



Follow-Up Evaluation of
Self-Directed Support Test
Sites in Scotland

FOLLOW-UP EVALUATION OF SELF-DIRECTED SUPPORT TEST SITES IN SCOTLAND

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Scottish Government Social Research
2012

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ACKNOWLEDGEMENTS

We are grateful to Scottish Government for the opportunity to extend the evaluation of the test sites, especially to Bette Francis and Jack Blaik in the SDS Team; and to Christine Sheehy, Fiona Hodgkiss and Aileen McIntosh in Social Research. Clearly we are indebted to the original larger evaluation team and all the people who participated in, or provided information for, the evaluation, as this follow-up study builds directly upon this work.

Without the help of key people from the original local authority test sites this follow-up evaluation would not have been possible. In particular we are grateful for the help we received from Lesley Law (Dumfries & Galloway), Adrian MacSween and Debbie Millar (Glasgow), and Sharlene Wright and Gail MacMillan (Highland). Thanks are also due to all those who participated in the research interviews who gave generously of their time.

We greatly appreciate the invaluable help provided by Angela Menhennet, who worked with us during the summer as a UCLan Research Intern. We also thank Adam Rosengard for his helpful input to analysing the cohort information used in Chapter 4.

Thanks are also due to Jane Jeffery for proofreading.

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LIST OF ABBREVIATIONS & ACRONYMS

ADSW	Association of Directors of Social Work
ARC	Action for Real Change
BME	Black and minority ethnic
CHCP	Community Health & Care Partnerships
COSLA	Convention of Scottish Local Authorities
DICE	Direct Inclusive Collaborative Enterprise (Dumfries & Galloway)
DP	Direct Payment
GAMH	Glasgow Association for Mental Health
GCIL	Glasgow Centre for Inclusive Living
IB	Individual Budget
ILF	Independent Living Fund
ISF	Individual Service Fund
IT	Information Technology
PA	Personal Assistant
RAS	Resource allocation system
RASG	Resource Allocation Screening Group (Glasgow)
REP	Risk Enablement Panel (Glasgow)
SCIF	Social Care Ideas Factory
SDS	Self-Directed Support
SEQ	Self-Evaluation Questionnaire (Glasgow)
SSA	Single shared assessment
SSAQ	Supported Self-Assessment Questionnaire (Highland)

EXECUTIVE SUMMARY

Background

The 10-year national plan for self-directed support (SDS) (Scottish Government, 2010) aims to bring SDS into the mainstream of social care and increase the number of people directing their own support, including the number doing so via Direct Payments (DPs). If enacted in 2013, the Social Care (Self-Directed Support) (Scotland) Bill will make offering SDS the duty of local authorities. In 2009, the Scottish Government selected 3 local authorities to act as test sites – Dumfries & Galloway, City of Glasgow and Highland – to trial targeted activities to address 3 themes as part of its investment in promoting SDS. The 3 target themes – leadership and training; cutting ‘red tape’; and bridging finance – were based on key issues identified by past research. The test sites were funded between January 2009 and March 2011.

Evaluation of the SDS test sites, demonstrated that local authorities face a number of challenges in implementing SDS and achieving transformational change (Ridley et al, 2011). Another study (Rummery et al, 2012) of the macro level financial and economic evidence on costs, benefits and impacts of increasing SDS in Scotland, concluded that while implementation remains an area of contention, the cost of further uptake does not differ significantly between SDS and more traditional services.

A number of commentators, including ADSW (2009), argue that the change needed will be transformational for the work of those at the frontline of providing support and services, as well as for the structures and systems of service delivery in local authorities and other sectors. Directors of Social Work from the 3 test site local authorities giving evidence to Scottish Parliament in May 2009 identified what they called the “seismic change” required, and referred to the inevitable slow progress in terms of numbers opting for SDS initially (Scottish Parliament, 2012).

Evaluation of the local authority test sites established that those accessing SDS packages were positive about the choice and flexibility offered, although it was unclear whether this was solely as a result of SDS or the greater levels of support and funding made available during the test sites (Ridley et al, 2011). Access to SDS increased particularly among people with learning disabilities, the main target group of at least 2 of the test sites. The study found that the test sites took longer than anticipated to get established – recruiting staff, raising awareness, training and setting up SDS systems, and providing support - and that numbers of people accessing SDS were relatively low across the 3 areas. It concluded that significant time and investment in infrastructure was required to implement such a major policy initiative.

The fieldwork for the evaluation was completed in March 2011 just as the test sites were building momentum and as new SDS systems were starting to see progress. By the end of the 2 year period, the 3 local authorities had resolved to move towards full implementation of SDS with support from senior management. Follow-up work

was subsequently commissioned by Scottish Government to examine progress and developments in implementing SDS in the test sites in the intervening 12 months i.e. from 1st April 2011 to 31st March 2012.

Purpose of the study

The overall aim of this follow-up evaluation study was to assess the continuing and longer term impacts of the interventions employed in the SDS test sites, and to build on the previous evaluation (Ridley et al, 2011).

Its objectives were to assess the continued uptake; to identify the activities to further promote and increase awareness of SDS; and identify system wide change within the test site local authorities. Additionally, the study looked at the extent to which innovative and creative practices developed during the test sites had continued, and the shift towards greater involvement and co-production in social care on a wider scale. Further, given the wider financial context of resourcing social care, the study sought to gain understanding of how this was impacting on implementing SDS.

Methods

Using the original evaluation of the test sites as its baseline, the study collected information about developments and progress over the time period of 1 April 2011 to 31 March 2012. Four main methods were used to build as comprehensive a picture as possible within a short timeframe as follows:

- Interviews with local stakeholders in each area (including staff and managers from the local authority, third sector organisations, advocacy and service user organisations) – 40 interviews involving 67 key stakeholders.
- Cohort information collating data about access to SDS and types of SDS packages – information analysed about 1,011 new SDS packages.
- Information from local documents including Social Work Committee reports, leaflets and promotional materials, including a ‘mystery browser’ exercise of local authority SDS websites.
- Questionnaire survey of care managers and other social work staff involved in community care assessment – 213 responses, 43% response rate.

Key Findings

Organising to Implement SDS

- The fast pace and momentum of change in Glasgow was in contrast to a more cautious and slower pace of implementation in both Dumfries & Galloway and Highland.
- Less active partnership arrangements were described in all 3 areas by third sector interviewees who often commented that joint working at a strategic level had been better during the test site period.
- All 3 local authorities had retained a specialist team to continue to be a source of expertise and support for operational staff developing new systems, and provided a link between strategic management and operations. These teams continued to

be highly valued by front line workers but concerns were expressed about their capacity to cope with greater demand.

- Specialist teams differed in the extent to which they were developmental and strategic and/or directly involved in implementing SDS.
- Only Highland had integrated SDS and DPs since the test site. DP Teams in both Dumfries & Galloway and Glasgow local authorities were now working more closely with the Personalisation/SDS teams and frameworks than during the test site period.

Promotion & Awareness of SDS

- Whilst there were continuous efforts to provide information, raise awareness and provide training about SDS in all 3 sites, a number of challenges remained.
- Paradoxically, increased awareness about SDS was coupled with uncertainties and anxieties for users, carers and agencies in the current context of implementation.
- In Glasgow, providers and social workers consulted expressed concerns about the discrepancy between aspirational presentation of SDS to service users and carers and the reality. However, where the other sites took a more cautious approach to implementation, this still left questions about how much to promote SDS more widely and how to manage any subsequent demand.
- The more SDS is 'mainstreamed' beyond the test site target groups, the more pressure there appears to be on front line services and support agencies (especially SDS teams) who are inevitably spread more thinly and this exposes lack of capacity and expertise elsewhere in the system.
- The specific focus of the test sites on particular client groups (e.g. learning disabilities and young people in transition) resulted in some of the information material not always being appropriate for other client groups.
- Whilst the majority of care managers said they had received training, their overall view was that it was still not sufficient to enable them to implement SDS effectively in the current context.
- SDS is essentially an individualised approach and therefore may require an individualised approach to training. While bespoke support was on offer from SDS teams, ensuring wide access to this for front line workers and providers would be resource intensive and remains a key challenge.

Accessing SDS

- Access and uptake of SDS had increased after the test sites, most dramatically in Glasgow.
- The sheer scale of the increase of SDS packages in Glasgow was in marked contrast to the steady growth in the other 2 sites.
- In the follow-up period over 1,000 new SDS packages had been set up, the majority (892) of which were set up by Glasgow.
- Most SDS packages in the follow-up period in Glasgow consisted of Individual Service Funds (ISF) with external providers. In comparison there were no ISFs in Highland and only a few in Dumfries & Galloway.
- People with learning disabilities were still the main client group accessing SDS across the sites (59% of all packages), although gaps in access were clearly being addressed.

- DPs to third parties were much more common in Glasgow than they had been during the test site, while a DP managed by the individual was the most frequent SDS option in Dumfries & Galloway and Highland.
- We sought information regarding whether SDS packages that were set up during the test site continued as a marker of sustainability. However, we were unable to obtain this information from Glasgow, and Highland appeared not to have developed sustainable packages (but rather focused on one-off payments during the test site).
- In contrast, Dumfries and Galloway had continued to fund SDS packages set up during the test site. This is important given the anxiety expressed by service users and carers who had benefited from SDS in the test site period about this (Ridley et al, 2011).

Systems & Processes to Implement SDS

- On-going change in assessment and resource allocation systems had persisted as a main preoccupation since the test sites in all areas.
- Key stakeholders in Dumfries & Galloway, however, stressed the cultural shift needed to implement real choice and control rather than systems being 'right'.
- Care managers were the least positive about new protocols and processes to implement SDS particularly in Glasgow.
- A key criticism of the assessment processes developed during the test sites was that they tended to be too orientated for use with people with learning disabilities and were having to be further developed.
- There was evidence of increased involvement of independent advocacy since the test sites in all areas though this was notably inconsistent, and dependent upon care managers' understanding of the role of independent advocacy as well as on the capacity and training of advocacy organisations.
- In all 3 areas, more resource allocation panels had been created to enable greater numbers of support plans to be considered and to enable decisions to be taken at locality level.
- Systems of resource allocation were a zone of high uncertainty and one of the most problematic aspects of implementation and these had not been fully resolved during the follow-up period.
- Paperwork resulting from implementing SDS had not decreased the bureaucratic burden but had rather increased it in those cases where self-assessment continued in parallel or was an addition to single shared assessment.

Perceptions of the Impact of Financial Context

- Perceptions of the immediate impact of the financial situation post test site differed across sites.
- We were unable to ascertain whether official eligibility criteria operated for social care services in either Glasgow or Highland. In light of the stated aim of increasing transparency, this lack of information is a concern.
- Eligibility criteria adopted by Dumfries & Galloway demonstrated a more holistic approach, focusing on early intervention and prevention. However, some parts of this region were operating stricter criteria.

- Whilst financial constraint was a huge challenge in all 3 areas, the consequence of Glasgow's strategy of coupling the agenda to reduce expenditure with a fast roll out of SDS, had resulted in front-line social work staff feeling under pressure, with a knock on effect on the quality of SDS assessments, levels of involvement, choice and control and staff morale.
- Short term sustainability of SDS support packages since the test site varied across areas – while the majority of personalisation packages set up under the test site had continued in Dumfries & Galloway only a minority in Highland had continued, and whether packages continued in Glasgow is not known.
- Longer term sustainability appears more challenging and uncertain given the financial context, especially staying true to the ethos of independent living and maximising choice and control which motivated users and carers demand for SDS in the first place.
- How this situation is managed has implications for how SDS is promoted to the public and service users (i.e. from its current focus on aspirational and transformational 'success stories').

Conclusion

In the year following the end of the test sites, the 3 local authorities had managed to shift perceptions of SDS further towards it being seen as a mainstream approach to service delivery. Scottish Government investment in the test sites enabled new processes and infrastructure to be established and knowledge of, and expertise in, SDS to be developed. This all contributed to increased take-up of SDS during the follow-up period. However, all 3 sites faced remaining and significant challenges. For example, ensuring communications about SDS were transparent and up-to date; managing the impact of financial and capacity constraints which might compromise choice and control; and, whilst specialist SDS teams were highly valued, they were all described as stretched. The pace of implementation was found to be a significant factor influencing perceptions of the success of implementation, and high numbers of SDS packages per se were not considered to be positive when this compromised quality of involvement and co-production in assessment and support planning. More generally, this suggests the need for a wider debate and greater transparency about eligibility, the future funding of social care and how to ensure that SDS develops in line with the broader philosophy of Independent Living.

1 INTRODUCTION

Study Background

- 1.1 While the term 'Personalisation' has been used to describe the approach applied in social care to increase self-determination, choice and control in England (Glendinning et al, 2008), in Scotland the focus has been on promoting self-directed support (SDS) defined in the recent Social Care (Self-Directed Support) (Scotland) Bill. The terms 'personalisation' and 'SDS' are sometimes used interchangeably, while elsewhere, they are used to distinguish a broad approach to social care (personalisation) from a set of particular mechanisms for implementing personalisation e.g. using a process that identifies an individual budget (SDS).
- 1.2 In 2009, Scottish Government selected 3 local authorities to act as test sites – Dumfries & Galloway, City of Glasgow and Highland – to trial targeted activities addressing 3 key issues identified by past research, as part of its investment in promoting SDS. A 2-year evaluation of the test sites was commissioned by Scottish Government to inform national strategy and the development of SDS legislation, and this found SDS to be an 'evolving concept' and one that was clearly interpreted variously in practice (Ridley et al, 2011).
- 1.3 The 10-year national plan for SDS (Scottish Government, 2010) aims to bring SDS into the mainstream of social care and increase the number of people directing their own support, including the number doing so via Direct Payments (DPs). If enacted in 2013, the Social Care (Self-Directed Support) (Scotland) Bill will make offering SDS the duty of local authorities. Evaluation of the SDS test sites set up 2009-2011, demonstrated that local authorities face a number of challenges in implementing SDS and achieving transformational change (Ridley et al, 2011). Another study (Rummery et al, 2012) of the macro level financial and economic evidence on costs, benefits and impacts of increasing SDS in Scotland, concluded that while implementation remains an area of contention, the cost of further uptake does not differ significantly between SDS and more traditional services.
- 1.4 A number of commentators, including ADSW (2009), argue that the change needed will be transformational for the work of those at the frontline of providing support and services, as well as for the structures and systems of service delivery in local authorities and other sectors. Directors of Social Work from the 3 test site local authorities giving evidence to Scottish Parliament in May 2009 identified what they called the "seismic change" required, and referred to the inevitable slow progress in terms of numbers opting for SDS initially (Scottish Parliament, 2012).

- 1.5 Evaluation of the local authority test sites established that those accessing SDS packages were positive about the choice and flexibility offered, although it was unclear whether this was solely as a result of SDS or the greater levels of support and funding made available during the test sites (Ridley et al, 2011). Access to SDS increased particularly among people with learning disabilities, the main target group of at least 2 of the test sites. The study found that the test sites took longer than anticipated to get established – recruiting staff, raising awareness, training and setting up SDS systems, and providing support - and that numbers of people accessing SDS were relatively low across the 3 areas. It concluded that significant time and investment in infrastructure was required to implement such a major policy initiative.
- 1.6 The fieldwork for the evaluation was completed in March 2011 just as the test sites were building momentum and as new SDS systems were starting to see progress. By the end of the 2 year period, the 3 local authorities had resolved to move towards full implementation of SDS with support from senior management. Follow-up work was commissioned by Scottish Government to examine progress and developments in implementing SDS in the test sites in the intervening 12 months i.e. from 1st April 2011 to 31st March 2012. This report presents and discusses the findings from the follow-up evaluation of the test sites.

Evaluation Aims & Objectives

- 1.7 The overall aim of the follow-up work was to assess the continuing and longer term impacts of the interventions employed in the SDS test sites in the original project. The objectives were to:
- Assess the continued uptake and impact of the interventions used to improve uptake of SDS in each test site.
 - Identify the activities to further promote and increase awareness and knowledge of SDS, particularly amongst care users, carers and the workforce.
 - Identify system wide change within the test sites and what can be learnt from this change.
- 1.8 Further, given that the evaluation report raised a number of questions around the sustainability of the systems introduced by the test sites, it was of particular interest to explore what progress had been made in each of these areas in terms of:
- The extent to which the local authorities had moved towards mainstreaming SDS and the leadership provided by senior management in achieving this.
 - Whether the creative and innovative ways of working developed by the SDS teams within the test sites had been maintained and further developed.

- The extent to which test sites had been able to implement a shift towards greater involvement and co-production of care and support.
- 1.9 The original evaluation suggested that the reach of SDS packages was limited mainly to people with learning disabilities, and that no one from a black and minority ethnic (BME) group had benefited. It was therefore important to investigate how local authorities had subsequently tackled such inequalities in access to SDS. Another issue raised was the absence of independent advocacy from the support available to those accessing SDS during the test sites. As well as evidence of brokerage arrangements, the follow-up evaluation sought evidence of support to independent advocacy organisations and about how their role may develop in the context of SDS.
- 1.10 Given the wider financial context of resourcing social care, it was also important to gain some understanding of how this might be impacting on SDS. For example, how SDS was being presented in this context to potential service users and carers; what information was being given to service users about SDS; how care managers perceived the impact on support arrangements; and assessing whether packages were agreed and/or sustainable post test site.

Evaluation Design

Methods

- 1.11 Building upon the design and data from the original evaluation of the test sites, the study collected information about developments and progress over the time period of 1st April 2011 to 31st March 2012. Four main methods were used to build as comprehensive a picture as possible within a short timeframe as follows:
- **Interviews with local stakeholders** in each area (including staff and managers from the local authority, third sector organisations, advocacy and service user organisations).
 - **Cohort information** collating data about access to SDS and types of SDS packages.
 - **Information from local documents** including Social Work Committee reports, leaflets and promotional materials, including a 'mystery browser' exercise of local authority SDS websites
 - **Questionnaire survey of care managers** and other social work staff involved in community care assessment.

Populations & Samples

- 1.12 A brief summary of the samples of different stakeholders and information obtained for the evaluation is given below.

Stakeholder interviews

1.13 We aimed to interview 12-15 key stakeholders in each test site, and worked with local authority SDS leads to identify the most relevant local authority and external stakeholders to approach. In addition to local interviews, we interviewed 2 members of the SDS Team at Scottish Government. We aimed to speak to those directly involved in and managing SDS teams and local authority senior managers including Directors of Social Work, service user organisations, advocacy organisations, and third sector service providers. A total of 67 individuals participated in 42 interviews during May to July 2012, that is, 65 local stakeholders and 2 members of the SDS Team at Scottish Government. Mainly individual face-to-face interviews (8 were requested by telephone) were conducted, and were a mix of individual and group interviews. The higher number of participants in Glasgow, and also Dumfries & Galloway, was due to greater numbers of service users and providers being involved in group interviews:

Table1.1: Number of stakeholder interviews and participants in the 3 test sites

Type of stakeholder	Dumfries & Galloway		Glasgow		Highland		TOTAL	
	No of interviews	No of participants	No of interviews	No of participants	No of interviews	No of participants	No of interviews	No of participants
Local authority (incl SDS Teams, DP Officers, Commissioners, & senior managers)	8	14	7	9	7	9	22	32
Service user organisations (including support organisations, group interviews with users)	1	1	2	10	1	1	4	9
Independent advocacy (including carers)	2	2	3	3	2	2	7	7
Voluntary sector providers	3	4	3	9	2	3	7	17
Total	14	21	15	31	12	15	40	65*

*Total number of interviews does not include 2 interviews with Scottish Government staff

Cohort information

- 1.14 The 3 local authorities were asked to complete a shortened database form (cohort form) used in the original evaluation to gather information on demographics and packages of SDS recipients during the test site period – i.e. from 1st April 2011 to 31st March 2012. As there are different definitions about what is counted as SDS we have summarised information from the local authorities about the populations counted.
- 1.15 Dumfries & Galloway supplied information for all those who had chosen SDS as their route and completed a support plan. Most had this agreed by a resource allocation panel. Information from Glasgow was derived from its client group database and distinguished those who had opted for SDS and had an SDS assessment only; those who had been assessed and had a support plan; as well as those whose support plans had been agreed including the SDS option(s) chosen. The cohort information for Highland included all who had opted for the SDS route, whether these were new SDS clients or reviewed DPs that were following the SDS approach (completed SDS assessment and support plan).

Documentary analysis

- 1.16 Each local authority was asked to provide relevant documentation. These were obtained electronically and included joint community care plans, SDS leaflets and promotional materials, newsletters, service change plans, action plans, press releases, committee reports and anything else that the local authority felt would help us to better understand developments since the test site. We also utilised a brief ‘mystery browser’ exercise where we searched each Council’s website for information about SDS.

Questionnaire survey

- 1.17 A questionnaire survey, using the *SurveyMonkey* internet tool, surveyed the views of staff with responsibility for community care assessment and care management in all 3 local authorities. While Dumfries & Galloway and Highland provided comprehensive lists of email addresses for all relevant staff in adult care, older people’s teams, and children and family teams working with children with disabilities, Glasgow provided a list of staff who had participated in personalisation training. This limits our ability to make any direct comparisons, especially in relation to increased awareness about SDS amongst staff. The survey was initially sent during July 2012 and two reminders were issued.
- 1.18 Out of 500 potential respondents, we received 213 replies (93% of which were fully completed). This equates with a response rate of approximately 43%. Some caution needs to be applied in interpreting the responses from Highland given the considerably lower response rate from this site. The number of non-

respondents who stated the survey was not relevant to them was also highest from Highland.

Table 1.2: Survey questionnaire responses by local authority

Local Authority	Potential no. of responses	No. of Responses	% response rate
Highland	175	40	23%
Dumfries and Galloway	127	61	48%
Glasgow	198*	112	57%
Total	500	213	43%

*31 email addresses from Glasgow were non deliverable

Analysis

1.19 Notes were taken at all individual and group interviews. Data were analysed using qualitative methods to identify themes and patterns (Coffey & Atkinson, 1996). This process was largely driven by the research aims and objectives. Data was initially organised under five main categories corresponding with the study specification. These were: awareness and promotion; access and systems; uptake; organisational and structural issues; and the impact of financial cuts. Data was analysed and themes collated by the team collectively.

Study Limitations

1.20 The original evaluation was hampered by the relatively short time period (2 years) given the delayed start of the test sites. This follow-up study therefore attempts to capture the longer term impact of the test sites. It was however limited in scope and there were many interesting lines of possible inquiry that could not be pursued within the limits of the project timeframe (6 months) and the budget. Most significantly the evaluation lacks inclusion of consultation with service users and carers in measuring impact and outcomes. Nevertheless, this study provides insights into the continued development of SDS in the 3 sites from the perspectives of stakeholders from different sectors.

Report Structure

1.21 The findings of the follow-up study are presented thematically in the next 5 chapters, which also draw out differences between the 3 local authority sites wherever possible. Chapter 2 begins by looking at what interviews with key stakeholders and local reports told us about the structures and organisational issues experienced since the test site. This includes whether or not the specialist SDS teams were retained and any changes in their role as well as perceptions of the leadership role of senior management. Chapter 3 summarises the data from interviews, documents and the survey on promotion and awareness raising of SDS by the local authorities, while

Chapter 4 presents the evidence post test site on access and uptake including from the cohort forms, commenting on ways that the sites had addressed equality issues and scale of implementation. Chapter 5 then describes progress and issues with implementing the systems and processes of SDS across the local authorities, and Chapter 6 looks at perceptions, particularly those of care managers and other professionals, of implementing SDS at a time of severe financial constraint on public services. The final section, Chapter 7, draws together some conclusions from the findings and the implications for policy and practice.

Terminology

- 1.22 As stated earlier, the original evaluation found SDS to be an evolving concept, and the terms SDS and personalisation to be used both interchangeably and distinctly. In this report we have used both SDS and personalisation in ways that reflect how the terms were used in the local sites. We have also used the term 'care manager' as shorthand when referring to survey respondents. While this included staff with the job title of care manager, it also included social workers, team leaders/managers, care coordinators, and practitioners who had responsibility for community care assessment and care coordination.

2 ORGANISING TO IMPLEMENT SDS

Introduction

2.1 In this chapter, we examine the post test site organisational arrangements and structures put in place by local authorities and partners to ensure increased access to SDS. This includes revisiting the theme of leadership and investigating how the local authorities were progressing SDS implementation. During the test sites, the local authorities created specialist SDS/personalisation teams and these have continued in some form, although their role and remit, as well as their locus within organisational structures and networks, had shifted since the test site period. We first revisit and summarise key organisational features of the test sites, and move on to consider how these had developed one year on. We explore perceptions of partnership and joint working, the changing role and remit of the SDS teams, the extent of SDS implementation, specifically addressing the issue of the integration of SDS and DPs.

Test Sites

2.2 This section begins by summarising the main elements of organisational structures operating during the test site period before examining how organisational arrangements and resources developed in the follow-up period.

Table 2.1: Summary of key test site structures, approach and reach

	Dumfries & Galloway	Glasgow	Highland
Structure	Personalisation Team managed by Senior Social Work Manager for Wigtownshire. Reporting to Executive Group and multi-agency Personalisation Programme Board	SDS Team managed via Head of Mental Health and Adult Support & Protection and Assistant Director of Social Care, Reporting to Health and Social Care Policy Development Committee	SDS Team managed by Head of Children's Services Reporting to SDS Project Board mainly of local authority staff
Approach	Part of existing plans to implement Personalisation; Community development; organic; bottom-up; Developed separately from DP	Built on IB Pilot in East Glasgow with people with learning disabilities; Partnerships with voluntary organisations Developed separately from DPs	Specifically aimed to increase number of DP recipients; Significant number of one off payments Developed separately from DPs
Reach/scope	Adopted open criteria with test site initially covering Wigtownshire but covering whole of region before end of test site	Targeted at people with learning disability in East of City but expanded before end of test site	Targeted at young disabled people in transition. Not geographically focused

- 2.3 Details of the SDS or Personalisation Team established by each test site were given in the previous report and so will not be repeated here (Ridley et al, 2011). In short, the composition and role of teams differed across sites, although each had created a project manager role. These specialist teams had been both instrumental in developing new SDS systems and provided expertise and assistance to frontline staff. Some had been directly involved in assessments alongside frontline staff (Dumfries & Galloway and Glasgow) and others, being more of a resource for care managers and others to draw upon in implementing SDS (Highland). During the test site, the SDS teams piloted new ways of working and were centrally involved in creating, and fine tuning, assessment and resource allocation processes. Indeed a significant proportion of staff time had been spent on this. Notably, all 3 teams had been set up in parallel to existing arrangements to deliver DPs, and at the end of the test site declared their intention to integrate these functions/processes.
- 2.4 The test sites started from different points, and while the intention in Dumfries & Galloway was to build on a strategy for personalisation, and in Glasgow to promote SDS starting from an initiative about IBs, Highland specifically planned to increase the number of DP recipients. Although it had been the Scottish Government's intention that the test sites would be local authority wide, the focus was on particular geographical areas. Furthermore the reach of initiatives was limited to specific target groups except in Dumfries & Galloway.

Transition from Test Site

- 2.5 During the follow-up period, all 3 local authorities were engaged in programmes of major reorganisation and modernisation of social care services with SDS being central to these programmes. These changes can be seen as enablers and/or barriers to the wider implementation of SDS, particularly in the context of significant budgetary constraint on public services. In Highland, a key change was the integration of Highland Council and NHS Highland services through a partnership agreement¹, while in both Glasgow and Dumfries & Galloway major structural reorganisation of social work departments into localities and/or under new responsibilities was taking place.
- 2.6 Even prior to the end of the test site, integration of local authority and NHS services was a major preoccupation in Highland, which various stakeholders including senior management considered, had slowed down the processes of cultural change needed to implement an SDS approach. Furthermore, it was suggested that underlying differences between approaches, practices and culture in health and social care were challenging to the implementation of SDS. In Dumfries & Galloway and Highland, stakeholders involved in the roll

¹ Partnership agreement (21.03.12) established that from 1 April NHS Highland was to be the lead agency for adult services and the Council to be the lead for children's services.

out of SDS identified that a period of reflection, of taking stock, happened immediately following the test site.

- 2.7 Even before the end of the Glasgow test site, the Council had embarked upon an ambitious service change programme to implement SDS across adult care services and of service modernisation². Culture change was seen to be critical to realising these intentions. Despite its early strategic start, the scale of the programme suggests an elongated and stressful transition period. SDS policy and strategy matters have been a focus of the Council's Health and Social Care Policy Committee since the dissolution of the 5 Community, Health & Care Partnerships (CHCPs) in 2010 with subsequent restructuring³. Another area of change relates to the Council's charging policy for non-residential services⁴. Those interviewed in Glasgow described the situation after the test site as "an endless series of meetings" for staff at all levels of the Council and across partner agencies, all of whom were said to be spending much more of their time on SDS, reflecting the scale, complexity and phasing of the programme of implementation.
- 2.8 In contrast, interviewees from Dumfries & Galloway reported a "hiatus" in the months immediately after the test site. Modification to the strategic infrastructure supporting development of personalisation in the local authority meant that for a short while the Personalisation Team became the hub of activity on personalisation. The Programme Board set up under the test site was disbanded after March 2011. A key shift had been the transfer of responsibility for leading implementation from a centralised Executive Group and Personalisation Board to 4 Locality Teams. Social Work was also restructuring its service along 4 related activity streams – integration; community engagement; personalisation; and early intervention. The focus on enablement and early intervention and prevention was identified as enabling a move from crisis only responses. Whilst this restructuring was perceived as complementary to promoting SDS, there were at least two key stakeholders who commented that this was in parallel to, and had slowed the pace of, SDS implementation.

² Report on "*Personalisation of Social Care*" to Glasgow City Council Health and Social Care Policy Development Committee - 22 September 2010. Report by Executive Director Social Care Services

³ From 1.11.2010 the 5 Glasgow CHCPs were dissolved and replaced by a single health-led CHP model covering 3 sectors - North-East, North-West and South. (Glasgow City Council Annual report on the 2010/11 audit. Audit Scotland October 2011)

⁴ Glasgow City Council Social Work Services (2011) Social Care Charging Policy April 2011 to March 2012.

Implementing SDS

- 2.9 Evidence gathered through interviews as well as documentary analysis showed that in all 3 sites there were determined attempts to embed SDS as the mainstream approach in social care as a result of the test site activity. Rolling out personalisation across Dumfries & Galloway was said by the Personalisation Team and senior management to be the way Social Work was moving forward now and in the future⁵. A high level of commitment to the SDS agenda from elected members, Chief Executive and the Director of Social Work in Dumfries & Galloway was commented upon by several interviewees. However, despite reports of strong strategic leadership from the top and support from the Personalisation Team to develop new approaches, it was remarked that SDS was “still not on a lot of managers’ radar” and that some were not even aware of the national SDS Bill. In the midst of a broader ‘change agenda’, personalisation was described by some of those more closely involved as “drifting”, which suggests the need for more joined up policies and legislation. These broader concerns appeared to leave the Personalisation Team feeling isolated during the transition period. Without this team, some remarked that SDS would have “died a death”. Indeed, other stakeholders saw the team as very important and one senior manager described them as “tireless in mentoring, enabling, facilitating” the SDS agenda forward.
- 2.10 In Glasgow, where SDS was promoted with high level corporate support, SDS was perceived by many of those interviewed including those in the third sector as a “top down development” with the SDS and Finance Teams being valued key resources for implementation. “Whole systems change in adult services towards personalisation” was typical of how most interviewees described the change that had taken place in social care services since the test site. Yet whole system change was not perceived by all stakeholders in a positive light, with communications highlighted as being problematic (SCSWIS, 2011). Social workers and care managers responding to our survey stated that SDS had become the default position of the local authority to the extent that opting in was not a choice. The scale of implementation of new SDS systems was said to have been a “jolt to the system” and a “huge journey” for many including the finance team who had had to increase in number in order to process the high volume of cases. The financial framework, governance and legal processes, as well as information technology (IT) had all faced major challenges. Third sector organisations have been forced to change rapidly too, for example, Glasgow Centre for Inclusive Living (GCIL)’s role had widened beyond physical disability to assist people with mental health problems and other disabilities. Service providers have been required to establish new internal systems and liaison arrangements and keep up-to-date with sometimes fast changing elements of the SDS process to meet targets.

⁵ See Press Release, Sept 2011, *Personalisation launch in Dumfries & Galloway*, Dumfries & Galloway Council, *Personalisation and Self-directed Support Learning and Development Action Plan Sept 2-11 to March 2012*.

- 2.11 The scale, direction and momentum of change to implement SDS in Glasgow were highlighted as major issues inhibiting positive implementation. Frontline workers stressed the pressure they faced to rush through assessments to meet targets. The pace of the SDS implementation programme was also criticised by various third sector providers and interest groups working across different client groups, who felt that the shift to SDS was being progressed too fast. While many recognised that the Council supported personalisation in principle, some perceived financial objectives rather than values to be a key driver of the time-scale, particularly given the Council's expectations of a 20% redirection of resources. It was also emphasised that compared with the test site period there was insufficient scope for creativity and choice in support arrangements. These concerns encouraged the Council to establish an independent scrutiny panel which has met 3 times, to address concerns about the programme, aspects of the process, as well as positive outcomes. For example, a city-wide network representing social work service users' interests, affirmed their appreciation of the rollout of SDS and referred to SDS as "working well" in terms of increasing choices for people previously on DPs⁶. However by March 2012, the Council had agreed an amendment to a motion put by the Green Party to stop or slow down the SDS roll-out, whereby the Council recognised "overwhelming concern" from service users, carers, and staff, and accepted the need for a "full and open review"⁷. Additionally, the Council committed to reviewing its communications and commissioning strategies in regard to SDS and to maximising consultation on these⁸.
- 2.12 The Council's leadership is therefore, fully aware of these reactions and has confirmed its commitment to personalisation and to engaging in dialogue with the trade unions and providers to improve communications, and made some notable adjustments such as slowing the programme and publicising Scrutiny Panel minutes. Providers also reported that the Finance and SDS teams have worked on adjustments to address issues faced and raised. It should be noted that the concerns highlighted about the speed of the programme reflect the findings of the recent study by the Social Value Lab (2012). One year after the test site, Glasgow had therefore has established a number of mechanisms for consultation, dialogue, reflection and problem-solving including: a Progress and Process meeting of social work staff and managers; other meetings with providers; as well as the Scrutiny Panel. In addition its Communications Strategy is undergoing review.
- 2.13 The stated overarching policy direction in Highland was that SDS was the anticipated approach throughout the organisation⁹. Commitment to

⁶ Glasgow City Council Social Work Services Personalisation Scrutiny Session Report. 14 December 2011

⁷ Personalisation - Motion Approved. Item 12. Glasgow City Council. Minutes of Glasgow City Council 2012-2013 - Print 1. 29 March 2012.

⁸ GCC Report on Personalisation Scrutiny Session - 27 June 2012

⁹ E.g. Highland Housing & Social Work Committee, *Transformational Change Programme for Community Care: a Progress Report*, 14 Sept 2011, 28 Feb 2012; Highland Council, Housing & Social Care Committee, 12th Jan 2011, *Infrastructure requirements for SDS*.

implementing SDS was perceived to come from the top, and as in the other areas was reliant on the work of the small dedicated SDS Team to 'spread the word' and lead change towards self-directed and outcomes-based assessment. Several stakeholders including senior managers in Highland, and those directly involved in implementing new SDS systems, commented that senior management "get SDS", and emphasised the helpful leadership from the top to ensure implementation. The impression gained from stakeholder interviews was that the momentum of change had definitely increased since the test site and the focus of the approach had shifted from a targeted group to encompass broader adult care groups and older people. However, survey respondents from Highland reported the lowest average inclusion of clients opting for SDS (8%) in their caseloads, as well as having the lowest engagement of care managers in the survey on account of the survey not being relevant to them. This would suggest that the reach of SDS implementation was somewhat slower than anticipated.

Joint/Partnership Working

- 2.14 A feature of the test sites was that inter-agency and partnership working was common, particularly with voluntary sector learning disability providers, in the strategic development and practical implementation of SDS. However, since the test sites, various stakeholders interviewed suggested that effective partnership working had declined. In some cases, mechanisms and structures for strategic involvement of different stakeholders created during the test site no longer existed. Third sector interviewees in Dumfries & Galloway, particularly those involved in advocacy, pointed to a decline in meetings about SDS with the Council post test site in contrast to when they had been part of the Personalisation Programme Board. The voluntary sector had thus been proactive in developing forums and support to promote SDS in Dumfries & Galloway such as the Special Interest Group (Learning Disabilities) set up by Action for Real Change Scotland (ARC) in collaboration with Turning Point, Capability and others. A positive development since the test site was that there was now voluntary sector representation on the Council's Adult Protection Committee. Also, good joint working links with providers and advocacy organisations were in evidence in respect of individual cases and developing support packages.
- 2.15 The Social Care Ideas Factory (SCIF), an umbrella membership group for providers in Glasgow, was said to be actively involved in taking SDS forward through partnership working, driving initiatives such as trades swapping, strategic information provision, training and consultations. However, some providers did not feel fully or well represented. Although there were many tiers and types of meeting including regular meetings with commissioners, finance staff and the SDS Team, and Council officers' attendance at collective meetings of service users, providers felt increasingly excluded from strategy development since the test site. Just as in the other 2 sites, third sector providers in Glasgow commented that partnership working between providers and the Council was not working as well as in the past – "it's become about

‘them and us’”, and others said “joint work is patchy” and “ we don’t have a shared vision and approach”. More recently new consultation mechanisms were being established between the Council and providers¹⁰.

- 2.16 Involvement of service users and carers in the strategic development of SDS was generally felt by voluntary organisations, including advocacy services, to have been disappointingly slow. While this applied in Glasgow, it emerged that there was increasing dialogue between the Council, carers and disability organisations over SDS, and as highlighted earlier, a city-wide service user network stressed its partnership working with the Council. One advocacy organisation that had built up expertise in representing people in Phase One of the SDS implementation programme felt that dialogue with the Council had improved through this experience, while others had not yet developed a strategy for advocacy in the area.
- 2.17 It appeared that the role of advocacy in regard to personalisation was emergent and re-active, and somewhat under-developed in Dumfries & Galloway. The lack of a user-led support organisation such as a Centre for Independent/Inclusive Living as operates in Glasgow was noted by stakeholders as a significant gap in Highland. In Dumfries and Galloway, Direct Inclusive Collaborative Enterprise (DICE) was established with Scottish Government funding to address this gap. In Highland, an SDS user network that was at an early stage of development at the end of the test site was said not to have progressed much in the following year. Reasons posited included the difficult logistics of remote rural areas with more people from Inverness participating than other areas: carers being unable to participate due to pressures of the caring role; and service users and carers not perceiving participation in such a network as valuable. What had been highly successful, however, was implementation of Community Connector posts across Highland in 8 areas. These were posts tasked with working with communities to promote SDS and to focus on developing community capacity. As will be noted in a later chapter, the Health and Happiness organisation, commissioned to support individual planning and employ Community Connectors, was an important part of Highland’s promotion and implementation of SDS.

SDS/Personalisation Teams & Role

- 2.18 In all 3 local authorities a specialist SDS or Personalisation Team had been retained post test site. Composition of the teams was, however, different. Dumfries & Galloway was the only test site to have retained the same team managers throughout and incorporated new staff roles for example, Neighbourhood Link Workers, local area coordinators and development workers from the short breaks team. In contrast, both Glasgow and Highland SDS teams had had a change of team manager/lead either just before or immediately following the end of the test site, and were primarily comprised of

¹⁰ E.g, Consultative meetings established between Social Work management and CEO’s of providers.

experienced social workers or social care workers. In Glasgow, members of the team had clear geographical responsibilities but this was less so in the other areas.

- 2.19 Comments were made by various stakeholders about the demands made on small specialist teams in moving from targeted pilots to mainstreaming SDS. Local authority staff and external providers in both Dumfries & Galloway and Glasgow commented that the teams' capacities to provide support had diminished after the test site due to their increased coverage and related demands. However, in Highland comments typically emphasised how the team had gone from strength to strength post test site, partly as a result of merging with the DP Team in April 2011. However, increased take-up is likely to place additional pressure on this team. Whereas the Dumfries & Galloway and Glasgow teams had been well established during the test site, in Highland the team had been consolidated in this follow-up period, which appeared to have improved staff morale and increased its effectiveness overall.
- 2.20 During and after the test sites, the specialist teams provided training, mentoring and support to frontline staff implementing SDS. Support generally meant encouraging and facilitating the development of new practices and approaches. However since the test sites, the teams have varied in the level of direct involvement with individual cases, including in assessment, that is, in the extent to which they were strategic and/or operational. For instance, the Personalisation Team in Dumfries & Galloway remained directly involved in individual cases, while the Glasgow team's role evolved from having had a limited involvement in care management alongside their wider role in supporting care managers to being predominantly about supporting care managers with new systems and approaches. This included support with completing SDS forms and IT systems.
- 2.21 A central role identified by all the teams was delivery and coordination of training on SDS approach and systems more of which is covered in the next chapter on promoting SDS. This could range from brief awareness raising sessions to staff and service users to delivering training on the *In Control* approach alongside external consultants. Additionally, some mentioned SDS staff increasingly undertaking a 'troubleshooting' role, for instance, in Glasgow the team were frequently asked to be involved in particular cases and/or to attend Risk Enablement Panels (REPs) which focus on complex cases and concerns arising through the support planning process¹¹. The increased frequency of REP referrals during the initial phase of the Glasgow rollout (the learning disability provider pathway) skewed organisational resources (personnel and time) but are reported to have declined since the care management pathway was embarked on. The Glasgow City Council's own Scrutiny Report reported that only a few of the 800 service users currently

¹¹ Glasgow City Council Social Work Services procedures: ref no: gcc3/11: Glasgow City Council Risk Enablement strategy and guidance: issued 29 March 2011.

going through the learning disability care management pathway had been referred to REPs¹². It also emphasises that Social Work is committed to ensuring regular reviews of support/care plans.

- 2.22 Specialist teams, particularly team managers, provided strategic input and consultancy on SDS: a role they undertook during the test sites. In acknowledgement of this, management of the team in Dumfries & Galloway had been split between strategic and operational management, and the roles of both team managers in Glasgow and Highland were now described as developmental (including systems, procedural framework, initiatives; responsive internal consultancy re SDS process; on-going support to care managers/ assessors on SDS process; training; participating in relevant joint meetings and joint working) rather than operational. The role was also defined as a mediating role between policy and planning and operational staff. While there were benefits from having an established team, it was suggested by senior management and the teams themselves that as social work teams become increasingly skilled in supporting SDS, the role for a specialist team would diminish. However, they found it difficult to predict when this might be as they were still very much in demand.
- 2.23 Frontline workers responding to the survey expressed some confusion over their own role in relation to the specialist team in promoting SDS, although most understood the teams' support role in helping to mainstream SDS. Personalisation champions had been identified in one of the locality teams in Dumfries & Galloway. This was presented as a positive development, though some frontline workers were concerned that some staff had been reluctant volunteers who were not experienced or confident enough to be effective. Champions were also trialled in Highland but this was abandoned as it was felt that too much responsibility for SDS was invested in individuals. In Glasgow, the roll-out meant that engagement with SDS and links with the SDS team were increasingly dispersed within area teams.
- 2.24 Although there were differences in role between the teams, they had commonly experienced increased demands on their time and were now expected to work across the local authority and all client groups. As a result, the specialist teams themselves expressed feeling hard pressed at times, which was something that area team members acknowledged alongside considering them to be an essential resource.
- 2.25 What had shifted was the accountability and line management of the specialist SDS team so that they were now more embedded in mainstream services. In Dumfries & Galloway the Personalisation Team is managed under Frontline Improvement and tied in to the development of the 4 themes, whereas during the test site they had been aligned with just one area but spread to cover the whole region before the end of the test site. In Highland,

¹² GCC Report on Personalisation Scrutiny Session - 27 June 2012

the team is now managed within Modernisation of Services and accountable to the Change Support Team leading service modernisation rather than linked to the Children’s Services Manager as it was under the test site. In Glasgow the reporting line is via the Head of Mental Health and Adult Support, to the Assistant Director of Social Care, the Strategic Head of Adult Services and Executive Director of Social Work Services who report to the Health and Social care Policy Development Committee.

2.26 The specialist teams provided useful information about SDS as well as support with SDS assessment and other new processes. As table 2.2 shows, these teams were highly valued by frontline workers in all 3 areas. This perception of the teams as a helpful and useful resource was also identified by third sector providers interviewed in all areas.

Table 2.2: Care managers’ perceptions of the usefulness of SDS/Personalisation Teams

Care Managers	Helpful info from SDS team	Helpful support from SDS team	SDS team useful resource
Highland	76% (26)	79% (27)	79% (26)
Dumfries and Galloway	72% (40)	66% (37)	69% (39)
Glasgow	70% (75)	70% (75)	63% (67)

2.27 In Dumfries & Galloway, the Personalisation Team was perceived as generally helpful but recognised as overworked and under resourced to be able to offer the support needed by frontline staff. There was least satisfaction of all expressed by care managers in Glasgow which was coupled with strong opinions on the scale and pace of change. A general view was that the SDS Team was basically “spread too thinly” across different client groups. This often meant support was difficult to access and often delayed. Some specifically mentioned that their relevant SDS team member was only available one afternoon per week in their area even though SDS was taking up most of their case load now. Levels of satisfaction with the specialist team were highest in Highland, although this has to be set in the context of the survey response showing an average of just 8% of care managers’ caseloads being people who had opted for SDS.

Integration of SDS and Direct Payments

2.28 Only in Highland had there been full integration of the DP team with the SDS team, which had merged in April 2011 with the DP Officer being re-designated as SDS Officer. In Dumfries & Galloway the DP Team, which sat independently from Social Work within the Benefits Maximisation section, remained distinct from the Personalisation Team although the DP Team was

reported to be brought in at an earlier stage of the personalisation process when this was to involve a payment. A gradual shift was being made from 'traditional' DPs (based on assessed needs and support hours) to payments under personalisation during the test site and this had continued because DPs were seen as lacking flexibility and were not sufficiently outcomes focused. Those interviewed said there was more flexibility for people accessing DPs under personalisation because "the rules are more relaxed".

- 2.29 In Glasgow SDS and DP systems remained separate but the stated future intention was to fully integrate DPs within the SDS process. New service users requesting a DP are able to access this through SDS, although a senior manager reported that DPs will not be fully integrated within SDS until older people are able to access SDS. It was commented that with traditional DPs the focus was on assessing impairments and the help needed in terms of hours; SEQ assessment aims for flexibility so that service users can determine and ration their own support. However some interviewees commented that the assessment still seems to calculate support in terms of hourly rates to cover pay, on costs/training etc.

Summary/Key Points

- The fast pace and momentum of change in Glasgow was in contrast to a more cautious and slower pace of implementation in both Dumfries & Galloway and Highland.
- Less active partnership arrangements were described in all 3 areas by third sector interviewees who often commented that joint working at a strategic level had been better during the test site period.
- All 3 local authorities had retained a specialist team to continue to be a source of expertise and support for operational staff developing new systems, and provided a link between strategic management and operations. These teams continued to be highly valued by front line workers but concerns were expressed about their capacity to cope with greater demand
- Specialist teams differed in the extent to which they were developmental and strategic and/or directly involved in implementing SDS.
- Only Highland had integrated SDS and DP since the test site. DP Teams in both Dumfries & Galloway and Glasgow local authorities were now working more closely with the Personalisation/SDS teams and frameworks than during the test site period.

3 PROMOTION & AWARENESS OF SDS

Introduction

- 3.1 The wider implementation process had major implications for promotion and raising awareness, not only of the ethos and values of personalisation, but also about new systems and mechanisms for promoting SDS to service users, carers and staff. Therefore, this chapter explores the extent and impact of promotion, awareness raising and training for staff in the year since the test site. It is important to note that our inability to access the wider population of care managers in Glasgow prevented any direct comparison between sites of the impact of the Council's attempts to raise SDS awareness amongst frontline staff. This is because all the staff we were able to survey in Glasgow had received some training in personalisation, and were therefore, by definition, more likely to report increased awareness.

Approaches to SDS Promotion

- 3.2 In Dumfries & Galloway, the Personalisation Team took on much of the role of keeping momentum up post test site, a process they described in terms of revisiting and reinforcing SDS values within frontline teams. A wide programme of information and awareness raising sessions with locality managers and staff were organised across the site, though it was reported that when these were not mandatory, some meetings were poorly attended. Case work reviews tended to be used as a vehicle for raising awareness although this was seen as an 'ad hoc' approach. In one of the localities in Dumfries & Galloway, 'champions' (e.g. administrators, care managers, team managers) were identified by the local authority in each office. In addition, workshops were delivered to service users and carers to raise awareness, including local drop-in sessions. Collaboration was evident with the third sector through an 'open dialogue' approach. A number of voluntary organisations who were members of the Special Interest Group (learning disabilities) set up by Action for Real Change Scotland (ARC) ran two conferences in March and September 2011 to raise awareness among third sector employees.
- 3.3 In Glasgow, an extensive, wide ranging and active promotion of SDS continued after the test site period. There was notable partnership working between the Council and specific organisations such as SCIF who had held many events such as information days to inform service users and carers about SDS, circulated Council updates to providers, and produced newsletters. One provider held briefing sessions for service users and carers and employed a consultant to support staff to engage with SDS; another appointed a lead officer to promote SDS and continue joint working. Council representatives also attended various information days initiated by provider agencies and service user organisations (e.g. GCIL, GAMH, Disability Alliance etc.). From February 2012, Glasgow launched a specific initiative to

engage mental health service users in SDS. This involved briefing providers and meetings with service users and carers (via GAMH). There were also some outreach efforts by the SDS team to raise awareness amongst BME communities. In addition, the Council has developed a new accessible Citizens Portal information project and was developing a comprehensive intranet site including guidance on the process and accessible information about SDS for staff.

- 3.4 Whilst Highland appeared to have taken a more cautious approach to implementation more generally, they also initiated various promotional activities. This included awareness raising sessions held across Highland for local authority staff in all adult care teams. It was decided to abandon the notion of SDS 'champions' within teams as it was felt there was too much responsibility invested in one person and instead to instigate a broader and on-going process of training. The SDS team was viewed as a vital resource in Highland and the team worked closely with a voluntary organisation, Health & Happiness, in promoting SDS to service users and carers across the Highlands. Some senior managers felt their more cautious approach related to delays in getting resource allocation systems (RAS) in place and wanting to 'wait and see' if demand arose first, leading to a potential 'chicken and egg' situation. Specifically, there was a lack of promotion of SDS to some service user groups (e.g. mental health service users) for whom SDS was seen as less relevant and, therefore, not prioritised. Some promotional activities focused on collaborative working with health care professionals with a view to developing SDS support for long-term care provision and re-ablement. As a result, 2 health staff had been seconded to the SDS team at the end of the follow-up period to raise awareness and promote SDS to healthcare professionals. At the time of evaluation, this initiative was in its infancy.

Impact on Awareness

- 3.5 Care managers and third sector organisations reported increased awareness about SDS in each of the sites. Most staff and providers had attended promotional and information events and these were generally experienced as helpful in raising awareness. However, there were some discrepancies in different areas and across different service user groups. Whilst awareness of SDS appeared to have risen across all service sectors in Glasgow, there was greater variation across service user groups and areas in Highland and, to a lesser extent, in Dumfries & Galloway. For example, not surprisingly given its lack of priority, there was less awareness about SDS amongst mental health service users in Highland.
- 3.6 In Highland, although 72% of care managers responding to our survey felt that their understanding of SDS had improved in the last year, almost 20% still felt that it had not. In contrast, 83% of respondents in Dumfries & Galloway and, perhaps not surprisingly, 90% in Glasgow felt that their understanding had increased. However, in both Dumfries & Galloway and Highland, 22% of

care manager respondents still reported not having any service users opting for SDS/personalisation.

- 3.7 Increased SDS awareness among social workers in Glasgow was not wholly viewed as positive as it was accompanied by a sense that the SDS agenda had been pushed too quickly and that it displaced other important activities. In addition, there had been opposition and associated bad publicity about the perceived constraints on service users' and carers' choices about SDS itself. In sum, the Council's policy to use SDS as the primary route for access to support for specified groups, coupled with a 20% resource redirection strategy, was interpreted by many stakeholders as a cost-cutting agenda.

SDS Information

- 3.8 Whilst general awareness about SDS had increased substantially across all sites since the test site period, there was some variation in perceptions about the suitability of the information provided. In Dumfries & Galloway, general awareness had increased but there was dissatisfaction about the specific information provided. For example, care managers largely felt the information received in relation to personalisation was inadequate; 51% felt they did not have enough information and skills to access personalisation; and only 25% thought there was sufficient information available for service users to access personalisation. In particular, some care managers and third sector organisations perceived the information as somewhat confusing, unclear, inconsistent and even contradictory at times. Some mentioned that there were still no local information sheets available for potential service users and that a "Guide to Support, Services and Individual Budgets" that had been commissioned and drafted by another Council team had not consulted with third sector providers.
- 3.9 In contrast, in Highland a higher proportion of care managers (52%) felt that the information provided to service users was suitable. However, some care managers, providers and local advocacy organisations felt the information was sometimes out of date. Some of the local provider organisations also expressed confusion about the lack of clarity regarding the SDS process.
- 3.10 In Glasgow, care managers tended to report that whilst they had sufficient information to access SDS, the information provided to service users and carers was not adequate. This perception may relate to the issues discussed later about the perceived gap between what service users were told about SDS and the reality of what was possible, given the local context of implementation. In addition, care managers raised some concerns that the information made available to service users did not make it clear that they would have to make a contribution to SDS funds and this caused stress and confusion. Despite efforts to increase awareness about SDS amongst BME communities, some third sector organisations reported that this did not always reach the range of different BME communities (and languages) in the area.

3.11 In both Highland and Glasgow, some care managers and representatives from third sector organisations felt that information tended to be pitched more appropriately to people with learning disabilities and, whilst useful for these service users, this was not suitable for other groups such as those with mental health problems and older people. Our 'mystery browser' exercise generally supported these perceptions. For example, we found the information available on the Highland and Glasgow Council sites to be highly accessible and coherent with information leaflets for service users and carers easily available. In contrast, unlike the other 2 sites, we found it hard to locate any information on SDS or personalisation on the Dumfries & Galloway website. Our interview with members of their Personalisation Team confirmed that this was work in progress.

Training Issues

3.12 At the end of the test sites, system improvements were suggested by service users, carers and care managers and there was consensus on the need to improve training of frontline workers in new systems to increase access to SDS. Most staff in the 3 sites had now taken part in some form of SDS related training. There appeared to be the most comprehensive and intensive training programme delivered across Glasgow to a wide range of staff including care managers, team leaders, middle and senior managers and administrators on personalisation and *In Control* '7 steps' delivered by the SDS manager with an *In Control* Consultant. This included a full 3 day training programme and an additional 3 full days of IT training for outcomes based support planning. A wide variety of SDS-related training has also been on offer to other organisations such as SCIF and Enable. Whilst our survey of care managers in Glasgow specifically focused on care managers who had received personalisation training, of our wider sample of respondents in the other sites, 70% in Highland and 71% in Dumfries & Galloway stated they had received relevant training.

3.13 Despite this, a large proportion of care managers across all sites still felt they did not have the relevant skills to access SDS. For example, 56% of care managers in Dumfries and Galloway, 47% in Glasgow and 47% of respondents in Highland did not feel suitably trained, and many still felt that they lacked sufficient training and guidance about how to implement SDS/personalisation (especially regarding criteria and the process of actually putting a package together). As a result, some care managers in Dumfries & Galloway wanted to attend training that was being provided by one of the third sector organisations. This situation appeared to be due to a number of factors such as:

- Training received not being comprehensive or long enough to address the complexity of the process and the different needs of clients.

- A perception that the process and criteria for access had changed since initial training was conducted. Since then some suggested there had been changes in eligibility criteria which affected people's access.
- There had been inevitable adjustments to systems and related guidance with a time-lag to these revised procedures being accessible and this created frustration and confusion.
- The style of training was questioned by some care managers who experienced the training as being overly positive and unrealistic and/or based on a negative critique of social care professionals, rather than being positive, practical and enabling.
- Continued misperceptions about SDS. For example, in Dumfries & Galloway the Personalisation Team expressed some frustration that care managers still seemed to think that there was a specific 'personalisation fund' and therefore viewed SDS as an 'add on' to traditional care packages.

3.14 The momentum of on-going change in systems, alongside the training agenda led the SDS teams to provide on-going consultancy/ secondary support services for area teams across sites. For example, in Glasgow, the SDS team is available during the week for consultation and assistance and every week each area link worker from the SDS team spends time in their main contact area. Whilst this situation worked well, it was felt that a half day a week in situ was insufficient time to support their increased case load. In Dumfries and Galloway the Personalisation Team focussed on one-to-one support and mentoring activities and bespoke group training for staff as well as training for providers.

Promoting SDS in a Harsh Context

3.15 Most stakeholders appreciated the values embedded in SDS and found the 'success stories' which characterised promotional events positive and inspiring. However, there were concerns reiterated about whether these continued to be realistic or achievable in the current climate. Essentially, there appeared to be a conflict between the aspirational nature of SDS, as emphasised in promotional material, and the limitations of the support available for people to take up these opportunities and the budget restrictions on care packages.

3.16 Whilst this was a concern across all sites, it was particularly evident in Glasgow where there was an expectation that all service users within a client group 'in scope' of the SDS programme would go through the SDS process. Here care managers felt particularly strongly about the discrepancy between how they felt the council had promoted SDS to the public (as aspirational) and how it appeared in reality to staff going through the process (as a cost-saving measure). Many staff felt this led to unrealistic expectations and put them in a difficult position when explaining to service users and carers what was actually possible within the current context.

- 3.17 Another aspect of promotion relates to awareness-raising re SDS with service users and carers. In Glasgow for service users with mental health issues this has been carried out via information provision and joint working with providers and collective advocacy organisations - Glasgow Disability Alliance and GAMH - during 2011 to 2012 in advance of the first phase of the programme going live. Even earlier, awareness was being raised through the process of Scottish Government consultations over the draft Bill (Rosengard Associates, 2010). There were strong indications from agency websites and our consultations that SDS was a real source of concern to many people with mental health issues, as well as to people with physical disabilities, at a time when they were facing changes to their benefits and their support arrangements were being reviewed.
- 3.18 In the other sites, this difficulty was expressed in relation to concerns about managing demand. In Dumfries & Galloway the Personalisation Team reported concerns about promoting SDS too widely “in case we’re swamped” as a faster pace of implementation may affect the quality of the process for service users. Similarly in Highland, some care managers expressed concern that SDS might be “over-promoted” and lead to unrealistic expectations of what might be possible. This wider concern about managing demand may have resulted in a cautious approach to promoting SDS, especially to other clients groups beyond the groups targeted during the test site period.

Summary/Key Points

- Whilst there were continuous efforts to provide information, raise awareness and provide training about SDS in all 3 sites, a number of challenges remained.
- Paradoxically, increased awareness about SDS was coupled with uncertainties and anxieties for users, carers and agencies in the current context of implementation.
- In Glasgow, providers and social workers consulted expressed concerns about the discrepancy between aspirational presentation of SDS to service users and carers and the reality. However, where the other sites took a more cautious approach to implementation, this still left questions about how much to promote SDS more widely and how to manage any subsequent demand.
- The more SDS is ‘mainstreamed’ beyond the test site target groups the more pressure there appears to be on front line services and support agencies (especially SDS teams) who are inevitably spread more thinly and this exposes lack of capacity and expertise elsewhere in the system.
- The specific focus of the test sites on particular client groups (e.g. learning disabilities and young people in transition) resulted in some of the information material not always being appropriate for other client groups.
- Whilst the majority of care managers said they had received training, their overall view was that it was still not sufficient to enable them to implement SDS effectively in the current context.

- SDS is essentially an individualised approach and may therefore benefit from an individualised approach to training and/or mentoring. While bespoke support was on offer from SDS teams, ensuring wide access to this for front line workers and providers would be resource intensive and remains a key challenge.

4 ACCESSING SDS

Introduction

- 4.1 Data from the cohort forms, in addition to information from stakeholder interviews and the survey of care managers, have been used to consider issues of accessibility and uptake of SDS, including the extent to which the sites had addressed gaps and inequalities in access that were identified in the original evaluation. This chapter looks at the evidence about the scale and scope of implementation in the past year, the reach of the local authorities roll out programmes to implement SDS, and differences in the type of SDS options that had occurred in the follow-up period.

Access Post Test Site

- 4.2 As the paragraphs that follow will evidence, access to SDS had increased in terms of numbers and for different groups of service users in all 3 local authorities over the follow-up period. That said, reservations about extending access to SDS to mental health service users were expressed even among stakeholders interviewed in Glasgow, where the current phase of development (since March 2012) involves their incorporation into the programme.
- 4.3 The sheer scale of the increase in Glasgow was in marked contrast to the steady growth of SDS in the other 2 sites. Care managers in Glasgow commented that SDS was not so much an option but was fast becoming enforced as the only way to access support. As a result most of their service users were now accessing SDS, compared with less than 10% of care managers' caseloads in the other 2 sites. Despite achieving a positive result in terms of increasing uptake therefore, care managers and third sector stakeholders in Glasgow commented that from their perspective implementation had been "rushed" and the focus had been on "quantity rather than quality". There was concern that this had a negative effect on their ability to carry out quality assessments and move towards genuine co-production. Consequently, care managers reported feeling pressurised, deskilled and overwhelmed.
- 4.4 While a steady increase in the number of personalisation packages was evidenced in Dumfries & Galloway, the perception of key stakeholders was that people with learning disabilities were accessing personalisation/SDS more than any other groups because there were fewer traditional services for people with learning disabilities, and also because staff working with this group were more open to adopting a personalisation approach. Third sector interviewees commented on an increased uptake amongst young physically disabled people and their enthusiasm for personalisation. The pace of uptake was reportedly slow partly because of the time it took to implement a personalisation package compared to arranging traditional services, which

was confirmed by care managers', third sector providers' and advocacy organisations' experience. Senior managers emphasised the approach as being "outcomes not numbers focused". It was noted that uptake from the geographical area – Wigtownshire – involved in the Dumfries & Galloway test site had slowed since the end of the pilot whilst care managers in other areas were promoting personalisation more enthusiastically. What had increased was the number of older people now interested in having a DP.

- 4.5 The relatively slow "incremental" pace of SDS implementation in Highland was reported by key stakeholders to be both deliberate, and the result of needing to develop new systems and train the wider workforce. Systems that had been developed during the test site were not felt to be suited to general implementation across all client groups. Uptake generally was perceived to have "plateaued" as they had learnt the process takes longer than was anticipated, and longer than arranging traditional service provision. The aspiration expressed by senior managers was that SDS would eventually become the norm. However, frontline workers reported an average of just 8% of their caseloads consisting of people who had opted for SDS, which suggests that it had not reached as far into practice as hoped. Nonetheless as the SDS team pointed out there was a sense that this would build up as more social workers become experienced and confident in the approach. The experience of advocacy organisations (including carers' advocacy), as well as providers, confirmed this slow and steady pace of implementation.

SDS Packages

- 4.6 Information was sought via a modified cohort form as used during the original evaluation to capture basic demographics of those opting for SDS, the types of SDS options selected, and the funding mix of packages during the follow-up period. Information was received from the 3 local authorities but Glasgow was unable to supply details of the funding mix of SDS packages for technical reasons. The numbers refer to those who started the SDS process and/or had an SDS package agreed during the period 1st April 2011 to 31st March 2012.

Number of SDS packages

- 4.7 There had been an increase in the number of people accessing SDS in the year immediately following the end of the test sites in all 3 areas. As Table 1 clearly shows in the intervening year the number of SDS packages when counted across the test sites had increased dramatically. While all sites had increased access to some degree this was not evenly spread, with Glasgow having more than 10 times the number in both the other areas. The table below, which presents the number of packages both during the test sites and the follow-up period, needs to be read cautiously as some of the test site packages have not continued and/or were one off payments.

Table 4.1: Summary of SDS packages during the test site and follow-up periods

	Test site (2009-2011)	Follow-up (2011-2012)	Total (2009-2012)
Dumfries & Galloway	35	67	102
Glasgow	57	892	949
Highland	40	52	92
All	132	1011	1143

- 4.8 By the end of the test site, Dumfries & Galloway had set up personalisation packages with 35 individuals and had another 51 people at earlier stages in the process, the majority (33) of which had continued. In the follow-up period, an additional 133 individuals were now at some stage in the personalisation process, that is, 67 new personalisation packages plus 66 individuals who were at either initial stages of assessment, had completed a self-assessment or support plan and were awaiting a Panel meeting to agree the budget and outcomes.
- 4.9 During the test site, Glasgow had set up 57 SDS packages and over 50 other individuals were reported to be at some stage in the process although packages had not been agreed. Information was not forthcoming from Glasgow about whether these SDS packages had continued after the test site so it is not possible to comment on the sustainability of test site packages from this test site. In the year following, Glasgow had begun the SDS process with 2,296 individuals, 69% of whom had a support plan agreed although not all of these had an agreed package. Of the 2,296 individuals, 39% (892 individuals) had progressed through the whole process and had an agreed SDS package.
- 4.10 A total of 40 SDS packages had been created in Highland and a further 101 individuals had expressed an interest in SDS during the test site. In the year following the test site, an additional 52 SDS packages had been set up and a further 7 individuals had been assessed and were awaiting a decision about the package. Only 6 of the original 40 SDS packages continued post test site – 4 were existing DPs that were involved with the test site; 21 were one-off payments; one was in or leaving hospital care and 8 had chosen not to continue.
- 4.11 The following analysis of demographic information and about the SDS packages set up in the year following the test site is in relation to those with SDS packages. It does not include all those in the process as this information was not consistently available. Therefore, it includes 67 individuals in Dumfries & Galloway, 892 in Glasgow and 52 in Highland.

Service user categories

4.12 People with learning disabilities were the main group to access SDS during the test sites, although this was less the case in Dumfries & Galloway. The following table shows a similar pattern one year on from the test sites even though larger numbers of other types of service user group were also in evidence, and the local authorities had aimed to promote SDS to all service user groups. The number of people with mental health problems accessing SDS across the sites remained low at just 2% of all packages. However, people with mental health problems accessing SDS had increased from just one to 18 people in Glasgow. While 2 local authorities had allocated cases as a main service user category, Glasgow also provided details from its client index system of secondary needs; however, the information collected overall does not reflect probable levels of multiple and complex needs.

Table 4.2: Comparison of main service user category

Client Group	Local Authority				
	Dumfries & Galloway	Glasgow	Highland	Total	
				Number	Percent
Learning disabilities	27	547	20	594	59%
Physical disabilities	20	152	17	189	19%
Older people	8	7	14	29	3%
Parent (disabled child)	9	56	-	65	6%
Mental health problems	3	18	1	22	2%
Not known	-	23	-	23	2%
Other*	-	89	-	89	9%
Total	67	892	52	1011	100

*includes vulnerable people, special educational needs, homeless, head injury, criminal justice, financial/material abuse, addictions.

Gender of SDS recipients

4.13 As during the test sites, men were in the majority (57%) of those accessing SDS overall. However, the gender distribution between the sites varied as the following table illustrates, with women being in the majority of those with personalisation packages in Dumfries & Galloway.

Table 4.3: Ratios of men and women accessing SDS in follow-up period

Sex	Dumfries & Galloway	Glasgow*	Highland
Female	(39) 58%	(371) 42%	(25) 48%
Male	(28) 42%	(520) 58%	(27) 52%

Age of SDS recipients

4.14 As during the test sites, the age profile of those accessing SDS varied between sites with a broader age distribution evident in Dumfries & Galloway. Table 4.4 below summarises the data we have on the age of SDS recipients. The proportion of recipients who were recorded as being younger than 25 years was greater in Dumfries & Galloway than during the test site – 45% of clients were under 25 years, which included some children where the SDS package was set up with the parent(s). Less than 10% of clients in Glasgow were under 25 years. Whereas nearly three quarters of the test site cohort in Highland had been under 25 years, in the follow-up period this was 27%, which reflects the increase in SDS packages including DPs with older people. Indeed, 27% of SDS packages were set up with people aged 65 or over, some of whom were 75 years or more. In a departure from the test site when 42% of clients were under 25 years, the majority (75%) of SDS recipients during the follow-up period in Glasgow were adults aged 25-64 years.

Table 4.4: Age of SDS recipients as percentage

Age	Dumfries & Galloway	Glasgow	Highland
Under 16yrs	9%	-	10%
16-17yrs	3%	0.1%	4%
18-24 yrs	33%	9%	13%
25-64 yrs	43%	75%	46%
65 and over	12%	16%	27%
Total	100	100*	100

*does not sum 100% due to rounding up

Ethnicity of SDS recipients

4.15 Apart from in Glasgow, SDS recipients were recorded as either white British or white Scottish. During the test site Glasgow did not record ethnicity, which precludes any comparison although it was noted in the original evaluation report that none of the 10 case study individuals were from BME groups. Post test site figures for Glasgow show the majority of those with SDS packages were of white ethnicity (853 or 95.7%) while 18 or around 2% were of Asian ethnicity (Indian, Pakistani, Chinese, other Asian), one person (0.1%) was Black (African/Caribbean), 3 were of mixed ethnicity (0.3%), 6 (0.7%) were of 'other ethnicity' and the ethnicity of 10 people (1.1%) was unrecorded. While indicating an increase in access for BME clients due to the rollout from zero to around 4%, this is lower than might be expected from current estimates of approximately 8% of the Glasgow population from BME groups¹³ and is in contrast to Dumfries & Galloway for example, where just 0.64% of the population were from BME groups according to the last census.

¹³ Glasgow City Council Development and Regeneration Services (2011) Population and Households by Ethnicity in Glasgow: Estimates of Changes 2001-2010 for Community Planning Partnership Areas and Neighbourhoods. Data Source: 2001 estimates - General Register Office for Scotland: Census 2001.

Range of options in SDS packages

4.16 Taken overall, a range of SDS options were offered across the test sites in the follow-up period including DPs and individual service funds (ISF) with either external providers or the local authority reflecting the broad definition of SDS advocated by Scottish Government (2010). The pattern of SDS options differs from that during the test sites with only Glasgow recording any mixed packages (e.g. a combination of DP, ISF) whereas only Dumfries & Galloway recorded mixed packages previously.

Table 4.5: Type of SDS options

Local Authority	DP	DP	ISF	ISF	Mixed
	Self	3rd Party	LA	Provider	Package
Dumfries &Galloway	59	-	-	8	-
Glasgow	73	368	37	821	380
Highland	27	25			-
TOTAL	159	393	37	821	380

4.17 In a departure from the test site period due to an alternative pattern emerging in Glasgow, using IBs to arrange support with external providers had become far more common than choosing DPs. No ISFs (either local authority or with external providers) were recorded as selected by service users in Highland, and it will be remembered that an initiative with Leonard Cheshire at the end of the test site had been unsuccessful. Plans by Highland to develop an ISF pilot with 2-3 providers working with people with learning disability were underway later in 2012. The SDS option most commonly taken up by service users in Glasgow was an ISF to arrange support from a commissioned provider, reflecting the nature of its SDS implementation programme, which started with what was termed a 'provider pathway' whereby providers undertook SDS assessments with numbers of people with learning disabilities. ISF was an option chosen by just 8 of the service users in Dumfries & Galloway, all involving using IBs to arrange support from a commissioned external provider.

4.18 The pattern of DPs – self or third party payments – had changed in the post test site period. While third party payments had been the norm in Highland during the test site on account of working with young people in transition, this was no longer the case and there were almost equal numbers of DPs allocated to individuals and to third parties. As during the test site, DPs in Dumfries & Galloway were received by the individual rather than a third party. Five times as many third party payments had been set up in Glasgow than DPs managed by individuals themselves.

Funding mix of SDS packages

4.19 As before, social work funding and client contributions were the main sources of funding of SDS packages in the follow-up period. We have limited information from Glasgow regarding the funding mix of SDS packages except about client contribution. It is clear from the table below that client contributions are a key feature of SDS packages in Glasgow while this is far less common in the other sites, particularly Highland. In the previous report we suggested that this might be accounted for by Glasgow's income maximisation and funding policy, and the young age group of the cohort in Highland, though the latter was not relevant in the follow-up period. Glasgow City Council's financial procedures for service users remain explicit that as part of SDS process, the financial assessment will determine the appropriateness and level of personal financial contributions¹⁴. Independent Living Fund (ILF) did not feature in any of the SDS packages and there was no evidence of any development towards mixed funding streams with for example, Health or Housing.

Table 4.6: Funding mix of SDS packages in each test site

Local Authority	Type of Funding Stream					
	SW	Housing	ILF	Health	Client contribution	Other
Dumfries & Galloway	67	-	-	-	15	-
Glasgow	892*				792	
Highland	52	-	-	-	6	

*Although only information on number of client contributions was given by Glasgow, it has been assumed that all had Social Work funding.

Summary/Key Points

- Access and uptake of SDS had increased after the test sites, most dramatically in Glasgow.
- The sheer scale of the increase of SDS packages in Glasgow was in marked contrast to the steady growth in the other 2 sites.
- In the follow-up period over 1,000 new SDS packages had been set up, the majority (892) of which were set up by Glasgow.
- Most SDS packages in the follow-up period in Glasgow consisted of ISFs with external providers, and there were no ISFs in Highland.
- People with learning disabilities were still the main client group accessing SDS across the sites (59% of all packages), although gaps in access were clearly being addressed.

¹⁴ Glasgow City Council Social Work Services (2011) Self-Directed Support – Individual Budget: Interim Financial Procedures for Service Users. SDS-03, January 2011.

- Direct Payments to third parties were much more common in Glasgow than they had been during the test site, while a DP managed by the individual was the most frequent SDS option in Dumfries & Galloway and Highland.
- We sought information regarding whether SDS packages that were set up during the test site continued as a marker of sustainability. However, this information was not forthcoming from Glasgow, and Highland appeared not to have developed sustainable packages (but rather focused on one-off payments during the test site).
- In contrast, Dumfries & Galloway did appear to show some sustainability in terms of continuing to fund SDS packages set up during the test site. This is important given the anxiety expressed by service users and carers who had benefited from SDS in the test site period about the likely persistence of support arrangements (Ridley et al, 2011).

5 SYSTEMS & PROCESSES TO IMPLEMENT SDS

Introduction

- 5.1 A key aspect of the test sites was the development of suitable systems and processes to implement SDS, particularly in relation to assessment and resource allocation. While the starting points had been *In Control's* 7-step process and self-assessment framework and the outcomes focused *Talking Points*, the test sites had invested significant staff time in redesigning processes in order to shift the focus to outcomes, and to fit with local circumstances and different service user groups. When the test sites ended, the local authorities therefore had bespoke processes of SDS assessment and resource allocation in place that would be applied to work with other service user groups and geographical areas.
- 5.2 In this chapter we use data primarily from stakeholder interviews and the survey of care managers to look at how these processes developed in the year following the test sites, and at the perceptions of those having to use these new systems and protocols. We focus especially on stakeholders' perceptions of the implementation of SDS assessment process, approaches to allocating resources and of the paperwork/red tape involved.

General

- 5.3 As a result of the test site activities the 3 local authorities had put in place new systems for implementing SDS. This had been a time consuming and lengthy process so that at the end of the test sites, this work remained on-going. The process of personalisation as described in Dumfries & Galloway involved individualised outcomes-based assessment, consideration of the proposed plan and budget by a resource panel and in most cases, an Individual Budget (IB). Similarly in Glasgow, the process comprised a self-evaluation questionnaire (SEQ), resource allocation panel, an agreed outcomes based support plan and IB. Since the test site, the local authority had set up Risk Enablement Panels (REPs) to address risk issues identified and discussed at the Resource Allocation Screening Group and referred by its Chair to the REP for help with "challenging or complex decisions" within the SDS processes of allocating IBs and support plan validation¹⁵. An outcomes based assessment framework had also been developed by Highland based upon *In Control* methods for those opting for SDS. An equivalency model was used instead of a RAS to decide SDS budgets and in all cases an IB was agreed. At the end of the test site the local authority had resolved to develop appropriate RAS for the future roll out of SDS.

¹⁵ Glasgow City Council Social Work Services Procedures (Reference No: GCC3/11): Glasgow City Council Risk Enablement Strategy and Guidance. 29 March 2011.

- 5.4 The original evaluation report suggested that some staff, service users and carers did not have enough information about SDS and did not understand the new processes or found them challenging. Varying experiences of resource allocation panels were also given: some describing positive engagement of service users and carers in presenting the case for a support package, others feeling frustrated at not being awarded the budget to meet the support needs they had identified or feeling baffled by panel decision making. This follow-up evaluation has enabled further exploration of these issues.
- 5.5 Although on the whole care managers were positive about SDS and its potential to offer flexibility and choice to service users, their views about new assessment protocols and processes were less positive. As illustrated in table 5.1 below, only about a third of care managers in 2 of the sites seemed to find these helpful. While those in Highland were relatively more positive, there was still criticism that paperwork was burdensome and protocols were too focused on young people with learning disabilities (the target group during the test site).

Table 5.1 Care Managers’ perspectives of SDS assessment protocols and processes

Local authority	Helpful	Unhelpful	Don't Know
Dumfries and Galloway	32% (17)	54% (29)	14% (8)
Glasgow	35% (37)	63% (67)	2% (3)
Highland	42% (14)	39% (13)	19% (6)

- 5.6 Care managers in Glasgow were the least positive overall and many reported that the SDS system incorporated a bureaucratic, lengthy and cumbersome ‘stepped’ process that was difficult to complete and often unnecessary, especially for very small packages of support. A number of care managers in Glasgow also mentioned the pressure of also having to get used to new IT systems (CareFirst6). Indeed much of the SDS Team’s time was said to be spent supporting practitioners to record SDS on this system. In addition, many felt that procedures and systems kept changing and the “goal posts kept moving” with regards to criteria and funding. This left them feeling they might give out-of-date, confusing and possibly contradictory information to service users.
- 5.7 Interviews with third sector providers in Glasgow supported this viewpoint as it seemed from their perspective that systems introduced to implement SDS were subject to frequent change and amendment. Furthermore, some said that while people are encouraged to want more choice and control, the system acts as a barrier to achieving this. In the words of one provider, “it

seems like a square peg in a round hole, trying to fit SDS into traditional systems”.

- 5.8 Some care managers in Dumfries & Galloway were also critical, suggesting there was no clear route through the personalisation system, that there was insufficient guidance about what was required, eligibility criteria, resource allocation, and recording information and so on. This was reminiscent of the previous evaluation when care managers involved with case study individuals had reported feeling confused when navigating new processes. There was also some concern expressed by care managers about their own and the Personalisation Team’s roles and responsibilities, which resulted in a “long winded” and “laborious” process for them and the service users to set up a support package.

Assessment

- 5.9 Key stakeholders interviewed in Dumfries & Galloway framed the main issue about assessment as being about supporting the cultural shift that would change the power relationship between professionals and service users. Similar language had been used about re-balancing power and culture change in all 3 areas during the test sites. Post test site, the Dumfries & Galloway Personalisation Team emphasised the continued importance of developing practitioners’ capacity for co-production rather than focusing on getting the ‘right’ assessment form in place, and this was where the team’s efforts had been directed. There was, however, a move to further develop the self-assessment document from the test site as this was considered “not fit for purpose”. A short life working group was set up during the follow-up period involving the Frontline Improvement Team, Personalisation Team, service users and carers to develop more appropriate tools. In contrast, care managers from this local authority expressed concerns about the process to implement personalisation stating this was not always clear to them and they needed more support.
- 5.10 Since the test site, many more staff in Glasgow had become involved in the process of supported self-evaluation and developing outcomes based support plans (OBSPs). Unlike during the test site, support plans are now agreed in localities by service managers and signed off by the resource allocation screening groups (RASGs). In parallel, a financial assessment is completed to determine levels of client contribution to the support package. The SEQ has continued to evolve (version 12 at time of writing) in light of experience and with the broadening out of the needs of service users included in the SDS programme. One criticism levelled by third sector providers at Glasgow’s SEQ was that the language and style is more appropriate to people with learning disabilities than to other groups.
- 5.11 Although the SEQ process used in Glasgow aimed to increase flexibility, third sector providers pointed out that in practice budget allocation is still based on

support hours, thus limiting creativity and choice. At the early stages of the SDS programme for people with mental health problems, providers reported difficulties in ensuring the sensitivity of the process to the people's fluctuating needs and circumstances. Moreover they found it essential to liaise closely with Social Work Finance personnel, which proved to be very constructive.

- 5.12 Whilst care managers from Highland were generally more positive about SDS processes than those from the other local authorities, they also expressed a number of concerns. For example, some care managers commented that they felt the self-assessment tools (e.g. 'My Plan' or SSAQ) were not specific enough to be able to identify detailed needs. In addition, some felt that the paperwork is still too burdensome and the protocols are better suited to young people with learning disabilities. As one care manager commented, other service users are "being shoe-horned into a process designed for people with learning disabilities". Some also found the SSAQ not helpful as the main assessment tool because in the absence of the RAS in Highland the SSAQ "carries little weight".
- 5.13 Despite aiming to involve advocates more in assessment processes, access to advocacy generally was reported as uneven, with the involvement of, and partnership with, advocacy organisations working with people with learning disabilities being the most common. Those examples where advocacy was used seemed to positively impact on the resulting support plans and outcomes, and we were given examples from all 3 sites. In addition, over time a better understanding of the role of advocacy in SDS had developed. However, advocacy organisations in all areas reported variable experience of supporting individuals going through SDS/personalisation assessment and suggested that some care managers did not fully involve service users while others made great effort to do so.

IBs and Resource Allocation

- 5.14 Although the test sites had adopted a broad definition of SDS in line with the Scottish Government's national strategy for Scotland (2010), they had universally implemented IBs and the *In Control* model of SDS, the emphasis being on financial allocations that were more transparent. As Glasby and Duffy (2007, p2) assert, an IB is about "being clear with people from day one how much is available to spend on meeting their needs", and then ensuring they have as much control and choice over how this money is spent. From the start, the resource allocation is "up-front" (Mind 2009b, p3). IBs were to combine different funding streams, align assessments, encourage self-assessment and introduce a transparent RAS (Manthorpe et al, 2011). They were to focus on outcomes and allow users to choose where to purchase their support (Rabiee et al, 2009). The test sites had all trialled approaches to identifying IBs and had set up systems of resource allocation. Two had implemented a Resource Allocation System or RAS in line with the *In Control* model, and one had been encouraged by Scottish Government to apply an alternative equivalency model (see original evaluation report). However, all

had faced challenges in terms of implementing a system that was equitable and appropriate to meet different needs, and at the end of the test sites, systems for IBs and RAS were under review.

- 5.15 According to key stakeholders in Dumfries & Galloway the main learning regarding implementing IBs and RAS had been that being up front about the budget at the start was distracting. Through experience they had found if a budget figure was given up front this skewed people's thinking about ways of meeting needs. They emphasised the importance of work at the start of the process identifying natural supports and user-defined outcomes before money came into the equation. As a result, the Council developed a 10-stage process going beyond *In Control's* 7 steps: 1. Information pack on personalisation; 2. Complete self-assessment; 3. Create a support plan; 4. Support plan is checked; 5. Council considers the support plan; 6. Informed of decision about support plan; 7. If approved, plan put into action; 8. Funding put in place; 9. Regular review of how budget working; 10. Regular check of support plan and changes if needed.
- 5.16 All 3 local authorities had shifted from a centralised resource panel during the test site to delegating responsibility for funding/budgetary decisions to local area teams or geographical patches. In Dumfries & Galloway RAS is applied consistently across the region. Key stakeholders commented that the funding of personalisation packages was still under review and the Council had a finance sub-committee that regularly reviewed systems and had devised a 4-part banding structure for guiding decisions about IB levels to meet different needs. This system, implemented during the follow-up period, was felt to have more potential than the *In Control* RAS to allocate appropriate budgets. Deciding on appropriate levels of funding was described as "an art not a system" because "people's needs do not fit into boxes", and because personal and community capacity has to be taken into account. Several care managers commented positively on the personalisation panels which met every month (or more often if necessary), and agreed that they tended to approve appropriate funding requests. However, others expressed more uncertainty about this process; third sector organisations were more critical about the process of agreeing budgets and the reality of final funding levels of some personalisation packages.
- 5.17 Since the test site, localities in Glasgow had played a stronger role in the process and there are now local resource panels (locally known as RASGs) in each of the 3 areas. Budget decisions are taken on the basis of service managers' assessments of priority needs with the RAS estimate viewed as a starting point. However, experience led to recognition that the formula cannot handle the complexity of needs. Since Sept 2011, it appeared that RASG were held 5 days a week for each locality due to the high volumes of cases being processed. The Council was still involved in a process of "testing" the RAS with different client groups post test site. Key stakeholders commented on how time consuming they had found the process of getting agreement on

levels of IBs, particularly where risks were identified. To address risk issues positively, Glasgow had set up Risk Enablement Panels (REPs), which involved multi-agency stakeholders including service users, carers, and advocates and were independently chaired. However, a third sector provider commented that in its experience, disputes about IBs were rarely resolved by the REPs, although other interviewees reported that budgets were amended as a result of REP hearings. It was also commented that IB levels tended to be lower than prior budgets so that for existing service users it appeared that their services were being cut. Service users and carers consulted for this research broadly held this perception or expressed concern about potential reduction in support.

- 5.18 Care managers were the least positive about how allocation panels were working and decisions about IBs in Glasgow. Many care managers perceived that decisions at the funding panel were often arbitrary and inconsistent. Some care managers felt that “it depended on who the chair (of the panel) was”, perhaps suggesting there is too much power given to the chair to make funding decisions or at least a lack of transparency regarding these decisions. The RASG meetings were often reported as being stressful for workers especially as they were experienced as very adversarial.
- 5.19 Local authority stakeholders interviewed in Highland argued that not having a RAS had held up development of SDS implementation during the test site. The equivalency model that they had been encouraged to apply had not provided a suitable mechanism, and since the test they resolved to move to RAS. They had used underspend from the test site to employ an independent consultant to work on developing 3 different RAS – for children, adults, and older people over 65 years. As in the other areas, the centralised allocation panel set up during the test site had since been disbanded, and decision making was now taken at local level. The mechanism for resource allocation in Highland was therefore under early stages of development during the follow-up period. As in other areas, third sector interviewees had expressed concerns about the budgetary allocation process and the IBs agreed.

Paperwork and IT Systems

- 5.20 One of the issues that arose during the test site period concerned the duplication of assessment processes because alongside new SDS assessments, local authorities continued to use single shared assessment (SSA). The evaluation concluded that the work of the test sites had not resulted in a reduction in ‘red tape’ but had instead increased the amount of paperwork required. The local authorities planned to address these concerns post test site.
- 5.21 Care managers from all the sites highlighted the paperwork involved in implementing SDS as burdensome, especially in light of duplication with the SSA, which had continued post test site. Some stakeholders argued that the

detailed paperwork was justified when taking an individualised approach, whilst others argued that unless the burden of bureaucracy for care managers was addressed, the desired widespread implementation of SDS would not take place.

- 5.22 As one stakeholder in Dumfries & Galloway commented “they (care managers) are spending too much time in front of a computer lacking permission to think and act differently, more creatively”. Similarly, it was suggested that as a result of implementing SDS systems, care managers in Glasgow were spending more time on form filling and inputting information to the IT system than on support delivery. One third sector provider asserted that the way SDS has been implemented is “dominated by centralised control”, which meant more bureaucracy. Similarly, third sector stakeholders interviewed in Highland felt there was too much paperwork and duplication of aspects of the system. Work had started on simplifying the forms used and in developing what was termed a ‘Personal Plan’, which they planned to pilot later in 2012.

Summary/Key Points

- On-going change in assessment and resource allocation systems had persisted as a main preoccupation since the test sites in all areas.
- Key stakeholders in Dumfries & Galloway, however, stressed the cultural shift needed to implement real choice and control rather than systems being ‘right’.
- Care managers were the least positive about new protocols and processes to implement SDS, particularly in Glasgow.
- A key criticism of the assessment processes developed during the test sites was that they tended to be too orientated for use with people with learning disabilities and were having to be further developed.
- There was evidence of increased involvement of independent advocacy since the test sites in all areas though this was inconsistent and dependent upon care managers’ understanding of the role of independent advocacy as well as on the capacity and training of advocacy services.
- In all 3 areas, more resource allocation panels had been created to enable greater numbers of support plans to be considered and to enable decisions to be taken at locality level.
- Systems of resource allocation were a zone of high uncertainty and one of the most problematic aspects of implementation and these had not been fully resolved during the follow-up period.
- Paperwork resulting from implementing SDS had not decreased the bureaucratic burden but had rather increased it in those cases where self-assessment continued in parallel, or was an addition to single shared assessment.

6 PERCEPTIONS OF THE IMPACT OF FINANCIAL CONTEXT

Introduction

6.1 Since the test site period, local authorities have faced increasing challenges due to the wider financial context and its impact on budget allocations to local authorities by central government. Therefore, it was important to find ways of assessing the impact of this situation on SDS implementation. This chapter draws upon the views of the range of stakeholders consulted but specifically draws on our survey of care managers because this enquired explicitly about their perception of whether budget cuts had impacted on SDS. This was necessary as they are at the frontline of service delivery and because their views do not appear to have been obtained in Scotland as elsewhere¹⁶. We have supplemented this data with information gathered from other stakeholders and official documentation provided by the sites.

Overview

- 6.2 There was some disparity in perceptions about the relationship between SDS and the wider financial context across the 3 sites. Senior managers in all sites stressed that SDS was being pursued on principle and to achieve better outcomes for people, and that the policy was not a response to the serious and persistent financial constraints on local authorities. However, some managers referred to how advocates of the personalisation movement had stressed this can generate positive lower cost options with potential for savings. This led to potential tensions and conflations between the two agendas of personalisation and cost savings. Senior managers tried to keep the two policy agendas separate and were keen to stress that the cost savings agenda had not negatively impacted on SDS. If anything, they stressed that SDS was a more creative way of utilising public money. However, care managers' responses illustrated more conflicting opinions and some were more ready to see SDS as part of a wider cost cutting agenda.
- 6.3 Care managers were asked if they thought SDS was being used to make budget cuts. It is hard to make any assessment about the strength of feeling in Highland because the overall response rate was low – nearly a quarter of respondents did not answer the question and of those who did the largest proportion of respondents (39%) felt that they didn't know or were unable to comment. Although in Dumfries & Galloway, a similar proportion felt that they didn't know/couldn't answer (34%), of those that gave a view there was a much stronger sense (54%) that SDS was not being used as a mechanism for making cuts. In stark contrast, we had a far higher response rate in Glasgow overall, with the majority of those respondents expressing the view that SDS was being used a mechanism to make cost savings (81%).

¹⁶ Community Care Personalisation Surveys covered by Reed Business Insight: Report on Personalisation Survey. Community Care, Unison and the College of Social Work (Community Care Online: June 2012 and June 2011). Accessed June 2012

Table 6.1: Care managers' opinion about whether SDS is being used as a way to make budget cuts

Local authority	Being used to make budget cuts	Not being used to make budget cuts	Don't know/unable to comment
Highland (n=31)	29% (9)	32% (10)	39% (12)
Dumfries & Galloway (n=56)	13% (7)	54% (30)	34% (19)
Glasgow (n=104)	81% (84)	13% (14)	6% (6)

*Figures do not always sum 100% due to rounding

6.4 Views were also sought about the impact of the financial situation on SDS. In Glasgow there was a very clear majority view from care managers that cuts in public expenditure was adversely affecting SDS/Personalisation (91%). In Highland and Dumfries and Galloway respondents were less able or willing to express a view on this (45% and 53% respectively). However, in Highland, despite an overall low response rate, 45% of those who did answer this question thought that budgets cuts were having an adverse effect on SDS.

Table 6.2: Care managers' opinions about whether cuts in public expenditure have adversely affected SDS/Personalisation

Local authority	Cuts have adversely affected SDS/Personalisation	Cuts have not adversely affected SDS/Personalisation	Don't Know
Highland (n=31)	45% (14)	10% (3)	45% (14)
Dumfries & Galloway (n=55)	20% (11)	27% (15)	53% (29)
Glasgow (n=106)	91% (96)	3% (3)	7% (7)

*Figures do not always sum 100% due to rounding

6.5 Despite these differences, however, in all 3 sites there was an evident conflict between the 'aspirational' promotion of SDS and budget-led constraints which were seen as limiting what could be achieved for individual service users. Some stakeholders felt that 'aspirational' and 'idealistic' promotion of SDS can unrealistically raise service users' and carers' expectations of what is possible in terms of choice and control. This was seen as compromising the ability of SDS to deliver on the broader aims of the Independent Living movement, on which it draws its legitimacy. This, in turn, has implications for longer term sustainability.

6.6 In relation to the shorter term sustainability of SDS support packages post test site, from the information provided, we can report the following:

- In Dumfries & Galloway, out of the original 35 people with personalisation packages during the test site, one person has now moved from the area, and one person has died. 32 of the personalisation packages remain the same, while one has increased.

- In Highland, of the 40 test site cases, 6 carried forward to continue with SDS, 4 were existing DPs that were involved with the test site pilot, 21 were one-off payments, one was a hospital case and 8 chose not to continue with SDS.
- We did not receive any information about the 57 test site cases in Glasgow.

Impact on Dumfries & Galloway

- 6.7 A complex and evolving picture emerged of the impact of financial constraints on the implementation of SDS in Dumfries & Galloway. In this site, there was evidence of sustainability in terms of personalisation packages post test site. Whilst there were undoubtedly concerns about budget savings as elsewhere, this appeared to have been managed in a way that resulted in less negative associations being made between SDS and cost-cutting than in either of the other 2 sites. In the early days of the test site period, the Council had initiated a day service closure and this had been negatively associated with personalisation. Yet, since then, despite the financial context, it was generally felt by care managers responding to the survey and other key stakeholders we interviewed, that implementation was kept within the spirit of SDS. Despite this, however, there were concerns expressed by different stakeholders about future eligibility for social care, as well as about the ability of the Council to sustain innovative packages at the same budget levels in the longer term.
- 6.8 Senior managers and others referred to efforts to concentrate on outcomes rather than the financial aspect during assessments, and the need to apply an holistic framework focusing on prevention and early intervention. However, it was reported that one of the 4 localities was only providing services for those deemed in 'critical' need. In this respect, despite the local authority's overall clarity about eligibility for support, it appeared that some areas were operating stricter eligibility criteria. In addition, there was some concern expressed that both financial constraints and mixed messages were impacting on decisions around access to personalisation.
- 6.9 In the 2013/14 starting budget there was a stated focus on protecting services, but this was coupled with recognition that it would be hard not to reduce frontline services. It was also suggested that adopting more creative approaches had the potential to achieve 'no cost – low cost' solutions by making more of personal and community assets. There was more focus on giving responsibility to provider organisations to make savings and this might be seen as merely shifting the responsibility for making savings elsewhere. Indeed, many providers were concerned about the impact of the current climate, and team managers were responsible for declaring monthly budgets and explaining any over-spend, which also placed pressure on them.

- 6.10 There was a sense amongst care managers that packages tended to be sufficient to meet assessed needs, at least at the moment. However, the Personalisation Team managers were concerned that an overarching focus on saving money will inevitably impact on personalisation. In response, they were attempting to link personalisation to early intervention and prevention and attempting to build a longer term vision about capacity building and developing community resilience.
- 6.11 During the test site period, some care managers were of the impression (though this was inaccurate) that personalisation packages were paid out of a 'ring fenced' budget and sensed that this was no longer available as personalisation has been rolled out. This meant that personalisation funding was now perceived as 'competing' with the rest of the social care budget. The Personalisation Team noted with some frustration that some care managers still thought this was the case and tried to use personalisation as an 'add on' to prop up traditional care package.
- 6.12 Concerns were expressed that future packages will not be as generous or flexible with pressure to make cost savings, and potential changes made to eligibility criteria. Indeed, one area was reported as only providing support for those deemed in 'critical' need, and there was a specific concern expressed that service users who had benefited from a personalisation package during the test site would no longer be eligible post test site (i.e. if they were in a 'lower' eligibility banding). Furthermore, some independent organisations involved in supporting service users in support planning reported that final budgets were significantly lower than that identified in the support plan and were being appealed.

Impact on Glasgow

- 6.13 Stakeholders interviewed in Glasgow stated that the Council was explicitly aiming for a 20% 'redirection of resources'. Furthermore, since 2007/08, there had been around 25% reduction in the number of full time equivalent staff¹⁷. As a result, care managers reported feeling under pressure, not only to make significant target savings, but to do this in parallel with a fast-paced move towards implementing SDS. There was consensus amongst care managers and third sector providers that these factors had created a "negative context" for implementation of SDS. It is worth noting that these were not new concerns but had been highlighted earlier by the SCSWIS scrutiny report (2011). Nonetheless, despite slowing down the process in response to these criticisms, the Council recognised that perceptions of SDS as a cost cutting measure would be hard to reverse.
- 6.14 Whilst there were concerns in all sites about the gap between an 'idealistic' promotion of SDS and the reality of what is possible in a challenging financial context, this concern was especially acute in the care manager responses

¹⁷ Glasgow City Council Joint Adult Services Plan 2012/13, Consultation Draft, July 2012

from Glasgow. Consequently, there appeared to be a strong perception amongst staff and the public that SDS was primarily 'about cuts'. Tellingly, one respondent referred to SDS in Glasgow as being about "rationalisation, not personalisation", and this sentiment was echoed in many care managers' accounts. Providers generally felt that what was often referred to as the 'Glasgow approach' to SDS has become more cost-based and constrained since the test site period.

- 6.15 Senior managers were aware of these concerns and this had prompted some adjustment to the programme. Some felt that the impact of dialogue has prompted benefits and that the programme should, for example, allow more transparency and clarification of available resources; increase sustainability; enable creativity; realise savings and so enable new demands to be met. Indeed some senior managers, as well as other local authority staff, saw SDS as a way of actually mitigating the effects of budget reductions because it actually generates more economic packages.
- 6.16 However, the majority felt the situation to be damaging. For example, a consultation event with Learning Disability Alliance Scotland and Unison advocating concerns from members highlighted the negative impact on service users, the voluntary sector and workers and potential effect on quality of support and risk. The pressure for costs savings was also impacting on providers and some speculated that this situation may lead to mergers which would ultimately decrease the range and choice of services. Additionally certain providers who had long pursued person-centred approaches at low cost reported that SDS as implemented actually reduced flexibility of support.
- 6.17 Sixty four per cent of care managers in Glasgow reported that the SDS panels did not approve the funding requested for individual care packages. This was significantly more than in the other sites where the majority of respondents felt they either did not know or could not comment. In Glasgow, however, a number of respondents felt that the panels were more focused on costs and budgets rather than on meeting assessed needs. As a result, a majority of care managers (59%) felt that support packages were insufficient to meet needs and it was becoming harder for people to access services generally, unless they have very high needs.
- 6.18 In addition, many care managers felt there was little opportunity for funding the types of social care that had been talked about when SDS was first introduced and promoted. Instead some specifically commented they felt funding was limited to personal care and support relating to 'life and limb', rather than facilitating social inclusion, community activities etc. Whilst packages approved during the test site included equipment and the scope for 'positive alternatives' to traditional provision, many felt there was far less scope for these now. Indeed there was concern expressed that packages that had been developed during the test site would be cut during the review process.

- 6.19 In addition, some referred to the pressure to change providers to reduce costs. Some Glasgow providers and advocacy organisations pointed out that local commissioning has required providers to adopt standardised rates which prevented flexibility and choice. For example, they reported that there was now only one rate for sleepover and 2 day time rates, regardless of need, whereas there used to be different levels depending on what was required (e.g. 3 levels of sleepover rates). This meant that some people were unable to maintain their support arrangements, especially if their needs were more complex.
- 6.20 These perceptions were echoed in a focus group conducted with a group of service users and carers through the Glasgow Centre for Inclusive Living (GCIL). Many of the participants were in the process of having their support package - that had been agreed during the test site period – reviewed. Although the outcomes of these reviews had not yet been decided, they expressed disillusionment and despondency about the situation.
- 6.21 A number of care managers also felt that the perception of an intrinsic link between budget savings and SDS had not been helped by the introduction of stringent financial assessment for determining client contribution to social care as part of new SDS processes during the test site. There was also concern around changes to welfare benefits which would affect people’s ability to pay any contributions. As a result, there were reports from care managers of service users disengaging with SDS entirely. In addition, and in this context, the pace of implementation seems to have meant that workers, service users and carers have not been afforded sufficient time and space to engage with the process fully enough, and to provide the necessary support to do assessments in a person centred and self-directed way, thereby undermining the very foundations of the stated policy objectives.

Impact on Highland

- 6.22 As in the other sites, senior management tended to assert that the financial situation was not negatively impacting on SDS. Indeed, SDS was often seen as “positive way of managing budget cuts” and “cost effective spending”. A number of those interviewed made a direct contrast with how they perceived the situation to have been managed in Glasgow.
- 6.23 Care managers in Highland were less vociferous in their criticism than those in Glasgow, but they did express concerns about the impact of the financial situation. Although most care managers stated they could not answer questions regarding the impact of the financial situation on SDS in Highland, 45% of those who did feel able to comment one way or another, felt that the financial situation had adversely affected SDS, and 30% felt SDS was being used as way to make cost savings. In addition, some care managers specifically referred to the problem of ‘top slicing’ 20% off requested

amounts/assessments. These reductions were deemed necessary in order to make 5% savings on infrastructure costs and 15% efficiency savings. In addition, some stakeholders referred to costs for providers' hourly rates being reduced, resulting in a perception that cuts have been 'passed on', for example, to voluntary sector providers. As a result, some of these organisations felt that the public perception of SDS was that "it's about cuts".

- 6.24 Having said that, the majority of care managers (who felt able to give a view about the level of agreed care packages) felt that the packages agreed were currently sufficient to meet needs. However, there was disquiet regarding budget constraints making it difficult to get funding approval for more aspirational needs. Therefore, like in the others sites, there was an evident conflict between the aspiration of SDS and budget led constraints. As a result some expressed resentment about the money spent on promoting and implementing SDS at the expense of direct services and care packages.

Summary/Key points

- Perceptions of the immediate impact of the financial situation post test site differed across sites.
- We were unable to ascertain whether official eligibility criteria operated for social care services in either Glasgow or Highland. In light of the stated aim of increasing transparency, this lack of information is a concern.
- Eligibility criteria adopted by Dumfries & Galloway demonstrated a more holistic approach, focusing on early intervention and prevention. However, some parts of this region were operating stricter criteria.
- Whilst financial constraint was a huge challenge in all 3 areas, the consequence of Glasgow's strategy of coupling the agenda to reduce expenditure with a fast roll out of SDS, had resulted in front-line social work staff feeling under pressure, with a knock on effect on the quality of SDS assessments, levels of involvement, choice and control and staff morale.
- Short term sustainability since the test site varied across areas – while the majority of personalisation packages set up under the test site had continued in Dumfries & Galloway only a minority in Highland had continued, and whether, or to what level, packages continued in Glasgow is not known.
- Longer term sustainability is even more challenging, especially staying true to the ethos of independent living and maximising choice and control which motivated users and carers demand for SDS in the first place.
- How this situation is managed has implications for how SDS is promoted to the public and service users (i.e. from its current focus on aspirational and transformational 'success stories').

7 SUMMARY AND CONCLUSION

Introduction

7.1 The overall aim of this follow-up evaluation was to assess the continuing and longer term impacts of the interventions employed in the SDS test sites funded by Scottish Government between 2009-2011. Some of the same methods from the original evaluation were used in addition to a survey of care managers and documentary evidence to gather information about what progress had been made in the year following the end of the test sites, that is, from 1st April 2011 to 31st March 2012. Our findings support the claim of the 3 test sites that an evaluation over 2 years was insufficient to do justice to what they had achieved in implementing SDS. This is a dynamic and evolving situation. It is also likely that perceptions of developments will change over time, which underlines the need for on-going research particularly into impact and outcomes. There were more recent and significant developments highlighted by participants in the study, such as promotion of SDS to new groups, which would be of wider interest but have not been included because they fell outwith the end of March 2012 timeframe. Nevertheless, the findings provide supplementary evidence of the progress made by the local authorities in 3 years. In this chapter, we consider the findings in relation to the research objectives, and what can be learnt to inform future implementation of SDS.

Overview

7.2 Taken as a whole, the evidence concerning uptake, activities and systems evidences substantial progress towards the implementation of SDS and system wide change in the 3 local authorities. Scottish Government investment in test sites had encouraged development of a firm foundation of processes and systems to implement SDS and more importantly, the investment had facilitated change in practice and approach to delivering social care. However, both strategic choices about implementation, such as the scale and pace of change, and wider constraints, particularly the financial context, were compromising the ethos of independent living and the degree of choice and control afforded through SDS.

7.3 Reviewing activities and implementation one year on revealed continuous building of infrastructure, trialling and reviewing of systems and approaches in all 3 areas. A high level of political and strategic support and integration of SDS/personalisation as a policy priority was in evidence. However, there was less emphasis on addressing wider implementation issues, that is, ensuring SDS/personalisation becomes more than Social Work's responsibility. For instance involvement of Health was lacking apart from in Highland, where integrating health and social care services was at an early stage. Different streams of funding were not being brought together – the SDS packages set up were all funded by Social Work and client contributions. There is clearly potential to further explore such links and inputs to SDS.

- 7.4 As well as building positive foundations and infrastructures for SDS, the commitment and expertise developed in the SDS/personalisation teams, as well as among social work staff and across providers, was clearly evident. The commitment and vision of the specialist teams had enabled the momentum and vision to continue at a time of “hiatus” and other policy changes, which were both enabling, and a barrier to, SDS implementation. There was no doubt about the value of the SDS/personalisation teams, which care managers, senior managers and external agencies all identified as an essential resource to support implementation. It was notable in all 3 areas however, that such teams remained extremely small (4-8 staff) and are limited in their capacity to offer support and guidance to the numbers of staff, service users, carers and external providers who might potentially need support in accessing and using SDS. How best to share such expertise and how to cascade skills and knowledge about SDS throughout the organisation so that the approach becomes more widespread, remains a key challenge.

Successful Implementation?

- 7.5 A key contrast between Glasgow and the other 2 sites was the rapid pace of implementation achieved in the past year: Glasgow increased its number of SDS packages from 57 to 892, while the other 2 test sites showed more steady increases. Though full scale implementation was what Scottish Government had originally asked of the test sites, our findings show high levels of uncertainty and dissatisfaction with the SDS programme in Glasgow, and indications that this had caused major stress for service users, carers, staff and providers alike. The Council was aware of, and had responded to such criticism about the pace of the implementation programme by adjusting the timeframe, while emphasising that implementation will stretch into 2016. Despite these contrasts in the pace of implementation, all 3 sites struggled with the development of wider systems which were user friendly, flexible, and accessible, and all had concerns about longer term capacity and sustainability.
- 7.6 The starkness of the contrast between the test sites in terms of scale of implementation needs to be examined further. If we were to measure success by numbers of SDS packages alone, then only in Glasgow could it be said that implementation had shifted from a pilot to mainstream. However, other evidence, such as negative feedback from care managers, service users, carers and providers, suggests this would be to lose sight of the importance of involving service users and carers as fully as possible in the assessment process and the co-production of their support. Key stakeholders in Dumfries & Galloway frequently referred to the importance of focusing on the quality of the conversation with service users and spending time assessing personal and community capacity in order to build packages of support. The key challenge is how to ensure that the movement to increase the scale of SDS/ personalisation programmes will enable the ‘quality of

conversation' about SDS to be sustained and that good outcomes in terms of control and choice are achieved.

- 7.7 Full implementation thus needs to be measured by something other than quantifying the uptake of SDS. Further, a balance needs to be struck between encouragement and enforcement, which can exhaust capacity in the system to change, which has potential to ruin any progress made. A next stage could be to investigate the outcomes, gains and losses that have accrued throughout the SDS implementation process.

Innovation & Co-Production

- 7.8 Although unable to assess outcomes of SDS for individuals from service user and carer perspectives, there were positive reports of involvement and innovation in support packages from independent advocates working alongside individuals and care managers, and also from those involved in assessments. Countering this were indications of uncertainty amongst advocates about how to engage with SDS. Additionally there were reports of rushed assessments, of care managers not having time to do the process properly, of variation in approach between different care assessors, and IBs not being enough to meet people's needs, all of which were more common in Glasgow.

- 7.9 With fewer resources for social care, it is unclear how the limited, but nonetheless, important innovations demonstrated during the test sites can be sustained. Only in Dumfries & Galloway did we find that personalisation packages set up during the test site had been sustained. Whilst this situation may require more detailed investigation, it does raise questions about whether, and the extent to which, the kinds of support packages that were highly valued by service users and carers during the test site period can be sustained and replicated. In other words, whether the level of support to enable these packages to be set up, as well as the level of packages themselves, will be available to a wider section of the social care population once the spotlight of the test sites has disappeared.

Addressing Inequalities of Access

- 7.10 The test sites had begun to address the inequalities of access to SDS that were highlighted in the original evaluation report. The follow-up work showed an increase in access by older people in some areas, and the inclusion of those from BME communities in Glasgow. Stakeholder interviews revealed that staff time had been spent consulting different service user groups including BME groups, and systems created during the test sites had been reviewed and modified to take account of different needs. Nonetheless, access by people with mental health problems was still an issue, although a recent programme of implementation in Glasgow was attempting to address this gap. There remains wariness amongst key stakeholders about how far

SDS will be able to meet the needs of people with fluctuating conditions including mental health problems. People with learning disabilities were still the main service user group to benefit from SDS in all areas, and one criticism levelled at new SDS processes was that they were too learning disability orientated, and thus created a barrier for other groups wanting to access SDS. This would suggest that there is still work to do on the approach and systems to open up access to SDS.

Independent Advocacy

- 7.11 In a departure from the test sites when we found little or no involvement of independent advocates in assessments and support planning, advocacy organisations including carers' advocacy were becoming more involved in individual cases. Advocates were extremely positive about some of the support planning they had been part of and were full of praise for care managers, while others were critical and felt that care managers did not understand the value of independent advocacy, and the process of SDS was still baffling for their advocacy partner. It appeared that learning disability advocacy organisations were the most involved and there were still gaps for some groups, such as mental health advocacy, to become involved in the implementation of SDS.
- 7.12 There was an indication that advocates and advice agencies needed access to more training on SDS. Scottish Government resources had been used to support advocacy organisations to develop their role. However, it was not the experience of the advocacy organisations that we consulted that financial support for independent advocacy from the local authority had changed as a result of SDS implementation. Furthermore, the existing role and/or capacity of Independent Living Centres in Scotland needs further consideration if SDS is to develop in accordance with the Independent Living philosophy which is supposed to underpin it.

Impact of Financial Context

- 7.13 While some have argued that limited budgets can encourage innovation, this study suggests that innovative practice may be impacted upon by financial challenges faced by local authorities in terms of expenditure. This was evident in a number of ways, including in regard to resourcing for implementation and resource allocation to individual budgets. The 3 local authorities, like all others, had received Scottish Government funding (*note: they were given some start-up funding previously*) and were committed to continue the role of specialist teams and to on-going development of infrastructure, such as information resources. However, only in Highland had the team expanded with the scale of the programme. Across the areas, budget levels currently and in the future were of concern to managers and teams, personal contributions appeared to be increasing, and there were indications that experience of the SDS process could be very uncertain and sometimes fraught for service users, carers and professionals.

- 7.14 A strong message from the research was that a top-down process of fast paced implementation in a context of resource constraints, results in front-line social work staff feeling under pressure, which has a knock on effect on the quality of SDS assessments and support packages. Some providers are concerned about future viability of services and a number have lost staff or services due to re-commissioning.
- 7.15 There was a perceived and growing discrepancy between how SDS is promoted as aspirational with accompanying 'success stories' versus the increasing reality of the kinds of packages that might be supported in the current context. This has a number of implications for the future integrity of SDS and its underlying value base and for the way that SDS is promoted to service users, carers and the public. These perceptions seem to be in tension with aims to increase the exercise of choice and control, and the Independent Living philosophy which is supposed to underpin SDS (Morris, 2011).
- 7.16 It is worth bearing in mind that the findings from this study in relation to the different sites need to be considered in the context of the differential financial pressures experienced by local authorities. For example, local authorities in large urban areas with the most concentrated social care needs (such as Glasgow) may feel they are hardest hit by UK Central Government austerity measures. This study has not had the capacity to evaluate this context.
- 7.17 Given that there are no indications that the financial context will improve in the immediate future (revenue funding for local government for the next 3 years is being maintained in the form of a flat cash settlement, although this represents a cut in real terms), this could be argued presents a bleak picture for SDS and for social care generally. However, it also strengthens the case for finding creative ways to maximise choice, control and innovation in this context, as well as the need for a commitment to increase resource capacity in areas that will facilitate this.
- 7.18 Monitoring will also be a challenge as it will be important to ensure clarity about SDS outcomes for individuals and their support packages and how these have changed. In particular, transparency about each local authority's eligibility criteria for the range of social care services would help address this situation.

Lessons

7.19 The findings from this follow-up study of the test sites suggest there are a number of lessons that can be learned by other local authorities implementing SDS. In summary, we believe these are:

- In order to successfully implement SDS, local authorities need to develop greater capacity and skills to enable co-production and involve service users and carers more fully in assessments and setting up support packages.
- In auditing and monitoring implementation of SDS, local authorities need to capture how service users have exercised choice and control especially when the option of not making changes to existing support has been chosen.
- Implementing SDS requires transforming the culture and delivery of social care, embracing new roles and approaches to working with individual and community assets and resources.
- Local authorities need to carefully consider how they manage the pace of SDS implementation in the context of constraints on local government funding and local decisions made around expenditure as this will impact on perceptions of SDS, and its long term sustainability.
- Increased clarity by central government and local authorities about funding and eligibility criteria operating for social care is necessary in order to ensure transparency, and to enable assessment of SDS and the impact of the financial context on implementation.
- Local authorities may need to re-consider how SDS is promoted to service users and the public, and to continually revisit the support and training needs of staff as this situation continually evolves.
- SDS information and forms need to be constantly updated, and to be flexible and adaptable to different client group needs to ensure equity. A system of alerts may be helpful to prevent confusion over what is the most up to date version.
- Careful planning is required to enable SDS skills, expertise and capacity to be developed and shared throughout the organisation and to ensure that the expertise of specialist SDS teams are maximised but not overstretched.
- When making strategic implementation decisions, local authorities need to be aware that the pressure to make budget savings will impact on the way personalisation is perceived and can compromise the ethos of independent living and the degree of choice and control afforded by SDS.
- Local authorities need to consider the position of Independent Living centres and other service user-led organisations as they have a critical role in supporting a more service user-driven development of SDS.

Conclusion

7.20 In the year following the end of the test sites, the 3 local authorities had managed to shift perceptions of SDS further towards it being seen as a mainstream approach to service delivery. Scottish Government investment in the test sites enabled new processes and infrastructure to be established and knowledge of, and expertise, in SDS to be developed. This all contributed to increased take-up of SDS during the follow-up period. However, all 3 sites faced remaining and significant challenges. For example, ensuring

communications about SDS were transparent and up-to date; managing the impact of financial and capacity constraints which might compromise choice and control; and, whilst specialist SDS teams were highly valued, they were all described as stretched. The pace of implementation was found to be a significant factor influencing perceptions of the success of implementation, and high numbers of SDS packages per se were not considered to be positive when this compromised quality of involvement and co-production in assessment and support planning. More generally, this suggests the need for a wider debate and greater transparency about eligibility, the future funding of social care and how to ensure that SDS develops in line with the broader philosophy of Independent Living.

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Social Research series

ISSN 2045-6964

ISBN 978-1-78256-280-1

web only publication

www.scotland.gov.uk/socialresearch

APS Group Scotland
DPPAS13712 (12/12)

