OUTCOMES WORKING AND SUPPORT PLANNING

Summary

There is broad consensus amongst those who are keen to see real transformation of social care that the current Assessment and Care Management process has to be replaced. There is much less certainty about what should replace it. Government practice guidance is based on what will work best for those with the highest levels of ability and will to manage their own assessment, support planning and purchasing, with ‘assistance’ available for those less able to do so. The following argues that a better route will be to build a system designed to ensure control is made possible for the least able and willing, but which allows the more able and willing to deliver it for themselves. Outcome based working can provide the basis for a practice framework to deliver this.

1. CONTEXT

1.1 As approaches to the transformation of Social Care emerge, there is consensus that the days of the service centred Assessment and Care Management process are numbered. It has failed to engage service users, failed to deliver the original vision of ‘needs led’ practice creating ‘tailor made’ packages, and even failed in the task which arguably subverted its vision, that of controlling spending in social care.

1.2 However, there remain important questions about what should take its place. The Government’s key advice is set out in the Personalisation Toolkit through the document Support Planning Brokerage. It contains a wealth of ideas about new ways of working with people and the processes that need to be in place. It is based on learning from the thirteen Councils that piloted Individual Budgets.

1.3 But there are doubts about whether its advice will do the trick for all service users, indeed whether it will address the situations of only a minority.

- Although the service users selected within the thirteen pilots were meant to be randomly chosen, in the event those who got an Individual Budget were five times more likely to be already receiving a Direct Payment than the average. This suggests the pilot was biased in favour of those people most eager to try new ways of being able to buy their own social care.

- The evidence was that older people were significantly less impressed with the Individual Budgets way of receiving support than younger age group.

- Those Councils who are most advanced with Individual Budgets retain a process, sometimes panel based, that takes the decision whether or not to agree the Support Plan. However, there is no transparency as to how these decisions are made. It risks retaining all the ingredients of the current Assessment and Care Management process, thereby undermining the new approach for those people whose Support Plan is deemed not to be fit for purpose.

1.4 Support Planning and Brokerage kicks in at the point that the RAS has allocated a resource to the person. From that point it is about identifying how best to spend the money.
All the decisions are made by the service user, who has the option of calling on a professional for advice if they so wish. It calls the tick box process that results in the RAS allocation as ‘the assessment’.

1.5 This approach intuitively troubles many. They are concerned that this model assumes a mind set from service users that simply is not always present. It is one where either the service user or their representative have the energy, inclination, skills and time to act as their own commissioner and purchasers within a free market ideology. Whilst some fit this bill, the sceptics see mostly people who simply want services to be better and more responsive to what they need. They see people who do not think they should have to do the job of creating such services for themselves. This is not to say they do not want control, they very much do. They want control that ensures that services do the right things for them, the things that will work, which are the things they themselves know to be the right things to do. They want services that will respond to them flexibly. They want services to be transformed. The full concept of ‘self directed care’ - using cash based resource allocations to be used within a free market – is to them like taking a sledge hammer to crack a nut. The argument from the enthusiasts that in time everyone will want to be players in the free market ideology is not convincing.

1.6 However, the status quo cannot be allowed to continue. An alternative route is required. A way of understanding and then going on to resolve the tension can be captured in the following way. How should we judge the fitness for purpose of the Support Plan (accepting the definition of the Support Plan in the guidance as “...the means by which information is presented to release funding...”). Arguably there are two broad options:

- **Test one** - the extent to which the Plan is one that the person wants and has chosen for themselves

- **Test two** - the extent to which the Plan will bring about the best possible levels of independence, health and well being.

For those who see transformation as being about empowerment of service users first and last, they will choose the first test. However, achievement of the Government’s strategic objectives for the reform process actually requires the second test to be satisfied. This can be called the over-arching **strategic outcome**. Supporters of this approach will say that the second test will be satisfied as a natural by-product of the achieving the first, given independence, health and well being are things that people want for themselves.

1.7 The alternative view is that this is optimistic to a degree that is not responsible. There are significant factors at play that undermine their pursuit of their best levels of independence health and well being for a large number of people, for example;

- Situations where people just don’t know what is possible for them. This is not about what services are available, but what kind of outcomes might be possible, how their lives could be different.

- Situations where people’s expectations of life are not themselves healthy, which is not uncommon for people who have the range of conditions that give rise to requiring social care
• Situations where people are surrounded by others with their own interests and who are very powerful – principally other professionals, family and friends who may take a more protective and risk averse view than would the person themselves if left to their own judgements.

• Situations where people do not have the capacity to plan their own support and those around them are not doing so to the standards the law requires

1.8 It may well be that these are the kind of risks that the ‘back stop’ panels of the Councils who are implementing self directed planning are tackling when the self directed Support Plans come to them. Similarly, the Department of Health is increasingly recognising that a number of people will need ‘assistance’ to self direct (Transforming Social Care Circular, March 2009). However, it similarly leaves a dark space where this ‘assistance’ is not defined nor the circumstances under which it should be offered (or insisted upon) set out. The problem with these devices is the lack of transparency about how they work. They risk the perpetuation of the ills of the current system.

1.9 A route that addresses this risk is to give primacy to the second test, not the first. All Support Plans should be built first and foremost with the aim of explicitly delivering the best possible levels of independence, health and well being, (no matter what route is used to determine how much funding will be made available to the person). In effect, the choice and control agenda becomes a means to an end, and not the end in itself. The real end is the impact the support plan has on the person’s life.

1.8 Doing this, though, creates the dilemma of how to bring it about without undermining the shift in control to the service user. At one end of the spectrum is the current model with the balance of power firmly with the professional/Council; at the other, the balance firmly with the service user. Neither is tenable as the basis for delivering the strategic outcome of the transformation agenda. What is required is a relationship between service user and Council that strikes the right balance.

2. HOW DOES OUTCOME WORKING ADDRESS THIS CHALLENGE?

2.1 Outcomes are all about the impact services have on the quality of life of the person. Outcome based working is concerned with bringing about support to people that is flexible, responsive, with the person who receives the support being in control, whether the supports are delivered through services unique to them or mainstreamed commissioned services. It requires an assessment and support planning process that sends people into the delivery of services clear about what they want from those services – their personal outcomes - and sure the outcomes are the right ones for them. This has to be the case for every single service user, whether they are allocated resources through an ‘up front’ allocation of money or following the support planning process, and whether or not they control the money or the Council does for them. As a consequence, the benefits of personalisation – defined in terms of the experience of social care, and not in the narrow sense of the resource allocation process – are made available to all.
2.2 Outcomes working requires a relationship between service user and the Council that fits Charles Leadbeater’s description of “co-production”¹ This stems from the following elements of outcome focussed support planning:

- It requires a clear articulation of **outcomes**, and also the **issues** the outcomes address. Whenever these elements are left assumed, or unstated, it can lead to service users and their friends and advocates as much as professionals being service led in their thinking. The process of articulating issues and outcomes – involving reflection, discussion and thinking - can lead to a clarification and re-definition of the situation that significantly changes the direction of travel for the person.

- The outcomes have to be ones that the person owns and is signed up to – they have to be their own. Melanie Henwood and Bob Hudson² point to the research evidence of the importance of this.

- This thinking then becomes the driver for everything that follows. It sets a vision, and enough detail to know what needs to be put in place.

- While the **personal outcomes** belong to the person, the professional has a duty to ensure that the **strategic outcome** the state is concerned with is also satisfied. If the two do not match, it is the skill of the professional to inform, advise, negotiate or use any other strategy to help the service user shape their personal outcomes.

2.4 Outcomes thinking is a process of thought that is completely natural, its just the language that is unfamiliar. When a family gets together to decide who does what as their ageing parents start to lose their ability to self care, this is what they do. What they don’t do is to use the above language, or necessarily apply a structured thought process. Also, they may not do it very well.

2.5 The cornerstone of outcome based support planning is that people can do it for themselves. However, assistance will be needed in all situations at one of four levels.

- At the **first level**, all the person and/or their representative will need is material that tells them the language and process, and they can get on with it themselves. Access to a good resource directory will enable them to complete a Support Plan in full. Even if the numbers of people able to work in this way is small, it is important to recognise the possibility and to start with the option of offering it.

- At the **second level** people will need support to work through the process, what might be called assistance to **frame** their thinking and support plan. The skills are all about **facilitation**

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1 ...are active participants in the process – deciding to manage their lives in a different way – rather than dependent users

2 An important finding from research is that it is individuals’ assessments of their circumstances which appear to have the greatest influences on reported wellbeing, as opposed to their actual circumstances. So if individual well-being is the policy goal, and if this is to an important extent shaped by the subjective perceptions of individuals, then it suggests these individuals should be influential in determining their own priorities.
• At the **third level**, having looked at the resulting support plan, if the Council forms the view that plan will not result in the best levels of independence health and well being, it will then want it’s professionals to open discussions with the person in order to help them **develop** their thinking.

• At the **fourth level**, the Council actually does have to take control. This should only been in a clear and defined circumstances as it will produce the least effective and enduring Support Plans. Circumstances may be;
  
  • The gap between personal and strategic outcomes remains too great to enable the Council to support the service users chosen outcomes
  
  • The person does not have the mental capacity to articulate their outcomes and there is no-one in their network willing and able to represent them
  
  • The situation is urgent and high risk and there is not the time to carry out the work required

The work at the first and second level can be supported by community groups, including user led organisations.

The diagram below represents this process.

2.6 In this way, the involvement of the professional/Council can be made clear at the outset along with the terms upon which a support plan will be agreed and funded.
3 WHAT DOES IT TAKE TO DEVELOP OUTCOME FOCUSED SUPPORT PLANNING?

Whilst the Personalisation Toolkit acknowledges the importance of outcomes, it does not explore the implications of what working to outcomes actually means in practice. It cannot be achieved by simply changing language and rhetoric. Without addressing the full change agenda, Councils will fall into the trap of simply re-branding the "same old, same old". The following elements need to be addressed;

- **Culture change**
- **Practice process**
- **Linked policies**
- **Linked strategies**

3.1 Culture

- It will require a workforce who see their job as working creatively and with high levels of responsibility, not simply delivering a system that belongs to someone else.
- Field workers will have to give up control of the service delivery process in order to pass control to the service user and provider where it needs to be.
- It will be important to engage all staff in the work to re-design the service as a key element in getting it right locally and in ensuring staff are enthused. ‘Off the shelf’ solutions should be avoided as however admirable they may be, staff may see their job still as ‘delivering a system’. However, this does not preclude using the work of others as learning.
- There is a challenge to a performance culture where external targets dominate operational activity. This work cannot be delivered by practitioners who are inappropriately dominated by targets. There is a need to work out a way of accommodating government targets in a way which does not undermine the pursuit of the vision.
- It is essential to engage all interests – members, other Directorates, service user organisations, other organisations – in the creation of a vision, and as appropriate, in service design.

3.2 Practice process

The practice process has to be completely re-defined.

- The concept of ‘assessment’ which consists of the practitioner gathering information in order to assemble a view and a plan should be replaced by a **thinking process**, with the thoughts of the service user the key element.
- Systems that standardise the assessment through a series of questions and tick boxes have to be rejected. They are anathema to person directed thinking by placing
the service user in a passive, information giving role. Outcomes working requires the service user or their representative to be setting the agenda on their terms. Linked to this:

- If it is decided to allocate resources through a RAS, it will be important not to confuse the system for deciding the points with an ‘assessment’ (as Government guidance tends to). The RAS process should be stand alone.

- It is important to avoid the trap of so called ‘self assessments’ which come in the guise of asking people to provide some preliminary information which the practitioner then goes on to use – in a way they choose to see fit – in the assessment proper.

- If Councils are required by central Government to deliver a standardised set of data (Common Assessment Framework) this should be delivered outside of the mainstream support planning process at the least possible bureaucratic cost and inconvenience for staff and service users.

- Create a practice structure for the process. An agreed structure is not the same as standardisation. A structure is needed that takes the practitioner and service user through the stages for thought and planning in order to create a fit for purpose Support Plan. The structure must be one that is capable of being used by a member of the public with no more than a reasonable level of mental capacity. The structure has to be clear about the role of informal carers both as contributors the planning for the cared for person and as people in need of their own support.

- The structure must embrace the ability to think laterally at the point of planning how to achieve outcomes with the ability to use resources outside of the mainstream commissioned market.

- Re-design forms to replace the current requirements of a task and volume commissioning with outcomes.

- Re-design IT systems so that they are better able to reflect the more individual nature of outcomes based support planning. This primarily means being able to capture more free text information (reflecting the structure of the assessment).

- A workforce development strategy that recognises this is a learning and development process most of which will happen in the workplace rather than the classroom. It also needs to recognise that the workplace includes the interface with providers, and to use joint training opportunities.

- Create a Quality Assurance system that both sets standards and tests their delivery, and also a Performance Management strategy that tests the achievement of key strategic indicators. The latter might include the rate that service user believe that they are driving their Support Plan. It might include others like a reducing rate of admission to residential care if it is believed that good support planning will achieve this.
3.3 Linked policies

There are certain policy areas that have to be developed to support the process and which, if not, will undermine it

- Outcomes working cannot compromise on the need for the assessment and support planning process to be holistic, which means it must be not be limited to needs that can be afforded or for able to respond to this. It is not the need to ration resources in itself that undermines good, person centred practice, but the way it is done. A key aspect is that the policy will need to address how to manage unmet need.

  A formula based RAS will deliver these requirements, if fully trusted and without recourse to the ability to top up the allocation if it doesn't produce enough to meet the need. Otherwise, a policy will be needed that supports sensible rationing that balances the cost of meeting a need with the importance of the outcome it will achieve. All blanket policies that fetter this discretion have to be avoided.

- The role of advocates and representatives must be clarified. Outcomes working requires the service user to be in the driving seat. In some cases that is straightforward as the service user can articulate their own issues. More often, it is not straightforward. There must be clarity that when others are representing the service user, they are required to do it to certain standards. These can be based on those in the Mental Capacity Act practice guidance, even if the person has mental capacity. Family and friends cannot be allowed to impose their own views about the needs of their family member but can represent what their family member thinks. The policy must be clear about what will be done if these requirements are not delivered.

- A policy on managing disagreements. Person directed working does not mean giving blank cheques – support plans have to be fit for the purpose of delivering the best possible levels of independence health and well being. While the practice structure will require practitioners to assist people to develop their thinking if it will not result in the best outcomes for them, at the end of the day there has to be a policy that deals with what to do if agreement is not reached.

3.4 Linked strategies

Transformation of the field work service should take place within a broader vision of required changes for it to be fully effective.

- It has to be seen within a wider personalisation strategy within the whole Council.

- Development of providers to be able to work with higher levels of responsibility, flexibility and responsiveness. This in itself is a significant change process, requiring changes in the way strategic commissioning is carried out, and the way providers manage their organisations. (In the interim, the field staff can augment the support plan which will be more broad brush and assumes higher level of provider responsibility, with a risk management plan that contains more of the detail usually associated with task and volume based commissioning)
• Minimise the volume of the budget committed to pre-purchased services. This will give service users the maximum degree of choice about what type of support to use. However, it is also important to create a secure provider market. This should be achieved through providers having commercial confidence rooted in confidence in their ability to meet demand for personalised services on a day by day, continuous basis.

• Creation of an effective Resource Directory. A key source of power that practitioners have is knowledge of services. A good directory can make this information directly accessible to the person.

• Integrating the assessment process with other agencies, primarily health. Plans need to be agreed with health partners about sharing of the process and how to integrate respective processes. There is nothing in outcome focussed and person directed working that health colleagues cannot recognise. This element is particularly important in ensuring that specialist contributions are made in a way consistent with outcomes working.

• Establish a strategic commissioning process able to shape the future market in response to the range of outcomes – both met and not met – that the process will reveal.

4. CONCLUSION

There is a risk that by adopting the more radical options for transformation, we will be throwing the baby out of the bathwater. Whilst it clearly works very well for some, how confident can we be with the argument that in time, all service users will want to behave in the way that the relatively small numbers who currently want complete and direct control do? What might be more appropriate is not the complete over throw of current practices, but their transformation in a way that makes it possible for all to have the flexibility and responsiveness which is at the heart of the reforms, whilst still allowing those who want complete and direct control to have it.

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