

IMPACT Evidence Review: Choice and Control

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What is the issue?

"...choice is fundamental to achieving citizenship, social inclusion and human rights"¹

All four nations of the UK are trying to make sure that people who draw on adult social care can have **greater choice and control** over the support they receive.

Evidence suggests that providing choice and control promotes **independence**, **wellbeing** and a sense of **empowerment** as well as enabling people to **creatively personalise care** and support to their own needs and preferences in ways that are flexible and responsive.²

However, offering choice and control is sometimes (wrongly) seen as an 'all or nothing' approach: the person either receives a direct payment and is in control, or they don't (and therefore aren't in control). There is also an impression that people either want to do everything on their own, as a private individual, or want to access group services and settings – when in practice we all want to do some things by ourselves and some things with others.

In Wales, Scotland, England and Northern Ireland, there are various approaches to providing the 'middle ground' between directly provided or commissioned services and direct payments. The language used varies but they are essentially options that aim to provide choice and control for people who may not want to or be able to manage a direct payment, and who have a trusted service provider who they want to work with.

For service providers, these approaches offer the opportunity to move away from bureaucratic block-contracts to a much more flexible way of working, which enables the person and the provider to work together on creating the best outcomes for the person being supported. For example, this could work well for some people with **mental health problems and/or learning disabilities** – yet seems very under-developed across all four nations of the UK. In particular, these approaches could work well in supported living settings as these services are meant to offer very individualised approaches. However, there has been some concern – particularly during the pandemic – that some of supported living services could go further to ensure genuine choice and control.³

IMPACT is therefore running one of its 'Networks' to explore how approaches that offer a **middle way between commissioned services and direct payments** can be taken forward at the local level, with a specific focus on how they can be used by **people with mental health problems or learning disabilities**.



What are the different approaches used in England, Northern Ireland, Scotland and

Wales?

In England, 'Individual Service Funds' or 'ISFs' have been argued to move away from traditional hierarchical relationships between commissioners, providers and people who receive support.⁴ They have been used for more than 20 years but were formally included in policy in the 2014 Care Act.⁵

In Scotland, ISFs are one way of managing an individual budget available under 'Option 2' of the Social Care (Self-Directed Support) Act 2013 where funding is allocated to a provider of choice or other third party. Though explicitly referenced in policy in the past 10 years, ISFs have used for over 25 years in areas of Scotland.⁶

In Wales, a different model emerged, described as a 'citizens or user-led co-operative approach,⁷ in part influenced the long history of co-operatives in Wales and by Section 16 of the Social Services and Well-being Act 2014. This provides a duty for local authorities to promote social enterprises, co-operatives, user-led services and the third sector in providing social care and support.⁸

In Northern Ireland, the introduction of self-directed support in 2014 included the option of receiving a direct payment as a 'managed budget', with the Trust, broker, care provider or another organisation holding the budget for a person who would ultimately be in control of how it is spent.

Though the language and the history of their development is different across the four nations of the UK, all of the above are **approaches that can provide people who draw on care and support with choice and control if they do not have the capacity to, or do not want the responsibility of, managing a direct payment.** In these cases, a person would work with a trusted service provider or other organisation, who might receive money on the person's behalf, but then work with them on a flexible basis as to how the money is spent.

What are the 4 key elements of ISFs/ Managed Budgets/ the Co-operative approaches?⁹

- 1. An upfront individual budget allocation
- 2. A flexible support arrangement designed around the person
- 3. A budget that is used to focus on a good life, not just a service
- 4. Maximum control for the person over decision making.

What do these approaches look like to person who draws on care and support?¹⁰

What: "I can use my hours/ budget flexibly and I can choose what I am supported with."

Where: "I am supported where it makes sense for me, at home and out and about."

Who: "I choose who I want to support me, my support worker knows me and I know them."

When: "I get the support on the days and times that are right for me."

How: "I choose how I am supported and my support workers know this is important to me."



With the ISF model, people have been able to **pool their resources** to purchase goods or services that would be of mutual benefit but beyond their own funding allocation.¹¹ This seems a good way of enabling people to do some things together, but some things on their own – but in practice are under-developed at present. Pooled resources also could be particularly useful in the context of supported living.

In Wales, the pooling of resources has been taken further with the **creation of formal co-operatives**.¹² A spectrum of co-operative approaches have been developed, including: i) citizen-directed or user-led co-operatives; ii) multi-stakeholder co-operative with service users, staff and community organisations as members, and iii) services provided to direct payment recipients on a contracted basis from an employee-owned co-operative home care provider. ¹³

Why use these approaches?

Evidence highlights several benefits of using these models. They have been found to:

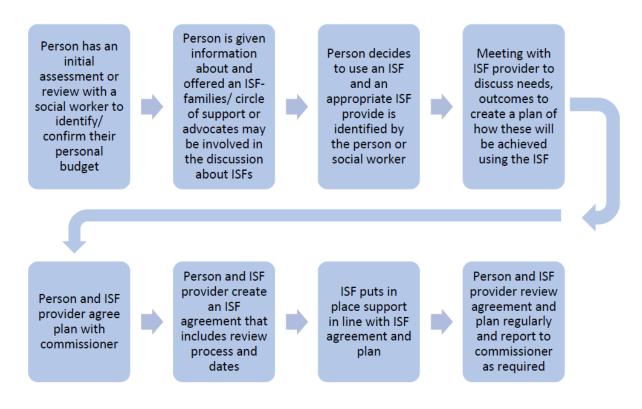
- Promote choice and control for the person.¹⁴
- "increase... self-confidence, improved health and wellbeing, reduced professional support, improved relationships, increased autonomy and greater self-advocacy".
- Improve outcomes, and the better use of their own and community assets.¹⁶
- Offer a flexible, responsive approach that allows for creativity ¹⁷, and are beneficial if a person has a fluctuating health condition.¹⁸
- Provide clarity and accountability, where everyone knows what their rights, responsibilities and roles are.¹⁹
- 'Keep it local' by ensuring councils' funding is spent locally when used alongside micro enterprises.²⁰
- From a provider perspective, they increased business opportunities; ability to 'flex' support around a person and be creative; improved cash flow; becoming a trusted provider; being up to date in terms of best practice; growing business opportunities.²¹

How do these approaches work in practice?

Developing and enhancing the use of any of these approaches will require change in several areas by various actors in the system. Commissioning authorities, providers of services and community groups need to work alongside the person who needs support, their family and others in their 'circle of support', including advocates.



Taking ISFs as an example, for local authorities/ councils/ health and social care trusts, a practical implementation process could look like this²²:



Other tips for implementing these approaches include²³:

- 1. Consider piloting the new approach to build experience and knowledge.
- 2. Place the person at the centre of decision making, and focus on outcomes.
- Communication is key and regular meetings between commissioners, social workers, providers and people who use service to share and explore problems and practice are important.
- 4. Create training opportunities for both social workers and providers to ensure everyone is 'on the same page'.
- 5. Co-create accessible information with <u>and</u> for people who use services and their carers about the model you're using.
- 6. Develop a transparent system to monitor expenditure which allows for a degree of over/underspend.
- 7. Factor in the administrative costs for providers using these models so that they are sustainable.
- 8. Monitor and evaluate progress but with realistic expectations- change takes time.

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More resources: Videos

- 'Option 2 Self-Directed Support: <u>https://youtu.be/uuwS-eoTa68</u>
- ISFs: https://youtu.be/fqcdTirYHks; https://youtu.be/IHOyIZLxqms
- Self-directed support and managed budgets in Northern Ireland: <u>https://www.youtube.com/watch?v=CGv4xmG8jEA</u>
- Co-operatives and care in Wales: <u>https://youtu.be/VI-E9JxKO2g;</u> <u>https://youtu.be/N0D_yRdSAp8</u>

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