care inspectorate

Thematic review of self-directed support in Scotland

West Dunbartonshire 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 were being met and delivering positive personal outcomes.

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

- people were supported to identify and achieve personal outcomes
- people experienced choice and control
- people felt positive about their engagement with professionals and services
- staff were enabled and empowered to implement self-directed support
- the principles and values of self-directed support were embedded in practice
- there was 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 West Dunbartonshire, 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 a supported person questionnaire to ensure we got their perspective on how self-directed support had shaped their experiences of receiving services. The survey was completed by 128 staff and the supported person questionnaires were completed by 18 people.

We read the files of 60 supported people who received a social work assessment and subsequent care and support services and 20 files of people who had been signposted to other services at the point of enquiry. During the inspection we met with a further ten supported people and nine 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 and 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 be 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

The available performance data relating to self-directed support for West Dunbartonshire was less positive than the national picture and supported the inspection findings that self-directed support was underdeveloped in this partnership area. There were examples of positive self-directed support approaches achieving good outcomes for people with a learning disability or with acquired brain injury. While these approaches were not as evident across other larger service areas, such as in services for older people, there were still beneficial outcomes for supported people in these services. However, practice in these areas was not yet underpinned by the principles of self-directed support. Current assessment tools did not prompt staff to have or record good conversations and were not focussed on personal outcomes. Carers we met had mixed experiences of their outcomes being met. While the partnership did not have systems in place for measuring and collecting aggregated data on personal outcomes, they were in the early stages of developing an approach to do this.

Evaluation – Adequate

In West Dunbartonshire, we saw that staff worked hard and were committed to the delivery of person-centred and person-focused services. Whilst overall staff had a sound understanding of how to support people to achieve positive outcomes, a truly asset-based approach was only consistently evident in learning disability services and acquired brain injury services. Most of the evidence of supported people experiencing positive personal outcomes through accessing self-directed support options was in these services. In these service areas, self-directed support was relatively well embedded and supported people had more choice and control. We saw some good examples of creative and personalised approaches to meeting personal outcomes.

The majority of people were being supported in line with their needs, wishes and agreed personal plans. The supported person's strengths and assets were considered in just over half of the records we read. This was having a positive impact. However, the outcomes being achieved were through a deficit-led approach to assessment rather than as a result of asset-based, personal outcomes approaches. There was still work to do to ensure that all assessments were outcomes-focused and that practice and processes were underpinned by the principles of self-directed support. There was evidence of poor personal outcomes in 32% of the files we read. Therefore, there was still work to be done by the partnership to identify where poor outcomes were occurring and why.

Unpaid carers we met had mixed experiences of their outcomes being met. The majority of them spoke about having good conversations with staff from the carers

centre and the health and social care partnership (HSCP). However, some described the partnership's responses as primarily reactive rather than proactive or preventative and not outcomes-focused.

The partnership had recently implemented a two-tier carers' assessment tool which had been developed following consultation with carers and carers' organisations. The majority of carers who needed support following assessment had had their needs met primarily by universal services without accessing services through self-directed support. In half of the records we read there was evidence that the assessment had led to improved outcomes. As the implementation of the Carers (Scotland) Act 2016 embeds, it will be important that the partnership is able to demonstrate how carers' outcomes are being improved.

The partnership told us they used a number of tools to measure progress against individual personal outcomes and to monitor the impact and outcomes of support plans. These tools were used in addiction services, children's services and services for people with a learning disability. However, we saw little evidence of the use of outcomes tools or frameworks in practice in the case files we read. Only 2% of the files from these services had evidence of an outcomes tool/framework being used.

The performance data in respect of West Dunbartonshire was less positive than the national picture. The partnership was behind in their progress with self-directed support in relation to other authorities across a range of measures. Nationally the self-directed support implementation rate in 2016/17 was 39%, an increase from 26% in 2015/16. In West Dunbartonshire the rate had remained static from the 2015/16 figure of 3% and continues to remain considerably lower than the national average. The partnership was ranked 28 of all 32 local authorities on the percentage of adults that used direct payments or personalised managed budgets to meet their support needs. It was ranked 32 of all 32 local authorities on the percentage of social care clients who made an informed choice regarding their self-directed support[1]. The partnership was developing a new self-directed support tool which would be able to consistently record how supported people made informed choices about their support and this would enable the partnership to target improvements in performance in a more informed way.

The partnership had not used data to shape and inform the practice and direction of self-directed support and to help improve people's outcomes. We saw that they had been able to use data, including outcome related data, to good effect when looking at, for example, data to support anticipatory care planning and additional preventative support. This approach had not however been extended to self-directed support.

[1] Source: Local Government Benchmarking Framework: Areas of council performance – Adult Social Care Services 2014/15 to 2015/16

At the time of inspection, intelligence on personal outcomes for people could only be checked manually. Information about individual outcomes could be gathered from reviews, supervision and the contracts team, however, this information was not routinely collated and used for improvement.

The partnership was in the early stages of developing an approach to collecting outcome related data. They were developing a new outcomes-focused assessment tool for their recording system Carefirst. This would allow them to interrogate their information system and produce reports on how effectively outcomes are being met.

Recommendation for improvement
The partnership should seek to ensure that supported people across all service groups and all unpaid carers consistently experience positive personal outcomes and take action to ensure that it is able to record, measure and report on these.

Recommendation for improvement
The partnership should take steps to analyse and understand its local and national performance information and use this to inform and drive improvement in self-directed support.

3. Getting support at the right time

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

Summary

Supported people benefited from the engagement and good conversations they had with staff. The carers centre, Alzheimer Scotland and in particular the direct payment staff had made a positive contribution to informing and advising supported people about self-directed support. There was a comprehensive, well used, award winning telephone advice line for older people in West Dunbartonshire called link up. This service was a good example of co-production and community capacity building. However, information on resources specific to localities was not as widely available within communities as it could have been. We saw evidence of people having choice and control in learning disability services and also for children in transition. The partnership had a single point of access through which they effectively signposted people to community resources. Access to independent advocacy was limited but where it was received this was well regarded and provided for as long as required. There were no systems in place to capture or measure the impact of preventative or early intervention services.

Evaluation – Adequate

The range and quality of information about self-directed support available to the public in West Dunbartonshire was variable. The council website provided easily accessible information about self-directed support. The council also had a Facebook page on self-directed support. There was nothing specifically about self-directed support on the West Dunbartonshire health and social care partnership website. We were told that work was underway to improve the quality of the information on this website.

The carers of West Dunbartonshire organisation had a website offering a range of services such as information, advice, support, training and practical assistance to carers and supported people eligible for self-directed support. The support given was free, confidential and independent. The good life group provided training and advice to supported people and unpaid carers on self-directed support. Alzheimer Scotland also provided good, quality information and advice on supports and self-directed support.

There was a comprehensive, well used, award winning telephone advice line for older people in West Dunbartonshire called link up. This service was run by the partnership along with West Dunbartonshire community and volunteering service. It was widely promoted throughout West Dunbartonshire. This service provided a range of information for older people and signposted people to a range of services and supports in the community. It had been recognised with a care accolade award from the Scottish Social Services Council in 2014, the 2014 self-management project

of the year for the Health and Care Alliance Scotland Awards and in 2015; it received the gold award in the local matters category at the COSLA excellence awards. Link up was a good example of co-production and community capacity building.

There was a need to develop and extend access to information in more formats and within more community settings. As part of their improvement support for self-directed support the partnership had established the self-directed support review group. This group was to look at the provision of public information as part of their review activity. There were no details or any timescales available for this activity at the time of inspection.

There was no evidence that the sources, impact, understanding and value of information given to supported people had been evaluated. Evaluation would give the partnership an awareness of the timeliness and the quality of information being given and any gaps that had to be addressed.

Reflecting the trend we saw throughout the inspection, there were better examples of informed decision making about the four options within specific care groups. Some supported people and unpaid carers spoke positively about the information they were given about the four options and how this influenced their choice of option. There were positive examples of individuals being able to change their chosen option. We saw good practice examples where two physical disability service users were supported to use self-directed support creatively to complete university courses. This included adapting the self-directed support as their needs changed. However, practice was not consistent and many people did not have the same levels of choice and control. Younger supported people in transition and people with learning disabilities had more opportunities for innovative support and had more choice and control than other groups.

The results of a consultation exercise in 2018 with users of local third sector organisations showed a concern about slow progress in the embedding of self-directed support in the West Dunbartonshire area. In June 2018 following this consultation, Clyde shopmobility and West Dunbartonshire community and volunteering service successfully applied to the Inspiring Scotland Support in the Right Direction 2021 fund and secured 36 months funding. The IDEAS project (increasing discussion and encouraging access to self-directed support) was created through this funding to address some of the gaps in progress of self-directed support.

This project had identified a suite of measures to help embed self-directed support and its principles across the partnership. Among these measures were an improvement in information pathways, an increase in the number and availability of published resources about self-directed support and a raising of community awareness of these locally. The IDEAS project was also looking at the creation of a team of peer advocates to support people investigating and potentially accessing self-directed support. Independent brokerage would also be developed through this project. This work was at a very early stage but would go some way to ensuring that self-directed support information was more widespread and comprehensive.

Independent advocacy was only provided in a small proportion of cases. The partnership acknowledged that there were limitations to the extent that people could access independent advocacy. It was predominantly available for statutory interventions for people with mental health problems, a learning disability or acquired brain injury. This impacted upon people, other than those who required statutory support, getting access to advocacy to support good conversations, choice and control at the point of considering self-directed support options. Where advocacy support was provided however, this appeared to be well regarded and effective. The partnership said the use of advocacy services was under review as part of a wider review of commissioning and procurement.

The partnership had a single point of access for adults and older people. Through this they made an initial assessment of the care and support required. People were then signposted to alternative support such as the carers centre or into the formal assessment process from the first point of contact. During file reading we looked at 20 cases that did not progress to a formal assessment and where supported people were signposted to alternative support services. We saw that people were signposted appropriately in the majority of these records.

Self-directed support was not routinely discussed at the first point of contact. From our analysis of records and from speaking with supported people, this was only discussed if a full assessment was then being carried out. The partnership did not capture information about referrals or services provided for those who were signposted to alternative support and did not have any system for evaluating the effectiveness of prevention and early intervention services. It was difficult for the partnership to evidence how these referrals might reduce the need for services funded through personal budgets.

Consideration of investment in the development of community and early intervention services was at an early stage. The partnership recognised that they needed to be more open to the third and independent sector being involved in service development and new models of care.

Staff we spoke with demonstrated some awareness of local informal services. There was no formal directory on informal supports available so individual worker knowledge or local knowledge was relied on. We were told that locality-based directories were being developed to bring together information about early intervention and prevention services.

Recommendation for improvement
The partnership should develop appropriate pathways for individuals to access advocacy and/or independent brokerage if and when they need it to support decision-making around self-directed support options, choice and control.

Recommendation for improvement
Where people are signposted to early intervention and preventative services the partnership should take steps to measure the effectiveness of these supports in reducing the need for more formal services and supports.

4. Impact on staff

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

Summary

While staff spoke confidently and demonstrated a basic broad knowledge about the principles and values of self-directed support and how they could apply these within their work, not all staff were confident in using asset-based approaches in practice. Staff from learning disability services and those working in the acquired brain injury service demonstrated a sense of confidence and competence in relation to self-directed support principles and had the frameworks in place within their services to be able to carry out the principles in practice. Most other staff we spoke with outside of these service groups, said that they were unable to build on their knowledge and become confident in practice because they did not have the supporting framework in place to allow them to do so. There was a lack of communication between service areas to share asset-based approaches in practice. Systems and forums for staff to support and inform an asset-based approach were not used effectively. There were missed opportunities to discuss self-directed support and support improved practice with staff.

Evaluation – Weak

During the course of the inspection, we met with staff at all levels of the partnership, including 11 frontline staff and a similar number of frontline managers. We also received 130 responses to our staff survey. Of these respondents, 48% were employed by the local authority in social work or social care and 43% by the NHS.

Staff felt they had a broad understanding of self-directed support and outcomes-focused practice. They spoke with confidence about the principles of self-directed support, how the four options might work for people and the role of good conversations in facilitating this. In our staff survey, most of the respondents agreed or strongly agreed that staff had positive conversations with people about what mattered to them and the support they needed. However, while they had a sound understanding of self-directed support, less than half of the staff in the survey agreed that they felt confident in delivering self-directed support in practice. A lack of creative options for supported people was given as the primary reason for this. The impact of time constraints was also frequently highlighted. Only slightly more than half of respondents in our staff survey felt they had adequate time and capacity to work in a person-centred way.

Staff acknowledged that self-directed support ethos and practice was more effectively embedded in learning disability and mental health services than older people's services. They felt the creation of a self-directed support team within the learning disability service at the time of the legislation had helped establish and embed the ethos more successfully there than in other areas. Staff felt that there was inconsistency in how self-directed support was applied across the partnership

and that there was little communication and sharing between teams in relation to self-directed support and how to apply the principles in practice.

Most respondents to our staff survey agreed that they were encouraged and enabled to exercise professional autonomy. However, staff we met felt they would benefit from greater autonomy in decision making processes in relation to self-directed support. The decision-making processes following assessments were widely viewed as challenging. Some staff had not developed the confidence and competence to present to the resource groups. Some staff felt the process for securing approval of service requests was not in keeping with the principles and values of self-directed support and that the focus was more on finance than realising positive outcomes for supported people.

Staff in the partnership who received supervision generally felt supported through their supervision arrangements. In learning disability services however, staff emphasised the role of supervision in encouraging and reinforcing the use of asset-based approaches with supported people. We did not hear about supervision being used like this in other areas of service.

Recommendation for improvement

The partnership should take action to measure the impact of learning and development and practice processes on staff competence, confidence and motivation.

5. Delivery of key processes

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

Summary

File reading showed a predominance of practice and recording which was not in keeping with a self-directed support approach. The partnership recognised this and was moving in a direction that advocated the use of asset-based and outcomes-focussed approaches. It was laying the foundations for changes in assessment and recording that would support this. New assessment documentation was at the point of being piloted and the business system was being developed to support self-directed support practice. Positive risk taking and protection were appropriately considered during assessment processes in the majority of records looked at. While there were no significant delays in people getting an assessment, there were sometimes delays in people accessing services due to the resource allocation process. There was some evidence that the partnership engaged people in planning and feeding back on services. There was no evidence that they actively monitored, evaluated or sought feedback on the co-production of assessments. The impact of employing asset-based approaches was not routinely captured making it difficult to accurately assess the benefit of using such approaches.

Evaluation: Weak

The assessment formats and templates that were being used across services in the partnership were not effective in supporting a personalised outcomes approach. The single shared assessment format was deficit-led and not reflective of good conversations that may have taken place. Just over half of the personal plans we looked at were not comprehensive and were not SMART (Specific, Measurable, Achievable, Realistic and Time-bound). There were no contingency arrangements in just over half of the records we read.

The partnership had recognised these gaps and had drafted a new assessment format to support an outcomes-focused approach. This format was in line with self-directed support values and principles. Assessment and other supporting tools such as care planning and review documentation also being developed at the time of inspection supported an asset-based approach. This documentation was to become operational at the end of 2018 and rolled out across all service areas.

The partnership did not monitor and evaluate how well or how meaningfully people engaged in planning their own support. The Carefirst recording system was highlighted by frontline staff as being unable to capture how people's strengths and assets could be used as alternatives to formal services and supports. The impact of employing asset-based approaches, where these were used in practice, was therefore not routinely captured making it difficult to accurately quantify the benefit of using such approaches.

In most of the files we read, appropriate consideration was given to looking at supported people taking positive risks as part of the assessment. Most of the staff in our staff survey felt that positive risk taking took place**.** Work was underway to adapt the risk assessment tool used in adult support and protection and modify it into a general risk assessment tool for both adult protection and non-protection risks. The tool had a clear focus on risk enablement and positive risk taking which the partnership felt was transferable to a self-directed support approach.

The decision-making and resource allocation processes following assessments were widely viewed as challenging. Some staff felt the resource allocation process was more to do with finance than realising positive outcomes for supported people. Other staff were not confident or had not developed the necessary skills to be as confident as they could be when presenting assessments to the various resource groups that had responsibility for allocating resources. This meant that assessments and service requests considered by the resource group were occasionally declined by the group or put on hold pending further information. This led to delays in assessed needs being met. Our review of case records showed no evidence of unreasonable delay in supported people getting an assessment. However, we heard from some supported people about delays at times in getting services following assessment.

When we spoke to supported people and to frontline staff it was evident that supported people had a limited understanding of what happened during the resource group process. Supported people were not involved in meetings to agree service requests and relied on feedback from their allocated care manager. We did not see where supported people had influenced their care packages. This lack of involvement of supported people did not support a transparent approach to systems and processes and impacted on people's experience of control.

While the carers centre was seen as positive, carers told us their experience was that it was so busy the centre could only manage new referrals and was unable to review existing carer support plans. There was a risk that without review, carers needs would not continue to be met.

Recommendation for improvement
The partnership should embed a self-directed support ethos and approach across all key processes and systems. It should progress the planned changes to tools and processes and to the business system to ensure these support asset-based and outcomes-focused practice.

Recommendation for improvement
The partnership should ensure that they can demonstrate that good decisions are made in relation to positive risk taking. This should be monitored and evaluated to inform ongoing risk management and risk enablement.

Recommendation for improvement
The partnership should ensure that supported people are better informed about and more involved in key processes regarding their support.

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

Outcome-focussed commissioning had not been a focus for the partnership. Approaches to support flexibility, choice and control for people using services were at an early stage of development. Commissioning in the partnership was weighted towards traditional services with little evidence of innovation. With most services still provided directly by the council and significant levels of services under block contracts[2] there was little flexibility, choice and control for supported people. We saw some use of spot purchasing resulting in more personalised support for people in learning disability services but not elsewhere. There was an increasing awareness of the issues and the gaps in the partnership's current provision and a recognition that their commissioning direction needed to change. Steps had been taken to increase the range of providers available and for provision to be more in line with self-directed support. Work had started on changing the shape of the market in care at home and respite services. The partnership was in the process of appointing a commissioning manager to bring more focus to their change in direction.

Evaluation: Weak

The services provided in West Dunbartonshire were traditional and not consistent with the principles and values of self-directed support. The chief officer was leading a review and refresh of their approach but this was at an early stage.

The partnership's service delivery was predominantly through block contracts. Partnership staff at all levels recognised that the existing model of block contracts hindered choice and control. There had been some use of spot purchase[3] and this was supportive of innovation and tailored support for some people. A few examples of this were given in relation to supported people with learning disabilities.

In the partnership, there was still a reliance on council-provided service delivery. Eighty per cent of services were provided directly in this way. Corporate and political decisions in the council had directed the shape of service delivery to a great extent. There had been a commitment to retain as many services as possible within the council as this was seen as a way of supporting local employment. This had restricted innovation and the development of alternative care models. The level of in-house provision for care at home clearly limited choice. In practice, the majority of people had to accept council services. The senior management team felt strongly that a culture change was needed in the provision of services and that this could be done without impacting on the council's commitment to support local employment.

[2] Block contracts are payments made to a provider to deliver a specific, usually broadly defined service

[3] Spot contracts are when a service is purchased by a partnership as and when they are needed for a supported person. They are purchased on an individual basis for a single person.

The partnership had begun to work on shaping the market. There had been a minor shift of some care at home provision to external providers and the partnership was looking at new models of care using reablement. It was also seeking to increase respite provision and the range of respite opportunities. The partnership was keen to encourage small and medium-sized providers and had highlighted this in their market facilitation plan. They recognised that this would give more choice to individuals, increase choice and grow the market. However, there was no clear strategic plan in place for the partnership to continue enabling and growing the market.

The partnership had established a market facilitation consortium which included partners from across the statutory, independent and third sectors. The consortium aimed to make the best use of the resources across local communities. The consortium principles were described as *'*a comprehensive partnership approach across all sectors providing health and social care services; a commitment to provide enhanced delivery of service to individuals and communities and a need to create diversity within the marketplace based on population needs[4]*'.* This initiative was a positive one and borne out of a commitment to partnership working at locality levels. It was, however, not clear how this was to be translated into locality developments. The approach was developed in 2015 and there was little evidence that this approach had resulted in any real diversity within the marketplace. There was no evidence that it had been updated and linked into their strategic needs assessment, strategic plan, commissioning plans or locality planning forums.

While expenditure on self-directed support Options 1 and 2 in the partnership had increased[5], the partnership had a higher percentage of people opting for Option 3 compared with other partnerships. The partnership felt that high satisfaction with the partnership's social care services meant that people were less motivated to take up self-directed support direct payments or individual service funds options. The high number of people choosing Option 3 did not necessarily mean that this was not the right option for them. Within the partnership however, supported people did not necessarily have real choices open to them across all four options. The partnership did not routinely engage supported people or staff in getting feedback after options had been chosen so it was impossible to evidence that people were happy with their option choices.

Commissioning needed to be more creative and responsive. While there was still a requirement for traditional services for some supported people, it was clear that new models of care needed to be explored. Some staff recognised that due to the majority of services being in-house, people were steered towards taking services under Option 3. Staff felt they had ideas to offer about options that would support more innovative service, save money and improve outcomes.

[4] West Dunbartonshire Market Facilitation Consortium Paper September 2015
[5] From 1.39% of the overall adult social care spend in 2013/14 to 2.16% 2017/18

Service managers were very clear about the need to move to an outcome-focussed approach to commissioning. Procurement was predominantly corporately based. While the service managers worked closely with procurement services, there was a task ahead to educate their corporate partners as to what they wanted to achieve as they embedded the self-directed support approach, and how corporate partners could support them in doing this.

The commissioning of services was led by service managers. While all the managers had a good knowledge and understanding of self-directed support this was not reflected in their commissioning practices and the services commissioned. The partnership recognised the issues and risks around the current approach to contracts and commissioning. They were developing a commissioning manager post for the partnership. The partnership stated that this would clarify the responsibilities and roles of strategic commissioning and contract management within the health and social care partnership alongside the council's procurement team. The commissioning manager's role was to consider how primary and secondary health services could support the implementation of self-directed support. The partnership wanted this approach to lead to the embedding of self-directed support across all social care and health planning and ensure that the corporate approaches taken reflected the self-directed support ethos. They hoped this approach would support a streamlined and consistent contract monitoring approach across the partnership.

The Carers (Scotland) Act 2016 places additional demands on the partnership's budgets at a time of continuing financial austerity. The potential implications of the Act, including the financial impact of waiving of charges for carers, had not as yet been fully quantified. Finance staff had some concern about the financial impact of meeting carers' needs via self-directed support. The senior management team members were more confident. At the time of inspection, carers' needs were mostly being met through universal services. There was little use of self-directed support and budgets therefore it was having little financial impact. There was no evidence that the partnership was monitoring services to carers to ensure that needs were being appropriately met or forecasting need for newly commissioned services and ensuring any financial impact from that would be met. A detailed financial plan was to be developed over the next year to ensure a robust financial framework for the delivery of the priorities of the Act. The position of having no eligibility criteria for carers would be reviewed at that point.

The development of the partnership's approach to planning and commissioning services to support flexibility, choice and control was at a very early stage. There was no overarching commissioning plan which explicitly showed the self-directed support improvement actions.

Recommendation for improvement
The partnership should engage with supported people, carers and frontline staff to inform the development of new models of care focussed on delivering positive outcomes.

Recommendation for improvement
The partnership should take steps to increase local choice of provider and flexibility in the delivery of services to ensure people have genuine choice and control over how their support is delivered.

7. Management and support of staff

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

Summary

Training, supervision and management support was not being used effectively to promote self-directed support. There had been an investment in training at the time of self-directed support implementation in 2014. This had not been maintained. There was no existing training for current or new staff including those moving into management roles, nor was any training extended to external providers. The partnership had begun to refresh their self-directed support guidance and had begun to develop continuous professional development material. The specifics and timescales for implementing these were unclear.

Evaluation: Weak

There had been a strong focus on self-directed support awareness raising and training in the early years of self-directed support. The partnership had delivered training to staff across social work, health and the third sector in 2014. This included creating champions or peer mentors. The direct payment team was also established at that time to support implementation within the learning disability team. This team was recognised by staff and managers as being knowledgeable and confident in working with supported people and staff around self-directed support.

The self-directed support team and guidance co-produced with the Royal National Institute of Blind People (RNIB) "*My life My choice; A Guide to Planning My Support*" were identified as helpful sources of information about self-directed support and for awareness raising amongst both staff and the wider community.

There was no ongoing training for new or existing staff at frontline and first line management level. There was a need for awareness raising and training about self-directed support to be refreshed and undertaken on an ongoing basis.

The senior management team acknowledged that they need to be confident that all stakeholders, including external providers, are working with a self-directed support ethos but they had no plans to offer any training to the third sector.

The partnership had recently released a practitioner from frontline work to develop new guidance and continuous professional development (CPD) material on self-directed support but there was no clearly articulated work plan to deliver the material.

Supervision for social work staff took place routinely on a six-weekly basis, with case file audits on a quarterly basis. Staff had the opportunity to attend practitioner forums although many staff told us that operational pressures often stopped them from attending. These were potential opportunities for staff to reflect on self-directed support within these forums but there was no evidence to suggest that this was happening.

In older adults' case records we saw that most interventions were positive and person-centred. However, much of this was done from a deficit-led approach to assessment and was process driven. This did not fit with the principles of self-directed support. Training, supervision and management support could have been used more successfully across all service groups to support staff to shift their practice to a more self-directed support, strengths-based approach.

The partnership indicated an intention to develop established practitioner forums and identify champions to get frontline staff more meaningfully engaged in the agenda. They were looking at ways that they could evaluate the effectiveness of these new initiatives.

Recommendation for improvement
The partnership should take a strategic approach to the development and delivery of self-directed support training for staff at all levels across the partnership.

Recommendation for improvement
The partnership should consider the training and development needs of all partners.

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

Some staff expressed doubt about the degree to which leaders in the organisation were committed to self-directed support. The senior management team had seen a number of senior staff retire or move onto other promoted posts. This led to a change of leadership. At the time of inspection, there were still temporary positions within this team. This had led to difficulties in driving the changes required to deliver self-directed support and maintaining a consistent approach to its implementation. The partnership's focus on health and social care integration over recent years had diverted their attention away from self-directed support. New members of the senior management team were committed to ensuring that self-directed support would be a significant and central activity for the whole health and social care partnership over the next year. They felt that once all senior managers were in post, they would have the opportunity to start a cultural shift in how they approached the delivery of all of their services. They recognised the need to develop a common understanding and direction around self-directed support across all partners including external providers. They had taken some steps to put the required foundations in place to reinvigorate this agenda. They needed to develop more robust plans to take this forward.

Evaluation: Weak

In the partnership's annual public performance report 2017, there was a large section on self-directed support which reinforced their commitment to meeting the requirements of the self-directed support legislation. The partnership had not yet met the commitments set out in this report.

The newly appointed senior management team articulated a commitment to reinvigorate full implementation of self-directed support. They had taken important initial steps, including the establishment of the self-directed support review group. All service managers were part of this group which demonstrated their commitment and their ownership of the agenda. This group was in the process of producing practitioner guidance during our inspection. The senior management team had overseen early progress on developments in training, tools and processes. Within a relatively short period of time they had also overseen a number of specific actions demonstrating their commitment to change.

Senior managers recognised the limitations in care at home and care home provision in supporting the delivery of self-directed support by the third and independent sector and were keen to develop their partnership with providers. They were developing plans to progress this. They recognised the importance of improving their approach to commissioning and planned a review of procurement and commissioning procedures. They were developing a commissioning manager post to address this.

It was evident that statutory partners across health and social care were starting to look at how they could work together to create a cultural change which would support innovative practice in line with the values and principles of self-directed support. Their stated intention was to use self-directed support as the approach that they would take in delivering all services. To ensure this cultural shift, the senior management team recognised that all leaders across the statutory partnership and all other stakeholders had to be more meaningfully engaged. Health leaders in particular had to be more visible and active in this agenda. A paper on self-directed support had gone to the integration joint board in November 2017. This board needed to be more actively involved in leading and supporting the changes that self-directed support required.

The senior management team recognised that the third and independent sector had to be more fully involved. While this was stated in the market facilitation plan, there were no plans as yet to show how this would be achieved.

While leaders had taken initial steps to progress self-directed support, we saw no overarching plan which brought together all the various improvement actions into one place. We saw no evidence of the use of evaluation and performance information to inform how they moved forward in developing and embedding self-directed support. While the senior management team could articulate their vision about where they needed and wanted to be, there was a lack of robust planning to support this. There were no clear timescales, pathways or plans in place to achieve their vision.

Finance staff had a very good understanding of self-directed support. There were constructive relationships between the senior management team and finance managers. They offered a supportive role to operational services. While driven by best value and the recognition that embedding self-directed support had to be done within the confines of decreasing resources, finance staff were committed to the ethos of self-directed support. They were advocates of transparency and equality of spend across care groups in relation to self-directed support and understood the principles of choice and control. This was important in preparing for the partnership to expand access to self-directed support across all care groups.

To embed self-directed support the partnership recognised that it has to more closely align to other factors such as its charging policy, its eligibility criteria and the implementation of the Carers Act. It had not yet assessed the impact of full implementation of self-directed support on its finances. This was a key risk yet they had not formally logged any identified any risks around this in the partnership risk register.

Staff completing our survey and those we met expressed significant levels of doubt about the degree to which leaders in the organisation were committed to self-directed support and how they facilitated and supported creativity and innovation. Senior managers and leaders were keen to stress their confidence that this perception would change in time, as a result of the changes that had more recently taken place at senior management level. It was too early however to say how effectively this would be progressed.

Recommendation for improvement
The partnership should accelerate its progress in embedding self-directed support and set clear timelines for full implementation of self-directed support across all care groups.

Recommendation for improvement
The partnership should develop a robust strategic plan for self-directed support aligned to its other partnership plans. The strategy should be underpinned by detailed action plans setting out how the partnership intends to fully implement self-directed support for all care groups across the partnership.

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