care inspectorate

Thematic review of self-directed support in Scotland

South Lanarkshire local partnership report

June 2019

HAPPY TO TRANSLATE

Contents

1. About this report

Background

Self-directed support: A National Strategy for Scotland was published in October 2010. This was a 10-year strategy which set the agenda for self-directed support in Scotland. The subsequent Social Care (Self-directed Support) (Scotland) Act 2013 was implemented on 1 April 2014. The strategy and legislation were designed to encourage significant changes to how services are provided. They require public bodies to give people more say in decisions about local services and more involvement in designing and delivering them.

Fundamental principles of self-directed support are built into the legislation: participation; dignity; involvement; informed choice; and collaboration. Further principles of innovation, responsibility and risk enablement were added. Social care should be provided in a way that gives people choice and control over their own lives and which respects and promotes human rights.

The thematic review

This report forms part of a thematic review led by the Care Inspectorate, which was undertaken jointly with Healthcare Improvement Scotland. The inspection teams included associate assessors with lead roles in self-directed support in partnerships and other organisations across Scotland.

The review looked at the implementation of self-directed support in six partnerships across Scotland: East Lothian; East Ayrshire; West Dunbartonshire; Shetland; Moray and South Lanarkshire. The specific findings from and recommendations for the individual partnerships visited are reported separately in these local partnership reports.

As part of the thematic review we have also published an overview report. This sets out the key messages and recommendations from the review. We hope that all partnerships across Scotland and organisations interested in self-directed support will be able to learn from these findings.

The focus of our thematic review

The main purpose of the review was to improve our understanding of the implementation of self-directed support to support improvement in the delivery of this important agenda in Scotland. We sought to find out if the principles and values of self-directed support are being met and delivering positive personal outcomes.

Under this overarching inspection question we explored the extent to which the partnerships had ensured that:

- people are supported to identify and achieve personal outcomes
- people experience choice and control
- people feel positive about their engagement with professionals and services
- staff are enabled and empowered to implement self-directed support
- the principles and values of self-directed support are embedded in practice
- there is information, choice and flexibility for people when accessing services.

This local partnership report sets out our findings, evaluations and recommendations against the following themes:

- Key performance outcomes
- Getting support at the right time
- Impact on staff
- Delivery of key processes
- Policy development and plans to support improvement in services
- Management and support of staff
- Leadership and direction that promotes partnership.

Approach to the partnership inspection

To find out how well self-directed support is being implemented in South Lanarkshire, we gathered the views of staff across social work, health and provider organisations. We carried out an online survey between 27 June and 13 July 2018, aimed at gathering the views of staff in relation to self-directed support. In addition, we worked with partnerships and invited them to coordinate the issuing of a questionnaire to ensure we heard the perspectives of supported people on how self-directed support had shaped their experiences of services. The survey was completed by 136 staff and the supported person questionnaires were completed by ten people.

We read the records of 60 supported people who received a social work assessment and subsequent care and support services and 20 records of people who had been signposted to other services at the point of enquiry. During the inspection we met with a further three supported people and ten unpaid carers to listen to their views about their experiences of services. We also spoke to various staff from a range of agencies who worked directly with supported people and unpaid carers. We are very grateful to everyone who talked to us as part of the thematic review of self-directed support.

Staff survey and case file reading analysis

Where we have used figures, we have standardised the terms of quantity so that ‘few’ means up to 15%; ‘less than half’ means 15% up to 50%; ‘the majority’’ means 50% up to 75%; ‘most’ means 75% up to 90%; and ‘almost all’ means 90% or more.

Evaluations

Evaluations are awarded on the basis of a balance of strengths and areas for improvement identified under each quality indicator. The evaluation is not a simple count of strengths and areas for improvement. While each theme within an indicator is important, some may be of more importance to achieving good outcomes for supported people and unpaid carers that they are given more weight than others. Similarly, weaknesses may be found that impact only on a small number of individuals but are so significant, or present such risks, that we give them greater weight. All evaluations are based on a thorough consideration of the evidence.

Definitions

"Self-directed support options" refer to the four self-directed support options under the legislation:

- **Option 1:** The individual or carer chooses and arranges the support and manages the budget as a direct payment.
- **Option 2:** The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
- **Option 3:** The authority chooses and arranges the support.
- **Option 4:** A mixture of options 1, 2 and 3.

'Supported people' or 'people' describes people who use services or supports as well as people acting as unpaid carers for someone else.

'Good conversations' are the conversations that take place between supported people and staff. These conversations allow an understanding to develop of what is important to, and for, supported people on their terms. This allows the identification of desired personal outcomes for the supported person.

'Personal outcomes' are defined as what matters to supported people in terms of the impact or end result of activities. These can be used both to determine and evaluate activity.

'Staff' includes paid staff working across health, social work and social care services; this includes staff from all sectors statutory and third and independent sectors involved directly or indirectly in the provision of advice, care and support.

'Providers' refers to organisations that employ and manage staff in the provision of advice, care and support. These organisations can be from the statutory, third or independent sector.

'The partnership' refers to the Integration Authority which has statutory responsibilities for developing strategic plans and ensuring that the delivery of the functions delegated to the local authority complies with the integration delivery principles.

‘Independent support’ including independent advocacy is impartial, can take many forms and may be provided by different organisations. It does not involve providing direct care or related tasks; rather, it helps people make informed decisions about self-directed support.

2. Key performance outcomes

Supported people experience positive personal outcomes through the implementation of self-directed support

Summary

There was some evidence of positive personal outcomes being achieved as a direct result of self-directed support. For supported people we found evidence of positive outcomes in most of the case files we read and poor positive outcomes in only a few. This included the creative use of personal assistants and people using review processes to change options and achieve positive outcomes. However, for some people, particularly unpaid carers, we found that while positive outcomes were generally achieved, it was after a lengthy and difficult process. The partnership had developed and implemented tools for assessment, support planning and reviews that could be used to show what positive outcomes were being achieved. Their use however was inconsistent. The partnership was therefore not gathering data on personal outcomes as effectively as it could at this time, but recognised it was important and was considering how to address this.

Evaluation - Adequate

There were some examples of where receiving self-directed support had led to positive outcomes being achieved and the lives of both the supported person and their carer improving. There were also examples of the creative use of personal assistants, going above and beyond traditional roles to ensure the most positive outcomes for people. This included things like supported people modifying their support plans to allow them to build up a budget so they could be supported to go on holiday, with their personal assistants. We found some evidence in records of reviews we read of people changing their self-directed support options to better meet their outcomes. This demonstrated that in some cases, self-directed support was being used to improve positive outcomes for people. We particularly found evidence of this for supported people with learning or physical disabilities.

There was a mixed picture as to what degree positive personal outcomes were being achieved as a direct result of self-directed support. In the supported people questionnaire all respondents felt they had achieved positive personal outcomes as a consequence of self-directed support. Within the staff survey, the majority of respondents agreed or strongly agreed that there was evidence of positive personal outcomes for people as a result of self-directed support.

For the majority of carers we spoke with, positive outcomes only came following a difficult journey through the process of self-directed support. Carer stress increased due to the problems they had experienced trying to get the best outcomes for the supported person and themselves. Some supported people had to wait for up to a year to have their assessments completed and have budgets approved during which time their defined outcomes were not being met. Managers and staff in the partnership acknowledged that they needed to improve how they worked with carers.

We found no clear data or information held by the partnership about outcomes for people using self-directed support at an aggregated level. The partnership was not capturing outcomes data to evaluate its performance or to drive improvement. Within records and in particular in support planning, outcomes were often not recorded which made it difficult to generate aggregated data. There was also a lack of evidence of the supported person agreeing or informing the support plan. This meant the partnership was not able to provide recorded evidence to show positive personal outcomes were being met as a direct result of self-directed support.

The assessment template in use at the time of the review was designed in a way that should encourage a co-production approach, fully involving supported people, unpaid carers and staff. This had the potential to allow people the opportunity to define the positive personal outcomes that were important to them and how they wanted to achieve them. This template, along with the support planning template was also linked to the national health and wellbeing outcomes and had scope to include personal outcomes, based on the talking points approach. Linking the template to established outcomes frameworks made it more robust but it was not being consistently used to record information on outcomes. This made it more difficult for people to achieve the positive personal outcomes they wanted, as there was not a clear record of what outcomes were being sought.

The partnership had established a three-person self-directed support team in February 2018, to directly work on all areas of self-directed support implementation. The team was working with support staff on how to gather and collate outcomes data from the assessment form and the care and support plans to drive improvement. The team was also working with staff using the templates to guide and support them to use them properly. The team had the licence and autonomy from senior managers to work towards making change happen. If this work was successfully completed it would help supported people and unpaid carers to better achieve positive personal outcomes. This was because staff would have clearly-recorded information on what outcomes were important to people and how they were meant to be achieved.

Recommendation for improvement

The partnership should take action to ensure that it is able to robustly record, measure and report on the personal outcomes being achieved as a result of self-directed support on an individual and aggregated basis.

3. Getting support at the right time

Supported people are empowered and have choice and control over their social care and support

Summary

The information being shared with people by the partnership was not always consistent. Information about personal budgets was particularly confusing for supported people and unpaid carers. A significant number of staff lacked confidence in talking about self-directed support. This meant people often relied heavily on independent support organisations for advice and help. The partnership had developed positive close working with the partnership's main independent support organisation, Take Control, and also developed creative and accessible tools for sharing information. Take Control was based in Hamilton and worked across the four localities. Their staff, while independent, worked closely alongside social work staff, making communication far stronger. The partnership had a strong commitment to ensuring advocacy was offered to supported people and unpaid carers, which helped people to access services that were right for them. However, advocacy services were under pressure in being able to meet the level of demand. The partnership was committed to early intervention and prevention and had developed good links with community planning partners, but was not yet able to capture the impact of such services. Proposed changes to eligibility criteria meant that early intervention and prevention services might soon become less readily available.

Evaluation - Adequate

A key element of our review was whether people were able to exercise choice and control through having adequate and timely information and support. In the staff survey almost all staff felt they were able to have good conversations with people, where they discussed what outcomes were important to them and how these might be achieved. Almost all staff felt they shared information appropriately and at the right time with supported people and unpaid carers.

However, slightly less than half of the staff felt confident in discussing self-directed support. The partnership needed to identify why such a large proportion were not confident about this as supported people were often dependent on partnership staff for information and guidance about self-directed support. A lack of good information and guidance for people would lessen the likelihood of positive personal outcomes being achieved

Supported people and unpaid carers experienced some inconsistency when discussing self-directed support with partnership staff, which reinforced the point that not all staff felt confident. Our file reading indicated that most people received information in a timely manner but supported people and unpaid carers told us that while they may get some basic information from partnership staff, they found they received additional more helpful information when talking to independent support organisations.

The partnership had developed tools and resources such as a self-directed support passport and a self-directed support board game. These were designed to inform people about self-directed support. They were popular with people who used them and helped them understand self-directed support better. They were particularly well-used with supported people who had communication difficulties as the tools conveyed information in a very accessible and user-friendly manner.

The process for setting individual budgets was confusing for supported people and unpaid carers. Individual budgets for the supported person and their unpaid carer often came from one joint assessment. The assessment took place prior to budgets being agreed. This made it difficult for people to talk about what outcomes they wished to achieve and how they might achieve them, as they did not know whether there would be sufficient funding to do so. This meant it was more difficult to carry out genuinely outcome-focused assessments, which are critical to self-directed support. This lack of transparency about allocating resources had a negative impact on choice and control for supported people and unpaid carers.

The partnership had taken positive steps to strengthen preventative and early intervention services. Services like these helped steer people away from unnecessary formal support services. The steps included closing some hospital beds to free up an estimated annual £700,000 to spend on community-based services. At the time of the inspection, this money had yet to be allocated however, which meant that its potential benefit was not yet evident.

The partnership had closely engaged with community planning partners around its "Building and Celebrating Communities" programme. This meant there were a number of initiatives that contributed to prevention and early intervention for people which were shared across a range of agencies. The health and social care partnership's involvement meant that supported people and unpaid carers could get this additional support without the partnership having to find the resource for health and social care services.

There was little evidence of 'signposting' ('signposting' is where people are directed away from formal supports to less formal supports that can meet their needs adequately). The partnership had reviewed and redesigned its access routes in the previous two years, centralising and streamlining them to make them more efficient, through a single point of contact. A consequence of this was that there was less scope to always record when successful signposting had happened, though regular recording of this wasn't evident prior to the change. The partnership intended to change its access route so that it was managed within its four individual localities. This would be positive as it would more easily allow the partnership to find out how many people were 'signposted' and to which services. This would also allow them to establish whether this was freeing up resources for formal support. Moving to a locality-based first point of contact would mean supported people and unpaid carers were getting local information from local staff. This could lead to better outcomes for people as they would be getting information and advice based on what as available to them in their own communities.

The partnership recognised this and was seeking to find ways of doing so, but plans were at an early stage. The leadership team stated that they felt there was scope for GPs and allied health professionals to play a greater role in actively 'signposting' people away from formal support but this was still to be developed at the time of inspection.

The partnership was introducing changes to its eligibility criteria policy. This policy described what level of need people must have to access formal support. The changes meant that people assessed as having low or moderate needs would no longer be automatically considered for formal funded support. The partnership felt these changes were essential to maintain services for people with critical or substantial need. The partnership was sharing its intentions with local councillors at the time of the inspection. Staff working directly with people had little knowledge of these changes and neither did supported people and unpaid carers themselves. The partnership was not able to state what impact the changes would have on preventative and early intervention services. If these changes reduced people's access to preventative and early intervention services there was a risk that ultimately more people would end up requiring greater formal support, impacting on people's control over their support.

The partnership had a well-established relationship with Take Control, the main independent support organisation. Take Control workers, while retaining their independent status would regularly accompany social work staff visiting people for assessment, planning and review purposes. This was positive as it meant communication between partnership staff and Take Control staff was strong and they had a clear understanding of each other's role. This meant that supported people and unpaid carers were more likely to get good, consistent advice from social work staff but this didn't necessarily extend to health staff. Supported people and unpaid carers spoke very positively about independent support organisations in the partnership area.

There were pressures around demand for advocacy services. This was in part because partnership staff were very good at making sure people knew about the availability of advocacy and discussed it at the outset with people. There was also pressure due to an increase in demand for advocacy in other areas as a result of national policy changes – this was essentially outwith the partnership's control but nevertheless something the partnership needed to address. The partnership clearly recognised the value and importance of advocacy services. It intended to address these issues as part of its revised strategic commissioning plan to ensure people continued to have access to advocacy as and when they needed it.

Recommendation for improvement
The partnership should gather evidence to understand the impact of 'signposting', preventative and early intervention services.

Recommendation for improvement
The partnership should evaluate the impact of changes to its eligibility criteria policy and how these might affect preventative and early intervention services.

4. Impact on staff

Staff feel confident, competent and motivated to practice in an outcome-focused and person-led way

Summary

The majority of social work staff felt confident about their understanding and practice in relation to self-directed support. The majority also felt that the systems they worked within were supportive of them practising to the principles and values of self-directed support. Nonetheless a significant minority felt they had not been adequately trained and were not confident about self-directed support. The partnership intended to look into the reasons for this in more detail to understand why it was the case. This difference in staff understanding led to inconsistency when working with supported people and unpaid carers which could have a negative impact on their experience of self-directed support The partnership had taken steps to give frontline staff more autonomy and was considering whether and how to take this further. The partnership had developed a formal structure for supporting social work staff through the self-directed support team and workplan. This should, in time, ensure greater consistency in staff practice. Health staff generally had no training or involvement in self-directed support and the partnership needed to address this to ensure they were empowered and enabled.

Evaluation - Adequate

During the course of this inspection we met with staff at all levels of the partnership, including frontline social work staff and frontline social work managers. We also received 136 responses to our staff survey, most of which were from frontline social work staff or managers.

Almost all social work staff felt confident in having good conversations, including positive discussions about risk, which is important in ensuring that the principles and values of self-directed support are met.

A majority of social work staff felt they had adequate training in self-directed support, although a sizeable minority (almost a third) felt they had not. Health staff generally had no training or involvement in self-directed support. The partnership needed to address this to ensure they were empowered and enabled in relation to the delivery of self-directed support.

Take Control was often asked for advice by partnership staff about self-directed support. This was not their specific remit, but was a valued source of support for partnership staff. Some partnership staff did not feel confident with self-directed support and the training they had received and this was reflected in inconsistencies in practice. In turn this meant that supported people and unpaid carers would receive different levels of service depending on which worker they were involved with.

The partnership had devolved decision-making about agreeing assessments and budgets for supported people from a centrally-based group of senior managers to its locality managers, who met and discussed each request for funding with the relevant team leaders and social workers. This meant that social workers and social work team leaders were more directly involved in the process. This was positive as they had more knowledge of the supported people whose assessments and budgets were being agreed. Frontline staff felt they were able to directly contribute their insights to the decision-making process, making it more person-centred.

Managers and staff felt that there was scope for further devolution, for example by more routinely allowing team leaders to agree changes to budgets. Doing this would empower staff and frontline managers and enable the partnership to be even more responsive and flexible to changes in supported people's needs. Senior managers recognised the potential benefits of this, but were also mindful of the need for adequate levels of supervision and oversight of budget decisions.

A consistent message from staff was that they felt the self-directed support team was very supportive. The team helped workers understand systems and processes but also gave them the opportunity to reflect on and discuss their practice. This was a critical element in ensuring that workers consistently linked their practice to the principles and values of self-directed support. Support for staff was a feature of the partnership's self-directed support workplan. This document carried a large number of actions to help support staff and its implementation and effectiveness were kept under review by senior managers. This meant that support for staff was embedded in the partnership's planning. This was reflected in the staff survey where a significant majority of staff (70%) felt that the leadership team were committed to self-directed support and more than half felt the leadership team encouraged creativity and innovation.

Recommendation for improvement

The partnership should take action to develop staff, amd in particular health staff, to be knowledgeable about self-directed support and build their confidence to enable them to support the delivery of self-directed support.

5. Delivery of key processes

Key processes and systems create conditions that enable supported people to have choice and control

Summary

The partnership had taken a number of steps, particularly in the last twelve months to review its systems and processes with the intention of improving them and thus implementing self-directed support more effectively. A number of these changes were still in the planning or implementation stages. Ongoing evaluation of the assessment and support planning tools along with the gathering of feedback from staff had enabled the partnership to improve the effectiveness of these processes. At the time of this inspection it was still very much a work in progress. Both established and recently introduced systems and processes lent themselves to outcome-focused approaches but in practice this was not happening on a consistent basis. Assessment forms offered clear scope for the recording of supported views. Comprehensive outcome support plans had been developed that clearly linked to established outcomes framework. These were still being rolled out for all supported people. The financial assessment process was cumbersome. Processes for deciding personal budgets were efficient, but lacked transparency and rarely directly involved the supported person or unpaid carer. The partnership needed to do more to demonstrate that people agreed with their assessments and support plans and that they were given copies of them, when completed.

Evaluation - Adequate

We examined the systems and processes the partnership had in place. This was to see whether they made it easy for supported people to have choice and control, built on their assets and were positive in relation to risk.

The partnership had developed and implemented a new assessment form, on a phased basis over the previous year. They had formally evaluated and revised this tool in June 2018. Ongoing evaluation and the gathering of feedback was also taking place through the self-directed support team. The form was being used across all the partnership's service areas and teams, replacing the previous arrangement where different forms were being used in different settings. This meant that staff and supported people were now consistently using the same tool and were therefore more familiar with it. This made the process easier to understand for all.

The form was designed so that there was lots of scope for the supported person's views to be recorded. However, the recording of supported peoples' views had not reached a consistent and comprehensive level yet. Despite the form offering scope to record in an outcome-focused manner, we found that often it was focusing on needs rather than personal outcomes, even though there was generally evidence of asset-based approaches. This meant that the form was not always being used to its best effect.

The form also included a clear calculation of what a personal budget was likely to be. This gave both the supported person and the worker some sense of the likely levels of support that would be available. This was helpful for the supported person in thinking about what their support plan might look like, but critically at this stage, the budget was still to be confirmed and could be changed, meaning people couldn't make firm plans or decisions about their support at that stage.

Following assessment, workers regularly discussed the content of the form with their team leader before it was taken to a decision-making group chaired by a service manager (the Practice Review Assessment Group, or PRAG). These discussions helped ensure the assessment was written in a way that made it easier for PRAG to consider. PRAG agreed the final budget a person would receive. Many staff felt this was a fair and consistent process, although some felt it was laborious. Some staff also felt this aspect of the process could sometimes be more focused on finance rather than outcomes. Both a number of staff and supported people described the PRAG process as being difficult to understand and lacking transparency.

Unpaid carers felt the process of agreeing resources and budgets was complex and confusing and were unclear about how budgets were allocated and the process for agreeing rates for care. Carers also described uncertainty as to what they could and could not use personal budgets for. Partnership staff expressed discomfort at the notion of sharing the detail of PRAG discussions with supported people and did not feel that it would be helpful for supported people or carers to be present at PRAG meetings when their needs were being discussed. While the establishment of the PRAG process at locality level had brought decision-making closer to where practice was taking place, there could often be delays where requests for service were pushed back to future meetings so that more information could be sought, which meant delays in getting services in place for people.

Overall, the PRAG process meant there was an established structure for making decisions about people's support that was generally consistent. However this did not actively involve supported people and carers themselves. The PRAG process was robust but not transparent. This meant that supported people and unpaid carers were not fully involved or supported in exercising choice and control, in line with the principles and values of self-directed support.

The partnership had developed a new form for support planning to complement the assessment form. This form was used after a budget had been agreed. This was not being used consistently – in most of the records we examined there was no support plan available at all, or if there was, it was not fully completed. The support plan was intended to capture a number of different elements including finances and personal outcomes. Some staff spoke of confusion about how to complete the form. The partnership recognised that there were issues around the design and use of the support plan and intended to review and revise the form and to issue clearer supporting guidance to staff. This should improve practice and lead to a stronger focus on outcomes for supported people and unpaid carers.

Staff told us that the financial assessment process was cumbersome. They expressed uncertainty as to when it should be undertaken as it potentially influenced support planning decisions and steered people towards thinking about finances rather than outcomes. The partnership recognised a need to address this as part of its broader review of eligibility and access to services.

Asset-based approaches consider what natural assets and strengths a person may have and the relationships, networks and informal support available in their communities. In our staff survey just over half of staff felt they were able to work to this approach, although when we read records we found evidence of some degree of asset-based approach taking place in most cases.

There was well-recorded evidence of the use of asset-based approaches in specific areas – notably work with adults with learning disabilities in the a number of localities. This involved close working with families, helping make connections between them to identify possible and better alternatives to traditional day services.

Commissioning officers also had a deliberate focus on encouraging staff to work with supported people on developing their own informal networks of support, particularly in services for adults with learning disabilities. This had been successful in reducing levels of formal 1:1 support for people in a safe manner. This meant people were more independent and had more choice and control over who they spent time with.

In general we found that there was a positive attitude towards managing risk and enabling positive risk-taking on the part of managers and staff. When we read records we found evidence of people using self-directed support to develop packages of care that reduced formal supports while increasing positive risks. This included the use of technology-enabled care and staff told us that they felt increasingly confident in discussing this with people as a means of encouraging more risk-positive approaches.

In the case file records we read, we found evidence of nearly half of all people exercising option 2 or option 4. These were the two new options that were introduced as a result of the self-directed support legislation. This meant that people were discussing options and exercising choice and control. However, it was also the case that people were steered towards options due to other circumstances – for example, we were told by staff that option 2 was particularly promoted to people in the Clydesdale locality due to the difficulties in accessing local authority provided services through option 3.

Carers did not feel they had the level of choice and control they desired. They said they did not see finalised assessments and were only given indicative budgets to plan support. They had little understanding of the system for allocating resources and how final budgets were calculated. Carers said that they and supported people routinely did not have copies of their own assessment.

Recommendation for improvement
The partnership should engage with supported people and unpaid carers to find ways of ensuring they are involved and informed in the process for finalising budgets.

Recommendation for improvement
The partnership should ensure it records that people agree with their assessment and support plan, in line with the principles and values of self-directed support. The partnership should ensure that people have copies of their assessment and support plan, should they so wish.

6. Policy development and plans to support improvement in services

The partnership commissions services that ensure supported people have a range of choice and control over their social care and support.

Summary

The partnership had difficulties in delivering and sustaining care services in some localities. It had taken positive steps to significantly increase the range of providers it had available to supported people, whether through Option 2 or Option 3. As part of this, they were inviting providers who wished to offer Option 2 support to agree to meeting a set of defined quality standards. The partnership was working to ensure its next strategic commissioning plan would better reflect its commitment to implementing the principles and values of self-directed support. It had held a number of engagement events open to the public, to help shape the strategic commissioning plan with a focus on self-directed support. The partnership wanted to develop locality commissioning to reflect the different localities. Planning was at a very early stage and the partnership needed to find ways of capturing good-quality local data to help inform this process.

Evaluation - Adequate

The partnership had taken positive steps to ensure it had a greater number of providers available. This was important in providing choice and flexibility and was also a reflection of the difficulties in delivering and sustaining care services in some localities. The partnership planned moving from working with five or six providers to more than twenty. The existing providers were generally delivering good-quality services and the partnership recognised the importance of maintaining this. The partnership intended to have an increased number of providers in place by April 2019 and had developed its criteria and service specification for potential providers as well as holding information-sharing events with them.

The partnership had established a framework for Option 2 whereby providers could voluntarily sign up to a set of quality standards set by the partnership and similar to the standards they set providers they contracted with under Option 3. This new framework was for the delivery of services through Option 2. Supported people were still able to use Option 2 to choose providers who were not on this framework, but had the knowledge that those who were had been quality assured by the partnership. This meant that people were able to exercise greater choice and control, but had the security of the partnership's quality assurance procedures if they wished.

Signing up to this framework was a necessity if providers wished to seek work through Option 3 with the partnership. Commissioning leads had analysed and assessed the levels of supply and demand for care and were confident there was enough work to ensure an increase in the number of providers was sustainable.

The partnership was in the process of developing the next iteration of the strategic commissioning plan (2019-2022). This had included locality public engagement events. At these, the partnership shared information about the level of demand it anticipated for health and social care over the coming years and its thinking on this. This was important to ensure people were encouraged and supported to help shape plans.

The partnership intended to ensure the principles and values of self-directed support were reflected throughout its strategic commissioning plan. The public engagement events had highlighted the role self-directed support could play in helping people achieve positive personal outcomes. Embedding the principles and values of self-directed support in the strategic commissioning plan was intended to allow the partnership to build on the progress it had made over the last 12-18 months. This included an intention to continue the engagement with the new, increased pool of providers so that there was clarity and a shared understanding about the partnership's ambitions regarding self-directed support. In order to know that this ambition was being realised, the partnership needed to ensure it was able to monitor and evaluate the performance of its providers.

The partnership had a robust approach to ensuring independent advocacy was offered as a matter of course to supported people but recognised that demands for services like this were increasing, for a variety of reasons and not always linked to self-directed support. The partnership recognised its new strategic commissioning plan needed to account for this and describe how it would build on existing relationships with independent support organisations such as Take Control. This was important as access to good-quality advocacy and independent support when required is fundamental to meeting the principles and values of self-directed support.

The partnership wanted to develop locality-based commissioning, which was important as there were significant variations in needs, demand and capacity across the various localities. Implementing this was challenging – the in-house procurement team had significantly been reduced in capacity, although it still retained an identified link officer to social work services. The partnership recognised that there was limited quantitative or qualitative data at locality level to support creating commissioning plans. Thinking and planning to address this was at a very early stage.

Recommendation for improvement
The partnership should ensure that the increase in the number of providers is monitored to ensure it is sustainable and delivers positive outcomes for people.

Recommendation for improvement
The partnership should establish clear systems for capturing self-directed support performance information and this is evaluated and used to drive improvement and change.

7. Management and support of staff

The partnership empowers and supports staff to develop and exercise appropriate skills and knowledge

Summary

The senior leadership team had carried out evaluation work including case file audits and a staff survey to establish what support staff required. This led to changes including the development of a self-directed support workplan. This plan included actions in relation to staff training. In February 2018 the partnership established a self-directed support team to support staff to develop their knowledge, skills and understanding of their role in relation to self-directed support. This team was valued by both staff and managers. A short-life working group was developing a suite of specific training materials. Social work team leaders had been facilitating focus groups for their staff where they were encouraged to reflect and discuss their practice. This was supported by clear messages from senior managers promoting self-directed support as a priority for the partnership. These factors were important as in the staff survey some staff had still spoken of lacking confidence in relation to self-directed support. There was no established training on self-directed support for first line managers in social work. Health staff had had little or no training to date and had yet to be actively engaged in this agenda.

Evaluation - Adequate

In the 12-18 months prior to our inspection, the partnership had conducted a number of pieces of self-evaluation work, including its own case file audit and a staff survey, in relation to self-directed support. This was due to recognition by senior managers that progress since April 2014 had been limited.

The audit and survey had identified a number of issues which were affecting implementation, some directly relating to staff. These included staff concerns about systems and processes being unwieldy and about their levels of confidence and competence in relation to self-directed support. In response to this a self-directed support work plan had been created with actions prioritised so that these were progressed on a planned and phased basis. Much of the initial work had been focused on revising and implementing the tools and forms workers used and on increasing their confidence in using them. The next planned steps related to how the partnership managed financial processes and information and how it would establish and undertake ongoing evaluation of its work in relation to self-directed support.

The self-directed support team was established in February 2018. It worked closely with staff, whether in teams or on a one-to-one basis, to support them in developing their knowledge, skills and confidence and the understanding of their role in relation to self-directed support. The team was well-respected by staff and had the confidence of senior managers to develop self-directed support and deliver improvements in the practices and processes surrounding it.

Support for staff had also been bolstered by the development of focus groups, led by team leaders. These were popular and staff felt they were a good forum for reflecting upon and sharing practice. Having the opportunity to reflect and discuss practice in relation to self-directed support is important in developing the knowledge and confidence of staff. This also meant that professionals were collaborating, which is one of the principles and values of self-directed support.

A short-life working group had been established in August 2018 to look at what learning and development needs there were for social work staff around self-directed support. The group was in the process of developing a suite of training tools which were to be taken to and approved by the partnership's self-directed support implementation board before being rolled-out. This board had been in existence providing an overview and strategic steer since work started to implement the self-directed support legislation prior to 2014.

Given the limited progress in implementing self-directed support, the board had been reconfigured and expanded in the previous twelve to eighteen months. Positively it now had a particular focus on ensuring health managers were actively involved. This helped promote a message that self-directed support was something the whole partnership needed to understand and deliver.

Social work staff had access to a staff practice guide for self-directed support, developed at the point the legislation became active in 2014. This was comprehensive but lengthy, and while some staff spoke positively about it, most of the staff we spoke to acknowledged they had not read it all the way through. The development of new training tools that were sharper and more focused was necessary to properly engage staff. This was also necessary as in our staff survey, a significant proportion of staff said they had not had adequate training on self-directed support.

There was no established training for team leaders around the principles and values of self-directed support and how, as first-line managers, they would promote and meet these. Team leaders play a critical role in supporting staff, through monitoring their practice and offering guidance and support. The partnership needed to take action to address this.

Health staff in general had not received any training in self-directed support and there was a perception amongst some health staff that it was not something they needed to consider as it was a function for social work services. While there were a number of multi-disciplinary teams in the partnership, most of these were not multi-agency, meaning health staff were not participating in regular meetings or conversations with social work staff where their exposure to self-directed support would be increased. Health staff required training to understand the principles and values of self-directed support and the tools used to implement it.

Recommendation for improvement
The Partnership should give particular attention to the role of managers, at first-line level and above, and identify specific training requirements for them in relation to self-directed support.

Recommendation for improvement
The partnership should ensure that health staff at all levels understand their role in relation to self-directed support and have had adequate training to allow them to fulfil these roles.

8. Leadership and direction that promotes partnership

Senior leaders create conditions that enable supported people to experience choice and control over their social care and support.

Summary

There had been significant and positive change in how leaders promoted self-directed support over the last eighteen months. We found evidence of a commitment to promote and embed the principles and values of self-directed support. This was reflected by the senior leadership team identifying what issues there were and ensuring a coherent and structured workplan was developed in response. In discussion with the senior leadership team, they highlighted the importance of ongoing evaluation – for example, some recording issues with new forms had been identified at an early stage and brought by the self-directed support team to the implementation board. The board was then able to ensure remedial action was taken. The partnership had work to do to ensure all health staff were engaged in how self-directed support was implemented. Engagement with supported people and carers around how self-directed support was implemented required ongoing action. The planning, direction and leadership of the senior team, if maintained, should ensure the partnership continues to make progress with self-directed support.

Evaluation - Adequate

Through the course of this inspection it became clear that over the previous 12 to 18 months, there had been a real step-change in the partnership's approach to self-directed support. The senior leadership team, which had undergone key changes in personnel over the previous 12 to 18 months, had taken significant steps to address the limited progress on implementation since 2014. Senior managers had implemented an approach that considered systems, processes, culture and practice within social work. This was initially based on gathering their own evidence through tools like their staff survey and case file audits. They had taken the findings from this and used them to develop their workplan, which addressed issues they had identified in every aspect of implementing self-directed support. These actions or changes had been ranked by priority. This demonstrated that the senior leadership team had a clear sense of what they needed to address and in what order.

The actions and changes that had either already been implemented or had been identified as necessary, had the potential to be very positive, although it was too early to assess whether they had achieved their desired impact. It was clear that the senior leadership team was very committed to ensuring self-directed support was fully and properly implemented across/ the partnership. Their commitment and encouragement to their staff to fully embed these changes needed to be sustained to help achieve this goal.

The senior leadership team also recognised that some of the changes that had taken place required further work or revision (e.g. refining and improving the format of the

recording templates to ensure they were encouraging outcome-focused working). This demonstrated that the senior leadership team were aware that the actions and tasks in the workplan needed monitoring on an ongoing basis to ensure they were effective in the way intended and that they were leading to positive personal outcomes for supported people and unpaid carers. Where this was not the case, this monitoring allowed them to take remedial action.

This visible commitment to fully embedding the principles and values of self-directed support was recognised by staff with the majority of respondents in our survey agreeing that the current leadership team were committed to doing this. Some specific groups of staff (e.g. commissioning officers, the acquired brain injury team) clearly stated that the leadership team supported creativity and innovation in relation to self-directed support.

The senior leadership team acknowledged that they had significant work to do in ensuring health staff at operational levels in the partnership understood and were committed to the principles and values of self-directed support. This was recognised in the self-directed support workplan. This was important as while the duties of the self-directed support legislation sit with the local authority, in reality, people's care and support comes from a number of sources, including a range of health services and professionals.

The partnership still had work to do to fully embed the principles and values of self-directed support. It was clear that addressing this was a task that the senior leadership team felt responsible for and had adopted a whole-system approach, across health and social care, to make it happen. Notably, leaders we spoke to highlighted the importance of ensuring staff felt engaged and included in the change process, especially health staff. This demonstrated an understanding of how to make change succeed. The senior leadership team also recognised the importance of ensuring supported people and in particular, unpaid carers felt engaged and involved. The partnership had been doing this, notably through its engagement events in relation to the strategic commissioning plan, and it was important this was continued.

Recommendation for improvement
The senior leadership team needs to ensure its vision for progressing self-directed support is maintained and seen to completion.

Recommendation for improvement
The partnership should develop a strategy for ensuring supported people and carers are meaningfully involved in helping shape the full implementation of self-directed support.

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

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Care Inspectorate Enquiries: 0345 600 9527

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 I Published by: Communications I COMMS-0619-271

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