Self directed support learning exercise evaluation

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1.0	20th September 2009	Initial draft by Nick Horn
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Contents

Short Summary

Areas of success

Brokerage has been a great success with both staff and people receiving services stating that it has helped with setting up their support plan. The response from those in receipt of the support is that self directed support has increased dignity in their daily lives and increased the level of control over their support.

There were differences in brokerage with council brokers being quicker than non-council brokers, likely due to them being full time and having previous experience. This is not all positive as these previous care managers may have attended with pre-conceived ideas for solutions rather than determining what the person who requires the support wants.

Both brokers and care management staff are clear about their roles and responsibilities but both agree that communication with the other group needs to be improved.

Personal budgets allocated through the Resource Allocation System ranged from £40 to £870. There was an average of £22 a week left over from each allocation.

In the learning exercise the average cost of external home support sourced by brokers was lower than that procured by the council. This may be down to cherry picking for the best prices on behalf of the providers.

The use and cost of personal assistants has made a big impact by improving the flexibility, control and type of support that people receive. The average hourly rate for a personal assistant (PA) is £12 an hour compared to £20 for Oxfordshire County Council (OCC). Of the 11 people out of 55 with completed support packages who have hired a personal assistant as part of their support, 4 were in addition/ working alongside recognisable home support provider companies. The remaining 7 hired PA's as their sole means of home care support.

33 of the 57 cases which have been implemented have elected to receive their budget through a direct payment.

Areas where improvement is needed

Paperwork is still perceived to be too much by the care management staff. It is also acknowledged that the interim I.T. arrangements that are in place at the moment are sufficient to manage the current number of clients, but once the project is implemented across the county the current measures will not be able to cope with the increased numbers and data. The emphasis on the systems review is how do we implement self directed support with sufficient I.T. support.

The development of self directed support for people with mental health issues needs to be continued.

Executive summary

Oxfordshire County Council Social and Community Services directorate has tested the model of self directed support and personal budgets in the north of the county between December 2008 and September 2009.

Background

The Government introduced a major change programme for adult social care in December 2007 called: *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*. Its aim is to "replace the paternalistic, reactive care" by developing "person centred planning and self directed support… through individually tailored support packages supported by the allocation of personal budgets". To take forward the Putting People First agenda in Oxfordshire, a self directed support project was set up in May 2008. Phase one of the self directed support learning exercise began in the Cherwell district on 1 December 2008. This expanded to the entire north of Oxfordshire region (following the Integrated Care boundary) on 2 March 2009.

The aims of the learning exercise were as follows:

- To test and fine-tune an assessment tool and resource allocation system that will work for the majority of clients within existing funding.

- To achieve a demonstrable change in the way that social care is delivered which promotes choice and control for the service user.

- To achieve a demonstrable change in the marketplace.

In March 2009 Kate Linsky, an independent consultant, was engaged by the self directed support project team to provide a framework for the evaluation of the SDS learning exercise. Her evaluation model as illustrated below has been the basis of this report.

In May 2009 it was recognised that the number of people being processed through the self directed support model was lower than initially predicted. A pilot was devised to assess the possibility of "fast-tracking" potential users of social care through the self directed support process. Those chosen were people who had contacted social services and were awaiting an assessment by the Adult Assessment Team in the north of the county. Brokers were asked to support people who were awaiting a formal assessment by conducting a "Life Check" visit and providing services such as: information, advice, signposting and requisitioning some of the council's single internal services.

Numbers

It must be mentioned from the outset that any conclusions are based on a small set of results. Early calculations estimated that 325 people would have received support and had their support plans implemented through the self directed support process by the end of August 2009. In fact only 158 people have been assigned a personal budget in the nine months of the learning exercise with 55 support plans having been implemented. There is no single reason why the numbers are so low; Swift reports indicate that numbers are an accurate reflection of the number of people who have been assessed and that no one has been bypassing self directed support. Some hypothesised reasons, anecdotally collected are: that the project has failed to get sufficient buy-in from staff; leading to new behaviours not being adopted which are required to drive the learning exercise forward and in-turn resulting in staff possibly bypassing the self directed support approach for more traditional care management approaches.

However, there is sufficient data to recognise early trends and identify differences or issues in the model trialled and it is these trends which are discussed below.

Clients and Carers

Overall, clients and their carers were happy with the outcomes achieved to meet their needs and the self directed support process that they went through. This was echoed by staff who felt that self directed support was making a discernable difference to people's lives. Brokers were specifically highlighted as providing a positive experience and everyone interviewed felt that receiving a personal budget and support in this way had increased the level of dignity in their daily lives. Where self directed support was perceived to not have made a difference were in the areas of relationships and the perception of safety both inside and outside the home. Everyone participating in the process agreed that too many people were involved, something that the future model for self directed support hopes to address.

Brokerage

Five stages of the self directed support process were measured:
- The time taken for referral from operational staff for an indicative personal budget
- The time taken from the budget being calculated to referral for brokerage
- The time between the case being referred to a broker and the support plan being produced
- The time between the support plan being produced by the support broker and the sign off by a care manager
- The time from sign off by a care manager to implementation of services.

The production of support plans through to implementation took on average 44 days which is far longer than originally expected and also misses the national indicator target of 28 days by a large margin. There was a statistical difference between council brokers and non-council brokers, the former producing support plans more quickly, which is hypothesised to be down to experience levels; council brokers have had involvement with the generation of care plans (which may have led them to thinking about support based on contact assessments and budgets before meeting people) and were brokering on a full time basis, both of which may have provided additional experience to generate support

plans quicker. There was no difference in brokerage for the Life Check pilot possibly due to it being a new experience for all and the fact that preparation was difficult before visits as needs were often not known. Communication between brokers and care management staff was highlighted as an issue on both sides with suggestions of joint visits and meetings and a clearer understanding of respective responsibilities being recommended as ways of resolving this problem.

The Market

The biggest shift in the market place is the employment of personal assistants, with 11 of the 55 cases reviewed using a personal assistant in some capacity.

Personal assistants on average work out £8 an hour lower than existing care providers. In most cases the support brokers were able to procure home support services for a lower rate than the average price paid by the council from the same provider. In many instances the brokers were able to obtain a rate that was lower than the minimum price available to the council from the same provider during the same period.

Budgets

The average annual budget allocation for older people (including those with mental health issues) was £13,089 a year. Once a support plan had been generated the average amount remaining unspent was £22.64 a week or £1,177 a year. This is linked to both the sourcing of better hourly rates by brokers and the use of personal assistants at a lower rate than current service providers.

60% of all budgets were allocated as a direct payment. This is in line with the national findings, but what makes it interesting is that the majority of people receiving a personal budget as a direct payment in Oxfordshire were older people. The IBSEN report (Individual Budgets Evaluation Network, Glendinning et al, 2008) is based on the findings of mainly those with learning disabilities, physical disabilities or those with mental health issues.

Our findings are generally consistent with national findings by IBSEN; who undertook the evaluation of the initial pilots of individual budgets from 2005 to 2007 and the *Putting People First: Measuring progress report* (May 2009).

One of the big issues that has become apparent as the learning exercise has progressed is the need for improved information technology support. The interim IT arrangements that are in place at the moment are sufficient to manage the current number of clients, but once the project is implemented across the county the current measures will not be able to cope with the increased numbers and data.

Although more work needs to be done on communication to staff regarding the processes, overall the picture is positive with early indications that brokers are providing a service which meets the needs of those they are helping support; facilitating people to have more choice and control over their support, leading to improved wellbeing and dignity in their lives and costing less than in-house services.

1   Purpose of this document

The purpose of this document is to report on the findings of questionnaires, reviews, pilots and workshops undertaken in conjunction with external agencies, Oxfordshire County Council employees and those who use social care services following the trialling of self directed support (SDS) in the north of Oxfordshire. This report will highlight good practice, identify areas that are perceived not to have worked and provide information that will help to shape the future model of self directed support in Oxfordshire.

2   Introduction

2.1   Background to the implementation of self directed support

The post war baby boomers are now approaching retirement leading to the first major demographic shift since the 1940's. The number of people aged over 85 is set to double in the next 20 years. This, accompanied by a change in the life expectancy of British citizens, is set to put increased pressure on social services which is estimated to have a £6bn deficit in funding by 2025 (National Statistics dataset, 2003).

In 2002, life expectancy at birth for females born in the UK was 81 years, compared with 76 years for males. This contrasts with 75 and 69 years respectively in 1970. Projections suggest that life expectancies at these older ages will increase by a further three years or so by 2020[1]. People can now expect to spend up to a third of their life over the age of retirement, while younger disabled people are living further into adulthood and therefore require support for longer. The average age at death of people with Down's Syndrome increased from 25 years in 1983 to 49 in 1997 while people born today are expected to live into their 60s.

The principles of choice and control started in the learning disability community and came to prominence with the government white paper: *Valuing People: A New Strategy for Learning Disability for the 21st Century*, published in 2001. The key values of rights, independence, choice and inclusion lay at the heart of the proposed changes. It soon became apparent that people, now used to the choice, control and flexibility offered by the

internet and 21st century living, wanted such things to apply to the care that is designed to meet their needs.

These principles of choice and control will now be applied to other areas of social care. The Government introduced a major change programme for adult social care in December 2007 called: *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*. Its aim is to "replace the paternalistic, reactive care that is of variable quality with a mainstream system focussed on prevention, early intervention, enablement and high quality personally tailored services" by developing "person centred planning and self directed support… through individually tailored support packages supported by the allocation of personal budgets" (Putting People First, 2007) . There is no new legislation relating specifically to self directed support. It will operate within the current legislative framework; the system will need to be consistent with a range of legislation and guidance that forms the basis of how adult social care is delivered in England.

To take forward the *Putting People First* agenda in Oxfordshire, a self directed support project was set up in May 2008. Phase one of the self directed support learning exercise began in the Cherwell district on 1st December 2008. This expanded to the entire north of Oxfordshire region (following the Integrated Care boundary) on 2nd March 2009. The aim of the learning exercise was to test a model of self directed support.

On 2nd July 2009 Joanna Simons, the Chief Executive Officer of Oxfordshire County Council, announced that the council had to make efficiency savings of nearly £90 million over the next five years. Consideration therefore needs to be given on how self directed support can contribute to these efficiency savings when it is considered as part of a larger infrastructure change.

2.2   Aims of the self directed support learning exercise

The aims are as follows:

• To test and fine-tune an assessment tool and resource allocation system that will work for the majority of clients within existing funding.

- To achieve a demonstrable change in the way that social care is delivered which promotes choice and control for the service user.

- To achieve a demonstrable change in the marketplace.

There are also eight outcomes identified form the *Our Health, Our Care, Our Say* (2006) and *Putting People First* (2007) papers which are aimed specifically at individuals participating in self directed support. These are:

1. Improved health and emotional well-being; irrespective of illness or disability
2. Improved quality of life staying healthy and recovering quickly from illness
3. Making a positive contribution, participating as active and equal citizens
4. Increased choice and control and where appropriate the lives of their family members
5. Freedom from discrimination and harassment
6. Economic well-being
7. Maintaining personal dignity and respect
8. Sustain a family unit which avoids children being required to take on inappropriate caring roles

It is important to acknowledge that *Our Health, Our Care, Our Say* (2006) and *Putting People First* (2007) are just two of the national drivers for self-directed support and the wider modernisation agenda.

3   Method of approach

In March 2009 Kate Linsky, an independent consultant, was engaged by the self directed support project team to provide a framework for the evaluation of the SDS learning exercise. The framework was informed by the following criteria:

- National regulatory requirements

- National guidelines and good practice recommendations

- Locally agreed success factors

- Work already undertaken by the project team and business analysts

- Existing data and research findings from other councils

- The need to fit into any wider evaluation programme

- The need for simplicity

The following diagram was developed to help analyse the learning exercise based around four main project strands that were identified, not only to address specific stakeholder interest, but also to more easily facilitate any required changes within the separate areas. The model also utilises information and findings drawn from other existing local, regional and national work around self directed support:

Figure 1: The Kate Linsky model for the evaluation of self directed support
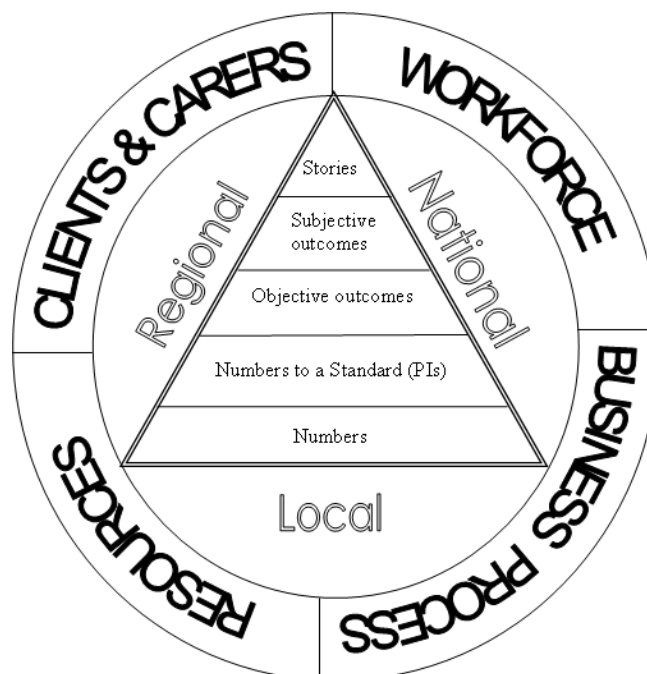
Predictions of the number people expected to receive self directed support were drawn up by the project team and were based on the number of new people entering the social care system in previous years; Table 1 shows what those estimations were.

Table 1: Estimated forecast of the number of people expected to progress through self directed support in the first nine months

Forecast numbers of people through SDS
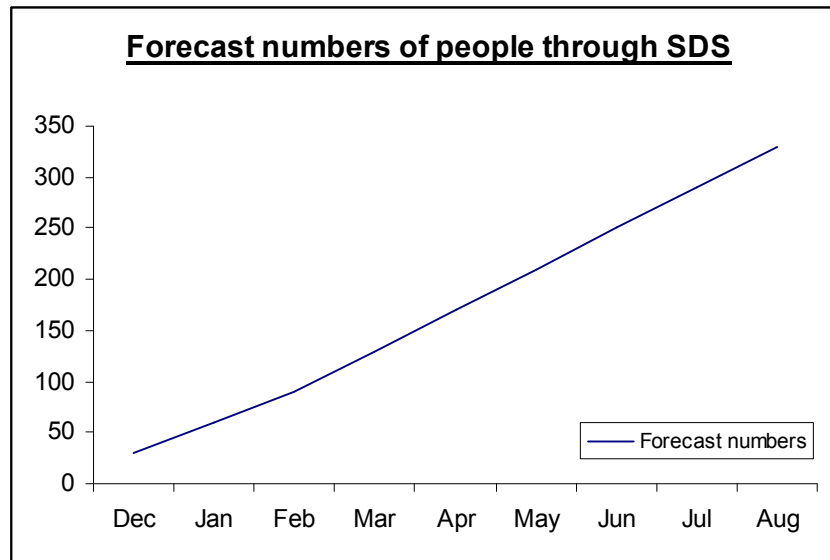
These estimates led to the engagement of 23 support brokers from 9 agencies, including Oxfordshire County Council, who were put in place to help people produce their support plans. Brokerage was referred on a capacity basis, with those who had more time to devote to brokerage referred more cases. Of the 12 active support brokers only 4, who were brokering on behalf of Oxfordshire County Council, were originally full time. The rest worked on a part time basis. Towards the end of the learning exercise Age Concern employed a single full time broker.

One of the intentions of the learning exercise was to provide information on the longer term financial implications of self directed support in Oxfordshire. Oxfordshire provided a personal budget (solely social care funding) rather than an individual budget (which includes other funding streams such as the Independent Living Fund and Supporting People) to make the calculation simpler within the resource allocation system (RAS). Once a budget was calculated, a broker was assigned to build a support plan together with the person seeking support. A financial eligibility assessment to determine the level of the person's contribution or whether their care would be funded by the council was undertaken after a support plan was generated. This means that any prices procured for services were not dependant on the person's financial eligibility.

A conscious decision was taken to focus the learning exercise on older people to start because it was recognised that this is the group which presents the most challenges when implementing self directed support. Due to the large numbers of people with fluctuating needs and the fact that national studies had focused primarily on people with learning disabilities, mental health issues or physical disabilities; so there was a lot of learning to be done. It also comprises the vast majority of new cases to enter the system and the larger part of social care recipients.

Guidance was produced for both brokers and council operational staff to encourage them to be flexible and creative with the use of a budget, whilst at the same time setting clear parameters for what is an appropriate use of the money.

Phase one of the self directed support learning exercise began in the Cherwell district on 1st December 2008. The learning exercise was initially only open to older people (over 65). As of 2nd March 2009 this expanded to the entire north of Oxfordshire (following the Integrated Care boundary) when the learning exercise was opened to all adult client groups, except those of working age with mental health issues. Self directed support was tested within the existing team structures in the north of the county.

In May 2009 it was recognised that the number of people being processed through the self directed support model was lower that initially predicted. A pilot was devised to assess the possibility of "fast-tracking" potential users of social care through the self directed support process. Those chosen were people who had contacted social services and were awaiting an assessment by the Adult Assessment Team in the north of the county. Brokers were asked to support people who were awaiting a formal assessment by conducting a "life check" visit and providing services such as: information, advice, signposting and requisitioning some of the council's single internal services. Support brokers received training to identify people whose risk level was substantial or high and who were in need of an urgent assessment by the council.

A further aim of this pilot was to determine the efficiency of using support brokers to help enable social work professionals to give the most effective support to those people they are responsible for. All clients visited received help to complete a self assessment life checker. Support brokers gave information and advice on activities and services, signposting onto other agencies for support and advice and assistance to set up single

services from the council to stabilise and reduce the risk of problems deteriorating until an assessment of their needs was undertaken by the council. When identified by a broker that someone was at a substantial risk, they referred them back to the social work team for an urgent assessment. This pilot has been included in this report under the business process section as it has direct implications on the future model of self directed support.

In order to evaluate the success of the learning exercise a number of questionnaires and interviews were conducted. Service users and their carers were interviewed to determine the difference that a personal budget had made to their lives. They were also asked about their experiences of progressing through the self directed support process. Support brokers and care team operational staff were also consulted on their experiences. To monitor the development of support plans the project office recorded referral events, while brokers were asked to record the dates when support plans were produced, agreed and implemented.

When comparing hourly rates of home care services by different providers, the electronic time management system (ETMS) was used as a source of Oxfordshire County Council home care providers' rates. Brokers recorded the hourly rate charged by an agency in the person's support plan.

A second pilot taking place throughout the learning exercise was the Individual Service Funds pilot in residential care homes. Around 4,000 older people live in Care Homes in Oxfordshire, and 40% of them are funded by Social and Community Services (S&CS). As part of the Learning Exercise, a trial of the application of self directed support principles in three Care Homes (Manor House, Lake House and Lincoln House) was started in May 2009. Care fees continue to be paid in the normal way but people were asked if they would like to undertake any additional social activities. In the longer term, the trial will contribute to our understanding of 'Individual Service Funds', where a single fee is paid to the provider, and services are then negotiated directly with the customer.
The process went through was:

- Identify Unit, staff and suitable residents for project
- Clarify funding available from Homes, S&CS and community resources
- Identify and introduce Age Concern broker to staff and residents

- Provide training to staff in identifying outcomes
- Offer enhanced support planning opportunity to new residents on admission
- Include existing residents if affordable/appropriate

4   Results

4.1   Numbers

At the time of writing this report (16th September 2009), 158 people have been assigned a personal budget, of which 136 have been allocated a broker to assist them with the production of

> **Simple, but effective**
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> کودکان زیر ۱۲ ماهه بخورند. اب را براي در بچه (فرمولا) استفاده
>
> An elderly gentleman is enjoying daily news and interesting reads in his native tongue with the help of his support broker.
>
> The gentleman who is originally from Iran, lost his ability to speak English as a result of Alzheimers' Disease. Online articles of interest in Farsi are printed off by his carers, enabling him to keep up with news from his native country.

their support plan. The remaining 22 have all had their care organised by a care manager under the existing system. 67 cases were referred to brokers working on behalf of Oxfordshire County Council, leaving 69 cases to be undertaken by brokers from eight partner organisations. 55 support plans have been implemented, while 6 more have been agreed and signed off by a care manager and unit manager and are awaiting the start of services. 141 of the 158 cases belonged to the older people client group. 7.5% of all adults cared for in Oxfordshire are receiving their money as a direct payment or personal budget.

> **National Picture**[1]
>
> The latest picture identifies that 6.5% of people cared for by local authorities are receiving their budget as a direct payment or personal budget. The rate drops to 5.7% in the South East region.

4.2   Clients and Carers

At the beginning of August we invited all 30 people who had had their support plans implemented to take part in a follow up questionnaire. 14 people agreed to be interviewed with their carers if appropriate. At the time of this report 7 people who use services and five carers had been interviewed and their results form the basis of this section.14 respondents out of 30 contacted for the client and carer questionnaires is only a 46%

return rate. Reasons for people not willing to take part in the satisfaction and evaluation questionnaire were: inability to make contact with the person (7 out of 30) to ask if they would be willing to take part in a questionnaire; due to the nature of their situation, (seven respondents felt that they would not be able to take part due to communication and/or memory problems). Not wanting to take part as they felt it was too soon to evaluate whether outcomes had been achieved or they had seen too many people already as part of self directed support (two people). All results from these surveys can be found in the table in Appendix 1.

Objective outcomes

Staying in

Housebound Mrs P in Banbury identified that her friends and family are most important to her. She uses her personal budget for her personal care and visits from a hairdresser. She is clear in wanting to remain at home.

"I make all my own choices with support from my family, friends and care team. The decisions that I make are appropriate to my life and the way that I choose to live."

Of the 7 interviewed 2 were self funders and 4 received their budget as a direct payment, with the remaining person having their budget managed by the council on their behalf.

The personal budgets were spent on a variety of things: 4 people used it to get help around the house with tasks such as housework, medication reminders, assistance with shopping or the provision of meals. 3 people used it to hire a personal assistant to help with some of the previous tasks but also to help with getting ready in the morning. 1 person spent their money on short breaks, which combined with respite was designed to provide relief to their carer. 3 of those interviewed had someone else (usually their carer) answer the questions on their behalf; the rest had help with answering.

3 of the carers interviewed lived with the person they cared for and spent more than 20 hours a week providing support. The remaining two did not live with the person they supported and provided less than 20 hours of care a week.

Fishing and reminiscing

An ex-service man and cabinet maker who now uses a wheelchair, asked his support broker if it was possible to take up fishing as a way to get out more and socialise with people. The broker found a suitable fishing pool, located on an former military base.

Staff at the base were delighted to hear of the request to use the pool, and were more than happy to help with the arrangements. Invitations were also extended to Mr R for special events at the base, such as 4th July and Thanksgiving, giving plenty of scope for reminiscing too.

Subjective outcomes

Both those in receipt of care and their carers were asked their opinion on the difference (if any) that self directed support and personal budgets had made to their life.

When asked what had worked well as part of the self directed support process 3 people replied that it was brokerage, while one thought it was the assessor with another believing that "everyone was very friendly".

When asked what could be improved, the following responses were recorded:
- Needs to be a quicker process (finance, in particular the time awaiting assessment and the time taken to receive funds is too slow)
- Too many people involved from start to finish
- The scheme needs to be promoted to the public more to make them aware of their options

Respondents were also asked to rate the difference a personal budget or self directed support had made to different aspects of their lives by classifying each section as 'helped (got better)', 'stayed the same', or, 'has not helped (got worse)'. Below is the percentage of cases where a person believed that having a personal budget has helped improve different aspects of their life, health and wellbeing:

<u>Table 1: The percentage of respondents who thought that having a personal budget for their care had helped improve an area of their health and wellbeing</u>

Subject	% of respondents who thought a personal budget helped
Overall Health	66 (4 out of 6)
Safety in own home	43 (3 out of 7)
Feeling safe going out	57 (4 out of 7)
Money	83 (5 out of 6)
Control over their support	100 (5 out of 5)
Social life	66 (4 out of 6)
Increased Dignity	60 (3 out of 5)
Physical Health	57 (4 out of 7)*
Mental health	71 (5 out of 7)
Control over their life	29 (2 out of 7)*
Relationships	29 (2 out of 7)

* 1 person believed it would help make a difference in the future

Table 2: The effect of personal budgets on different aspects of the carer's health and wellbeing

	Got better	Got Worse	Stayed the same
How has your financial situation changed	1	1	3
Has the level of support changed?	3	0	1
What is the effect on carer's quality of life?	2	0	3
What is the effect on carer's mental and physical wellbeing?	4	0	0
What is the effect on carer's capacity to have a social life?	2	0	1
What is the effect on carer's capacity to undertake paid work?	0	0	3
What is the effect on carer's relationship with person cared for?	2	0	3
What is the effect on other relationships?	0	0	4
What is the effect on level of choice and control for carer?	1	1	2

Care management staff involved with the learning exercise were asked "To what degree has the impact of personal budgets given choice and control to people?" The average answer on a sliding scale of 1-5 was 3.61 (a clear difference). When asked what difference brokerage in particular has made, the average response was 3.27 (some difference).

Going out

Thanks to his support broker Mr A now lives in a brand-new flat in Bicester, but fifteen years of homelessness have taken their toll on his health. He walks with difficulty and is at risk of becoming socially isolated.

Using the money in his personal budget, Mr A employs a Personal Assistant who helps him to complete forms and documents to ensure his benefits continue. The PA also encourages him to do his own shopping when he is well enough, and accompanies Mr A to the pub to socialise and catch the odd sports game.

National Picture[2]

Table 3: Overall satisfaction with the support planning process and financial arrangements

	Support planning process	Financial Arrangements
Extremely satisfied	13	19
Very satisfied	34	30
Quite satisfied	29	30
Neither satisfied not dissatisfied	8	10
Quite dissatisfied	4	6
Very dissatisfied	3	2
Extremely dissatisfied	4	4
Unaware of the planning process	5	N/A

Nationally, people receiving an individual budget were more likely to feel in control of their daily lives, compared with those receiving conventional social care support. Individual budgets appear cost-effective in relation to social care outcomes, but with respect to psychological well-being, there were differences in outcomes between user groups; older people reported lower psychological well-being when given individual budgets. Yet almost half of those who accepted the offer of an individual budget, across all client groups, described how their aspirations had changed as a result, in terms of living a fuller life, being 'less of a burden' on their families, and having greater control and independence.

4.3   Workforce

Objective outcomes

It took an average of 26 days from the Overview Assessment being completed by the care manager to the referral for a personal budget being received by the self directed support finance lead.

The average time between the allocation of the personal budget and the referral for brokerage was 7 days. It took an average of 28 days to produce a support plan (from referral to submission to care manager for sign-off), a further 8 to have it approved and 8 days for it to be implemented. Of the 55 plans submitted for approval to the care

managers 12 went through a period of appeal or adjustment before they were finally signed off.

> ### National Picture[3]
>
> The national indicators for Local Authorities and Local Authority partnerships devised by the Department for Communities and Local Government states that local authorities have 28 days to undertake a social care assessment (NI 132- Timeliness of social care assessment, all adults) and 28 days from assessment to the provision of services (NI 133- Timeliness of social care packages following assessment)

The average times taken to complete each stage of the brokerage process were compared between council brokers and non-council brokers using the z-test to compare the two means.

The question "is there is a statistical difference between council brokers and non-council brokers regarding time taken to produce a support plan?" indicates that the difference is statistically significant enough to be unusual (P= 0.05), with non-council brokers taking longer (31 days) than council brokers (22 days).

The amount of time it takes to get a support plan signed off by a care manager is not significantly different between groups (P= 0.09) with council brokers getting support plans signed off in 5 days and non–council brokers having support plans signed off in 9 days. Although a probability of 0.09 is not considered statistically significant it is still likely that there is a difference between the two groups.

When looking at the total amount of time taken by each group for the brokerage process up to implementation of services there is a highly significant difference (P=0.01) with non-council brokers taking longer (49 days) than OCC brokers (35 days) (see Appendix 2 for calculations).

Subjective outcomes

Brokers were asked to review their roles and responsibilities through a questionnaire and rate their answers on a sliding scale of 1-5 with 1=very negative and 5= very positive (see Appendix 3 for questionnaire).

Eight out of the 13 brokers involved in the learning exercise replied to the questionnaire.

Table 5: Support broker satisfaction with clarity over their role and responsibility

Question	Mode	Average
How free have you been in generating Support Plans?	4	3.71
How appropriate are the referrals you receive?	4	3.79
How confident are you in flagging up safeguarding issues?	4	4.36
How easy has it been to source appropriate services?	4	3.71
How easy/difficult has it been working with care managers?	2	2.86
Have you received enough training?	3	3.00

When asked of ways to improve the self directed support process the main responses were centred on reducing the number of staff visiting people who require support. More meetings for brokers which include care management staff were suggested as it was felt that communication between brokers and care management needed to be improved. Joint working with care managers was suggested as a way of improving the fairer charging and overview assessment stage of a person's assessment.

Care management staff were also asked to evaluate their understanding of their roles and responsibilities on a sliding scale identical to the brokers, although the questions differed (the staff questionnaire can be found in Appendix 4).

25 members of staff from the Specialist Team for Older People North (STOP), the Learning Disability North Team and the Integrated Assessment and Enablement (previously Adult Assessment) Team replied with feedback. Not all have had direct involvement in the self directed support learning exercise.

Table 6: Care management satisfaction with clarity over their role and responsibility

Question	Mode	Average
How clear are you about your role/responsibilities?	3	3.33
How easy has it been working with brokers?	2	3.21
How confident are you in explaining self directed support to people?	4	3.73
How confident are you in helping people review their support?	4	3.79

Ideas for making the process of supporting people more efficient whilst promoting the principles of choice and control were sought from staff too. Some of the most common suggestions were:

- Improve communication with brokers by arranging regular meetings
- Have brokers carry out reviews and financial assessments
- Create a list of resources and services which includes personal assistants and a list of council approved providers
- Limit the number of people who visit those looking for help and provide clarity on who the central point of contact should be for them
- Improve the financial allocation system, which includes eligibility and the disseminating of funds
- Monitor budget allocations against spend and change in needs
- The messages and principles of self directed support should be simplified for non professionals
- That the project office should have a single point of contact

> **National Picture[2]**
>
> Staff involved in piloting individual budgets nationally encountered many challenges, including devising processes for determining appropriate levels of individual budgets and establishing legitimate boundaries for how individual budgets are used; there were particular concerns about safeguarding vulnerable adults.
>
> Self employed brokers working on a 'spoke basis' (not working within a hub) are more cost effective than internal or independent providers due to lower overheads (Finance Network, 2009).

4.4 Business Processes

Subjective Outcomes

As part of their questionnaire care management staff were asked how they felt the self directed support process was being managed and promoted by the self directed support project team. They rated their answers on a five point sliding scale with 1 = very bad and 5 = very good

Table 8: Staff responses to questions concerning the self directed support process

	Mode	Average
Is the self directed support process clear?	3	2.81
Is the paperwork associated with self directed support at the right amount?	3	3.65
How well has the change to working in a self directed support way been managed?	2	2.90

Brokers were asked if they felt that they had been given enough time to undertake brokerage, the average response was 3.29 (about right) with 1 = too little time and 5 = too much time.

National Picture[2]

Nationally, support planning was often judged to be person-focused and accessible. However, some problems were experienced over the level and complexity of the paperwork, difficulties agreeing the support plan, changes to the level of the budget during the support planning process, and slowness of the support planning process.

Those receiving social care were asked how they thought the process of self directed support went:

Table 9: Response of people asked about different aspects of the self directed support process.

|	Yes	No	Not quite
Was there enough money in the RAS?	3	1	1
Was the SDS process easy to understand?	5	0	0
Is the process to get your personal budget transparent?	4	0	1
Did you get enough assistance to put together your support plan?	6	1	0
Did you get enough assistance to find and set up support to meet your needs?	6	0	0
Have you received social service support from OCC before?	3	4	N/A

Feedback from the project team highlighted that many were impressed with the brokerage function and how it had worked. The team working and communicating well together was also mentioned as a positive but a lack of clarity of roles was seen as a problem. Having a clear rationale for the change and working with operational staff to promote that

message of change was a positive experience for some within the project team, however, it was acknowledged by a few that operational staff should have taken a stronger leadership role. A further area perceived in need of improvement by the project team was the support delivered to care management (in the early days) and responding to their feedback.

4.5 Life Check

During the 17 weeks of the pilot a total of 57 people on the Adult Assessment team North waiting list for a community care assessment were seen by eight brokers. 42 people required a care manager to undertake a full Overview Assessment. Of those 42, 20 were referred back to the Adult Assessment Team deemed to require an urgent assessment. Three people had died whilst awaiting an assessment, while 10 simply declined help from social services and two people declined help once a support broker had met their early needs. This makes a total of 15 of the 57 (26%) not progressing through to a care management team.

Figure 2: The outcomes of cases referred for Life Check from the Adult Assessment Team waiting list
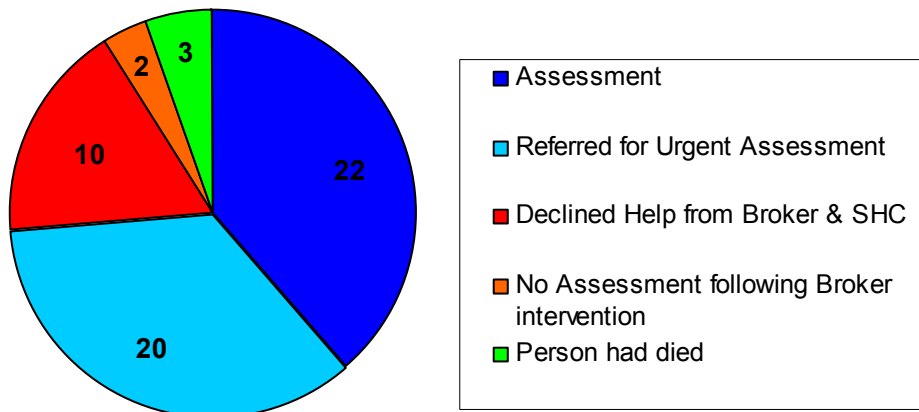
43 people required information about one or a number of services including benefits advice, carers information, the Befriending Service or housing guidance.

23 people had services arranged by brokers which included: Telecare, laundry services, access to day care or internal home support (personal care).

A total of 228 hours were spent on the 57 cases. This works out to be an average of exactly 4 hours per case. Figure 2 shows how the time was distributed across each of the

activities undertaken by the support broker, giving an average number of minutes spent on each activity per person.

Figure 3: Average time spent on activities during a Life Check visit
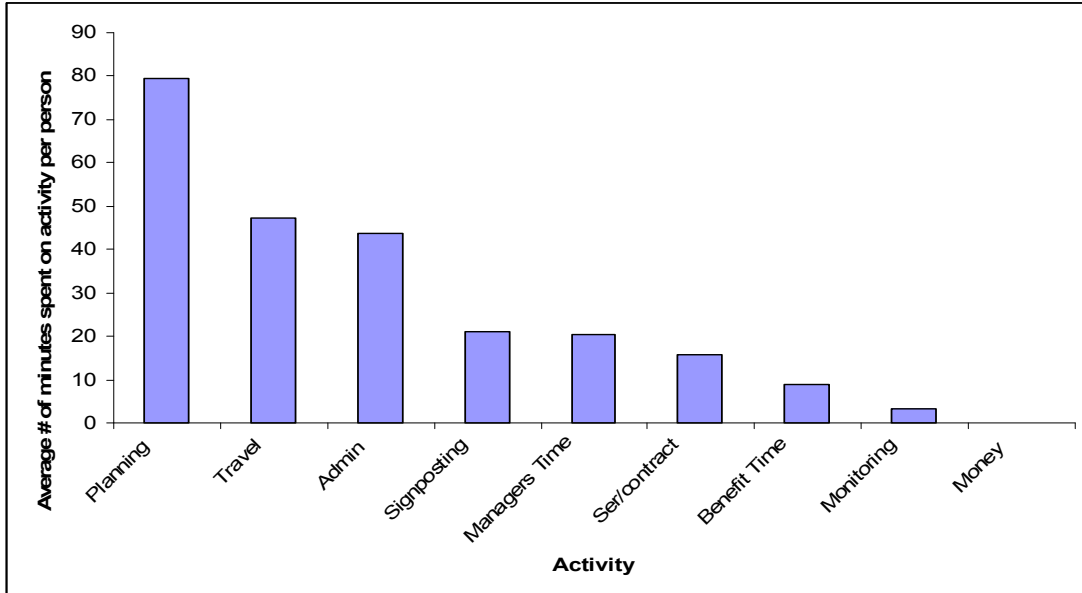
The hourly rate for brokerage was £14 p/h so each waiting list visitation cost on average £56.

33 of the cases were brokered by Oxfordshire County Council brokers. The remaining 24 were brokered by employees from other organisations. The table below shows the differences between the two groups.

Table 10: Comparison of services provided by Oxfordshire County Council Brokers and non-council brokers

Service	Council Brokers	Non-Council Brokers
Number of cases	33	24
Provision of information	23	20
Services put in place	15	8
No information or services put in place	10	3
Total time spent	139 hours	89 Hours
Average time with client	222 minutes	252

Statistical analysis of the data shows there is a very strong correlation between the amount of time spent by council brokers on each aspect of the case and the time spent by non-council brokers: R= 0.95. (When R=1.00 there is a 100% correlation between the two data sets.)

A comparison of the average time spent with each client using a statistical method called the z-test shows that there is a 95% confidence level that the means are not significantly different. The results, despite aiming at slightly different angles on the basic question of "is there a difference between the brokerage times of council brokers and non-council brokers, and if there is, is the difference statistically significant", indicate that although there is a small difference in a total consultation time (with council cases being slightly longer), the difference is not large enough to be unusual within the distribution of values from the non-council provider consultation times. (The analysis can be found in Appendix 5).

4.6   Resources

A study of how people are using their personal budgets to meet their needs and how they differ from what would have been provided under the old system was conducted. It was found that most people are still using their budget to purchase traditional services such as home support visits for medication checks, meal preparation and assistance in getting dressed and/or washed. The majority of these services continued to be purchased via an agency but a few are using a personal assistant.

There is a change in how day care/socialisation needs are being met. Previously people would have visited a day centre but people are now using their budget to pay for a personal assistant to take them out or using their budget to pay for a taxi to take them to and from hair appointments rather than visiting traditional day centres.

Respite continues on the whole to be internally managed with only one or two people using a direct payment to either purchase a bed in a residential setting or to increase a care package while family are away.

Brokers were also asked whether there were services that people wanted to buy but were not available. Answers included: lack of capacity by some care providers, housing issues, inadequate mental health services for older people including proficient counselling services.

National picture[2]

Table 7: National activity of personal budget spend

Service Personal Budget is spent on	% of people
Personal assistant	59
Leisure activities	37
Home care (agency)	22
Planned short breaks	22
Equipment – other	10
Home care (in-house)	5
Meal services	5
Adaptations	3
Equipment –Telecare	2

Of the 55 cases implemented, 33 opted to receive their budget as a direct payment. Seven people were self funding their care and so paid their care providers directly, while the rest had their money managed on their behalf by the Council.

National Picture[2]

Nationally In about half the cases (51 per cent; 144 people) the individual budget was paid as a direct payment into a personal bank account, and for a further 16 per cent (45) the budget was paid into a joint bank account of the budget holder and/or another person. The local authority organised services for 20 per cent (58) of budget holders. Twelve per cent (33) of people had their budget deployed in a variety of ways, including combining direct payments and the management of some of the budget by the local authority.

Numbers

The average personal budget allocated through the Resource Allocation System (RAS) was £231 a week or £12,036 annually (£13,089 for older people, including older people with mental health issues).

The average amount of money remaining after the support plan had been agreed was £22.64 under the allocated RAS (this is ignoring one off payments and assuming spend = allocation for self funders).

When comparing average hourly rates of home care services bought by brokers with council procured services, brokers managed to obtain rates that were on average £2.47 per hour less on weekdays (£17.43 compared to £19.90) and £4.06 per hour less at weekends (£19.71 compared to £23.77). (See Table 11 in appendices).

Even comparing the average lowest price paid by the council with the average broker rate we find the broker rate lower by £0.29 an hour on weekdays (£17.43 compared to £17.72) and £0.86 an hour at weekends (£19.71 compared to £20.57).

The average hourly rate for a personal assistant (PA) is £11.93 an hour. Of the 11 people who have employed a personal assistant as part of their support, four were in addition/ working alongside recognisable home support provider companies. The remaining 7 hired PA's as their sole means of home care support.

Statistical analysis (correlation coefficient) shows that there is a weak correlation between the amount of RAS a person receives and the hourly rate paid for home care services (R=0.331).

When looking specifically at council brokers, there is a much stronger correlation between the hourly rate paid for home care services and the amount of RAS allocated: R= 0.47.

Non-council brokers have a much weaker correlation between the hourly rate paid for home care services and the size of the original RAS budget with R=0.21.

Subjective outcomes

Care management staff were asked if they felt that the RAS allocations had been broadly right. Their answers were ranked on a sliding scale of 1 (too little) to 5 (too much), with 3 being just right. The average answer given was 2.88, however, it must be noted that some thought that the allocation was either too high in some cases and too low in others and so averaged it to 3.

Brokers, when asked the same question, came back with an average of 3.33.

> **National Picture[2]**
>
> The average budget nationally was £11,760 annually (£6,300 for older people)
>
> 51% was a direct payment into an account. 20% through a Social & Community Services managed account.
>
> After meeting needs other than personal care and meeting needs in a more individualised way, being able to choose one's own carers or employ informal carers was the second most common expected advantage of an individual budget. 41 % of older people chose to employ informal carers or choose their own.
>
> Very little difference was found between the costs of individual budgets and a comparison group receiving conventional social care support. The average weekly cost of an individual budget was £280, compared to £300 for people receiving conventional social care.

5   Conclusions

5.1   Numbers

It must be mentioned from the outset that any conclusions are based on a small set of results. Early calculations estimated that 325 people would have received support and had their support plans implemented through the self directed support process by the end of August 2009. In fact only 158 people have been assigned a personal budget in the nine months of the learning exercise with 55 support plans having been implemented. There is no recognisable reason why the numbers are so low; Swift reports indicate that numbers are an accurate reflection of the number of people who have been assessed and that no one has been bypassing self directed support. Some possible reasons anecdotally collected are: that the project has failed to get sufficient buy-in from staff; leading to new behaviours not being adopted which are required to drive the learning exercise forward and in-turn resulting in staff possibly bypassing the self directed support approach for more traditional care management approaches. Another reason may be that the whole process is too slow and complicated for staff. A study would need to be conducted to determine why people did not go through the system. If the decision was taken on their behalf then this would appear to go against the principles of choice and

control which are being promoted by this project. If people are making the choice then the reasons why they do not want to partake in self directed support need to be addressed. However, there is sufficient data to recognise early trends and identify differences or issues in the model trialled and it is these trends which are discussed below.

5.2   Clients and Carers

14 respondents out of 30 contacted for the client and carer questionnaires is only a 46% return rate, yet, this is deemed to be quite a good response rate for a local government survey (Siemiatycki, J, 1979). The last survey undertaken by Oxfordshire adult social services (Home care user survey, 2009) produced a response rate of 54%. None of those who took part in the self directed support process had previous care plans set up by Oxfordshire Adult Social Services; for this reason their previous experience of social care could not be compared.

All respondents felt that self directed support gave them more control over the support that they received. A high proportion felt that the support that they received had helped improve their physical and mental health and their financial situation. This is likely due to the nature of social services providing additional support to people who are in need of it who may not have had it before and helping people financially when they are eligible. Areas where self directed support was not deemed to have made a difference were in relationships and safety; both in own home and going out. The perception around safety is often affected directly by a person's age and the media (Williams & Dickinson; 1993 and LaGrange & Ferraro; 1989) rather than one's health which is determined at the individual or family level (Robert, S.A., 1998). All interviewed perceived that the net effect of self directed support and receiving a personal budget had led to an increased level of dignity in their daily lives.

Carers

Carers too felt that the level of support that they receive had improved their physical and mental health as a result of self directed support. This may be linked to the stress that carers feel when they perceive that responsibility falls on them to care for a family member or close friend and they do not have anyone to share that responsibility with. The provision of support by social services often incorporates respite breaks for carers and can provide direct support in the home with daily tasks. Like those they care for, carers

did not feel that self directed support made any difference to their relationships; however, a few did feel that the support they now received had improved their social lives. The feeling of self directed support improving choice and control for people was echoed by Oxfordshire County Council staff, who also felt that it made some difference.

Our findings are in line with a national survey (Glendinning et al, 2009) who found that personal budgets increased a feeling of control for people over their daily lives. This report goes against national findings which state that older people reported lower psychological well being as a result of personal budgets, perhaps because, nationally, people felt the processes of planning and managing their own support were burdens.

5.3 Workforce

Brokerage processes took longer than expected, with the referral for a personal budget after assessment taking 26 days. This is just within out requirements under the national indicator guidelines. The production of support plans (pre-sign off by care management) took on average 28 days. This is a new process which is largely being undertaken by individuals who do not have direct experience of developing care/support plans. Brokers who have come from a care management background are quicker at generating support plans than brokers from other organisations. However, this may bring its own problems as the principle is that brokers should not have pre-formed ideas on how to meet their needs prior to discussing goals, aspirations likes and dislikes with the person. The other possibility is that experience by council brokers is enhanced by them being full time, being able to take on more cases and gain further experience quicker as well as dedicating larger periods of time to brokerage, rather than being interrupted by the "day job". It is hoped that once the new model for brokerage is rolled out, all brokers will be on a full time basis and get allocated the same number of cases each month enabling them to receive the experience to make the process quicker. Another possible reason for the longer than expected time taken to generate support plans was the extended sickness absence of the brokerage lead from the project team, whose role is to provide direct support and monitor progress of the brokers.

The difference in sign-off time, although not significantly different, may be attributable to communication. Both brokers and care managers cited that getting in contact with the other party was difficult, yet there was a distinct difference in the perception of the

relationship with care managers between council brokers and non-council brokers. Council brokers scored the working relationship with care managers 4 (with 5 = very positive), while non- council brokers scored their relationship only 2. The advantages that council brokers have are access to internal communication methods and in some instances working in the same building as the care manager, all of which may have contributed to a quicker response time for sign-off and a better working relationship. Both staff and brokers recognise these issues and suggested joint meetings, visits and shared databases as methods of improving communications between parties.

The total time taken from generation of the indicative personal budget (RAS) allocation through to implementation of services took on average 44 days. This is far longer than the national indicator (NI 133) of 28 days, although it is based on a rough estimate as there appears to be a gap in recording at the end of the process. It is very hard to tell whether/when a plan has actually been put into action. If the support plan is not saved promptly into the Electronic Document Management System, then it is not clear whether the plan has been agreed or implemented. Non-council brokers do not have access to the Document Management System, relying on care managers to save support plans on their behalf. This delay in the saving of support plans is the likely explanation of the difference in total time taken to produce and have a support plan implemented between council and non-council brokers. Recording on diary sheets tends to tail off towards the end of the process.[1] Sometimes a note is made that the case has been transferred to the specialist team, but not always. All of this, however, will not bring the total time to anything close to the national indicator target of 28 days.

Brokers felt they understood their roles and were confident in their abilities to identify safeguarding issues and generate effective support plans. On average the level of training received was felt to be about right (3.0 out of 5, with 1= too little), although this may indicate that some felt it was too little, while others felt it was too much which is common on training programmes of people with mixed needs.

Care management staff were also clear about their roles and responsibilities within the self directed support framework and confident explaining the process of self directed

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[1] It should be noted that diary sheets were transferred to Swift profiles as of. This paper only refers to diary sheets saved within EDMS.

support to others. One group that scored lower in overall satisfaction and confidence were the Learning Disability Team who provided an average lower score compared to the Older People's team and the Adult Assessment team. One of the areas highlighted was lack of, or contradictory communications from the project team; the LD team scored an average of 2.3 out of 5 when asked how well the change had been managed, while other teams scored an average of 3.4. This is likely due to internal communications within the team. Each team involved in the learning exercise has received the same level of support and communications from the project. It may also have to do with the number of people within the team exposed to self directed support. Only five people with learning difficulties have been through self directed support compared to 141 older people.

Some of the main feedback given to the project team from brokers, staff and individuals receiving self directed support were that too many people were involved in the process. Some solutions suggested were that brokers should be more involved (where possible) in the assessment and review stages and that there should be a centralised list available of county council approved providers and resources available to help support people. All of these have been considered and incorporated into the future model of self directed support.

5.4   Business Processes

Early indications from the learning exercise are that people are tending to take a traditional approach to meeting their needs with home support visits and respite care still being used. The biggest shift in the purchasing of care support, brought about by personal budgets and self directed support, has been in the employment of personal assistants. Some have used personal assistants to assist with their home support activities, such as cleaning, washing, meals and medication visits, while others are using them in innovative ways to increase socialisation or simply get out of the house. Day trips, fishing activities, shopping visits or assistance in collecting pensions are all ways that personal assistants are being used. This is in line with national findings from IBSEN (Individual Budgets Evaluation Network, Glendinning et al, 2009) where 59% of people are spending their individual budget on personal assistants. Mental health services for older people is one area that was identified by brokers as needing development as they found it difficult to source services.

The spending of the personal budget in new ways such as on personal assistants supports the questionnaire findings that everyone who replied stated they understood the self directed support process. The same cannot be said of staff. The biggest issue raised by staff was that they felt the self directed process was not clear to them, even though they understood their roles and were confident in explaining the process to others; the average score was 2.81 out of 5 with 1 = a very unclear understanding of the self directed support process. This is supported by the fact that staff also rated the approach to managing the change to self directed support by the project team fairly low (2.90 out of 5). Such confusion over the process may be attributed to the delivery and communication of the process by the project team. Other findings from the questionnaires confirmed that care management staff were clear about their roles and responsibilities, so the issue may lie in staff not understanding the roles of others such as support brokers and so communication between the two groups would improve the situation.

What is positive is that this confusion does not appear to be transferred across to those receiving the support. This implies that those members of staff who are most confused about the process were those that did not have direct involvement with those receiving support through personal budgets. This may provide a possible explanation the low numbers encountered in the learning exercise, as care managers felt more comfortable providing support under the existing care management system.

Six out of seven people in receipt of support felt that they got sufficient assistance to put together their support plans, while all who replied felt that the support plan developed with them had met their needs.

Care management staff felt that the level of paperwork is still too high. The project team has endeavoured to reduce the amount of paperwork throughout the learning exercise and some members of staff conceded that the perception around paperwork is centred on social care being a largely bureaucratic system anyway.

During the Life Check pilot an average of 4 hours was spent by brokers and support staff on each case. Most of the time was spent making contact, planning and travelling to locations, with a smaller amount of time spent on office functions like administration and

managerial support. This time could be reduced by reducing the amount of travelling undertaken by brokers, i.e. referring cases according to a broker's geographic location.

Statistical analysis of all the cases shows that there is not a significant difference between the average time spent by council brokers and that spent by external brokers on each case. In fact compared on a case by case basis there is a very strong correlation between the amounts of time spent on each activity.

A quarter of all cases dealt with by the support brokers did not require an assessment by a care manager. This can not be translated into total figures as it is envisaged in the new self directed support model that Oxfordshire residents approaching adult social services would be triaged at an early stage to determine whether they require a full assessment or just information and advice.

42 people still required assessment; all were referred back to the Adult Assessment team waiting list with 20 of them considered to require an urgent assessment due to the nature of their needs and their current situation. This high number of urgent cases may have been compounded by the fact that they were on a waiting list; were the waiting list not present it is possible that there would not be so many requiring urgent attention.

Most people (43) were provided with information to help meet their needs or improve their overall situation. The majority were given information on what benefits they were entitled to, how they could access them and what support was available to their carers. 23 people required simple services to be set up, such as: Telecare, internal home support or meals and laundry services. 12 of these people require services to stabilise their situation while an urgent assessment was requested. Nationally, over half of all people aged 75 to 84 reported that they have a long-term illness that limits what they do (2001 census), but most older people still want to maintain their independence and sense of wellbeing to minimise the impact of these limitations on their lives (Audit Commission, 2004). The setting up of simple services will often stabilise a situation and provide more support to enable people to remain independent and in their own homes.

5.5   Resources

It is important to mention once again that the results here are based on a small number of cases. Oxfordshire County Council provide financial support to approximately 5,500 adults each year, which makes the 55 sampled here about 1% of the expected total. That said the results in this paper still provide a valuable insight into possible early trends.

The average annual RAS allocation during the learning exercise was £13,089 for older people (including those with mental health issues), which is more than double the national average of £6,300. This is probably the result of the fact that both in Oxfordshire and nationally personal budgets have only been introduced as pilots for a small selection of people which are likely to be different both from each other and from the population as a whole. The method of RAS allocation was based on the costs of the services the person would have received under the existing system and was designed to be cost neutral. However, a number of differences soon became apparent.

- The rate used for home support was based on the direct payment rate (which is lower that the actual cost paid by OCC).
- People received an amount of money for services such as day care and respite if they would have been offered this, despite the fact that under the old system they may not have chosen to use the service.

Based on the budgets allocated to date the overall effect will be cost neutral if 50% or more of the services offered had been taken up.

Once a support plan had been agreed and signed off by a care manager there was an average of £22.64 a week per person remaining (£1,177 annually) from the original RAS allocation. It is also possible that people spend less than the amount originally included in the support plan, but it is too soon for any meaningful conclusions to be drawn in this area, and the policy that will be applied reclaiming such money or setting the RAS at a lower level has yet to be determined. Care management staff and support brokers were asked if they felt that the RAS allocations had been broadly right. Their answers were ranked on a sliding scale of too little (1) to too much (5) (with 3 being just right). The average answer given by staff was 2.88 who obviously felt it was just on the low side, although it must be noted that some though that the allocation was too high in some cases and too low in others and so averaged it to 3. Brokers, when asked the same

question, came back with an average of 3.33 believing it to be slightly too much. The money left over shows the brokers' perception to be closer to the mark and this may be due to the fact that they are actively supporting people to source the care and support that they need to meet their needs, while trying to get the best market prices from companies and/or individuals who provide the care.

This shows that the new system appears to be more cost effective, although this should be treated with some caution as this is based on low numbers and there is considerable anecdotal evidence to suggest that people receiving conventional services frequently receive slightly less than the amount included in their care plan.

In most cases the support brokers were able to procure home care services for a lower rate than the average price paid by the council from the same provider. In many instances the brokers were able to obtain a rate that was lower than the minimum price available to the council from the same provider during the same period.

The hiring of PA's at a lower rate than agencies has had a marked affect on the average price sourced by a broker for home care services. With PA's proving to be on average £8 an hour lower than the equivalent agency rate it has a direct effect of lowering the average price obtained by brokers. However, removing personal assistants from the calculations still makes the hourly rate procured by brokers £1.62 lower than the same service purchased under a council contract.

Interestingly there is a stronger correlation between the RAS amount and the hourly rate paid for home care services for council brokers than there is in non-council brokers. This implies that non-council brokers are getting lower rates irrespective of the RAS allocated, however, this too should be considered with caution as the difference between council brokers and non-council brokers could be attributed to the random allocation of the cases. The hypothesis is that council brokers are culturally used to prioritising the meeting of needs rather than the sourcing of the best price for care; they are comfortable with phoning up existing providers and getting a price from them rather than phone several providers. It may also come down to new ways of working and thinking on behalf of the non-council support brokers. Of the 11 personal assistants employed to meet people's

needs non-council brokers arranged the employment of more than twice as many as council brokers (8 compared to 3 respectively).

Direct payments

60% of all budgets were allocated as a direct payment. This is in line with the national findings, but what makes it interesting is that the majority of people receiving a personal budget as a direct payment in Oxfordshire were older people. The IBSEN report is based on the findings of mainly those with learning disabilities, physical disabilities or those with mental health issues.

5.6 Mental Health Teams Pilot

A pilot has started with Oxfordshire and Buckinghamshire Mental Health Foundation Trust (OBMHFT) to implement the principles of self directed support for people with mental health issues. However, at the time of writing this report no person from the OBMHFT has been referred for a personal budget through the Resource Allocation System and for that reason this pilot has been excluded from this report.

5.7 ICT

One of the big issues that has become apparent as the learning exercise has progressed is the need for improved information technology support. The systems in place at the moment are sufficient to manage the current number of clients, but once the project is implemented across the county, the current measures will not be able to cope with the increased numbers and data. Overall, technology is inadequate for the job with the two main social care programs Swift and Document Manager not fully integrated. Even as stand alone programs they are not deemed to be user friendly for future assessment and brokerage tasks e.g., Forms Creator does not allow boxes to expand. Systems are also unreliable, particularly in the localities and IT skills are lacking in places across the directorate.

5.8 Efficiencies

A local efficiencies programme has just been announced which aims to make savings across the council of 10% over the next five years. This equates to £60m on top of the £30m already included in the council's forward plan.

Through the design of self directed support, there are many opportunities to streamline processes and eliminate unnecessary duplication of effort, inefficiencies and bureaucracy. Though this is by no means the main objective of the self directed support project and the larger Transforming Adult Social Care programme designing and implementing more efficient ways of working it will be an additional benefit from its outcomes. One of the issues raised by the project team was that the current perception of the self directed support project from front line operational staff is that it is intrinsically linked to the efficiencies programme and the original message of improving choice and control in people's lives is being watered down as a result.

Yet all the early evidence in this paper points towards brokerage providing a service which meets most or all of the needs of those they are helping support. It is also accepted from those who have received the self directed support service that it provides individuals with more choice and control over that support, which in turn has lead to improved wellbeing and dignity in their lives.

The cost of brokerage is also reduced as the hourly rate to help set up support for a person's care needs is lower than a care manager. For tasks like those involved in the Life Check pilot, care managers are not spending valuable time visiting a person on the assessment waiting list only to find that they require simple information needs or do not require the support from social and community services at all.

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7   Appendices

Appendix 1: Those in receipt of services questionnaire

\\S08-SAN-FS-02\
Social and Health Car

Carer's questionnaire

\\S08-SAN-FS-02\
Social and Health Car

Appendix 2: Brokerage statistics

\\S08-SAN-FS-02\
Social and Health Car

Appendix 3: Brokers Questionnaire

\\S08-SAN-FS-02\
Social and Health Car

Appendix 4: Care management Questionnaire

\\S08-SAN-FS-02\
Social and Health Car

Appendix 5: Life Check Statistics

\\S08-SAN-FS-02\
Social and Health Car