A RESPONSE FROM THE SCOTTISH FEDERATION OF HOUSING ASSOCIATIONS

SCOTTISH GOVERNMENT'S CONSULTATION ON SELF DIRECTED SUPPORT: DRAFT STATUTORY GUIDANCE ON CARE AND SUPPORT

July 2013

1 About SFHA

1.1 As the national representative body for housing associations and co-operatives in Scotland, the SFHA welcomes the opportunity to respond to the Scottish Government's consultation on the draft statutory guidance to accompany the Social Care (Self-directed Support) (Scotland) Act 2013.

1.2 Housing associations and housing co-operatives in Scotland own and manage 47% of the country's affordable rented housing stock. This represents almost 280,000 homes across Scotland, concentrated in some of the poorest communities in our country.

1.3 Housing associations and co-operatives have been working to provide, manage and maintain housing throughout Scotland since the 1960s and have a track record of making a significant contribution to improving housing for the people of Scotland.

1.4 There are some important and distinctive features of housing associations and co-operatives. They are:

- Independent businesses with goals aligned to the Scottish Government in providing and managing high quality affordable accommodation and housing services;
- Responsible for accessing and managing public and private resources;
- Managing our businesses, not to make a profit but using resources imaginatively and inventively to benefit housing and communities;
- Accountable to our members, who live or have other interests in the communities and places which we create;
- Publicly accountable and thus regulated given our use of government resources;
- Able to demonstrate value in terms of care and support, wider role and financial inclusion;
- Adaptable to changing circumstances.

1.5 Housing associations and co-operatives are diverse organisations at different scales, with different histories, purposes and goals. They collaborate in different ways with each other, with the private sector and with local authorities, according to their particular business imperatives. They share practice and collaborate on issues related to support provision under the auspices of the SFHA through the housing support group.

1.6 This response has been developed following consultation with members involved in delivering care and support across Scotland.

2 Introduction

2.1 'Support' for the purpose of the Self Directed Support Act, relates to community care services (p 70 of Guidance) under the Social Work (Scotland) Act 1968. Some housing associations deliver supported housing services which consist of housing management and support services. The likely impact of Self Directed Support (SDS) on such services is currently unclear. Whilst the costs of housing management can be distinguished from support, there may nevertheless be elements of the support service which would be difficult to disaggregate on an individual basis e.g. in a hostel where an element of the support provided relates to personal security arrangements. It would be helpful to acknowledge that accommodation based services may involve some housing related support services which it would not be appropriate to disaggregate for the purpose of SDS. The response to the draft guidance set out below is based on an assumption that SDS applies to the longer term care and support needs of individuals rather than short terms needs for accommodation and support typically provided for through emergency or short term accommodation based services. This issue is dealt with in greater detail below in our response to Question 4 in the consultation.

3 DRAFT STATUTORY GUIDANCE ON CARE AND SUPPORT

Section 2 – the person's support pathway

3.1 The steps of the pathway are clearly explained and easy to understand. We note, however, that there is no indication at which stage an individual financial allocation is made. The sequencing of this step is significant in ensuring that supported people are not financially penalised through the selection of one of the options.

Award of a different hourly rate dependent on option selected

3.2 There are currently significant differences between the hourly rates awarded/paid for support. [1] Direct Payment (DP) rates (set by the local authority) are usually low; in one local authority the rate range is £9 to £12.50. This is based on an assumption that those taking a DP will be employing a personal assistant. In practice, however, the majority of DPs are currently spent with a provider.[2]

3.3 Outsourced services (private and voluntary sector) are awarded a range of rates (usually above the DP rate) and in-house local authority service provision usually attracts the highest hourly rates. This is most likely due to the costs of public sector

[1] CCPS (2012), *Hourly Rates for Care and Support*. Available at http://www.ccpscotland.org/assets/files/ccps/publications/FOImainreportCCPS2%20(4).pdf (accessed 11th July 2013)

[2] Scottish Government (2012), *Self-directed Support (Direct Payments), Scotland*. Available at http://www.scotland.gov.uk/Resource/0040/00402717.pdf (accessed 11th July 2013)

staff terms and conditions, conditions which are no longer reflected in the voluntary sector due to ongoing downward pressure on hourly rates.[3]

Procurement and commissioning based on hourly rates

3.4 Although SDS places a welcome focus on outcomes (and a move away from hourly rates) it is important to recognise that care and support services are still being commissioned and procured on an output (hourly rates) basis. If supported people are to make their choice of option on the basis of the degree of choice and control they want to have over their resource, their choice must not be influenced by concerns that they will get a lower budget through selecting options 1 or 2 over option 3. Similarly their choice of type of provision must not be influenced by concerns that they may get a lower allocation if they choose outwith directly provided services.

Section 3: Values and Principles

3.5 The three newly proposed best practice principles are well-chosen and helpful and the definitions of all eight principles are clear and understandable. The principles could inform discussions around the review of the National Care Standards. This section could also include a link to SSSC codes of practice. http://www.sssc.uk.com/Codes-of-Practice/sssc-codes-of-practice-for-social-service-workers-and-employers.html

Section 4: Eligibility and Assessment

Eligibility

3.1 The description of eligibility criteria is helpful and the explanations of the respective roles of the professional and the local authority are easy to understand. We welcome the fact that the guidance states local authorities should 'publish its eligibility criteria in a clear and transparent way' as that will be one way to drive fairer application of the criteria. We also support what the guidance says in relation to local authorities taking a strategic approach to determining eligibility criteria, involving users, carers and key partners and doing this within the context of a broader framework of prevention, early intervention and support to carers and universal services.

3.2 In the experience of members, however, current practice does not reflect the draft guidance and the operation of narrow eligibility criteria which focuses on people with acute needs is widespread. This acts as one of the biggest barriers to people getting preventative support and seriously undermines the good intentions behind the legislation and guidance.

3.3 The guidance could usefully remind local authorities in paragraph 25 of the guidance that: 'they must conduct an Equality Impact Assessment when reviewing, or making

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[3] Cunningham, I (2011) *Employment Conditions in the Scottish Social Care Voluntary Sector: Impact of Public Funding Constraints in the Context of Economic Recession*. Available at http://www.ccpscotland.org/assets/files/Employment%20Conditions%20Report.pdf (accessed 11th July 2013)

changes to, their eligibility criteria' and include a reminder to make the criteria transparent by including the statement: 'Eligibility criteria should be made publicly available in an accessible format.'

Assessment

3.4 We would wish the guidance to state more strongly the importance of involving the right people in assessment, in other words the professional should involve anyone that the supported person wishes to be there (e.g. carer, support worker, advocate). While the inclusion of the exchange model of assessment is helpful here, wider involvement could be further highlighted.

3.5 Whilst the guidance acknowledges that providers may have an 'important role in the assessment and support planning process' when setting out the use of the term 'provider' on page 8, the actual sections dealing with assessment (section 4) and support planning (section 5) makes few references to the role of providers. These sections would be improved by acknowledging the role providers may play, depending on the wishes of individuals, in supporting a person during assessment and working with them to identify outcomes and develop a support plan.

3.6 The section on further assessment does not mention timing, which is a major factor. While there would be clear negative consequences to suggesting waiting times, the statutory guidance could stress the importance of a timely assessment, i.e. that an assessment should take place as soon as practicably possible while also giving the supported person sufficient notice of when it will take place.

Section 5: Support Planning

3.7 It is welcome that the guidance refrains from being too prescriptive about support planning and instead outlines the 'key ingredients' and stresses that every support plan will be unique to the supported person's individual circumstances and linked to their assessed needs and agreed outcomes. The table of 'key ingredients' in the guidance is helpful.

3.8 As with assessment, we think it is important to emphasise that other people can and usually should be involved in support planning (providers, carers, advocates) as long as it is the informed wish of the supported person. We would like this section to build on the description of providers on page 8 by acknowledging the role providers may play, depending on the wishes of individuals, in developing support plans and adjusting elements of support plans as required between reviews.

3.9 Providers have reported that a common problem with support planning is that it is often completely disregarded when circumstances change. For example, if a supported person is allocated a new social worker they are sometimes forced to 'start from scratch' by creating a new support plan. This is particularly a problem during transitions when good outcomes work may be abandoned after a person enters adult services.

Risk enablement

3.10 There is evidence that people receiving support often feel that risk management is imposed on them: 'risk is often perceived negatively by people using services (used as an excuse for stopping them doing something) – but risk needs to be shared between the person taking the risk and the system that is trying to support them.[4]

Balancing duty of Care and Risk

3.11 There is often a tension between the local authority's Duty of Care responsibilities to meet assessed needs (support with eating, bathing, dressing, personal care tasks, 'life and limb support') and the supported person's expectation for support to live a full life. Providers would therefore suggest an emphasis in the guidance on the risk to the supported person's human rights (particularly those cited as principles in s.1 of the 2013 Act.

3.12 The link between risk enablement and having a sufficient budget is closely related to this. Enabling a supported person to take positive risks whilst minimising risk to their human rights requires a sufficient budget for quality support and care. Allocation of 'life and limb only' budgets lead to supported people having to withdraw from meaningful activities; social interaction and, in some cases, employment.

3.13 Risk assessments should be about forward planning and putting in place support and help in advance of a crisis. Options 1 and 2 under the Act give the flexibility to identify and set aside resources for crisis. It is important that supported people have confidence that, where this is agreed, the resource will be made available. Local authorities should take this resource into account during review to ensure that it is not inappropriately "clawed back".

3.14 It would be useful to have a fuller description of 'proportionate response' in the guidance.

[4]Glasby, J., (2011*), Whose Risk is it Anyway? Risk and Regulation in an era of Personalisation,* published by the Joseph Rowntree Foundation. Available at http://www.jrf.org.uk/sites/files/jrf/personalisation-service-users-risk-full.pdf (accessed 11th July 2013.

Resource

3.15 Paragraph 47 of the draft guidance sets out a strengths-based approach to resource allocation that is welcome in its focus on strengths rather than needs. However, this approach must not be used as a cover for the cutting of individual budgets in the expectation that informal (i.e. .free) support will cover shortfalls in the supported person's package.

3.16 Paragraph 48 of the draft guidance states that all allocation of funding (regardless of method) should be done in a fair and transparent manner. We suggest changing this to "the authority should determine the supported person's funding by fair and transparent means." This still allows selection of method by the local authority but does require them to adhere to the core principles of ethical resource allocation (fairness and transparency.)

3.17 Concern has been expressed as to how local authorities communicate their resource allocation methodology. Experience from England [5] suggests that local authorities may be reluctant to share their methodology for a number of reasons. To avoid this reluctance we suggest the following addition at paragraph 50 of the draft guidance:

"In the interests of fairness and transparency the local authority should publish their resource allocation methodology, and how this methodology was developed on the local authority website."

The choices that must be made available to the supported person

3.18 The descriptions of the four options are clear and easy to understand. We are grateful for the inclusion of the line 'the resource can remain with the local authority or it can be delegated to a provider to hold and distribute under the individuals direction' in the description for option 2. This reflects the Ministerial commitment given to doing this at Stage 2 of the SDS Act parliamentary process.

3.19 It is helpful to clarify that local authorities retain the discretion to refuse support and that the supported person should be clearly informed of the reason their support choice is being refused and of their right to complain.

[5]Published by the London Self Directed Support Forum. Available at http://issuu.com/londonselfdirectedsupportforum/docs/making_personalisation_work_-_feb13 (accessed 11th July 2013)

Section 9.4: Direct Payments

3.20 The section on direct payments is clear and easy to understand. The guidance clearly states that a person can use a direct payment to purchase services from a provider organisation and the description of a third party direct payments service is also welcome.

Question 14: Financial costs and benefits

3.21 Whilst it is not possible to identify the costs of SDS to providers with any degree of accuracy, it is nevertheless possible to identify the likely areas of costs. These include:

- Changing financial systems from block to individual invoicing;
- Potential increase in bad debt/ cost of handling non payment;
- Increased costs associated with recovering local authority care charges (some areas have passed this onto providers which we feel should be guarded against as set out below in the response to Question 1 in the consultation;
- Financial destabilisation of support services during the transition to SDS;
- Increased development costs incurred by providers as they re-model services under SDS.

4 DRAFT REGULATIONS

Question 1: Calculation, payment and termination of direct payments

Local authority charging policies and SDS

4.1 Local authorities can charge individuals for services under the 1968 Act and are urged in the guidance (p.69) to decide how to apply charges to support packages under SDS. The guidance could usefully set out an expectation that local authorities publicise how it intends to charge under SDS before SDS is implemented.

Charging

4.1 The regulations allow a local authority to conduct a financial assessment after a person's direct payment has been set up and allows a local authority to ask for repayment of part of any previous payment made. The regulations could usefully urge local authorities to avoid such situations by conducting financial assessments in a timely fashion. This would allow an individual to appraise their options more effectively before support is put in place and promote informed choice (a statutory principle underpinned by Section 1 of the 2013 Act). The guidance could highlight this in Section 4 and Section 5.

4.2 The guidance and regulations do not say who collects any charge the local authority makes. Some local authorities require housing associations support providers to recover care charges from the people they support. This is confusing for supported people and may destabilise the relationship between the provider and the person. Where the provider is paid net of the care charge and the person defaults then the provider may wait up to 9 months to recoup the lost monies from the local authority.

Question 4: Restricting access to direct payments for those who are homeless, those who are fleeing domestic abuse or those who require support in relation to drug or alcohol addiction.

4.3 The general view of providers is that anyone has the potential to benefit from a direct payment if (a) it is the best solution to their individual circumstances (b) a person has the ability to manage a direct payment and/or (c) a person has access to the appropriate support.

4.4 Supported people seldom fit into neat service 'categories'. Many people have complex, multiple needs (e.g. both problematic alcohol use and a mental health problems.) This could lead to a situation where a person has a restriction on part of their budget; or is excluded from taking a DP where one of their needs relate to homelessness or problematic substance use. Some types of domestic violence services (e.g. refuges) and some support for homeless people (e.g. hostels, temporary move on accommodation) may not be suitable for direct payments. This is primarily to do with the stability of services designed to support people in a crisis where accommodation is a key part of that crisis support.

4.5 There is some interest in exploring another way to describe the 'split' between what was ineligible for a DP on the grounds of the function of the service (e.g. crisis support) not the group of people supported. This is for three reasons:

(a) The question of meaningful choice – when people are in crisis, choice and control may not be meaningful and indeed might increase their sense of stress and overwhelm. Using the common analogy of choice in the NHS, it isn't meaningful to give people a choice of A&E's when they have broken their leg; however it might be meaningful to award a direct payment for them to arrange their rehabilitation support;

(b) Crisis or acute services could be significantly destabilised by the use of option 1 leading to a gap in services for supported people;

(c) Crisis or acute services are often the sole provider of a niche service (e.g. non-statutory mental health crisis support) there is a question of what alternatives are available to the person in crisis should they take the DP.

4.6 This approach would mean that a homeless person living in a hostel and then moving into temporary accommodation with support would not be offered a direct payment but could be offered a direct payment once they have moved into settled accommodation and longer term support needs are identified.

Question 5: Restricting access to direct payments for those using long term residential care

4.7 The regulations use the term 'residential accommodation' and it could usefully explain that this means 'long term residential care'. Rather than restricting access to direct payments, those housing associations involved in delivering long term residential care have highlighted that there could be good reasons to offer direct payments for long term residential care:

- There will be wide variation in the personal outcomes of people in residential care and for some people, taking a direct payment will be the best route to meeting those outcomes. The similarity in age and need to live in a residential setting does not mean that each older person wants to participate in the same activities.
- Direct payments could help to provide a route out of care homes and back into the wider community as people grow in confidence and experience.
- Direct payments could help to create a mixed support package of part time residential care and care at home.
- Direct payments could be used to arrange personalised meaningful day activities and connect with friends, relatives and the wider community.
- Direct payments could be an option for younger adults who may be placed in a care home (e.g. in an emergency) designed for older people to explore alternatives.

- Direct payments would be compatible with residential care opening up services to non-residents and integrating further with the wider community.

4.8 An unintentional effect of the restriction on offering direct payments for residential care beyond 4 weeks is that a person would lose an existing direct payment and could find it more difficult to move onto a more independent living arrangement.

Issues to consider if long term residential care were to be subject to direct payments

4.9 Members delivering long term residential care have acknowledged the complex funding arrangements associated with such services involving the national care home contract, free personal care and NHS funding. If such services were to be offered under direct payment arrangements, further clarification about the interplay between these financial elements which would need to be provided.

4.10 There are various baseline costs associated with residential care which remain fixed regardless of the level of support required for individuals. Typically these costs relate to the accommodation, building maintenance and utilities and minimum staffing levels. If individuals are to be offered direct payments for residential care, these baseline costs should remain out of the scope of the direct payment to ensure financial sustainability of the service. Activity related elements of the service as well as care and support associated with higher levels of need are more suited to disaggregation for direct payments.

4.11 Implementing direct payments in long term residential care would require some re-modelling and re-development of services. A phased introduction could assist this process rather than a blanket approach being taken to all existing and prospective residents.

Conclusion

4.12 Housing associations welcome the introduction of self directed support as a means of further promoting personalisation of services. The guidance usefully sets out the values and principles underpinning self directed support and sets out the Government's expectations about how local authorities will put it into practice. This response has highlighted some areas in the guidance which could be clarified further in the interest of service users and housing association providers. It has also addressed some issues around charging and exclusions from direct payments set out in the regulations.

SFHA

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