care inspectorate

Thematic review of self-directed support in Scotland

Moray 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 Moray, we gathered the views of staff across social work, health and provider organisations. We carried out an online survey between 27 June and 13 July 2018, aimed at gathering the views of staff in relation to self-directed support. In addition, we worked with partnerships and invited them to coordinate a supported person questionnaire to ensure we got their perspective on how self-directed support had shaped their experiences of receiving services. The survey was completed by 117 staff and the supported person questionnaires were completed by 23 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 six supported people and 14 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.

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 which impact only on a small number of individuals but be so significant, or present such risks, that we give them greater weight. All evaluations are based on a thorough consideration of the evidence.

Definitions

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

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

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

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

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

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

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

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

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

2. Key performance outcomes

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

Summary

The partnership had made significant progress implementing self-directed support. Most supported people experienced choice and control in how they used personalised budgets and were achieving positive personal outcomes as a result. There were established approaches for getting feedback from supported people about their outcomes. Whilst the partnership collected some relevant performance information, it had more work to do to embed a systematic approach to capturing information about supported people and unpaid carers' outcomes and experiences across all services and demonstrate how it was used to drive improvement.

Evaluation – Good

Supported people and carers were clear that the partnership had made significant progress in implementing self-directed support and that this was making a difference in people's lives. For some people, relationships they had developed with their personal assistants had been transformative in delivering positive outcomes.

We met staff and managers who demonstrated a strong commitment to providing choice, control and support for people in achieving personal outcomes. They recognised that through good conversations they could help supported people and unpaid carers identify the personal outcomes they wanted to achieve.

Most supported people had choice and control over how they used the four self-directed support options and most people were achieving positive personal outcomes as a result of this. Significantly, where supported people experienced issues relating to capacity, for most supported people, this did not prohibit the individual's choice and control over their support. Supported people and/or their representatives felt listened to and that their views had been taken into account.

The nationally reported data on self-directed support showed high levels of direct payments in Moray. The proportion of the population in Moray in 2016/17 receiving direct payments was well above the national average. Older people were the largest proportion of people receiving self-directed support in Moray and this was above the national average.

Performance in direct payments was high compared with other authorities and was found to deliver good outcomes. However, there may have been a specific driver for this performance. There was less choice of services in rural communities which limited the self-directed support options available for some people. In some instances, this meant that Option 1 was realistically the only option that would deliver outcomes for supported people and unpaid carers. Supported people also experienced challenges in employing people or accessing bespoke services in more rural communities.

Most supported people were positive about the outcomes they had experienced through self-directed support. Some had experienced delays in receiving changes to their support and amended self-directed support funding and this delayed achieving positive outcomes.

Positively we found that in the majority of cases support provided to unpaid carers had led to improved outcomes for both the supported person and the unpaid carer. The partnership recognised that ongoing work was required to deliver improved outcomes for eligible carers across Moray.

While the partnership did not use specific outcome measurement tools, it had worked hard to develop assessment, support plan and review templates that had the capacity to record the extent to which positive personal outcomes were being achieved. They could also capture supported people's perspectives on the extent to which the self-directed support principles and values were being applied throughout the process. The tools were not yet consistently used across all service areas. However, we considered that they were a promising development which provided a clear opportunity for the partnership to gather and use meaningful individual and aggregated data about supported people's outcomes and experiences of self-directed support.

Managers were aware that they needed to further develop how the partnership better recorded and captured data on outcomes as a result of self-directed support on both an individual and aggregated basis. They had yet to routinely collate performance information relating to interventions for people across the range of support needs at all levels of complexity.

The partnership had a self-directed support steering group and this group had considered the purpose and use of existing performance measures around self-directed support options and personal outcomes. There was consensus that the data had not yet been used to best effect in driving improvement in performance and that performance measures and use of performance information should be reviewed. The partnership had commenced a review of its performance measures and this was being overseen by chief officers.

Recommendation for improvement

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

3. Getting support at the right time

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

Summary

The partnership had a well-established approach to managing the public's access to information and social care supports and services. Generally, this provided an effective approach to signposting and early intervention and prevention. The provision and impact of short-term focused interventions for supported people with moderate levels of need was particularly noteworthy. Overall, supported people knew about self-directed support and the options available to them and they had experienced choice and control over their care and support. Independent advocacy could be used more effectively to support people with self-directed support choices. The partnership demonstrated creative approaches to providing and disseminating information. There was room for improvement in planning for refreshing information and evaluating the extent to which supported people had good and timely access to quality information.

Evaluation - Good

In advance of the self-directed support legislation the partnership had agreed and developed an approach called The Moray partners in care (3 tier policy) (see appendix 1). This policy set out how it would manage the public's access to information about social care supports and services. This model reflected self-directed support principles. It placed a strong emphasis on having good conversations with people and identifying personalised outcomes at each tier of the policy. The aim was to ascertain the most appropriate level of intervention or signposting to community services for people at the first point of contact.

The access team was the first point of contact for all referrals to social care and community occupational therapy services. A personal outcomes and asset-based approach underpinned the work of the team. This team focused on prevention through providing information, advice and signposting to community and universal services (tier 1). There was short-term focused intervention available for supported people that needed immediate help in a crisis, reablement and regaining independence (tier 2). This included people with moderate levels of need. We considered that tier 2 was a promising and effective approach which essentially provided a front door focus on prevention and early intervention. This approach assisted with urgent and critical case work and with issues of capacity and flow through health and social care. For the majority of people supported through this approach, this had prevented the need for further longer-term formal service intervention. Positively some people with moderate needs accessed self-directed support options in the short-term as part of a personal outcome approach to prevention and rehabilitation.

Most supported people and unpaid carers were aware of self-directed support and knew the four options available to them. Supported people told us that their views and what mattered to them was respected by workers and that they had received the right information at the right time to allow them to make informed decisions about their care. Most supported people had experienced choice and control over the care they received resulting in positive personal outcomes.

Staff were confident that supported people had access to independent support services, including advocacy but evidence of their use in case files and the low number of referrals to advocacy services did not support this view. Without advocacy services reaching people when needed, the most vulnerable people may not be able to exercise their rights to choice and control over their care and support.

Case records indicated that overall, care support and individual self-directed support options were subject to regular review. Nonetheless, this was not the experience of all of the supported people we met. We heard of instances of reviews not taking place beyond an initial review of care and support and this was confirmed by staff we met. A few supported people expressed frustration that social workers did not always ensure proactive contact with supported people once their care and support was established. They told us that this had contributed to delays in reviewing care, support and their self-directed support options which in turn impacted their opportunity to make changes to options and/or support thereby limiting their choice and control.

The Moray partners in care approach and the implementation of self-directed support had encouraged a greater level of strategic engagement between the partnership, third sector and community resulting in the development of early intervention and prevention activities. We met a range of service providers who confirmed the partnership's strategic intention to continue investing in tier 1 and tier 2 services focused on providing early intervention, advice and information. This was working well in tier 2 services and we saw several examples of commissioned short-term outcome focussed work.

The partnership had taken positive action to promote take up of power of attorney within its approach to early intervention. We saw evidence of this within case records and in discussions with staff. However, the consideration and use of power of attorney powers was not well recorded.

The access team, the first point of contact, provided a range of verbal and written information. This was underpinned by a resource bank and a systematic approach to keeping up to date with the availability of the network of community support services. Less positively, this information was not systematically shared beyond the access team.

Notwithstanding the limited use of advocacy services; we were confident from our engagement with service providers, supported people and staff that most supported people had been offered the right kind of public information and support to help them understand how to direct their support or that of their family. A few supported people that we met expressed that public information about self-directed support could be more visible and that this may improve the take-up and impact of self-directed support.

Overall, however, the partnership was creative in its approach to developing and disseminating information. It established a social and micro enterprise development officer post in 2013 to stimulate micro markets within Moray. Central to the role of the social and micro development officer was informing communities and supported people about self-directed support and the variety of options and approaches available. Significant work had been undertaken with service providers in developing micro services to meet personal outcomes. This work included 'rolling roadshows', other public events and engaging with local businesses and third sector services. The partnership continued to support the development of micro businesses.

The partnership had developed a personal assistant finder website to provide supported people with easy access to information about employing personal assistants. While not without its challenges, the personal assistant finder service was a positive initiative designed to assist supported people to identify and employ personal assistants.

In response to the Audit Scotland self-directed support 2017 progress report, the self-directed support team undertook some self-evaluation activity, following which the partnership noted its intention to develop an information portal. This work had not been shared across the partnership, for example, the access team had not been consulted about this work and was unaware of the intended development.

We found varying views from staff about the quality of self-directed support public information, including variation in the extent to which providers themselves offered information. The partnership was committed to providing and reviewing good quality public information about self-directed support. There was room for improvement around governance and planning for refreshing information. There was also potential to improve evaluation of the extent to which supported people had good and timely access to quality information across Moray.

Recommendation for improvement

The partnership should ensure that supported people have access to independent advocacy when they need it to support 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-focused and person-led way

Summary

Social work staff had a solid understanding of the values and principles of self-directed support. The majority of staff felt motivated and supported by managers to work in a personalised way and expressed confidence in exercising professional autonomy in the delivery of self-directed support. The self-directed support team was a valued and important source of support and advice for staff across the partnership. Members of the team were highly motivated and knowledgeable about self-directed support. Social work and social care staff felt well supported by this team. Health staff had less visible and active roles in supporting self-directed support. Moving forward, work was required to further develop and use health staff to support the delivery of self-directed support.

Evaluation - Good

Social work staff had a solid understanding of self-directed support principles, including the importance of signposting. Staff valued the individual advice, support and training they received from the self-directed support team. They were confident about having positive conversations with supported people about what mattered to them and around self-directed support options. Providers that we met were also aware of the self-directed support principles and how these were implemented in practice.

Knowledge and understanding of self-directed support values and principles extended to other staff groups and there was evidence of collaborative working across partnership services. For example, commissioning, finance and business support staff had, over time, developed a good understanding and positive approach to self-directed support principles and worked to make systems reflective of this. Alongside this, operational staff understood that they needed to ensure that relevant information was recorded to support the whole system to deliver personalised budgets and support the effective delivery of self-directed support.

Advanced practitioners were deployed across services; their roles had developed differently in response to the services in which they were based with some providing professional supervision to staff. The advanced practitioners we met were confident in their knowledge of self-directed support and were well motivated and experienced practitioners. They continued to work as practitioners and experienced workload capacity challenges which impacted the extent to which they were able to fulfil some of the planned aspects of the post. This included sufficient time to mentor staff and provide them with opportunity to reflect on their practice.

The partnership identified supervision as a key means by which managers received feedback on self-directed support practice and provided support to staff. Both the access and self-directed support teams spoke positively about the support and supervision they received. As indicated earlier in this report, the partnership had deployed the Moray partners in care (3 tier policy) across the partnership. This approach was embedded across health and social care partnership, provider and community services. It therefore supported delivery of self-directed support principles and values in practice by health and social work staff.

While health staff applied the three-tier policy which was in line with the values and principles of self-directed support, they were less confident about the detail of self-directed support. It was evident that there was a gap in awareness and training for health staff to equip them to support the delivery of self-directed support. The partnership had identified the continued roll out of self-directed support awareness in a multi-disciplinary setting as an area for improvement but had yet to set out their approach to achieving this.

Recommendation for improvement

The partnership should develop health colleagues' knowledge of and confidence in self-directed support to enable them to support its ongoing delivery.

5. Delivery of key processes

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

Summary

A range of self-directed support information was available for stakeholders. The Moray partners in care (3 tier policy) provided a good structure for responding to needs in line with the principles and values of self-directed support. This 3 tier approach was widely understood and embedded across health and social care services. The partnership had worked hard to develop assessment and support plan templates that could effectively reflect self-directed support principles and practice. We saw good evidence of these working in practice, including a high proportion of good quality assessments and outcome focused support plans. The partnership needed to ensure that reviews took place consistently for supported people. Social work staff understood the value of positive risk-taking and felt supported by their managers to manage risk effectively. Overall, we found that staff, especially social work staff employed an asset-based approach with people though this could be further developed in services for older people.

Evaluation – Good

On the whole supported people found self-directed support processes in Moray easy to use. The majority of supported people had positive experiences when accessing support. The partnership used the national eligibility and priority framework. This was open and transparent with the majority of supported people being advised of their assessed level of eligibility and priority. We saw good evidence that signposting had been considered and discussed and the majority of people experienced positive outcomes from this.

There was pressure on the capacity of partnership staff to respond to tier 3 referrals which provided ongoing support, potentially through a personalised budget using one of the self-directed support options. We noted that some changes had been made to try and better manage people repeatedly in contact with the access team. This may have assisted with the smoother operation of this team but may have inadvertently resulted in longer waiting times for allocation for a tier three response for full assessment, planning and support.

There was clear evidence that the partnership was committed to an asset-based approach, but this had yet to be fully embedded. Further work was required to strengthen an asset-based approach in older people's services. Some service providers also acknowledged that implementing and embedding an asset-based approach was a continuing area of development for their staff.

An important element of the learning disability service transformation approach was increasing individuals' choice and using an asset-based approach in supporting people to achieve positive outcomes. The emphasis on an asset-based approach and positive risk taking genuinely seemed to facilitate maximum choice and control for people with learning disabilities.

The partnership had worked hard to develop an assessment and care plan template which could effectively reflect self-directed support principles and practice. The new care, support and treatment plan which had been developed by the learning disability service further strengthened this approach and had the potential to be rolled out to other service areas. In the main there was good evidence of these in the case files read, including a significant proportion of good quality assessments and outcome focused care plans

Whilst the majority of the personal plans we read were rated as good or better, there was room for improvement in the quality of personal plans. For example, contingency arrangements were evident in only a few records (12%). There had been a lack of proactive consideration given to contingency planning and this remained an area for improvement and one that was missed in the work to develop the assessment/care plan templates.

Carer assessments had been offered and accepted in the majority of the case records that we looked at and the majority of unpaid carers had an adult carer's support plan. The support provided to the majority of unpaid carers allowed them to continue caring for the supported person.

The partnership used a resource allocation system that identified an indicative budget. They used the same self-directed support self-assessment questionnaire for every supported person to calculate the indicative budget. Budgets were mainly authorised according to the assessment and self-assessment questionnaire, and staff reported that the processes were set up effectively.

There was variation in the process of approving budgets across partnership services. Budgets and support packages provided by the learning disability service were considered at a resource allocation group. Budgets for all other services were approved via the line management structure. Delegated financial authority was provided at varying levels of authorisation for head of community care, service managers and team managers. There was transparency around budget approval arrangements. Budgets levels were consistent across different care groups and were allocated without delay.

We concurred with managers' views that indicative budgets were "set at a level that most people should be able to make good choices over how to spend it". There was mixed evidence about whether or not people had enough information about their budgets thereby potentially impacting opportunity for choice and control. The partnership had work to do to evidence discussions with supported people about their allocated budgets and how this would be used to direct their support creatively and flexibly.

A self-directed support panel considered consistency and transparency around budget decision making across teams. This provided an opportunity for reflective learning. The partnership self-directed support steering group monitored the effectiveness of the resource allocation process.

The partnership had some mechanisms for seeking feedback from supported people on their satisfaction about the level of choice and control. Partners knew that they needed to provide more opportunities for supported people and informal carers to provide feedback on the quality of the service or support that they received and their experiences of self-directed support processes.

The partnership used Carefirst client information system and recognised that its functionality had become increasingly limited in support for evolving self-directed support practice. The partnership was considering options around an alternative client information system, but this was at a very early stage.

Whilst there was evidence that most supported people had choice and control over the kind of support they received, there could be delays in care at home packages and personal assistants being sourced, especially in some remote rural areas. This was largely due to available workforce and capacity issues. There was evidence that the personal assistant finder website, despite some limitations, had helped supported people to find and recruit personal assistants and carers.

While initial reviews were taking place consistently, subsequent reviews were not happening with the frequency that they should have. This appeared to be a problem in most service areas and in particular the east and west long-term teams. If a supported person or their unpaid carer was struggling this was unlikely to be picked up by the service unless the individual or family proactively contacted the service or the situation reached crisis point. This limited the partnership's opportunity to identify and manage risks in a timely manner. It also had the potential to impact people's ability to control their care and support on an ongoing basis. People in receipt of direct payments were amongst the service areas where reviews had been delayed. The partnership was working hard to address this and had reduced the number of delayed direct payment reviews.

Most the staff we met understood the importance and value of positive risk taking and were comfortable in working with it. Staff felt supported by their managers to manage risk effectively. The corporate risk register acknowledged the importance of positive risk taking and senior managers were supportive of staff taking this approach.

We saw evidence of appropriate consideration about how positive risk taking and protection was balanced between the person and the practitioner in the majority of the case records that we read. We heard about examples of positive risk taking through individual service funds. The mindful designs project was an example of this. This micro-enterprise set up by three supported people, highlighted work undertaken around positive risk taking in partnership with supported people, health and social care services.

Determining issues with capacity is a key factor for informing risk assessment and risk management. We found that the partnership was particularly strong in undertaking capacity assessments in a timely manner consistent with supported people's needs. This was evident in all of the records that we read where the supported person required such an assessment.

The partnership move from a charging policy to a contributions policy was partly prompted by a desire to improve equality of access, and to promote choice and control and shared risk-taking. This, along with changes in the use of language, was a positive initiative by the partnership to support a cultural shift; for example, moving away from the concept of formal day care to considering co-productive and self-identified solutions.

There were still some cultural differences in the approaches to risk management and positive risk taking between some agencies, with some elements of the NHS seen as only tending to see risk in terms of trying to eliminate it. There was also work to do, to help some families and local communities understand the benefits of positive risk taking.

Recommendation for improvement
The partnership should ensure more explicit recording of discussion relating to self-directed support information, options and personal budgets.

Recommendation for improvement
The partnership should make sure that supported people and unpaid carers receive regular reviews of their care and support to maximise the opportunities for ongoing choice and control.

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

There was strong evidence that the Moray partnership had been working consistently since 2010 to understand, develop and implement self-directed support. The partnership's approach demonstrated commitment and innovation in seeking to provide and deliver flexibility, choice and control for supported people. There was a shared understanding across social work staff, commissioners and finance about self-directed support and how it should work. The partnership had a clear commitment to developing supports and services which reflected self-directed support principles. It had co-produced and piloted an approach to delivery of support under Option 2 and was building on learning from this to embed the approach in practice. The partnership was working within the constraints of rural geography and sought to find alternative solutions to provide choice and control for people. Its approach to stimulating market activity had resulted in a more varied range of services and micro-providers providing support in communities, but there were still limitations on choice for some people living in Moray. Performance information was not routinely evaluated and was not being used effectively to drive improvement across services.

Evaluation - Good

The Moray strategic commissioning plan 2016-19 specified the partnership's intention to fully embed self-directed support. The partnership provided three supplementary self-directed support implementation plans which had been developed and used between 2014 and 2018 and supported progress towards this goal. The Moray partners in care (3 tier policy); the design of assessment, planning and support templates; and the transformation of learning disability services using the progression model were all examples where self-directed support values and principles were embedded in operational planning and service delivery. The majority of partnership staff and providers agreed there was a shared understanding across supported people, carers, providers and commissioners of what self-directed support is and how it worked. Nonetheless, we considered that there was more work for the partnership to undertake in developing and achieving shared understanding of self-directed support across all stakeholders.

Commissioning staff were closely involved in the partnership's work in delivering personalised services and support. Commissioning, finance and business support staff had developed a good understanding of the objectives and benefits of self-directed support and worked hard to make key processes and systems supportive of this. They were active participants in the self-directed support steering group and were well versed in the principles and values of self-directed support. They worked closely with procurement and finance officers to ensure that new services and contracts were based on self-directed support principles, although they noted that

the council's standing orders on procurement still created some challenges for flexible procurement.

We saw examples of services that had been commissioned in a way that supported flexibility and innovation to meet personalised outcomes for individuals, including the development of micro enterprises that could offer support in personalised and flexible ways.

Learning disability whole system service transformation had afforded the opportunity for social work and health operational staff and commissioning services to work closely together. Through this there was a strong focus on designing personalised outcomes for people with learning disabilities with complex needs through the use of individual service agreements rather than time and task approaches. Collaborative relationships with housing providers were also evident in the redesign of services for people with learning disabilities.

There had been significant changes in approach to service provision since self-directed support was implemented in the partnership. Moray Council had decommissioned services and encouraged the provision of bespoke packages of care through stimulating potential within the provider market. The partnership had developed a market position statement in 2014 and a separate market shaping strategy for learning disability services in 2018. Both strategies were explicit in setting out opportunities for service providers and inviting providers to the table to discuss these opportunities. Staff and service providers confirmed this had stimulated the market and a significant number of providers had engaged in the market development discussions. A few service providers that we met confirmed that they had developed micro services as a result of the partnership's approach to market development.

The partnership had invested proactively in the development of early intervention and prevention services, such as the mental health wellbeing centre managed by Penumbra and the carers centre managed by Quarriers, with the access team supporting access to prevention and early intervention services.

The partnership had recognised that in keeping with the ethos of self-directed support, there was a need to afford greater choice, control and flexibility under Option 2. The partnership had explored ways to implement self-directed support Option 2 through undertaking a pilot project focused on devolving both the personalised budget and technical support planning to a third party through an individual service fund (ISF). It co-produced a process with a number of service providers to test this approach, including developing a memorandum of understanding between the individual service fund service provider, the Moray council and supported person or representative. Whilst the pilot involved small numbers, it had been evaluated positively with good outcomes being reported by supported people, staff and service providers. At the time of the self-directed support review, the partnership was using the learning from the pilot to drive forward individual service funds being managed by third party service providers with a view to embedding this approach within self-directed support practice.

The partnership aimed to shift the balance of care at home provision. The local authority was providing 60% of care at home services and it was aiming to reduce this to 20% with 80% being delivered by external service providers. This was a challenging target for the council due the lack of service providers, particularly in rural areas. The partnership was taking a number of actions at a strategic level to try and address this, for example, reviewing contractual arrangements and providing support for the development of micro-businesses.

The partnership had developed outcome focused contract monitoring in some learning disability and mental health commissioned services, but this had yet to be developed across all service areas and commissioned services.

The partnership had a financial monitoring procedure in place for undertaking financial reviews of direct payments. This was consistent with Chartered Institute of Public Finance and Accountancy (CIPFA) guidance. The partnership had worked hard to reduce a back log of financial reviews. This had released significant resources arising from underspend in personalised budgets. They were continuing to work on this and were moving towards quarterly financial reviews with supported people particularly in the early stages of a package of support. This would help supported people to manage their budgets and identify any problems with financial management at an early point when it was easier to resolve.

Performance information was not routinely evaluated and was not being used effectively to drive improvement across services. Senior managers were aware that performance information did not support robust evaluation of progress in implementing self-directed support. They had begun working on revised performance information and measures and this was being overseen by chief officers.

A number of activities sought to involve people and communities in the commissioning of services and supports, including:

- consultation with supported people about issues identified in the self-directed support steering group
- the involvement of providers through market facilitation exercises
- the annual survey of people receiving direct payments
- the learning disability open space event held in March 2018
- a service providers forum
- the self-directed support working group which involved service users and carers.

While these activities were valuable, they had yet to be underpinned by a communication and engagement strategy.

Recommendation for improvement

The partnership should establish a clear system for capturing self-directed support performance information and this should be evaluated and used to drive positive change and improvement.

Example of Good Practice

Mindful Designs Project
Health and social care Moray participated in the pilot light pathways, facilitated by IRISS and sought to explore the possibility of self-direct support budgets being used to create small businesses. To support this, a small business network was established in September 2014. A group of three individuals chose to explore the use of personal budgets to create a small business. The small business network provided information and support to develop their thinking. They identified a common business interest and explored this with the social and micro enterprise officer in conjunction with their respective social workers.

This project challenged health and social care Moray's internal processes and thinking around risk enablement and the use of personalised budgets to support positive personalised outcomes for the individuals through a shared small business venture. The individuals pooled their personal budgets and secured premises and equipment for their small business 'mindful designs' producing items with wood. The individuals came together with a shared purpose and provided peer support for their own health and wellbeing. Since this time, they have established a sustainable business, whilst using their business as peer support for their own health and well-being.

7. Management and support of staff

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

Summary

The partnership had invested in awareness raising and training staff around self-directed support in its early days. This had positively impacted workers knowledge understanding and confidence of self-directed support and how they practised. We found some significant gaps around current training and development for staff around self-directed support. The partnership had no training needs analysis or learning and development strategy which covered self-directed support. There was a need for a more strategic approach to providing ongoing training and learning and development opportunities for health and social care staff on self-directed support.

Evaluation - Adequate

The self-directed support team was the main vehicle for delivering training around self-directed support within the partnership. It was a valued resource and was integral to the provision of advice and support offered to staff about self-directed support. It was clear that the partnership had placed a significant focus on training for social work staff ahead of the implementation of the self-directed support pilot. This had positively impacted social work staff's confidence in promoting and implementing self-directed support.

Newly appointed staff met with the self-directed support team as part of their induction process. The team sought to undertake self-directed support refresher sessions with community care teams twice yearly. This team was responsive to learning and development requests from individuals and teams thereby supporting self-directed support practice.

Managers of integrated teams were confident in their knowledge of self-directed support. Social work staff were provided with supervision and felt well supported by their line managers and by the self-directed support team. There was a focus on reflective practice; however, workforce capacity limited opportunity for this to take place.

Health staff uptake of training ahead of the implementation of the self-directed support pilot had been limited. Evidence of ongoing self-directed support training for health staff was also limited. The lack of partnership self-directed support training needs analysis; self-directed support learning and development strategy and action plan was a factor in the lack of health staff visibility and engagement in self-directed support.

An organisational development plan and separate work plan underpinned the partnership's approach to supporting staff during transformation of health and social care integration. While the partnership's strategic commissioning plan 2016-19 had identified implementing self-directed support as one of the partnership's improvement programmes, there was a lack of detail around health and social work staff's learning and development needs to successfully achieve this.

Work had commenced on developing a social work training strategy linked to health and social care Moray and Moray council strategic objectives, but this was at a very early stage.

There was no overarching approach to self-directed support training across the partnership. While learning and development activity had been included in self-directed support strategic group implementation plans this was not underpinned by a partnership self-directed support training needs analysis, learning and development plan or training calendar. The most recent self-directed support strategic group implementation plan identified the need for refresher self-directed support and outcomes training for social work staff however the timeframe for completion had not been established.

The partnership acknowledged that it had yet to put in place strategic approaches for evaluating quality and impact of training and that it was working towards this. For example, senior managers told us that training delivered as part of the community learning disability transformation project would be evaluated, including the quality and impact of training. They planned to use learning from this project to inform future development of strategic approach to quality assuring training.

Recommendation for improvement

The partnership should develop and implement a learning and development strategy to address health and social care workforce 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

Senior social work leaders demonstrated commitment to self-directed support values and principles and had focused on personalised outcomes approach over a significant period of time. The partnership's shared vision supported the personalisation agenda and confirmed that continuing to embed self-directed support across services was a priority for the partnership. The self-directed support steering group, chaired by a senior officer and attended by a range of senior managers, set the strategic direction for the implementation of self-directed support. Implementation plans underpinned the work of this group but there was room for improvement in the level of detail in these plans. Early policy and practice development had supported self-directed support implementation and facilitated mainstreaming of self-directed support and personalised outcomes approach in social work practice. Cultural change had progressed well in social work services, but further work was required to bring health colleagues fully on board. The partnership had made significant progress with the implementation of self-directed support. To further develop this agenda, it needed to take a strategic and whole-system approach across health and social care to fully ensure implementation, evaluation and continuous improvement.

Evaluation - Good

The health and social care Moray strategic commissioning plan 2016-19 demonstrated a correlation between the vision of the partnership and the principles of self-directed support. The partnership's shared vision supported the personalisation agenda and confirmed that continuing to embed self-directed support across services was a priority for the partnership.

Senior leaders were clear that the principles of self-directed support were coherent with the principles of other agendas in health provision and that they remained committed to embedding self-directed support. The self-directed support team had delivered sessions to the integration joint board to strengthen understanding about personal outcome approaches and support cultural shift; senior managers recognised that this would be an ongoing process.

Senior leaders were highly motivated and enthusiastic about self-directed support; they understood the values and principles well. Leaders and managers valued and were strongly committed to facilitating creative approaches to delivery of health and social care support through self-directed support. The partnership had been pro-active in looking at best practice and engaging in national and local pilots and self-directed support was now the standardised approach for delivering social work services.

The majority of service providers and social work staff confirmed that senior leaders within their own organisations and across organisations were committed to the principles and values of self-directed support. Around half of health staff that responded to our staff survey also agreed with this.

The partnership had adopted a collaborative approach within and across organisations in delivering self-directed support. There was a significant focus on the role of the self-directed support team in providing information and improving awareness about self-directed support for both colleagues and within communities. Whilst this was clearly valued by staff and supported people, the partnership had not evaluated the effectiveness of its communication to all stakeholders about self-directed support.

The partnership had made significant progress embedding a personalised outcomes approach within social work and social care services and delivering the four self-directed support options within their Moray partners in care (3 tier policy). However, whilst health colleagues understood and implemented the Moray partners in care (3 tier policy), senior leaders acknowledged that there was more work to do with health colleagues in raising awareness and knowledge about self-directed support and implementing this in practice across services. This was consistent with our findings. We also noted that the Moray partners in care (3 tier policy) had not been reviewed since health and social care integration.

The self-directed support steering group set the strategic direction for the implementation of self-directed support. This was an active group which met regularly. It was chaired by a senior officer and attended by a range of senior managers, integrated service managers, finance, commissioning, and self-directed support team. The steering group was well supported by senior managers who oversaw key strategic and financial proposals. Implementation plans underpinned the work group however there was room for improvement in the level of detail in the plans which were not SMART.

It was evident that the partnership welcomed and supported change and improvement activity. Evaluation and improvement activity appeared to be on an issue by issue basis rather than being underpinned by a strategic approach. The partnership recognised that improving performance information would inform and support future developments in self-directed support and were working towards this aim.

Moray council had demonstrated early commitment to developing and implementing self-directed support within social work services. The partnership had taken an iterative approach underpinned by a clear strategic direction in developing and implementing self-directed support in Moray. The partnership continued to develop self-directed support in response to emerging challenges. Through this approach, self-directed support was integrated across the partnership's social work and social care services. They had been able to deliver flexible and responsive services that were designed to meet personalised outcomes.

While the partnership had made significant progress, it had work to do in improving the implementation and evaluating the impact of self-directed support across the wider partnership. Evaluating their approach to supporting health colleagues to develop their knowledge and confidence around the implementation of self-directed supported was an example of this. This was important moving forward to embed self-directed support across the partnership which was a priority for the health and social care partnership.

Recommendation for improvement
The partnership should regularly evaluate the effectiveness of communication about self-directed support and its impact within self-directed support delivery in the partnership.

Recommendation for improvement
The partnership should ensure that it takes a whole system strategic approach to supporting implementation, evaluation and continuous improvement of self-directed support across health and social care. This approach should ensure that partners are fully involved, and the partnership can demonstrate a shared approach to the implementation of self-directed support.

Example of Good Practice

The learning disability transformation project was a good example of a strategic approach to delivering whole system change with health, social work and wider partners.

Learning disability transformation change programme

Health and social care Moray learning disability service was undertaking a programme of transitional change with the aim of delivering better personal outcomes for supported people and ensuring that future services were sustainable in a challenging economic climate,

The partnership recognised that better outcomes could be achieved for people with learning disabilities through a greater focus on longer term life planning. The basis of the transformational change programme was the progression model which was a systems wide approach for working towards better outcomes, reducing future demand and service costs.

The delivery of the model required a systems wide approach that encompassed Moray health and social care community learning disabilities team, commissioning in its broadest sense and support of health and social care Moray. The transformational change project aimed to profoundly affect the culture and future approach to learning disabilities. It included:

- new ways of professional practice including the way in which professionals interacted with supported people and their families
- revision to the operational framework within which health and social care services operated
- changes to the role and models of health and social care Moray services
- introduction of improved systems for commissioning, including new relationships with commissioned services supporting a more effective operation of the commissioning cycle underpinned through personal budgets and self-directed support.

The intended outcomes from the project were aligned with the vision and outcomes identified in the Moray learning disability partnership board strategy. The work stream was successfully underpinned by a project management approach. At the time of the self-directed support review, 32 people with learning disabilities had experienced change to their living circumstances using an outcome focussed individual budget approach with care and support commissioned to meet individuals' aspirations.

Appendix 1

Moray partners in care (3 tier policy)

The Moray partners in care (3 tier policy) was one of the first joint policies adopted by the health and social care Moray integrated joint board. This was an asset-based approach involving outcome-based conversations at each of the three tiers to identify which tier was best suited to supporting individuals' desired outcomes. The approach was underpinned by five key principles consistent with self-directed support values and principles and national health and wellbeing outcomes.

The access team was central to delivery of this approach at tier one and tier two levels. This team demonstrated an integrated approach to their work with regular liaison with health and social work colleagues. Tier one focused on prevention through providing information, advice and signposting to community and universal services. We read 20 case records relating to individuals that did not receive a personalised budget and found that signposting was discussed with the person in 19 out of 20 records. The majority of case records evidenced that signposting reduced the need for formal service intervention. Staff that we met emphasised that signposting was the responsibility of staff working at all levels of the tiers and we found evidence supporting this assertion in just under half of the 60 case records we read where people had accessed a personalised budget via self-directed support options (tier three).

Tier two 'help when you need it' focused on immediate help in a crisis, reablement and regaining independence. Intervention at this tier was focused mainly on people that met moderate or substantial eligibility criteria and was short-term and focused on early intervention to promote independence. This tier essentially provided a front door focus on prevention and early intervention. It assisted with urgent and critical case work and assisted with issues of capacity and flow and for the majority of people prevented the need for further formal service intervention. Discussion with staff and case record findings demonstrated that some people accessed self-directed support options throughout this short-term involvement as part of a personal outcome rehabilitative approach.

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