care inspectorate

Thematic review of self-directed support in Scotland

East Ayrshire 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 East Ayrshire we gathered the views of staff across social work, health and provider organisations. We carried out an online survey between 27 June and the 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 136 staff and the supported person questionnaires were completed by 16 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 two 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 relied on 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

Many people were being supported to achieve positive personal outcomes. Most of the supported people we met were positive about the difference self-directed support had made to their lives, including some who described it as having been transformational. The partnership's recognition of the key contribution that technology enabled care could make was helping provide good outcomes for a significant number of people. Staff and managers demonstrated a strong commitment to helping provide the best possible outcomes for the people of East Ayrshire. It had some good approaches in place for getting feedback from supported people about their outcomes and experiences, but it needed to develop a more systematic approach to capturing and making use of these on a more comprehensive basis

Evaluation – Good

Most supported people were very positive about the outcomes they had experienced due to self-directed support. Some described how it had helped transform their lives for the better. A number highlighted the flexibility of support options available to them and praised the alternatives to conventional support.

There were a number of issues raised by some supported people in particular about the impact of some of the processes for self-directed support. This included dissatisfaction about the length of time it had taken for personal budgets to be approved and whether the budget was sufficient to meet the individual's needs and desired outcomes.

The nationally reported data on self-directed support held by Scottish Government shows East Ayrshire performing positively on most, though not all, measures:

- the proportion of the population in East Ayrshire in 2016 receiving direct payments was well above the national figure
- there was a higher use of self-directed support options 1, 2 and 4 in East Ayrshire compared with Scotland as a whole
- whilst the proportion of the general older people population with self-directed support was above the national average, the proportion of frail older people was well below the average.

Across our inspection work, staff demonstrated a clear understanding of and commitment to self-directed support and how through good conversations they could help people identify what personal outcomes they wanted to achieve. Staff were often able to identify examples of where this had happened.

Managers at all levels demonstrated a strong shared commitment to achieving good outcomes for people. They recognised the importance of maintaining a partnership approach across different sectors, organisations and teams based on shared values. To help achieve this, the partnership made extensive use of personal stories based on the real-life experiences and accounts of supported people. These helped to bring to life the positive impact that self-directed support could have.

Technology enabled care was being very strongly promoted and developed by the partnership. It had introduced its smart supports programme with two self-directed support peer mentors and two technology peer mentors. They worked alongside staff and supported people and their unpaid carers to look at how technology could help support positive outcomes and experiences for the supported person. We saw a number of good examples of this.

In case records, we found that personal outcomes were being achieved in a positive fashion for almost all (92%) of the supported people and in a manner, which was in line with their wishes/agreed personal plan. The partnership's procedures and its assessment tool "My Life My Plan" had provided a strong basis for staff to practice in a way which was person centred and recognised supported people having choice and control.

The partnership needed to further develop how it recorded, captured and made positive use of data on outcomes as a result of self-directed support on both an individual and aggregated basis. It was not currently able to measure and report on personal outcomes being achieved via self-directed support to any great degree. the thinking differently team was leading on work to review "My Life My Plan" so that it could be used as part of the review process to measure progress in meeting the identified personal outcomes for supported people. We were advised this work was on track for completion by March 2019.

The partnership was taking action to improve how it was able to record and share information about the desired personal outcomes identified by unpaid carers. It had completed 50 carer support plans since the implementation of the new legislation on carers in April 2018. It was also about to implement an arrangement whereby carers centre staff would input relevant information from the carers statements onto SWIFT (the council's business management system).

The partnership had established an innovative approach to getting direct feedback from supported people and unpaid carers about their personal outcomes and experiences. They developed a quality checkers group made up of individuals who used services, family carers and people who worked in adult services. The quality checkers gathered feedback about the quality of service through individual meetings, focus groups and questionnaires. This included commissioned as well as directly provided services with information on the outcomes being achieved then being fed back to the partnership senior management team and managers from providers. East Ayrshire council's procurement strategy included a requirement for service providers to provide regular monitoring information on its delivery of agreed outcomes and community benefits.

The partnership recognised that some people and service user groups, for example, people with addiction issues or mental health problems might be seen or see themselves as less likely to engage with self-directed support. It had established a small pilot project to address this. Supported people involved in the pilot, described how it had helped to increase their self-confidence and determination to make other changes in their lives. Despite this approach, some staff and service user groups said that key processes and timescales could be off putting for people with mental health or addiction issues.

Recommendation for improvement

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

3. Getting support at the right time

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

Summary

Most of the supported people who responded to our survey or who we met were positive about the information they received about self-directed support and about the conversations they had with staff and third sector bodies. Most were also positive about being able to access the support they wanted, and they needed at the right time. The partnership had changed how it provided its initial response to people where the need for care and support had been identified. Its front door hubs provided an effective multi-agency means of engaging with people and linking them into community networks and supports. The partnership needed to improve its discussions with people about self-directed support options when they were in hospital and as part of the discharge process. Where supported people needed information and advice about self-directed support, partnership staff were generally attentive to this. The various independent support services in place, including the advocacy service, the carers centre and the brokerage network all made a positive contribution to providing information, advice and support to unpaid carers and to supported people.

Evaluation – Very good

The findings from our questionnaire of supported people were very positive. Nearly all of the respondents agreed that the four options had been discussed with them in a way they understood. In case records, we could see that in almost all (97%) supported people had had the opportunity of good conversations with practitioners about what mattered to them and the support they needed. We saw that the partnership had arranged for advocacy services to become involved when this was needed.

Positively, the partnership had invested in additional support for advocacy to meet demand created through self-directed support. It had also worked in close partnership with the community brokerage network since 2013 to provide individuals with independent and accredited brokerage support to design and arrange their supports. Supported people, their families and partnership staff spoke positively about the role and contributions made by the East Ayrshire advocacy service, the community brokerage network and also by the Ayrshire independent living network (AILN) which provided advice, guidance and a payroll and budget-management service.

The partnership had redesigned its front door approach and the multi-agency consideration of all new referrals which took place to allow for earlier and more holistic conversations to take place people where the possible need for support had been identified. Third sector partners said that a lot of good conversations took place at the frontline. Community connectors, based in GP practices, played an important role in these conversations. They were able to signpost individuals to

community supports, where appropriate, as an alternative or complement to statutory service provision. They were providing this service for more than 1000 people a year. Most supported people we met expressed satisfaction about the information they received and the discussions they had with staff when first in contact with the partnership.

Partnership and representatives from the independent support services were positive about the partnership's approach to self-directed support, and in the main, how it delivered this. Whilst able to identify that many supported people had benefited, they also said the experience for some people of self-directed support processes had not been good. An example offered was for people in hospital where conversations took place at a time of crisis, especially around hospital discharge with limited information provided about self-directed support options. The partnership said that its approach was to support people to return home from hospital (as an alternative to an inappropriate admission to a care home). More detailed discussions with supported people and their families about the self-directed support options would take place once the person had settled back at home for a few weeks. They said that this approach was more conducive to good conversations about self-directed support than a hospital ward environment. We considered that in line with good practice on hospital discharge planning, staff should look for opportunities to start having discussions with people about self-directed support at the earliest stage possible. This was, especially applicable where people had been in hospital for some time prior to their discharge.

The self-directed support finance team was very responsive, including home visits to supported people on occasions. Supported people regularly phoned them for advice, and they were generally able to quickly sort out the problem. The team was committed to making option two available to supported people. Their motto was "if we need to pay, we'll find a way". We saw examples of positive feedback the team had received from supported people.

Example of Good Practice

The self-directed support finance team
In 2013, the partnership recruited two self-directed support finance officers to provide peer support and develop its finance and business workforce in relation to self-directed support implementation. These staff also provided direct personalised and relationship-based support to people who used services and family carers by providing:

- One to one support to individuals, by telephone, emails and in their own home to develop their confidence and skills in completing financial return paperwork under Option 1.

- Flexible and personalised support for individuals and families to maximise their choice and control under self-directed support Option 2. The finance officers provided direct support to individuals to purchase goods and services agreed within their support plans. As the agent acting on behalf of the individual, the finance officers had the capacity and flexibility to facilitate this outwith complicated procurement and commissioning arrangements. This approach was believed to be unique within Scotland.

Until 2015/16 the facilitation of support planning costings, financial assessment and charging arrangements was completed by social work practitioners. However, partnership staff identified a need to separate finance and support functions. Their rationale for this was to streamline financial processes and free-up frontline time for outcomes-focused engagement and support planning. In 2016, to allow this happen the partnership created four finance officer posts who lead on all the finance related tasks for self-directed support.

We saw evidence of the positive feedback which the team had received from supported people, unpaid carers and frontline staff.

We were confident that the majority (71%) of supported people had the four self-directed support options explained to them. There was a well-developed set of guidance and procedures for staff on self-directed support.

The My Life My Plan assessment and support plan format provided a strong basis for staff to have discussions with people which were focused on their personal and social wishes and desired outcomes as well at their support needs. The peer mentors had a role in supporting, and where necessary challenging, staff if their practice fell below the expected standards for self-directed support.

Reflecting the partnership's well-developed approach and commitment to community planning, we found good evidence of a range of community supports having been developed, and of staff making the necessary connections so that they could signpost supported people and unpaid carers effectively. The front door hubs were a good example of the partnership's approach to early intervention and signposting.

Other examples of the kind of local supports which had been developed were:

- The Things Tae Dae social hub at Cumnock
- The Buns 'R' Us social enterprise group
- Movement2Music and Sing-a-long and Smile sessions

Another example was WG13, a centrally located resource in Kilmarnock providing an inviting environment for members of the public to visit. It provided a job coaching service and the connect call service which used volunteers to deliver one or two telephone calls a week to particularly isolated people in the community. It also housed the digital hub. It had a range of its supports and equipment on display. Members of the public could call in or visit to see and discuss the equipment or simply to seek advice on related matters

Nearly all questionnaire respondents agreed that they had been offered the right kind of information and support to help them understand how to direct their own support. In the case records reviewed, more than three quarters (76%) of the supported people had been given information and advice about the variety of self-directed support options available.

The partnership had developed a helpful range of information to support the implementation of self-directed support. This included information on the My East Ayrshire web portal. A lot of the information had been co-designed with partners. The East Ayrshire carers centre provided information and advice to unpaid carers and the carers we met spoke positively about this.

Some third sector staff and representatives did not think some of the partnership's existing information about self-directed support was as detailed and clear as it could be. We also noted that some of its printed information was now of an age where it could usefully have been reviewed.

Example of Good Practice

The community brokerage network
The community brokerage network (CBN) and the partnership had worked together to establish independent brokerage support for individuals who had been assessed as having social care needs that required an intervention and for which an individual budget was agreed. Practitioners were actively encouraged to refer individuals to the project where it was thought the involvement of an independent broker might be beneficial. Individuals could also directly refer themselves. The partnership provided significant in kind support to the network, including the use of accommodation for meetings/base from which it could work. It also seconded a member of the thinking differently team to provide project management to the network. Working together, they had also developed a Scottish Qualification Authority accredited training programme around brokerage for supported people and unpaid carers.

Supported people we met were very positive about the support and service the network provided. It had recently been awarded further funding from the Scottish Government to allow it to expand its service across Ayrshire

4. Impact on staff

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

Summary

There was a strong ethos across the partnership for the delivery of the principles and values of self-directed support, along with the desired personal outcomes for supported people and unpaid carers. This was evident with only limited exception amongst staff at all levels and across the range of partner agencies and organisations. It was very much the driver for the partnership's good performance on the delivery of self-directed support and was exemplified by the thinking differently approach and team. The partnership was well aware of the need for staff to be supported to practice in an outcome-focused and person-centred way. Overall, partnership staff were well trained in the principles and values which underpin self-directed support. They demonstrated they had the knowledge and competence to deliver self-directed support to supported people and their unpaid carers. The extent to which health and provider staff were involved in and felt confident in dealing with self-directed support could be improved.

Evaluation – Very good

The majority of staff responding to our survey (58%) agreed that they had adequate capacity to work in a person-centred way and that they felt confident delivering support to people through self-directed support.

The partnership's early implementation activity for self-directed support was informed by the learning and recommendations from the Scottish Government evaluation of the self-directed support test sites in Scotland. The evaluation from the test sites found that frontline practitioners felt frustrated and under supported with a top-down approach to self-directed support implementation. In recognition of this, the partnership created a workforce development support model that comprised of four complementary approaches; namely a peer mentor model, workforce development, learning and reflection focus groups and support for wellbeing and resilience.

The peer mentor model was established to provide ongoing coaching support to all areas of the workforce. The peer mentors were part of the thinking differently team which provided coaching and mentoring support to frontline practitioners to think differently in relation to self-directed support, personalisation, technology enabled care and carer support. The peer mentors provided a range of support to practitioners, including support in attending home visits, in having good conversations; creative person-centred planning and sharing good practice.

We met with all of the members of the thinking differently team, and were impressed by their energy, enthusiasm and commitment for the delivery of self-directed support and achieving the desired personal outcomes of supported people. The team was a very effective and highly energetic champion for the delivery of self-directed support. It acted as a catalyst for the delivery of self-directed support across the partnership.

Practitioners were very positive about the support they received from thinking differently team members. There was a strong positive culture among staff who felt that they had permission to act imaginatively in respect of the delivery of self-directed support.

All of the managers in the partnership, up to and including senior managers, had undergone a mandatory four-day self-directed support training session as part of the partnership's drive to implement self-directed support. The evidence was that through this training managers felt enabled to support their staff effectively with the delivery of self-directed support.

Some independent advocacy staff we met expressed the view that they were disempowered in respect of the personalised budget approval system and the level of budget assigned to the supported person. They said they were either not involved in this important process or were not involved until a very late stage.

Example of Good Practice

The thinking differently peer mentor model
Self-directed support peer mentors provided bespoke on-site coaching and support to frontline practitioners and managers. The peer mentors spent much of their time within operational teams offering advice/guidance, reflection support, practical support and at times a critical friend role. They facilitated regular drop in sessions and toolbox talks for frontline practitioners.

The thinking differently team was established in 2012 and had continued to evolve. It now included coaching/mentoring support to frontline practitioners in relation to personalisation, technology enabled care and support for unpaid carers. It also included two part-time carer peer mentors, two young carer peer mentors (all with current lived experience of caring). There were also three thinking differently co-ordinators who were leading on the development of creative and personalised solutions to support adults with learning disabilities and children and young people. It had a close relationship with the self-directed support finance team.

The team operated in a highly effective manner to drive, support, and champion the delivery of personalisation in East Ayrshire. The team was one of the key planks in the partnership's effective development and delivery of self-directed support.

5. Delivery of key processes

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

Summary

The partnership's commitment to self-directed support had resulted in a can-do culture and a desire to make systems work for supported people and their unpaid carers. The partnership had good systems to signpost people, where appropriate, to the wide range of local and mainstream support networks and services it had developed. There was a need to streamline, speed-up and make more consistent its processes and systems for resource allocation, including the approval of personal budgets. For supported people the partnership carried out comprehensive and good quality self-directed assessments. Support planning and review processes also operated effectively, in the main. Action was being taken to more effectively capture the needs of unpaid carers. Most staff demonstrated commitment to promoting positive risk taking by supported people as well as taking action to protect them from significant risk and harm. In the main, we found that supported people had a good level of choice and control over their care and support.

Evaluation - Good

In our questionnaire of supported people, 13 out of 19 people responded positively to the statement that "I found the self-directed support processes straight forward and easy to use".

The partnership used the national eligibility criteria for determining people's access to social care services. Some partnership and provider staff said that in the early days around the implementation of self-directed support, a lot of low-level support had been available. We saw evidence of this in our file reading where a proportion of supported people whose records we read had been deemed to have moderate, rather than critical or substantial needs. However, some staff said that the threshold for eligibility had increased more recently, limiting the extent to which social care support was based on broader needs as well as on personal care.

There was evidence that the local authority had considered whether supported people met its eligibility criteria and that people had been advised of their assessed eligibility level. From the referrals we looked at which had not proceeded to the provision of a personalised budget, signposting had been considered and discussed with all of the people concerned. This had reduced the need for formal service intervention for nearly all of them.

The partnership's early intervention and prevention approach had been a key driver behind its redesign of the front door to community health and care services. A single multi-disciplinary team of social workers, occupational therapists and support assistants based across two locations had been established two years previously to replace the access/duty teams for people looking to access services. This front door approach was designed to focus on reablement, personal strengths and assets and

to utilise community resources to provide appropriate support. A range of partners were involved in hub meetings. These had helped to free up care managers to develop relationships with people requiring longer-term support. As well as being cited as a good practice example by the Accounts Commission, the partnership's approach had been awarded silver in the 2018 UK-wide iESE (local government and public sector consultancy) awards under the transformation in health and social care category.

Staff at various levels and from the range of agencies spoke positively about the partnership's front door arrangements. These brought together all the relevant staff and allowed early decisions to be made about who was best placed to have the initial conversation with individuals and for this to happen at an early stage with a strong focus on community supports. In addition, community health staff were more involved in self-directed support considerations and discussions.

In our questionnaire of supported people nearly all agreed with the statement that "workers focus on my strengths as well as the areas I recognise I need care and support with".

For almost all the supported people whose records we read, we rated assessments as good or better; they experienced no delay with the completion of their self-directed support assessment, and they experienced a good conversation with the social worker or equivalent when they were assessed.

There was clear evidence in the My Life My Plan documents that they were underpinned by good conversations with supported people and their unpaid carers. At times, this could have been slightly fuller and more explicit, including the narrative on personal outcomes. For example, whilst for the majority (63%) of supported people there was evidence that they had the benefits of each of the self-directed support options clearly explained to them, the fact that the remaining third had not, indicated the need for improvement. The same was the true for the extent to which we saw evidence that supported people had been made aware of the personal budget available to them, where again for almost a third, this had not happened.

For the majority (83%) of supported people there was evidence their care and support were subject to regular review. In addition, most of the personal plans we looked at, we rated as being good or better and the majority (61%) of the records included a contingency plan for the supported person.

The partnership was taking action to improve its approach to meeting the aspirations and needs of unpaid carers. The need for improvement and action in this area was reflected in our file reading findings. Of the 60 supported people, 38 had an unpaid carer, of whom only 17 of appeared to have been offered a carer assessment.

The partnership had collaborated extensively with unpaid carers to develop the format and template for the new unpaid carers support plans. This impressed as a good example of co-production.

Our staff survey findings about the delivery of key processes were fairly positive with most respondents agreeing that systems, processes and tools are outcome focused and assist supported people to direct their own support. A similar proportion agreed that staff regularly review changes to support plans and choice options.

The partnership used a resource allocation system (RAS) for setting self-directed support personal budgets. This used the national eligibility framework categories to calculate an indicative budget allocation. Supported people received a greater number of points if they had higher needs (e.g. substantial and critical) and these were converted to an indicative budget by applying a weighting for each eligibility assessment domain and then a "price point" (£49 for over 65 and £70 for under 65). Some staff described how there were well established processes for varying the budget if individual needs required this.

There was an inconsistency in the systems for approval of the personalised budgets for adults under 65 and for older people over 65 years. Team managers could approve up to £30k personalised budget for older people, but all personalised budgets for adults under 65 had to be approved by the resource allocation group (RAG). Senior managers said that it's resource allocation system (RAS) when being established had taken some account of historical budgets. This had often reflected higher spend for younger adults with disabilities than for older people.

There were issues with the resource allocation group (RAG) including delays in the approval of individuals' personalised budgets or delays in approval due to requests for further information. Some supported people had not been aware of their personalised budget. Senior managers acknowledged that how it managed its processes for how personal budgets were discussed, considered and approved was a key area of its improvement agenda. This included working towards a level playing field for all self-directed support recipients.

For almost all (91%) of supported people whose records we read, appropriate consideration had been given as part of the assessment to how positive risk taking and protection was balanced between the person and the practitioner. We saw some good examples of how this had been approached. The My Life My Plan assessment framework incorporated a conversation and assessment in relation to feeling safe and decision making.

In our staff survey, the majority although not all staff agreed that positive risk taking was undertaken jointly between staff and supported people.

The partnership had a well-developed and mature approach to risk and risk management. Amongst other things we noted that:

- a protecting people learning and development framework had been in place since 2013
- 25 safe places (shops/facilities) in East Ayrshire had received training from local people with disabilities to understand their needs and rights to feel safe when out and about
- a legal solutions forum was held on a monthly basis to provide frontline practitioners and managers with support in balancing its duty of care with the right of individuals to make their own decisions about risk.

Whilst a lot of the material focused on risk protection, there was also a good recognition and material about the importance of positive risk taking and enablement. Staff demonstrated a good understanding of the importance of both and of the need for approaches which balanced the two. The partnership's approach and use of technology enabled care exemplified this. It had recruited two co-ordinators as part of the thinking differently team who provided intensive peer mentoring to staff, supported people and their families. It focused on the use of technology and how this could both promote choice and independence as well as providing elements of protection and keeping people safe.

The findings of our supported people questionnaire were positive with nearly all agreeing that their views about what mattered to them had been listened to and that they choice and control over their care and support.

In our file reading exercise, we found that almost all the supported people had choice and control over the kind of support they received. However, we found room for improvement in the extent that assessments, support plans and reviews were signed by and shared with supported people. This was disappointing as an earlier audit undertaken by the partnership had also identified this as an area requiring improvement.

A small number of older people who were in permanent residential care were supported by the partnership to leave residential care and return to their community. Although there were small numbers of such episodes, this was good evidence that the partnership was applying the values and principles of self-directed support to people in care home settings.

We met with workers from the national self-directed support training service (Scottish Government funded). They were very clear that they considered that the East Ayrshire partnership was well advanced with the implementation of self-directed support and a strong focus on the involvement of supported people and their unpaid carers.

The partnership had undertaken a couple of audit/self-evaluation activities which included a focus on getting feedback from supported people and the extent to which they felt they had choice and control over their support. In the 2014 self-evaluation, 91% of respondents said that the things which mattered to them were included in their My Life My Plan assessment. The 2016 "did we get it right" questionnaire also noted positive feedback around choice and control.

This was also reflected by the supported people we met, most of whom said they were happy with the level of control they had over their care and support. However, we also met a few supported people where this was not the case and who did not feel involved on engaged in decisions about the type and level of support they received.

Recommendation for improvement
The East Ayrshire partnership should press forward as a priority with its planned review and streamlining of its resource allocation processes for the approval of personal budgets for support people. In doing so, it should consider the views of supported people who have found the current processes problematic.

Recommendation for improvement
The East Ayrshire partnership should take action to ensure that:

- it records the discussions with supported people about the four self-directed support options
- it makes supported people aware of the personal budgets available for them and it records this
- it consistently ensures that contingency plans are in place for supported people
- it ensures and records that unpaid carers are made aware of their right to a carer's support plan.

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

We found a strong understanding and commitment to the development and provision of self-directed support in East Ayrshire. This extended beyond the social work service to other council departments, to provider and third sector organisations and to community groups. There was scope for this to be developed still further, especially amongst health staff. The partnership had a robust approach to developing supports and services on a community planning basis and one which reflected self-directed support principles. We saw numerous examples where this had resulted in supported people being able to access community networks and supports. The partnership provided helpful services and supports to older people, but needed to progress actions to ensure that older people had greater choice in the range of support available and that this was more personalised and flexible. Partners had developed a number of ways of obtaining performance information and getting feedback from supported people, but it still had more to do so that this is done consistently and comprehensively. There was a clear track record of involving stakeholders, including supported people and unpaid carers, in strategic and service planning activity.

Evaluation – Good

In responding to our staff survey:

- a majority agreed that there was a shared understanding across supported people, unpaid carers, providers and commissioners of what self-directed support is and how it works
- a majority also agreed that strategic planning, commissioning and implementation plans clearly supported flexible and innovative support
- fewer than half (44%) agreed that self-directed support performance information was evaluated and effectively drove improvement across services.

The partnership demonstrated a strong commitment to planning on a community planning basis with an emphasis on locality approaches and community empowerment. This approach was reflected by the vibrant communities service established in 2013 with the underpinning principle that the public service will work with and for local communities rather than doing to them. The service had supported the development of community led action plans, which were community owned and developed. These were now in place in 18 of the 31 identified communities in East Ayrshire. This approach was recognised in Audit Scotland's May 2018 best value assurance report for East Ayrshire which found that "The council empowers and helps communities develop the skills and confidence to deal with local needs and priorities."

Whilst recognising that there was still more to be done, the clear consensus from provider organisations and those providing advocacy was that there was a strong commitment to self-directed support across the partnership.

The partnership was committed to supporting children and young people as they moved in adulthood. The transitions forum, a meeting of social work and health managers and practitioners provided a positive forum for multi-agency planning for young people with disabilities in transition.

The partnership had taken a positive approach to Option 2 in addition to the standard approach (where the supported person choses the provider and the budget is held by the local authority). East Ayrshire's customised approach enabled supported people to choose to allow the partnership to act as their agent to manage their budget and support plan on their behalf. As part of this approach the self-directed support finance officers provided direct support to supported people to purchase goods and services and to do so without having to work within complicated procurement and commissioning arrangements. The partnership had instead co-designed a four-page contracts template letter with service users and unpaid carers detailing what they could expect from the partnership as well as their own responsibilities.

Supported people who were using Option 2 were very positive about their working relationship with the finance officers. In undertaking their monitoring role, the finance officers said they took a proportionate approach in line with the Chartered Institute of Public Finance and Accountancy (CIPFA) guidance. We considered that the partnership's approach allowed supported people and families to maximise their choice and control under self-directed support Option 2.

Commissioning staff were strongly committed to self-directed support principles and to supporting imaginative and person-centred approaches. The partnership had been working closely with the community brokerage network since 2013. This was an approach which combined help for people in deciding on what support they wanted and how this should be provided, whilst maximum use of natural community supports.

The partnership had historically been dependant on a small number of larger providers for its commissioned services for adults. To increase choice, it wanted to expand the number of service providers available for supported people. During 2016/17 a new framework for service providers for adults with mental health problems or learning disabilities had been developed. This was done in conjunction with the quality checkers, who arranged a user's panel and interviewed all potential providers further to the partnership's decision to tender for an adult services framework for Option 3.

We saw some encouraging examples of NHS involvement and commitment to self-directed support, but also some indications that this needed further development. For example, health practitioners were sometimes viewed by council and third sector colleagues as being more risk averse than other staff. The NHS was regarded as less visible than others, including the third sector, at some strategic levels and groups.

In 2016, the partnership integrated the self-directed support thinking different team, the SMART technology enabled care team and the performance and business support functions, including the dedicated self-directed support finance officers. This had significantly enhanced partnership and imaginative working across services and agencies, including statutory services, third sector organisations and local communities.

Older people were more likely than others to choose Option 3 for the provision of their support. Partnership staff and managers said this was because older people were comfortable and used to services (including care at home services) provided by the local authority. The council retained a strong commitment to its care at home service which had historically attracted positive inspection gradings.

Nonetheless, there were indications that older people may not always have been given as much information and choice about the self-directed support options as they should have been. This included older people who had been in receipt of care at home prior to the introduction of self-directed support and the extent to which they had subsequently had meaningful discussions about the options now available to them. Managers acknowledged this and said that in future, the reviews for these older people would include a full discussion about their wishes and the various self-directed support options. Its commissioning intentions also included a focus on increasing the proportion of care at home support provided by external providers. This should increase the level of choice available to older people.

The partnership's approach seemed to be largely based on an evolutionary process, coupled with some expansion in the choice of service providers. We had some concerns that it was likely to be some time before older people were able to benefit from the flexible and personalised types of support which younger people were already able to enjoy. The partnership had identified the need for it to develop a partnership provider statement as an area for improvement in order to further developing the diversity of provider support available. The statement needs to support service provision which is fully consistent with self-directed support principles and requirements.

A number of mechanisms were in place for getting feedback on self-directed support, for example the use of quality checkers as referenced earlier in this report. However, the partnership needed to develop the extent and range of its approaches for gathering information about self-directed support performance, especially in terms of meaningful aggregated data. The work underway to review My Life My Plan was designed to strengthen how personal outcomes and progress on achieving these could be better measured.

We looked at information about complaints during 2017/2018. Of the 124 complaints about social work services only three were categorised as relating directly to self-directed support. We were surprised about this low number, given the very high proportion of the social work service's core business which involves self-directed support. The views of supported people also suggested that levels of dissatisfaction with the delivery of self-directed support might be greater than reflected in the

complaint's information. The partnership said that any complaints received had been audited and that public information was in place promoting the right to complain.

Communities and supported people influence planning and commissioning. The partnership had positively engaged and involved supported people, the third sector and community representatives in its planning processes, both in general and also specifically on self-directed support. The chair and vice-chair of the thinking differently project board, a key strategic group, were the chairs of the brokerage network and the advocacy service respectively.

The partnership actively engaged with local people and communities in its planning processes. This included 10 "everyone together" events where over 800 people came together to collectively engage with practitioners, families and providers in discussing self-directed support and what it could potential achieve locally. It included input from local people about how self-directed support pathways could be streamlined and improved. A similar approach was taken as part of two place-based "hakathons" where local people were able to look at local opportunities for taking forward five key issues, three of which were relevant for self-directed support, namely, wellbeing and good health, loneliness and isolation and vibrant and empowered communities

Aligned to this approach was the development and piloting of participatory budgeting in Mauchline and Dalmellington where £20,000 was made available in 2015/16 to support the community led action plans and to fund a significant number of local initiatives. Since then participatory budgeting has been used in a further 12 localities.

Recommendation for improvement
Where the East Ayrshire partnership receives negative feedback or complaints about its provision of self-directed support, it should proactively consider whether these provide any opportunities to make improvements.

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

7. Management and support of staff

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

Summary

The partnership had worked hard over a protracted period to develop its overall capacity to deliver self-directed support. It had taken close account of the workforce related findings of the national test sites for self-directed support. This was reflected by its provision of a range of positive and comprehensive staff development activities. The partnership had put in place some coherent quality assurance processes for the delivery of self-directed support. The partnership's approach to managing and supporting staff was an integral part of its innovative whole system approach for its delivery of self-directed support for all of the citizens of East Ayrshire.

Evaluation – Very good

In our staff survey, the majority agreed that they had access to training which ensured they had the appropriate level of knowledge and skills to promote self-directed support. However, it was notable that the levels of agreement were lower amongst provider and health staff than social work staff.

The partnership had taken a proactive and strategic approach to developing its workforce in readiness for the implementation of the self-directed support legislation in 2014. It had given careful consideration to the findings of the national self-directed support test sites and it particular for the need for staff to be supported to practice is an outcome-focused and person centred way. It had developed a clear plan and strategic approach to supporting the workforce as a whole and, frontline practitioners in particular, in doing so.

There were four mains strands to its approach; an information and knowledge exchange; peer mentor on-site coaching and support; continuous reflection and improvement, support and supervision; and professional standards and registration

The partnership had successfully implemented a workforce action plan. This included a four-day management development programme and a two-day frontline worker development programme. Supported people and unpaid carers had been heavily involved in developing the latter.

We were impressed that the partnership had made the four days self-directed support and personalisation training compulsory for all of its managers, including health managers. Managers we met reported that this training had been effective in terms of educating and supporting them for the delivery of self-directed support.

Almost all of the partnership staff we met reported that the training they had, including induction on self-directed support was very good. Some occupational therapists from health had been trained (and had acted as the lead professional/care manager) in the My Life My Plan assessment framework and associated care planning methodology. However, according to some staff we met their involvement in self-directed support had been withdrawn by health managers because of time constraints. We considered this was a missed opportunity.

Social work and social care staff who were directly involved in assessment and self-directed support planning and engagement with supported people and their unpaid carers commented on the good support they received from their managers and from the organisations as a whole for their work to deliver self-directed support. As stated earlier in the report, the thinking differently team actively supported staff from across the partnership in positive self-directed support practice.

There was strong leadership and support from senior leaders within the partnership for mindfulness training. There was evidence that staff found this beneficial.

The partnership had developed a range of forums to provide opportunities for staff to reflect on and explore practice issues in relation to self-directed support. These included the self-directed support focus group which brought service managers and team managers from across the partnership to come together to discuss some of the more operational issues identified by teams, including by frontline staff. We saw this had a helpful focus on trying to identify solutions to practical operational difficulties.

The social work and social care leadership forum was chaired by the chief social work officer and routinely gave consideration to self-directed support and personalisation. The chief social work officer was the head of children's services and provided a cross cutting approach and opportunities for learning about self–directed support across both adult and children's services.

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

The partnership had a well-developed and robust approach to community planning which was consistent with and reflective of self-directed support principles. Leadership in general was strong as was the leadership and strategic planning for self-directed support itself. It had been taken forward very much on a partnership basis involving the range of stakeholders. The partnership was committed to working with local communities in the development of a range of community supports and services which would complement statutory services. Staff were encouraged to collaborate and to work in creative ways with supported people and to seek and respect their wishes and aspirations. There was a high level of awareness of the need to ensure a culture and support for the workforce to deliver self-directed support effectively and much had been done in support of this.

Evaluation – Very good

We found a strong correlation between the overall vision of the partnership and the principles of self-directed support. This was evident in the East Ayrshire community plan 2015-30 at the centre of which was the vision that "East Ayrshire is a place with strong, safe and vibrant communities where everyone has a good quality of life and access to opportunities, choices and high quality services which are sustainable, accessible and meet people's needs."

As early as 2013, the council as well as expressing its commitment to self-directed support also expressed "its recognition that some changes will be required across the council and the services we commission in order to implement it".[1]

Staff knew who their leaders were and saw them as being visible and supportive of self-directed support. They expressed confidence that the partnership wanted them to have the autonomy to be creative and use their imagination in their work with supported people. A number of comments made by senior management had become part of the culture, including that "there is yet to be a red line in terms of what cannot be done under self-directed support".

Respondents to our staff survey were positive about the quality of leadership. The majority (74%) agreed that leaders both in their organisation and across organisations were committed to the values and principles of self-directed support. A majority also agreed that leadership and strategy in their organisation facilitated a creative approach to the delivery of self-directed support. There was also a strong view that the leadership of change and improvement ensured that relationships between the care organisations and sectors were trusting and collaborative.

[1] November 2013 East Ayrshire Council: 'A Quick Word about Self-directed Support'

There had been a significant period of stability in the senior leadership group. At the time of our inspection, the council's chief executive, its chief social work officer, the chief officer to the integration joint board and the NHS associate nurse director had all been in their current or similar senior roles for more than five years. The political context within the council and the integration joint board was also relatively stable. The chief officer (who has a social work background) had a pan-Ayrshire lead role for primary care and unscheduled care which he was able to use with health colleagues to promote self-directed support principles and approaches.

The transformation strategy had a focus on empowering communities to be more closely involved in local service provision and enabling communities to share decision-making and jointly deliver services. The strategy recognised the need to challenge traditional approaches, to engage broadly to unlock collective knowledge, skills and experience to better serve communities. The council produced a regular newsletter, the buzz, which was distributed to every household with information on activities for children, adults and older people.

The partnership was making good use of personal outcome stories to spread positive messages and examples of self-directed support. Supported people were invited to attend key strategic meetings, for example, the thinking differently programme board to share their experiences.

A number of independent documents and reports contained numerous positive references to how East Ayrshire had approached the implementation of self-directed support. These included the Audit Scotland progress review and Social Care Alliance Scotland's 2017 report of national research. More recently the May 2018 Audit Scotland best value report for East Ayrshire had identified a number of significant strengths in the senior leadership of the council and in its partnership arrangements.

Our own scrutiny identified a number of similarly positive findings on how the partnership had taken an effective and leading role in promoting and delivering self-directed support. Key features were strong executive leadership in the council, community planning partners having a long track record of working well together, and a good history of joint working between health and social care services, which had been further enhanced under the integration joint board.

The partnership demonstrated that it understood the impact of continuous change on the wellbeing and resilience of the workforce and the need to support staff through change. In response, the thinking differently team had led on the introduction and use of mindfulness to support staff to develop their own personal resilience and a wellbeing culture. Eight staff had been trained as mindfulness teachers and over 300 staff had attended mindfulness events and programmes. We met some of these staff who commented positively on how this had helped them focus of their practice. They said they were now aware of the need to feel well to do well.

Example of Good Practice

The thinking differently programme board

The partnership established a self-directed support programme board in 2012. This was successful in terms of recognising the scale of transformational change, managing the implementation and ensuring systems and process were in place to meet legislative requirements. In 2016, the partnership replaced the programme board with the thinking differently programme board to drive forward the 'thinking differently' agenda which included self-directed support, technology enabled and carer support. It did so in order to bring together the programme management of these complimentary agendas that shared similar principles, values of choice, control, self-management and empowerment.

The partnership's key vision and approach were very firmly based on working with local communities to develop community resources, networks and resilience. It had a clear strategy and plan in support of this which was fully consistent with self-directed support principles. All the evidence from our inspection confirmed that the partnership had taken a very clear, strategic and real partnership approach to the provision of self-directed support and the impressive progress it had made across the board.

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