care inspectorate

Thematic review of self-directed support in Scotland

East Lothian local partnership report

June 2019

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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 are 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 Lothian, 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 questionnaire to ensure we got the perspectives of supported people on how self-directed support had shaped their experiences of receiving services. The survey was completed by 115 staff and the supported person questionnaires were completed by 19 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 seven supported people and 12 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 are so significant, or present such risks, that we give them greater weight. All evaluations are based on a thorough consideration of the evidence.

Definitions

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

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

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

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

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

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

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

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

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

2. Key performance outcomes

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

Summary

Supported people consistently experienced good outcomes that had a demonstrably positive impact on their lives. Staff were having good conversations that delivered choice and control to the majority of supported people and unpaid carers we met. Most of the supported people and unpaid carers we met were positive about the difference self-directed support had made to their lives although some found accessing it challenging. The partnership had laid some foundations to measure personal outcomes such as the 'quality of life questions' but this needed further development so that it could more effectively analyse personal and aggregated data across the whole system.

Evaluation - Good

Good conversations and positive outcomes were clear strengths of our inspection findings in East Lothian. Staff completing our survey and those we met during the inspection were confident that they were supporting people to achieve positive outcomes and there was evidence of this in our case file reading findings. Many supported people and unpaid carers were clear that they were experiencing flexibility, choice and control in their care and support and that this was making a difference to their lives.

This was supported by the local government benchmarking framework who ranked East Lothian first out of 32 local authorities for people being supported at home who were satisfied that the services and support they have received have positively impact on their quality of life.

While there was evidence of many good conversations taking place, people were not always clear about self-directed support and the four self-directed support options. The partnership had more work to do to raise the profile and increase understanding of self-directed support to ensure people could maximise its potential and be empowered to have choice, be in control and achieve increased personalised outcomes.

The partnership was challenged in measuring the outcomes being achieved. In 2014 the partnership had introduced a 'quality of life' tool that supported the measurement of broad outcomes relating to health, safety, money, control, people and life. This was to be used at the initial assessment and review stages of a person's contact with services. It laid a positive foundation for outcome recording and reporting. While the tool had potential there was little evidence that the partnership had developed the tool or had used it to support self-evaluation or drive improvement towards more personalised outcomes.

Some independent and third sector providers have been reporting progress against the achievement of individual personal outcomes. The new care at home framework (2017) helpfully introduced a balanced score card for providers which had a clear focus on delivery of personal outcomes. While it was too early to measure the impact of this it had the potential to support a more coherent strategy to address this across the whole system of care and support.

The partnership recognised they needed to better aggregate and analyse outcomes by modifying Mosaic, their client information system. The data programme board was taking work forward and useful foundations were being put in place to enable them to make quick, simple and helpful changes to improve the system.

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

Many supported people experienced good conversations and were afforded choice and control over their care and support, but key groups of staff were not as informed as they need to be. There were key points in people's contact with services where some staff were not yet empowering people with the information, they need to make informed choices and exercise control over their care and support. Community capacity building projects were helping to develop alternative, community-based networks of support and there was good collaboration with carers agencies, technology enabled care and community networks of support all designed to further embed a self-directed support approach. Pressure to get immediate care and support to people was outweighing a personal outcome approach in critical situations. As a result, some people were missing out. Independent advocacy was underused and could be better utilised to support people with self-directed support choices.

Evaluation - Adequate

Overall, respondents to the questionnaire that we issued to supported people were satisfied with their involvement in co-producing their care and support. However, the views of supported people we met during the inspection in face to face interviews in East Lothian were not universally positive indicating that there was still some way to go to embed the principles of choice and control across the partnership.

Some people reported that they did not have the right information at the right time to make informed decisions. Others did not know about or clearly understand their options under self-directed support. They told us they had been given contradictory information by different staff, or at different times, about what they could and could not use their budgets for.

Some people were frustrated when they had to give the same information every time they needed a change to their support. This was because of the way contact with services was managed through the community access team, which was the first point of contact for all social care enquiries, and social work duty systems. This was not supporting implementation of the principles of good conversations, choice and control.

Staff were confident that supported people had access to independent support services but evidence of their use in case file records did not support this view. There was inconsistency in the extent to which workers promoted independent advocacy. Supported people who may need advocacy to help them understand self-directed support and the four options were not always being signposted or referred to advocacy quickly enough to ensure they were able to exercise their rights to choice and control. The partnership was in the process of developing a local advocacy plan that outlined current provision, highlighted gaps in access for particular groups and plans to address them.

There was a range of positive service developments focussed on prevention and early intervention. However, staff we met who were involved in this work found it challenging undertaking early or preventative work as their priority was with situations deemed 'substantial' or 'critical' under national eligibility criteria. Most of their work centred on unscheduled care or crisis interventions and most support plans did not contain contingency measures which might have helped to address the need for more forward planning. Both the 2017 contract for care at home services and Option 1 risk enablement approach offered the opportunity to assess risk at an early stage and work much more flexibly with supported people who had fluctuating needs.

The extent to which people experience choice and control in their support was highly dependent on the understanding of, and approach taken by, the staff they met, particularly at early stages of their contact with services. Call handlers in the community access team signposted efficiently at the point of triage to a host of other agencies. Advice about wider community-based services was being provided through duty or through the social work teams.

Staff in the community access team were trained to handle and screen initial referrals for social work services however had limited knowledge of self-directed support. As a result, few people who were signposted to other services received self-directed support information and advice. This was a missed opportunity for the partnership to take a self-directed support approach with people at the initial contact stage with services and increase awareness of self-directed support amongst the wider community.

The community access team had no framework in place to analyse the demand, capacity and future needs from this service. It captured some quantitative but no outcomes data, limiting its ability to fully assess the impact the service was having on statutory services, wider community networks of support or the outcomes for people contacting the service.

The understanding of self-directed support among staff in the health service was growing but needed strengthened, particularly for hospital-based staff. The duty response and rehabilitation team and short-term assessment and rehabilitation team were integrated health and social care teams. These provided a good foundation for having early conversations with supported people and unpaid carers about self-directed support. However, conversations about care and support for supported people in transition from hospital to home or vice-versa were still mostly focussed around traditional support services like care at home. Staff said this was because of the pressure to get immediate and available care and support to people outweighed a personal outcome approach in critical situations. We considered that both health and social care staff should start having good conversations with supported people at these critical times, or as soon afterwards as possible when circumstances are more appropriate.

Achieving positive outcomes through implementing self-directed support also requires a range of services and support options to be available, known about and accessible. Community based support options were being appropriately developed. The partnership had funded neighbourhood networks who developed peer support in local communities to vulnerable adults with learning disabilities, physical disabilities and mental health issues. They effectively reported on personal outcomes to the partnership.

The partnership had also invested in carer organisations to provide additional support to carers including completion of adult carer support plans and the development of a carers local directory. These initiatives had driven up enquiries made to their services by carers and that earlier support was being provided as a result.

Technology enabled care is an innovative way of helping people to access alternative support options. The partnership was making good use of grant funding to provide helpful learning and development opportunities to a wide range of stakeholders. The wellbeing hub proposal was well developed and will be a dementia friendly centre of excellence that will enable staff training and awareness raising about technology enabled care and dementia. The facility will be available to carers, families and members of the public for specialist advice, support and community awareness about these issues. There was a strong focus on prevention and 'low level' support for those most at risk which was supporting the development of operational and cultural change in service delivery.

The lead for technology enabled care was being reviewed. The decision to withdraw or extend this will be significant in terms of capitalising and progressing the partnerships technology enabled care agenda.

The partnership was committed to providing supported people and carers with information and had established a number of platforms to promote their work. There were documents available through social work, council websites and social media forums outlining eligibility criteria and people's rights to self-directed support.

While this was positive results from a 2016 survey indicated that the partnership would benefit from improving information, communication and engagement. Supported people, unpaid carers and staff we met during the inspection continue to have mixed views about the quality and accessibility of information provided and varying levels of knowledge and understanding workers had about self-directed support.

Despite the partnership's recent refresh of their self-directed support information, their policy and procedures 'easy read' and pictorial information and leaflets these were not being easily accessed by all staff. This meant they found it difficult to convey key messages to certain service groups which was weakening the principles of self-directed support.

The partnership was planning to use innovative social media tool software to support sharing of good practice examples to wider audiences. Other use of social media options included links made with a local radio station and there was a firm plan to run 49 adverts focussed on self-directed support. These were promising initiatives, but it was too early to measure progress in this area.

Recommendations for improvement
The partnership needs to continue to strengthen supported people and unpaid carers understanding of self-directed support and the four options. This should include a review of their self-directed support information and how it is delivered to ensure it is as effective as it could be.

Recommendations for improvement
The partnership should use independent advocacy services earlier to assist with aspects of complex decision making around self-directed support options, choice and control.

4. Impact on staff

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

Summary

The majority of social work staff we met and who completed our survey felt autonomous, confident and supported. Independent and third sector responses were still good although not as positive. Responses about leadership also reflected confidence within the partnership. There were appropriate arrangements in place to express views, share, discuss and reflect on practice issues at events, workshops and individual support levels with managers. While there were examples of close working arrangements and a growing focus across the partnership on personal outcome approaches self-directed support was largely seen as a social work priority amongst front line staff. There was a helpful synergy between self-directed support and health person centred approaches. More work was needed to align the various personal outcome agendas across health and social work.

Evaluation - Good

Social work staff were mostly very positive about leadership of self-directed support and how they were implementing change and innovation. There were clear arrangements in place to enable, empower and support them in the delivery of self-directed support with manager guidance being routinely recorded in social work case file records.

Third and independent sector responses were good but less positive about the level of support for self-directed support within the partnership. The senior management team understood that self-directed support was everyone's responsibility and were working collaboratively to achieve this.

Stakeholder engagement events called 'the big conversation,' had been held to refresh the partnership's strategic vision. These resulted in constructive developments such as the refreshed contract for care at home services. Some providers offered positive testimony about the change to care at home services, reporting that increased flexibility was helping them to maintain and motivate their staff.

Self-directed support was still mostly seen as the responsibility of social work. Most health staff had yet to have the benefit of self-directed support training but there was, however, a helpful synergy between the principles of self-directed support and health colleagues' commitment to a person-centred health and care agenda.

Leaders were committed to nurturing a culture across the whole system where staff have good conversations with supported people about how they want to be supported rather than telling people what they need. While this was a strongly held partnership vision, more work needed done to deliver this message to staff in health services.

Staff were being supported to cope with change by attending ‘resilience in the workplace’ training. The council’s adult wellbeing staff survey results provided regular sense checks on the wellbeing of staff and questions relating to motivation and support were largely positive.

We did hear from some staff who were frustrated about aspects of their work which they identified as barriers to implementing self-directed support. For example, the social work assessment tool did not always lend itself to capturing good conversations. Documentation for reviews did not properly capture personal outcomes. Having to prove a person’s eligibility impacted on staff taking an asset-based approach to their assessment work and resources were scarce in rural areas making it difficult to arrange supports the way someone wished to receive them impacting on choice and control. Additionally, there were challenges around recruitment, particularly to third sector provider organisations.

Some staff told us these factors influenced their practice and held them back from having discussions about self-directed support and the four options for fear of building up false expectations. It adversely affected how some staff felt about self-directed support and the potential it has to deliver the principles of choice and control.

5. Delivery of key processes

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

Summary

A wide range of self-directed support information was available in various helpful formats but some stakeholders we met did not always find it easy to access when they needed it. Referrals for support were screened effectively through developing personal outcome focussed arrangements and supported people were being well informed about their eligibility for services. Assessments were of a good quality and proportionately reflected the needs for the majority of supported people. Refreshed delegated financial authority arrangements were in place and working well. Some people found managing direct payments challenging and overly bureaucratic despite the support in place to help. Information technology systems and key tools used to capture good conversations had progressed purposefully but needed to be modified to strengthen evidence of self-directed support conversations. Eligibility criteria was influencing staff to focus on deficits, but most assessments were asset-based and staff were working in a risk enabled way, supported by guidance and procedures. The frequency of reviews needed to be improved and measures put in place to address this. Overall supported people were well involved in their care and support and also in the development of strategic self-directed support shaping key processes.

Evaluation - Adequate

Staff at various levels and from the range of agencies spoke positively about the partnership's front door arrangements. A personal outcome approach was developing, and these were helping decisions to be made about signposting and what help people needed at an early stage.

While staff we met were positive about access arrangements some supported people and unpaid carers expressed less favourable views including access to information, consistency of key messages from staff and repeating their stories through community access team and social work duty systems.

Once through the contact system our supported people questionnaire indicated that the majority of respondents found the self-directed support processes straight forward and easy to use. However, some supported people and unpaid carers found accessing and managing options difficult. Direct payments were described as particularly challenging despite helpful services such as Lothian centre for inclusive living (LCIL)[1] and independent cash management services[2] being in place.

[1] Lothian Centre for Inclusive Living; is a user controlled organisation which supports disabled people, people with long term conditions and older people to live independently in their own communities.

[2] Independent Cash Management Services; provide financial support for Direct Payments, ILF funding and individual budget management to supported people through corporate appointee-ship.

Helpful partnership initiatives such as the introduction of the prepaid payment card, refreshing of key information and the independent advocacy review provided the partnership with helpful opportunities to address some of these issues and halt the diminishing numbers of direct payments.

The partnership used the national eligibility criteria for determining people's access to social care services and staff appropriately considered and applied it. For most supported people to access personal budgets they required to meet either the critical or substantial risk threshold. The case file records indicated that decisions about eligibility and personal budgets were routinely fed back to supported people and this helped to set the foundations for good conversations.

In our questionnaire of supported people nearly all agreed with the statement that workers focus on strengths and the areas they needed care and support with. This positive view was reflected in discussion we had with supported people and the assessments we read in case file records. This was an important finding because staff faced a dilemma between promoting self-directed support, an asset-based personal outcome approach and eligibility criteria, a deficit-based model.

For most of the supported people whose records we read assessments were consistently of a high quality and accurately reflected the support needs of the individual. The amount of resources provided as a result of assessment processes typically met the individual's eligible needs.

While good progress was being made in assessing and allocating the right level of resources to match supported people's needs more needed to be done to record fuller and more explicit narrative on personal outcomes. Less than half of the cases we read evidenced these conversations about self-directed support and the four options. This made it very difficult for the partnership to measure if personal outcomes were being achieved as a result of self-directed support and to determine the extent to which choice and control was being offered, met and delivered.

Mosaic offered a platform for staff to work within but needed to be more effectively used to record self-directed support outcomes following conversations between staff and supported people. Supported people had been meaningfully consulted by the partnership and played a key role in helping to co-produce core self-directed support documents and policies. Further engagement of this nature was needed to continue refining the tools which workers described as limited and clunky. Once modified they should more accurately capture self-directed support principles rooted in good conversations, options, choice and control.

In an attempt to improve planning and service delivery processes the partnership had implemented delegated financial authority in May 2018. Staff had found its introduction helpful. This had introduced greater clarity across systems for approving personal budgets. Social work and finance staff worked together to align processes including audit and finance more closely. Managers reported being more empowered to authorise budgets, promoting autonomy and more efficient commissioning at their level. A growing mutual understanding of personal outcome support planning linked to commissioning and budgets was also developing between social work and finance staff.

The delegated financial authority scrutiny group oversaw self-directed support performance information. At the time of the inspection the purpose of the scrutiny group was mostly to focus on financial and quantitative data. The group were appropriately evaluating the suite and style of reports being presented to the scrutiny group with a view to developing these to be more outcomes focussed. This group was well placed to oversee and maintain a clear balance between personal outcomes and eligibility criteria moving forward.

From reading the case file records we identified that fewer than half (25%) of supported people whose records we read who had been assessed for a personal budget were signposted to a range of other services and supports. This did not align with the more positive staff views about signposting in our survey results. Clearer recording of this in case file records would address this anomaly. It would also corroborate the partnerships commitment to their asset-based approach and promotion of community networks of support.

Reviews were evident in just over half of the case file records we read. Some supported people and carer groups we met were concerned about complex cases going too long without a review. Where supported people's needs changed, support plans were being routinely updated instead of undertaking formal reviews. This meant the partnership was missing opportunities to routinely assess risk and revisit good conversations about choice and control over self-directed support options.

Review processes were being considered as part of the transformation project with a number of recommendations made, including a service redesign, document review and investment of additional resources. Work was progressing with providers to establish a common methodology to provide a more systematic approach to reviews. The partnership had taken the positive step of agreeing to formally evaluate the changes made and were aiming to complete this by the end of 2018.

Almost all supported people had support plans in place but fewer than half (41%) were SMART. The combined effect of irregular reviews and limited personal outcome-based support planning restricted opportunities to review changing needs and supported people's regular engagement in their own care planning.

The in-house brokerage team had introduced an electronic system which mapped service provision from street to street. Capacity in the care at home system had grown as a result meaning they were better placed to accommodate flexibility, choice and control. But there remained significant challenges between promoting choice and control and the obvious temptation to deliver services more efficiently to people clustered closely together in neighbourhoods.

Looking at the partnerships own data they still had work to do in service areas traditionally more difficult to engage such as mental health. The partnership recognised the inconsistencies it had across the self-directed support options it offered. It was working hard to commission and deliver services through its transformation programme in a way that maximised supported people's control over their own lives across the whole system.

In the main, staff were being well supported to manage complex work. We saw evidence of this in our case file reading and discussions with supported people we met where positive risk taking and protection was being routinely considered between supported people and the worker. While this was positive some case file records, we read lacked the appropriate level of depth and analysis of risk proportionate to the needs of the individual which needs improved.

Risk enablement plans had been purposefully introduced by the partnership which supported people and workers to reflect on and manage risks associated with direct payments. The risk enablement form effectively ensured that risks to both the council and the supported person were considered from the supported person's perspective, balanced and managed. These were helpful measures the partnership had implemented that had the potential to begin reversing the declining numbers of people accessing direct payments.

Self-directed support and eligibility criteria guidance for staff had also recently been refreshed and these documents promoted a positive approach to risk and risk enablement for each self-directed support option.

Case file records and people we met indicated that most supported people were involved in good conversations that meant what mattered to supported people and unpaid carers was valued and respected.

Staff were identifying vulnerable adults early and assessing capacity promptly. This helped to highlight those who needed help from families or independent support organisations to make choices and take control over their care and support. Although not used early or often enough to help with self-directed support option choices independent advocacy was being appropriately used in later stages to guide supported people and carers through the subsequent challenges emerging.

Recommendation for improvement
The partnership should improve the frequency of reviews to better track personal outcomes, changing circumstances and option appraisals and mitigate risk.

Recommendation for improvement
The partnership should ensure they develop Mosaic and more accurately capture self-directed support conversations in case file records.

6. Policy development and plans to support improvement in services

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

Summary

The partnership had effectively communicated and engaged its stakeholders and promoted more flexible commissioning strategies. There was good evidence the partnership was attempting to stimulate the market and increase available provision although the changes were not welcomed by all supported people. Front line managers welcomed having greater delegated authority and this had resulted in increased transparency and accountability of decision making. While these were positive steps more focus needed to be given to balancing quantitative and qualitative performance data and using it to drive improvement across the whole system. The approach to managing complex cases was encouraging. Investment in carers was having a positive impact and growing awareness of self-directed support. High level strategic plans took account of self-directed support and linked well to transformation and cultural change programmes. There had been progress in getting a shared understanding of self-directed support legislation among the different stakeholders but there needed to be more consolidation.

Evaluation - Good

The partnership had responded flexibly to meet the challenges self-directed support has posed. A particularly promising development was the newly introduced contract for care at home services introduced in 2017 which introduced an Option 2 type personal budget model based on personal outcomes within their refreshed Option 3 framework. This presented an innovative alternative to the more traditional 'time and task' approach.

Under the new contract the partnership introduced a single service specification applicable to all ages, linked to the new national health and social care standards[3], which promoted greater equity of access to supported people and some providers we met said they liked it. Helpful quality control criteria had also been introduced to the contract requiring providers to meet high standards. This was a positive step towards ensuring good quality care and support services. Under this contract the council paid equal payments to providers over the year which allowed for fluctuation needs to be managed between them and supported people independently of social work. This promoted delegated authority, autonomy and trust with partners and increased control for supported people.

[3] The National Health and Social Care Standards; These ensure everyone is Scotland receives the same high quality of care across health, social care or social work services no matter where they live or the service you use.

Despite the well-intended principles behind this one of the consequences of the transition over to the new contract was that it limited the choice of providers for some supported people. If they chose or remained with a service not on the new framework their support could be more expensive, and they might have to meet the difference in cost themselves. There was evidence of good work by the partnership to mitigate the identified risks including a communication strategy and support from independent advocacy, but not all the supported people we met agreed that these measures were as helpful as they could have been.

To tackle waiting lists for services the partnership had helpfully introduced a brokerage team to streamline capacity and commissioning of service provision. They were attending collaborative allocation meetings with the providers on a two-weekly basis. But not all providers were engaged in this process. The partnership recognised this and was formally reviewing the situation to ensure these meetings were more inclusive of all parties.

Under the new care at home contract newly commissioned services were expected to consider signposting, reduce dependency on 1:1 care and support, and make the most of community resources. While this was a promising initiative aimed at strengthening community capacity it was too early to determine if this had made any impact.

The level of shared understanding about self-directed support across the partnership was not as strong as it could be amongst some staff, supported people and unpaid carers. However, more positively independent and third sector organisations we met during the inspection said they felt listened to and involved by the partnership particularly through effective conversations, engagement and monitoring of the new contract for care at home services.

The partnership had challenges gathering and using personal outcome performance data. Senior managers agreed more needed done and noted that the 'quality of life questions' that they had developed were too simple and needed developed to better capture personal outcomes. Internal social work audits were happening, but these focussed on case file management issues rather than on the principles of self-directed support.

The delegated financial authority group undertook some audit work but was focussed on spend, thresholds and approaches to allocating resources. More needed to be done to include personal outcomes in this activity and how they might be collected and reported from services across each sector.

The self-directed support project group was established in May 2017 to reinvigorate work which had lost impetus during health and social care integration. It had the potential to positively affect the staff views. The group had an action plan and requested update reports at each meeting. While the group had made good progress appropriately outlining their priorities the action plan was not SMART[4] and governance was not as strong as it could be. This meant tracking progress was not as cohesive as it could be.

[4] SMART; Specific, Measureable, Agreed, Realistic and Time Based.

The partnership took a positive approach to reviewing complex adult cases. This meeting was attended by strategic partners from across the partnership including housing colleagues. They considered people with high cost or complex needs. Although supported people were not there in person staff met with them beforehand and accurately presented their case in the context of the four self-directed support options. Discussions were asset-based, took account of positive risk-taking and rooted in the principles of choice and control.

Strategic oversight was good and considered in the context of the transformation programme for adults with complex needs. Health was not represented at this meeting, but the senior finance officer understood health budgets in the context of the integration joint board[5] and was sighted on their contribution. The finance role in this work and across new commissioning activity was very positive with a high proportion of the corporate finance team's time dedicated to social work and developing new ways of working. They had also re-branded staff as financial business partners to reflect the more cohesive cultural change emerging.

While many positives emerged from the complex case meeting, we did note in this and other focus groups the significant impact of supported people bridging financial costs. In complex cases the potential impact could equate to significant amounts where people chose providers outwith the new care at home framework. This could significantly impact on choice, control and limit options.

Over regulation was commonly associated with managing direct payments. Support organisations had been appropriately commissioned to help people, but processes remained complex and difficult to navigate even with support. The partnership had firm plans to introduce a prepaid payment card for supported people accessing direct payments. The prepaid payment card offered the partnership an opportunity to increase choice and control, promote positive risk taking for supported people and make Option 1 more attractive.

The East Lothian carer working group was tasked with promoting policies for carers and had a very good understanding of self-directed support. The partnership had appropriately supported a secondment from the carers of East Lothian[6] on to the carer working group. They helped them to develop their short break statement, re-design adult carer support plans and align the council's eligibility criteria to the carers self-directed support framework. This work combined generated considerably more conversations and contact with carers organisations about self-directed support options.

The partnership had a health and social care partnership communication plan in place and there were separate but specific plans for both carers and self-directed support. These helpful strategies had promoted some examples of constructive engagement. The partnership's carers working group had had some early conversations with locality groups to shape strategic commissioning plans. There were also a promising number of other third sector organisations being attracted into

[5] Integration Joint Board; NHS boards and local authorities have delegated the responsibility for planning and resourcing service provision for all delegated services to the IJB which then decides how it is going to use the resources.
[6] Carers of East Lothian; Support all adults in caring situations in East Lothian to get information and services to help them in their caring role, enhance their wellbeing and strengthen their collective voice.

East Lothian to join in the discussions about community capacity building opportunities.

Overarching 10 and three-year strategic commissioning plans were in place, as was a two-year health and social care partnership's transformation programme for learning disability and mental health complex cases. There was a clear focus on self-directed support and a personal outcomes approach in these high-level strategies and it was also positively embedded as a 'golden threads' running through the transformation programme.

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

Staff survey responses from social work staff about access to training were positive. Independent and third sector providers were also positive. Health staff were less positive with responses being more mixed. The partnerships approach to phase one of their personal outcomes training was well formulated and delivered an effective foundation from which to progress although this has not been fully capitalised upon. The strategic aspect of phase two plans was less evident but despite significant organisational changes self-directed support principles had been systematically embedded in training and development initiatives. Provider forums were accessible vehicles for sharing information and newly appointed staff from across the partnership were being directed to various self-directed support learning resources and opportunities. Despite some good collaboration between agencies and services in respect of training and development there needed to be more focus on developing an overall self-directed support specific strategic approach. Senior managers were focussed on this and had drafted their draft joint work force plan. Both this and the self-directed support project team's action plan priorities were frameworks that could take this improvement work forward.

Evaluation - Good

During 2013-15 social work services delivered phase one of a structured approach to personal outcome training across services centred on five day 'good conversation workshops' for assessment staff. The work force and Lothian centre for integrated living were involved in developing the content which was heavily focussed on the principles of the Act. In 2016 the partnership accessed funding from Social Work Scotland to run a reflective practitioners forum that was co-produced with social work professionals. This strengthened the phase one activity and both initiatives were well received at the time.

While the above had laid a sound foundation for the implementation of self-directed support, new arrangements that came into force with the integration of health and social care had unintentionally averted phase two of the training programme. However, the partnership identified and implemented alternative multi agency training some of which was delivered through corporate resources in East Lothian council and NHS Lothian. Importantly, this included leadership development programmes including the 'playing to your strengths' initiative. The model of workforce development has subsequently been tailored to support the strategic priorities of the partnership in relation to self-directed support over this period.

Positive examples of where this has occurred included work with Alzheimer Scotland, occupational therapists, the Thistle Foundation and palliative care redesign project amongst others.

At a time of significant organisational change, the partnership had demonstrated an ongoing commitment to the professional development of its workforce. However, while these initiatives and responses to our staff survey were generally positive, some stakeholders said they felt specific and coordinated self-directed support training had stalled. They would benefit from a more strategic approach to ongoing training and development for all staff groups.

There was an established providers forum that social work staff regularly attend to discuss key developments and East Lothian inclusion services had fully evaluated lunch time sessions for their staff. Lothian centre for inclusive living also provided a range of training to personal assistant employers, including employment responsibilities and community capacity building peer and carer groups support groups for people with disabilities.

Induction included staff helpfully visiting other teams across the partnership, so health and social services staff experienced aspects of each others ways of working including self-directed support. Self-directed support was also a feature in the social work mandatory Learn-pro induction module and was aimed at refresher level and accessible to staff in other sectors. Completion rates were appropriately being monitored. Learn-pro modules were also available and self-directed support principles were being weaved through other aspects of modular work on this system such as telecare.

Importantly, self-directed support policies and processes were comprehensive and had recently been refreshed providing a helpful guide for both new and experienced staff.

The partnership's draft joint workforce strategy promoted a personal outcomes approach and both this and the self-directed support project team's action plan provided the opportunity to plan and deliver shared learning and development more coherently. Performance management systems were also developing and beginning to highlight professional development themes which could potentially offer some strategic oversight of all self-directed support training needs when fully implemented.

Recommendation for improvement

The partnership should develop and implement a learning and development strategy to address the health and social care work force self-directed support learning and development needs.

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

Leaders showed a clear understanding of the requirements of the self-directed support legislation. The self-directed support vision, values and culture were generally well established across the partnership although progress was needed to engage and develop the understanding and role of health staff in delivering self-directed support. For a period of time, much of their attention had been taken up implementing health and social care integration, with the recent challenge of managing a number of changes to the senior management team. However, leaders were focussed on strengthening a shared understanding of self-directed support across the partnership and the key strategic policies were appropriately aligned. Overall, the partnership was collaborative, innovative and had designed and embedded numerous new ways of working all based around efficiencies, market stimulation and self-directed support principles. Their work would be boosted if there was a stronger focus on systematic feedback from all stakeholders to inform self-evaluation and the development of a personal outcomes performance framework. The self-directed support project team had done some good work since being re-established. But more needed to be done to strengthen governance across all the areas they identified for change

Evaluation - Good

Leaders at every level of the partnership had a clear understanding of the requirements of the self-directed support legislation. All staff groups supported this view particularly social workers when responding about leaders in their own organisation, but more work needed to be done to foster a stronger shared view on the front line across the partnership including health, independent and third sector organisations. This was particularly the case for frontline health staff who were more disconnected than most.

The partnership had introduced an implementation group prior to self-directed support being implemented. While this group lost impetus during the early stages of integration leaders had since taken the valuable step of reinvigorating a self-directed support project team in May 2017. This was in recognition of the importance of the delivery of the national priorities and taking forward the messages of the 2017 Audit Scotland report. The project team action plan had been appropriately shaped by these documents. It had clearly outlined the priority areas of work, but leaders acknowledged the promotion of self-directed support still needed to be accelerated to make up for the lost ground.

A previously stable senior management team had been subject to some recent changes just prior to the inspection but remained committed to their self-directed support vision, values and culture. While this level of continuity provided a promising platform for improvement more work was needed to raise awareness of self-directed support in the integration joint board. In time this would support a deeper understanding and more effective scrutiny of the personal outcomes approach.

The partnership's self-directed support vision, values and culture were appropriately consulted upon and set out in their strategic plans. These reflected a commitment to collaborative working. We saw some examples of this developing approach such as consultation events, new commissioning approaches and joint leadership events. Leaders were implementing new ways of working and developing key strategic roles to support the delivery of self-directed support. Importantly this included finance staff who played an increasingly central role in the development of self-directed support policy and practice.

While leaders were committed to self-directed support more work was needed to promote it within health services, particularly early intervention and prevention services. Senior managers acknowledged they were mostly working with people at a late stage (when in crisis) and needed to work with people at an earlier stage. They also wanted to strengthen their community response, increase support at the lowest level and divert people from formal services. There were some examples of well-established and effective services, but more work was needed to further develop self-directed support conversations in these areas. The role of health services is critical to self-directed support implementation across integrated health and social care services and leaders needed to do more to support this cultural shift.

The leadership of strategy within the partnership had undoubtedly facilitated a more creative response and approach to the delivery of self-directed support. They have progressed innovative, and nationally recognised measures including the consultation and refreshment of their Option 3 contract for care at home services. The partnership had sought feedback about self-directed support in the past using Lothian community care forum to undertake research about how people were using self-directed support. This was a helpful approach the partnership would benefit from routinely applying to elicit the views of supported people and unpaid carers. This will further benefit their approach to self-evaluation and developments of new initiatives and services.

The partnership had reviewed their care at home contract and operational processes for self-directed support. Leaders had also committed to a two-year change programme across the rest of its community services. To date this has proved an effective vehicle for re-designing aspects of their key processes. Staff and front-line managers benefitted from greater flexibility and empowerment. Audit, accountability and resource management were also much more closely aligned as a result. These measures left the partnership in a better position to deliver self-directed support but more work was needed to address the lack of a personal outcome performance reporting. The potentially valuable 'quality of life' questions provided the partnership with a helpful starting position that could be further developed.

The partnership had taken the valuable step of re-establishing the self-directed support project team to coordinate progress in respect of all the above. The project team had done well to scope the work needing done, members were committed, and work being undertaken was innovative. While these were clear strengths of the group there was a lack of clear leadership, coherent governance and performance reporting.

Recommendation for improvement
Leaders should embed self-directed support principles and practice in appropriate health services to nurture the culture of good conversations, choice and control equally across the partnership.

Recommendation for improvement
Leaders need to ensure that self-directed support principles, values and personal outcomes approaches are embedded in the work of key strategic planning and delivery groups, clearly reported and governed to evidence continuing progress.

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