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Counting The Cost of Choice and Control: Evidence For The Costs of Self-Directed Support In Scotland

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COUNTING THE COST OF CHOICE AND CONTROL: EVIDENCE FOR THE COSTS OF SELF-DIRECTED SUPPORT IN SCOTLAND

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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EXECUTIVE SUMMARY

Introduction

1. Self-directed support (SDS) allows people needing social care services to exercise greater choice and control over how they receive services and support.

2. The Scottish Government aims to introduce legislation in 2012 (the Social Care (Self Directed Support) (Scotland) Bill) which will consolidate existing (sometimes complex) provision for SDS. It is intended to bring SDS into the mainstream of social care and increase the numbers of people directing their own support.

3. Under the forthcoming bill, Local Authorities will be placed under a duty to offer service users a variety of options which include:

   - Direct Payments (DPs) - the making of a payment directly to service users to arrange their own support;
   - Directing the available resource - where the user selects the support that they wish and the Local Authority arranges matters on their behalf. In practice this would encompass options such as Individual Service Funds (ISFs) where the Local Authority contracts with providers on behalf of the service user;
   - Local Authority 'arranged' support where the authority arranges support on the user's behalf to meet their needs; and
   - A mix of the above options for distinct aspects of the user's support.

4. This study was commissioned to provide inform the SDS strategy and to provide evidence for the forthcoming SDS bill on the current and future costs of SDS in Scotland in order to understand the resource implications of making SDS mainstream and increasing the numbers of people directing their own support.

Background

5. Recent years have seen a growing emphasis in Scotland on developing social care services that allow service users greater choice and control, whilst being as cost effective as possible. Developments such as the use of Direct Payments (DPs) - where users can purchase their own services (for example by employing a personal assistant (PA) rather than receiving home care services) - have been demonstrated to offer some users more control and better outcomes (including improved health and social wellbeing, the ability to combine health and social care support, and to combine formal and informal care more effectively, as well as greater independence and control over services, and more cost-effective delivery of services).

6. However, the take-up of DPs in Scotland has been variable, and the option of directly purchasing their own services is not the only way that users can gain the benefits associated with greater choice and control over their services. Some of the barriers to the take-up of DPs included lack of awareness from front-line workers and managers, and the need to invest in advocacy and support

organisations to help users manage their payments, as well as concerns expressed about the risks involved for vulnerable users and a resistance to the perceived 'privatisation' of social care. Self-directed support (SDS) offers a range of options giving service users increased control over more personalised services.

7. The Scottish Government has commissioned several studies to contribute towards an understanding of the factors which determine the uptake and impact of SDS. These studies have informed both the SDS Strategy (Scottish Government, 2010) and the SDS Bill. These studies have included an evaluation of three SDS test sites in Scotland (Ridley et al, 2011) which were set up to assess the impacts of three types of intervention (bridging finance, cutting red tape and leadership and training).

Aims of study

8. The overall aim of this study was to provide macro-level financial and economic evidence on the potential costs, benefits and impacts of an increase in the uptake of SDS in Scotland.

9. The first specific objective was to describe the baseline in three Local Authorities, looking at the current operation of SDS, the number and profile of SDS clients and type of SDS accessed, to assess the current costs of providing SDS for providers, and to determine the financial and socio-economic impact of the move to SDS, including the resources needed to facilitate a shift towards higher levels of SDS and to compare this to the previous spend on social care.

10. The second specific objective was to consider the future and to estimate the ongoing and future costs resulting from the predicted shift to more SDS, and to assess the sustainability of this shift. It was also to estimate how further changes in SDS resulting from the forthcoming legislation may impact on Local Authorities, service providers, SDS users and family carers and to consider the external validity and reliability of the results.

Methods

11. Three Local Authorities who had a high number of DP users across several user groups were and the availability and accessibility of data was confirmed.

12. A range of methods were used to carry out the study:
   - a reference group of SDS users, carers and advisors who were not based in the sample Local Authorities were appointed to provide assistance in the design of the costing methodology, and to check the external validity and reliability of findings.

- Data on overhead costs associated with DPs[1] including costs of central services, transport and accommodation was collected via meetings and structured interviews with a range of Local Authority officers (n=14).
- Information from a service provider with experience of providing services across several local authorities was gathered through a focus group (8 participants).
- Interviews with service providers in the private and third sectors providing services in different geographical areas and for different user groups (8 participants).
- A group interview with representatives of a DP support organisation (2 participants).
- Anonymised, matched samples of DP users and users of standard services, stratified in terms of disability type were provided by the three Local Authorities (265 usable records).
- A postal survey sent to 210 DP users. A total of 59 responses were received.
- Desk based analysis was used to simulate different rates of increase in SDS provision and to estimate future demand and costs using information from the user survey and qualitative elements of this study and information on the prevalence of various types of disability and population estimates by Local Authority from GROS.

Main issues for Local Authorities

13. The research found that the full costs of providing SDS were difficult to measure and predict. However, the experience of DPs showed that it was possible to develop transparent costings systems for individual users.

14. There were significant variations in costs, and the way these were calculated, across different user groups and different Local Authorities. More transparency about service costs may make things fairer: however, they may also expose inequities across different groups and locations that are not easy to address.

15. Evidence suggests that Commissioners, such as Local Authorities, are likely to continue to play an important role in safeguarding the quality and cost of care services. However, individual SDS users will be able to exercise their choice about service provision, and move contracts more quickly than Local Authorities.

16. Initially, the research indicated that the resources needed for SDS assessments and monitoring may increase, but these costs were considered likely to decrease over time as SDS becomes more mainstream and systems develop. There was no evidence to suggest that the resources and costs associated with SDS will be significantly greater than those associated with managing the provision of social care generally.

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[1] In all three local authorities, Direct Payments (DPs) were the only form of SDS identified with reliable data, and therefore the data collected relates to DPs rather than the whole range of SDS options.

Main issues for service providers

17. There was broad support for the aims of SDS, particularly around the increased empowerment, choice and control offered to users. However, there were also concerns about the costs of providing flexible services, particularly the risk of investing in staff training and infrastructure if services are destabilised (e.g. by SDS users changing contracts at short notice).

18. Variations in pricing and the demand for services may make it difficult for some providers to effectively plan and deliver services.

19. There was a perceived danger of a 'two tier' care workforce emerging, with (relatively unregulated, relatively unprotected and therefore cheaper) PAs on the one hand, and (more regulated, more protected and therefore more expensive) workers for care agencies and Local Authorities on the other.

20. New possibilities and new markets may open up for providers with the expansion of SDS, particularly those able to provide high quality, responsive and flexible services, and additional support for training, advocacy and advice.

Main issues for SDS users and family carers

21. Although it is difficult to predict what these will be, the research indicated that some of the costs of the increased flexibility of SDS will fall on users and family carers. Some of these risks may be offset if Local Authorities invest in independent advocacy and support organisations, to give users and family carers support in managing SDS.

22. DP users were overwhelmingly positive about the increased choice and control offered by DPs and SDS. The benefits of increased empowerment and flexibility were also felt by family carers.

23. There was concern expressed that users and carers may find the complexity of SDS difficult to manage without sufficient support.

Future trends

24. Our research indicates that the relationship between an individual user's needs and the costs of the support they receive is not clear: higher needs do not necessarily mean costlier services. DP users are most likely to purchase services from a PA, and least likely to purchase Local Authority services. We predict that this pattern will continue under SDS.

25. There were no significant difference in the hours of care between DP users and those who received Local Authority social care services. This suggests that a move to SDS will not result in a reduction in services, and that costs do not differ significantly between DPs and Local Authority social services. We conclude that fears about reduced services and increased costs associated with SDS are therefore unfounded: personalisation and SDS do not, per se, lead to reduced services and support.

26. However, as SDS becomes mainstream, there are likely to be concerns about the market for care services if costs are driven up by new contractual forms, or by more SDS users opting to employ PAs rather than use services.

27. Our research and modelling indicates that the costs of care will increase in the next 10 years: however, these rising costs are due to rising levels of need for social care services in the population and are not specific to SDS.

28. Our predictions on the costs of SDS are sensitive to the rate of expansion – e.g. the costs of employing PAs compared to 'in-house' (public, private or voluntary sector) carers. If these costs change, or if the types of choices SDS users make deviate significantly from the way they have used DPs in the past, our conclusions are likely to be less robust.

Conclusions

29. The expansion of SDS in Scotland is not uncontentious. The aspirations for improved empowerment, choice and control which drive the policy are broadly supported by all the stakeholders involved in this project. However, it is not yet clear that SDS can deliver all it promises, particularly in the era of resource constraints and significant pressures on social care budgets. This project has highlighted significant concerns about the variations in costs across Local Authorities and different user groups, and uncertainties about equity and fairness in delivering high quality, cost-effective social care services to individual users. There are concerns about where costs will fall, and what the impact of SDS will be on different sectors. Implementing SDS policy will require, to a certain extent, a 'leap of faith' for Local Authorities.

30. However, there is no evidence to suggest that SDS is more costly than other options for delivering social care services. Given the potential for increased empowerment, choice and control for users and family carers, that 'leap of faith' will, hopefully, prove justified.

1   INTRODUCTION AND BACKGROUND

Introduction to the study

1.1   Self-Directed Support (SDS) is an umbrella term used to describe recent developments in social care policy. These developments are designed to be:

Part of the mainstream of social care delivery, targeted at empowering people and putting the principles of independent living into practice. It enables individuals to direct the care or support they need to live more independently at home and can be instead of, or in addition to, services that might be arranged by their Local Authority. These might be community care and children's services, and equipment and temporary adaptations.
(Scottish Government, 2012).

1.2   The Scottish Government aims to introduce legislation in 2012 (the Social Care (Self Directed Support) (Scotland) Bill) which will consolidate existing (sometimes complex) provision for SDS. It is intended to bring SDS into the mainstream of social care and increase the numbers of people directing their own support.

1.3   Under the forthcoming Bill, Local Authorities will be placed under a duty to offer service users a variety of options, which at the time of writing include:

- Direct Payments (DPs) - the making of a payment directly to service users to arrange their own support;
- Directing the available resource - where the user selects the support that they wish and the Local Authority arranges matters on their behalf. In practice this would encompass options such as Individual Service Funds (ISFs) where the Local Authority contracts with providers on behalf of the service user;
- Local Authority 'arranged' support where the authority arranges support on the user's behalf to meet their needs; and
- A mix of the above options for distinct aspects of the user's support.

1.4   This study was commissioned to provide evidence on the current and future costs of SDS in Scotland in order to understand the resource implications of making SDS mainstream and increasing the numbers of people directing their own support.

The history and development of SDS

1.5   SDS is neither a new nor uniquely Scottish policy development. It can be usefully set against an international background, in which there are designs across many developed welfare states to move away from state-provided services for disabled people towards more individualised, personalised, and user-centred services (Rummery, 2011). The benefits of such schemes include improved health and social wellbeing, greater independence, improved control over service delivery, improved ability to combine health and social care support, improved ability to combine formal and informal support, and more cost-effective provision of services and support (Rummery, 2006).

1.6   Recent years have seen a growing emphasis in UK social care policy on developing services that allow service users greater choice and control, whilst being as cost effective as possible. This emphasis is sometimes seen as part of a 'personalisation' agenda: giving service users access to social care services that are 'personalised' to their needs and under their control. Developments such as the use of DPs - where users can purchase their own services (for example by employing a personal assistant (PA) rather than receiving home care services), have been demonstrated to offer some users more control, and better outcomes (including improved health and social wellbeing, the ability to combine health and social care support, and to combine formal and informal care more effectively, as well as greater independence and control over services, and more cost-effective delivery of services) (Rummery, 2006).

1.7   DPs have not been without their detractors, and several commentators have voiced their concern about their implementation. These include: ideological and practical objections to the marketisation of support services (Spandler, 2004; Pearson, 2004); concerns about the destabilisation of statutory services (Rummery, 2006); the problems associated with accessing and managing payments (Pearson, 2000); the potential for exploitation and abuse of both users and workers (Witcher et al, 2000); the low level of payments compared to levels of need (Zarb and Naidash, 1994); the supply and quality of PAs to meet demand (Scourfield, 2005); equity issues concerning the differences between users and non-users of schemes (Glendinning et al, 2008; Leece and Leece, 2006); employment protection issues for statutory and agency home care workers (Ungerson and Yeandle, 2007; UNISON, 2012); concerns about the role of social work and care management support (Leece, 2007; Ellis, 2011; Dickens, 2012); mixed evidence for improved outcomes when compared with statutory services (Glendinning et al, 2008); the unsuitability of such schemes for particularly vulnerable users, including those in periods of acute mental or physical ill-health, those experiencing significant crisis or upheaval and those unable to act as employers without suitable advocates (Rummery, 2006; Ferguson, 2011); and the risks of destabilising statutory services which are aimed at those adults for whom such schemes are unsuitable (Spandler, 2004; Ferguson, 2011).

1.8   Take-up, at both institutional and individual level, has varied considerably across the UK. Priestly et al (2007) found that rates of take-up in England were more than double that of elsewhere in the UK, with some single Local Authorities (e.g. Hampshire) having more users registered than the whole of Scotland. According to latest figures rates of take-up of DPs are still far higher in England than in Scotland and, as at 31 March 2011, both Cumbria and Lancashire had more DP users than the whole of Scotland (Scottish Government 2011; NHS Information Centre 2011). Concerns have also been voiced about low and inequitable takeup amongst certain groups, particularly learning disabled, older people and Black and Minority Ethnic (BME) groups (Priestly et al, 2007). Some of the barriers to the takeup of DPs included lack of awareness from front-line workers and managers, and the need to invest in advocacy and support organisations to help users manage their payments, as well as concerns expressed about the risks involved for vulnerable users and

a resistance to the perceived 'privatisation' of social care (Pearson, 2000; Riddell et al, 2006).

1.9　DPs and the option of directly purchasing their own services are not the only way that users can gain the benefits associated with greater choice and control over their services. Several pilots in England and Wales have enabled the pooling of various budgets streams to provide 'individual budgets' for a variety of user groups (Glendinning et al, 2008). In recent years SDS developments other than DPs, such as ISFs have begun to emerge offering users greater choice and flexibility without the responsibilities inherent in DPs.

1.10　Under the current existing legislation permitting DPs and other forms of SDS, users still need to undergo a community care assessment to see if they have eligible needs. The forthcoming Bill will not change this: no 'new' users will be eligible for support who would not have been under existing arrangements. However, the legislation will provide a framework of options with the 'default' assumption being choice for individuals rather than a particular mechanism such as DPs or ISFs - it will be for users to select their preferred option and for Local Authorities to ensure that they can make an informed choice. In practice, this is expected to mean a larger volume of people using DPs and ISFs than is currently the case.

SDS in the Scottish context

1.11　In Scotland SDS is the latest in a series of policies including the Community Care and Health (Scotland) Act 2003, which placed a duty on Local Authorities to offer DPs in lieu of standard community care services. The Local Authority made the payment to the individual (or representative) to arrange the services they were assessed as needing, which for some users improved the choice and control they could exercise over their services. Scottish Local Authorities (in line with English and Welsh Local Authorities) have a duty to offer eligible people DPs. From April 2005 the first non-disabled user groups became eligible: parents of disabled children and older people (aged 65 and over) who have been assessed as needing care services due to infirmity or age (Scottish Executive, 2007). Under the Bill all Scottish Local Authorities would have to offer service users the option of directing their own support, which can take various forms including DPs. Users will still need to undergo an assessment to see if they have needs which services could meet.

1.12　A closer analysis of areas where there has been a significant uptake of DPs reveals that these areas show a history of strong disability-led user organisations (and a history of quasi-legal DPs, for example through third party trusts), and/or a political commitment to the development of markets in social care provision (Leece and Leece, 2006). The twin impetus of strong user demand and a policy move towards mixed markets in social care which have driven the development of DPs and related schemes (such as individual budgets) appears to be less prevalent in Scotland, although there has been a reduction in home care directly provided by Local Authorities from 82% in 2000 to 44% in 2011 (Scottish Government, 2011) and Scottish users of DPs

report similar improved outcomes to users elsewhere in the UK (Homer and Gilder, 2008).

1.13 However, institutional barriers to implementation of DPs in Scotland remain embedded and difficult to tackle, including an ideological resistance to 'privatisation' in social care (Pearson, 2004: UNISON, 2012) and a lack of commitment from senior managers, lack of awareness and training on the part of front-line care managers, and perceived budgetary inflexibilities (Riddell et al, 2006). In order to inform the development of SDS, the Scottish Government established three test sites to assess the impact of three interventions (bridging finance, cutting red tape and leadership and training). In the evaluation of the test sites, Ridley et al (2011) identified a number of process-related challenges facing Scottish Local Authorities and made a told of 24 recommendations for change to enable SDS to become mainstream.

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1.14 Nevertheless, uptake of SDS in the form of DPs has increased in Scotland from 207 users in 2001 to 4,392 in 2011, and the total value of DPs has increased from £2.1 million in 2001 to £50.2 million in 2011 (Scottish Government, 2011). The sharpest increase nationally has been in recent years, with 29% of DP packages ongoing in March 2011 being in place for less than a year. The forthcoming legislation, which is predicted to increase take-up of these types of SDS, builds on the growing number of users and Local Authorities with experience of using DPs.

1.15 Recent Scottish Government data indicates that SDS users who receive DPs are purchasing the following types of support:

Type of provision	Number of SDS (DP) packages	% of all SDS (DP) packages
Personal Care	2918	52
Social/educational/recreational activities	1062	19
Respite	984	18
Domestic Tasks	827	15
Housing Support	535	10
Other	334	6
Health Care	181	3
Meals	147	3
Equipment and temporary adaptations	31	1

Source Self-directed Support (Direct Payments) Survey, Scottish Government (2011)

1.16 Moreover, the same data indicates that 39% of DP users are employing a PA, and 34% are purchasing support directly from a service provider. "Care-providers" within the context of SDS can mean individual PAs AND organisational service providers. The important role that support and advocacy organisations play in facilitating access to DPs means that their perspectives on the costs of SDS are also vital to understand.

1.17 Uptake of DPs has been variable across Scotland, as the following data shows:

Figure 1.1 Rate of SDS (Direct Payment) per 10,000 population

Area	Rate
Scottish Borders	25.8
Orkney	22.4
East Lothian	16.4
Argyll and Bute	16.3
Moray	15.0
Edinburgh	14.0
Midlothian	11.7
Dumfries and Galloway	11.4
East Dunbartonshire	11.2
Highland	11.0
Stirling	9.8
Shetland Islands	9.4
Perth and Kinross	8.7
Scotland	8.4
South Lanarkshire	8.3
Fife	8.3
Aberdeenshire	8.2
Inverclyde	8.0
Clackmannanshire	7.8
Falkirk	7.8
Eilean Siar	7.5
Aberdeen City	7.2
East Ayrshire	7.2
East Renfrewshire	6.9
West Dunbartonshire	5.6
Angus	4.9
South Ayrshire	4.9
West Lothian	4.8
Renfrewshire	4.5
North Ayrshire	4.2
Glasgow	4.1
Dundee City	3.3
North Lanarkshire	2.3

Source: Self-directed Support (Direct Payments) Survey, Scottish Government (2011)

1.18 Low rates of take-up are typically found in urban areas with relatively high levels of deprivation (e.g. Glasgow, Dundee and North Lanarkshire - however other forms of SDS have been developed in North Lanarkshire which do not show in these figures). Higher rates are associated with rurality (e.g. Scottish Borders, Argyll and Bute, Dumfries and Galloway). Higher rates may also be due to the retendering of services in some areas (e.g. Edinburgh, Scottish Borders). The absolute number of DP packages is also typically larger in the larger Local Authorities.

1.19 Figure 1.2 shows that across Scotland uptake of DPs is more common for those with physical and learning disabilities than for frail older people, even though the latter form a larger proportion of the population eligible for social

care support. This is an important issue, with implications for the future demand for, and therefore the sustainability of SDS.

Figure 1.2 Number of people in receipt of SDS (Direct Payments) by user group

- Other (including Frail Older People) 24%
- People with Physical Disabilitites 40%
- People with Mental Health Problems (including Dementia) 8%
- People with Learning Disabilitites 28%

Source: Self-directed Support (Direct Payments) Survey, Scottish Government (2011).

The implications for this study

1.20 Evidence from England suggests that the costs of DP and other SDS-type packages varies considerably across user groups and across levels of need (Glendinning et al, 2008). The evidence also suggests that the variation possible in SDS will make it difficult to accurately assess the possible costs and different models of take-up across Scotland. The national SDS strategy, published in 2010, stressed that:

The mechanisms for getting support through SDS can be through a Direct Payment (DP) or through the person deciding how their individual budget is allocated by the council to arrange support from a provider. Some people may choose to leave the decision on how their support is provided to the council. (Scottish Government 2010, p7)

1.21 The DP model – whereby people manage their own payments and directly purchase their own support – is however the most well-established model of SDS. A recent evaluation of SDS test sites in Scotland concluded that:

…progress [towards SDS] will very much depend on local areas getting agreement at senior level on the scope of activity and having dedicated resources in place to take this forward…rather than perceiving DPs as an option on the SDS continuum, new and parallel SDS systems to those

delivering DPs were created, with subsequent attempts at integration occurring late on in the test sites. (Ridley et al, 2011, pg 68)

1.22 This does suggest that considerable investments in management systems would be needed if Local Authorities were to deviate too far from those systems established to support DPs. It is therefore likely that DPs, or DP-type options, will continue to be one of the preferred options for SDS. Certainly at the time this study was commissioned and carried out, DPs were the most common form of SDS. The aims, methods and findings of this study – discussed in the next chapter – should therefore be approached within that context, and with some caution. We do not really know what the full range of SDS options will cost for Local Authorities, users, carers and providers because we do not as yet have a full understanding of the mechanisms or methods which may be pursued, particularly those which offer greater choice and control to users without using DPs. We have focussed on DPs as offering the most robust evidence to date for the costs of SDS and we can surmise what some of the costs of SDS will be based on our understanding of how the costs of using DPs have impacted on Local Authorities, users, carers and service providers.

Structure of report

1.23 The next chapter of this report gives an overview of the aims and methods used in this study. The following four chapters present the study findings. Chapter three presents the Local Authority perspectives on the costs of SDS, and chapter four presents the views from service providers and advisor organisations. In chapter five we present the findings from DP users on the costs of their social care services, and in chapter six we present the analysis of findings from the users of DPs and standard community care services, and apply these findings to modelling the resource implications for the future of SDS. In chapter seven we discuss the implications of our findings for the different stakeholders involved in our research and in the future of SDS in Scotland. Finally, in the Appendices we give further details of the methods used in the study, a glossary of terms and some additional demographic information about the users we surveyed.

2 OVERVIEW OF STUDY

2.1 In this chapter we give details of the aims, design and methods used in this study. Further details, particularly of the sampling frame, data sources, and the ways in which we analysed the data and tested for the validity and reliability of our findings, as well as ethical considerations, can be found in Appendix 1.

Aims and design of the study

2.2 The overarching aim of this project was to establish the current costs of SDS in three Local Authorities in Scotland, and from that baseline estimate the future costs of giving users more choice and control using SDS options. The most robust evidence available to date is around DPs and 'standard' community care packages rather than the fuller range of options envisaged in the forthcoming legislation. We have therefore based our methods on using the DP evidence base. This project gathered macro-level financial and economic evidence on the actual and potential costs, benefits and impacts of an increase in the uptake of DPs and DP-type SDS services in Scotland.

2.3 The study aimed to:

- establish the baseline and current position of DP services in three Local Authorities;
- compare the costs for a group of DP users with a matched group of users receiving standard services for a stratified sample of users controlled for user group and need level; and
- use any differences between levels of resources allocated to DP users compared to matched recipients of arranged services revealed by this data to model and predict the future costs associated with an increase in uptake of DP-type services within those Local Authorities.

Methods

2.4 We used a flexible design and drew on methods which had been used and validated in previous studies, in particular interrogating a range of existing health and social care-related datasets to inform a microsimulation model (Bowes and Bell, 2007) and using questions developed and validated in related studies (Glendinning et al, 2000; Glendinning et al 2008) as the basis for establishing the costs of SDS for users. The data collected via these different methods contributed to our understanding of the present and future costs of SDS in Scotland, although we drew primarily on the qualitative data from interviews with Local Authority/service commissioners and service providers, and on both qualitative and quantitative data from the comparison of data on DP users and users of standard services, the survey of users and other data in the public domain.

2.5 The following outlines the methods and the information collected in each element of the study:

Reference Group

2.6 We appointed a reference group of SDS users, carers and advisors who were not based in the sample Local Authorities to provide assistance in the design of the costing methodology, and to check the external validity and reliability of findings.

Local Authorities

2.7 Three Local Authorities were selected to take part in the study based on key criteria (range and volume of DP users, non-overlap with SDS test sites). It was important that participating Local Authorities would be able to provide data on sufficient numbers of DP users across the range of user groups for use in the microsimulation modelling process. SDS test sites were not approached as it was felt that these might not be reflective of the national position in relation to the implementation of SDS.

2.8 All three selected had a high volume of DP users across several user groups, and together represented a mix of urban and rural provision. In advance of confirming their inclusion in the study it was established, as far as possible, that the data required for the study was available and accessible. All three Local Authorities agreed to take part in the study.

2.9 Data on the profile of DP users in the three Local Authorities and the costs of their packages was collected using a pro forma. The pro forma provided an indication of the required fields for data extraction for the purposes of the research. In order to minimise the additional burden on the participating Local Authorities and facilitate the data extraction process the pro forma was based on selected elements of the Scottish Government Health Directorate's 2011 data specifications for annual returns related to Self-directed Support and Home Care respectively.

2.10 The overhead costs associated with DPs in each of the Local Authorities were examined. This included costs of central services, transport, accommodation etc. The data was collected through a combination of email and telephone conversations, structured preliminary meetings and structured interviews with relevant Local Authority officers. In total 14 Local Authority officers were consulted. Participants in preliminary meetings (n=10) included Heads of Social Work and Health and senior staff in contract management, business performance, research and information services, and financial teams supporting social work. Interviewees' (n=5) held senior roles in social work development, assessment and care management services (2), contracts management and direct payments team management. One person was both a meeting participant and an interviewee.

Service providers

2.11 A focus group with 8 participants was conducted with a service provider with experience of providing services across different Local Authorities. The participants included the CEO, Finance Director, Contracts and Commissioning Officer, Director of Client-related Services and a number of Regional Managers. We asked about: experiences of SDS implementation across different Local Authorities and understandings of the experiences of their clients; experiences of Local Authority contract models and anticipated changes; costing and provision of services and whether this would change with different numbers of SDS users; perceptions around support required by and provided for SDS users; workforce requirements in anticipation of changes in SDS use; and threats and opportunities around the promotion and implementation of SDS.

2.12 We identified and interviewed service providers (with experience of providing services to DP users) in the private and third sectors operating in different geographical areas and providing services to a mix of different client groups. The interviews aimed to estimate the providers' setup and running costs for SDS packages (two interviews with single interviewees and two group interviews with 2 and 4 interviewees respectively). We also asked them about perceived opportunities for and obstacles to expansion should demand increase, including both labour and finance constraints.

2.13 We then estimated set up and brokerage costs for providers using data provided by service provider interviewees.

2.14 An interview with representatives of a DP support organisation (2 participants) was also conducted to provide data on costs of support services for DP users, to discuss the implications for support organisations should numbers of SDS users increase, and to get support organisation perspectives cost-related issues raised by interviewees from other stakeholder groups.

Service users

2.15 The three participating Local Authorities were asked to provide the anonymised records of 'matched' samples of SDS (DP) users and 'standard' users (receiving care services arranged by the Local Authority). Users included in these samples were matched in terms of type of disability[2] and basic demographic details such as sex and age. Local Authorities were requested to stratify the samples in terms of disability type but to select user records randomly within each type.

2.16 The sample sizes varied between participating Local Authorities, based on numbers of SDS users and the authority's resources available to access the required information. Data requested as part of the anonymised records

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[2] For simplicity we use 'disability' to cover anyone, of any age, who has social care needs covered by self-directed support. This can include disabled children (and carers of disabled children), older people, and people with mental health needs and learning disabilities.

included: age; gender; marital status; household structure (if known); service user type; risk band; date current SDS / arranged package started; details of current SDS / arranged package in terms of numbers of hours and type of support; sources of funds included in package (DP, ILF etc); date of assessment; date of care plan; and details of previous package(s).

2.17 In sampling the non-DP users for comparability, we matched user groups, service users and levels of need as far as possible. The sample of DP users for the user-derived costs was stratified according to levels of need using Local Authority data. Additional data was also collected on need levels from users themselves, using a structured questionnaire and validated measures such as the GHQ IADL scores to ensure our findings were valid and reliable (see para 2.18).

2.18 Supplying the requested data provided a challenge for all of the participating authorities, as individuals' records often spanned different computer and paper-based systems. In total 265 usable anonymised records were returned.

User survey

2.19 A postal survey of the sample of DP users provided by the Local Authorities was conducted to gain structured information about levels of need (using GHQ IADL[3] and other validated measures). The questionnaire was initially tested with the reference group, advisory group and with the three Local Authorities. The wording on a number of questions was subsequently modified to try to provide greater clarity of purpose and to reflect variations in terminology and differences in ranges of services included in DP packages across the participating Local Authorities.

2.20 The questionnaire sought information on the size of the DP package, the length of time the user had been receiving the DP, the support services purchased using the DP, other services purchased and demographic data. Respondents were also asked why they chose a DP and whether they were satisfied with the value of the DP. Data on costs including set up costs and hidden costs borne by users and carers was also collected. We distributed 210 questionnaires to DP users and received 59 usable responses.

Modelling

2.21 Desk based analysis was undertaken to simulate different rates of increase in SDS provision to estimate future demand and costs, using information on the prevalence of various types of disability and population estimates by Local Authority from GROS.

Validation of findings

2.22 We tested the reliability and validity of our findings by checking them with our reference group and by carrying out a workshop at the University of Stirling to

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[3] General Health Questionnaire Instrumental Activities of Daily Living

which we invited all the research participants, together with a range of other stakeholders.

The participating Local Authorities

2.23 Table 2.1 details the characteristics of the three Local Authorities which took part in this study with respect to uptake and value of DPs.

Table 2.1 Characteristics of participating Local Authorities

Authority A was a primarily urban Local Authority. It was the largest of the participating authorities in terms of the population that it served, but the smallest in terms of area. Authority A had a rate of receipt of DP per 10,000 population higher than the Scottish average, and an estimated median value of DP package higher than the Scottish median value.

Authority B was a primarily rural Local Authority. It had the smallest population of the three participating Local Authorities but was responsible for the largest area. Authority B had a rate of receipt of DP per 10,000 population higher than the Scottish average and an estimated median value of DP package lower than the Scottish median value. Authority B has a relatively larger proportion of older DP users compared to Authorities A and C.

Authority C was a mixed urban-rural Local Authority. It had a population smaller than Authority A but larger than Authority B, and covered an area larger than that of Authority A but smaller than that of Authority B. Authority C had a rate of receipt of DP per 10,000 population lower than the Scottish average and an estimated median value of DP package higher than the Scottish median value.

Costings data

2.24 Data gathered from Local Authorities was likely to miss some components and under-report the full costs of packages of care (particularly of DPs). Data gathered from individual users therefore gave a fuller picture of the range of costs to users and carers. However, there were problems of recall or lack of data about full amounts, frequency and type of services and timings, and users could not be expected to know details of the costs of 'standard' services. We therefore used both data sources to allow for the strengths and weaknesses of each approach, relying on Local Authority data and a modified version of the costings used by Curtis (2009), adjusted for inflation and the local context, and on the results of the postal questionnaire of users.

2.25 For a fuller discussion on reliability and validity of instruments and results and limitations of the data please see Appendix 1, paragraphs 8.3 to 8.7.

3   FINDINGS 1 – LOCAL AUTHORITY/SERVICE COMMISSIONER PERSPECTIVES

Introduction

3.1   In this chapter we present findings concerned with the costs of SDS for Local Authorities in their role as commissioners of social care services, which we used for predicting and modelling the costs of changes to SDS from 'standard' care. The evidence from this chapter is drawn from the individual interviews with commissioners and managers in the Local Authorities, interviews with workers in support and advocacy organisations, views from the reference group and the participants in the workshop discussions.

Variation

3.2   We found wide variation in the kinds of structures, systems, criteria and expectations concerning SDS across the three Local Authorities participating in this study. Although all three authorities had a relatively long history of offering DPs to service users, there was considerable variation in the criteria for accessing services, the kinds of assessment systems in place, and the types of services that users could use their DPs to purchase. This variation was also found in other Local Authorities.

3.3   Local Authorities A and C had large numbers of DP users who were younger disabled people or people with learning disabilities, and few frail older people on DPs. In contrast, over half of Local Authority B's DP users were frail older people.

3.4   In all 3 Local Authorities there was also wide variation in the assessments and records kept between different user groups (with learning disabilities the group likely to have the most standardised criteria for accessing services and DPs across Local Authorities), and between DP users and those receiving 'standard' services.

3.5   Systems for keeping records and allocating unit costs for individual packages of care were much more developed for DP users, with individual service users having to provide often quite detailed accounts of expenditure on different services. Bespoke service systems and, in some cases, distinctive support structures created specifically to enable the use of DPs meant that robust ways of costing services had been identified. These methods varied: sometimes services were costed by hour, sometimes by service input, sometimes on a block or individual contractual basis.

3.6   However, identifying the costs of services to individual service users who were not using DPs was far more problematic, even though, in all three Local Authorities, these remained by far the majority of service users. Unit costs for some types of service (e.g. home care and residential care) were relatively easily available, but for others (e.g. daycare) this was more difficult. Local Authority B in particular envisaged that unit costs for daycare would increase significantly if more users switched to DPs and withdrew from using the

service: concerns regarding the longer-term service viability led to daycare services not being included in DP packages whilst that situation was being assessed.

3.7 Accessing individual-level data was difficult: often the information was held over several different, often incompatible, systems. Local Authority A in particular noted that it was often easier to see where money had come from (e.g. Independent Living Fund, NHS etc) than to track where it went. There was not necessarily any easy way to link up assessments of needs and the costs of directly provided services, and identifying the 'matched sample' of service users was difficult across all three Local Authorities. Moreover, it was often difficult to access information for service users with longer-standing care packages.

3.8 There was also considerable variation in how the unit costs of packages that were available to DP users were calculated over time. One informant in Local Authority C explained:

[To calculate the costs for SDS users] we are using equivalency at the moment - we are basically just saying whatever it costs now for the service they are getting is the funds we are making available to them on an SDS package....if they are employing their own staff we have a rate that we use for that and we would give it based on whatever the current cost was. If they are using an agency just now, we would give them whatever the agency cost. If they are attending a day centre, we will given whatever the day centre cost. We have a unit cost for home care, we have a daily cost for all day care resources and we know how much respite costs so that pretty much covers it.[However] that will definitely change. We are in the very early stages of starting to look at how to get to a resource allocation system....it is just an indicative amount...it is an exercise fraught with difficulty. (Interview, Local Authority direct payments team manager, LA C).

3.9 It is interesting to note that costs for DP users are therefore likely to be far more transparent than for non-DP users. If more users switch to DP-type schemes, it will therefore become much easier to track the relationship between the type and cost of individual services and support. This can make the direct impact of a reduction in, or change in the distribution of, available resources more transparent to users. For example in the case below where the method of support agency funding changed, with DP users able to both see the amount of their DP allocated to support services and to choose where to spend it as a result:

Last year the direct payment rate was £12.20 an hour and the council funded us to provide the employer, admin and payroll support to folk….. We had a complete change, the hourly rate was reduced to £11.50 to the clients....we are now selling our services to individual clients. (Interview, direct payments agency support and advice agency, LA B).

3.10 As Local Authorities develop resource allocation systems[4] that enable the tracking of costs of services at an individual level, it should become easier to identify discrepancies in resource allocation across different user groups and across different individual users. Several commentators therefore expressed the concern that different user groups who might have been relatively generously served might lose out under SDS developments, and Local Authorities will face a significant challenge in managing this change fairly. In terms of how this relates to our cost predictions and modelling, it is likely that increased transparency in costings will reduce variations, enabling simpler and more effective administrative systems. This may well reduce the organisational costs associated with changing systems in the longer term.

History, structures and responsiveness

3.11 There was a concern across Local Authorities that a shift to more variation in different types of SDS would introduce significant costs because of the risks and costs associated with destabilising existing providers. One informant explained:

We are having quite a difficult time for service providers actually because they get a contract for two years so you know where you are with that, but if, during those years you might lose half your contract, that could be quite worrying. (Interview, Local Authority direct payments team manager, LA C)

3.12 History and structures played a significant role in how responsive commissioning arrangements could be to the needs of SDS users. Service level agreements with key providers were usually contracted on the basis of long-standing relationships based on trust and on evidence about the quality of provision. Similarly, prices and contracts for standard services were usually negotiated on a clear indication of the relatively predictable level of demand, based on past volume. If unpredictable numbers of SDS users were to renegotiate contracts on an individual basis at short notice, for example due to change in provider status or ownership or adverse publicity, there was some doubt as to whether commissioning arrangements would be sufficiently robust to cope with the need to be responsive to users' needs.

I would think service providers would be a bit anxious that they could set up a whole approved package of support for someone and then six weeks later they say, no I do not like you and I do not want you anymore (Interview, Local Authority direct payments team manager, LA C)

3.13 Support agencies also pointed out the possible need for fair 'notice periods' to be built into contracts so that SDS users could not abruptly cease using a service:

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[4] Resource Allocation Systems (RAS) are a means of deciding how much money people are entitled to, to be able to purchase the support they need – see
http://www.centreforwelfarereform.org/innovations/resource-allocation-system-ras.html

You do not know how the future is going to be. We have four weeks' notice on either side, but it may be that we have to put something about if you wish to no longer use our services you will need to give x months notice. It is difficult because they have only got a limited pot of money as well (Interview 2, Local Authority B Direct payments agency)

3.14 There was a concern that moving away from historically tried and tested methods of commissioning would place an administrative burden on Local Authorities, who may have to bear the costs of ensuring that individual SDS users pay invoices promptly. All three Local Authorities had relatively high numbers of DP users who directly employed their own PAs and were therefore experienced in dealing with payroll, invoices and other administrative details. Systems had been developed to ensure that users were given enough information and support to manage their funds appropriately, and support organisations had built up a history of knowledge and good working relationships with both users and providers. It was felt that these systems and organisations could come under threat if high numbers of new users wanted to opt in and out of services quickly, although our data also suggests that users prefer to remain with reliable providers rather than make many changes which may threaten the continuity of the support they receive.

Quality and cost

3.15 The relative strength that Local Authorities have, as large scale organisations, in the commissioning process has an impact on the kinds of service contracts they are able to negotiate with providers. It gives them a particularly strong lever to direct the quality of care that individual contractors may not have.

Obviously all service providers are required to register with the Care Commission so the quality of the care should be up to a certain level of standard, but we currently have issues with direct payment recipients who are pretty much seen by the service providers as self-funders and so restrictions in relation to charges rates they charge do not apply. There is no protection at the moment for service users in relation to that. (Interview, Local Authority direct payments team manager, LA C)

3.16 Nevertheless respondents across all three Local Authorities pointed out that the flexibility of SDS, coupled with the amount of control exercised by users, enabled users to quickly change providers when they were unhappy with the quality of the service being offered, if alternative providers were available. Where providers are forced to respond quickly to users' needs in this way, the likelihood of Local Authorities being locked into large scale contracts with poor quality providers may be reduced. By shopping around between providers, SDS users may well be in a position to improve the quality of care provision more quickly and cost-effectively than using the Care Commission and inspections.

Local Authorities as care commissioners

3.17 Under SDS Local Authorities will still have an important role to play in assessing the needs of potential SDS users, enabling them to put together packages of care (and as the guidance makes clear, they may well retain involvement in directly providing or commissioning services on behalf of users for a significant proportion of their users). The views of respondents varied significantly as to their perceptions of the impact that the move to SDS would have on these costs. Local Authority C found that it took significantly longer for social workers to carry out assessments for DPs than for directly provided services - they estimated twice as long. However, Local Authorities A and B asserted that the level of assessment, monitoring and review needed for DPs was not significantly greater than that needed for traditional care management.

3.18 Moreover, as systems for assessment and monitoring of SDS become more streamlined and simpler to use, respondents envisaged a reduced role for social workers as more like 'care brokers' for the majority of service users. Whilst they saw a continuing important role in safeguarding vulnerable adults, many Local Authority respondents were hopeful that SDS would enable a greater share of the responsibility for monitoring and review to be held by users rather than the Local Authority. In time this might make the reinvestment of resources from assessment and care management to frontline services possible, which would increase the volume of resources available to SDS users. The anticipated savings from the reduced role that Local Authorities would play as care commissioners would also offset the costs associated with moving to new governance and organisational systems resulting from SDS.

> *I do think that if self-directed support is implemented in its purest sense and we are empowering individuals to the extent that the Bill suggests that you should be doing, then the responsibility will move to the service user. (Interview, Local Authority direct payments team manager, Local Authority C)*

3.19 However, respondents were keen to point out that any such savings might well take a long time to materialise. Support agencies also pointed out that the need for sufficiently resourced support would continue and probably increase under SDS, as the possible multiplicity of options and providers could prove challenging for users to negotiate. The need for clear, transparent and fair systems for both costing and managing SDS was stressed: costs were estimated to be significantly increased by the complexity and fragmented nature of the present system.

Summary

3.20 The findings from this chapter are;

- We found considerable variation in the management systems concerning SDS across the three Local Authorities. Simplifying the management systems associated with SDS, particularly reducing the variations in the way information is kept across systems, user groups and accounting procedures in different Local Authorities, could significantly reduce the costs of SDS;
- Respondents suggested that costs for users with DPs were likely to be more transparent than costs for those receiving standard services. Improved transparency in costing might improve efficiency and equity across different geographical areas and different user groups;
- Providers may be at risk of bearing the costs of SDS users changing service with little notice, although we do not know how likely or prevalent this will be;
- SDS users may be in a relatively weak position to directly negotiate the costs and quality of service provided;
- However, SDS users may be a relatively strong position to elicit improvements in quality by withdrawing from poor quality providers;
- A gradual reduction of the monitoring role played by Local Authorities (as is recommended in the guidance for the forthcoming legislation) as SDS users take on more responsibility may, in the long-term, produce some cost savings that could be reinvested in services.

4 FINDINGS 2: PROVIDER AND ADVISOR PERSPECTIVES

Introduction

4.1 In this chapter we discuss a range of issues and concerns associated with the costs of SDS that were raised by provider organisations. The findings discussed in this chapter, alongside those discussed in chapters three and five, informed the analysis and modelling of SDS costs in the chapter six, and our discussion of the issues raised for various stakeholders in chapter seven. They are based on the interviews with individual provider organisations (both Local Authority specific and crossing Local Authorities), interviews with workers in advisor and advocacy organisations, the focus group with representatives from a user-specific provider organisation, and views expressed in the workshop discussion.

SDS: Empowerment or cost cutting?

4.2 At the time the fieldwork for this project was taking place, cuts to social care spending in Scotland and the wider UK were making headlines both nationally and locally. Several Scottish Local Authorities had moved large numbers of users onto DPs whilst re-assessing their needs and reducing service packages, and there was a general feeling amongst all the participants in this study that the 'new austerity' in welfare following the financial crisis was having, and going to continue to have, a significant impact resulting in the reduced availability of social care services. The timing of the move towards SDS and cuts to social care happening at the same time had the effect of linking DPs and SDS in the minds of provider and advocacy organisations with cuts and reductions to services, rather than with the broader goals of user empowerment and control. One provider discussed how a public disquiet engendered by the withdrawal of some services affected perceptions of SDS:

> *When this is being discussed, it is consistently stated that self directed support is not about saving money, it is about transforming the way things are done, however, the issue about having to use resources wisely and the eligibility criteria and so on - it is all there anyway. It would be clear to everybody who is in the social care sector that the council is not going down this route because it is going to save them money, that is not the case....[However] I think the experience in [Local Authority A] showed that if you do not do commissioning and retendering in the way that is carefully thought out...people can take the wrong message from that in terms of feeling that they are being put for sale...we have the experience... of people reacting very strongly to the way that self directed support was being approached. (Interview, voluntary sector provider, Local Authority B)*

4.3 Providers cited many case examples where, despite reassurances that SDS was not 'about saving money', support packages were being reduced due to resource constraints as SDS packages were being negotiated with users. They were alarmed about the implications of this for users:

The council had identified a budget for some individuals, but we had identified catastrophic risks associated with just changing and agreeing that because what it meant, essentially, is that individuals who have always had 24 hour support had someone with them all of the time. With the new budgets that were identified, it would not be possible to give them 24 hour support, so there may well be periods in the day and in the week where they have no support and, ultimately, that comes with a lot of risks. (Focus group, client-specific cross LA providers)

4.4   However, there was a sense that different Local Authorities were managing this budgetary pressure in different ways, with a differential impact on DP users and the transition to greater uptake of SDS. One provider stated that he was 'very uncomfortable' with the overt use of SDS as a vehicle to save money, which ran in direct opposition to the stated aims of the policy. This had the effect of damaging relationships between providers, users and Local Authorities:

The difficulty which providers have in this process is that a Local Authority have gone into this with a determination of what is going to come out, so it has been predetermined in some ways. That is something we have been incredibly uncomfortable about because it does not seem to be a personalised approach. Our perception is that in getting to the place we have with some individuals now, that has only been at significant compromise to those individuals in terms of the quality of their life and life experiences just now. That, in our view, has not been the intention of personalisation. (Interview, voluntary sector service provider, cross Local Authority)

4.5   A related concern was that users with good past experiences of DPs offering choice and empowerment would find moving to a service that had been reduced due to resource constraints difficult, and that this would cause significant anxiety. One interviewee spoke of a conversation with a client with a learning disability who had recently switched to SDS:

[S/he] was saying that it is brilliant, I have got a life, I can do the things I want to do. I used to go to a day centre and I was bored but now it is great and I am really really happy but I am worried what if someone takes that away from me in the future, what if somebody changes that, and that was a really understandable concern. (Interview, voluntary sector provider, Local Authority B).

4.6   It is difficult to estimate what the costs associated with these concerns might be. On the one hand, managing changing needs and resources is what the present system of social care allocation in Scotland is explicitly designed to do. As one provider pointed out:

We have experienced a number of people we support whose care packages have been reviewed downwards in a way that really the priority, I suspect,

was to save money for the council, but that has not been anything to do with self-directed support, that has been to do with the financial constraints within the council. (Interview 2, voluntary sector provider, Local Authority B).

4.7 On the other hand, if, as some of the Local Authority commissioners asserted, the costs associated with monitoring and review of SDS are not very different from those associated with standard care management (and indeed may well reduce as users take on more responsibility for managing their own care packages), then the implications are that the risks - and therefore the costs - of managing changes will be borne by users.

Cost and quality

4.8 The second range of concerns expressed by providers with regards to costs related to their view that there will be strong pressure for SDS users to commission services for themselves based on price rather than quality - although we do not know, of course, whether this will really be the case, and both our own research and that conducted by Leadbetter et al (2008) and Wood (2010) indicate that factors such as the quality and continuity of care are of greater importance that price alone.

That [perceived pressure] can be quite difficult for families who are thrust with this responsibility that they have never ever had, where the authorities dealt with that, where the authorities assessed a provider, where there is quality assurances procedures in place between the Local Authority and the provider. Parents of individuals that have got significant disabilities are going to have the responsibility to decide and they will probably be driven by cost initially without really having the understanding about the quality, about the quality assurance models that are behind all that and essentially what they may or may not provide. (Focus group, client-specific cross Local Authority providers).

4.9 Some of the costs associated with providing a high quality service are to do with the recruitment and training of the workforce. There were concerns expressed that currently investment in training is supported by providers and by Local Authorities who have quality standards, including workforce qualifications, in mind when they commission services. PAs who are directly employed by individuals using SDS do not have to attain social care qualifications, which caused some concern amongst providers:

We invest a lot in the recruitment process to taking up references, to supervising workers, to training them and protection issues, to having an organisational stance on disclosures. It worries me when you are buying personal assistance as to the power imbalance and the relationship issues that may well transpire as a consequence of that. (Focus group, client-specific cross Local Authority providers)

4.10 Some providers were concerned that SDS users may be able to undercut agency providers by compromising on the quality of care:

There would be a financial attraction in employing a personal assistant because they buy a service from us and we charge them, say, £15 an hour. They will say, I can hire a personal assistant, a good one, and I will pay her £8 an hour - there's a wee bit on costs, I can do the whole thing for £10 an hour - so I can buy more hours, or I can do something else. But the £15 we are charging includes the costs of training, the costs of managing staff, staff supervision. Potentially you could get a whole lot of unregulated, unsupervised, untrained people providing support to vulnerable people. (Interview 2, voluntary sector provider, Local Authority B).

4.11 However, in some cases SDS users will be effectively providing the 'training, managing and supervision' of staff themselves, so it makes sense that this investment frees up resources to be used elsewhere. If they chose to commission a service from an agency at a higher fee, then it could be argued that they will be making a rational choice to pay for the 'training, managing and supervision' element rather than provide it themselves. It is difficult to predict how much SDS users would make these decisions based on cost rather than other criteria (Leadbetter et al, 2008; Wood 2010), but the aims of the SDS legislation would indicate that policy makers intend these choices to be made by SDS users themselves.

Variation, flexibility and costs

4.12 Some of the larger providers contracted for services across different Local Authorities, and were used to the different ways of setting prices and service level agreements (as one informant put it: '32 different Local Authorities means more than 32 different contracting arrangements'). They were confident that this ability to respond to variation would translate into good practice in contracting with individual SDS users.

Our basic financial system could cope with 95 invoices instead of one invoice. We are big enough to be able to have that infrastructure probably in place. (Interview2, voluntary sector provider, Local Authority B).

4.13 However, this might mitigate against smaller providers who only had experience of contracting with one Local Authority. Representatives from smaller providers voiced concerns that if provider organisations were not able to develop systems that could cope with varying and flexible demands from SDS users, they might not be able to continue operating if a large amount of business came that way. This would mean that fewer, larger providers could dominate the market, potentially reducing choice, increasing costs and increasing prices for SDS users.

4.14 However, it is difficult to assess the real impact this would have on the costs of SDS. Experience with DPs shows that most (but not all) users preferred to directly employ PAs rather than to contract with agencies, partly because of the flexibility, control and working relationships that this makes possible.

Although not yet extensive, there was anecdotal evidence of PAs leaving agencies to work privately for DP users and concern that this would become more common if more users directly employed their own carers: some users in our survey had done this and several examples were cited by provider agencies. Whilst this has cost implications for the agency, it also indicates that good quality workers would have a potentially wider range of employers under SDS. Provider agencies and SDS users may well compete to offer better working conditions: the scope of SDS users will be limited to do this if the wages they can offer PAs are not competitive. The increased choice and flexibility offered to good quality care workers might have the effect of forcing both agencies and SDS users to be very careful about the conditions and pay they offered workers.

4.15 There was a concern expressed that providers would be left to take on the costs associated with SDS users terminating contracts with short notice, or having changing needs and experiences:

In terms of DPs, people are shopping around so there is very much that bit in our service agreement we have to look at cancellation periods or ending periods as well. In terms of recruiting staff, if you recruit a full time member of staff because a family come to you looking for that but six weeks later it is not there, you are then left with staff, and there are practical issues about contracts. (Interview with voluntary sector service provider, cross Local Authority).

4.16 Other informants pointed out that some of the costs associated with wanting flexibility and the ability to change providers quickly would fall on users:

It affects the cost of the service to the person. There is an issue there about how much money people will have available to them to purchase support and obviously individuals would not want to be in a position where they are signing up to something and they are having to pay for that when they no longer want it or whatever....In terms of expecting people to take that on and pay for it, I think would be unrealistic - and would they have the money to be able to fund that, because in effect, that individual would have to double fund probably if they decided they had the need and they had to get it from somewhere else, they are funding the new services while they are funding the old services. (Interview1, voluntary sector provider, Local Authority B).

4.17 In effect, this is a micro-version of the argument that providers and Local Authorities will need bridging finance to enable them to invest in new services and systems before resources are released from the closure of old services. However, the 'bridging finance' in this case is likely to come from the resources available to SDS users themselves, rather than through Local Authorities. There is therefore a tension between the needs of providers (to be able to recruit and retain trained staff, to be able to keep their organisations in business) and those of SDS users (the need for flexibility in support options).

What kinds of systems are developed will have an impact on the costs for users and providers, and where those costs fall.

4.18 Some providers were positive about the possibilities opened up to new providers entering the market who might be in tune with the needs of SDS users. It was felt that this was likely to increase choice and quality for SDS users whilst keeping costs down.

The role of care managers, carers and advocates

4.19 Like the commissioners, many providers envisaged a reduced role for care management as SDS users and their carers took on more responsibility for arranging and managing their own care packages:

During your usual commissioning meeting, we had mum, care manager, and us. Throughout the whole meeting the care manager did not have anything to say because it was mum who was doing it all. She was effectively put in control of that because she held the budget. She knew exactly what they wanted to do and it was more a case of her getting into discussion or constructively challenging us about how we could actually achieve those key outcomes with that amount of money, but all through the meeting I was getting more and more conscious that the care manager was just kind of there and had nothing much to say. (Interview, voluntary sector provider, cross Local Authority).

4.20 Clearly articulate and well-informed SDS users (or those with powerful supporters and advocates) are going to be in a fairly strong position to negotiate services at a higher quality and reduced cost. However, as a higher volume of users without these attributes enter into SDS, it is clear that care managers and advocacy and support organisation will have to play a significant role in enabling more vulnerable users to receive care services that meet their needs and are within their allocated budgets. It is therefore likely that any anticipated cost savings in care management for more experienced SDS users (or those with strong informal support) will be offset by the need to retain (and possibly invest in) care management and advocacy and support organisations for newer and more vulnerable users.

Summary

4.21 The analysis of our findings indicates that:

- SDS is being implemented at the same time as resource constraints are leading to cutbacks in service provision;
- SDS users have more responsibility in managing their care than users of standard services. In the view of service providers they may also be more likely to bear more of the risks and costs associated with reductions in service packages;
- Some providers were concerned they would find it more difficult to recoup investments made in staff training and quality assurance under SDS;

- The complexity and variation of SDS systems means that larger providers may be better placed to absorb the costs of the changes to managerial practices and structures needed. Fewer variations, and clearer pricing structures, would make it easier for smaller providers to compete fairly; and
- As more vulnerable users take up SDS options they may be disadvantaged in terms of negotiating quality and cost effective services unless there is investment in care management and support/advocacy organisations.

5 FINDINGS 3: SURVEY OF DP USERS

Introduction

5.1 Previous research has indicated that Local Authorities are rarely aware of the full range of costs for social care that are borne by users themselves (Rummery, 2006; Bowes and Bell 2007; Pearson 2000). We therefore knew that Local Authority data alone was likely to miss some components and under-report the full costs of packages of care. This chapter presents summary findings from a survey of SDS users in three participating Local Authorities which was designed to address this gap in the cost data (for more detail see Appendix 2). Many social care users will also receive unpaid care and support from family and friends and this was also considered in the survey of users.

5.2 We were advised by the Local Authorities that, although our interest was in the full range of possibilities for SDS, we should couch our questions in terms of DPs as survey recipients would not necessarily be familiar with or associate the payments they received with the former term. The report therefore looks at people using DPs to purchase services which is one option under the new Bill. It does not consider some of the other options such as 'Directing the available budget' which may become more prevalent in the future.

Results and discussion

Respondent characteristics

5.3 Response rates varied between Local Authorities, from 20% in Authority A to 38% in Authority C, with an overall response rate of 28%. The lower participation rate in Authority A could also have been the result of 'participation fatigue'; we were told by the Local Authority that this group had been invited to participate in a number of consultations over the past 24 months. DP user locations reflect the different rural/urban make-ups of the three Local Authorities, as described earlier in the report: Authority A is an urban area whereas Authority B and Authority C are primarily rural areas with a number of smaller population centres.

5.4 Overall, in 40 cases (68%) the respondent was a person receiving a DP, with a carer or informal supporter responding in a further 12 cases (20%) and a person formally managing DPs on behalf of the SDS user responding in 7 cases (12%). There were differences in the proportion of respondents of each type across the 3 participating authorities, which may have been a reflection of local practices in terms of the establishment of SDS. DP users were all adults. Participating authorities all advised us that they had very small numbers of SDS users under the age of 18 and therefore a decision was made not to include this group as a separate stratum in the sampling frame. Twenty-nine per cent of DP users responding to the survey were older people (aged 65 or older). Overall 41% of DP users were male and 59% female, although all three DP users aged 80 or older were female.

Respondents by user group

5.5   The main reason for receipt of DP was physical disability (40 cases, 69%), followed by learning disability (10 cases, 17%), age-related illness or disability and mental health needs. Service users with physical disability are over-represented and those with learning disabilities under-represented amongst respondents when compared with figures for SDS (DP) users across Scotland as a whole. Scottish Government (2011) noted 40% of individuals received SDS (DPs) due to physical disability, with 26% receiving SDS (DPs) due to learning disability, and a further 3% having both physical and learning disabilities. The longer history of access to DPs for those with physical disabilities explains the relatively high mean time for which respondents' have been in receipt of DPs (mean 6.0 years, s.d. 4.9 years). The wide variation in length of package echoes the national position. According to Scottish Government (2011) figures, 29% of all SDS (DP) packages in Scotland existing at 31 March 2011 have been in place for less than a year, whilst 19% of SDS (DP) packages have been in place for greater than 5 years.

Respondents assessment of abilities

5.6   Respondents were asked to provide an assessment of their abilities to carry out 18 different activities spanning mobility inside and outside the home, personal care and more general tasks requiring physical and/or manual dexterity, and other domestic activities. This information was requested in order to provide data on the relationship between levels of need as reflected by ability to perform instrumental activities of daily living and size of DP package which would inform the microsimulation model. As might be expected, there was wide variation in individuals' abilities although most respondents' experience appears to be one of limited mobility inside the home and lack of independent mobility outside the home, reflected in the proportions never driving a car (90%) and either never accessing public transport or requiring a lot of help to do so (72%). Appendix 2 provides more detail.

Value of DP packages

5.7   Respondents were asked to indicate the value of their packages either in financial terms or in hours. Sixteen respondents provided no indication of the value of their package and of these 7 indicated that they did not know this information. Where information was provided there was considerable variation in the value of respondents' DP packages as expressed in either hours per week or in financial terms. Tables 5.1 and 5.2 provide indications of means, standard deviations, maxima and minima. Some respondents provided both hourly and financial values for their DP packages.

Table 5.1 Respondents' weekly financial value of SDS (DPs)

Weekly financial value of Direct Payments (n=25)	(£)
Mean	391.46
Standard deviation	515.57
Minimum	21.12
Maximum	1800.00

Table 5.2 Respondents' weekly time value of SDS (DPs)

Weekly time value of Direct Payments (n=23)	(Hours)
Mean	24.3
Standard deviation	31.8
Minimum	3
Maximum	170

5.8   In general, respondents' DP packages have been stable over time, with 52% of those providing data in response to questions on changes to their DP packages having experienced no changes other than normal uplifts in hourly rates. A further 20% had experienced a single change, and 28% had had their packages changed more than once.

5.9   The most frequently advanced reason for change of DP package was deterioration in the respondent's condition which triggered a need for increased support, as illustrated in the following quotes:

'I was given extra hours as my condition has deteriorated.'

'Health and ability improved so package reduced. Following a severe stroke ability reduced so package increased.'

5.10   A number of respondents highlighted changes in their domestic arrangements, for example '*Increased amount to allow for living away from home. Support moved from 20 hours per week to 24/7*', and in several cases the need for formal services to replace previous informal support, for example:

'Carers replaced hours done by my Mother who is now unfit and elderly.'

'My condition deteriorated and was increased then (my husband) who is my main carer took a heart attack, so I needed more help then re ironing and housework.'

How respondents used DPs

5.11   Respondents were asked about the types of support for which they used their DPs. Table 5.3 illustrates the main categories of support purchased. The majority of respondents (71%) used their DP to employ a carer or PA to provide personal care. Figures from the Scottish Government (2011) indicate that in 2010 39% of all packages of DPs involved a PA. However, the figures do not distinguish which type of support the PA provides and the authors note that this data was not provided for all DPs. Section 2(28) of the Regulation of Care (Scotland) Act 2001 defines 'personal care as '*care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without*

prejudice to that generality, to remembering to eat and wash)'. We did not define 'personal care' in the survey questionnaire and as a result some respondents may have interpreted this term more widely than the statutory definition.

5.12 More than half (57%) of the survey respondents purchased help with leisure activities. Other more frequently purchased services included help with shopping (44%) and transport (39%). In addition, under the heading of 'Other' different individuals indicated that they had purchased: domestic support; support to develop life skills and to attend work; emotional support, mediation, and access to other services; day services - payment towards costs as 1:1 required; a deaf blind guide communicator; twice-weekly outings; subscriptions/fees to support organisations; time at specialist educational/training facilities; cleaning services; and transport services.

Table 5.3 Support services purchased with DPs

Type of support	Number (percentage) of respondents using DPs to purchase this
Personal care from an employed carer (e.g. personal assistant) (n=48)	34 (71%)
Help with leisure activities (n=49)	28 (57%)
Shopping (n=48)	21 (44%)
Transport (n=46)	18 (39%)
Personal care from a private agency (n=49)	16 (33%)
Meal services (cooking, preparing and/or providing meals) (n=47)	13 (28%)
Help with work or study (n=45)	7 (16%)
Personal care from a Local Authority (e.g. home care) (n=43)	5 (12%)
Accommodation (n=43)	2 (5%)
Private health services (n=45)	2 (4%)
Child care (n=43)	1 (2%)

Note: Respondents were asked to indicate all types of provision purchased

Weekly pattern of DP support

5.13 The survey questionnaire also asked about the days on which the different types of support purchased were provided. There were differences in the data provided in response to this and to the earlier questions about the purchase of services and support. For example, as Table 5.3 shows, 34 respondents indicated that they purchased personal care from an employed carer when given a choice of 'yes' or 'no', 14 respondents said they did not use their DPs to purchase such services, and 11 provided no answer. In the later questions asking about the days on which purchased services were provided, 38 respondents indicated receiving personal care from a PA, including 2 respondents who had previously indicated not purchasing this type of support and 2 respondents who had not provided an answer on the previous question.

5.14 It was relatively unusual for any services or support purchased using DPs to be provided 7 days a week. Nearly a third of respondents (32%) received personal care from a PA or carer purchased using their DPs and almost a fifth of respondents (19%) received meal services 7 days a week, but more normally the receipt of services purchased using DPs tended to be on days from Monday to Friday.

5.15 Respondents were asked to say how the time purchased for a particular type of support was divided by indicating the time spent on that type of support on each day of the week. In many instances respondents elected not to follow the instructions given in the survey on how to provide this data, and information was provided in a variety of formats, e.g. '*15 hrs*' or '*Various up to 8 hours per week, normally Monday and Thursday*'. As a result, some of the data lack the precision which we had hoped for when deciding to use a survey data collection method and as a result are less useful for modelling purposes. In addition, responses to this question did not always accord with the data provided on the value of the respondent's DP package, e.g. the respondent would indicate that purchased support was provided '24/7', but the value of their DP package in terms of number of hours per week would be significantly less than this. This may be because the respondent had provided an indication of all support rather than only purchased support, and family provide support when the PA is not working.

Services purchased using other income sources

5.16 Respondents frequently used money other than their DP package to purchase support services. Table 5.4 shows the services purchased. Greater numbers of respondents declined to provide answers to this section than to the previous question about the purchase of support using DPs. This may be a disinclination on the part of respondents to talk about what they would consider to be 'private finances', but it could also indicate that some respondents did not / were not able to make a distinction between spending from separate sources of income. Fewer respondents used money other than DPs to purchase personal care from an employed carer (39% as opposed to 71% who purchased using DPs) or help with leisure activities (45% as opposed to 57%), but more respondents spent other money on accommodation-related services (40% compared to 5% spending DPs on this) and transport (60% compared with 39%).

5.17 In addition to the services in Table 5.4, respondents also listed purchasing a range of services under 'Other', including: domestic care; a regular massage; housework; cleaning; beautician; home services, 'e.g. cut grass, get in fuel, change a light bulb, e.g. non agency activity: not allowed to do'; and art therapy. Several respondents' comments suggested that they found it difficult to separate expenditures by support type or funding source:

'I have funding from Independent living fund I'm not sure what's being paid for what.'

'Benefits are used for all activity payments. DPs used solely for Carers'
wages. Carers supervise or assist in all aspects of day to day life. I'm
not sure if I've filled this in correctly'.

Table 5.4 Services and support purchased with money other than DP package

Type of support	Number (percentage) of respondents using money other than DPs to purchase support
Transport (n=35)	21 (60%)
Shopping (n=36)	18 (50%)
Help with leisure activities (n=38)	17 (45%)
Accommodation (n=35)	14 (40%)
Personal care from an employed carer (e.g. personal assistant) (n=44)	17 (39%)
Meal services (cooking, preparing and/or providing meals) (n=33)	9 (27%)
Personal care from a Local Authority (e.g. home care) (n=36)	9 (25%)
Personal care from a private agency (n=38)	6 (16%)
Private health services (n=32)	3 (9%)
Help with work or study (n=32)	2 (6%)
Child care (n=32)	1 (3%)

Note: Respondents were asked to indicate all types of provision purchased

5.18 Respondents indicated using a number of sources other than DPs for funding the purchase of services or support, as shown in Table 5.5. The most frequently used sources of funds were: Disability Living Allowance (DLA) / Attendance Allowance (AA), used by 59% of respondents; other disability-related benefits (usually identified as Independent Living Fund (ILF)), used by 25% of respondents; and pensions, used by 24% of respondents.

Table 5.5 Sources of funds other than DPs used for purchasing services or support

Source of money	Number (percentage) of respondents using this source of money to purchase support (n=59)
Disability living allowance/Attendance allowance	35 (59%)
Other disability related benefits (e.g. independent living fund/sickness benefits)	15 (25%)
Pension	14 (24%)
Money from family and/or friends, Salary, Other private income	8 (14%)
Carers Allowance or other carer related benefits	4 (7%)

5.19 We were interested in whether service users spent part of their DP package on the rental or purchase of items or on other non-service or support costs associated with their disability/illness. Few respondents provided data for this

part of the questionnaire, and where provided it lacked detail. This may be because the three participant Local Authorities are at different but still relatively early stages in the implementation of SDS, and as such their service users have little experience of the more flexible use of funds envisaged by SDS. The data that we did collect generally reflected the more limited ability to spend funds creatively under previous DP regimes. Respondents provided ongoing costs for a range of different items including: the rent/hire of personal emergency alarm systems and communication aids; maintenance contracts for stair-lifts and hoists; one-off costs for the purchase of voice recognition software; recurring costs such as Employer's Liability Insurance for those employing PAs; and memberships for gyms or for charities supporting the respondents specific disability/illness. Respondents had purchased a range of goods and services with their DPs, including: beds, wheelchairs, recliner chairs, and TENS machines; bath lifts and 'wet room' conversions; various respite breaks; and moving and handling courses for employed carers.

Unpaid care

5.20 Respondents were asked about receipt of unpaid care or support using the same service/support categories. A large proportion of respondents provided no data regarding unpaid care. As the analysis of other data from the questionnaire has established, it is not safe to infer that a lack of response means that respondents actually receive no unpaid care. It is possible that support provided by family and friends is not thought of as unpaid care by the questionnaire respondents, or that respondents found it too difficult to quantify the contributions of those who provide them with unpaid care. Where data was provided, respondents often received significant numbers of hours of unpaid care across different support types. Respondents were often unable to separate out the time spent on different unpaid care and support activities. Unpaid care was often seen as 'filling in the gaps' left by purchased care as the following quotes in relation to personal care illustrate:

'Requires 24 hours supervision so any time not with day service or paid carer needs family support.
'

'Daily within 12 hour period unless carers are with me 24 hours a day'.

Costs associated with setting up and maintaining packages

5.21 In the penultimate section of the questionnaire respondents were asked about paying for activities associated with setting up and maintaining support received as part of a DP package. Table 5.6 illustrates the responses to this section. Most respondents had not had to pay for or provide any of the listed activities themselves, either because they had not encountered these types of costs or because amounts were provided in the DP package to cover these.

Table 5.6 Paying for activities associated with setting up and maintaining support received as part of a DP package

Type of costs	SDS user has not had to pay these costs setting up or maintaining support paid for using DPs	This was paid for or was provided as part of SDS user's DP package	SDS user paid for or provided this him / herself	Did not answer
Recruitment costs (e.g. advertising for or interviewing carers, etc)	16 (27%)	18 (31%)	5 (8%)	20 (34%)
Ongoing costs of being an employer (e.g. payroll costs for a personal assistant)	14 (24%)	26 (44%)	4 (7%)	15 (25%)
Training for user (e.g. on employment law or bookkeeping, etc)	20 (34%)	3 (5%)	2 (3%)	34 (58%)
Training for carers (e.g. on helping with medication or on health and safety issues)	16 (27%)	10 (17%)	2 (3%)	31 (53%)
Other setup costs (e.g. using an accountant or bookkeeper to help manage Direct Payments)	19 (32%)	8 (14%)	4 (7%)	28 (47%)
Fees and other payments (e.g. Agency carer or personal assistant Introduction or placement fees)	20 (34%)	9 (15%)	2 (3%)	28 (47%)

Users' perspectives

5.22 As discussed at the beginning of this chapter, the purpose of the questionnaire was to gather data that would feed in to the overall research aim of providing macro-level financial and economic evidence on the actual and potential costs, benefits and impacts of an increase in the uptake of SDS in Scotland. The questionnaire was thus primarily concerned with costs and not with outcomes or exploring the link between the two. However, respondents were invited to comment on their perceptions of the value of their DP package and to make any other comments about whether the cost to them is different when using DPs to meet their care needs compared to the cost to them of receiving services arranged by their Local Authority.

Reasons for opting for DPs

5.23 In relation to the first question, why respondents opted for DPs, there were both 'push' and 'pull' factors involved in decision-making processes although the latter seemed to be the more frequently alluded to. In terms of 'pull' factors, respondents talked about flexibility, choice of not just service provider but individual carer, control, and the ability to 'shop' for care to get the most for the available money. 'Push' factors included the inability of provided care

packages to meet respondents' specific needs and the desire to keep a service provider after changes to preferred suppliers by Local Authorities. The following quotes illustrate these factors:

'It allowed more flexibility to choose appropriate care. Direct social work provision was not appropriate since it did not provide the hours I needed.'

'Due to the nature and type of support I receive I prefer a regular support worker and due to [the Local Authority's] tendering process for care contracts most likely resulting in a company reliant on an ever changing group of agency staff, Direct Payments were the only other option that enabled me to retain the organisation providing my support services.'

'Choice, flexibility. Respite care provision did not meet my needs. Social care provision in day centre did not appeal so I have a PA to take me out and about.'

'Having complete control over my care package allows me to tailor my care around my lifestyle and more importantly gives me a sense of independence that my injury took away.'

'Because it made things easier and less complicated.'

Satisfaction with value of DPs

5.24 In the final section of the questionnaire, all 54 respondents who answered the question reported being 'satisfied' or better with the value of the services that they bought or paid for using their DP package, with 30% 'happy' and 43% 'very happy' with the value of services.

Comparison of DPs with arranged services

5.25 Respondents were then asked to comment about whether they experienced differences in costs to them between DPs and arranged services. A number of respondents indicated that they had never received arranged services and so could not comment. Where respondents had views, four main topics emerged. The first relates to the hourly rates for DPs and comparison with prevailing Local Authority or agency rates:

'I pay £11 per hour for Homecare to wash/dress me Mon-Fri mornings as I am only 56. Direct payments staff do not receive anything like this - approx £7 per hour. However, I am not allowed to use my Direct Payment for personal care (although I know others do this).'

'I only wish I could pay my carers more as they are underpaid for what they do for me.'

'The Local Authority control the amount that can be spent by costing any assistance provided. Costings are not at agency level costs. In theory the Local Authority would be cheaper than alternatives.'

5.26 The second issue for respondents relates to the degree of administrative work required in relation to DP packages:

'Administering the direct payment which involves completing a quarterly balance sheet is a complete pain as the provider bills 4-weekly but the council want calendar month returns.'

'You've got to be grateful for what you're given and when you find good care - it's always worth the money. They (Local Authority) can make it hard to get what you really need, but once you fight for it, it usually runs smoothly. My only gripe is the responsibility us as carers have with the administrative, accounts and organisation is huge. While caring for our adult son - we have to fit in meetings, draw up planners, label, add up figures, keeping a home, jobs and many more things. While there are 168 hours in a week - we have 50 covered - more than most but still a strain on us as parents. Money doesn't buy happiness especially when you've got to justify every penny til they'll give you it.'

5.27 The third area of concern related to a situation which arises when there are multiple funding streams and systems are not properly integrated, leading to an increased administrative burden:

'As [the respondent's] Mum, only carer and one who manages his finances and benefits, I find the system increasingly complex. He is given, I think, a generous DP. Then he has to give back a substantial amount from his benefits. Why cannot a DP be paid to him on a decreased amount, and not claimed back? I have been unhappy with this system, causing more unnecessary work and frustration to the unpaid carer'.

5.28 Finally, a number of respondents had views on perceived oversights in terms of what is paid for as part of the DP package:

'It's sometimes very difficult to get people to fill in an hour or 2 hours work, with the cost of petrol is sometimes not economic for them to do that. When I go for a meal it cost me two. There are a lot of hidden costs which really build up and this should be taken into account. After all we are saving the council a lot of money.'

Summary

5.29 The purpose of the survey was to gather data that would inform and be used in the modelling of the actual and potential costs, benefits and impacts of an increase in the uptake of SDS in Scotland. The findings from our analysis of the data collected from the user survey can be summarised thus:

- The questionnaire was distributed to 210 DP users across 3 Local Authorities and a response rate of 28% was achieved. The service users were all adults, with 29% aged 65 or over, and 69% of respondents received DPs because of a physical disability. Respondents received DP packages with a mean average of 24.3 hours or £391 per week;

- The services that respondents were most likely to spend their DPs on were: personal care from an employed carer (e.g. PA), (71%); help with leisure activities (57%) and help with shopping, (44%).
- Service or support purchasing patterns using money other than DPs varied from DP-related spending, with higher proportions of respondents purchasing accommodation related support (60%) and transport services (40%). Where respondents received unpaid care or support from friends and relatives this often amounted to more hours per week than the respondents' DP packages and tended to be provided more often at weekends;
- Few respondents paid for activities associated with setting up and maintaining support received as part of a DP package themselves. Most respondents either did not incur such costs or there were amounts included in their DP packages to cover them;
- Respondents were generally very positive about the benefits of DPs, the value of the services and support that they purchased with their DP packages, and the comparison with arranged services:

  'My carer (self-employed) does a lot better job than Council carers - she gets more time of course but she has more training than Council carers - I would have nobody in if I had to go back to Council carers - this is all down to money.'

6 FINDINGS 4: COSTS AND MODELLING THE FUTURE

Introduction

6.1 In this chapter we describe the micro-simulation model which we used to project aspects of SDS in Scotland. We present our analysis of the user interviews and Local Authority data sets, and what the data in this study and other research tells us about the future costs of SDS in Scotland. The development of the costings model used here was informed by the quantitative and qualitative data presented in the earlier chapters.

Microsimulation

6.2 This section describes the micro-simulation model which was used to project aspects of SDS in Scotland. The model began by generating a Scottish population in a chosen base year. The population does not regenerate: there are no births, therefore analyses with the model should not extend beyond a 10 to 20 year time horizon.

6.3 The populations were generated from life tables. These were constructed separately for each Local Authority in Scotland from data produced by the General Register Office Scotland. The base year from which the initial life tables were drawn is 2007. Projection runs started from this year. There were separate projections for each Local Authority.

6.4 The life-table calculations estimated time to death of each individual measured in months - thus date of death was calculated in months from the beginning of 2007. With a monthly time interval, it was feasible to make detailed calculations of lengths and costs of spells of disability. The model converted these monthly data to annual equivalents as required.

6.5 Due to its use of life tables from Local Authorities, the model accurately simulated differences in life expectancy across Scottish Local Authorities. It also provided estimates of age specific populations in each Local Authority over the projection period. These life tables can be manipulated to simulate changes in mortality, but such manipulations do not form part of this study.

6.6 The projections also considered care needs in the population as a whole by generating intervals during which individuals may require social care. These were derived by matching the Scottish Household Survey by age, gender and Local Authority to the population generated from the life-table. Some of these individuals were disabled in the base year, others become disabled over the course of the projection. The simulations assumed constant rates of disability by age, gender and Local Authority. Therefore, for these projections, we implicitly assumed no change in "healthy life expectancy".

6.7 We used these estimates of disability to drive estimates of the population that are offered and elect to use SDS. The shares of SDS users in each Local Authority were adjusted to be consistent with numbers of SDS users by age,

gender and Local Authority published by the Scottish Government. In our projections we adjusted these shares to show the effects of changing rates of take-up of SDS.

6.8   The outputs of the micro-simulation model should be regarded as projections rather than forecasts. Given the lack of detailed market information relating to SDS, forecasts of future numbers and costs of SDS users are extremely uncertain. This is partly due to the wide variation in take-up at the Local Authority level, which cannot be explained by variations in level of disability. There is also uncertainty, as there was with free personal care, about the effect that the legislation will have on levels of demand. However, the right to request SDS has existed for some time. The Scottish Government has made this point clearly (see below).

If I am entitled to social services, am I automatically entitled to self-directed support?

Yes, most people who get social services have a right to self-directed support. There are some limited circumstances where self-directed support is not given and your council will be able to tell you about these.(Scottish Government, 2008: p.14)

6.9   More users may choose to exercise this right after the passage of the Social Care (Self-directed Support) (Scotland) Bill since the process of legislation will itself draw attention to the availability of SDS. However, unlike the case of free personal care, any increase in take-up will be due to increased visibility of an existing right, rather than due to the creation of a new entitlement.

6.10   After the passing of the legislation relating to free personal care, there was a large and unanticipated increase in demand for personal care at home. This is a so-called "woodwork effect": the provision of the entitlement appeared to cause an increase in demand. The implication was that many users that had personal care needs and had previously not been in contact with Local Authorities were willing to engage when a legislative entitlement to free personal care was enacted.

6.11   There is limited information on woodwork effects in relation to SDS. One of the few papers addressing the issue is Benjamin and Matthias (2001). They conclude that "organisation of services (i.e., the relative presence or absence of consumer direction) is probably less important than the age of the recipient in understanding unmet IADL needs." (In the US, the equivalent terminology for self-directed support is "consumer direction"). They argue that young users are more likely to have changed their provider and are more likely to be dissatisfied with the hours they receive. As a result, young users are more willing to argue that support packages should satisfy their unmet needs, irrespective of the organisation of the service.

6.12   The authors do not address the issue of whether these differences in willingness to challenge the composition of a care package are cohort, rather than age, effects. That is, the existing population of older people may be more

willing to accept more modest care packages, but that cannot be assumed for younger cohorts. As younger cohorts age, they may display different preferences compared with those that are currently old. In particular the "baby boomers" may be more demanding than previous cohorts and may thus drive a significant increase. This group may seek to drive an increased volume of care, perhaps using consumer direction as a mechanism to facilitate such change.

6.13 We return to some of these issues when we discuss the projections.

What did we learn from the DP user survey?

6.14 In total we received responses from or completed on behalf of 59 DP users across three Local Authorities who received direct payments. 40 responses were completed directly by the users. Twelve of the responses were completed by a person caring for, or informally supporting, someone receiving DPs. Finally there were seven responses completed by those acting as guardian or with the power of attorney for individuals receiving DPs.

6.15 The sample was distributed across different geographical locations. Around 28% lived in cities. The same proportion lived in villages or small groups of houses. The remainder lived in large towns or small towns. Thus there was a wide geographical spread among the respondents, with medium-sized towns perhaps being under-represented in our sample.

6.16 The majority of the respondents were aged between 19 and 59. There were relatively few older people, which may reflect their less intensive use of DPs. There were somewhat more females than males. All respondents aged over 80 were female.

6.17 On average, individuals had received direct payments for six years. However, there was a very wide variation around this mean, with a minimum period of six months and a maximum claimed of 24 years. The distribution of DP durations is shown in Figure 6.1.

Figure 6.1 Distribution of durations of direct payments from user survey

Source: DP User Survey

6.18 The main reason that users qualified for DPs was overwhelmingly physical disability. Seventy per cent of respondents fell into this category. Next most important was learning disability which accounted for 17% of those responding.

6.19 The median weekly value of the DP package was £160. The mean was £391.5. The difference is attributable to some very large packages (up to £1,800 per week). The relationship between the calculated scores based on the ability to carry out tasks and the weekly value of DPs, when calibrated using a simple regression, is positive but not significant. This implies that the cost of the package rises with increased inability to carry out tasks, but not significantly so. A similar result is found when hours of care are substituted for the value of the package in the regression. These results imply that the size of the DP package or the number of hours of care does not necessarily equate to the severity of disability. This may be because the DP represents only a component of the full package. As well as DPs, individuals may have unpaid carers to provide help. They may receive additional benefits from the Local Authority such as telecare systems or additional hours of conventional Local Authority care, though we have no indication that this is the case.

6.20 As reported in Chapter 5 (Table 5.3) buying personal care from a PA was more common than buying it from an agency which in turn was more common than buying from a Local Authority. Only 11 respondents used DPs to buy meals. Virtually none used them to buy childcare. On the other hand, a majority used DPs to buy leisure activities. Using DPs for work or study, for private health, or for accommodation was unusual, but 48 per cent of clients used DPs for transport and/or for shopping. Other uses to which DPs were put included a domestic worker, developing life skills, emotional support, mediation, a deaf blind communicator, cleaning and to provide transport to enable the respondent to engage in voluntary work.

6.21 A relatively large proportion of respondents used PAs for support rather than Local Authority "in-house" provision. This may partly reflect the lower cost of PAs compared with "in-house" provision. Our data indicates that many DP users believe that they receive better value for the budget made available to them by the Local Authority by employing a PA rather than using Local Authority staff. This issue is important in relation to modelling the costs of SDS and we explore it further in our micro-simulations.

What did we learn from the Local Authority sample?

6.22 We received matched samples of SDS and conventional social work (the control group) users from two Local Authorities. Together, these comprise the records of 265 individuals split almost exactly between the SDS group and the control group. These were matched across a number of variables. For example, Figure 6.2 shows the distribution of the control group and SDS group by form of disability, while Figure 6.3 shows the distribution by age. On both these dimensions, it is clear that the control and SDS group were reasonably well matched.
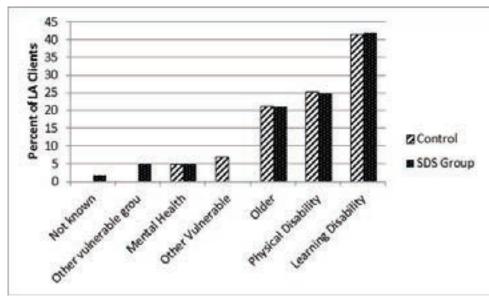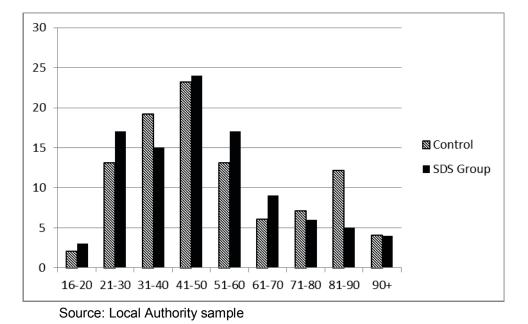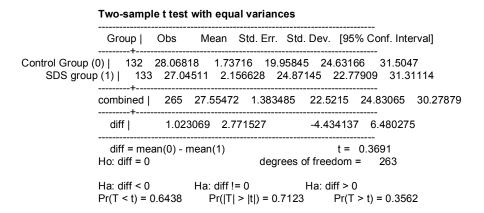
Figure 6.2 Distribution of Local Authority sample of users by user group

Source: Local Authority sample

Figure 6.3 Distribution of Local Authority sample users by age group

Source: Local Authority sample

6.23 There were virtually no differences in the distribution of user group type between the control and SDS groups. The main difference in age structures was that there was a slightly higher proportion of older users in the control group.

6.24 If one assumes that the control group and SDS group are well matched, one can test whether their respective packages involve differing level of resource. One simple test is whether the number of hours provided in an SDS package differed from that in the control group. This can be assessed using a simple test of difference in means. The results are shown below:

```
Two-sample t test with equal variances
-------------------------------------------------------------------------
      Group |   Obs      Mean    Std. Err.  Std. Dev.  [95% Conf. Interval]
---------+---------------------------------------------------------------
Control Group (0) |   132   28.06818   1.73716    19.95845   24.63166   31.5047
    SDS group (1) |   133   27.04511   2.156628   24.87145   22.77909   31.31114
---------+---------------------------------------------------------------
   combined |   265   27.55472   1.383485   22.5215    24.83065   30.27879
---------+---------------------------------------------------------------
       diff |         1.023069   2.771527              -4.434137   6.480275
-------------------------------------------------------------------------
       diff = mean(0) - mean(1)                         t =   0.3691
Ho: diff = 0                          degrees of freedom =      263

Ha: diff < 0           Ha: diff != 0            Ha: diff > 0
Pr(T < t) = 0.6438     Pr(|T| > |t|) = 0.7123     Pr(T > t) = 0.3562
```

6.25 Mean hours for the SDS group was 1.02 hours less than that for the control group. However, such was the variability of packages in terms of hours, both for SDS and control group users, that this difference cannot be statistically distinguished from zero.

6.26 This analysis suggests that for matched users, the numbers of hours incorporated in their packages did not differ by mode of delivery. There were undoubtedly difficulties in assigning hours to DP packages, but our understanding is that the Local Authorities involved in the survey based their estimates of hours on packages agreed with users. This might differ from the actual hours provided, if, for example, the user found that market prices differed from those assumed by the Local Authority. Nevertheless there would be no cost implication if the original budget agreed between the user and Local Authority remains in place. If market prices are less than those assumed by the Local Authority, then users will be able to enjoy a better standard of care. If market prices are higher, then users may seek to renegotiate their package.

6.27 While this result may partly assuage fears that a shift to greater SDS provision would result in greater demand being placed on limited Local Authority budgets, there are a number of caveats. Whereas we understand that the data relate to DPs, there is always the possibility of confusion between DPs and hours provided through traditional Local Authority care. Hopefully, the matching process has reduced this possibility. But in addition, it might be the case that not all the hours listed in the Local Authority records were actually delivered. Unfortunately, there is no easy way to resolve this difficulty.

6.28 We also tested the significance of the difference between average hours received by the control and SDS groups after allowing for individual characteristics. However, the number of such characteristics was limited by the variables made available by the Local Authorities. Thus, for example, one could construct a model where, conditional on age and gender, one could test whether there were significant differences between SDS and control group users. As with the simple test of means, the results suggested that the differences in average hours did not come close to statistical significance.

6.29 These results seem to imply that the resource costs associated with SDS packages will be no greater than those from existing modes of delivery. If Local Authorities calibrate SDS packages based on their own costs, then, as stated above, users may be able to enhance their packages by purchasing, for example, more hours of care. This might come about if users using SDS rely more on relatively cheap modes of support, such as PAs. Thus, this conclusion depends on (A) the hourly costs and (B) the overhead costs associated with SDS packages. We now discuss this issue.

6.30 The evidence on cost savings associated with the introduction of individual budgets is limited. Where there are claims that SDS costs less than traditional care packages, one should be wary about whether start-up and delivery costs, and informal support resources such as family and friends have been properly accounted for.

6.31 In a recent study of the extension of individual budgets in Coventry (Hurstfield 2010), there was not felt to be any need for additional resources to support their rollout. However, there was some requirement for setup costs to recruit staff and to develop a model focusing on outcomes.

6.32 The most relevant comparable study is IBSEN (Glendinning et al. 2008) which was based on a large scale pilot study to evaluate the implications of individual budgets (IBs) in England. This study was able to compare resource costs in considerable detail. It concluded that:

'We found very little difference between the cost of support received by the comparison group and the cost for IB holders. Over the full sample, IBs funded a mean of about £280 of support per week compared with an estimated mean weekly cost of about £300 for support packages for people receiving standard mainstream services. This difference was not statistically significant, but it is likely from this evidence that IBs would be at least cost-neutral.'

6.33 This suggests that differences in the costs of support are negligible. Note that the mean weekly cost in the IBSEN study was £280 per week for IB users. The equivalent mean value from our user survey was £391 per week. However, the effects of inflation (the IBSEN study was carried out in 2008) may partly explain the difference. Further, note that the average weekly value of SDS packages in Scotland in 2010, was £207 per week while the median was £121 per week (Scottish Government, 2011), considerably below either the IBSEN estimates or those from the data supplied by Local Authorities to this project. Those included in the Local Authority survey were well above average in terms of the value of their SDS packages.

6.34 Taking this evidence together, it seems unlikely that the extension of SDS is likely to cause a significant increase in the demands on the social care budget. However, the evidence does not relate to the supply side of the market. We discuss the implications for the supply side, particularly in relation to contracts, in the next section.
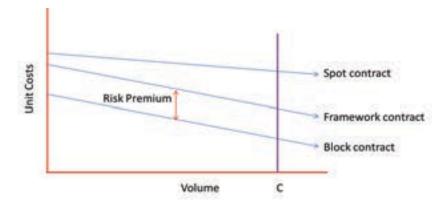
The effects of SDS on contract structure

6.35 Many existing care packages are delivered using block contracts. These are arrangements where a Local Authority and provider agree an amount of care to be delivered during the contract period. This can lead to a formulaic approach to care provision that is focused on timekeeping and the delivery of specified tasks rather than outcomes.

6.36 The introduction of SDS changes the focus much more towards outcomes, which is difficult to deliver under block contracts. Under SDS, since users decide which services to purchase, individual providers cannot be assured of a pre-specified level of demand. This is likely to make the market more dynamic. Some providers may seek new opportunities in areas such as training and brokerage. Small providers may emerge in rural areas where transport costs render provision from a distance uneconomic.

6.37 An alternative model that better suits this more consumer led market is a "framework agreement". This is an agreement to provide care for a certain price but with no assurance on volume. This means that the provider is

exposed to considerable risk. In a normal market, suppliers would charge a "risk premium" to compensate for the uncertainty associated with a framework agreement. The risk premium would be the equivalent of the cost of insuring against variations in demand. In the worst case, a supplier might not attract any users and be forced to cease trading. The more dynamic providers will then have an opportunity to expand.

6.38 Yet another alternative is the so-called "spot contract". This is a sample agreement to supply services immediately, or in the near future, at an agreed price. For providers, this is the most risky form of contract since they cannot readily plan for volume. For purchasers, spot contracts carry very little risk since there are generally no penalties for changing provider. At present there is little evidence about the willingness of users to change providers, but there is some evidence that when people are happy with their provider, they will make an effort to maintain the relationship. For example, where councils have opted for a new provider as a result of the tendering process, many users have opted to stay with the original provider, using DPs as a mechanism to achieve this goal.

6.39 In principle one would expect providers to charge a premium for spot contracts or framework agreements since they bear an increasing share of the risk with such arrangements. The transactions costs associated with framework agreements and spot contracts are likely to be greater simply because there are likely to be more frequent transactions. These costs must be recovered either in higher prices being charged by suppliers or by Local Authorities subsidising providers to facilitate such agreements. Local Authorities themselves will have increased costs associated with a greater number of transactions as an increasing share of their business is moved from block contracts to framework and spot contracts. These relationships are portrayed in Figure 6.4.

Figure 6.4 Relationship between costs and volume for different types of care contract

6.40 The vertical axis measures unit contract costs. These costs will include both administrative costs and the costs associated with risk. The horizontal axis measures the volume in terms of numbers of users covered by contract. Block contract costs decrease with volume since there is only one contract, whose costs are being defrayed over an increasing number of users. The framework

agreement follows the same pattern, but at a higher level due to the increased costs of risk associated with uncertainty over volume. Finally the spot contract has the highest unit costs, since administratively a separate contract has to be constructed for each user. These costs may decline with the number of users due to administrative economies of scale.

6.41 However, in a monopsonistic market (where there is a concentration of market power on the side of purchasers - in this case Local Authorities), there may be a tendency to try to force costs downward below marginal costs. This has arguably been the case with block contracts. This may endanger the sustainability of the market if producers withdraw, which will reduce choice for users. Whether this effect will be replicated as the market shifts to SDS is less clear, partly because SDS users, as we have seen, frequently use PAs, who effectively are individual suppliers and, as such, increase the choices available to users. These PAs may have previously worked for larger providers and therefore have a set of relevant skills in care provision. However, they may not have the necessary business-skills to operate a small enterprise, which may create market opportunities for companies willing to supply such business-related expertise.

Interviews with Local Authority informants

6.42 Our interviews with Local Authority informants suggested that the move towards SDS will result in a wider range of contract types, and particularly the phasing out of block contracts which are not well suited to SDS. However, some existing contracts are not due to expire for some time so if there was policy pressure to expand SDS quickly respondents felt this could cause market difficulties. Users can opt into framework agreements, often receiving a better rate than they would under a spot contract. Framework agreements perhaps best fit the SDS agenda, particularly where those previously with DPs were precluded from accessing council contracts. Where there are differences in quoted provider costs, councils may seek to standardise rates on grounds of equity. This is a sensitive issue in relation to the equality agenda, but Local Authorities may find it difficult to ascertain a unique sustainable market price.

6.43 Providers will have to adapt to the new market structure as block contracts are phased out. They will also have to be more open about their pricing, which up to now has largely been agreed with Local Authorities. Instead of having a single purchaser, the market is likely to have many potential buyers. As a result, providers will have to advertise their pricing structure. This will have to be easily understandable for potential users.

6.44 They will also have to make new provision in respect of debtors that they had not previously considered. This means pursuing late and non-payments, which may take up considerable administrative resources. Again, this is a function that other companies might be willing to undertake for a fee.

6.45 Local Authorities have given some thought to the increase in advice and support systems necessary to undertake an extension of SDS. One estimate

was that 6% of the amount spent on DPs should be allocated to advice and support services.

6.46 In the future, the function of contract managers will partly be to stimulate markets to ensure that sufficient market capacity is available. This will be particularly important in rural areas where providers are much less dense and transport costs therefore higher. Opportunities for diversification are also more limited in rural settings. For example, in urban settings, providers may be able to generate income from taking over administrative functions for PAs, providing advice to users or perhaps training for PAs. Local Authorities may choose to support the uptake of PAs, since these are more cost-effective than in-house services, though there is concern over their accreditation. Again, the need for PA accreditation services may provide a market opportunity for existing providers.

6.47 One provider estimated that the transactions costs associated with SDS amount to 2% of turnover. On the council side, one estimate is that £66,000 worth of administrative assistance is required for every 500 DP users. This would imply a cost of £132 per year for each DP user, or 0.6% of the average DP cost, similar to the IBSEN findings (Glendinning et al, 2006).

What can we learn from elsewhere about the effects of personal budgets on care providers?

6.48 Wilberforce et al (2011) reviews the effects of the introduction of Individual Budgets (IBs) in England. They argue that care providers regard their introduction as positive in the sense of potentially improving outcomes for users. However, there are concerns around administrative and workforce issues.

6.49 The research was conducted through a set of 16 semi-structured interviews with providers and seven commissioning managers in the four pilot sites in England. They argue that commissioning practices restrict choice in two main ways:

- Because contracts are arranged with a limited set of providers, some services are unavailable to users. Commissioning managers may favour the cheapest, or in-house, tenders as a matter of policy.
- The use of long-term block contracts, which are more easily subject to downward price pressures give providers little incentive to "personalise" services for individual users.

6.50 The research examined three hypotheses:

- Home-care providers would lose business as service users opt for PAs
- Day care services would lose out because they are generally perceived as unpopular
- In-house providers would be too expensive and would therefore not be popular amongst IB holders. This is based on Local Authorities basing

charges on actual hourly staff costs, rather than on costs prevailing in the private sector, where overhead charges and hourly labour costs are likely to be much lower.

6.51 The providers felt quite keenly that competing with PAs posed a challenge. However, the general perception was that the loss of business would not be extensive. Further, confirming our responses from finance directors, it appeared that providers could offer IB holders administrative services such as payroll and reference checking. Providers could also cover for holidays and sickness.

6.52 Commissioners of services noted that the high unit cost associated with in-house services meant that their use was increasingly difficult to justify. As mentioned above, higher overheads and labour costs mean that, in general, in-house services are more expensive than those purchased externally. Some services were developed in response to IB holder demands. For example, one provider saw an opportunity to work more closely with telecare and meals on wheels organisations with a view to subcontracting components of IB budgets to these partners.

6.53 The new forms of service most commonly chosen by IB holders included cleaning and domestic assistance, gardening, transport and shopping. Care workers working with an IB holder were expected to show greater flexibility since there was less rigid adherence to specified care plans.

6.54 Some of the administrative costs included those of invoicing individuals and following up on non-payment. The introduction of individual invoices to replace block contracts resulted in significant increases in administrative costs. Some providers were experimenting with alternatives such as swipe cards to reduce paperwork.

6.55 Finally, the authors felt that improvements in care services due to increased choice, competition and coproduction would take some time to become established. This would partly reflect inertia amongst those users provided with in-house services before IBs became widespread. This was particularly true for older people, who were least likely to adopt a consumerist approach. It may be the case that a substantial reorientation towards IBs will occur when new cohorts of users are offered these as an alternative at their initial assessment.

6.56 The implementation of IBs in England has been supported by the National Reform Grant. It had a value of £520 million over a three-year period and one seventh of this money was used for provider and market development.

6.57 Important points for Scotland from this study in England include:

- Changes to the structure of care service provision are likely to occur at a relatively slow pace. Thus, changes in the relative demand for in-house provision, care providers and PAs may take some time to filter through.

- Care providers are likely to act innovatively to improve the care they deliver and to develop new services which are required as a result of the introduction of SDS (e.g. PA training).

What does the model tell us?

6.58 In this section we present the findings from our analysis of some micro-simulation runs relating to SDS. As described in the methodology section, micro-simulation methods are used to answer "what if" questions. We baselined our projections on 2010 Scottish Government SDS data. That is, we tried to ensure that the model produced broadly the same number of disabled people receiving SDS by age, disability type and Local Authority as indicated in the March 2010 Census of Direct Payments. It also replicated the published estimates of the total value of SDS packages in Scotland for 2010. As mentioned previously, the average value of such packages is £207 per week.

6.59 The driver for the number of SDS packages was the level of disability by type, age and Local Authority. Home care provision is not a strict substitute for SDS in the sense that, as our user survey reveals, individuals may opt to purchase services that are outwith conventional Local Authority provision. However the two are likely to be closely linked, since home care users form a large proportion of those that currently receive social care services and therefore most, but not all, the growth in their SDS expenditure will be on the purchase of care services. It will also depend on the availability of unpaid care and its distribution across different forms of care, such as personal care and domestic help. As we have seen, some purchases within SDS packages are made to support leisure, education and other activities. Our perception is that the value of such purchases is relatively small, though our user survey did not give sufficient detail to estimate their actual size.

6.60 One important issue for the simulations is the proportion and relative cost of PAs. The Scottish Government SDS data for 2010 indicate that 39% of SDS packages involve the employment of a PA. We have therefore used estimates of PA costs from the Department for Education and Skills in England. These suggest that additions of 12% for National Insurance, 15% for holiday pay, 11% for sickness pay, 12% for insurance costs and 15% enhancements for overtime bank holidays etc. should be added to the basic hourly pay rate. This would imply that a user receiving £10.50 per hour from a social work department for a DP could only afford to pay a PA £7.50 an hour. This is consistent with a sample survey of 512 PAs by Reid and Howie Associates (Scottish Government, 2010) that found that PAs in Scotland earned between £7 and £9 per hour gross, with a mean of £8.27 per hour. We have therefore used this as our guide rate for PA care before adding national insurance and other oncosts.

6.61 We have based our estimates of the costs of Local Authority services using data on Local Authority charges collected by Learning Disability Alliance Scotland. Local Authorities are unlikely to charge above marginal cost per hour of social care. Otherwise, they might be accused of making profits from

disabled people. However, some may feel that they should charge close to marginal cost, given the financial constraints under which they are now operating. Thus, given the distribution of care charges shown in Figure 6.5, we would argue that actual Local Authority costs are likely to be towards the upper end of the distribution. Therefore, in the absence of published data on Local Authority charging policies, our initial assumption is that that Local Authority charges for social care services are likely to be around £15 per hour.
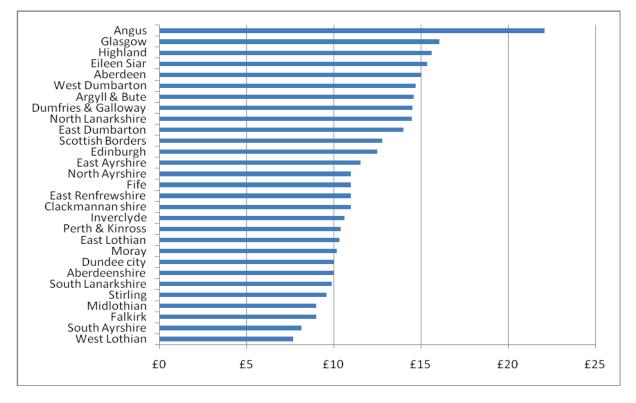
Figure 6.5 Local Authority charges per hour for social care Scotland 2011

Source: Learning Disabilities Alliance Scotland

6.62 We focused on PA costs and "in-house" costs because they provide the lower and upper end of the costs distribution. Private and third-sector providers are likely to incur costs that are intermediate between these extremes. Likewise, their aggregate costs will be intermediate between those that are exclusively based on PA or "in-house" provision. Thus, we did not explicitly model this sector in the current experiments.

6.63 We have conducted a number of experiments with the model based on these assumptions of the hourly costs of PA and "in-house" hours. First, we have constructed a "base run", which shows how much expenditure on SDS is likely to increase between 2010 and 2020 based solely on an ageing population and consequent increasing numbers of disabled people. The incidence of SDS is constant across Local Authorities (0% growth), but the numbers increase due to increases in the number of disabled people. Second, we have assumed that the take-up rate of SDS in each Local Authority increases each year by 1% and 5% respectively. Third, to allow for overheads

associated with the establishment of a viable market in SDS, we have increased hourly charges for both PAs and Local Authorities by 33% from the first year. Finally, we have increased the average charge made by Local Authorities from £15 per hour to £20 per hour, while holding the hourly wage for PAs (before on costs) at £7.50 per hour. Consequently we expect a shift towards the use of PAs and have simultaneously assumed an increase in the take-up of PAs take-up from 39% to 60% of SDS packages. Results are shown in Figures 6.6 and 6.7.
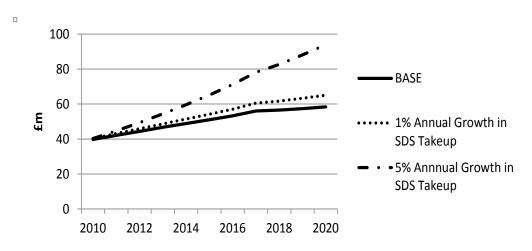
Figure 6.6 1% and 5% changes in take-up rates of SDS

Source: Micro-simulation model

6.64 With no change in Local Authority take-up rates of SDS, annual expenditure would increase from just above £40 million in 2010 to £64 million in 2020. If each year, the numbers receiving SDS increase by 1% in each Local Authority, expenditure increased to around £70 million and if it increased by 5% each year, expenditure would more than double by 2020 to £102 million.

6.65 Most of the increases in spending would be offset by reductions in spend on traditional services such as day care and home care. This would be true if Local Authorities value SDS packages in an equivalent way to conventional Local Authority delivered care. Indeed, users might be able to enjoy a better quality of care if they were able to find more efficient uses of the budgets allocated to them. For example, if they are able to hire care workers at a lower price than the Local Authority, they may be able to buy goods and/or services outside the normal range of Local Authority provision.

Figure 6.7 Alternative cost drivers

Source: Micro-simulation model

6.66 Alternative drivers for cost increases are shown in Figure 6.7. These focus on increased costs, rather than changes in incidence. For comparison, we show the base run, where cost increases are driven solely by population ageing.

6.67 We then increased both PA and Local Authority hourly charges by around 33%. Hourly pay of PAs increases from £8.27 to £10 per hour, while Local Authority charges increase from £15 per hour to £20 per hour. These increases might capture increases in transactions costs associated with SDS, which will impact on both PAs and Local Authorities. For PAs, there are the increased administrative costs associated with training, contracting, administration etc. For LAs, there are increased unit costs due to reduced volume and high fixed costs. Under these assumptions of increased unit costs, total SDS expenditure increases by around £25 million between 2010 and 2020.

6.68 Secondly, we assumed that LA costs increase to £20 per hour. We further assumed that in response to this cost increase, SDS clients increase their utilisation of PAs from 39% to 60%. Costs then increase by only £15 million due to the lower hourly costs of PAs compared with LA provision. However, such an outcome assumes that LAs are willing to switch additional funding into support for PAs and that there is quite a marked response from SDS clients to take advantage of cheaper provision.

6.69 Overall, the experiments show that projected SDS expenditure is quite sensitive to changes in assumptions regarding the rate of roll-out of SDS and the relative costs of PA and conventional provision. There are no targets for this roll-out and there is clearly wide and persistent variation in the existing provision of DPs across Local Authorities. In these circumstances, it is difficult to transform any of these projections into a forecast in which one can have any confidence.

6.70 The increase in SDS spending will be offset by reductions in the aggregate costs of conventional Local Authority social care packages. If these forms of provision were exactly substitutable at the same cost, then the change from conventional packages to SDS would be cost neutral. If SDS packages can be delivered more efficiently than those provided by Local Authorities, and Local Authorities use their own costs as a guide to setting SDS budgets, then the likely outcome is no increase in costs other than those driven by demography, and some improvement in the quality of provision for disabled users receiving SDS packages.

Summary

6.71 The key findings from this chapter were:

- The passage of the SDS Bill will highlight an existing right rather than create a new entitlement, as was the case with the legal framework for Free Personal Care.
- It is difficult to predict the increase in take-up of SDS. It will depend on the extent to which it is promoted by Local Authorities and will also be influenced by age and cohort effects that are not fully understood.
- The statistical linkage between severity of disability and size of the DP package (measured either as cash, or in hours of care) in our data was not strong. This may be because DP packages are only one component of the overall care package.
- There was no significant difference in the number of hours of care supplied to DP clients and the Local Authority control groups, implying that increased take-up of DP would not significantly change the number of hours demanded.
- Attempts to compare the costs of DP with Local Authority provision have generally been unsatisfactory due to uncertainties about the accuracy of the measurement of costs. Analysis of English pilot studies did not reveal significant differences.
- Changes in the structure of contracts may mean increased risk for providers. They are unlikely to be able to pass on the costs of this additional risk, because they are largely confronted by monopsonistic purchasers – Local Authorities. In these circumstances, providers may seek to diversify into other related activities such as training or brokerage.
- Local Authority informants did note higher administrative costs associated with arranging individual contracts, or contracts based on a "framework" agreement compared with the traditional block contract.
- However, costs may be reduced if a greater proportion of supply is given by PAs rather than channelled through the traditional Local Authority route. The extent to which this occurs will depend on the relative price and relative quality of PA and Local Authority provision.
- Spending on SDS will increase even if there is no change in the take-up rates by Local Authority, simply due to the effects of population ageing. Increased take-up is likely to result in some reduction in Local Authority costs. The net effect will depend on the balance of the considerations listed above.

7 DISCUSSION AND ISSUES

Introduction

7.1   In this chapter we discuss some of the main findings in the report, focussing particularly on the implications for policy and practice as the move towards SDS in Scottish social care policy takes shape.

SDS in the policy and practice context

7.2   As both our own, and previous, research indicates, SDS has the potential to deliver significant potential benefits in terms of improved choice and control by service users, better co-ordination of services across different sectors (public, private, voluntary and family carers), and improved cost effectiveness and efficiency of services. However, these potential benefits need to be weighed against a cautious approach about the risks to service providers, front-line staff, service users and family carers, particularly concerning the potential destabilisation of services, exploitation of vulnerable users, exploitation of workers, the risks to family carers and users, and the inequity across different user groups caused by different criteria and uptake.

7.3   Local policy and practice contexts are, and will continue to be, important. The range of providers available locally, and how prepared they are to work with individual users rather than Local Authorities as commissioners of services, will have an impact on whether the potential benefits of SDS can be realised for users and their families. Similarly, the availability of impartial, local, advice and support will continue to be crucial in helping users make well-informed and appropriate choices about SDS.

7.4   At the time the fieldwork for this project was taking place, cuts to social care expenditure were making headlines both nationally and locally. In the light of this, the participants in this study voiced concerns that SDS will be associated in the minds of providers, advisor organisations and users with cuts in resources and services. This association may make it difficult for the positive messages about the potential for SDS to be empowering and give users greater choice and control to inform practice.

Issues for commissioners of services

7.5   The evidence from our study suggests that a number of potential trends could emerge with increased levels of SDS. The costs of services are as yet not fully understood: however we predict that they will become more transparent if Local Authorities can learn effectively from the costing systems that have been developed for DPs.

7.6   Whilst our data indicates that the increased flexibility and choice potentially offered by SDS is broadly welcomed, the evidence also suggests that there are significant variation in costs, and the way they are calculated, across different local contexts and for different groups of social care users. Tackling these variations appear to be important to ensure the fair and equitable use of

scarce resources. More transparency around service costs could make things fairer: on the other hand, they may well expose inequities that are difficult to address.

7.7 Local Authority informants were very concerned that SDS could destabilise existing service providers. They also felt that support agencies will need 'fair notice' of changes in contractual arrangements. Our data indicates that there is clearly some variation as to how prepared providers are to adjust to the flexibility in provision that will be needed for SDS. The ability of commissioners to influence the quality of SDS services will continue to be important: even though SDS users could, theoretically change providers more quickly if they were unhappy with the quality of services.

7.8 Although initially the resources needed for SDS assessments may increase, our data indicates that these should decrease over time as SDS becomes more mainstream and assessment systems develop. There is no evidence to suggest that the resources and costs associated with managing SDS will be greater than for managing social care resources generally.

7.9 Spending on social care services will increase, but this is due to an anticipated increase in demand, and not to SDS *per se.*

Issues for service providers

7.10 Providers were broadly in favour of the increased empowerment, choice and control offered to users through SDS. However, there were concerns about the costs and workforce implications of the predicted flexibility arising from SDS: investment in staff training and infrastructure may prove difficult to sustain for those providers who would be destabilised if SDS user changed contracts at short notice.

7.11 Variations in pricing and demand for services may make it more difficult for some providers to effectively plan and deliver services. Some provider organisations also felt they may be vulnerable to staff leaving to work as PAs to SDS users.

7.12 At present PAs do not have to register with the Scottish Social Services Council, unlike care workers working for Local Authorities or care agencies. The evidence from this project suggests there are concerns about a 'two tier' workforce emerging in social care, which has implications for vulnerable service users and for PAs working with less employment protection and training than their colleagues in the more regulated sector - these concerns are echoed in other studies (Ungerson and Yeandle, 2007; Rummery, 2011).

7.13 Changes in the structure of contracts may increase risks for providers who cannot easily pass these on when faced with large Local Authorities as their main commissioner. New opportunities for providers (for example in providing training, advocacy and advice/brokerage services) may arise.

Issues for SDS users and family carers

7.14 Although it is difficult to judge precisely what these will be, it is likely that some of the costs of increased flexibility in SDS will fall on users and family carers. Users and family carers will be particularly vulnerable to increased costs and risks if Local Authorities do not continue to invest in independent support and advocacy services for SDS.

7.15 However, in line with other research, the DP users in our study were largely positive about the benefits of using DPs, and we judge that these benefits would translate to other SDS users. These benefits included increased flexibility, choice and control over services and support, and the benefits were felt by family carers as well as users.

7.16 Most DP users had chosen DPs because previous service options had not adequately met their needs. However, they did highlight that there was sometimes significant additional work associated for themselves and for family carers in administering DPs, and we predict this burden will continue to fall on users and carers under SDS. Again, this highlights the need for continued investment in support, advice and advocacy organisations.

7.17 It may prove difficult for individual SDS users to use their purchasing power to improve the quality of services in the way that Local Authorities can. It is possible that there may not be sufficient volume of SDS users willing to change contracts and exercise 'choice, voice and exit' to push down prices whilst ensuring that providers who offer high quality services thrive.

Future trends

7.18 Our research indicates that the relationship between user needs and the costs of packages of care is not clear: higher needs do not necessarily mean larger, or costlier care packages.

7.19 DP users are most likely to employ a PA, and least likely to purchase services from a Local Authority: we predict that SDS users will follow similar patterns and chose options like directly employing PAs which offer users the most control and flexibility.

7.20 Our research also indicates that there is no significant difference in hours of care between DP users and the matched sample of users receiving 'standard' service packages. This suggests that SDS, if it follows the same pattern as DPs, will not mean a reduction in services, and costs will not differ significantly between DPs, other forms of SDS and 'standard' services. We conclude that fears about reduced services and increased costs associated with SDS are therefore unfounded: personalisation and SDS do not, *per se*, lead to reduced services and support.

7.21 However, consideration of scenarios in which SDS becomes more mainstream raises questions about what will happen in the market for care if unit costs are driven up by new contractual forms, or if more SDS users opt to employ PAs. The role of, and costs to, Local Authorities are also likely to

change, particularly the costs associated with stimulating local markets to deliver sufficient capacity, putting in place additional support for SDS users (particularly with administration, and training for PAs).

7.22 We predict that opportunities for new providers are likely to increase under SDS, particularly for those offering additional administrative services and those well placed to offer flexible, responsive care services.

7.23 Our modelling indicates that the costs of care will increase. However, these rising costs are mainly the result of the changing demographics and the rising levels of need in the population. They are not specific to SDS. However, projected expenditure on SDS is sensitive to the rate of expansion of this provision and to the costs of (for example) PAs as compared to 'in-house' carers: PAs have associated costs which are not well understood (such as administrative and training costs).

Conclusions

7.24 The expansion of SDS in Scotland is not uncontentious: it remains an area of significant debate. The aspirations towards improved choice and control for users, which drive current policy, are widely supported by all the stakeholders involved in this research.

7.25 However, it is not yet clear that SDS policy and practice can deliver them fully for all users, nor what the impact on the costs of care will be. In the context of the significant variations between Local Authorities in terms of care provision and the uncertainties regarding equity of provision, whether users' needs are being met, where the various costs associated with SDS will fall, and what the impact of SDS will be on service provision in different sectors, the policy drive towards choice becoming the 'default' position in social care policy in Scotland appears to require, to a certain extent, a 'leap of faith' for all concerned.

7.26 Nevertheless, there is no evidence to suggest that SDS is more costly than other options for delivering social care services. Given the potential for increased empowerment, choice and control for users and family carers, that 'leap of faith' will, hopefully, prove justified.

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9   APPENDICES

Appendix 1: Methodology and analysis

Sampling frame

The project used a flexible design, developing and refining costing methodologies which have been validated in other projects but whose reliability and applicability had not yet been robustly tested within this particular context (Bowes and Bell, 2007; Glendinning et al, 2000; Glendinning et al, 2008). We sampled three Scottish Local Authorities with a high volume of SDS users (in the form of DPs, as these were the easiest group on which to access data) crossing several user groups, with a mix of urban and rural provision, where it was possible to establish the availability and accessibility of the data we needed.

In sampling the non-DP users for comparability, we matched user groups, service users and levels of need as far as possible. In sampling our range of SDS users for the user-derived costs, we initially stratified this sample according to levels of need using Local Authority data and collected additional data on need levels from users themselves using a structured questionnaire and validated measures such as the GHQ IADL scores to ensure our findings were valid and reliable.

Data sources

User survey

A postal questionnaire was distributed to a total of 210 SDS users by three participating Local Authorities. The Local Authorities were provided with questionnaire packs containing a copy of the questionnaire and a pre-paid reply envelope, to which the Local Authorities added a covering letter and an address label. The survey instrument was prefaced by information about the study and the research team, following which there were eight sections of questions collecting: basic demographic information; data on service users' support needs; the value of their current SDS package; the support that they receive (whether paid for using SDS (DPs), using money from other sources, or unpaid support); use of their SDS package more generally; other costs associated with their use of SDS; service user views on the value of their SDS; and a section requesting contact details. We received 59 usable responses (28%).

Local Authority sample

Three participating Local Authorities were asked to provide the anonymised records of 'matched' samples of SDS (DP) users and users receiving care services arranged by the Local Authority. Users included in the samples were matched in terms of type of disability and basic demographic details such as sex and age. Local Authorities were requested to stratify the samples in terms of disability type but to select user records randomly within each type. The sample sizes varied between participating Local Authorities, based on numbers of SDS users and the

authority's resources available to access the required information. Data requested as part of the anonymised records included: age; gender; marital status; household structure (if known); service user type; risk band; date current SDS / arranged package started; details of current SDS / arranged package in terms of numbers of hours and type of support; sources of funds included in package (DP, ILF etc); date of assessment; date of care plan; details of previous package(s). Supplying the requested data provided a challenge for all of the participating authorities, as individuals' records often spanned different computer and paper-based systems. No authority was able to supply all of the data requested. In total 265 usable anonymised records were returned.

Data gathered from Local Authorities was likely to miss some components and under-report the full costs of packages of care (both standard and SDS). Data gathered from individual users therefore gave a fuller picture of the range of costs to users and carers, but there were problems of recall or lack of data about full amounts, frequency and type of services and timings. We therefore used both data sources to allow for the strengths and weaknesses of each approach. We used both Local Authority data and user-provided data for the costs and service use associated with SDS packages. However, it was unrealistic to expect users to be able to provide accurate data concerning the costs and service use of standard care packages for comparison, so we relied on Local Authority data and a modified version of the costings used by Curtis (2009), adjusted for inflation and the local context.

Main qualitative sources

- Notes of meeting with Local Authority A (4 participants)
- Interview with Local Authority A Senior Managers (2 interviewees)
- Interview with Local Authority A Contracts Manager
- Notes of meeting with Local Authority B (4 participants)
- Notes of meeting with Local Authority C (2 participants)
- Interview with Local Authority C - Direct Payments Team Manager
- Interview with SDS lead in non participating Local Authority
- Interview with DP support organisation Local Authority B (2 interviewees)
- Interview with Provider 1 (voluntary sector, cross Local Authority)
- Interview with Provider 2 (voluntary sector, cross Local Authority) (4 interviewees)
- Interview with voluntary sector provider Local Authority B (2 interviewees)
- Interview with Managing Director Private Sector Provider Local Authority C
- User-specific voluntary sector provider Focus Group (8 participants)
- Interviews and email correspondence with Reference Group (2 users, 1 carer and 2 Local Authority care managers from non participating Local Authorities)
- DP policies and procedures, and internal evaluations from participating Local Authorities
- Workshop notes (15 participants, including reference and advisory group members, representatives from participating Local Authorities, provider organisations, local and national user advocacy groups)

Reliability and validity of instruments and results

We based all costing tools and measurements on previously tested and validated measures (both in our own previous research and in similar studies in other contexts).

We appointed a reference group comprising a range of stakeholders, including Local Authorities care and commissioning managers, provider managers, and SDS users who were not part of the sample. We used them to check the external validity and reliability of our costing tools and findings as it is our experience that even previously-validated costing and measurement tools cannot simply be replicated in different contexts.

As far as possible we developed costing methodologies that allowed for the comparability of data across Local Authorities, and that could be linked to the development and implementation of Resource Allocation Systems. This ensured the internal validity and reliability of the measures and findings, and provided a framework for the improvement of data gathering and costing for the future development of SDS services across different Local Authorities in Scotland.

However, our ability to do this was limited due the availability and accessibility of Local Authority-derived data and the findings in one Local Authority are not necessarily transportable across different contexts. To a certain extent our use of alternative costings methods based on user-derived data did mitigate against the limits of comparability due to data insufficiency and improve the internal reliability and validity of our findings. In addition, we checked the validity and reliability of our findings across Local Authorities with invited stakeholders (participants in the study and wider informants, including representatives from user and carer organisations, through our reference group and workshop).

Ethics and equalities issues

Prior to commencing fieldwork, ethical approval was sought from the Ethics Committee of the School of Applied Social Science at the University of Stirling, which conforms to the Economics and Social Sciences Research Committee's Research Ethics Framework. The research team adhered to the ethical guidelines of the Social Research Association and the Social Policy Association, which can be found at http://www.the-sra.org.uk/ethical.htm and www.social-policy.com respectively. The key ethical considerations which were relevant to this project included:

- **Risk of harm to participants:** The risks of this were low due to the non-invasive and non-sensitive nature of the research. Data from Local Authorities and users which was used for costings purposes was fully anonymised, and individual-level data from users was not fed back to care managers in an identifiable form. We anonymised the Local Authority sites in this report and will do so in other dissemination activities, although it was not possible to ensure internal anonymity for the study participants. However, we do not feel this impaired the reliability and validity of the research results. All service users were reimbursed for their time (with high street vouchers to reduce the risks associated with directly paying vulnerable adults). This resulted in fairly good response rates for the postal survey. Any areas unmet need that were uncovered during the course of the research were dealt with by users and carers being given information about services and support in their

area wherever possible to ameliorate this risk. All the research team were Disclosure Scotland checked and complied with the necessary adult protection legislation.

- **Confidentiality**: Data was anonymised and kept completely confidential for the purposes of data handing, storage, and external and academic dissemination. We have anonymised the location of the Local Authority sites and participants. However, due to the nature of the methods used, some internal participants (particularly Local Authority and care provider managers) were able to identify each other: they were aware of this when consenting to take part in the research. Data provided by users was completely anonymised and not made available in identifiable format to the Local Authority.

- **Equalities issues**: Participants in this study were chosen to reflect their experiences, roles and expertise, rather than being representative of the population as a whole, so it was inappropriate to stratify the sample on the basis of age, gender or ethnicity. We did attempt to pay particular attention to the recruitment of black and ethnic minority users but this proved impossible due to the low numbers of respondents.

Glossary of terms

Community Care Assessment	In order to access social care services all disabled[5] people in Scotland have to undergo an assessment of their needs. This is usually done by a social worker or other professional working on behalf of the Local Authority, and assesses whether the disabled person has needs which are considered 'eligible'. Local Authorities have discretion in deciding what these needs are, and whether they can afford to meet them.
Direct Payment (DP)	Anyone who is assessed as needing social care services can chose to take these in the form of a 'direct payment', which enables them to employ their own carers and purchase their own services.
Disability Living Allowance	DLA is a tax-free benefit for disabled children and adults to help with extra costs they may have because they are disabled. The equivalent benefit for over 65s is called Attendance Allowance. It is not administered by Local Authorities, and is due to be replaced with Personal Independence Payments.
Independent Living Fund	The ILF was set up as a national resource to enable disabled people to live independent lives in their community rather than in residential care. It is now closed to new applicants, but some long-standing users of social care still receive funding from this scheme.

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[5] for simplicity we use 'disabled person' to cover anyone, of any age, who has social care needs covered by self-directed support. This can include disabled children (and carers of disabled children), older people, and people with mental health needs and learning disabilities.

Individual Budget (IB)	The Individual Budgets pilot programme was a cross-government initiative led by the Department of Health working closely with the Department for Work and Pensions, and Communities and Local Government. The pilot was conducted over two years 2006-2007 involving 13 Local Authorities. The evaluation of these pilots can be found in Glendinning et al (2008).
Individual Service Fund (ISF)	When someone wants to use their individual budget to buy supports from a provider, it is called an Individual Service Fund (ISF). Individual Service Funds mean that • The money is held by the provider on the individual's behalf • The person decides how to spend the money • The provider is accountable to the person • The provider commits to only spend the money on the individual's service and the management and support necessary to provide that service (not into a general pooled budget).[6]
Personal Assistant (PA)	This is the term used for a carer/supporter who is usually directly employed by a disabled person holding a direct payment.
Personalisation	Personalisation is a social care approach described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings". (Dept of Health, 2008). While it is often associated with direct payments and personal budgets, under which service users can choose the services that they receive, personalisation also entails that services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion. It also encompasses the provision of improved information and advice on care and support for families, investment in preventive services to reduce or delay people's need for care and the promotion of independence and self-reliance among individuals and communities. [7]

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[6] source http://www.in-control.org.uk/support/support-for-individuals,-family-members-carers/glossary/individual-service-fund-(isf).aspx accessed February 6th 2012
[7] source http://www.scie.org.uk/publications/reports/report20.pdf accessed February 6th 2012

APPENDIX 2: Survey of DP users

Detailed results

This Appendix contains tables detailing the results of the survey of DP users previously discussed in Chapter 5.

Table 9.1 Respondent demographic data

Local Authority area	A	B	C	All
Number of respondents /sample size	18/90	18/60	23/60	59/210
Response rate	20%	30%	38%	28%
Respondents	(n=18)	(n=18)	(n=23)	(n=59)
Someone who receives Direct Payments	10 (56%)	12 (67%)	18 (78%)	40 (68%)
A person caring for or informally supporting someone who receives Direct Payments	8 (44%)	0	4 (17%)	12 (20%)
A person formally managing Direct Payments for another person as their Guardian or Power of Attorney	0	6 (33%)	1 (4%)	7 (12%)
SDS user location	(n=17)	(n=17)	(n=23)	(n=57)
A city	16	0	0	16 (28%)
A large town	0	4	5	9 (16%)
A small town	0	9	6	15 (26%)
A village or small group of houses or place in the countryside	1	4	12	17 (30%)
SDS user age	(n=18)	(n=18)	(n=23)	(n=59)
16-59	14	11	6	31 (53%)
60-64	0	5	6	11 (19%)
65+	4	2	11	17 (29%)
SDS user sex	(n=18)	(n=17)	(n=23)	(n=58)
Male	8	8	8	24 (41%)
Female	10	9	15	34 (59%)

Table 9.2 Service users' DP packages

Local Authority area	A	B	C	All
Years in receipt of Direct Payments	(n=16)	(n=18)	(n=23)	(n=57)
Mean	4.2	5.0	8.0	6.0
Standard deviation	6.3	3.6	4.0	4.9
Minimum	0.5	1.5	0.5	0.5
Maximum	24.0	14.0	20.0	24.0
Direct Payments paid to:	(n=17)	(n=18)	(n=23)	(n=58)
SDS user	10	12	22	44 (76%)
A parent, Guardian or person with Power of Attorney on SDS user's behalf	6	4	1	11 (19%)
An advocate or organisation (e.g. centre for independent living) on SDS user's behalf	1	2	0	3 (5%)
Main reason SDS user qualifies for Direct Payments	(n=18)	(n=17)	(n=23)	(n=58)
Physical disability	5	14	21	40 (69%)
Learning disability	9	0	1	10 (17%)
Mental health needs	2	1	0	3 (5%)
Age-related illness or disability	2	2	1	5 (9%)

Table 9.3 Service Users' abilities to perform selected tasks

Ability (n=59 unless otherwise stated)	Can do this by him / herself	Can do this with some help	Needs a lot of help to do this	Never does this
Bathing/showering	13 (22%)	17 (29%)	24 (41%)	5 (8%)
Using the toilet	26 (44%)	11 (19%)	19 (32%)	3 (5%)
Getting dressed	18 (31%)	14 (24%)	25 (42%)	2 (3%)
Take care of own appearance	15 (25%)	17 (29%)	24 (41%)	3 (5%)
Transferring him / herself from the bed to a chair	29 (49%)	4 (7%)	18 (31%)	8 (14%)
Feeding him / herself	34 (56%)	9 (15%)	10 (17%)	6 (10%)
Using the telephone (n=58)	26 (45%)	11 (19%)	9 (16%)	12 (21%)
Doing laundry	9 (15%)	9 (15%)	14 (24%)	27 (46%)
Preparing meals (n=58)	6 (10%)	9 (16%)	13 (22%)	30 (53%)
Doing housework	6 (10%)	7 (12%)	17 (29%)	29 (49%)
Managing household finances (n=57)	13 (23%)	18 (32%)	6 (11%)	20 (35%)
Shopping (n=58)	5 (9%)	12 (21%)	26 (45%)	15 (26%)
Taking medication	16 (27%)	23 (39%)	13 (22%)	7 (12%)
Driving a car	4 (7%)	2 (3%)	0	53 (90%)
Using public transport (n=58)	7 (12%)	9 (16%)	14 (24%)	18 (48%)
Walking from room to room	22 (37%)	6 (10%)	6 (10%)	25 (42%)
Climbing a flight of stairs	17 (29%)	6 (10%)	7 (12%)	29 (49%)
Walking outside his / her home	9 (15%)	11 (19%)	12 (20%)	27 (46%)