care inspectorate

Thematic review of self-directed support in Scotland

Shetland 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 Shetland, we gathered the views of staff across social work, health and provider organisations. We carried out an online survey between 27 June and the 13 July 2018, aimed at gathering the views of staff in relation to self-directed support. In addition, we worked with partnerships and invited them to coordinate a supported person questionnaire to ensure we got their perspective on how self-directed support had shaped their experiences of receiving services. The survey was completed by 50 staff and the supported person questionnaires were completed by seven people.

We read the files of 59 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 three supported people and eight 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 unpaid 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

Staff were having good conversations with supported people and there was evidence of positive personal outcomes being achieved as a result. Supported people and unpaid carers described how the flexibility offered through self-directed support helped them achieve good personal outcomes. Choice and control was offered where possible but this was limited in Shetland where the market was only beginning to generate new models of support. There was significant use of personal assistants in creative roles to support a wide variety of activities linking people to family, friends and their wider communities. The partnership was at the early stages of gathering feedback from supported people on their experiences and outcomes in order to develop and improve services. The With You For You assessment template used by the partnership had the potential to capture personal outcomes. This was not yet being consistently completed making analysing personal and aggregated data difficult.

Evaluation – Good

The partnership had embedded a culture of positive practice whereby people's strengths and assets were considered when they first made contact with the social work service and as part of any subsequent assessment. This was supporting a shift towards a personal outcomes approach.

The availability of the self-directed support options and the ability of people to exercise choice and control were limited and this impacted on the extent that positive outcomes were achievable for some people. Support was delivered predominantly through Option 1, direct payments and Option 3, directly provided services. Option 2, to choose your own support was limited to a small number of supported people, most of who lived on Shetland's mainland, rather than the outer isles. Option 4, a mixture of the other three options, was occasionally used. Direct payments had been widely used before self-directed support was introduced and positively, the uptake of Option 1 had continued to rise.

To address the limitations on the availability of options the partnership encouraged positive responses to any realistic requests to meet personal objectives and outcomes via self-directed support. Under Option 1 there was a wide variety in how personal assistants were used and this supported good personal outcomes for supported people. Significantly, many personal assistants were used not only in direct care but in other creative roles such as supporting attendance at community-based activities, maintaining positive relationships with key individuals such as GPs and assisting with travel for supported people to meet with friends. Supported people commented on how this use of personal assistants reduced or removed any sense of social isolation by allowing them to enjoy a range of community activities

and supports. Supported people also experienced positive personal outcomes from the flexible use of funding for short breaks and activities of their choice. A number commented on how this had improved their health and well-being and/or had prevented crisis situations from occurring. Unpaid carers were mostly positive about self-directed support and the quality of care and support they could access.

Where we saw evidence and examples of supported people having choice and control over the kind of support they received, this included some people with more limited capacity for decision making.

Not all supported people were able to spend their personal budget, but the partnership was taking action to address this. This was because it was difficult to employ people in more rural communities due to high levels of alternative employment and the very low numbers of people living on some of the islands. The partnership faced long-standing difficulties in attracting third and independent sector providers to the Isles. Consequently, it did not have a provider framework to call upon to provide a range of models of care and support. This significantly curtailed choice and control for people in Shetland and had the potential to impact on people achieving their desired outcomes.

The partnership was taking steps to better capture personal outcomes for supported people. It had embedded the health and social care standards in its approach to self-directed support within its With You For You assessment template. A number of versions of this were in circulation which was confusing for staff. The most recent version had not been in use for long. This meant that reliable information about trends was not available and also prevented the gathering of consistent individual and aggregated information and data on the personal outcomes being achieved for supported people. The tool had shown early promise with a snap shot report on personal outcomes April 2018 – June 2018. The results looked promising and this version had the potential to more effectively capture personal outcomes

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

Supported people had a positive degree of control over how they managed their personalised budgets. Almost all of the supported people we met knew what to do if after time they changed their views on how they wanted to be supported and felt they had the power to do so. There was evidence of supported people and unpaid carers changing their support. Frontline social work teams actively sought to have conversations about self-directed support. Health and community resource services were not as involved as they should have been. The partnership had a helpful selection of information and guidance on self-directed support for the public. There was some frustration amongst unpaid carers and supported people that information and advice was not always available at the right time and that not all agencies had sufficient knowledge of self-directed support. There was a lack of clarity and consistency about how personal budgets could be used which impacted on people's choices and control. There was a dedicated self-directed support officer whose role and contribution in supporting choice and control were much appreciated by supported people, unpaid carers and by staff. The Shetland communities had strong local networks of support and staff routinely signposted people to these as part of their early discussions with them.

Evaluation – Adequate

Almost all cases files we read reflected that good conversations had taken place between supported people and staff. These had enabled a shared understanding about what was important to the supported person. Most supported people we met said their views were valued and respected by staff and that they were aware of self-directed support and the four options available to them. They felt that staff had discussed the options with them in a way they understood. This was not the universal view. A few supported people we met found their experience of self-directed support varied between different staff and different services. We heard from some supported people that staff were not always clear about the possible supports available.

We also heard about delays in referrals being actioned and that the conversations did not take place at the time when supported people most wanted them. Young people in transition from children to adult services and their families were amongst those who experienced such delays.

We found that supported people had effective control over how they managed their personalised budgets. Almost all of the supported people we met knew what to do if they changed their views on how they wanted to be supported and felt they had the power to do so. There was evidence of supported people and unpaid carers changing their care and support through discussions with staff.

The partnership sought to ensure those who were accessing support prior to the introduction of self-directed support were informed about self-directed support. Some unpaid carers we met had been made aware of the four options when they became available and were offered the choice of alternative supports.

There was a dedicated self-directed support officer whose role and contribution in supporting choice and control were much appreciated by supported people, unpaid carers and by staff. The role included helping supported people to manage what could be complex direct payment arrangements and associated tasks such as acting as an employer.

Some supported people had been helped at an early stage to consider the potential benefit of receiving independent advocacy support. While this was positive, advocacy services were not always available due to the level of demand. Staff were not always aware of advocacy services and its important role. This also impacted on the extent that supported people were able to access advocacy and benefit from it.

The Shetland communities had strong local networks of support and staff routinely signposted people to these as part of their early discussions with them. This also reflected a preventative approach rather than simply a focus on how statutory services could meet needs. The adult social work team had established link professionals for each locality to help supported people and unpaid carers to access local networks and services. Staff said this would also help families to be better supported to understand what they could and could not do with their care and support. It was too early to measure the impact of this development.

Unpaid carers found that peer support and local unpaid carers groups helped them to find out about self-directed support. Unpaid carer and peer support groups were not established in every area in Shetland and access to information varied as a result.

The partnership had made progress in working with voluntary organisations for them to support people in a range of daily activities. The use of technology enabled care options was also developing, including in the more remote locations. The ‘just checking’ project and the use of GPS and sensor pads were examples of this. Older people, and in particular in remote areas, appreciated the use of technology which allowed them to remain living in their own homes. Unfortunately, limited or variable internet access placed some limitations on the use of some technological supports as alternative models of support.

The partnership had introduced a personal assistant network. This had improved access to locum personal assistants for some supported people who were very positive about the benefits of having a personal assistant. They commented on how this reduced or removed any sense of social isolation by allowing them to enjoy a range of community activities and supports.

The partnership had some arrangements in place to measure its performance in providing early intervention. This was largely limited to some of its existing key processes, such as the timescales for undertaking assessments and providing services. The partnership had a useful selection of information and guidance on self-directed support for the public**.** This included information on the council's website, newsletters with examples of how self-directed support might be used and a booklet with detailed information about supports and services and how to assess them. This was widely available in offices and community resources. Information was available in a variety of accessible formats. There was a self-directed support newsletter which directed people to helpful advice, guidance and resources. Social work staff routinely sent out information to people having an assessment on self-directed support, including information about advocacy.

Unpaid carers found local groups linked to dementia and autism helpful in providing information on ways that self-directed support could be used. Most unpaid carers and supported people thought that they received helpful information. Although Voluntary Action Shetland had a part time worker dedicated to assisting with the set-up of direct payment packages some commented that there was no independent source of advice on self-directed support in Shetland. There was minimal information about the self-directed support process for unpaid carers with young people in transition.

More generally, we found limitations in the extent to which health staff had the knowledge to actively promote self-directed support with their patients. Health staff we met said they did not know much about self-directed support and a number expressed frustration that they could not prioritise this area of work.

We found some variation and inconsistency in what people were told about how they could use their personal budgets. For example, while variation regarding transport was based upon individual circumstances and agreed outcomes it was not always clear to the supported person on what basis this occurred. The partnership needed to ensure that it was providing consistent information and messages about self-directed support.

Recommendation for improvement

Independent advocacy resources and referral processes should be reviewed to ensure that supported people can access advocacy when they need it to discuss options and increase choice and control.

4. Impact on staff

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

Summary

Social work services staff were confident about having conversations with people about what really mattered to them. Staff knowledge and confidence about self-directed support diminished greatly away from frontline social work staff. NHS staff were generally less confident in dealing with enquiries about self-directed support and referred people on to social work. This resulted in a loss of NHS knowledge and perspective to the supported person at initial point of contact. Social work staff described self-directed support "as just what we do" and felt encouraged and supported by managers to exercise professional autonomy. They had a clear understanding of the principles and values of self-directed support. They were less confident about putting them into practice. There was a lack of clarity for staff working directly with supported people about the extent of any delegated authority they had. This impacted on their confidence in delivering of self-directed support. The self-directed support implementation officer had effectively supported frontline social work staff in engaging with people about self-directed support.

Evaluation - Adequate

Social work staff working in services for adults felt confident about having conversations with people about what really mattered to them, describing this "as just what we do". They felt supported by managers to respond positively to any realistic requests to meet personal objectives and outcomes via self-directed support. The partnership had encouraged this approach to mitigate the impact of the limitations of options available for support in Shetland.

Frontline social work staff received an appropriate level of support from managers. Case records showed evidence of discussions of social work practice within supervision sessions. There was an opportunity for the existing joint children and adult social work staff forum to have a regular focus on self-directed support, to support learning across the services. Senior social workers said that examples of good practice were being circulated amongst staff to raise awareness, but staff we met seemed unaware of this happening.

Staff felt encouraged and supported to exercise professional autonomy. Local authority staff felt supported in this by their line managers and the self-directed support Implementation officer who gave them greater confidence in promoting self-directed support.

NHS staff were generally less confident in dealing with enquiries about self-directed support and tended to refer people on to social work staff for a response. This resulted in a loss of NHS knowledge and perspective to the supported person at initial point of contact. Positive exceptions were some community-based health staff and those supporting early intervention. The partnership needed to do more to ensure that health staff felt confident in discussing self-directed support with supported people at an earlier stage.

The self-directed support implementation officer had effectively supported frontline social work staff in engaging with people about self-directed support. Staff were very appreciative of the support provided. However, we found that a significant proportion of staff had come to rely on this support and were not always developing their own skills and confidence in discussing and dealing with self-directed support.

Some frontline staff expressed uncertainty about the extent of the delegated authority they had to approve support plans and packages. Similarly, personal assistants said there was a lack of information and resources available to enable them to be clear about the extent of their role. They were uncertain who they could contact to access information about this. Overall there was a lack of clarity for the range of staff and personnel working directly with supported people about the extent of any delegated authority they had. This impacted on their confidence in their delivery of self-directed support.

The extent to which staff received feedback on their self-directed support practice to inform their learning and development was limited. Case records had been audited by line managers and this offered some support to frontline social work staff that key processes were being followed correctly. However, similar arrangements did not take place for health staff who had little opportunity to access training and development opportunities on self-directed support.

Recommendation for improvement

The partnership should improve staff knowledge and confidence in delivering self-directed support across every sector of the partnership to support the delivery of self-directed support.

5. Delivery of key processes

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

Summary

Social work staff took an asset-based approach to assessment and most care plans were of a good standard although access to support under the four different self-directed support options was limited and shaped by what was known to be available. self-directed support related discussions about options, choice and control were not routinely recorded in case file records and uncertainty persisted for staff and supported people about how resources were allocated and what these could be used for. Few supported people had contingency arrangements in place where having one would have been helpful. It was positive that once budgets were allocated supported people had effective control over how they managed their budget. People were effectively signposted away from statutory services and towards community-based supports. Support to people through independent advocacy was underused or subject to delays. The partnership had invested positively in the With You For You assessment format in consultation with staff and supported people and self-directed support principles were embedded within it. As well as staff in the social work fieldwork teams, it was beneficial that staff from the care at home service and care homes also undertook With You for You assessments.

Evaluation - Adequate

Our examination of case records identified solid evidence of people being signposted away from statutory services and towards community-based supports and services. We saw that this had reduced the need for many people to receive formal service intervention.

The partnership provided information and advice about the four self-directed support options. Supported people we talked to and who responded to our questionnaire confirmed that they had discussed the four options with staff and understood what they each involved. The evidence from case records was more mixed with less than half of case file records showing that the individual and/or their representative had been given information and advice about the variety of self-directed support options available.

We found that assessments were generally comprehensive, and of good quality. The partnership had invested positively in the With You For You format for assessment and staff were confident that self-directed support principles were embedded within it. As well as staff in the social work fieldwork teams, staff from the care at home service and care homes also undertook With You For You assessments.

The partnership had made some improvements to its assessment documentation. The new assessment tool was shorter, more person centred and encouraged analysis of the difference support had made. There was a need to improve the financial aspect of assessments as the tool used was very much linked to tasks and not aligned to the individual's desired personal outcomes.

Our findings on assessing need and on planning and delivering support were generally positive. Case records showed that the support received by supported people had mostly or completely met their needs. Almost all (98%) of the case file records evidenced that staff had taken an asset-based approach to their assessment. There was appropriate consideration of supported people's strengths and assets, including the existing supports the person had. The tone and the language used within reports reflected the principles of self-directed support. Individuals and their families had been involved in preparing their support plans. The Thistle Foundation had delivered the "making it personal" training for a number of supported people and unpaid carers groups, as well as for partnership staff. This had supported the development of personal plans.

Assessments completed by social work staff were shared effectively with other relevant parties, including the third sector, NHS and other local authority staff. This supported a joint approach across services to the management of risk. The intermediate care team played a key role in managing risk. The team was focussed on rehabilitation and promoting independence and had early conversations with families about risks including the importance of positive risk enablement.

The partnership had helpful information about positive risk taking which they shared in discussions with individuals, families, unpaid carers and other professionals involved. Positive risk taking was evident in almost all of the case file records we read where we saw protection considerations appropriately balanced between the person and the practitioner.

Less positively, reviews did not routinely consider risk which meant that an opportunity to evaluate any changing risks was being missed. When reviews were taking place, staff were often simply updating the existing support plan, rather than using the review process as an opportunity to refresh or complete a new assessment. More positively, a new tool to support a more personalised approach to reviews had been developed. Staff were still getting accustomed to using it.

Line managers were undertaking monthly case file audits using the With You For You quality assurance tool to quality assure the self-directed support referral, assessment and review processes. These audits were not linked to the separate performance management activity which provided senior social workers with information on assessments, caseloads and review activity.

There was confusion for staff about processes for budget approval. A panel system had been in operation until early 2018 but had been suspended due to the executive manager, adult social work post being vacant. The role of the panel system was under review. There was also variation in how resources were approved dependent upon the option selected and the type of service required. Options 1 and 2 cases were approved by the executive manager, adult social work, but Option 3 could be approved by senior social workers and team leaders. There was a need for greater clarity and transparency about decision making. The panel needed to be reviewed to ensure greater clarity, accountability and that the right resources were allocated to the right people at the right time.

The partnership used an "equivalency model" for setting personalised budgets. Our analysis of case records showed that for almost all the supported people involved, the level of resources provided met identified needs. The partnership had guidance which advised on equivalency for staff and supported people in what was included or excluded in budget allocations. Despite this, there was also a lack of clarity amongst staff about the operating systems to support this key process. To address these issues, the partnership planned to implement a refreshed resource allocation model in the near future.

There was a high reliance on, and usage of, Option 1 in Shetland. The fact that some of the islands had very small populations (as little as 50 people) meant it could be difficult to recruit personal assistants in some circumstances. The partnership sought to address this by working closely with the community councils to develop local solutions and initiatives. In addition, community care resource team leaders had been given the delegated authority to allocate and administer an amount of care at home hours.

Most case file records indicated that supported people had no contingency arrangements in place where one would have been helpful. Staff and supported people we met during the inspection acknowledged this. There was a high level of usage of personal assistants in Shetland and this was stretching resources in rural communities which increased the risk of service disruption. For many supported people and unpaid carers these risks were predictable to a degree and the partnership needed to develop more pro-active approaches to how it mitigates risks.

Personal assistants had important insights into how successful risk management plans and support packages were working. However, some told us they had not been asked for their opinions, when reviews were taking place, including their views about dealing with risk. The partnership needed to ensure personal assistants are consulted and their views are represented within reviews.

Social workers recognised the importance of identifying capacity issues affecting supported people and unpaid carers. Our review of case records showed appropriate attention given to ensuring that appropriate legal powers were in place whilst also minimising the extent that capacity issues impacted on supported people's level of choice and control.

Feedback from supported people and unpaid carers had led to the partnership changing the arrangements for providing independent advice and support. Some supported people had started to use a commercial accountancy and this arrangement seemed to be working well.

Recommendation for improvement
The partnership should ensure that budgetary allocation and decision-making processes are transparent, and that supported people are involved at all stages in key processes to enhance choice and control.

Recommendation for improvement
The Partnership should support staff to be more creative and innovative in their solutions to address risk and to increase the risk threshold to the benefit of supported people.

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 lack of external care providers limited choice for supported people in Shetland. The partnership had focussed upon developing support under Option 1, direct payments, and had established a personal assistant network. The partnership had formed a self-directed support project board, but this was at an early stage of development. Strategies implemented in the previous two years had improved social work staff knowledge and understanding of self-directed support. There was little shared understanding amongst business support and commissioning staff who knew little of the underpinning principles. Commissioning and implementation plans supported flexibility and innovation but these plans were not implemented consistently. The role of supported people and unpaid carers in developing self-directed support was at an early stage. The partnership had made some progress engaging with communities but now needs to scale up successes. Monitoring arrangements were poorly adapted to support the allocation of resources or the effective gathering of information to inform and drive improvement.

Evaluation – Adequate

Shetland faced particular challenges with no external providers in the third and independent sectors to deliver alternatives to partnership provided services. Shetland Islands council was the predominant organisation providing care at home, care homes and day care services. A care home for older people and a short break and respite support service for unpaid carers were provided through third sector organisations. The partnership had faced persistent difficulties in trying to attract more third sector and private sector providers to the Isles. It was investing resources in supporting community co-production and participation as its preferred alternative model of care in localities. There had been some good locality initiatives, but overall progress was slow to date.

There was a strong commitment to self-directed support amongst local authority social work and social care staff, personal assistants and organisations providing advocacy and brokerage. A detailed understanding and knowledge was evident amongst social work frontline staff, but was less prevalent amongst health staff.

The personal assistant network had effectively increased direct employment of support workers. Supported people who were members of the network were positive about directly employing a personal assistant and the flexibility this provided to their support. The personal assistant network was well established in parts of Shetland, although it was not available in all areas. It continued to encounter challenges in recruitment, with recruitment easier around Lerwick than in the most remote areas.

Support staff were in short supply in some areas of Shetland. This meant that supported people could be reluctant to change from an existing support type in case of potential difficulties in re-instating this, should the alternative not work out. Older people in particular were often reluctant to explore options other than the council's directly managed services because of this concern.

The challenges of recruitment within the Isles continued to constrain the development of co-produced services. The partnership was helpfully addressing recruitment issues in collaboration with Orkney and Western Isles councils. This collaboration sought to boost the economy and jobs to support the ageing population. However, it was too early to measure progress.

Most corporate finance, procurement and commissioning staff had a very limited understanding of self-directed support. This lack of understanding impeded the introduction of outcomes-based contracts and commissioning new services. In our staff survey less than half of respondents agreed that there was a shared understanding across supported people, unpaid carers, providers and commissioners of what self-directed support is and how it works. The partnership clearly had much work to do to achieve a shared understanding across the whole system of care and support to ensure that self-directed support informs the partnerships approach to developing new models of support.

The partnership had a suite of strategy, commissioning and community plans which reflected the principles and values of a personal outcomes approach but did not specifically reference self-directed support. This made it difficult for a wider audience to see how self-directed support was planned and commissioned.

The importance of building individuals' and communities' capacity was seen as a priority. The partnership had used community forums and a series of events involving local and third sector staff, user and unpaid carer representatives, and community leaders to inform the development of the partnership's strategic commissioning plan.

The partners in policy making programme, an In-control Scotland course, assisted supported people and unpaid carers to become leaders in developing local support. This was working effectively with members of the public now having a key role at community and strategic meetings. In addition, people who attended the partners in policy making programme were developing an independent support service with funding from Scottish Government. People who had input into the development of services and plans found that the opportunities to be involved in development meetings were increasing.

Supported people and unpaid carers were encouraged to attend events to broaden their awareness of local supports and resources. A small number of unpaid carers, linked to unpaid carers groups, attended key council meetings and the integration joint board to share views about self-directed support engagement and service delivery.

The partnership had recently created a self-directed support programme board, which was chaired by the executive manager for adult social work. It included unpaid carers who had completed the partners in policy making programme. It was intended that the programme board would address the planning requirements for self-directed support and drive forward its development.

The North Isles project had been established which sought to increase community capacity in the North Isles by redesigning health and social care services through community participation. It also aimed to provide an increased level of early intervention and preventative approaches. It had achieved some success, especially in the use of technology enabled care in supporting isolated older people. While the principles of the project were sound, staff were unclear about its role and purpose, despite considerable effort having been put into publicising it. Unfortunately, some local initiatives in the North Isles were coming to an end due to staffing turnover and vacancies.

An example of positive locality planning was the extra care housing on Unst which had been established with effective community involvement. The partnership was keen to build on this success. The scheme used technology support, active links to the community council, third sector agencies and anticipatory care through the local GP practice. This was leading to improved personal outcomes for the older people using the scheme. Local community initiatives on Unst were well developed, in part on the back of the success of the extra care development. The partnership planned to extend this type of provision and support to other parts of Shetland, although progress was limited at the time of our inspection.

A new brokerage service, Shetland community connections, identified local community alternatives to organised social work support, thereby offering supported people a greater degree of choice and control. It was an unpaid carer led development and it was in the process of recruiting a manager for the service. We considered that it had some potential to be a catalyst for the further development of self-directed support in Shetland.

The partnership's project approach was not progressing sufficiently; successes were not being capitalised and scaled up enough. The Council's 2017 statutory annual audit identified that long term success would be achieved through service redesign and service innovation through self-directed support and community co-production. The limited progress to date highlighted that the partnership still had much to do to achieve the level of transformation it needed.

Performance monitoring and quality assurance of the delivery of self-directed support was limited. There was no consistent process in place to fully evaluate the uptake, distribution and allocation of resources. For example, the partnership's business system was limited in its capacity to report. A finance module within the Swift information system was not used and so key information remained unrecorded. Many staff were unclear about performance reporting and less than half (27%) agreed that self-directed support performance information was evaluated and effectively drove improvement across services.

Overall monitoring arrangements were poorly adapted to support the allocation of resources or the effective gathering of information. This made it more difficult to inform and drive improvement in the delivery of self-directed support. Some staff and unpaid carers expressed frustration that Shetland's performance could not be compared against the national picture. We had concerns that a number of the partnership development priorities were not supported and underpinned by robust performance and outcomes data.

Recommendation for improvement
The partnership should develop a shared understanding across the whole system of care and support to ensure that self-directed support informed the partnerships approach to developing new models of support.

Recommendation for improvement
The partnership should ensure that the pace of service development and redesign is increased in order to better support flexible and innovative support across all parts of Shetland.

Recommendation for improvement
The partnership should develop relevant and robust data measures to more effectively aggregate, analyse and report self-directed support activity in order to drive improvement across services and enable self-directed support benchmarking with other Scottish authorities.

7. Management and support of staff

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

Summary

The partnership had recently invested in “making it personal” training for a significant number of staff from various disciplines. Some unpaid carers had been involved in this training as well as the training for ‘partners-in-policy making’. At times staff were not empowered to exercise self-directed support principles when the need for formal supports and services was identified. By focusing predominantly on what people could not do and areas of unmet need, this resulted in a deficit-based approach. Some key staff in areas such as contract monitoring, procurements and administrative support had not received any related training. There had also been limited training for health staff. They had early training but lacked ongoing development. Leaders were too heavily dependent on the self-directed support Implementation officer. This role was overused. Knowledge, skills and expertise about self-directed support could be more widely disseminated across staff groups. Awareness and understanding of self-directed support was good amongst social workers in adult services but limited across health staff and other agencies. The self-directed support Implementation officer delivered much of the training, guided by a specific workforce plan for self-directed support. This training was highly regarded by staff who received it. The NHS had agreed to part-fund a second implementation post to support training and development for self-directed support for a wider staff group, including health staff.

Evaluation - Adequate

The majority of frontline social work staff agreed that they had access to training and had an appropriate level of knowledge and skills to promote self-directed support. There was a commitment within the community health and social care directorate plan to develop and maintain the skills of its workforce. Each service area had its own workforce development plan and these linked to the national health and wellbeing outcomes.

There was a specific workforce development plan for self-directed support. The self-directed support Implementation officer had a key role in taking this forward. Some 100 staff from various disciplines, including care home, community nurses, community outreach, occupational therapy, housing, day centre and ICT had attended the partnership’s “making it personal” training. Reflective practitioner training had been offered and taken up by some staff and both of these were deemed very helpful.

There were plans to add capacity to support the self-directed support implementation officer. A post was to be established and was designed to broaden out the advice, guidance, training and development work around self-directed support to a wider staff group, including with health staff.

Adult social work senior social workers had received 'training the trainers' input from the Thistle Foundation and said they had subsequently used this with other services, including housing, to promote a shared focus on the desired personal outcomes of supported people.

Contract monitoring was undertaken by the executive managers across community health & social care, who were the lead commissioning officers (procurement) for external contracts. Key staff in areas such as corporate contract monitoring, procurements and self-directed support administrative support had not received any related training which meant that they were not specifically deployed to support self-directed support development.

There had also been limited training for health staff. Self-directed support awareness sessions had been delivered by social work to various health team meetings. They had early training but needed ongoing development.

At times staff were not empowered to exercise self-directed support principles when the need for formal supports and services was identified. Staff said they sometimes felt they needed to describe the person's levels of need at a higher level to meet the partnership's eligibility criteria. By focusing predominantly on what people could not do and areas of unmet need, this resulted in a deficit-based approach.

Leaders were too heavily dependent on the self-directed support implementation officer. This role was critical to frontline staff, senior managers and to the Integration joint board and programme boards. This role was overused. Knowledge, skills and expertise about self-directed support could be more widely disseminated across staff groups.

The partnership planned to expand and revise self-directed support training to ensure it continued to meet the requirements of the legislation. Plans to develop an iLearn programme as part of health and social care induction programmes were under discussion.

Some training opportunities had been made available to unpaid carers, including training provided on mainland Scotland. The partnership needed to do more to provide access to training and development opportunities for third sector staff and for people working as personal assistants. Positively where this had happened, we heard examples of how personal assistants had found new and imaginative ways of supporting the people they worked with.

Recommendation

The partnership should improve the shared understanding of self-directed support across all staff groups and, in particular, health care staff so that supported people can use support creatively and promptly.

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

While leaders promoted a visible commitment to self-directed support, the pace of change to develop and adopt new models of care urgently needed to be accelerated. Joint working across agencies to deliver self-directed support was not as strong as it should have been. Critically, full implementation of self-directed support was constrained by ongoing limitations in availability of options in the delivery of support. The lack of knowledge and engagement of corporate finance, commissioning and procurement staff impeded the creative use of resources for delivering self-directed support. Leaders needed to do more to increase awareness of self-directed support amongst health staff and support them in working jointly with supported people. Yet it was clear that leaders were motivated, knowledgeable and confident about the direction for self-directed support. The integration joint board supported self-directed support and told us that they saw this approach underpinning the way forward for the partnership. Leaders said they were fully committed to a co-production model and were actively engaged with individuals and communities. Indeed, it was clear that self-directed support was impacting positively on planning for the future delivery of services and projects undertaken in Shetland had increased options for supported people and their families.

Evaluation - Adequate

Leaders in Shetland, including the integration joint board, were motivated and enthusiastic about self-directed support. They understood it well and were passionate about delivering it successfully. They were confident in the direction of travel. Our staff survey indicated that most staff supported this view and agreed that the leaders in their organisations were committed to the values and principles of self-directed support.

The partnership senior leadership team had changed in the last year and a new chief executive for Shetland Islands council was in post. Key roles remained vacant, representing a significant risk to continuity of leadership required to progress self-directed support. Some posts had been successfully filled which had helped to stabilise the delivery of self-directed support at an operational level. In tackling recruitment difficulties to address this risk, the Shetland partnership board was encouraging leadership roles across all agencies and devolving power to communities. These medium-term plans were intended to support consistent leadership in Shetland in the future.

The Shetland Islands council had introduced a new customer service strategy and charter. This was fully consistent with and reflected the self-directed support principles of choice, involvement and collaboration. Staff were aware of the strategy and charter and were positive about its potential impact on other parts of the council to work more collaboratively and in a personal outcome focussed way.

The need for innovation in developing appropriate future support in Shetland was outlined in the Shetland Islands Audit Scotland report 2016-17. Its overall conclusion was that there was a need for service redesign for a sustainable future to be achieved. It identified self-directed support and community co-production as being key to this.

Leaders felt it was critical to develop community capacity. This would allow communities to provide alternative models of care. Doing this would support the implementation of self-directed support.

The partnership had chosen to invest in a co-production approach in its engagement with local communities and leaders identified this as the most effective means for embedding self-directed support into community services. Senior managers had a good grasp of the approaches to information sharing that worked best within the island communities. They also had a very hands-on approach to co-production. The chief officer of the integration joint board and the head of NHS planning had been attending meetings at locality level with local community councils and their key stakeholders for some time. They also attended what matters to You, joint health and social care events which were held regularly around Shetland to offer information and consultation with communities. This level of engagement was helpful in making connections with Shetland's numerous informal networks of support.

As well as formal meetings with the management team, the chief officer also met periodically with senior social workers at their meetings. Frontline staff said that they were confident in the partnership's leadership and the findings from our staff survey largely confirmed this.

Leaders had endorsed an approach whereby staff were encouraged to be creative in the delivery of self-directed support. However, there were ongoing limitations in what staff could achieve within existing services. There had not yet been any significant redesign or development of care at home services. Support under Option 2 was not yet available and continued to impact upon the implementation of self-directed support. The lack of knowledge and engagement of corporate finance, commissioning and procurement staff impeded the creative use of resources for delivering self-directed support.

The strategy for self-directed support was under development and was still at an early stage of implementation. The key elements of the strategic actions taken by the partnership had focussed on using existing resources in conjunction with local communities to address the shortfalls in supporting individual outcomes. This had resulted in the project approach which the Integration joint board and senior management team were reinvigorating through the recent formation of the self-directed support project board.

The self-directed support project board comprised of senior managers from the partnership. Supported people and unpaid carers had also started to meet more frequently to help develop and strengthen collective leadership and a more integrated approach by the key stakeholders. Strategic leads had also completed self-directed support training and both these developments had helped foster a greater shared understanding of how the implementation of self-directed support should be taken forward.

The projects undertaken in Shetland have increased options for supported people and their families. The partnership had yet to scale up successful projects to address the significant gaps in external provision. There was clear recognition of the need to generate capacity to support Option 2 for supported people as a priority. The pace of change to support the large scale and consistent implementation of self-directed support was too slow. Supporting further developments in services using learning from successful projects could help to scale up projects in future.

Senior leaders were aware that more learning and development opportunities were required for health staff and that the staff need to take advantage of these when provided. Leaders acknowledged the need for health staff to become more knowledgeable about self-directed support to improve work with supported people. We saw little evidence of action from leaders to take matters forward with the speed and commitment the issue requires.

While social work staff were confident that leaders were taking the workforce in the right direction, responses from health staff to our survey were less encouraging. It was clear that staff shortages in NHS Shetland and the resulting lack of capacity for existing staff was impacting negatively on collaborative work on self–directed support.

Despite integration joint board members being knowledgeable and enthusiastic about self-directed support, they did not provide a high level of scrutiny and challenge to the partnership's implementation of self-directed support. Neither did the partnership's two parent bodies. The integration joint board received progress reports on self-directed support. These reports focussed on the level of spend and the number of people in receipt of a personalised budget. They did not report on personal outcomes nor did they provide reliable data on the take-up of the self-directed support options. The partnership has the opportunity to use the recently adopted service user and unpaid carer participation together with improved audit tools to provide feedback about self-directed support and drive further improvement.

Recommendation for improvement
The partnership should pick up the pace of delivering self-directed support by setting out its vision and facilitating a creative approach to delivering self-directed support across all health and social work staff groups

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

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