as Supporting People already had a system (SPOCC) that was straightforward, and that providers were familiar with, that it would be this system that would be used to make payments on behalf of individuals direct to providers.

It was also decided that the two 'pots' of money would be combined into one 'Community Floating Support Fund' (CFS). As the CFS was designed specifically for people who would like community based floating support, a service expectations document was put together to address what would be covered by the fund, and more importantly, the expectations on the provider when packages were paid from this fund. The document concentrates on the delivery of an outcome focussed support service which encourages development of skills in identified areas, fosters an approach of enabling service users to achieve and work towards their personally identified outcomes, and promotes a recovery focussed model. As this piece of work was specifically around Mental Health, a recovery focussed model was the preferable approach. If this work were to be reproduced with other service user groups, it would be important to concentrate on an outcome focussed approach, but there may be less focus put on 'recovery'.

The document was shared with all the teams, and with all the providers that may possibly support people with mental health problems in the community. It replaced any contracts that were in place previously, but there is still an expectation that providers use this document as their 'contract' with the Local Authority. As the services develop, and people start to make a wider variation of choices around the use of their Individual Budgets, it will be vital to keep this as an evolving document that changes as the consumer market changes.

The payment on behalf of each individual for their support package commenced following the majority of people having come through the process, and having their Individual Budgets in place. All those who are part of Mental health services are now back into the normal review timetable, and will have their packages reviewed every 6 months as a minimum, with reassessment to address changing needs recommended every 18 months at a minimum. If people's needs change at any point, then that would also trigger reassessment, regardless of where they are in the timeframe of review.

Those that are not part of Mental Health services are reviewed on a similar timetable via the provider. All these people are monitored through the Resource Allocation Panel, and via commissioning. This monitoring includes changes to packages, and monitoring of the budget spend.

Challenges

As the first piece of work to be completed around unpicking of a block contract, there were many challenges, and lessons to be learned to take forward in subsequent work around other contracts held within commissioning with all service user groups

Workload of staff

As all the service users required an integrated assessment, this presented a large demand on staff, compounded by the short timeframe . The work was reliant on these staff being able to assess and plan with all the service users, and it would not have been possible to complete the project without this input.

Motivation of staff

There were some challenges around staff understanding, ownership and sponsoring of the work. Extensive training and the availability of support was crucial to enable staff to feel ownership of the work, and to fully understand the focus behind the work, primarily giving service users more choice and control than they had previously. A culture of dependence building and a paternalistic approach to service delivery challenged the expectations of the project, and although this has been a common challenge with any work around personalisation and self directed support, it remained a risk to the project being delivered in a way that promoted the values of choice and control. Traditionally, particularly in Mental Health services, there has been some scepticism about service users leading their own support, and huge concerns around the risks associated with transferring ownership of recovery to the individual. Managing this required a large amount of support from all angles, and sponsorship from management in order to ensure the changes happened in a meaningful way. These are things that are common challenges in change management, and were managed through ongoing support, consultation with staff at all junctures, and if necessary, directives from management to help ensure the work was completed in the timeframes and to a high standard.

Payment processes

Setting up and managing the payment process involved meeting with all the providers that would be potentially providing community based floating support, liaising with the finance department to ensure that the systems were adapted accordingly, a large amount of work from the IT part of the Supporting People team (who manage the SPOCC payment system), and close working with the Project officer to ensure that the data was accurate and set up in a manageable way. These back office systems were a vital part of the work, and it would not have been possible to complete the project to a satisfactory conclusion without a system that allows management of a large amount of payments to various different providers on a regular basis. Reconciling the payment system on a regular basis remains a challenge the team grapple with, although it is hoped that experience and time will iron out some of those issues.

Understanding from service users point of view

Although sessions were held with service users prior to, and as part of the process, there was a heavy reliance on staff to be able to explain the self directed support process, to complete the paperwork (assessment and support plans), and to generally guide people through the process. Together had a good knowledge of Individual Budgets, and outcome focussed approaches to working, and this additional knowledge and sponsorship from them helped to guide people through the process in a meaningful way, to ensure the focus was kept, and that people felt the ownership that they needed to. There was, however, varying quality in the amount of support and information shared with service users, and one of the lessons learned will definitely be an increase in this kind of work at the beginning of the process, with potentially less onus on the staff to deliver that support and information. Alternatively or additionally, improved training and support for the staff may have enabled them to do that more effectively. By the nature of people, it is impossible to ensure that every staff member has extensive knowledge needed to answer all possible questions. It may have therefore been useful to have assigned 'experts' within each team that received extensive training and support in order to then provide that support within teams that is more tailored to each individual team. As the Project Officer was not employed full time and was also involved in other work, it sometimes meant there were periods of time when queries would be held up, and by having those team based experts, it would have broadened the availability of specialist knowledge and help.

Management of data & budget

As packages are constantly changing, it has proved an ongoing challenge to manage the ever evolving data, and ensure that providers are paid correctly at all times. However, this would be the case with any setting up of individually based model of service delivery and payment. It is somewhat compounded by the shorter review period of 6 months in Mental Health, as opposed to annually in other disciplines.

Management sponsorship

There was a strong commitment to the work from commissioning, and from Supporting People, as well as the Self Directed Support team within the Local Authority, and this was vital in order to get the permissions needed and the support for the work. Sponsorship was also needed from NHS management, and there were other factors influencing their ability to focus and support the work including the imminent introduction of the clustering tool (PbR), budgetary challenges faced at the time, and the recognition that NHS staff would be required to do a large amount of the work at a time when understaffing, and extremely large caseloads were already putting a strain on staff. However, the developments as part of the project were fully supported when needed and the impact of the lack of involvement had a minimum effect. However, another lesson learned would have been to involve NHS management more, and at an earlier point to aid more ownership throughout the work. More awareness raising and training for NHS management may have also helped with that sponsorship.

Budget challenges

Due to cuts in funding there were already existing challenges in the management of the budget, particularly around supporting the same amount of people with a smaller pot of money. There were also challenges around having a separate funding pot from the Purchasing budget, and managing the prospect of those who were currently funded from the Purchasing budget for community based floating support, but were not part of the original group on the block contract subsequently becoming a pull on the CFS pot. The timeframe for this transition has been extended in order to manage it more effectively from a financial point of view.

Preventative vs FACS

One of the major implications of pooling two funding streams together was the eligibility issue in relation to the fact that Social Care funding is for those who are FACS eligible, whereas Supporting People funding is designed to meet a lower subset of needs. The Supporting People Lead was very keen that this preventative focus was not lost in the pooling. The service expectations document was written to ensure that it covered these issues, and the integrated assessment was designed to assign importance appropriately. However, it became clear when analysing the actual spend in comparison to the assessed need in the different domains that Social Care monies put into the put did not sufficiently cover the liability of FACS eligible need, and that in fact the Supporting People contribution was effectively shoring up the spend, outstripping its actual liability for funding Supporting People related need identified in the assessment. For this reason, the decision was taken to allocate a percentage of the overall budget specifically for Supporting People only budgets, for those who are not FACS eligible but have Supporting People related support needs. There will be a need to address the shortfall in the Social Care contribution in the future.

Indicative Allocation vs spend

It became clear once the majority of assessments had been carried out that the indicative allocations resulting from the assessment were commonly higher than the current spend on the service users. If all service users had utilised their entire allocation, there would have been a serious overspend to contend with. Luckily the majority of people chose packages that were very similar (hours wise) to their previous packages, and some, as a result of outcome focused approaches to planning actually reduced their packages through the process. This potential issue highlighted both the need for effective and accurate assessment of need, and the possibility of work needed around the price per point as part of the resource allocation system to tie in with the budgetary envelope. This is possibly a direct result of a reducing budget, and the challenges of providing the same level of support with less money. It also highlights the need for further work with providers in the market to charge equitably and realistically in line with the support provided, and presents a challenge for them to be able to provide a high quality level of support at a price that Local Authorities can afford to pay. This is obviously not contained to this particular project, and is a challenge faced throughout Social Services at the current time as a result of the financial climate. There are several directions of work in other service area's in Barnsley looking at some of these issues, and it would be hoped that as this work progresses more lessons can be learned about how to work effectively with both staff and providers.

Effective planning

One of the things that became very clear, especially in light of the point made above, was that effective planning with service users had a massive impact on both the quality of support, the quality of the outcomes the individual identified, and the effective spending of budgets appropriately. There was a clear distinction between the outcomes and approaches used by some staff in comparison to others, and this in turn had a direct impact on the quality of plans being produced. It also had an impact on the quality of the experience for service users. As part of this, a lack of knowledge of options on the part of the worker and the individual meant that plans were not necessarily as varied or creative as they could have been. This combined with the institutionalised approach to receiving services that exists in the culture of both staff and service users resulted in a large number making little or no change to the structure of their packages.

Market knowledge & competition

One of the issues when looking at varied planning was the lack of knowledge of what was available as alternatives to the currently received service. This was partly due to lack of knowledge within staff teams, and partly because providers have not traditionally needed to market themselves, meaning that knowledge is often word of mouth. There is also a recognition that it cannot be expected for all staff to know about all providers in the market. Therefore a more specific way to address that would be to have specialised resources that allow both staff, and individuals the tools to be able to look at their options, and consider a wider selection of solutions to meet their needs. Barnsley are currently addressing these issues as part of their Universal Information and Advice project, and there are plans to include this type of information in the tools as part of that project, as it is identified as one of the deliverables in the future. However, this was not in place at the time of the project, so proved to be a real barrier in terms of varied planning.
The lack of competition within the local market also caused some problems, as ideally a wide choice of providers offering varying types of support and methods of delivery would have provided more of an actual choice than was possible in the current local market.

Assessment & review of Supporting People only clients

It has been the intention, as mentioned earlier in the report, of delivering some Individual Budgets to those that are Supporting People eligible but not FACS eligible. However this has highlighted some capacity issues around the assessment, planning and review of these clients. It has not been part of the Supporting People remit in the past to be involved in this part of the process, as it has always been part of the contract with the provider that they perform this function, therefore resulting in a need to consider how this will happen in the future. It can be argued that by asking a particular provider to assess, plan and review that it is possible that this…….

- could adversely affect the outcome of support planning through intentional/unintentional influence for example not working within an outcome focussed approach
- could challenge the objectiveness needed in planning
- could result in inaccurate assessment of need because of lack of knowledge and understanding of assessment
- could result in inaccurate assessment of need because of the provider having a financial incentive to increase packages
- could mean providers not feeling empowered to take positive risks with people

- would mean that commissioning would have an additional function of monitoring and reviewing the quality of assessment, planning and reviewing for each individual that the provider was carrying out
- would affect the quality of planning dependent on the providers ability and knowledge to refer into appropriate statutory services following assessment
- would affect the quality of planning dependent on the providers knowledge of other available providers and types of support
- would have a financial impact in terms of paying providers to carry out this function
- may result in inadequate representation for the service user when reviewing

However, the other side of the issue is that if these functions are not carried out by the provider, but through internal functions ie Supporting People staff, there are huge resource issues. There is no separate funding available for this specific function, and so this cost would most likely need to be met through the funding stream, meaning a reduction in the amount of money available for direct support. It would also have training implications, as there are no staff qualified or experienced in assessing and planning with individuals at this current time, so staff would need to be employed and trained accordingly. Whichever option is explored will have financial implications. A separate research paper discussing these issues is available.

Specific project support

Because of the volume of organisation, and ongoing support needed throughout the work, it would not have been possible to complete this work without dedicated staff. This results in the need to recognise that any further work in the future would most likely require some dedicated officer time to ensure that timeframes and quality levels are maintained. Commissioners felt that the work would not have been possible without the Project Officer to lead the work, and keep abreast of ongoing issues.

Benefits

The main benefit of the work has been for those individuals who are now directing their own support. By going through the process of a supported self assessment, there has been an ability to work with individuals to help raise insight into their needs. By considering their own personal outcomes, they have been able to identify what is important to them and for them, and then incorporate that into their support plans. One comment from a service user recorded that ' I have never been asked what is important to me, and what I want to do to help manage my illness before'. Because of the tendency previously to 'prescribe' support packages, this has represented a huge shift in the ownership of outcomes, and recovery to the service user.

Although some staff have struggled with the transfer of responsibility to the individual, and the positive risk taking approach needed, others have truly embraced the opportunity to work with people differently, and in a more person centred way. This has resulted in staff that feel they more fully understand the value and focus of personalisation and self directed support, and this in turn will enable them to incorporate those learned skills into future work with individuals.

Although small in number, there have been a proportion of service users that have moved to a different provider that is more suited to their needs, and therefore are now being provided with more appropriate support. This represents a higher quality of support, not because the previous provider was not providing high quality support, but because the new provider is set up to support particular needs more effectively. As a result of setting up the new CFS pot, there have been two examples of people who had previously been in residential/low secure settings utilising the pot to gain and maintain their own tenancies with the appropriate support included in their package. Although these two people were not part of the original block contracts, the nature of the Community Floating Support pot has allowed them to go through the Individual Budget process, access both funding streams in one package, and have a package that meets their needs outside of a residential type setting.

There have been benefits for the providers involved in terms of their ability to support Individual Budgets, both through the payment processes being set up, and their ability to provide more flexible services. This change to their business model has been partly as a result of the support they received through this process, and the providers motivation to be part of the work. They have also commented on the heightened quality of information they receive now about each individual as a result of having copies of the support plan, where previously it was not always possible to gain such a detailed level of information. This in turn has also ensured, because of the support plans being written in an outcome focussed way using a recovery based model, that they are able to provide much more focussed support for people. They have much better clarity about what they are being paid to do with each person. This results in a higher quality, more effective and appropriate package for the individual.

It has been possible through the work to highlight the process and the value of self directed support to a wider audience, and it has helped to raise awareness within service user groups and staff groups. As an aside, it has also helped to raise awareness and understanding of Supporting People funding, and its function. It has helped to expand the thinking of staff, and to highlight people where this funding and types of support attached would be more appropriate. Although this has meant that there is a larger demand than previously for this type of funding, this has allowed the Supporting People budget to be utilised across a larger group – more people for the same money!

In terms of management information and targets,

- the amount of people now directing their own support within Mental Health is now at 85%, mainly due to this piece of work.
- the amount of people has remained fairly static despite an 11% reduction in the budget (some natural wastage has occurred but only 1 person is known to have withdrawn from service because they did not want an Individual budget)
- the amount of people now receiving a jointly funded budget of both social care and supporting people funding has risen from 0 to 50
- a small proportion of people have chosen to reduce their packages as part of the planning process, in recognition of a recovery focused plan
- a small proportion of people have reduced their packages in the months following their individual budget commencing as a result of better quality, more focussed support
- a proportion of those who have jointly funded budgets have also completed a Right to Control form as part of the assessment process, meaning they are legally exercising their Right to Control, raising the number of people that are part of the trailblazer work being completed elsewhere

How was it for the provider?

The Together Barnsley service was extremely keen to have the opportunity to work on this project and support the work of the JCU. This enabled us to be one of the drivers in ensuring that Personal Budgets within mental health became a reality across Barnsley. Being part of this project from the beginning also ensured that we could work alongside Service Users to ensure that they understood the process; felt supported throughout and most importantly remained in control.

We had recently, due to Public Sector cuts taken a 25% funding cut overall, yet were still required to provide the same number of support hours. We decided to restructure the whole service and look at what would be required of us as a service in the future, and this project gave us the opportunity as a provider to become more autonomous and innovative whilst modernising the service to meet changing needs and the Personalisation Agenda. Due to the cuts, the team had experienced a pay restructure and change in role, some had taken voluntary redundancy and others were considering this option. The previous role of support worker was replaced with Community Wellbeing workers to reflect a more personalised and person centred service and this role still continues to change over time as we respond to new requests and adapt to the changing needs and demands of our new purchasers.

We decided to invest heavily in the staff team as part of a transition programme and sourced externally a combination of coaching and training for all the 24 staff members in the team. It was considered that the programme should have two main deliverable outcomes and assist "Together" to manage socially responsible organisational change taking into account staff wellbeing, maximising flexibility and to assist staff to work with service users in a more personalised and creative way. The C.E.C .S model was used, a coaching model based on:

Connect

Working with the team to connect and to give space for viewpoints to be aired and working out any realistic concerns, positive contributions and crucial decisions to take back to the management team. Gain an understanding of their current position and plan for how to use future coaching sessions.

Explore

This is where the team look at current and future opportunities for themselves, the service users they support, and the organisation, highlighting what choices and available actions can be made and what the effect of those choices and actions would be.

Create

Take the learning from the connection and exploration and apply it in attitudes and actions in or out of the work place. Create understanding of past experiences, current position and future changes that will be made.

Share

Take the learning and actions and share it between colleagues and service users creating standards for practice, creating a different approach for further change. Continue to share personal development through practice and supervision.

We then had 3 further days understanding the ethos of Personalisation and where we were as a service:

Exploring

- The current personalisation environment - whilst looking at our own organisational environment - highlighting areas that would be effective and areas for improvement
- Our own organisational identity and how that feels in the current climate, looking at how it is shaping up to meet the personalisation agenda
- Scoping the organisations shared values and how this ethos is related to this new way of working
- A capabilities and skills framework of matching current strengths in the organisation to operate in the current climate as well as looking at training needs for the future
- An action plan of what needs to be done and what we want to do in the future
- A coaching circle to provide a timeline framework of how to take this forward.

Whilst these internal measures were in place to support and increase skills within the staff team we were looking at the completion of the self assessment form and received Support Planning training from a member of the SDS Team. In addition to this, 5 staff members accessed more comprehensive brokerage training, with the view that they would then be able to mentor other team members through the process, add momentum, and bring additional experience. Towards the end of these sessions Together also held a joint Personalisation workshop for service users and staff.

Copies of the self assessment form were taken out to service users who had indicated that they would be happy to go through the process, and Together Staff started to have conversations with service users, supporting them to identify and think about their goals, aims and aspirations for the future. The self assessment forms then went to the appropriate Care Co-ordinators so that they could complete their assessment of the service users needs. There was initial resistance from some Care Coordinators at this stage and this significantly delayed the time scales, but was out of our control. As the process got back on track and service users were advised of their indicative budgets, some team members were asked to support plan at the request of the service user.

Ideally service users would complete the plan themselves, but many requested the support from their individual support workers. We received some negative feedback from some professionals at this time, as they did not think it was right that we as a 'service provider' carried out this role, even though we were only responding to the request of the service users themselves. An example that I feel important to share is of one gentleman, who's indicative budget was higher than his current support allocation, and even though he initially decided to purchase more support hours from Together, he was actually supported by his worker to think about other ways of supporting his mental wellbeing. He eventually continued with his original support hours, and bought a greenhouse to develop and pursue his love of gardening. We believe that *who* writes or supports an individual with their support plan should be the choice of the individual and no one else. Initially the Together team supported service users to write their support plans, but as time has gone on this role appears to have been taken on more and more by Care Coordinators.

Throughout this time we continued to look at the future model for Barnsley and worked with service users to redesign the service and the way in which it was delivered, including producing new marketing material that is directed toward a far wider audience to support mental wellbeing. The new model included more extensive group working at the request of some service users, and a small group of service users decided that they would like to use some of their support hours for social activities and outings, deciding they wanted to pool their resources and buy the support of one worker to maximise their support hours, increase social interaction and support their own wellbeing and recovery. Unfortunately this was frowned on by some professionals who thought that support should only be provided on a 1:1 basis, dismissing the choice that individuals or groups were making in directing their own support! This has still to be addressed.

Another issue we faced was that previously on the block contract, travel was always included for service users who did not use public transport for one reason or another. However most individual budgets do not include an amount for travel unless this is an assessed need, therefore individuals themselves now pay an amount per mile should they wish or need to travel in a workers car during their visits. We initially thought this may be problematic in terms of the work we do around social inclusion, motivating, encouraging or supporting people to engage in their community. However service users were accepting of this, and have reported that it provides them with opportunities and therefore a sense of control over where and how far they travel. One lady particularly likes the fact that she can now travel further afield to access new opportunities and increased community resources. Sometimes public transport is used and on other days the lady decides to travel in a workers car and receives an invoice for the miles travelled at the end of each month. Another lady quickly took to directing her own support and will contact us on a Friday and plan her support for the following week, picking which Wellbeing workers she wants to support her with different elements of her support plan on particular days, again using public transport during longer visits.

We also have some self funders who choose to purchase the service themselves. Some choose to top up their support as and when they require us, others not in receipt or eligible for a individual budget purchase support directly and may ring requesting support later that week or that afternoon. As a personalised service, we certainly have more autonomy and are able to support the wellbeing needs of other groups or individuals within the community.

Internal structures had to be developed quickly to support the project and the way in which we monitor the service. We developed spreadsheets for each individual service user with a budget, detailing all support hours delivered, banked and miles travelled. Most service users chose to have virtual budgets and one service user has an Individual Service Fund, but has control of their travel budget and pays for travel via their monthly invoices. We developed a new invoicing system that is far more personal, contains less jargon and explains clearly how to send payments. We changed record of visit forms so that they contained information on mileage for each visit, so that service users can sign to agree distance travelled at the end of each visit. We developed a contract that has a cancellation period of one week's notice for holidays, as if an individual decides not to use their hours one week we will have already put a staff member in place. We did not initially have anything other than one cost per hour, but as individuals request bank holiday support, we have had to reconsider this as we pay staff appropriately for bank holiday working. In line with other providers, we will soon be implementing an hourly rate that reflects bank holiday working. We also have to show the hours that have been banked by individuals, this may be due to hospital admission or a holiday for example.

Some individuals have chosen to bank hours over time, saving them up for a particular event. Large numbers of banked hours are hard to manage in terms of staffing and require an extremely flexible staff team who are prepared to work weekends and unsocial hours. We now have a staff team that can provide support any time of day 365 days a year.

The "Together Drop In" is an important Community resource especially for people who are not FACs eligible, and it now receives funding for only one afternoon. However we have managed to keep it open for two afternoons a week through constant fundraising initiatives carried out by service users, volunteers and staff. We also introduced a nominal charge for attending the Drop In, and it is still well attended and valued. Other positive results have included the increased recruitment and retention of peers and volunteers supporting individuals who may not be eligible to receive an IB, but need low end support and preventative work. This has resulted in volunteers and peers working alongside paid staff to facilitate the "Together Drop In", arrange trips and group activities for service users, or offer 1:1 support. We have also developed a 'Befriending service' after consultation with service users, who expressed that there was a need for such a service. There is constantly a high demand for this service, and we are keen to develop more opportunities for volunteers to become befrienders in the future. We are continuing to build peer volunteers within the service as we believe that one of the most powerful ways to help is through peer support. It is about people with lived experience supporting each other in their wellbeing journey through similar experiences and insight. Such a system of mutually giving and receiving help is founded on respect and shared responsibility. Receiving peer support leads to increased self esteem and self confidence, a sense of belonging, and motivation to learn new skills. Some people are even using peer support to overcome problems that traditional services have not helped with.

We still have concerns in terms of Support Planning. Any service user has the right to request support with writing their plan from whom they wish, and should be able to support plan with an individual, except where the person is responsible for holding the overall budget. The plan should also be accepted in different formats, it maybe a written plan, a plan presented in drawings or a DVD. And we are keen to see more individuals creating plans in different ways. The role of the support planner is not to make the choices, but to find out about the individuals life, their needs and wishes, and offer options and possibilities. All the plans have to be passed at a panel, and service users and staff report back that what is being looked for within the plans does not appear to allow for creativity and is only 'passed' if the plan is extremely task orientated. They are not, and were never set out to be care plans. They were developed and sold as a very personal document about someone's life, their goals, aims and wishes for the future, staying healthy, safe and well, and maintaining their wellbeing and dignity, living their lives how they chose to. Most Care Co-ordinators have worked closely with service users and ourselves and the best support plans still tend to be those where a variety of people, at the service users request, have had some input.

We have been very fortunate in that most service users who now have a budget still chose to receive services from Together. Some of the reasons service users tell us they continue to use the service are:

- We listen to them
- We respect them as individuals
- They have received a good quality service from us in the past
- Staff are well trained and experienced within Mental Health
- We understand
- Together doesn't feel like a Mental Health service

However we cannot become complacent and will continue to work closely with service users, other individuals, groups, professionals and partners within the local community to see what services are needed now, or may be needed in the future. We recognise that we can offer and provide so much more if we take time to listen to people's experiences and how they feel their wellbeing, recovery and outcomes can be achieved.

This project has been a really steep learning curve for Together and we acknowledge the support from Commissioners, and their ability to keep an open mind throughout. They have been supportive of us as an organisation and there is acknowledgement of some of the resistance and problems we have encountered along the way, and support for us in continuing to challenge issues still being encountered by service users. We recognise that Barnsley is committed to the Personalisation agenda and know that we all still have a long way to go and much to learn. We believe that in order to provide excellent and seamless services to support the needs of local people, we all need to start working more closely and developing and building stronger partnerships for the future. This will enable us to be more responsive to the changing needs of our community, and in turn deliver more cost effective services that people actually want to use or be part of. This is how we will support good quality services that meet the changing needs and required outcomes of local people, thus ensuring that Barnsley services remain fit for purpose and sustainable in the future.

Justine Pearce - Together

...ow was it for the care co-ordinator?

As a practitioner within a mental health team I found that, on balance, the process was beneficial to the service user and mental health services. In the beginning there was a lot of confusion and practitioners not wanting to take part in the process. I believe this was mainly due to the idea of change in practice, no clear benefits to the service user, and added paperwork. As the training rolled out it was clear that some practitioners were enthused, and some continued to ignore the issues. Eventually it was apparent the process was not going away, and the team mangers were very clear that practitioners needed to work with the process instead of fighting or ignoring it. I believe that due to the ambivalence of some workers, this meant that service users had different experiences and perceived ideas (service users do talk to each other!). Some of the service users were keen to look at new ideas and the possibilities seemed endless, others refused to work with the process. For those who embraced it, they had clear ideas on the benefits to them, but unfortunately for some, it was about increasing their support because that was what they wanted. This sometimes was in conflict with the assessments of need, which in many cases was looking at a reduction in support. For those who refused to engage, some were told they must or the service would stop. This was very stressful for practitioners and broke down therapeutic relationships.

The idea of a service having objectives and outcome measures, which for years was 'just delivered' was alien to service users, and to some practitioners. It felt like this was a process of proving they were still ill or deserving. It was very difficult to help service users see the benefits of this new way of working. Sometimes it felt like it would be easier to agree and collude with the service users, carers, and provider. However because of the real drive for recovery focused services, and the constant TV coverage over the lack of services and money, the drivers for change were obvious to me and the other parties.

The introduction of Fairer Charging in mental health was a real help. It made the real cost of services apparent to the service users and myself as a practitioner. Once the service users were contributing, they demanded more from the services they received, and questioned the benefits they were getting. The idea of the service being time limited and outcome focused had a higher value; it did not seem to be about being deserving or undeserving of a service.

Some of the main issues I faced, apart from the work with the service users and carers were:

- Lack of choice of providers
- Mixed messages from the resource allocation team
- The development of innovative ideas, but for them to be 'too innovative' and then not approved (slow cultural shift within resource allocation)
- Other workers reluctance to give service users choice and responsibility

Eventually some of the service users I worked with did embrace this process and are now more attuned to outcomes ie what's in it for me? They are also able to express their choices. It has given them the power to 'sack' providers or threaten to go elsewhere. However, for some there has been no change and some don't want change.

I have seen the real benefit for people. The change was very quick once it got started, it was sometimes confusing for practitioners, and this anxiety and frustration can be picked up on by the service users. I believe this shows the need for practitioners to understand processes and work within change, and focus on the benefits - not the added work.

How was it for the individual?
Tom's story

Tom was originally receiving support from the Assertive Outreach Team in Mental Health services, and 6 hours per week of support from Together. The support was part of the Supporting People Contract, and although Tom was FACS eligible, his primary need was housing related following a stay in registered residential accommodation.
Tom's needs were primarily around managing a tenancy, and daily living skills.
He was also at risk of people exploiting him, so was a vulnerable adult. A combination of family support, support from AOT and support from Together have in the past, and continue to provide the safeguarding from that risk through the support they provide.
Tom had the chance to think about his aspirations, which he was supported to identify as part of the support planning process, and he looked at how he could gain confidence, make more friends, get out more, join some groups, and remain in independent living.

Tom's needs, as documented in the integrated needs assessment were in the following areas:

- Personal Care
- Eating & Drinking
- Daily Living
- Maintaining Housing Commitments
- Safety & Security
- Support with Finances
- Wellbeing
- Community & Relationships
- Work & Learning

Tom felt that in some ways his support had been quite restrictive up to the point of the integrated assessment and chance to be involved in his planning.
Tom worked with his worker, and the worker from the provider to write his plan.
It was identified as part of that process that there had been a limit to what Together could support Tom with previously, due to the restriction of the single funding stream, and the care plan that had been written with only consideration for some of his needs, rather than his whole life holistically.
Tom considered:

- separating his support, continuing with Together to meet his Supporting People related needs and consider another provider to support around his Social Care needs
- using Together, but expanding the remit of support, and meet both all his needs through a jointly funded package
- changing his provider, or looking at a Personal Assistant

Tom decided that he did not want to consider a direct payment due to his lack of ability to manage finances, and there were no one-off purchase requests as he felt that his needs would be better met through ongoing low level support.

It was identified that part of his support would be around managing medication, and appointments. This role had previously been done by the MH AOT team, and would now become part of his support package. There was also an identification of Tom's desire for the provider to become more involved in the safeguarding side of his support, allowing the MH team to take a step back, and to help Tom to work on understanding and embedding structures and safeguards into everyday life. Shopping, which had not previously been included would also become part of his support. Areas he was already being supported in, such as managing the tenancy, and paying bills would continue.

Tom identified that he had an established support relationship with a worker at Together, and that he would like to continue to pay him specifically for his wider reaching support. He therefore chose to continue using the same provider to provide his integrated, jointly funded budget, but negotiated with the provider that this was with a particular support worker for the majority of the time.

Tom has felt that he outcomes of the plan have been very positive for him. He has maintained his tenancy using the support, which had not been possible previously. His previous attempts to live independently had failed, and Tom feels that the increase in the scope of the support has meant that it has worked much more successfully for him this time.

The ability for him to negotiate with Together and the nature of the more flexible support has meant that if any changes or tweaks to the support are needed, then Tom is able to vocalise and manage that effectively. The AOT team have been able to take a step back from responsibility for all areas of his support, and this has started to shift to the provider and the support package in a way that means Tom can start to take more ownership of his support and work on the areas he would like to take full responsibility for at some point in the future.

Tom says that he has met new people because he is now accessing a drop in clinic with support from Together, and this has also helped with giving him more confidence and increased self esteem.

He feels that he is slowly but surely having a better life, and that the support works much better for him than it did before.