



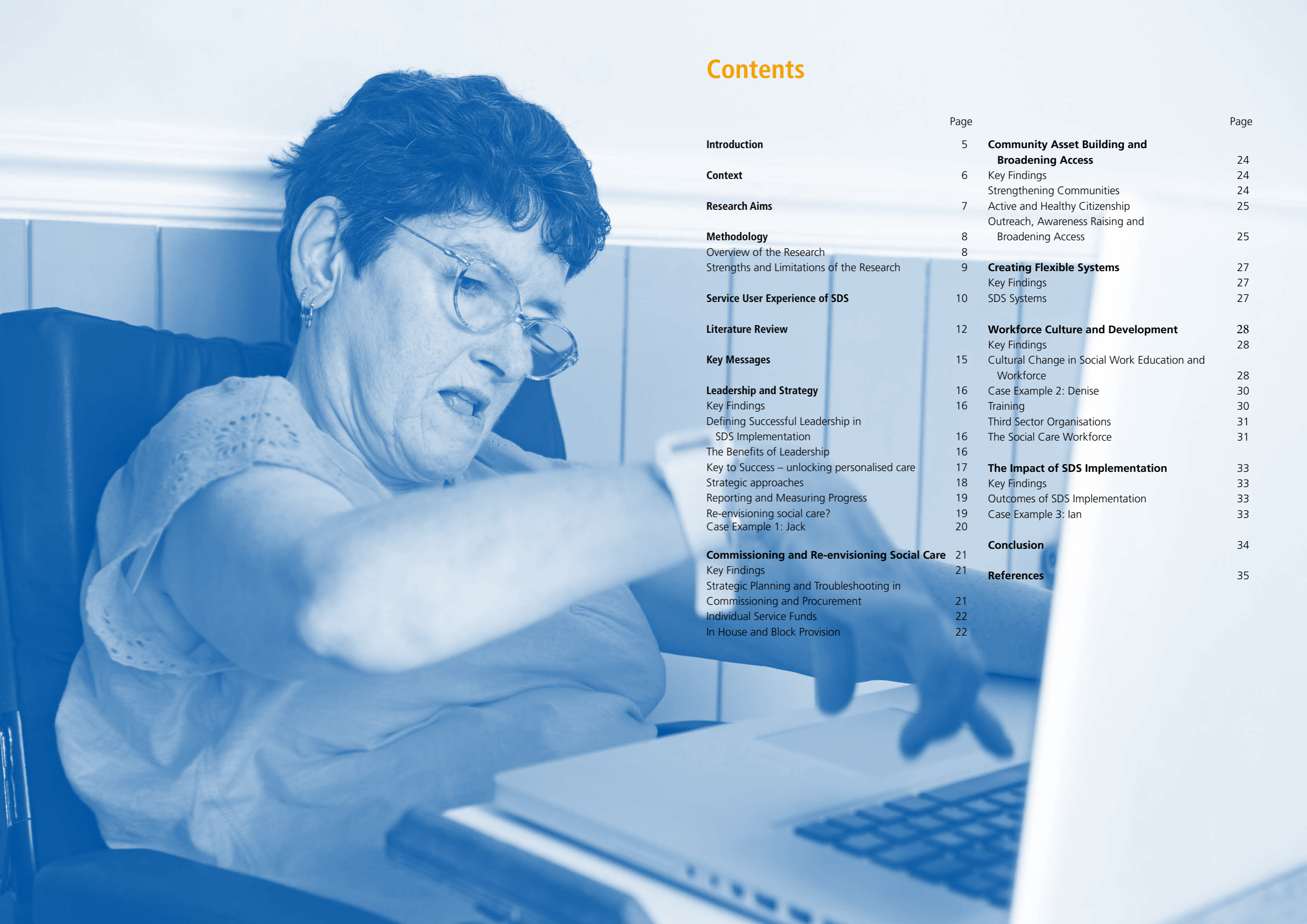
Best Practice and Local Authority Progress in Self-Directed Support

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Contents

	Page		Page
Introduction	5	Community Asset Building and Broadening Access	24
Context	6	Key Findings	24
Research Aims	7	Strengthening Communities	24
Methodology	8	Active and Healthy Citizenship	25
Overview of the Research	8	Outreach, Awareness Raising and Broadening Access	25
Strengths and Limitations of the Research	9	Creating Flexible Systems	27
Service User Experience of SDS	10	Key Findings	27
Literature Review	12	SDS Systems	27
Key Messages	15	Workforce Culture and Development	28
Leadership and Strategy	16	Key Findings	28
Key Findings	16	Cultural Change in Social Work Education and Workforce	28
Defining Successful Leadership in SDS Implementation	16	Case Example 2: Denise	30
The Benefits of Leadership	16	Training	30
Key to Success – unlocking personalised care	17	Third Sector Organisations	31
Strategic approaches	18	The Social Care Workforce	31
Reporting and Measuring Progress	19	The Impact of SDS Implementation	33
Re-envisioning social care?	19	Key Findings	33
Case Example 1: Jack	20	Outcomes of SDS Implementation	33
Commissioning and Re-envisioning Social Care	21	Case Example 3: Ian	33
Key Findings	21	Conclusion	34
Strategic Planning and Troubleshooting in Commissioning and Procurement	21	References	35
Individual Service Funds	22		
In House and Block Provision	22		



Introduction

In 2017, The Scottish Government commissioned research from Social Work Scotland to find examples of best practice in Self-directed Support (SDS) within local authorities and integrated authorities across Scotland. Almost half of all Scottish local authorities engaged with the aim of this research and shared their progress and successes in implementation, as well as some of their challenges.

Our research found that the implementation of SDS has led to a positive shift to more outcomes and relationship based work. This has been achieved through investment in training and a significant cultural shift in adult social work and social care.

However, the full benefits of flexibility, choice and control for supported individuals are only realised when there is leadership at every level and in all areas of service delivery affected by SDS legislation. This is by no means confined to health and social care services but includes commissioning and procurement sections, finance departments, services for communities and families, care providers and support services, and importantly supported people and their families. A coherent, corporate approach was therefore found to be necessary to realise the full potential for supported people to achieve more control over their own care, and their own lives.

The need for collaboration and leadership represents a significant challenge and the professionals and service users who spoke to us recognised this fact. Different areas had success stories to share in implementing SDS across various aspects of service delivery. However, all felt there was still progress to be made and that shared learning can help in realising change.

The purpose of this report is to share the good practice examples identified in the course of the research and promote learning between local authority areas and across different fields of practice. The findings are presented to assist the development of social work practice and creative commissioning and community asset building, and partnership with the third sector in broadening access to all four SDS options. Through sharing examples, this report is intended to provide a useful contribution to the legislative aim of SDS that a personalised approach underpins social work and social care Scotland.

Context

The research presented in this report was carried out in the context of the Audit Scotland report on the progress of Self-directed Support implementation (Audit Scotland, 2017). This audit found that significant work still needed to be done to offer the full benefit of SDS legislation to all who need it, but that there had been progress and there were pockets of good practice. We were tasked with finding out more about that best practice in order to inform public reporting on SDS implementation and to support local authorities and integrated authorities to make even greater progress.

We note that under the Public Bodies (Joint Working) (Scotland) Act 2014, all adult social care services (and in many areas children's and justice services) are delegated to an integration authority. When referring to local authorities in this report we include those services delegated to the integration authority. Whilst integration offers new opportunities, the significant work required to achieve organisational change is one of the challenges acknowledged by the Audit Scotland (2017) report on SDS.

Other challenges well described by the Audit Scotland report (2017) and by participants in our study include:

- Decreasing budgets;
- Increased demand for and expectations of services;
- Resultant caution in public spending, which can in turn have the effect of decreasing creativity;
- Risk aversion in social work practice, linked to the concern to minimise risk in wider society;
- Skills drain on social work due to experienced staff opting for early retirement or voluntary severance packages offered in the context of the mounting financial constraints on services.

We acknowledge the very real pressures that exist for local authorities. However, this study focused particularly on positive practice and progress in SDS across Scotland, despite ongoing challenges. Sharing learning in order to contribute to the development of best practice is therefore the major purpose of this report.

Research Aims

Our research aims were structured under the Strategic Outcomes provided by Scottish Government's Self-directed Support Strategy (2016: 6):

- 1 Supported people have more choice and control;
- 2 Workers are confident and valued;
- 3 Commissioning is more flexible and responsive;
- 4 Systems are more widely understood, flexible and less complex.

Our study aimed to discover what evidence there was of progress to meet these strategic outcomes across Scotland, and what best practice in achieving these outcomes looks like 'on the ground'.

We were interested in the impact that SDS has had on communities, families and individuals, eight years into the Scottish Government's SDS Implementation Plan. Our approach was informed by Alliance's (2017a) recent report on service users' experiences of Self-Directed Support. This report found a mixed picture of SDS, and suggested that access to personalised care and support was limited by factors including an individual's age or support needs. We were therefore interested in canvassing the spread of best practice across the range of service delivery as well as geographically. We were limited by the timescales for the research, but were very grateful for the high level of participation in the study, and for all of the evidence provided.

Methodology

Overview of the Research

Participation in this commissioned research was made available to all local authority SDS Leads through the Social Work Scotland SDS Forum. 15 of the 32 Scottish local authorities came forward to offer evidence and examples of best practice in SDS implementation:

- 1 Angus
- 2 The City of Edinburgh
- 3 Dumfries and Galloway
- 4 East Ayrshire
- 5 East Dunbartonshire
- 6 East Lothian
- 7 East Renfrewshire
- 8 Falkirk
- 9 Fife
- 10 Highland
- 11 Midlothian
- 12 Perth and Kinross
- 13 South Ayrshire
- 14 Scottish Borders
- 15 South Lanarkshire

All of the fieldwork was qualitative in nature and conducted over a very short timescale: recruitment of participants took place during November 2017, with visits to local areas and interviews following between December 2017 and February 2018.

Ethical clearance was achieved through Chief Social Work Officers and local procedures and participants gave signed and verbal consent based on a detailed information sheet covering the purpose of data collection and reporting. Given the time constraints and the original brief to seek evidence of good practice in SDS, this was a highly exploratory piece of research and whilst a thematic interview schedule was developed, participants were encouraged to share evidence that was relevant to the way SDS legislation has been implemented in their local area.

It was also left to the discretion of responding local authorities which staff would be best able to describe progress in their area. The timescales of the fieldwork did not allow for more than one visit to each local authority area. In some areas, access to more than one

participant was organised, in others one worker could speak to developments across a range of services. Most of the staff who took part in the research were operational and middle level managers, or senior practitioners in seconded SDS roles. However, a small number of senior managers and frontline social workers also took part in the study. Given that the research sought to provide a picture of positive steps in SDS implementation and examples of best practice, the inclusion of staff who could offer 'on the ground' experience of this in the sample was very helpful. However, had there been more time, it would have been interesting to broaden the range of professionals taking part to test findings more widely.

13 face-to-face interviews were conducted with 17 participants across the 12 local authorities who responded within timescales to allow this. Participants included frontline staff, senior social workers, operational and senior managers, with one head of service. The majority of participants were local authority staff but one third sector employee and one CEO of a care agency were also included.

Two local authority managers were spoken to by telephone due to timescales for reporting, these were Dumfries and Galloway and South Lanarkshire. South Lanarkshire, East Lothian and East Renfrewshire provided helpful written evidence on particular aspects of their implementation progress.

All of the local authorities were approached about including supported people in the research. Two local authorities made possible the involvement of a total of six families in the research:

- The City of Edinburgh Council facilitated access to a popular weekend drop in service for families which had originally been seed-funded by the SDS implementation grant.
- Through Encompass¹, we were able to access the views of two supported people and one carer living in the Scottish Borders.

Face-to-face interviews were audio recorded and field notes of all research encounters were kept. This

qualitative data was then analysed thematically by the first author and used to draw out the findings presented in this report.

Strengths and Limitations of the Research

We were able to include almost half of Scottish local authorities in the research sample. There was a good geographical and socio-economic spread within the sample, with a range of rural, urban and suburban areas. However, the sample of local authorities was self-selecting and not purposive.

Furthermore, the research was very open and exploratory in nature (Cresswell, 2014). This allowed a broad range of responses, in terms of the range and types of evidence offered and how this was shared. However, it prevents any meaningful comparative analysis of the data. Rather, we present here broad themes arising from the data, illustrated with case studies and practice examples. The spread of practice described by local authority respondents was varied and included:

- Children and Families – children with disabilities;
- Children and Families – mainstream services for children in need or at risk;
- Support for Adults with Learning Disabilities and Transitions into adult services;
- Support for Adults with a Disability;
- Support for Adults with Mental Health difficulties;
- Support for Older People – care at home;
- Support for Older People – residential care (very limited evidence);
- Community Services Groups and Capacity Building;
- Beginnings of creative inter-generational work.

We were able to interview and seek written views from six families who use support relevant to the research. Due to the fast pace of the fieldwork, and the opportunistic nature of the sampling, we were not able to triangulate this research. So the views of service users do not link directly to local authority evidence. Service users provided a very valuable insight into the experience of using support and there was some notable commonality of themes across the two local authorities where service user participation was possible.

¹ <http://www.encompassborders.com/>

Service User Experiences of SDS

As detailed above, one of the limitations of this research was the focus on good practice as identified by participating local authorities.

We recognise, however, that it is important to set the findings reported here in the wider context of service user experiences of SDS.

The purpose of this research was to demonstrate the possibilities of the SDS approach and explore in some depth, with respondents, the conditions for successful implementation of SDS. Where creative initiatives that led to tangible benefits for individuals or families were identified in the research, there was not necessarily an association with transformative change across services. We recognise, just as Audit Scotland (2017) reported, that the pace and scale of change in social care under the new legislation has been uneven.

Our research was suggestive of uneven progress within local authority services, since evidence was largely provided in terms of adult social care, with very few children and families examples. SDS applies across all age groups and across all possible social care needs. Yet as even the short literature review included in this report shows, research into SDS and related personalisation policies in other UK areas has found variable access to choice and control amongst different groups of service users (Eccles and Cunningham, 2016, Rabiee *et al.*, 2016, SDSS, 2016, Woolham *et al.*, 2017). Overall this picture suggests that there are likely to be ongoing frustrations for some service users who are seeking the autonomy and personalised care that they are entitled to under the Scottish legislation.

Whilst the research reported upon here was not designed to gather data around the experiences of service users, it was important that a small number of service users did agree to speak to us about their experiences. Their voices enriched the study and provided evidence of some of the ways that SDS can enable individuals to take control of their own care and support. These accounts of the benefits of SDS are very important, as they speak to the existing body of evidence of the difference SDS can make to people's lives, as well as providing indications for best practice. However, we can make no claims to representativeness for the service user experiences described in this report.

The limited available research into service users' experiences reflects the picture found by the national audit of SDS (Audit Scotland, 2017): That satisfaction levels with care are high but access to choice and control remains much more limited than envisioned by the legislation. Self-Directed Support Scotland (SDSS) surveyed a sample of people who use social care (SDSS, 2016) and found that the majority of respondents were satisfied with the care or support they received. Yet many were not well informed about SDS or the four options available to them. A concerning 34% of respondents stated that they did not feel they understood the options well enough to decide which one they wanted. This study, which surveyed service users across three local authority areas, also indicated particular barriers around the uptake of option 2.

Research which successfully unpicks the factors that contribute to service user satisfaction with their arrangements would be particularly helpful. The Alliance's research finding that satisfaction levels have increased since the introduction of SDS (2017a: 52) in the context of overall dissatisfaction with levels of care and support (2017a: 48) is interesting. Although it arises from a small sample, this finding invites questions about the extent to which financial and demographic pressures are a major factor here (Audit Scotland, 2016a). Choice and control over an insufficient budget may still be conceptualised as choice and control, but without necessarily leading to better outcomes. The timing of policy and legislative change makes disentangling SDS progress from issues of austerity and reorganisation for local authorities difficult.

This report, however, attempts to show some of the ways that public sector organisations have worked together to deliver on the promise of SDS despite financial constraints and other demands. Knowing the extent to which this translated into better experiences for the people who use social care and support would be very helpful in terms of informing transformative change. Even on a small scale, local authorities who had tried to close the feedback loop on the way that changes impacted on the communities they serve had found this useful. However, it is not currently possible to close this loop on a national scale, given the data available.

We acknowledge that the examples of best practice explored by this research are not representative of progress on a national level. Rather, this report is intended to be supportive of an ongoing process of change. A major finding of this research is the significance of strong leadership across all relevant areas of service delivery, in creating the transformative change in social care that the SDS approach requires. Greater recognition of the conditions for successful implementation will hopefully enable the creative practice that our research discovered to flourish. In order to achieve the goal of all service users being enabled to have as much choice, control and flexibility over their care and support as they want to have, in order to realise their own outcomes.

Literature Review

SDS legislation has very wide reach. It affects the way that eligible social care needs should be met across a wide range of ages, circumstances, and types of support. The SDS approach can be used in children's services all the way through to care for frail elderly people and end of life care. Therefore, it is not possible to survey the full range of relevant literature within this report and we have not undertaken a systematic review. However, we present here some of the key themes arising from the literature in relation to SDS and to personalisation and co-production in social care more broadly.

Social work with adults and older people under previous community care legislation has been described as a model of 'professional gift' (Duffy, 2003), whereby supported people were granted such services and resources as professionals decided were right for them. A self-directed support (SDS) approach offers a very different perspective. The professional social work role is no longer that of 'care management', but of 'enablement'. The theory of SDS is that outcomes are defined and co-produced with individuals who choose how much control they want over how these are met, are offered choice about the care they receive, and are thereby able to live their best possible life through flexible support. Our research was interested in discovering to what extent that theory has become a reality in Scotland, through implementation of the Social Care (Self-directed Support) (Scotland) Act 2013.

Whilst there are clear crossovers with the personalisation agenda in other UK nations, as Manthorpe *et al.* emphasise, Scotland has 'distinctive policy ambitions' (2014: 37) in introducing SDS. These are explicitly linked to creating a healthier nation and stronger communities. SDS can be understood as coming under an overarching policy turn in Scotland which places emphasis on community capacity building (Pearson *et al.*, 2018) and partnership, underpinned by the work of the Christie Commission (Scottish Government, 2011). As Pearson and colleagues (2018) highlight, the SDS approach conceptualises care users as active partners who can both contribute to and benefit from their community resources, rather than consumers of services exercising market choices about their care.

Overall the SDS approach can be understood as aspiring to provide empowering and equitable access to control over their care for a broad range of individuals and families. Although there exists debate in the literature about the extent to which SDS has so far been successful in offering equal benefit for all those eligible to take control of their own support. For example, research by The Alliance (2017b) focused particularly on women's experiences of SDS and found there were significant differences from those of men, particularly an inexplicably longer wait time for services.

Writing in the English context, Woolham *et al.* (2017) highlight the lack of research focus on the impact of personalisation for elderly people, who represent by far the largest section of the UK population in need of care and support. The low uptake of direct payments by elderly supported people has generally been viewed as a challenge to practice, rather than an issue about the suitability of the SDS approach to meet this population's needs. However, Woolham *et al.*'s (2017) English study found that elderly people did not actually achieve significantly better outcomes through direct payments. Their work suggests that older people have different aspirations and hopes in terms of what they want from personal budgets and rethinking is required to make the policy drive around personalisation much more relevant to this age group. However, it is important to remember that older people who use care and support in daily life are a diverse population. Buffel's (2018) co-produced research with older people points to the numerous benefits of meaningful involvement of this group in studying their own communities through co-created research. Not least the way that co-produced research can act as a means to harness the contribution older people can potentially make to their neighbourhoods.

Nevertheless, a number of authors (Cf. Rabiee *et al.*, 2016, Woolham *et al.*, 2017) have emphasised the tendency for elderly people to have small budgets, from which they purchase personal care and domestic help, rather than accessing social or recreational activities. The added value of directing their own support may thereby be negated by the need to focus on 'traditional' (Rabiee *et al.*, 2016) homecare services in planning their own care. These themes are reflected in the evidence provided by local authorities through this study. The majority of creative case examples shared with us

featured working age people who had used SDS to be able to live their lives on their own terms, often with the support of wider family. Work to increase the national relevance of SDS legislation to Scotland's older population is arguably needed. Buffel's (2018) work offers a possible model for the role of action research in discovering how SDS can be put to work for diverse groups and communities.

Audit Scotland's report into SDS described supported people as having to be 'determined and persistent to access SDS options 1 or 2' (2017: 24). The question of which service users are in reality able to access the range of SDS options is raised by Eccles and Cunningham's recent research (2016: 6). This question was echoed by our own research, and in some local authority areas (Midlothian, and Perth and Kinross notable in our sample), services were making specific efforts to break down barriers of access. These barriers were described by our participants as arising from level of social capital, as Eccles and Cunningham suggest, but also from ethnicity and culture.

Irvine *et al.* (2017) highlight specific barriers for members of the Chinese community in accessing personalised care and support, including language and culture. SDS Scotland's findings (SDSS, 2016) illustrate how a lack of good quality support in understanding and arranging different means of care could effectively act as a barrier to some service users being able to access all four SDS options. SDSS's research raises the thorny question of whether having somebody close to offer support is actually necessary for some service users to avail themselves of all the possibilities of SDS. There appears to be a need for further research into equality of access to SDS. And crucially, more refinement to practice in terms of recognising and overcoming potential barriers.

Third sector organisations as well as social work services can fulfil a very important role in increasing access to SDS. This agency support role was found by Arskey and Baxter (2012) to be critical, both in access to and in the continuing use of personalised budgets, in their longitudinal study which cut across service user groups, and geographical areas of England. Arskey and Baxter's (2012) research also queries the responsiveness to change of personal budgets over time. This was not

a difficulty that came up in our sample, but the issue of responsiveness to very high levels of individualised need (McGuigan *et al.*, 2015:4) was raised by our study participants, in relation to children with significant disabilities in particular. As McGuigan *et al.* (2015) describe, the process of changing the way support is received can raise anxieties, at least in the short-term. And we found evidence of high levels of existing stress being a barrier for parents and carers feeling able to cope with changes to the way they received support.

Arskey and Baxter's theme of 'learning the hard way' in managing one's own budget through a Direct Payment (2012: 156) also occurred in our service user data. Meaning that it took service users time to experience a sense of mastery over the process and to be clear about their own needs and who would be best to meet them in terms of recruitment. It can take time for supported people to become expert in managing their own care if they have not previously had the opportunity to do so.

As will be explored later in this report, SDS can be understood as offering an opportunity for relationship-based practice (Ruch *et al.*, 2010). An invested and authentic form of engagement with clients that is the foundation for meaningful co-production (Hunter and Ritchie, 2007). Whilst relationship based practice has remained a major theme in social work, it has been much less evident in settings that involve a high through-put of assessments and care provision, particularly in social care for adults and elderly people. Here shifts into 'care management' have affected the capacity for social workers' use of self and for partnership working (Skerrett, 2000). The evidence gathered in the course of preparing this report was highly suggestive of social work staff valuing new opportunities for relationship-based practice and 'good conversations' in their work. This highlights the importance of suitably qualified and well-supported staff being involved in assessment and planning with individuals and families (Velzke, 2017).

Overall the literature suggests the need for more refinement, both in research into SDS and in how care and support needs within different sections of the Scottish population are met through the SDS model. As Audit Scotland's (2017) report suggests, SDS represents an ambitious project of change in social care and

support for the people of Scotland and there is still far to go in terms of implementation. Progress is also needed in increasing the knowledge and practice base of how best to adapt SDS to the diverse needs and circumstances of individuals, their families, and carers.

Key Messages

- Supported people in Scotland are benefitting from increased opportunities for greater flexibility, choice and control over the care and support they receive through SDS.
- There are coherent and inspirational examples of local authority attempts to personalise care and to increase individuals' choice and control.
- SDS represents a significant challenge of leadership; in services, in communities and in workforce education and training. In areas of strong leadership and collaboration across services and functions far swifter progress in implementation has been possible.
- Across all geographical areas contributing to this research there was an understanding of the need for social work staff to be skilled in the co-production of assessments and support plans, and evidence of a high level of commitment to training and mentoring to support this.
- In health and social care services, significant changes in workforce culture were found. This involved a shift from care management to a process of maximising personalisation and engaging in outcomes based conversations consistent with the intentions of SDS legislation.
- Efforts to personalise support for individuals who need residential care have begun.
- There were a small number of examples of children's services implementing SDS, where this study found a natural fit between the outcomes focus of SDS and that of the GIRFEC approach in its use of well-being indicators (SHANARRI).
- Many areas reported that they had successfully increased or hoped to build community resources locally, and understood the need for stronger, more supportive communities.

Leadership and Strategy

Key Findings

- Local areas varied in their interpretation of SDS legislation.
- Respondents held strong views on the spirit of the legislation. These views were not consistent, although overlap did exist. Some areas had prioritised community capacity building in their approach, while others had a more rights-based understanding based around access to care and support through the four SDS options.
- A small number of areas in our sample had been successful in achieving wholesale change in their vision and delivery of social care services.
- Strong and committed leadership and partnership from senior management of services across the local authority was crucial in this progress.
- The majority of respondents described progress in some areas of service delivery and not yet in others. Most progress has been made in adult social care services, but much work remains to be done in order to offer older people genuine choice and control.

Defining Successful Leadership in SDS Implementation

In order to offer individuals and their carers greater choice, control and flexibility, a high level of partnership working is necessary. Successful SDS implementation requires that the following conditions be met:

- That flexibility in provision has been secured, ideally through collaborative outcomes-focused commissioning.
- That mechanisms within finance, procurement and contracts can accommodate the range of options for delivering care and support that SDS offers.
- That the social work workforce be skilled in good conversations and creative co-production of assessments.
- That social work management are leading on changes in practice and workplace culture.

However, even this is not enough to maximise the potential of SDS for individuals and families in need of support with day-to-day living. To do this requires strong, inclusive communities with resources and activities that can be accessed and contributed to by individuals who need some support.

This is complex work and demands strong leadership at every level and in every setting. Effectively it requires that managers of all aspects of service delivery affected by SDS legislation work together to make the new possibilities for health and social care that this offers a reality in their area,

'We set up an SDS programme board, which was chaired by our Director of Health and Social Care and on that was all of our Heads of Service from across Social Work, Finance, Legal, Contracts and Commissioning, operational Social Work, some Health folk, Internal Audit. Recognising the scale of transformational change wasn't just about social work practice it was everything: How we deal with invoices, how we deal with money, how we deal with contracts, all of it, everything... We had HR there, we had the unions... it was really a strong message from our Director that this is really a transformational change agenda and it will affect every department sat around this table' (Manager, local authority wide role).

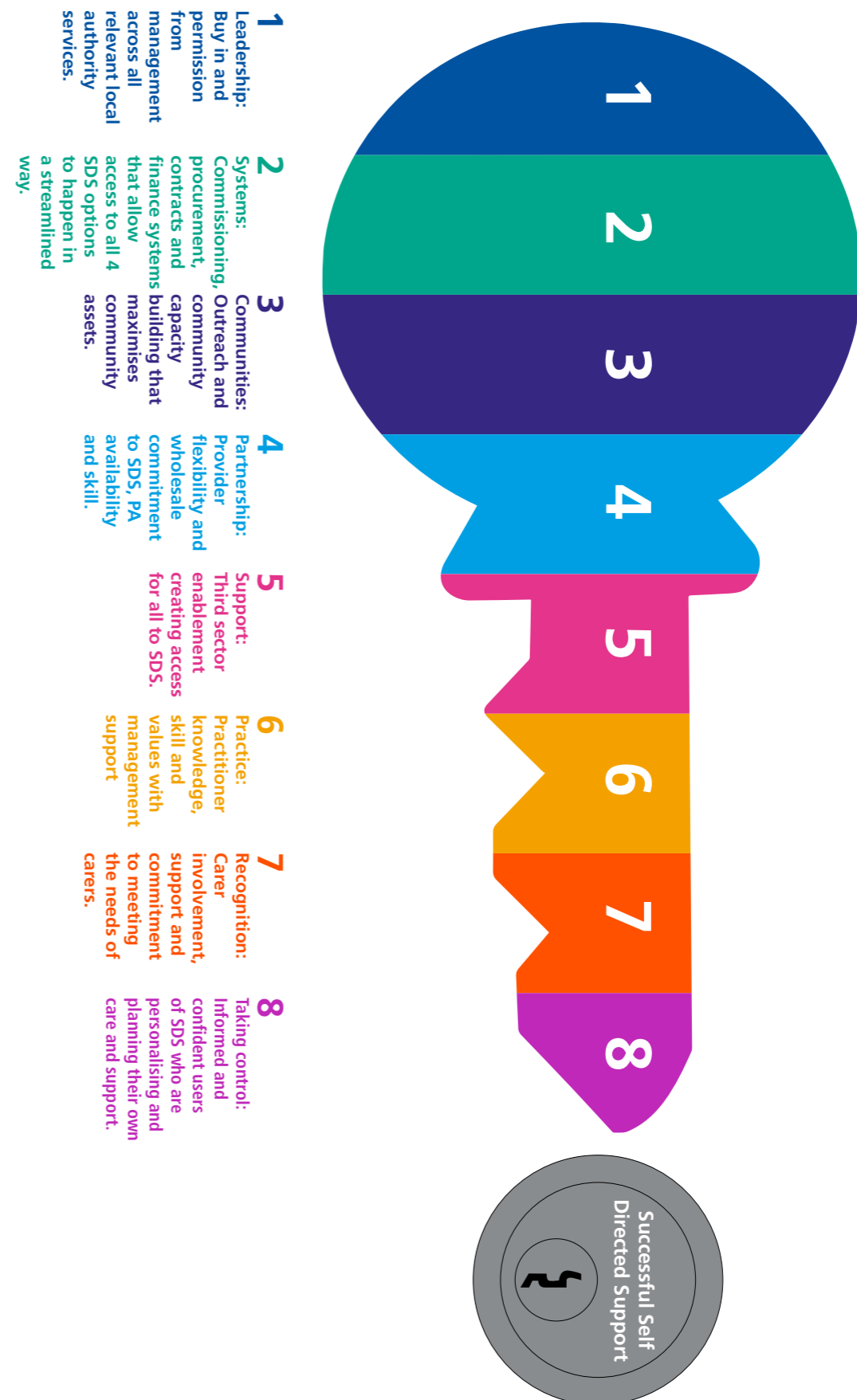
Involving people who use services in strategic processes of planning and review can add a great deal of value. Local authorities which had included supported people as essential contributors to achieving change found that this helped move implementation along. The perspective of carers and people who need support helped professionals to understand the value of personalised care. Leadership from service users is therefore also very important, and reflects the spirit of empowerment found in the legislation,

'At every programme board, somebody who used services or a family carer came and told their story. And what that did was bring a lot of the policy and systems stuff to life. Particularly for people who didn't work in social work, the senior managers. So if you were an Audit Manager, a Finance Manager, you were hearing what it actually meant for people' (Manager, local authority wide role).

The Benefits of Leadership

Senior management support, direction and permission were crucial to achieving lasting change in local authority and health services. Where this was present, huge progress could be made.

KEY TO SUCCESS – UNLOCKING SELF-DIRECTED SUPPORT



In adult and older people's services, the integration of health and social care services, and the impact of austerity measures on budgets were cited in some areas as barriers to growing creativity in social work practice. In children's services too, there was a feeling that the legislative burden placed on local authorities had been heavy in recent years,

'It's a big shift in the context of a lot of other change as well. It's not just budget but you know the ongoing implementation of The Children and Young People Act, Children's Hearing Act, new adoption legislation. I think it's another ask on top of many other asks of practitioners. In terms of developments that have been going on across Scotland in children's services... You know continuing care, Throughcare'

(Manager, Children's Services)

In some areas there was a perceived lack of commitment to the change agenda of SDS in senior management. This appeared to impede progress. Staff could become demoralised if they had been asked to make changes to their practice, which they then struggled to actualise due to lack of appropriate organisational change. An example of this is where creative care plans are being co-produced but there is a lack of providers to fulfil these for people: Changes in commissioning and community engagement need to come in tandem with shifts in practice.

Community leadership was recognised as another important factor, and two respondents described a lack of community resources and assets within their rural communities. This could cause a push-pull effect where local authorities were unsure to what extent their role is to enhance and support community development. All services consulted recognised that getting their own staff on board with changes was necessary but not sufficient for successful implementation.

'The leadership is interesting given the model you've got to have for SDS to work isn't it? Because actually it's not dependent on just the ones who provide the cash for the Option 1s. It's predicated on the notion of a supportive community with activities within it and that you can access, and that you can use a DP to do something there... we're not always masters

of our destiny in that regard and we have to work with other people and recognise that because if you take that model and apply it at the root end you have to have supportive communities, communities you can do something in'
(Senior Manager).

There is clearly a great deal of important work taking place under the banner of SDS implementation across Scotland. Impressive pockets of good practice exist and are emphasised in this report. However, we also found an apparent lack of consistency in the extent to which leaders in the professions of health and social care had been able to work with providers and local communities to overcome challenges. Elected members and community leaders had a very important role in this process, both in supporting and instigating positive changes. Good partnerships helped to grow strong communities, helping people to remain in their own communities and to be active citizens.

Strategic approaches

Our research found a variety of strategic approaches which had been adopted to achieve SDS implementation. There was also variation in the extent to which local authorities felt confident in the vision that the Scottish Parliament has set out introducing legislation on Self Directed Support. A small number of respondents suggested that the legislation is open to multiple interpretations and that it would be helpful for Scottish Government to 'fine tune the vision' and provide stakeholders with a stronger message on what successful implementation should look like 'on the ground'.

For example, East Dunbartonshire had interpreted the SDS agenda as being primarily around community capacity building and funding preventative initiatives. The aim being that these become self-sustaining and can then act as 'assets': Resources that provide opportunities for active citizenship or an alternative to traditional social care. Whereas the majority of local authority areas had focused on personalisation of the formal assessment and delivery of individual care and support to those with eligible levels of need. However, some had been able to successfully combine elements of both personalisation and community building approaches. Fife provided an example of this

and suggested that they had embedded SDS as the mainstream social work approach across adult social care and some community health services.

Whilst the majority of authorities had instigated governance arrangements to oversee implementation, membership of this varied. A very few areas, East Ayrshire and Highland standing out in our sample, had understood full implementation of SDS legislation as requiring 'transformational change' across the local authority/NHS board area. East Ayrshire took a highly strategic approach to providing services in the spirit of SDS and integration.

Reporting and Measuring Progress

A small number of local authorities questioned the mechanisms for reporting on progress. They expressed confusion over the conflicting messages that uptake of the different SDS options was not to be used as a measure of progress but that this has continued as the government's primary tool for tracking change.

Outcome based annual reporting was favoured in some areas (Midlothian, Fife) in line with the outcomes based approach of SDS. The City of Edinburgh Council used their mandatory training sessions for social work staff as an opportunity to relay progress and 'sticking points' up through their management structures. NHS Highland and East Ayrshire had found visual planning tools invaluable in their change processes.

Where ongoing evaluation was seen to have been built into the implementation strategy for an area, it became a powerful tool for measuring progress, and closing the feedback loop for practitioners working hard at the frontline, who were able to see outcomes in action.

Re-envisioning social care?

The reach of SDS legislation referred to in the literature review could be seen in practice. One example of a strategic issue was raised in Falkirk and Scottish Borders. In both areas support at home for an adult was being proposed as an alternative to residential or hospital care but there was a delay in finding appropriate social housing in order to realise this for the individual. Since no SDS mechanism was in place within housing services to house the supported person in an environment where they could receive the proposed care package,

given the pressure on housing resources, delay occurred.

Where access to social housing is based on a bidding system such delays are possible. This raises the question of whether a 'corporate responsibility' strategy that cuts across social care and housing procedures within local authorities may be helpful to address such circumstances. Joining up policy may allow supported people to leave a residential setting and receive support in a community setting more quickly and in all likelihood at less public cost.

When considered in this way, the agenda for changing services is very large indeed, and some participants in the research perceived that our understanding of social care is at a pivotal point,

'In ten years' time we'll be buying things that don't look like services and that'll mean it's worked'
(Team Manager, Adult Services).

Commissioning and Re-envisioning Social Care

Case Example 1: Jack

Jack was due to leave residential school at 17 and he and his parents decided he should move to live close by family. Although Jack had been living some distance away from his home town in a specialist resource, he had close relationships with both his mum and dad. Jack has very significant difficulties in terms of learning and communication. Within the residential school environment Jack was regularly self-harming at huge detriment to his face, which was a concern for everyone.

Jack's social worker perceived an opportunity here to provide choice and control to Jack and his family and they were keen to build a network of support around Jack that could meet his needs.

The family interviewed three care providers and chose the one they liked best.

'They knew what they wanted and they didn't wobble'

(Jack's social worker, Donald).

One issue was housing as there was no straightforward mechanism for getting housing in place to go along with the proposed care arrangements. Jack's social worker had to get permission from management to be able to allocate housing to Jack in an area where his mother herself grew up. Jack is known and part of that community, and *'you can't buy that'* (Donald).

There was an anxiety Jack would isolate himself. However, in terms of day to day life, from day one there was some routine there and he is now out three or four times a week and copes with the chores he has to do. Jack visits a local sensory room, attends football matches, and is part of a recreation club. He attends amateur dramatics performances with his dad, and is regularly out in the local community.

A year on from his move Jack is much healthier and happier.

'The biggest safety and health outcome that we've got is we are still getting incidents we are using [restraint] on average twice or three times a month compared to twelve or fifteen times. He still looks a bit like a boxer but his skin's rosy and healthy and the actual inflammation has slowly gone down... because in school it was happening several times a week, in fact there was a pattern first thing in the morning that he would get upset and basically punch himself in the face... there's other triggers and there's triggers we don't fully understand yet but they are much rarer because, I don't know, he must feel he's got more control over his life'

(Donald).

Key Findings

- Where senior management took on an active role in negotiating and relationship building with providers this unlocked the potential of SDS to be creative and flexible in meeting individual outcomes.
- There is evidence of change from traditional tendering to collaboration.
- Where local authorities agreed a set and hourly rate for care with providers, this was positive.
- Flexibility can be achieved within block contracts and Service Level Agreements when providers can tailor their services around individual outcomes.

Strategic Planning and Troubleshooting in Commissioning and Procurement

Excellent examples of changes in commissioning came from South Ayrshire, East Ayrshire, East Renfrewshire and Highland, where managers had taken new approaches to social care delivery. In these areas a strategic approach was taken whereby dialogue was opened up between users of services, frontline staff, managers and providers of care and support, in order to create new ways of working together,

'That's what we're trying to say to providers, if people want to do something a bit differently, you're working with these people every day. The social worker doesn't see them every day, you know we see people from time to time, you know we would be happy in that situation for us to look at an Individual Service Fund, and to pass that equivalence, using the equivalence model that money, to provide that service that the person wants and that is something that we will actively manage'

(Senior Manager).

There was a lot of hard work described in changing these traditional commissioning relationships and shifting the balance of power and responsibility between agencies. Some areas described significant efforts in this direction, but with little effect in terms of flexible Option 2 arrangements for supported people so far.

Some local authorities had taken the strategic decision to troubleshoot issues as they arose through SDS implementation. Midlothian health and social care

partnership and the City of Edinburgh's Council's Communities and Families department were examples where SDS Lead Officers had been able to work together with colleagues in finance and procurement and with local providers as challenges became apparent. Building new systems as they went was very labour intensive for social work staff but had satisfying results. For example, the outcomes for a group of three friends, who had previously used traditional residential respite for adults with learning difficulties on an individual basis.

'They went and rented a lodge or log cabin and used their budget to pay for the accommodation and pay support staff to go away with them as a trio and then do stuff while they were away and the feedback I had from that was that it was just amazing. Because they felt like they'd had a holiday and their parents felt like they'd had proper respite because they knew that they were together, it also then connected all these families and they built a kind of network'

(Manager, local authority wide role).

Respite and short breaks provision was an area that most local authorities had successfully personalised in order to provide service users with a much more enjoyable experience and carers with meaningful respite. East Renfrewshire, Falkirk and Fife provided strong evidence of this and South Ayrshire was actively working on this.

As an example, following the closure of their building based respite service in children's services, East Renfrewshire took a partnership approach to commissioning a new model. The Partnership worked with providers and parents to develop creative and flexible supports for young people with additional support needs. Providers pooled resources and 'pitched' a range of ideas to parents who identified strengths in the proposals. Working together, providers developed a range of activities using universal and public services based on the feedback. The outcomes for young people improved as they experienced a broad range of activities and benefited from a diverse range of peer and staff support. The approach has increased parental involvement and activities are now being co-produced between parents and providers.

Individual Service Funds

Where groundwork had been put into building good working relationships between commissioning local authorities and providers, this allowed trust to develop. The goal being that Individual Service Funds could be transferred to providers who could then manage them flexibly with individuals and families.

The success of Highland Home Care which is explored later in the report, has been predicated on Individual Service Funds sitting with the provider. This was surprisingly uncommon practice across the local authority areas who responded to our research. However, South Ayrshire have actively shared their approach to collaborative and outcomes based commissioning in Learning Disability services with us and with other areas. South Ayrshire were supported by Evaluation Scotland in developing an approach to reimagined commissioning. This involved a shift to outcomes based commissioning, with a view to transferring Individual Service Funds to providers and allowing them to work directly with individuals and families to meet those outcomes in creative ways.

In some areas, Individual Service Funds largely remained an aspiration at the time of the study, but the work was well underway to achieve flexible uptake of Option 2 by service users in this way. In other areas this was very much a reality, East Ayrshire had seen a large increase in uptake of Option 2. Some local authorities felt that the principle of proportionality was important here, since for many support plans the budget is small and it makes more sense for the local authority to make purchases on behalf of service users at their request. Particularly in children's services where 'mainstream' activities such as swimming lessons or soft play passes might be important aspects of the plan.

In House and Block Provision

Local authorities recognised the need to make Option 3 a positive choice for people. And to offer personalised support to local residents, understanding that *'Option 3 is a perfectly legitimate choice for individuals and the spirit of the legislation would suggest that it should continue to be so'* (Manager).

East Lothian have redesigned their home care provision in order to build what they describe as 'Option 2

flexibility' into Option 3 services and at the same time address the issues of care at home capacity which are highlighted elsewhere in this report. Their new approach is not limited to, but does involve a single tariff for all home care, an approach that other local authorities have found to be helpful and equitable.

'We developed one service specification and contract for care at home providers which allowed providers to deliver to all age groups and disabilities. This promoted the standard of care and ensured equity across all groups of supported people. It also regulated the cost of service – one cost for Care at Home – all Providers were expected to deliver the same standard of care at the same cost.'

'Previously the same carers delivered to people over and under 65 and yet they were paid different rates. The development of one Framework ensured equity across the disability groups. This initiative was welcomed by Providers. The new contract allowed for two models of support to be delivered under option 3; Time and Task and Personal Budget Model' (Manager, adult social care).

The 'Personal Budget Model', essentially allows high quality providers to receive a personal budget for service users in order to meet their defined outcomes, and thereby free up an Option 3 contract to personalisation. East Lothian have not yet had the opportunity to review these new developments but are hopeful that they will allow far greater flexibility within Option 3 care at home in the area.

Residential care is an area where personalisation has been slowest to embed, but in Highland there were the beginnings of good evidence of this. In Highland, personalisation has been just one part of wider cultural change and quality improvement in their residential care settings.

The City of Edinburgh Council had brought personalisation of care into their residential care services for accommodated children and young people, through a pilot project which eventually took in three residential units. This gave young people the opportunity to engage in their support planning and share their ideas on how their outcomes could be met flexibly. This also

brought residential care workers into the SDS training on offer, increasing understanding of the possibilities the legislation offers across all services.

Personalisation of long-term residential services for those who need them remains a challenge, but one which some areas were beginning to take on.

Community Asset Building and Broadening Access

Key Messages

- The extent to which stakeholders in implementation understood the need for a fit between changes in social work practice and supporting communities to increase their assets varied.
- Promoting active citizenship and community assets was taken on as a priority in some areas, and many were seeking to develop this locally.
- Some local authorities were making small scale spends on individuals, families or community groups in order to achieve defined outcomes, without building in additional bureaucracy.
- There were pockets of streamlined individual spend in Children and Families and addiction services, but for high volume adult social care services this remains a major challenge.
- Barriers to access were being challenged in different ways in order to broaden awareness and uptake of the different ways of accessing support and social care.

Strengthening Communities

Part of the SDS agenda for change has been an emphasis on community building so that there are opportunities to divert from traditional social care provision. In addition, stronger communities offer greater potential for individuals to access meaningful activities and supports of their choice. In some areas, as part of SDS implementation, seed funding was provided to kick start 'bright ideas' for community activities and initiatives. Some successful examples provided included:

- A Recovery Café for individuals and families affected by substance misuse (East Dunbartonshire)
- Men's Sheds (East Dunbartonshire)
- The 'Small Sparks' scheme in Fife, which funded a variety of projects including a highly successful community garden and a Story Stones project linking a care home with the wider community (Fife)
- Young people providing peer mentorship and running activities including a drama group for younger children with disabilities (Angus).
- Four weekend drop ins for families who have a child with a disability, two of which are still going strong over 3 years on from the original seed funding (The City of Edinburgh Council)

'The Drop-In has been a godsend for my two boys and me... As both boys have autism but with very different needs it is rare to find somewhere I can take them both together... The fact that the Drop-In is on at the weekend is important. The boys need routine and structure and weekends can be long and challenging... The benefits to my boys have been huge'

(Direct extract from parent's recent feedback shared with parental and agency consent)

A common theme across all the projects described above was reducing isolation and overcoming stigma. This was something that the supported individuals who took part in our research also emphasised in their description of the outcomes that Self-Directed Support allows them to achieve.

This should not be under-estimated as an important goal, since research participants described very serious effects on their mental health, of feeling excluded and isolated from everyday activities. David described how his support worker took him to take part in competitive sports, horse riding with his family, and on holiday with them, but also helped in small ways so that he could simply choose his own shopping or go to a café,

'It's like a social life again, it's normality, it's what any normal person would do. That is the big thing. But you wouldnae be able to do that with... the council saying that's it, 15 minutes in the house... you can get somebody to pick you up and take you to the beach for a couple of hours if that's what you want in the summer. The freedom of not having to sit in your hoose... I cannae actually praise it high enough, just normality, what a difference in life... it's life again'

(David and Jennifer, Direct Payment under Option 1).

The control that David and Jennifer have been able to achieve over David's care, working with the support worker they employed directly has allowed them to continue to live as a family. But also for David to gradually pick up activities and pursue his own interests, and importantly for Jennifer to continue with her career, which is very important to her sense of identity and for the family to be financially self-sufficient.

This brings us back to the point made by one senior manager that SDS requires not just personalised support but communities that provide opportunities for individuals and groups to be active and contribute to the life of the area. Some very powerful examples of this were provided across Scotland, and this was something that many respondents hoped to continue to develop.

Active and Healthy Citizenship

There were several good examples of a commitment to active citizenship for service users. South Ayrshire were challenging their providers to think differently about their support to people with learning difficulties and to get beyond maintaining individuals in safe and familiar ways, and instead work towards supporting them to become actively involved in their communities through volunteering or employment, and simply *'getting out and having a bit of a life'* (Manager). In Falkirk too, the Learning Disabilities team were challenging the understanding of institutional residential care as safe, supportive and the only choice for individuals with complex needs and behaviours.

In other local authorities small spends have been made available to help individuals to meet particular outcomes and take greater control over the direction of their lives or their family's life. Budgets varied between £250 and £500 and bureaucracy was kept to a minimum to maximise flexibility: Individuals were simply asked to apply for individual budgets, explaining the outcomes they intended to achieve. Examples of this approach were provided by East Ayrshire and the City of Edinburgh Council in our sample.

Outreach, Awareness Raising and Broadening Access

There was some strong evidence of local authorities seeking to broaden access to Self-Directed Support in different ways. The first of these was information sharing and awareness raising, recognising that knowing what is available is the first stage in increasing service user choice and control. South Ayrshire had built consultation with, and outreach to, supported people within their changes to commissioning and provision, and had actively sought views on the reimagining of services. Almost a step back from this,

some respondents (East Dunbartonshire, Fife, Perth and Kinross, Scottish Borders) suggested that broader public awareness of social care systems and options was important and a means of empowering individuals to think about support before they need it and to be able to access support when necessary.

Fife did a huge amount of active publicising of their 'On Your Doorstep'² initiative which provides information on community resources, and on health and social care processes and services, through local radio, leafletting posters and 'team talks' at local agencies.

Perth and Kinross undertook large-scale public awareness raising in order to increase access to services for minority ethnic communities. The SDS implementation team along with a local third sector partner provided extensive outreach and creative means of information sharing, e.g. DVD and YouTube short films in a variety of languages featuring service users' experiences, posters in local shops and getting out to events and places people gather, *'we went everywhere!'* (Outreach Link Officer, Minority Communities Hub, Perth & Kinross).

'Our Outreach worker has worked very closely with Self Directed Support Team. This partnership work has been hugely successful for our clients. We have been able to establish a very successful partnership with the SDS team which has benefited so many of our clients.'

'In the life of the project, we have referred and supported 16 individuals including 4 Gypsy Travellers, 1 Chinese, 2 Eastern European and 9 South Asians to the access team to have them assessed for SDS. Due to support offered by the Outreach Link Officer during the Joint assessments, 13 clients are now in receipt of SDS care packages. Others are going through the system. Feedback from those clients suggests that they are now living a better quality of life and feel they are in control. We continue to deliver awareness sessions about SDS' (PKAVS Minority Communities Hub, Bridging the Gap Project, Impact Report 2015-2017).

² <http://www.onyourdoorstepfife.org>

Creating Flexible Systems

Broadening access in a different way, implementation workers in Midlothian realised there was a strong class element in the use of Direct Payments under Option 1. One aspect of this was the ability of families or individuals to find personal assistants through their existing networks and word of mouth and they wondered if there were ways of breaking down those barriers.

'We set up the PA Scheme to try to level the playing field a little bit... it's across children and families and adults and social care and it's a directory of people who are interested in becoming PAs or who already have experience as PAs and so they can register on the scheme, it's held by Midlothian Council but we don't recommend or endorse anybody who's on it, and it was that recognition... that we were finding with direct payments when people wanted to employ their own Personal Assistants... that who you know really matters. So if you are well-connected family, generally it was quite easy to find somebody to be employed as a PA. Whereas if you were isolated and didn't have that community... there was the equal opportunity... but there wasn't actual equity because one person's much more able to do it than the other person so the PA scheme was to bring them more in line with each other so it shouldn't matter as much who you know'
(Manager, local authority wide role).

Another barrier to choosing a Direct Payment could be the accounting required, and in East Ayrshire, they have tried to mitigate this by providing support from their own specialist Finance Officers who will make home visits and sit with supported people to help them to do their returns.

Key Findings

- There was limited evidence of large scale system change, but it had happened in some areas, most notably East Ayrshire and Highland in our sample.
- Processes may have changed but they remained complex in most situations, sometimes despite huge efforts in redesign of assessment tools and IT systems.
- There was wide variation in the extent to which local authorities viewed the powers and duties of SDS legislation as necessitating new assessment forms and processes.
- The reduction of bureaucracy remains an aspiration but not a reality well evidenced by this research.

SDS Systems

Not all local authorities reported on the systems and processes they had introduced but where they did it tended to be on the challenges of getting IT systems to cope with more creative assessments, co-produced support plans, or to make budget calculations. One local authority worker described spending months, if not years, working very hard to incorporate an SDS assessment into their IT system for case recording in children's services. However, in other areas, hardly any change in paperwork or process was seen as necessary.

The challenge to think carefully about the information collected and held about individuals and how much of this was needed came up only rarely in the research, but some areas were giving thought to this and also to the proportionality of the new systems they introduced, including shortened initial assessment processes for adult services in new locality 'hubs' or offices.

The City of Edinburgh Council had tried to introduce a little process as possible into their initiatives for children and their families using the new SDS powers and duties, and Angus were also working to introduce streamlined systems for small spends to support families, possibly using Family Group Conferencing as a forum to agree this.

In adult social care services, it appeared much more common for complex eligibility and resource allocation systems to be tailored to include the four SDS options rather than being broken down and simplified. The

need to establish eligibility according to set criteria, and both to provide equity in service delivery, and to be seen to provide that equity were barriers to the streamlining of processes. Guidance for staff then needed to be provided so that they could complete assessments which demonstrated eligibility and which allowed decisions to be made about the level of support to be provided. This research found little evidence of shorter or simpler assessment processes as a result.

Both staff and service users participating in this research were concerned about how difficult it can be to prove eligibility for services. Strict eligibility criteria were cited as a potential barrier to creativity.

Once eligibility was established many local authorities used a Resource Allocation System (RAS), Funding Allocation System, or Resource Allocation Panel (RAP) in order to agree individual budgets (Angus, The City of Edinburgh Council, Scottish Borders). Others were working with an 'equivalency' system (Midlothian, East Dunbartonshire). South Lanarkshire described a points based and a banded system for adults and for children respectively. However, none of these systems appeared to have decreased the bureaucratic demands on workers. There was also a tendency for these systems to tie thinking back into the language of 'hours' under a 'time and task' model rather than emphasising individual budgets and creativity.

Once support was agreed and in place, there were efforts to reduce the administrative demands on supported people and third sector support organisations under Option 1, and on providers under Option 2 in terms of providing receipts and an audit trail. Many areas were trying to move towards the use of a standard bank card for individual budget or support fund transactions, and seeking to minimise the need for active reporting by individuals.

Workforce Culture and Development

Key Findings

- There was good evidence of a commitment to new approaches to assessment and planning that are a necessary condition for the personalisation of care and support.
- All local authorities have recognised the need for extensive training and peer mentoring to help with this process.
- Social Workers in Children and Families services have found SDS a natural fit with existing policy and practice. For practitioners in most adult health and social care settings the SDS approach has involved major cultural change.
- Social Work education is perceived by practitioners as having major gaps in its preparation of new practitioners in relation to SDS. The profession needs qualifying training to be informed by relevant research and standards, incorporating the SDS approach.
- There is a challenge to professional leadership to develop the skills, values and identity of social work in health and social care services.
- Significant challenge in recruiting sufficient social care workers to meet need were described by almost all local authorities, particularly in care and support at home in rural areas. Where this has been overcome, results have been outstanding and provide evidence of how new models can work.
- The work of third sector partners was highly valued by local authority staff and supported people, particularly in enabling users of their services to choose a direct payment under Option 1 and in educating the public on SDS.

Cultural Change in Social Work Education and Workforce

Social work students and newly qualified social workers were not seen by participants in the research as having a good understanding of SDS from their qualifying courses, put very frankly they 'don't seem to know a lot' (Manager). Several agencies had addressed this when students were on placement within their organisation and found that SDS and co-production were then enthusiastically taken up by students, who had real passion for the values and opportunities SDS represents.

Interestingly, another group of qualified social work staff

identified by our research as having natural commitment to SDS were those nearing retirement. Practitioners in this category understood the new legislation as a renaissance in social work values and of the locally delivered, community based social work of their own early years in practice. They approached SDS as a welcome opportunity to empower individuals to have more choice and control.

'Some of the feedback that we've had from various bits and pieces that we've done is that we're taking it right back to how we did it 20-30 years ago, looking at community now and individuals' assets and only using statutory services to plug any kind of major gap... whereas before a lot of people were coming from an age where we just did everything 'for' and we built up a bit of an expectation. So workers were used to doing for individuals and their families. Families were used to well they'll just sort it for me'

(Manager, authority wide role).

However, between these poles of enthusiasm is a large section of the current social work workforce in Health and Social Care services who had only ever worked under the policy paradigm of Community Care,

'We spent so long in a period of care management where it was all about kind of packages of care and kind of joining the dots between people and services, it was... for those of us who've maybe been in practice for a while unlearning'

(Manager, authority wide role emphasis original).

What this means is that local authority social workers in health and social care services began the SDS implementation journey from a difficult starting point. They had been care managers acting as gatekeepers whose professional gift it was to allocate services under the Community Care paradigm. For these practitioners SDS has been a challenge to accepted practice. Therefore, significant levels of training, peer mentoring and feedback have been needed to encourage major cultural shifts in practice.

It is important to recognise within this picture the fact that Direct Payments were well established in some areas, primarily for adults with disabilities, and to an

extent for older people and their carers. Direct Payments have also been well used for children with disabilities, managed by parents in ways that suit their family life. In many local authorities we met enthusiasts who have made use of the longstanding powers to co-produce assessments of need with individuals and to support them to create packages of care that meet those needs in ways that are acceptable to them.

The principles of Self Directed Support were readily understood by the children's services staff who participated in the research. SDS principles were seen as having a natural policy fit with the GIRFEC approach and its use of wellbeing indicators, which underlie all practice with children and young people. With their focus on outcomes, SDS and the GIRFEC approaches are well aligned: 'we've done that for a long time and we wouldn't call it self-directed support' (Manager, Children's Services). So it is perhaps unsurprising that NHS Highland are applying a similar framework to adult social care; 'Getting it Right for Every Adult' (GIRFEA).

Notwithstanding these developments, our research strongly echoes the 2016 findings of the Critical Friend evaluation of the Scottish Social Services Council self-directed support workforce development project³.

In terms of the extent to which SDS implementation demands cultural change within social work practice, particularly in social work with older people.

Partly these are the 'additional skills challenges', that the SSSC have previously identified for the workforce⁴. Including the challenges of changed relationships with providers, employing numeracy skills in constructing budgets, and a need to be aware of the language of commissioning and procurement.

'You come into this job and you're a social worker and suddenly you're learning this whole new language!'

(Manager, Children's Services).

But beyond this, there are values underlying SDS legislation around promoting independence, thinking creatively and taking risks with supported people within a strong community framework. These values may once have been core to social work, but research participants described how they have been forgotten in much of adult social care. Therefore, significant re-learning and strengthening of the profession is needed to make progress in this area.

³ <http://ssscnews.uk.com/wp-content/uploads/Critical-Friend-Evaluation-Report.pdf>

⁴ <http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/workforce-development/workforce-skills-report-2016-17>

Case Example 2: Denise

Denise has a diagnosis of Schizophrenia and has been living with the condition for almost 30 years. Living in the community has been a struggle for Denise at a number of points in her adult life. Her wider network of friends has not always been a source of support, and Denise felt she had experienced a lot of stigma and social isolation due to her mental health diagnosis.

Denise had been living in hospital for almost a whole year when her social worker Alison first met her. One attempt to go home with a care package during that time had faltered after four weeks. Denise had found the care provider at that point difficult to work with and was distressed by the having a constant turnover of workers coming into her home. She wanted her 'home to be home and not a hospital' (Alison). This led to Denise disengaging from the regular support coming in and she became very unwell, very quickly. She was then admitted to hospital under a compulsory treatment order, which distressed Denise

further and lessened her trust in the professionals around her.

Denise enjoys reading, researching and writing and has an interest in alternative therapies. Alison saw this as a potential strength in Denise's life and asked her more about this. This became a 'turning point' in their working relationship. Focusing on strengths was new for Denise, who felt that previous assessments had always been deficit focused and she had found that difficult. Alison suggested exploring different options and they went together to a local third sector agency who helped Denise to draw up a support plan, which was then approved by the local authority.

Everything is now in place for Denise to recruit her own staff and she is planning positively for the future. Alison feels that using an SDS approach allowed her to work with Denise to co-produce her own support plan and begin to see a way that she could live more happily in the community again.

Training

It is clear that local authorities have understood the need to train their staff in SDS legislation. We found that training was particularly targeted towards upskilling social work assessments. All participants in this study reported investment of SDS funds from Scottish Government in training and supporting staff to shift their practice in order to have more 'good conversations' with service users⁵, or in very similar assessment skills.

The aim of these conversations is to find out what is important to people in need of support to achieve their outcomes, and to co-produce appropriate plans. The capacity for workers to do this skilfully was prioritised across the board. However, the ways in which training was approached varied between local authorities. Training that has served to embed SDS into practice and been positively received is:

- mandatory for both staff and managers
- based on values rather than processes
- is described in terms of best social work practice
- focuses on and supports practitioner understanding of outcomes
- has an in-house commitment
- is delivered in partnership with third sector and ideally involves service users
- is ongoing and responsive to need and new challenges

'We employed a dedicated training officer to train our staff on Self Directed Support and co-production... We had a management development programme so every manager in the social work department attended a 4-day training programme solely around self-directed support... We worked with an organisation called Diversity Matters... they had set up an organisation called 'Everyone Together'. They were funded through the Scottish

Government for capacity building and all of the training that we did, and all of the awareness raising that we did, we designed it with people who used services, we delivered it with people who used services, in fact they just delivered it, I didn't deliver it at all. And we learned everything all at the same time'

(Manager, local authority wide role).

Many local authorities had sought to provide peer mentoring for staff. Fife had a particularly strong commitment to embedding SDS through full induction for new staff backed up with the ongoing availability of a team of SDS staff who could answer any specific questions that arose for workers. Other areas had 'SDS champions' within area social work teams.

A small number of local authorities had extended their training offer beyond social work practitioners and managers and were actively involved in supporting and training personal assistants in order to increase skills in this workforce to enable the use of Direct Payments (East Dunbartonshire, Angus) and others were considering this approach (Midlothian). Our respondents found this difficult territory as they were wary of creating too much uniformity in provision or of bringing the function in-house without a plan to do so. However, training was seen as a helpful way of plugging particular skills gaps locally and thereby allow supported people to use a direct payment when they chose to.

Third Sector Organisations

Evidence on the third sector workforce is very limited since it was not the focus of the research. However, the vulnerability of funding for staff posts was raised in several areas, with the risk that expertise and experience in SDS will be lost due to the lack of job security in third sector organisations supporting SDS uptake.

Independent organisations are integral to the success of SDS. This research did not set out to ask directly about their role. However, the commitment and support from staff in independent organisations was valued and seen as crucial by local authority social workers and managers who relied upon it to help their service users navigate Option 1 and to inform communities about different ways of accessing care and support.

Service users and carers participating in this study reflected this view, when they emphasised how important the role of the third sector was in allowing them to use Option 1. The support with payroll and employment responsibilities was crucial for the supported people participating in this research choosing a Direct Payment.

Significant as this finding is, we acknowledge that the scope of third sector organisations' role in implementing the SDS legislation and national strategy is far wider than supporting uptake of Option 1. As detailed in the Community Asset Building and Broadening Access section of this report, we found that independent organisations are doing essential work in breaking down barriers to social care access. However, it was beyond the scope of this research to gather systematic evidence about the very significant contribution that independent organisations are making nationally. Further research in this area would be welcome and may bring some balance to the findings of this report concerning the activities of local authorities towards embedding SDS.

The Social Care Workforce

Whilst there were examples of providers in a number of geographical areas who were willing to be flexible and fleet-footed in their approach to recruiting carers to deliver flexible care under Option 2,

'It's the willingness of the provider to employ somebody, to go through the interview process, and they were able to turn that around reasonably quickly. But we've only got a couple of organisations who are doing that, who've got the capacity as well and the flexibility. So we haven't got an awful lot of providers who are, our main provider isn't offering individual service funds or direct payments so that poses challenges. It tends to be the smaller providers that seem to be, can be a bit more flexible'
(Social Worker).

Almost all local authorities reported difficulties in the recruitment of care workers, particularly home care workers, and particularly in more rural areas. The exception to this was Highland, where Highland Home Carers have worked in partnership with NHS Highland and with communities and users of services to find innovative ways to deliver localised care at home.

⁵ <https://www.thistle.org.uk/practitioners/houseofcare>

The Impact of SDS Implementation

'We, maybe uniquely in Scotland, don't have a problem with recruitment and the Highlands is an area with very low unemployment but we are managing to continuously grow and recruit and a lot of that growth has been... in these smaller communities where people have a sense of identity where care is something they can do within their own communities. Many of these people are not looking for full-time jobs and I think that's part of the problem with recruitment is people tend to think we can't recruit, we're looking for somebody to do 30 hours or whatever, well we're not in these communities because there isn't that much work... what they can do is deliver care as a supplement to what they are doing. I'm not saying it works perfectly but we don't have the problems of recruitment that other agencies seem to have. I think the fact that we are employee owned makes a big difference'
(Chief Executive, Highland Home Care).

Highland Home Care and NHS Highland are firmly focused on supporting people to remain in their own communities with the help of local care and support. This community-based approach whereby people within a remote community who are able to offer some support to their neighbours by join the workforce of Highland Home Care. They then work co-operatively within their own communities to deliver care to those who require it locally. This model has been open to criticism because it can effectively limit people in remote areas to using one care provider. This approach is therefore less concerned with whether individuals are offered care and support under all four options, according to the SDS legislation. Effectively it means that Option 2 is the only viable option for supported people in some cases. The company does recognise this fact,

'So you could say they are not having any choice. Well, they do have a choice they could take it or leave it! But there wasn't going to be a lot of options to them. They could have Direct Payments... some people do have Direct Payments in Cromarty and choose to do it themselves but there wasn't any

longer going to be a traditional service'
(Chief Executive, Highland Home Care).

Nevertheless, this local solution has achieved better outcomes for individuals: People have been able to choose to remain at home, in their remote and rural communities as opposed to moving into urban residential and nursing care settings. And across the piece, there has been a recognition that in order to offer this, homecare has to be valued and developed in creative ways. These benefits have been weighed against limited choices under all four options for this specific local context, with achieving outcomes used as the measure of success

The requirement for good quality, flexible social care will continue to increase in the context of an ageing population. We are likely to need increasing levels of support to allow individuals to live independently and in their own communities. It therefore seems important to celebrate this good example of home care and the way that NHS Highland have worked with providers and with community leaders to create new models. These new models for rural areas have since been used to strengthen home care in Highland's urban settings using the Buurtzorg model. Buurtzorg is a Dutch model of neighbourhood health care⁶ which has gained popularity in the Scottish context⁷ as a means of delivering personalised care and support and at the same time maximising the autonomy of those delivering community health and social care services. The Buurtzorg model is also being developed in Scottish Borders and Angus, areas which have struggled in providing rural home care, as has East Ayrshire despite a very strong commitment to SDS implementation.

Key Findings

- We found evidence of supported people gaining more choice and control over their lives and care across all the areas that took part in the research
- These examples can be used as a basis for shared learning across Scotland
- There can be no doubt about the capacity for SDS to enable people to live their lives in ways that they choose and to open up far greater flexibility, choice and control.
- There is a need for far greater consistency across Scotland and across different groups of people.
- Our research supports the view that the aspirations of SDS are very ambitious. Such a scale of change requires systemic management.
- Where frontline staff perceived visible management support at all levels there was greater and more coherent progress reported.
- In-house mandatory training combined with ongoing

peer support allowed staff to work in new ways to deliver the aspirations of SDS.

Outcomes of SDS Implementation

Research of this scale, speed and design does not allow for detailed analysis and generalisation. We cannot confidently state that overall supported people across Scotland, or in any one local authority area, do have access to greater choice and control through the mechanisms of SDS. We might assume that in areas where greater progress has been made in implementation there are more people benefitting in this way. However, we simply cannot know this from such an opportunistic approach to sampling and data collection.

We did, however, learn of many inspiring examples of hugely positive outcomes for supported individuals, relatives, unpaid carers, and wider families.

Case Example 3: Ian

Ian is a young man with a life-limiting and degenerative condition. He had a package of care at home both for personal care and social support. However, the carers who were providing both personal care and social support were not of Ian's age and did not share his interests. He became reluctant to use that support and found it very difficult to recruit like-minded people as personal assistants. So, Ian had support in place, but it was not working for him, particularly over the weekends.

Ian wanted to complete an HND. He was finding it difficult to consistently get into college because of his health condition. This was preventing him from making progress in his course. In order to do his college work, he needed access to a computer with specifications that he did not have at home.

Ian suggested that what he really wanted to do with his weekends was college work on a computer. It was something that he was completely passionate about and he was focused on graduating from college in his chosen subject.

Ian's social worker spoke with the college about the specific kind of laptop Ian would need. A request to divert Ian's social support funds into the purchase of the right laptop was approved. Ian's family members agreed to provide some personal care on weekends to make this possible for him.

It all worked out really well, the laptop was purchased as an alternative to social support, Ian finished his course, graduated and he was able to move on to further education.

⁶ <http://www.buurtzorgnederland.com>

⁷ <https://theknowledgeexchangeblog.com/2017/07/05/buurtzorg-reinventing-district-nursing-in-scotland>

Conclusion

This report demonstrates the sheer scale and complexity of change that the SDS agenda demands of services at a time of pressurised budgets, organisational change and high levels of demand. There may be understandable frustration with the pace and inconsistency of change across geographical and practice areas in Scotland. Findings from research into service user experiences of SDS reflect the challenge reported by our respondents of implementing the spirit of the SDS legislation into all relevant areas of practice and delivery. This extends beyond social work management and practice to areas of commissioning and procurement, finance, and legal practice. Making high level strategic changes in line with the SDS Act whilst training frontline and operational staff in skilled outcomes based practice is a goal that is yet to be realised across most of Scotland.

Almost all of the local authority areas taking part in this research described how important networking and shared learning was to the journeys their own local areas had taken. The Social Work Scotland SDS forum was cited by respondents as a valuable opportunity to come together with workers from other areas, to ask questions, and learn of creative initiatives. This report is intended as a contribution to that necessary but ongoing process of shared learning. Learning that will bring greater progress towards the goal of transformative change in social work and social care envisioned by the SDS Act and Strategy.

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