



Thematic review of self-directed support in Scotland: Transforming lives

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Foreword

The Care Inspectorate led this thematic review of self-directed support in Scotland, which was carried out jointly with Healthcare Improvement Scotland.

In this review, we considered the delivery of self-directed support in six partnerships across Scotland to evaluate how well they have embedded the principles and values of self-directed support to deliver better outcomes for supported people.

We found there has been much progress in the implementation of self-directed support, with some partnerships demonstrating significant change in the delivery of social care under this agenda. Yet more needs to be done to fully implement self-directed support and realise its potential in supporting the transformation of social care delivery in Scotland.

In most partnerships, we found good-quality services providing care and support to people. However, this was not always happening in a way that allowed for personalised approaches or that reflected a shift in choice and control from services to people. Partnerships needed to build on what they had already achieved to ensure a focus on personal outcomes was consistently at the heart of how services were planned and delivered.

We have reported separately on each of the six partnerships we inspected, including recommendations to support improvement in the delivery of self-directed support within these partnership areas.

This overview report provides a summary of what we found across the partnerships and what that tells us about self-directed support in Scotland in general.

In our analysis of the current challenges, we recognise that there are some issues that are bigger than any one partnership and will not be resolved by partnerships working alone. We present these issues here in this report as four topics for national debate involving interested parties from across Scotland.

I commend this report to you and trust that it will make an important contribution to the development of and improvements in the delivery of social care in Scotland in line with the values and principles of self-directed support.



Peter Macleod
Chief Executive
Care Inspectorate

1. Introduction

Self-directed support

Self-directed support: A National Strategy for Scotland was published in October 2010. This was a ten-year strategy that 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 were provided. It required public bodies to give people a greater voice in decisions about local services and greater involvement in designing and delivering them. Fundamental principles of self-directed support were 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 in their lives. It should also support the implementation of a human rights-based approach based on the principles of participation, accountability, non-discrimination, empowerment and legality.

The thematic review

The thematic review led by the Care Inspectorate was undertaken jointly with Healthcare Improvement Scotland. The joint inspections of partnerships were carried out under section 53(1) – Part 5 of the Public Services Reform (Scotland) Act 2010. 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. These were East Lothian, East Ayrshire, West Dunbartonshire, Shetland, Moray and South Lanarkshire. The partnerships were selected to reflect different demographics, population sizes, urban and rural mix and geographic variations including an island partnership.

What we found in these inspections does not necessarily reflect a comprehensive picture of self-directed support across Scotland. However, it does give us a good understanding of the key issues in the partnerships we visited. It tells us about work in these partnerships that has supported the implementation of self-directed support and identifies some of the barriers to implementation.

The focus of our review

The purpose of our review was to understand whether self-directed support had been implemented effectively, in line with the principles and values of the legislation. The review also sought to establish whether the implementation of self-directed support was delivering positive personal outcomes. This would allow us to support improvement in the delivery of this important agenda in Scotland.

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
- there was information, choice and flexibility for people when accessing services
- staff were enabled and empowered to implement self-directed support
- leaders had embedded the principles and values of self-directed support in practice.

How we approached the partnership inspections

We started with each partnership's evaluation of its own performance. Each partnership provided us with a detailed statement that set out how they had implemented self-directed support in their partnership area.

To understand how well the partnership had embedded self-directed support, we carried out a series of inspection activities for each partnership we visited. These inspection activities included:

- a questionnaire for supported people about their personal experiences of self-directed support
- a staff survey within social work, health, and third and independent sector organisations.
- reading case file records of people who had used services through self-directed support, including a selection of records for people who had been signposted to other services at the point of their initial inquiry.
- meetings with supported people and unpaid carers to listen to their views about their experiences of services
- meetings with managers and staff from a range of services and agencies that provided support.

Across the six partnerships inspected, we received 693 completed staff surveys and 93 supported people questionnaires. We met with 43 supported people, 61 unpaid carers and a large number of staff and managers from across partnership organisations. We read 358 case file records and also reviewed 87 referral records.

From our inspection activity for each partnership area, we reported 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.

The local partnership reports set out our findings, evaluations and recommendations against these themes.

Review reports

The specific findings and recommendations for the individual partnerships we visited are reported separately in local partnership reports available at <https://www.careinspectorate.com/index.php/publications-statistics/120-inspection-reports-local-authority/self-directed-support>.

This overview report provides a summary of what we found across the partnerships and identifies key issues for self-directed support in Scotland in general. We hope that all partnerships across Scotland and organisations interested in self-directed support will be able to learn from these findings and recommendations.

Acknowledgements

We would like to acknowledge and thank everyone we met across the six partnerships we inspected who contributed to this work. This includes all staff working in services who supported our visits and other inspection activities. We are grateful to supported people who took the time to complete our questionnaires. We thank everyone who came to meet with us and shared their experiences and their views.

We are grateful to the members of the advisory group and reference group for their input into the development of our methodology. We also wish to thank the many associate assessors and inspection volunteers who supported us in carrying out the review.

2. Terms used in this report - definitions

“**Self-directed support options**” refer to the four self-directed support options within the legislation.

- **Option 1:** The supported person or unpaid carer chooses and arranges the support and manages the budget as a direct payment.
- **Option 2:** The supported person or unpaid carer 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**’ describe 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, third and independent – 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.

3. Key messages

Most of the supported people and staff we met were very positive about self-directed support and the principles and values of personalisation. In practice however, more needed to be done to inform, empower and enable people to fully participate.

Almost everyone we met agreed that the self-directed support legislation and underpinning principles could change how care and support was delivered to a more outcome-focused and relationship-based approach. More still needed to be done to empower supported people to understand how this was available to them. This included partnerships making better information available more widely and more consistently.

In situations where self-directed support was effectively implemented, supported people found it transformational and experienced positive personal outcomes. However, effective self-directed support was not accessible to all.

Good conversations between supported people and staff helped to identify the personal outcomes that were important to people and the support required to achieve these. Where self-directed support was well-implemented it offered a degree of flexibility, choice and control for people that was previously unavailable. However, flexibility, choice and control were not available to all, should they wish it. Most partnerships had yet to fully implement self-directed support, meaning that its true potential was not being realised.

Self-directed support was more readily available or more frequently accessed by people in some care groups. In many partnerships, we found that for people with a learning disability, it was easier to access and use self-directed support. This seemed to build on well-established person-centred practice, developed in response to national strategies. There was little partnership data available to clarify or explain why there were differences between care groups. This meant it was difficult for partnerships to demonstrate they were ensuring equity of access in delivering self-directed support.

Discussions and decisions about options, choice and control were not routinely documented in case records.

Good conversations were often taking place between supported people and staff, to inform assessments and support plans. There had been genuine progress in developing more outcome-focused practice. This meant that supported people were participating in discussions about what was important to them. However, there was often little recorded evidence that people had discussed the four options available to deliver their support. There was also a lack of written evidence in case records that people had made an informed choice about which option was the best for them or of people agreeing to their final assessment or support plan. This made it impossible to determine the extent to which choice and control was being offered and delivered through self-directed support. Improvement in recording is essential to provide transparency and accountability for practice within

partnerships.

Partnerships were not consistently collecting, aggregating, analysing or reporting on personal outcomes. This was making it difficult to evaluate progress in self-directed support and to drive improvement.

Collecting and using data effectively to drive improvement across the whole system is a critical element to improving the delivery of social care. This applies at both a local level and a national level. Overall, we found a lack of coherent processes in place to collect, aggregate, analyse and report on personal outcomes. Partnerships were unable to fully assess progress around the implementation of self-directed support. As a result, partnerships are unable to combine or compare data making it difficult to create an accurate national picture of progress and performance.

Eligibility criteria frameworks were hindering staff from working in a way that supported the principles of self-directed support.

There was an ongoing tension for frontline staff between working to the principles and values of self-directed support and, at the same time, to the eligibility and priority frameworks used by partnerships to determine allocation of resources. This caused a lot of frustration for frontline staff.

In some partnerships, staff had robust asset-based, outcome-focused tools to support their practice. Yet most resource allocation systems were such that staff still felt that they had to highlight people's deficits in order to get the level of services required. Doing so made securing the necessary resources to meet assessed need more likely but contradicted the principles of self-directed support.

In practice we found that staff in many partnerships were essentially having to speak in two different languages. The first language was with supported people and unpaid carers and appropriately based on the principles of personal outcomes approaches and self-directed support. The second language was that of deficits, when they were seeking resources from decision-makers and budget-holders in their partnership.

Key processes and business systems did not always support a personal-outcomes approach and lacked transparency and accountability.

Some partnerships had developed and implemented business systems, tools and processes to support the delivery of self-directed support, but further development was required. Most systems were limited in their ability to fully reflect personal outcomes. Where systems and tools were able to be used in an outcome-focused manner, staff were not always using these systems consistently.

Supported people were rarely involved in processes determining personal budgets and allocation of resources. This restricted their ability to make choices and exercise control, should they have wished to. Resource allocation was often protracted and lacked transparency and accountability. This was a source of frustration for both staff and supported people. While we found that partnerships generally were meeting assessed needs by ensuring services were in place, the principles and values of self-directed support were often not being met.

All four self-directed support options were not consistently available to supported people. Different challenges for different reasons across the country meant that certain options were unavailable to people.

Some partnerships had made progress in designing and developing new and flexible models of care to support the delivery of self-directed support. There remained significant variation in the level of progress across the partnerships. Supported people did not always have access to all the self-directed support options. Option 1 was generally well established in all partnerships. Availability of Option 2 remained limited although there were some positive examples of partnerships taking steps to promote and increase the availability of this kind of support. Option 3 was still the most easily available and commonly used support for people, particularly older people. A combination of the first three options through Option 4 was used by some people but hindered by the lack of progress on making Option 2 widely available. This often influenced why people were using Option 3.

While Option 3 may be a very positive choice for many people, the absence of recorded evidence meant it was not clear whether people were always actively choosing Option 3 in the full knowledge of all their options. This was important as the right to choose not to exercise control over budgets or support planning is an entirely valid choice and one that many people would wish to exercise. Capturing this in recording would help partnerships demonstrate they were transparent and accountable. Across the partnerships inspected, the services delivered under Option 3 had not all consistently been developed to fully reflect the principles and values of self-directed support. Regardless of their choice of delivery option, people are entitled to good, principled, outcome-focused practice and flexible and responsive services.

Across health and social work, leaders demonstrated a shared understanding and knowledge of self-directed support. In practice, frontline health staff were not yet actively engaged in this agenda.

Across the partnerships, health and social care leaders had a good knowledge and understanding of self-directed support. Health and social care leaders also had a clear vision of what they wanted to achieve. The picture for health and social care staff on the ground was more variable. Most social work and social care staff and managers had a well-developed understanding of self-directed support and were very positive about it. Some partnerships had made good progress and were working well together to develop and deliver new models of care and support bringing together commissioners, finance staff and the independent and third sectors. This was helping to develop a shared understanding of self-directed support. This was not true of frontline health staff. Significant progress was still required to improve health professionals' knowledge of self-directed support and strengthen the role of frontline health staff in supporting the delivery of this agenda.

4. Recommendations

Recommendations for partnerships

We have issued each of the six partnerships we inspected with a local report that outlines the progress the partnership had made implementing self-directed support. Within these reports we made a number of recommendations for improvement, specific to each partnership.

The following recommendations are based on themes, issues and concerns we found to be common across partnerships.

Partnerships should:

Support staff to more accurately record good conversations with supported people about the four options, choice and control in case records.

This is critical in order to determine the extent to which choice and control is offered and delivered as a result of implementing self-directed support. Doing so would demonstrate transparency and accountability and also provide evidence of the positive shift towards more outcome-focused practice.

Further develop and implement systems and processes for assessment, budget-allocation and support planning that are designed to support a personal-outcome approach.

This would help address the major issue of staff having to take good conversations with supported people and then adapt them to be deficit-based (a more traditional kind of approach where the worker assumes the role of an expert who is there to solve the problems of the individual by assessing them and providing the support they think will help) to ensure people received resources. This should also support partnerships to more coherently capture, aggregate and evaluate personal outcome data and drive social care improvement across the whole system. This change will require collaboration with the Scottish Government, health services and the third and independent care sectors.

Provide accessible and up-to-date information for supported people and unpaid carers.

Partnerships should undertake regular reviews of the self-directed support information they provide. It should encompass consideration of a range of communication needs including those supported people and unpaid carers who experience difficulties with decision-making and need support. Ensuring that information is readily accessible for all people in a manner that suits them will also ensure partnerships are being consistent with a human rights-based approach.

Focus on increasing the transparency around how resources are allocated to supported people.

Supported people, unpaid carers and staff should experience greater participation, where they wish to, in the processes through which resources are allocated to them. This would mean decision-making about personal budgets are less complex, more flexible and transparent and more widely understood.

Address the lack of established and consistent training arrangements and lack of shared understanding across the whole workforce.

Partnerships should implement more coherent strategic approaches to the delivery of their self-directed support workforce development plans. There should be a focus on the training needs of health staff and frontline managers in social work. Partnerships should also take account of the national Health and Social Care Workforce Plan Part 2 – ‘**A framework for improving workforce planning for social care in Scotland**’.

Ensure that leaders across health and social care demonstrate a clear commitment to self-directed support.

Leaders should ensure that systems, processes, culture and practice within and across the partnership organisations fully meet the principles and values of self-directed support and human rights-based approaches. Where this is not currently the case, this should be addressed as quickly as possible.

Support integration joint boards and joint monitoring committees to play an active role in the planning and delivery of self-directed support.

Integration joint boards and joint management committees should ensure planning and delivery is consistent with national drivers. This includes adherence to a human rights-based approach that reflects the principles and values of the self-directed support legislation. This also includes ensuring that commissioning and procurement practices support the availability of all four options within self-directed support. Commissioning arrangements should reflect the Chartered Institute of Public Finance and Accountancy guidance on self-directed support and The Procurement Reform (Scotland) Act 2014 statutory guidance. As social care for adults is delivered within the context of integration, this agenda needs to be owned and driven by all leaders at these levels.

5. What did we find about the implementation of self-directed support?

This section describes in some detail key findings from the six inspections we carried out. What became clear over the course of this work was that there were many nuances and challenges in evaluating the implementation of self-directed support. We sought to find practice that truly reflected the principles and values of self-directed support. We were looking for practice that reflected people having the opportunity to take control over their own support. Often, we found practice that could be described as 'good' on the basis that it was clearly helping people and making a difference to their lives. But this practice was not necessarily delivered in line with the principles of self-directed support and the spirit of the legislation particularly in relation to people being in control of their own support.

There are subtle but important differences between good practice in general and good delivery of self-directed support. A person may have experienced good outcomes but may not have had control over their support. Having choice and control should support better outcomes for people, though this cannot be guaranteed. However, it is very likely to support better experiences. In this inspection, we set out to ascertain how well self-directed support was being implemented. Our findings do not provide a commentary on the extent to which people in the six partnerships inspected are experiencing good outcomes from work delivered by more traditional approaches.

5.1 Supported people's outcomes and experiences.

While we found that partnerships generally were meeting assessed needs by ensuring services were in place, the principles and values of self-directed support were often not being met. Our case file reading analysis showed that most supported people benefitted from their care and support. However, through our discussions with supported people we did find evidence of choice and control being limited for some people. There were common issues such as the four options not being available, discussed or offered. There were also difficulties in relation to personal budgets. These often took a long time to be approved and there was a lack of information about this process. Sometimes staff did not have the right information, or different staff provided contradictory information, particularly about what budgets could and could not be used for. These problems contributed to people experiencing a lack of choice and control and impacted on people's potential outcomes. Overall, more work was necessary to improve transparency and empower people accessing self-directed support.

There was a clear difference in people's experiences where the values and principles of self-directed support were embedded in practice. Where self-directed support was well implemented, supported people and unpaid carers highlighted the greater flexibility and creativity of support options available to them. They praised the alternatives to conventional support and how these had helped transform their lives for the better. We heard comments like the following on each of the six inspections we undertook.

"Self-directed support has given us our lives back. It has given me more independence."

"I've worked with carers for years and have been one for years. I love what I'm seeing now, and I wish this had all been around when I was in the darkest days of being a carer."

Overall, the respondents to the questionnaire that we issued to supported people were positive about the staff they met. Our file reading analysis indicated that staff were often having good conversations with supported people and unpaid carers that respected what mattered to them and were about the support they needed. This was important as there has been significant effort and investment in trying to effect a culture change whereby outcome-focused practice becomes the norm. However, the feedback from some supported people and unpaid carers about their experiences was not always positive. They acknowledged staff worked hard to engage with them but felt that discussions about self-directed support were not always clear or consistent. Partnerships need to continue improving how they routinely communicate and engage with supported people about self-directed support.

Staff within partnerships and across partnerships had variable knowledge, awareness and confidence to discuss self-directed support. This impacted on practice and therefore on the experience for supported people. Although not a feature of every inspection, supported people frequently said that staff did not always know about or clearly understand the self-directed support options that should be discussed. They said staff did not always interpret practice guidance in the same way. A significant issue was that the message about what people could spend budgets on was inconsistent or contradictory. This detracted from effective empowerment of supported people to know and understand their rights.

Staff lack of knowledge and confidence was impeding progress for partnerships in embedding self-directed support. In areas that had dedicated self-directed support leads or teams, staff were very positive about the support and guidance they could access. However, this reliance on the skills and knowledge of dedicated leads or teams risked creating a level of dependency and gaps in the wider staff group's understanding that was reflected in the feedback we received from supported people in some of the areas we inspected.

The role of independent support to help supported people exercise choice and control was important. This was particularly effective in supporting people with progressing support under Option 1. This was important because, across the six inspections, supported people and unpaid carers found this option particularly complicated. They described managing their complex lives, conditions and self-directed support budgets as challenging.

"I have yet to meet a carer who having gone through the process of getting Option 1 or possibly Option 2, wants to go back to Option 3 - local authority provision. It does make a positive difference for people but it often comes at quite a price."

Supported people talked very positively about the various organisations that partnerships had commissioned to support people with all aspects of financial management including payroll and employment issues. Similarly, organisations funded by Scottish Government to provide independent support within partnership areas were generally held in high regard by supported people.

Independent advocacy has a critical role in helping maximise the participation of those with limited capacity. Supported people, unpaid carers and staff were not as aware of independent advocacy as they should have been. In instances where advocacy was used to assist people with social care we found there were clear benefits for people but only half of the partnerships we inspected could show evidence that they consistently and appropriately considered the need for such assistance. In most areas, independent advocacy services struggled to meet demand and were heavily committed to statutory mental health and protection work, thus limiting their availability to help people navigate through self-directed support.

At the time of this thematic review, partnerships were still developing their responses to the requirements of the new Carers (Scotland) Act 2016. They were at various stages of revising their assessment and support plans to take account of the duties placed upon them. The unpaid carers we spoke to had mixed views about accessing self-directed support. They recognised that self-directed support had delivered some very positive personal outcomes for supported people but expressed some frustration about their ability to access self-directed support in their own right. Carer Centres were described as valuable resources for providing quality information about self-directed support especially as many carers felt they did not receive accurate or consistent information from staff. More work was needed to ensure carers were routinely recognised and able to access self-directed support in their own right.

A consistent message from supported people and unpaid carers was that partnerships did not routinely seek feedback from them about their experience of staff, support and services. Some partnerships had undertaken work at the time of self-directed support implementation to assess the strength of their personalised approach with supported people and unpaid carers. However, most partnerships had not developed this further, so partnerships had limited understanding of people's experience of self-directed support.

Getting feedback was important because most partnerships had responded to self-directed support by changing how they delivered services. These changes did not always improve supported people's and unpaid carers' experiences of support. People strongly advised us that sometimes, albeit unintentionally, developments in the models of delivery of services had limited people's choice and changed how their care and support was being delivered, in ways they did not wish. Partnerships need to ensure they better understand the opportunities, challenges and impact of change and gather the views and experiences of supported people. This is the essence of participation, whereby those who are being affected by change can participate in shaping those decisions that affect them.

There was clear evidence that staff were increasingly collaborating with supported people about outcomes, which was positive and reflected the work done to promote personal outcomes approaches across partnerships. This was evident in case file records that highlighted the good conversations about what support was right for people. However, staff were not routinely recording discussions

about options or articulating why supported people chose one over the other. This was not happening at the initial assessment stage or review stages. This made it impossible to determine the true extent to which choice and control was being offered and delivered. It also made it very difficult to determine the overall impact self-directed support was having on people's experience and outcomes.

5.2 Initial contact, signposting and access to information

Partnerships we inspected provided resources to people through the national eligibility framework, which employs four criteria. This assessed people as being at critical risk, substantial risk, moderate risk or low risk. Most but not all of the partnerships we visited prioritised the allocation of resources to those assessed as being at critical or substantial risk and signposted the others to less formal services and other sectors for support.

Partnerships had introduced various contact arrangements for supported people and unpaid carers when they first needed to access services. In most instances, these arrangements were effective in guiding people to appropriate services. There was evidence that partnerships were placing or planning to place more emphasis on a personal outcomes approach at this point of access. While more progress was required in some areas, others had implemented or had firm plans to implement a range of helpful, often multi-agency approaches using outcome-focused assessment tools. These were beginning to effectively elicit what was important to people and their choices about support at the first point of contact.

One partnership took a genuinely comprehensive approach to providing access to self-directed support across all levels of need. The first point of contact for all referrals to social care used a self-directed support approach with people at low or moderate risk, as well as those who met eligibility criteria for formal services at higher levels of risk. Unusually this team also used self-directed support approaches and options for supported people who were assessed as requiring urgent support and short-term interventions. Responses were quickly arranged but still co-produced with supported people and unpaid carers. These were often targeted at seldom heard populations including people using mental health services where the benefits of short-term interventions are well understood. Responses were multi-agency in nature with good use of third and independent sector services in particular. In many instances access to this kind of personalised preventative care and support prevented the need for more formal or longer-term interventions. This was very much in line with a human rights-based approach, embodying key principles of participation and inclusion in the community.

In almost all other partnerships the population who did not meet the eligibility criteria of higher levels of risk were signposted to third and independent sector services in their communities. While signposting was mostly found to be effective for this population, partnerships were not routinely providing them with information about self-directed support. This was a missed opportunity in some areas to develop a wider understanding about self-directed support in their communities. This meant people would have been better informed and prepared if they required further formal services at a later time.

In cases where people met the eligibility criteria and were receiving packages of care and support using a personal budget, the use of wider personal and community support resources was much less evident. This was an important gap in practice. There was limited evidence in the case records that staff were looking at the supported person's own assets and options including any networks of support and informal community networks of support. This lack of evidence suggests that there remains too much of a focus on traditional service-based models of care and support as a way of supporting people to meet their desired outcomes.

Partnerships had generally made progress in ensuring information was available that outlined supported people's right to self-directed support. Some partnerships were consulting, reviewing and refreshing the information they had available to the public. There were innovative examples of social media being used to promote personal assistant networks. One partnership was planning to use digital stories to support sharing of good practice and had made plans with a local radio station to run adverts focused on self-directed support. There were also positive examples of partnerships using newsletters, public events and consultations to reach wider audiences.

Staff in some partnerships, had difficulties accessing information to assist supported people and unpaid carers. In these partnerships information was hard to find, particularly the bespoke pictorial versions used for people with communication challenges. Health and third sector staff we met were consistently less positive about having access to information about self-directed support than social work staff.

The majority of supported people who responded to our inspection questionnaire said they had been offered the right kind of information to help them better understand self-directed support. This helped them to make choices and take control at the times they needed to. Case record findings and a significant number of supported people we met during the inspection offered a different perspective. Here we found evidence that supported people did not consistently get access to the right information at the right time or have it explained to them in a way they understood. How information was conveyed often varied depending on the knowledge and confidence of the staff member providing the information. This left supported people and unpaid carers confused and frustrated. It was a common barrier to empowerment, participation and non-discrimination that needed to be addressed if choice and control was to be delivered.

5.3 Self-directed support in processes and practice

Some of the partnerships had designed and implemented robust assessment, focused on personal outcomes, and support planning tools. While it was positive to see these tools in place, they were not always being used to their full effect. In some cases, staff said they found these tools difficult and laborious to use. In other partnership areas, tools were more recently developed and not yet fully-embedded. Overall, partnerships had more work to do to ensure that case file recordings consistently summarised what was important to supported people, reflected discussions about the self-directed support options available to them and ultimately, the person's final choice of option.

We found this particularly useful example in a case record.

"I explained that self-directed support is not a direct payment but the ethos and legislation in which adult community care worked and the priority was to find out what [person's name] aspirations were and what he needed to support him to achieve his goals, to look at who supports him with this, what the gaps are and what support he may need to fill these gaps. Then we could look at the four options under self-directed support and one of the options was a direct payment in order that a person can employ their own personal assistants."

Our case file reading indicated that almost every partnership we inspected effectively considered eligibility criteria and undertook good quality assessments within a reasonable timescale. Almost always, resources were delivered based on the supported person's eligible needs, indicating that assessment activity and resource allocation were aligned, accurate and robust in addressing assessed needs. However, some partnerships still had more work to do to convey decisions about eligibility and what this means to people being assessed. This is important because a consistent feature of these partnership inspections was that many supported people and unpaid carers did not feel informed about eligibility and how this impacted on them. Discussing eligibility criteria with supported people is an important step towards ensuring that there is a culture of collaboration, choice and control from the start. Increased transparency is also important to allow supported people to challenge decisions if necessary and for partnerships to be accountable.

A recurring message we heard from staff was that eligibility criteria were negatively steering their practice towards a deficit-based approach, which was not compatible with self-directed support. A deficit-based approach is a more traditional approach, where the worker takes on the role of an expert who is there to solve the problems of the individual by assessing them and providing the support they think will help. Staff were shaping conversations, assessments and support plans to focus on deficits in order to meet the two higher levels of eligibility criteria that unlocked budgets and resources. This was undermining the principles and values of self-directed support and was a dilemma for staff who were struggling to work across two opposing policies shaping their practice. Staff were having to manage the tension of having two kinds of approach – one, outcome-focused with supported people and unpaid carers, the other, deficit-based with those who controlled budgets.

Another recurring issue was that supported people and staff were often unclear or detached from decision-making processes about personal budgets and resources. Staff in most partnerships expressed some dissatisfaction with their resource allocation process. This usually related to the processes being laborious or complicated. Staff were not always involved in these, other than providing assessments or support plans. In some areas, there was a significant lack of clarity about what information was shared and how with supported people. This made it difficult for staff to give supported people feedback about reasons for delays or explain decisions they were unhappy about. It also undermined the extent to which supported people could challenge decisions or seek remedies.

Staff across partnerships expressed some other frustrations about aspects of their work affecting their ability to deliver self-directed support. Paperwork and IT systems did not always lend themselves to

capturing good conversations and review paperwork did not properly capture personal outcomes or lend itself to revisiting options and choices about support.

Resources were often scarce, and choices limited in rural areas, making it difficult to arrange supports in the manner the supported person wished to receive it. Additionally, there were challenges around recruitment and retention of care staff across all sectors of care provision. Because of these issues, some staff were reluctant to discuss self-directed support and the four options for fear of building up false expectations, particularly in the more rural areas where services were more difficult to facilitate and access. This negatively affected how some staff felt about self-directed support and their potential to deliver the principles of choice and control. This also raised equality issues regarding access to services, which partnerships needed to consider.

Partnerships are challenged to deliver more innovative personalised care and support and empower people to be in control of their support, including taking managed risks. Creative types of support can involve increased risk for both supported people and partnerships. Most of the creative support we found was being delivered through Option 1 or Option 2. In every partnership, we saw evidence in the majority of case files that staff and supported people were working well together to manage risk. Staff generally sought to take a positive view of people's ability to think about and manage risk and tried to strike a positive balance between risks and benefits. In most areas, these approaches were supported by managers. Some partnerships had balanced risk taking and risk management better than others.

As finance teams became more knowledgeable about self-directed support, we found they were becoming less risk-averse and more welcoming of creativity in the use of budgets. We saw examples of partnerships actively promoting participatory budgets¹ and individual service funds². Direct payment cards were being implemented in some areas to give supported people more flexibility and enable them to exercise more control in how they used their budgets. We found these initiatives were underpinned by robust policies and procedures that encouraged staff to take risks in an enabling way. The role of finance teams in the delivery of self-directed support was rapidly developing in some partnership areas and was impacting positively on the implementation of self-directed support. Other partnerships still had considerable progress to make to engage finance staff in supporting new and more flexible models of care and support.

Reviews are important in evaluating the impact of care and support and ensuring people have ongoing choice and control over the support they receive and the option through which it is delivered. They provide people with the opportunity to challenge decisions or seek remedy if they are unhappy with how their care and support is being planned, managed and delivered.

¹ Participatory budgeting describes a process whereby people and communities are actively involved in allocating a portion of budgetary resources.

² Individual service funds are a mechanism whereby a person can exercise increased choice and control over how their services are delivered, via their provider, without taking on the direct responsibility of managing a personal budget.

In general, our case record findings indicated most partnerships were carrying out regular reviews. There were some exceptions however, with reviews for some supported people not having taken place for over a year.

Across the partnerships, reviews often lacked evidence that self-directed support options had been revisited or that personal outcomes had been discussed. Reviews were often driven by process and too focused on whether the level of care and support needed to increase or decrease, rather than about options, choice and control, and outcomes. During the inspection, partnerships acknowledged they needed to strengthen personal outcome approaches within their processes and ensure their systems allowed for timely reviews focused on outcomes.

5.4 Staff experience and staff support

Almost all the staff we met were broadly supportive and enthusiastic about self-directed support and they acknowledged its potential to change how care and support is delivered.

In looking at the role of staff in promoting self-directed support, our staff survey measured the level to which staff felt encouraged and enabled to exercise professional autonomy. We found it varied considerably across the six inspections we undertook.

The levels of confidence staff felt about delivering support to people through self-directed support also varied in each partnership. Our staff survey highlighted that the highest level of confidence in any of the six partnerships was 71% with the lowest level 41%. This demonstrated the need for improvement in this area. Empowerment of staff to play their role in helping people realise their rights is an essential accompaniment to shifting choice and control to supported people.

The absence of joint strategic planning for workforce development that was clearly linked to self-directed support was a significant gap for most partnerships. Most partnerships did not have coherent performance reporting or joint workforce planning for self-directed support. This was preventing the level of cultural shift required to collectively enable and empower all staff groups to fully implement self-directed support. There was an overall lack of training needs analyses, few SMART (specific, measurable, achievable, realistic, timed) action plans for learning and development and limited opportunities for shared learning. Development was mostly driven by requests from specific teams, with support often coming from dedicated self-directed support leads rather than as the result of a strategic approach.

There was considerable variation in levels of positivity and confidence across staff teams. Where staff were most positive, partnerships had made significant attempts to redesign processes in consultation with them. Increased positivity in these areas had spread beyond social work staff and included other professional groups such as commissioners, planners and finance staff who felt actively involved in self-directed support and new ways of working.

Most social work staff agreed they had had opportunities to undertake self-directed support training but health, independent and third sector organisations were less positive about this. Some partnerships had made some good early progress following the implementation of self-

directed support and we saw a number of initiatives designed to help staff focus on personal outcomes. However, in some cases momentum had been lost as the mechanics of implementing the requirements of the integration legislation, the Public Bodies (Joint Working) (Scotland) Act 2014, absorbed most of partnerships' attention. Re-establishing progress was at different stages across the partnerships we inspected and needed to be accelerated to ensure staff were as knowledgeable and resourceful as they could be.

Training opportunities were available and being delivered, often by specifically-assigned staff. Many of these initiatives positively included jointly planned work with independent support organisations and included participants from every sector. While progress was being made across partnerships, significant gaps remained in some areas, particularly in training for health staff and for social work managers who play a critical role in overseeing the quality of social work practice.

The shared view across partnerships was that training and awareness had not extended as fully as it should to health staff. Senior health staff were generally aware of the strategic context but knowledge and understanding of self-directed support amongst frontline staff was limited.

Some partnerships appropriately suggested that self-directed support dovetailed neatly with NHS commitment to the person-centred health and care agenda. While we agreed with this, more needs to be done to share the self-directed support agenda with frontline health services staff if they are to support its implementation.

In one partnership, rurality and remoteness meant there was a relatively high number of direct payments, leading to a large personal assistant workforce. Here, personal assistants felt they did not have a lot of support or access to advice. Their knowledge of self-directed support and how it works was mixed and they described inconsistent messages being given by their employers. This partnership had established a support network for personal assistants to overcome these challenges. While these issues were highlighted in this particular partnership, the knowledge, confidence and skill levels of personal assistants in relation to self-directed support is an issue for all partnerships to consider.

Where partnerships had invested in individual leads or teams specifically supporting self-directed support, they were typically doing some very good work with staff from all sectors. While this was positive, it did mean that in some areas staff were over-reliant on these leads at the expense of their own personal development. An example of where a very good balance had been achieved was in a partnership that had developed a peer mentor model. This provided bespoke on-site coaching and support to frontline practitioners and managers. It also included two part-time carer peer mentors and two young carer peer mentors, all with current lived experience of caring. There were three 'Thinking Differently' co-ordinators who were leading on the development of creative and personalised solutions to support adults with learning disabilities, and children and young people. They had a close relationship with the local self-directed support finance team. The peer mentors spent much of their time within operational teams offering advice, guidance, support for reflection on practice, practical support and at times, a 'critical friend' role. They facilitated regular drop-in sessions and talks with frontline practitioners who greatly benefited from this approach.

Across the partnerships, staff generally felt well supported by their line managers. In some partnerships, we saw clear evidence in case file records that staff were discussing issues with their managers and consistently recording decisions. While this evidenced good oversight of case file recording of issues, staff in most partnerships acknowledged that these discussions were not as focused on the principles of self-directed support as they could be. This meant that partnerships were missing opportunities to explore how well self-directed support principles were being embedded in frontline practice.

5.5 Leadership and self-directed support

We found that there was a considerable difference in the level of progress being made to implement self-directed support across the six partnerships we inspected. Not surprisingly, we found there was more evidence of good progress in partnerships that had stable senior management teams and where community planning partners had a consistent record of working well together.

Almost all the leaders we met were motivated, knowledgeable and confident about their vision for self-directed support and social care more broadly. In the main, visions were aligned to high-level strategic planning and delivery plans although some more clearly aligned than others. Most leaders were explicit in stating their commitment to ensuring the principles and values of self-directed support were embedded in the partnership's approach to the delivery of social care. Some leadership teams had made significant progress, and this was reflected in developments in practice, increasing development of outcomes-focused tools, improving key processes and a commitment to staff development to support implementation. Importantly, most staff recognised this too. However, staff across the sectors were more confident when talking about leadership of self-directed support in their own organisations and less positive about collaborative leadership across the various partnership agencies. This indicated that partnerships had more work to do to strengthen the shared vision for the future delivery of social care for adults.

Across all partnerships, leaders were actively promoting community capacity building. We found a range of integrated early intervention and prevention services. Health and social care integration had provided fertile grounds for innovation in this area. Each partnership was at a different stage of development but where it was well-embedded this was making a positive difference to the choices that supported people could make about their care and support. New models were being developed to better engage local people and communities in planning processes. This included events where people came together with partnership managers, staff and providers to discuss self-directed support and what it could potentially achieve locally. The participation of those engaging with self-directed support is important in developing and reviewing processes as well as in planning their own support. In the main, leaders were appropriately supporting and encouraging their health and social care locality planning groups to develop community-based services. This approach of building services around the needs of particular populations meant that people could have access to supports that were more suited and relevant to their needs. It fitted well with the principles of self-directed support.

One area where leaders needed to accelerate change was in commissioning for outcomes and alternative models of care and support across all options for delivery. This was essential if real choice

and control was to be realised for supported people irrespective of the option they chose for their own support, including services delivered under Option 3 for people who make Option 3 a positive choice. While all partnerships were experiencing significant pressures from increasing demand and limited budgets, some leaders had been proactive and taken steps to address this.

One partnership had introduced an electronic system that mapped service provision from street to street. This increased efficiency in deploying staff and as a result capacity in the care-at-home system had grown. This meant the partnership was better placed to offer increased choice and control in the delivery of the service. While this was beneficial, tensions remained for this partnership in developing new models of delivery of support between promoting choice and control and delivering services more efficiently to people clustered closely together in neighbourhoods. This tension between improving efficiency and delivering choice and control was evident in other partnerships we inspected and highlighted a key challenge partnerships face in striking a balance. We recognised that there were other constraints outwith the control of partnerships, particularly in rural and remote areas, in attracting new services and maintaining established ones centred on the challenge of recruitment and retention.

There were particular gaps in the availability of support under Option 2 but we found evidence of emerging initiatives to address this. One partnership had created a self-directed support finance team to specifically promote Option 2. This team provided direct, personalised and relationship-based support to people who used services and family carers. It included one-to-one support in people's homes to assist with challenges in managing their support under Option 2. The finance officers had helpfully been granted the delegated authority, capacity and flexibility to work through the complicated procurement, commissioning and financial arrangements. This flexibility had benefited several of the supported people and unpaid carers we met in this partnership.

Another partnership had introduced a new contract for care-at-home services. This introduced an Option 2-type personal budget model based on personal outcomes within their refreshed Option 3 framework. The council made equal payments to providers over the course of the year. The supported person and the provider could then agree any increases or decreases over the course of the year, within the overall budget. In another area, the partnership had undertaken a pilot project focused on devolving both the personalised budget and support planning to a third party through an individual service fund. At the time of our inspection, this initiative had just been evaluated. The evaluation had been positive, and leaders were considering ways of extending this approach.

Governance of self-directed support needed strengthening. Integration joint boards and joint monitoring committees are responsible for the planning of integrated arrangements for the delivery of health and social work services delegated to them. We found that their understanding of self-directed support was not as strong as it could be. Key messages delivered to integration joint boards were mainly about service redesign as a result of self-directed support rather than meeting the principles of the legislation. In some partnerships, this limited their understanding and ability to hold leaders to account for the pace of change.

Self-directed support oversight groups were typically in place within partnerships and overseeing some positive work, but leaders were not always holding them fully to account. The quality of action plans and performance reporting was variable, making the measurement of progress difficult in some partnerships. What exaggerated this difficulty in every partnership was the lack of personal outcomes reporting. Partnerships were not routinely capturing, aggregating, analysing and reporting on personal outcomes. This meant learning opportunities to drive social care improvement were not happening. It was significantly restricting leaders' ability to assess whether the implementation of self-directed support in their area was delivering positive personal outcomes and the impact being made across the partnership. This was an area all leaders should urgently address.

6. Where next with self-directed support?

Beyond the partnerships – proposed national conversations

In addition to the recommendations for improvement we have made to local partnerships, the findings from the review have led us to identify four broad themes that require wider debate across Scotland. These are crucial issues that will benefit from shared discussion within and across partnerships, and with interested parties at national level including Scottish Government, scrutiny and regulatory bodies and the third and independent sector.

6.1 The first conversation needs to discuss the shared challenge of making self-directed support accessible to all.

Empowering people with enough information is critical in allowing them to know their rights. Discussion needs to take place to establish how information is made available to people. This discussion could consider how we ensure access to information is at the right time and the right level of detail for people to ensure they are empowered and enabled. To meet the self-directed support legislation, it is also vital that people can access independent support and advice when they need to. The nature of independent support that people need will vary. A conversation about what people want and need, and how to improve the effectiveness of independent support, is required. This needs to include the role that can be played by organisations that receive national funding to promote self-directed support.

There is significant variation in the levels of access to self-directed support across care groups. Ensuring equity of access across care groups is critical for partnerships, allowing them to demonstrate they are meeting the principle of non-discrimination in the application of self-directed support. In some cases, there are major challenges both for partnerships and among supported people in shifting cultures and expectations. Exploring why variations exist should help in finding solutions and ensuring equity.

Finally, it is clear that the provision of all the options is sometimes not completely in the control of partnerships and their commissioning staff. This sits within a broader context of challenges delivering social care in many parts of the country. While these pressures and challenges are evident, there are still examples of partnerships finding ways to be flexible and imaginative to meet the principles and values of the legislation. There is scope for partnerships to learn from one another about how these challenges can be addressed. A conversation would be helpful to talk about the limitations on partnerships, people's expectations and how the principles and values of self-directed support can be met.

6.2 The second conversation needs to find a way of reconciling the tension that arises when staff try to work in an outcome-focused manner within systems that are not aligned to that.

We need to ensure self-directed support and personal outcomes approaches are fully implemented, in the spirit as well as the letter of the law. Systems and processes need to be more supportive of outcome-focused working and a shift in control to supported people and unpaid carers. As this is a challenge across partnerships and one that is fundamental to fully realising people's rights within the self-directed support legislation, this conversation should include all stakeholders. We also recognise that there has been significant investment and progress over recent years in equipping staff to work in an outcome-focused manner and it may be worthwhile to reflect on the impact of this.

Consideration should also be given to the participation of supported people in relation to budgets and resources, where they wish it. One of the core principles of self-directed support is that supported people should be able to participate in decisions which affect them. Transparency in processes that take place without the involvement of the individual is therefore particularly important. There is a significant lack of transparency and accountability in how personal budgets and resources are agreed and allocated. Supported people routinely speak of feeling shut out and having no understanding of how and why decisions are being made about their lives without their involvement. A conversation about how best to address this would need to reflect the principles of participation, choice and control while also acknowledging the practical barriers that exist.

While these tensions are occurring within partnerships, they reflected a challenge that is widespread. A discussion at a national level is required around the use of eligibility frameworks and the process of allocating budgets as this often fails to align with the principles and values of self-directed support. This would seek to share learning and develop common solutions to this problem. More broadly, a discussion is required about the extent to which people can experience choice and control within current systems and processes. Recognising that systems and processes should support the principles and values of self-directed support, this discussion should seek to identify what can be done to make this happen.

6.3 The third conversation needs to consider a shared way forward in how partnerships can meaningfully record and use information on personal outcomes at every level.

There are challenges for partnerships in accurately capturing good outcome-focused conversations at an individual level. This in turn makes it more challenging for partnerships to demonstrate transparency and accountability in supporting people to achieve personal outcomes. A national conversation would help to clarify the barriers and consider possible solutions. This conversation would also refer to performance data and reporting at a national level. A consistent approach would build a clearer picture of how personal outcomes are being achieved across localities and populations. This would help support a shift to more outcome-focused planning and commissioning as partnerships, Scottish Government and other interested parties would have reliable data to work with. This would also build on work done over recent years by Scottish Government, partnerships and others, especially the collaborative action inquiry project 'Meaningful and Measurable'.

6.4 The fourth conversation needs to talk about leadership and integration.

We were repeatedly told that the imperative to implement health and social care integration had hindered progress on self-directed support. We see integration as an opportunity, rather than a barrier, in relation to self-directed support. The principles and values of self-directed support sit comfortably alongside the values that underpin person-centred approaches within healthcare. A national conversation would help clarify the role that health staff should play in supporting the full implementation of self-directed support, potentially including the revision and updating of the statutory guidance to better reflect integration.

This fourth conversation can also consider how leaders across the integration authorities develop a shared ownership of self-directed support. This would include discussion of what they need in order to drive the culture change that is required to fully embed self-directed support across health and social care. This change should see a shift in power, choice and control, from organisations to people. This shift is based on personal outcomes and person-centredness and rooted in the principles of a human rights-based approach. This would help fully embed self-directed support as the approach by which social care for adults is delivered, some five years after the legislation took effect and within the context of health and social care integration.

7. Conclusion and next steps

Each partnership we reviewed has been issued with a local report setting out the partnership strengths in self-directed support as well as the identified areas for improvement. We expect partnerships will develop local plans to take forward the recommended improvements. You can read the individual partnership reports here.

<http://www.careinspectorate.com/index.php/publications-statistics/120-inspection-reports-local-authority/self-directed-support>

Stakeholders from across Scotland now need to work together to further an agenda for self-directed support. We have set out in this report key areas for discussion at a national level that we believe will support the development of this agenda. The first three conversations need to be progressed about accessibility, eligibility and asset-based approaches and information about self-directed support within the context of the Scottish Government's adult social care reform programme. The fourth conversation needs to be linked to the work of leaders across health and social care. It should be considered in the context of the Ministerial Strategic Group for Health and Community Care and its proposals for acceleration of the integration of health and social care.

<http://www2.gov.scot/Publications/2019/02/8909/downloads>

Appendix 1

The Thematic review of self-directed support in Scotland Supported people questionnaire

Self-directed support allows people, carers and families to make informed choices about what their social care support is and how it is delivered. It places a duty on local authorities, as well as a duty of cooperation on health boards, to work to a set of principles including involvement, participation and dignity. Local authorities should offer supported people four options. Under the legislation the four self-directed support options include:

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.

The Care Inspectorate is visiting six areas in Scotland to establish how well self-directed support is being delivered.

We would be grateful if you could take the time to complete this questionnaire based on your own experience. Every question has a scale of response options for you to consider.

Please take time to answer your questions carefully. Your responses will be treated confidentially and will not be attributed to you personally in any reported material.

Thank you for your help.

Please select your age

18-24 25-64 65+

Gender

Female Male Transgender Other

Place

East Ayrshire West Dunbartonshire Moray East Lothian
 Shetland South Lanarkshire

Service Type

- | | |
|--|---|
| <input type="checkbox"/> Alcohol or substance misuse | <input type="checkbox"/> Dementia or cognitive impairment |
| <input type="checkbox"/> Acquired brain Injury | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Mental health issues | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Frail elderly | <input type="checkbox"/> Sensory impairment |
| <input type="checkbox"/> Carer | <input type="checkbox"/> Other |

Statement 1

I am aware of self-directed support and know about the four options available to me.

- Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 2

I have experienced positive personal outcomes through accessing self-directed support.

- Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 3

I have choice and control over the care and support I receive.

- Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 4

My views, about what I need and what matters to me, are valued and respected.

Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 5

The four options of self-directed support were discussed with me in a way I understood.

Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 6

Workers focus on my strengths as well as the areas I recognise I need care and support with.

Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 7

I am fully involved in reviewing my care and support including the self-directed support options available to me.

Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 8

I found the self-directed support processes straight forward and easy to use.

Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Statement 9

I have been offered the right kind of information and support to help me understand how to direct my support, or that of my family.

Strongly agree Agree Disagree Strongly disagree Don't know

Supported person(s) comments:

Appendix 2

Membership of the reference group

Karen Geekie	Scottish Government
Des McCart	Healthcare Improvement Scotland
David Williams	Glasgow City Health and Social Care Partnership
Zoe McGuire	Audit Scotland
Ali Upton	Scottish Social Services Council
Emma Miller	University of Strathclyde
Cathy Asante	Scottish Human Rights Commission
Margaret Petherbridge	Falkirk Council
Beth Hall	COSLA
Alison Ure	East Renfrewshire Health and Social Care Partnership
Helen Happer	Care Inspectorate
Mike Harkin	Care Inspectorate
John Skouse	Care Inspectorate
Fidelma Eggo	Care Inspectorate

Appendix 3

Membership of the advisory group

Dr Emma Miller	University of Strathclyde
Lucy Mulvagh	The Alliance
Jess Wade	Self Directed Support Scotland
Keith Hetherington	In-Control Scotland
Dr Donald Macaskill	Scottish Care
Claire Cairns	Coalition of Carers
Julie Gardner	The Thistle Foundation
Laura Finnan Cowan	Alzheimer Scotland
Becky Hilton	Midlothian Health and Social Care Partnership
Catherine Garrod	CCPS
Fiona Garven	Scottish Community Development Centre
Dr Martin Kettle	Glasgow Caledonian University
Professor Kirstein Rummery	University of Stirling
Cathy Asante	Scottish Human Rights Commission
Norma Curran	Values Into Action Scotland
Jordan Allan	Values Into Action Scotland

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