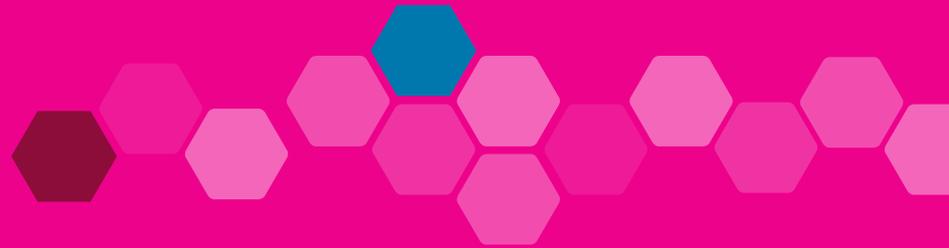




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# Self-directed Support Implementation Study 2018. Report 3: Self-directed Support Case Studies



**HEALTH AND SOCIAL CARE**



## Contents

<b>1. Introduction</b> .....	<b>1</b>
Strategic context.....	1
Case study areas and contributors.....	3
Structure of this report.....	5
<b>2. Dumfries and Galloway</b> .....	<b>6</b>
Local context.....	6
Implementation of social care and support in Dumfries & Galloway.....	6
Case Study 1: Jane, Dumfries and Galloway.....	7
<b>3. Edinburgh</b> .....	<b>10</b>
Local context.....	10
Implementation of social care and support in Edinburgh.....	10
Case Study 2: Alastair and Eleanor, Edinburgh.....	12
Case Study 3: Linda and William, Edinburgh.....	14
Case Study 4: Liz and Janet, Edinburgh.....	17
<b>4. Highland</b> .....	<b>18</b>
Local context.....	18
Implementation of social care and support in Highland.....	18
Case Study 5: Boleskine, Highland.....	19
Case Study 6: Violet, Highland.....	21
Case Study 7: Douglas, Highland.....	21
<b>5. Midlothian</b> .....	<b>22</b>
Local context.....	22
Implementation of social care and support in Midlothian.....	22
Case Study 8: Gerry, Midlothian.....	23
Case Study 9: McSence, Midlothian.....	26
<b>6. North Lanarkshire</b> .....	<b>27</b>
Local context.....	27
Implementation of social care and support in North Lanarkshire.....	27
Case Study 10: Joanne, North Lanarkshire.....	29
Case Study 11: Graham, North Lanarkshire.....	32
Case Study 12: Joyce, North Lanarkshire.....	34
<b>7. Eilean Siar (Western Isles)</b> .....	<b>35</b>
Local context.....	35
Implementation of social care and support in Eilean Siar.....	35
Case Study 13: James, Eilean Siar.....	37

<b>8. Reflections</b> .....	<b>40</b>
Introduction .....	40
Case study approach as an evaluation activity .....	40
Emerging themes.....	41
Local authority resource and cost implications of implementing self-directed support.....	41
Resource allocation panels.....	42
The need for review and changing circumstances .....	42
Sufficient supply and ensuring quality of supply .....	43
Does the use of the four self-directed support options to access social care reflect the intended policy outcomes? .....	43
Conclusion .....	44

# 1. Introduction

In November 2017, the Scottish Government commissioned a consortium of Blake Stevenson Ltd, Rocket Science and the York Health Economics Consortium (YHEC) to conduct a study of the implementation of self-directed support that will contribute to and help to shape ongoing national monitoring and evaluation.

The original brief was for a commission which covered three interconnected elements:

- A: an Evaluability Assessment of self-directed support;
- B: research on the economics/resource implications of self-directed support; and
- C: research on Option 2 in practice.

It was proposed that case studies were a good approach to address research questions related to elements B and C. Through discussion at the Research Advisory Group (RAG) for this project, it was agreed that a small number of detailed case studies would explore the various ways self-directed approaches are being implemented and the potential for scaling up and replicating good practice.

Four reports, including an overview of findings across the other three, have been produced to detail the methodology and findings of the Self-directed Support Implementation Study 2018:<sup>1</sup>

- Report 1: the SDS Change Map;
- Report 2: Evidence Assessment for Self-directed Support;
- Report 3: Self-directed Support Case Studies (this report); and,
- Report 4: Summary of Study Findings and Implications

## Strategic context

The Scottish Government launched *Self-directed Support: A National Strategy for Scotland (SDS Strategy)*<sup>2</sup> in 2010. The strategy set out the Scottish Government's aim to mainstream a self-directed approach to the delivery of care and support. This formed part of a wider shift towards personalisation, co-production and assets-based thinking in social care, in contrast to the case management approach brought in by the NHS and Community Care Act 1990.

Self-directed support, and the core principles underpinning it, represented a change in the relationship between supported people, commissioners and providers, with more choice and control given to individuals and more flexibility required of providers and commissioners. It encourages more creative solutions to meet people's support needs. This has entailed a significant cultural shift for some

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<sup>1</sup> All four are published on the Scottish Government's main website: [www.gov.scot](http://www.gov.scot)

<sup>2</sup> <https://www2.gov.scot/Publications/2010/02/05133942/0>

support services, from making decisions **for** supported people to making decisions **with** people.

Self-directed support was given a statutory footing with the Social Care (Self-directed Support) (Scotland) Act 2013 which was implemented from 2014. The legislation requires local authorities to offer individuals a range of options when they are thinking about how to meet their social care outcomes and health and social care services. These options are:

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

The Self-directed Support Strategy Implementation Plan 2016-2018 states the current priority is to “consolidate the learning from innovative practice and the application of guidance; and to embed self-directed support as Scotland’s mainstream approach to social care.”<sup>3</sup>

Audit Scotland’s progress report on the implementation of SDS<sup>4</sup> notes that not everyone who asks for social care or support is eligible to receive it. Each local authority is responsible for setting local eligibility criteria for access to social care services, based on national guidance produced by the Scottish Government and COSLA. Local authorities assess people’s needs in partnership between the assessor, the person with social care needs and, if appropriate, a family member or carer. Anyone assessed as being eligible for social care can expect to have a discussion with their social worker about the personal outcomes they want to achieve, what support they need to reach these, how much control they would like over arranging and managing their support.

Self-directed social care applies to all user groups and age groups. This includes children and adults as well as older people, people with disabilities and people with mental health problems. The main exception is people receiving re-ablement services (short-term support to help people regain some or all of their independence). Where the person lacks the capacity to provide consent themselves, a carer or guardian can apply for power of attorney or guardianship so they can make decisions on the person’s behalf.

Audit Scotland’s report also found that the pace of mainstreaming self-directed support in social care has varied across the country and for different groups of people, which made it difficult to draw conclusions about implementation ‘progress’ at a national level. The report did find that many people are being supported in new

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<sup>3</sup> <https://www2.gov.scot/Resource/0051/00510921.pdf>

<sup>4</sup> <http://www.audit-scotland.gov.uk/report/self-directed-support-2017-progress-report>

ways; although more information and guidance is needed to help individuals make informed decisions.

The progress report acknowledged that these changes to provision came at a time when public sector budgets were under significant pressure due to the ongoing financial constraints, while there is increasing expectations and rising demand for health and social care support, and when there are social care workforce shortages. All of these have contributed to a slower than expected speed of implementation of person-led and person-centred support and, in some cases, resulted in limited choices for supported people.

Audit Scotland<sup>5</sup> also identified that the integration of health and social care is likely to have further slowed the pace of self-directed approaches being mainstreamed.

## **Case study areas and contributors**

The case studies highlight that the local authorities started their journey towards self-directed support from different places. Some councils had already introduced more creative and flexible approaches to social care or demonstrated social work practice that already featured personalisation, choice and control. They also show how their populations and geographical locations present different challenges and needs.

Six local authorities took part, selected to provide the range of difference across areas of deprivation and urban and rural geography:

- Dumfries & Galloway;
- Edinburgh;
- Highland;
- Midlothian;
- North Lanarkshire; and
- Eilean Siar (Western Isles).

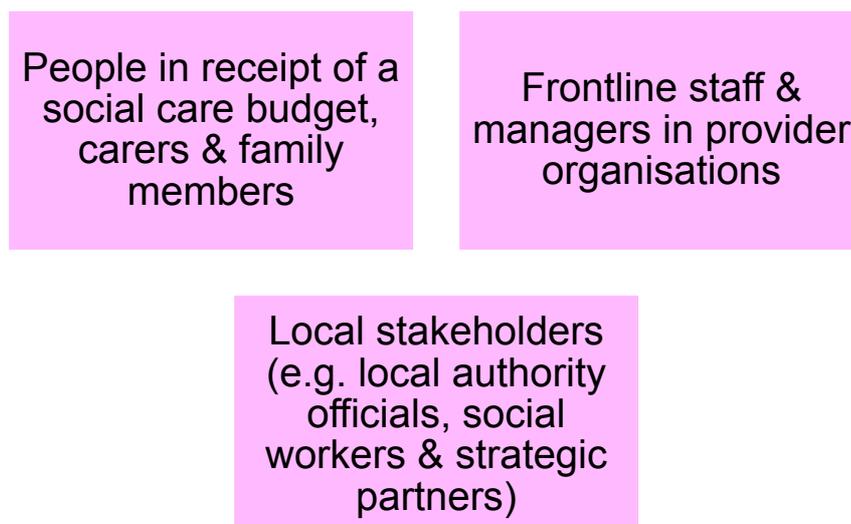
Initially the Scottish Government liaised with Social Work Scotland under an agreed research access protocol between the two organisations. In each area, the Chief Social Work Officer was then contacted by the Deputy Director for Care, Support and Rights in the Scottish Government. Following this contact, the study team liaised with local nominees to make the case study arrangements.

We requested case study examples from each area. It was easier for some councils than others to work with their social workers to identify cases and then secure informed consent from individuals and providers. We were able to complete at least one case study in each of the six areas. For each case study, we identified a range of contributors who were involved in or supporting the delivery of social care. This is detailed in Figure 1.

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<sup>5</sup> <http://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress>

**Figure 1: Range of contributors**



Again, the modes and degree of engagement across this range of contributors varied by area. In most cases, we carried out face-to-face interviews with participants along with follow-up telephone and email correspondence to confirm details. Each full case study has been signed off by a local authority contact. The research team have shared the case studies with the individuals involved when they had their contact details. In this situation, these case studies have been signed off by them or their family member/carer.

The discussions with people in receipt of a personal budget, carers, frontline staff, and provider organisations focused on their experience of accessing or supporting the delivery of social care.

With local authority officials in each area, the focus of the discussion was on the local context and the processes and structures that underpinned the approach to social care delivery that provided personalisation, choice and control. In order to understand the economic implications of self-directed support, the researchers asked the officials in each area to answer follow up questions about the resource allocation system, the time spent on key activities like the review and assessment, and the staff time and frequency for meetings like decision making panels. This exercise sought to capture information to allow greater understanding of the resources needed to implement self-directed support.

Two areas provided information about the economic resources associated with delivery, which is included in their case study and discussed in more detail in "Report 2: Evidence assessment for self-directed support". The reasons why the other areas did not respond is not known. It was possibly because calculating time and resources for some of the activities was challenging or that they were too busy to respond within the timeframe.

## Structure of this report

For the remainder of the report, each chapter is dedicated to a case study area, providing local context and the structures and processes that underpin self-directed approaches<sup>6</sup>.

The chapters document case studies of individuals, and a few social care providers, that capture a variety of experiences of self-directed approaches to care and support. In order to prevent the potential identification of individuals, some details were changed.

In the final chapter, we reflect on the experiences described in the case studies, and consider some of the emerging themes about self-directed support implementation for those who receive care and support and those involved in delivering it.

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<sup>6</sup> Each case study includes data about the population of each area and the number or percentage of social care recipients that receive a personal budget under the different self-directed support options. This drawn from Scottish Government published data:

<https://www.gov.scot/publications/self-directed-support-scotland-2016-17/>

Population data is based on National Records for Scotland's mid-2017 population estimates (<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2017>).

## 2. Dumfries and Galloway

### Local context

Dumfries and Galloway has a population of 149,200.

The Council's history with self-directed support began with one of the early pilots in Wigtonshire. This gave them some early insights into the issues around roll out and helped them with wider introduction of the processes.

For all people, regardless of age, a key aspect of the approach in Dumfries and Galloway is the use of resource panels where all supported people (and parents or guardians where appropriate) and/or their carers are invited to come to the panel to discuss their personal plan. With increasing financial constraints there is an emphasis on eligibility, with a focus on those assessed as having critical or substantial needs.

Weekly budget meetings are held to review individual cases – if a person's needs are no longer assessed as critical or substantial, their care package will be reviewed. Any new case which is not assessed as 'critical' is also discussed at a budget meeting. For the under 65s choosing Option 2 or Option 3, there is a budget limit linked to the equivalence<sup>7</sup> of the cost of providing support under Option 3, but social workers can escalate the case to the weekly budget meetings to seek approval for exceeding this limit.

The processes for assessing people's care needs have changed with the implementation of self-directed support. At the core is a change in practice and in how social workers perceive individuals who need support, moving away from asking supported people "What's the problem?" and instead asking "What do you want to do?" To answer this question well, the 'good conversation'<sup>8</sup> involves getting to know the supported person, what they can self-manage by using an asset-based approach, what is available locally, what gap needs to be filled and how social work can help to fill this gap.

### Implementation of social care and support in Dumfries & Galloway

Accessing their personal budget as a direct payment (self-directed support Option 1) has mostly been chosen by individuals under the age of 65 (53% and 11% of people aged under 18 and adults aged under 65 respectively in 2016/17). There is limited uptake by those over 65 (1% in 2016/17); local authority representatives suggested that social workers may find it more difficult to explain Option 1 to this group without it sounding daunting to some. Additional challenges include the rural

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<sup>7</sup> The principle of equivalence means that supported people are "given budgets based on the equivalent value of the services they would have got before SDS" (Audit Scotland (2017), 'Self-directed Support: 2017 Progress Report, [http://www.audit-scotland.gov.uk/uploads/docs/report/2017/nr\\_170824\\_self\\_directed\\_support.pdf](http://www.audit-scotland.gov.uk/uploads/docs/report/2017/nr_170824_self_directed_support.pdf))

<sup>8</sup> The accepted model detailed in "Talking Points: Personal outcomes approach" (Ailsa Cook and Emma Miller, 2012) identifies what should be discussed, how the conversation should be conducted, who should be involved and what should happen. (<http://www.ccpscotland.org/wp-content/uploads/2014/01/practical-guide-3-5-12.pdf>)

nature of Dumfries and Galloway, which makes it more difficult to recruit personal assistants (PAs) and increases the travel times involved. To help address these barriers, the Council is now using Facebook as a PA recruitment tool and they have established a web-based application process so that those keen to be PAs can record their details.

While there appears to be general agreement among practitioners that Option 2 would be the preferred option for many, the introduction of this option was delayed until an appropriate contract became available in September 2017. Therefore, the data for 2016/17 showed that no one had chosen Option 2 over that period but now that this is available, it is likely that more people will choose Option 2.

In many areas of Dumfries & Galloway, there is a lack of a critical mass in terms of the number of supported people, so even although Option 2 is now available it is hard to create a viable provider business model. A further challenge for providers is that the principle of equivalence means that Option 2 is the same price as Option 3 – so providers may need a business model which covers their costs for delivering services under both of these.

Option 3 was used by 96% of people aged 65 and over in 2016/17. The local authority selects a provider for a new supported person from an approved provider list. Unlike some other areas, where there can be considerable choice around Option 3 providers, individuals may only have one Option 3 provider locally and may need to accept the time slots that the provider has available.

The individual case study from Dumfries and Galloway provides an example of social care under Option 3.

### **Case Study 1: Jane, Dumfries and Galloway**

Jane is in her 40s and has had a chronic condition since she was in her late 20s. Her story shows how the good conversation can lead to an Option 3 choice that can be outcomes focused, flexible and responsive.

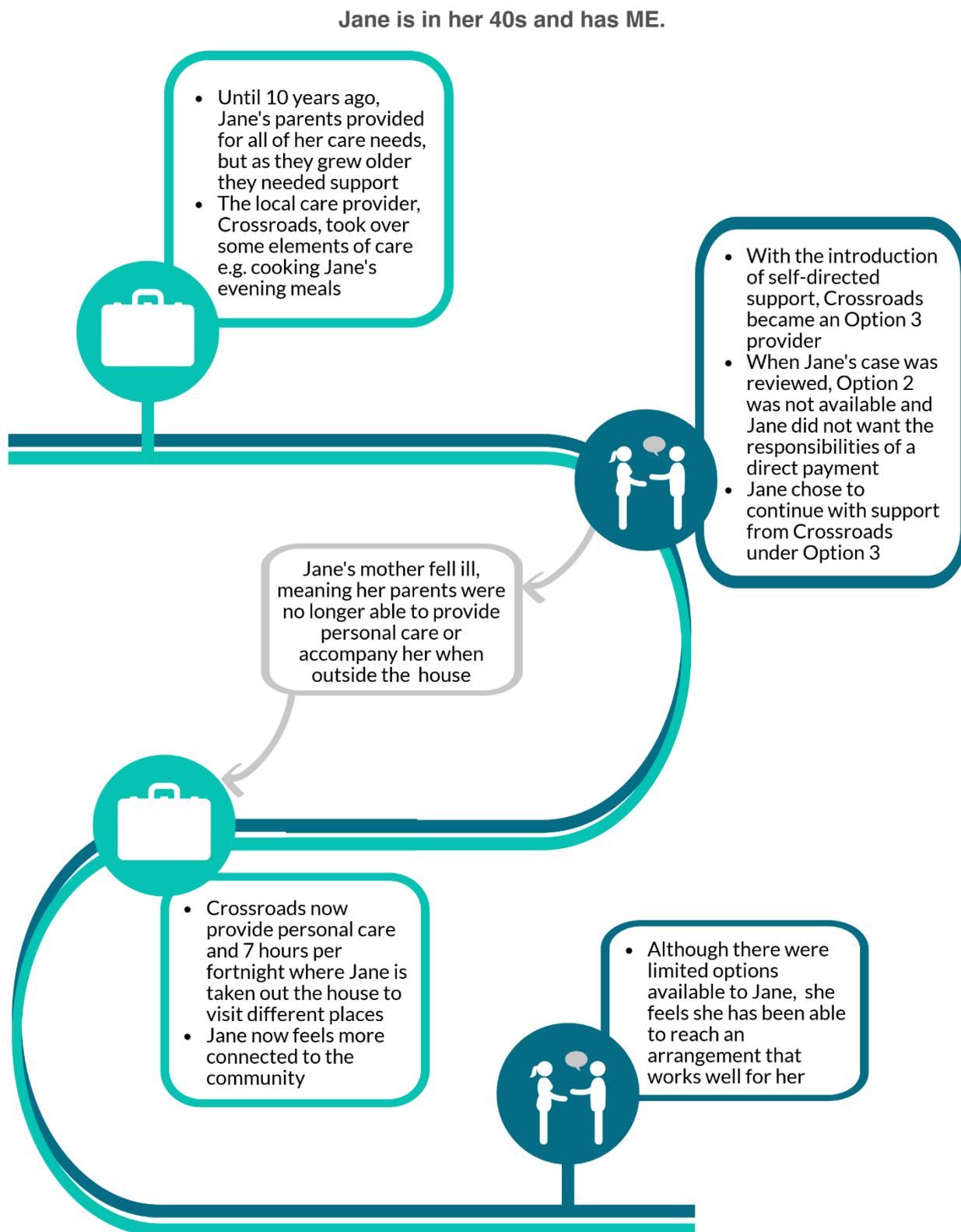
Jane lives in a small community outside Dumfries and her parents live in the same community. Until 10 years ago Jane's parents provided for all her care needs (for example going around every evening to cook a meal), but as they aged they became unable to do this and the local care provider was contracted to cook a meal for Jane every evening.

With the introduction of self-directed support, the care provider became an Option 3 provider – the only one in the area. With Option 2 not being available at that time, Jane's only other choice was Option 1. Jane was aware of this option but her view was that, 'It seemed quite complicated and too much for me to think about. You need to be on the ball and know what you are doing, and there are quite a few days when I am not like that. I have had relapses when I did not even know how to deal with a letter.'

Jane's provider has proved highly responsive and flexible under their Option 3 contract. More recently, Jane's mother became unable to provide personal care so the provider now provides personal care for Jane (under Option 3). In addition, because her parents can no longer take her out, Jane's funding was increased so she has an additional seven hours a fortnight with Crossroads which allows, for example, trips to Dumfries or Ayr. With her chronic condition having a cyclical component, when Jane is not feeling up to these experiences the contractor can bank the hours and agree a longer trip when Jane is feeling better.

There is a key component of this additional support linked to the outcomes which are important to Jane: keeping her connected with her local community which maintains her local network which is important to her. It also provides a more rounded model of support to include her family and community as well as the support provided through social care.

Figure 2: Summary infographic - Case Study 1, Dumfries & Galloway



**The package of support under Option 3 of self-directed support has adjusted to successfully meet Jane's changing needs**

## 3. Edinburgh

### Local context

Just over half a million people (513,210) live in the City of Edinburgh.

Before the implementation of the self-directed support legislation, the transition team in Edinburgh used In Control Scotland (a third sector organisation) to allocate individual budgets to young people and to make an Individual Service Fund for short breaks for adults with learning disabilities. When the legislation was implemented, there was a concerted effort by the Council to set up and implement self-directed support options. However, this was at the time of the financial crisis when managing a limited budget became a priority and, like other areas, integration affected and continues to have an impact with its associated significant changes to systems and processes and movement of key personnel. All this has affected the extent to which self-directed support is embedded in Edinburgh.

A dedicated funding and independence expert team, with social workers who previously provided support and advice to supported people, workers and assessors, was disbanded as part of restructuring and organisational review in 2017.

### Implementation of social care and support in Edinburgh

Across the city, social workers are said to base their assessments and reviews around 'good conversations' but this is not consistent. The Council has recently reinvigorated their approach, delivering training on having 'good conversations'. This is helping to progress and build greater personalisation, choice and control for individuals accessing social care and support in Edinburgh.

After a social worker has completed the assessment of someone's care and support needs, an indicative social care budget is calculated using a financial allocation system, which considers hours of care 'needed' and creates an equivalence in money terms. Like other areas that use this approach, it means the budget is calculated on a fixed number of hours of support related to 'need' at a particular cost rather than the more holistic assets-based and outcome-focused approach at the heart of self-directed support.

Once the budget has been calculated, a self-directed support option can be chosen. Authorising the support plan and personal budget, regardless of the self-directed support option, requires different levels of sign off, depending on the amount and the type of support. This approach to approving personal budgets is largely consistent across the City, but there are some differences, depending on the senior manager who has sign-off responsibility.

Data for 2016-17 shows that Option 3 is the most common approach in Edinburgh, with 51% of adults under 65 and 76% of those 65 and over taking it up. However,

Option 1 is also commonly used, particularly among people aged under 65. A third of those under 18 and 40% of those aged between 18 and 64 choose this.

Option 1 is administered via a payment card system (or a designated bank account for long established supported people) and social workers should check whether there is a sufficient amount of money on the card. There are restrictions as to which providers can be paid using the card. At present, the local authority is considering their duty of care and responsibility where the system allows people to use providers that are currently suspended from council contracts or that the authority would not use. Individuals taking up Option 1 can also access financial management services depending on their level of need. Those who access the mid-level service receive some support like completing tax returns and paying national insurance contributions for PAs. Individuals that access the enhanced financial management service receive more support, for example with payroll (delivered by Fife Business Services) or other practical help like recruiting a PA (delivered by Lothian Centre for Inclusive Living).

When an individual chooses Option 2, this is through an Individual Service Fund with a nominee, often the provider, managing the allocated budget on a supported person's behalf. Whilst the contract is between a person and a provider, the provider has to be on the local authority's framework having gone through the appropriate contract and commissioning checks. There are a limited number of providers on the framework, but there is more flexibility in what can be provided; and it is consistently the option that is quicker to put in place. The social worker draws up the support plan together with the supported person, a provider is found and the business support team arrange the funding.

The process for Option 3 can take many months. The support plan goes to the service matching unit, a finance and contract team, who complete a questionnaire about the support needed. This is sent to the providers on the framework and the matching service waits for a response. Social workers are aware of the potential for long delays and so actively encourage individuals to consider Option 2 instead. If the supported person prefers to opt for Option 3, they will use local knowledge to establish which provider has availability so they can make a specific request.

The local authority recognises that they need to continue to work with providers to develop the range of services needed to meet people's social care needs. They are increasingly engaging with providers about what they do and what they need, holding marketplace events to help foster working relationships between the different types of provider. The Council appreciates that more can be done to develop the partnership with providers and to involve communities and supported people in ways that enable them to influence commissioning.

Three case studies were undertaken in Edinburgh:

- Case study 2: Alastair uses self-directed support Option 3 to arrange his care;

- Case study 3: discusses the experience of a couple, Linda and William, who use self-directed support Options 1 and 2 to meet different aspects of their support needs; and,
- Case study 4: focuses on Janet's experience of using self-directed support Option 1 to receive support to help her care for her mother.

## **Case Study 2: Alastair and Eleanor, Edinburgh**

Alastair was a teacher and a Director of a business. In 2008 when he was in his late 50s, Alastair experienced a major stroke which left him with physical and mental impairments. He receives a lot of support from his ex-wife, Eleanor, and she has helped Alastair to ensure that the most appropriate package of care is in place.

Alastair was in hospital for almost 12 months and when considering the support that would need to be in place it was agreed that they should choose supported accommodation provided by Leonard Cheshire (a large UK-wide charity) to continue his rehabilitation.

Alastair stayed in this development in the south side of Edinburgh for a year, but he was very keen to return to the familiar surroundings of his own house and local community in the north of the city. However, because he would be living alone, it took several months to discuss and establish what package of care could support independent living at home. An independent advocate who participated in all the meetings that were held with Alastair, Eleanor and the social workers supported this process.

Eleanor continues to advocate on Alastair's behalf. When establishing the package of care, they were offered Option 1 (this was before self-directed support legislation came into force) but opted for a package arranged by the social work team.

The care at home package was provided by the same provider, Leonard Cheshire, and Alastair and Eleanor agreed the support and home adaptations required to ensure Alastair's safety. Alastair was able to move home in 2010 and a support worker provides daily support within the home and by accompanying Alastair to various activities which enables him to be involved in his local community.

The Leonard Cheshire contact explained that the working relationship with Alastair and Eleanor was effective and they had shaped the package to suit his needs and the personal outcomes he had identified.

Whilst the care at home package that Alastair receives is via a spot purchase contract<sup>9</sup>, they are also on the provider framework with the City of Edinburgh Council for Option 2 of self-directed support and can offer supported accommodation and respite care.

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<sup>9</sup> The service is purchased by the Council on behalf of an individual as and when needed on an individual basis

The social worker who had the most recent involvement with Alastair explained that, because of service capacity issues, his case had not been reviewed annually. The last review with Alastair and the provider (in February 2016), had shown that everything was working well and everyone seemed happy. The case review in 2014 also showed a positive arrangement. The social worker explained that Alastair and Eleanor had a lot of control over the service they received and an established relationship with Leonard Cheshire, so there has not been any discussion about other self-directed options. The social worker also commented that the backlog of cases and the time to complete the assessment and support plan and process contributed to there not being a recent review.

Alastair and Eleanor are reasonably happy with the care provided by Leonard Cheshire and, whilst they do not anticipate the need to make any change to the current arrangements, they would like to understand what self-directed options they have, should they want to consider alternatives in the future.

Alastair has received support for his care from the same provider for more than eight years under Option 3 and whilst this has been provided in line with his needs, he would like the opportunity to explore other options through more regular reviews and discussion of his needs.

### **Case Study 3: Linda and William, Edinburgh**

Linda and William are a retired couple. Their experience shows that self-directed approaches to care can be used flexibly to allow people to make different arrangements for the various elements of their care. It also illustrates the importance of local authorities ensuring that their systems are appropriate and enable the varied choices that people make for different aspects of their care.

Linda was diagnosed with Parkinson's in 2003 and has very little mobility. A hoist is required for Linda to move around the home that she has shared with William for over 40 years.

William does all of the cooking and cleaning in the house but, since an assessment with the City of Edinburgh Council in 2012, home care workers have supported Linda with personal care.

Initially, Linda received four one-hour long visits per day from one care worker under Option 3 but an assessment in 2013 identified the need for two workers to attend each visit in order to move Linda safely.

In 2014, the Council informed Linda that it could not provide two carers per visit but suggested she should source another provider herself under Option 2. However, it was difficult for their daughter Jillian to find a supplier with the capacity to deliver this service. She contacted 35 different agencies before finding one who could meet their needs. The family selected this agency.

The decision to select Option 2 in 2014 was taken because the local authority could not provide the service they needed, rather than because the couple proactively wanted to switch to this option. However, Linda and William appreciate having control over the choice of the home care company and the frequency and timing of visits from care workers, while the Council deals with the arrangements and the payments.

As well as home care, the couple receives support with respite care. Later in 2014, William had some difficulties coping with his caring role so Jillian contacted the local authority to discuss if any other support could be provided. This prompted a review, which led to Linda and William identifying a need for respite care. The couple's savings fund most of this, but the authority contributes (£2,500 per year, around 20% of the annual cost). This is managed via a direct payment, which was paid directly to William (Option 1). This means they can arrange the respite care themselves with the provider of their choice, which accepts the Council's payment cards, and at the times when they need it.

Linda and William are satisfied with their package of care and they are very happy with the home and respite care services they receive, however the administration of their budget has led to some confusion.

Up until 2017, the couple's main point of contact with the local authority was their Occupational Therapist (OT). They discussed their needs with the OT who then sourced the equipment and care services they required, without any discussion of

budgets, and the Council made the payments for home care on the couple's behalf. As William said, "everything was so simple".

In 2017, their OT advised the couple that she could no longer be the key contact for arranging the care and William needed to liaise with the Finance team in the City of Edinburgh Council. William was nervous about the new system for discussing their needs, and his son accompanied him to the meeting because he was asked for some information (such as an email address) that he would not have been able to provide on his own.

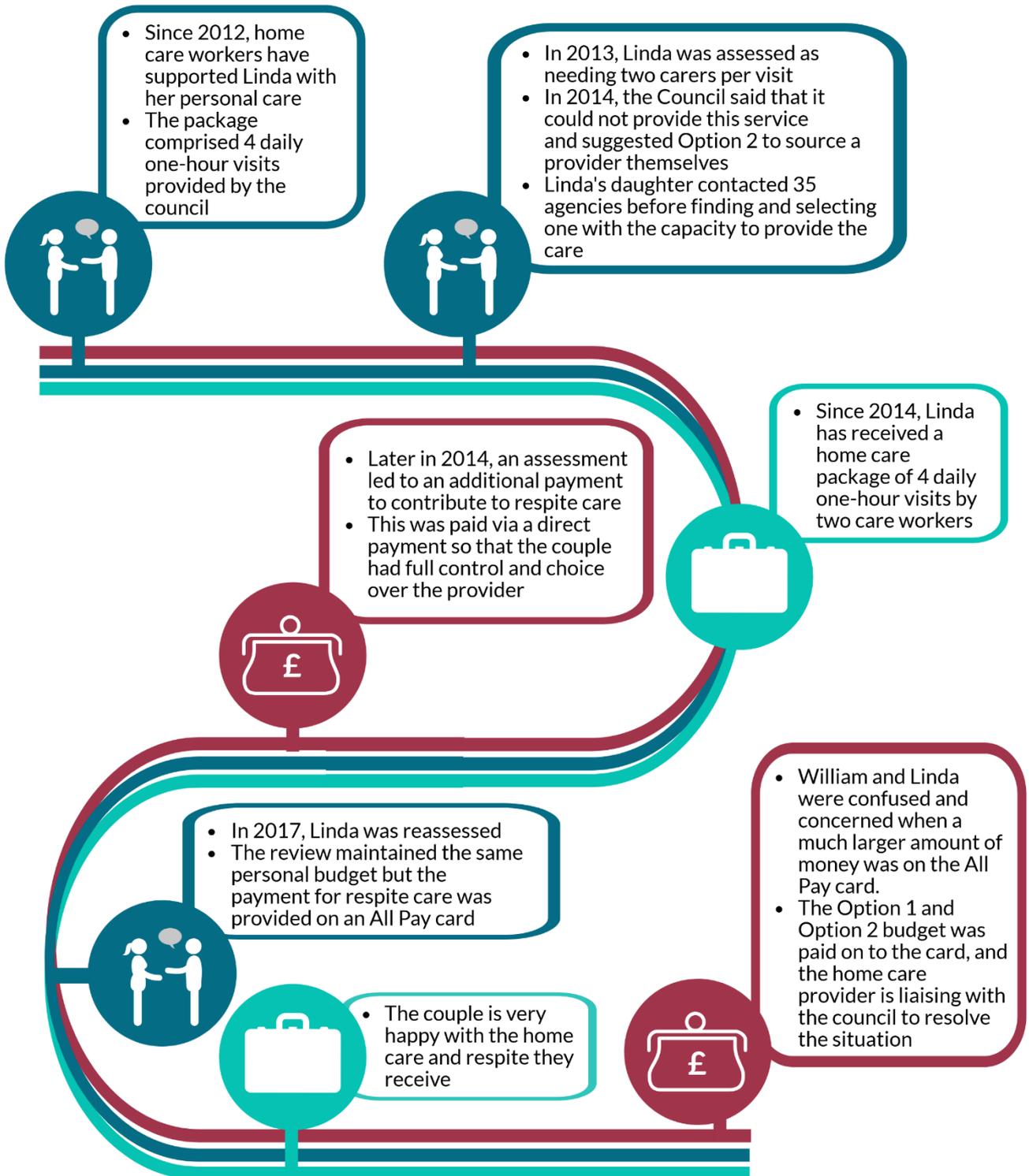
The assessment meant that the Council agreed to maintain the same level of funding for respite care, and the first instalment of the respite care budget (£1,400) was provided on a pre-paid (All Pay) payment card, instead of a direct payment into William's bank account, so that they could continue to manage the finances for this aspect of Linda's care.

However, confusion arose when William noticed there was a much larger amount of money (£24,000) on the payment card. The local authority has made excess payments on to the card, and the home care provider has not been receiving the payments it was due from the authority.

This has caused some concern for the couple: the provider cannot accept the payment card, and Linda and William want the Council to make the payments direct to the home care provider. The situation is not yet resolved, but the home care provider is currently liaising with the Council to revert to the original payment method so that they receive the funding directly from the local authority.

**Figure 3: Summary infographic - Case Study 3, Edinburgh**

Linda and William are a retired couple. Linda was diagnosed with Parkinson's in 2003.



**The options within self-directed support allow Linda and William to select the home and respite care providers best placed to meet their needs, but the excess money placed on the All Pay card has caused confusion.**

## Case Study 4: Liz and Janet, Edinburgh

Liz, who is in her 90s, has dementia and lives at home with her daughter, Janet. Their experience shows that Option 1 can provide the best choice and control for some people's care and support, especially in situations where there is more choice of providers.

Liz was first diagnosed with dementia in 2010. By 2014, the condition had progressed and, after an assessment, Liz was found to be eligible for social care. Janet is the main carer for Liz and they chose Option 1 to design a flexible package of home care that provides appropriate support and enables Liz to continue with everyday activities and hobbies. Janet set up a dedicated bank account to manage the budget.

This approach allowed Janet and Liz to appoint a carer of their choice, identified through personal contacts, to support them at the days and times that suited them. Janet was able to access the enhanced financial management services offered by the local authority and she received support from Lothian Centre for Inclusive Living (LCIL) to manage the administrative aspects of paying the carer.

This arrangement worked well until the carer left her post. Janet felt the potential replacements identified by LCIL could not deliver Liz's desired outcomes. With support and help from their social worker, Janet recruited a new team of carers (again identified through personal contacts) which was "quite complicated to get started". Without the social worker's help, Janet felt she would have been unable to arrange care.

Janet now undertakes all the employment responsibilities for the carers. The local authority continues to pay the budget directly into the bank account which gives Janet more flexibility than the All Pay card. To keep a track of the payments, Janet created her own receipt template that the carers complete each time she makes a payment. This, she feels, helps to "keep it right".

Janet likes using Option 1 because, although the local authority reduced the budget available after a re-assessment in 2017, she has been able to design a flexible care package delivered by carers she knows and trusts, at times that suit her. Liz's dementia has become more advanced over the past few months. There have been instances of wandering behaviour and Liz often requires care during the night. As well as daytime care, the budget includes funds for six sleepovers per month to provide night time support.

The flexible provision does mean that some weeks Janet uses more care than in other weeks, depending on what she has planned, and when this happens and the costs exceed the personal budget, Janet uses her own money to meet the shortfall.

A social worker involved with the case noted that the flexibility of Option 1 ensures that there is appropriate "support for the daughter which has helped Liz to remain at home". She also observed that this means Janet is able to identify a group of carers, people she has established relationships with, to support her Mum's care.

# 4. Highland

## Local context

The population of the Highland Council area is 235,180.

The Highland approach to self-directed support has developed to reflect features based upon geography and history, underpinned by a strong emphasis on enhancing performance and service quality across social care through a forensic focus on weekly performance data and understanding trends and patterns.

## Implementation of social care and support in Highland

For Option 1, the approach is to focus on a three-way assessment:

- What can the family offer?
- What can the community offer?
- What needs to be offered through Option 1 to fill any gaps?

Option 1 is the main choice for people aged under 18, with 92% choosing Option 1 compared to 2% of people aged 65 or over in 2016/17.

The roll out of Option 2 in Highland is based on the 'Boleskine Community Care model', named after an area on Loch Ness-side.<sup>10</sup> This features the delivery of support by community-based organisations, which ensures strong local ownership and connections, and close working relationships with District Nurses and GPs. Uptake of Option 2 is relatively low, with 3% of adults aged under 65 and 2% over 65 taking Option 2.

A strategy of reducing direct NHS provision of Care at Home and expanding the provision of outsourced Care at Home through self-directed support Option 3 contracts with a range of trusted providers has been adopted. This is seen as a way of offering better value, more flexibility and responsiveness, and greater choice for supported people.

Option 3 contracts in Inverness have now been awarded on a neighbourhood basis. This means that staff become familiar with local residents and build effective working relationships with other local services in each area and minimises travel time between home visits.

For adults, Option 3 is the choice made by the majority, with 78% of adults aged under 65 and 93% aged 65 or over taking this option. The distinctive feature of Option 3 is that NHS Highland, rather than the local authority, retains control over funding and variations through its contract terms. This contrasts with Option 2 where local teams, which are managed by community-based organisations, can

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<sup>10</sup> <http://www.boleskine-communitycare.org.uk>

vary services offered to meet personal outcomes without formal sign-off by NHS Highland.

There are three case studies from Highland:

- Case study 5: focuses on an example of local communities working with statutory agencies to develop services under Option 2; and,
- Case studies 6 and 7: outline examples of two supported people's use of Option 2.

## **Case Study 5: Boleskine, Highland**

This case study, based in Boleskine in the Highlands, highlights how local communities in combination with statutory agencies can work together to develop services under Option 2, and how learning from a relatively small area, with a dispersed population, can be disseminated across the wider local authority.

The approach to supporting people at home in Boleskine arose from a recognition that there was a growing local need. The ageing community and lack of local service provision meant moving to homes outside the area for some people. However, there was potential capacity to boost the supply of care, as there were local residents who felt keen and able to provide support.

Following discussions involving community leaders, NHS Highland and Highland Home Carers, a community-based organisation called Boleskine Community Care (BCC) was created and registered as a charity. Highland Home Carers (HHC) employs all the carers managed through BCC as well as the 3-day a week service manager. (HHC is an employee owned company with charitable status). HHC and BCC have a Memorandum of Understanding that sets out their respective roles, how they will work together and mutual expectations.

HHC funds provision of administrative support, employment and training by a levy on each Option 2 payment (of 15-20%). Their costs covered by this levy include 2 days of the manager's time: the third day is paid by Boleskine Community Trust from income from local energy production.

BCC now has 10 part time carers and a part time service manager, and 14 supported people. All BCC support is funded through Option 2. Boleskine carers are locally recruited – adverts are placed in the BCC newsletter and the local post office. Currently all 10 care staff live locally. They are all part time and work flexibly to suit their availability on zero-hour contracts but with the terms and conditions of permanent posts (e.g. in terms of paid holidays and other employment rights).

Referrals for assessment are made by GPs, District Nurses or through BCC (who may identify additional support needs when people attend their range of other activities). A social worker (sometimes accompanied by the BCC manager) makes assessments.

Each care plan is the subject of a tripartite agreement between the supported person, HHC and NHS Highland. This agreement is designed to be easily understood by supported people and their relatives. Care plans may be subsequently adjusted by BCC staff (any increase in provision needs to be agreed by a social worker) and are often adjusted downwards in the short term – with any savings in funding being ‘banked’ for later use on other forms of appropriate support for that person.

The key features of the Boleskine model are therefore local ownership through a community based organisation, and a strong working relationship with a support organisation (HHC) and other local professional services.

The relationships between BCC and other local services – notably with local GPs and District Nurses – has strengthened considerably. BCC now has a physical base in Lower Foyers (The Hub) and District Nurses have the access code and are able to leave equipment there. District Nurses have trained BCC staff in skincare so they can apply ointments and related care to their own supported people or others if convenient. BCC staff are also willing to deliver mobility aids and commodes in response to local requests.

Much of this activity is designed to ensure that BCC and its services are seen as highly approachable – so that in the future, there will be less resistance to seeking and accepting support and so a reduced risk of unplanned hospital admissions related to a lack of support. This approachable local service should be valued as part of an approach of investing in prevention.

The role of BCC is evolving and it is extending its local services into a range of other activities for elderly people in the area. It is doubling the size of its base and this will allow it to deliver additional services such as day respite care.

Elements of the Boleskine approach have now been adopted by the Community Health Project of the Strathdearn Community Developments Company (which includes Tomatin and Moy) and by Black Isle Cares. Both these charities drew on the experience and support of HHC and BCC in developing their local model – but in both the areas, elements of the model and the agreements that underpin it have been adjusted to respond to the nature of the community and the concerns of local trustees in each area.

It is possible to identify some of the features for successful transfer.

There needs to be a strong local group of potential Trustees ready to take on responsibility for the approach and drive its implementation. In all three areas to date, there has been a pre-existing community trust, which has provided a base of local commitment to build on. An organisation, which is able to act as employer, trainer and source of technical HR support, is needed as well as a close and trusting relationship with this organisation.

It is paramount that local people are able and willing to provide support and keen to be trained to do this. The role of the service manager is also critical – they are central to the ethos and values of the approach and are important in terms of

building local trust and strong working relationships with other sources of local support such as GPs and District Nurses.

The existence of independent local income is important but not vital – the managers in two of the three areas which have adopted the approach are at least part funded from community interest from wind and/or hydro schemes. Particularly in smaller communities, the scope for adopting the approach may be limited by a lack of alternative sources of income.

### **Case Study 6: Violet, Highland**

Violet started drawing on BCC support when she needed skincare on her legs. Over time, this has developed to become 3 day a week support – 1 hour in the morning just after getting up. Violet clearly has a strong relationship with all her carers and looks forward to their visits – they provide what she needs and provide an opportunity to share local news.

Option 2 means that she can get the support she needs from a trusted local provider staffed by local people without the difficulties of organising the service herself.

### **Case Study 7: Douglas, Highland**

Douglas suffered a bad accident at home; he broke his neck and was advised that he may never walk again. Following surgery outside the area he returned home to his daughter's house (which was suitable for a wheelchair) with 1 hour of care every day of the week, provided under Option 2 by BCC. His condition improved significantly over time and he was able to walk with the aid of sticks and move back to his own home nearby with his wife.

He now gets 1 hour of support 3 times a week. Under Option 2, he is able to get support from a local, trusted organisation and it is clearly an arrangement with which he is happy.

## 5. Midlothian

### Local context

There are 90,090 people who live in Midlothian.

People in Midlothian move into a self-directed support approach to their social care when:

- existing supported people cross the threshold into the critical/substantial risk categories; or
- people approach the Council to ask for an assessment; or
- the Review Team carry out a re-assessment; or
- retendering leads to a review of the status of supported people of a particular provider.

The local authority has a policy of equivalence when offering care packages under Option 1 or 2 – in other words, supported people are offered support to the value of its cost under Option 3. Option 1 and 2 supported people are able to make decisions about the balance between cost and quality and the outcomes they achieve.

The Council is also responding to fiscal austerity by focusing on the development of more cost-effective approaches to service delivery.

### Implementation of social care and support in Midlothian

Midlothian Council has around 2,500 people in the critical/substantial risk categories that determine eligibility for social care. Of these, 800 are under 65 and 1,700 are over 65. Most people eligible for social care access this under Option 3, and, in practice, considerable choice is available under this option because most of the local providers have contracts under Option 3.

A high proportion of people accessing social care do so under Option 2. One of the reasons is that many supported people did not want to change provider when a provider unsuccessfully retendered for their contract to provide services under Option 3. Others have used Option 2 to move from an unsatisfactory Option 3 provider or to providers who have good local reputations.

The local authority regards the redesign of Option 3 as an important part of implementing self-directed support – in other words, they seek to ensure that the quality and responsiveness of services delivered under Option 3 are seen as appealing and closely related to the specific needs of individual supported people, as other Options.

One of the other challenges is around Option 1 when it involves directly employing Personal Assistants. There is no requirement for PAs to undergo a Protecting Vulnerable Groups disclosure check or to be registered with the Scottish Social Services Council. There is a shortage of PAs and, with an ageing population, this

challenge is becoming more severe. The Council has established an online PA registration scheme. Most of those recruited have a care background but a package of training for PAs is available.

Two case studies were undertaken in Midlothian:

- Case study 8: Gerry used self-directed support Option 1 and then Option 2 to meet his care needs.
- Case study 9: focuses on a care provider's experience of delivering services funded under Option 2 and Option 3.

### **Case Study 8: Gerry, Midlothian**

Gerry is 26. His story illustrates the importance of the regular review of personal outcomes achieved. This introduces a check to assess how people are managing their self-directed care and support, and the flexibility needed to change options if that becomes appropriate.

Gerry has muscular dystrophy and uses a wheelchair. He has a 24/7 care package and was offered Option 1 or Option 2 (there was not an Option 3 contractor available). He originally chose Option 1 because he thought that choosing his own care provider was an attractive idea.

Gerry threw himself into selecting a provider, with active support from his mother. He met several companies but many of their hourly rates were unaffordable for his personal budget. Gerry found a new local provider and they were encouraged by their social worker to "give them a go".

Gerry interviewed the provider, discussed his care plan and agreed a price for providing the service. The cost was slightly higher than his personal budget so he approached the local authority who agreed to fund the higher cost of the package.

The provider identified the carers Gerry needed, he then paid the provider and sent invoices to Midlothian Council, setting out the care hours that had been delivered, in order to draw down the money.

This arrangement worked well until Gerry started a full-time course at his local college. Due to the demands of the course, Gerry started falling behind with his invoicing and there were discrepancies between the provider's record of hours of care provided and Gerry's record of hours of care received:

"I was getting weekly phone calls chasing invoices – and because I was doing a full time college course I got really stressed".

When Gerry was offered a place at university, he decided that it would be better for him if he changed to choosing a provider under Option 2 so that he would not have the responsibility and added pressure of managing his care under Option 1.

Moving to university still meant identifying appropriate providers and again, supported by his mum, he identified care organisations in the city and looked for those located near to the student accommodation. A pool of 50 potential providers was whittled down to 20 and then five were interviewed. He selected one of them and they used a subcontractor to provide the package of care.

Moving to Option 2 was more beneficial for Gerry. He explained, “I am able to pick who provides the care – but the payment and organisation is done by someone else”.

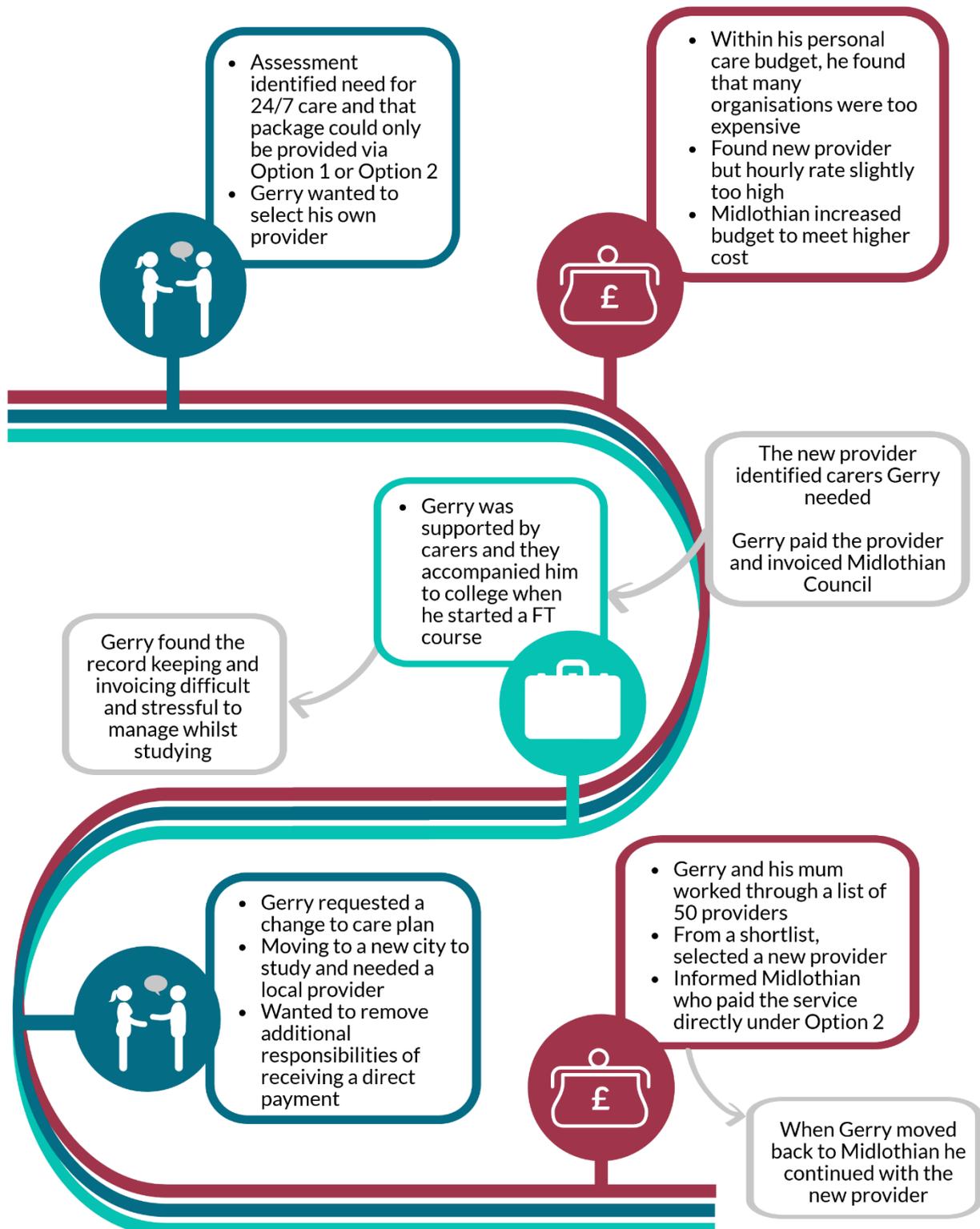
Gerry left university before the end of his course and moved back to Midlothian. The local authority directed him to a website of local providers and the same subcontractor was operating in the area so he was able to continue to work with the same organisation. Like many local providers, the organisation initially found it difficult to recruit appropriate carers, but they succeeded and continue to work with Gerry.

Gerry had both the time and the inclination to carry out the research on his providers under both Option 1 and Option 2 choices and he felt that, “It gave me something to do, it gave me good communication skills, and it gave me skills with money – I found it quite fun”.

However, it was time consuming to pursue his choices and it was challenging, particularly in balance with other demands such as full-time study, to control the care that was provided in a way that enabled him to pursue his personal outcomes.

Figure 4: Summary infographic - Case Study 8, Midlothian

Gerry is 24. He has muscular dystrophy and uses a wheelchair.



The flexible self-directed approach enabled Gerry to change providers and the way he accessed his personal budget in response to his changing needs.

## Case Study 9: McSence, Midlothian

McSence is a locally owned and controlled social enterprise based in the Mayfield area of Midlothian. It has a number of business strands including home help, care at home and training. Their experience highlights how Option 2 not only provides benefits to individuals but also helps to support innovative small businesses.

Four years ago, following a Care Inspectorate report, Midlothian Council offered McSence a contract for a total of 50 hours a week for Option 3, which gave the local authority the ability to call on care-at-home for elderly supported people. McSence is a well-known local community organisation that offers care-at-home as well as property maintenance services and workforce training on topics like adult support and protection. It has many contacts and, as a result, when they promoted their service demand very quickly went above the 50 hours.

Their service was focused initially on their home area of Mayfield. Most supported people also accessed McSence's home help service, and several social workers had confirmed that supported people could switch and receive all the services from the same provider.

McSence maintained its 50 hour per week contract until a new three year framework agreement was created when three larger and longer established providers were commissioned to provide all services on the Option 3 framework. "We had existing clients and the Council sent them letters saying they would be moving to a new provider." However, they wanted to remain with McSence and approximately 20 of the supported people switched to Option 2 so they could continue to receive care from the organisation.

The current situation is that McSence is now providing 1,000 hours of care per week in Midlothian, following their success in a subsequent tender round when they became approved suppliers again on the framework. This has meant that many of their Option 2 people have switched back to Option 3 and new supported people are also accessing services under that option.

For the business, Option 2 represents a way of minimising their risk. Their manager described, "Option 2 is a godsend as a community business – without it big players can have people write tenders and will always win – Option 2 gives small organisations like us a lot more power." They know that if they are unable to secure a place on the framework in the next procurement round, their customer base can still be maintained under Option 2.

## 6. North Lanarkshire

### Local context

The population of North Lanarkshire is 339,960.

North Lanarkshire was developing self-directed approaches for some time before the legislation. In 2006, the local authority started working with In Control Scotland to help understand how individualised support could be delivered, building on work that was already happening for people leaving long term care. A key component of this work was understanding the costs of care for individual supported people.

In 2007, work started on developing a resource allocation system that developed into a guided self-assessment tool that has now been in place for 11 years. Where a social worker and their senior practitioner determine that an individual meets the criteria for funding, the person's case is referred to the Local Enablement Group (LEG). If the LEG agrees, the social worker then completes the guided self-assessment tool together with the supported person at their home. It contains a series of eight questions about the individual's care needs, and asks for the views of both the supported person and the social worker. The results of this are used to calculate an indicative budget, and for most people this has proved to be an accurate estimate of the resources that are actually required.

### Implementation of social care and support in North Lanarkshire

At the heart of the approach to social care in North Lanarkshire is a high-quality conversation with a social worker to help people understand the different self-directed support options and develop a care plan. As well as guiding people through a process of identifying the outcomes that are important to them and helping people to think creatively about how these can be met, social workers also explain the different organisations offering services under Option 2 and how Option 1 can be managed.

North Lanarkshire estimate that their social workers spend between 4 and 8 hours completing each social care assessment, resulting in a cost of social worker time of between £172 and £344.<sup>11</sup>

North Lanarkshire operates a preferred provider framework for Option 2. It does not guarantee work for providers on the framework, as the emphasis is on choice and flexibility for supported people. This creates an atmosphere where social workers themselves keep in close contact with local provider organisations. This keeps the social worker informed, as they understand what services providers offer; their current levels of capacity and locations they cover; and allows them to keep

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<sup>11</sup> Based upon a cost of an hour of social worker time of £43 from the Personal Social Services Research Unit (PSSRU): Unit Costs of Health and Social Care 2017

supported people informed. Quarterly provider development days help to build the relationships with the providers and social workers.

Each new proposed budget and support plan or review of funding is first approved by the social worker, before being discussed at one of six LEGs. The groups meet fortnightly and involve two social work managers, at least three senior social work managers for each area, service managers and administration support. The meetings last between 1.5 and 3 hours at an estimated cost of social worker time of between £405 and £810<sup>12</sup>.

At each meeting, up to 80 cases are discussed. As social workers have already approved plans, the meetings necessarily focus on those cases that are most challenging in terms of whether the proposed package will meet a person's outcomes or where the support package may have risks, e.g. for the individuals or reputational implications for the local authority.

Decisions are approved at the LEG before being passed to the Council-wide Social Work Enablement Group (SWEWG) for final sign-off. The SWEWG meets fortnightly, meetings last three hours, and are attended by a locality social work manager and senior social worker and a local authority service manager, senior officer and finance representative. The cost of the social worker involvement at LEG meetings is estimated to be £453.<sup>13</sup>

North Lanarkshire is clear that, whilst choice and control are central to delivery of all support they provide, they have not managed to roll out self-directed approaches to everyone. They are actively working towards the full process for people over 65 receiving homecare who currently are not offered a choice over their social care. Planning around this includes building in capacity for the LEG/SWEWG systems to manage increased demand. The Council remains committed to maintaining people in their own homes for as long as possible.

Three case studies were undertaken in North Lanarkshire:

- Case study 10: describes the experience of Joanne, who used Option 1 to meet her care needs
- Case study 11: is an example of a supported person (Graham) using Option 2 to design a package of care
- Case study 12: explores the case of Joyce, who takes up Option 1 to fund her support package.

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<sup>12</sup> Based upon a cost of an hour of senior social worker time of £54 from PSSRU: Unit Costs of Health and Social Care 2017

<sup>13</sup> Based upon a cost of an hour of social worker time of £43 and senior social worker time of £54 from the PSSRU: Unit Costs of Health and Social Care 2017

## Case Study 10: Joanne, North Lanarkshire

Joanne is in her early forties and a mother of a 6-year old boy called Joshua. Her story illustrates the flexibility available to meet very specific outcomes, but also highlights the need for continued review of changing situations and the challenges of finding appropriate care.

In 2015, Joanne was diagnosed with a rare degenerative disorder that results in declining physical and cognitive capacity, similar to dementia. She has been unable to work for several years due to her condition and her husband, David, needs to work full-time to financially support the family.

The condition means Joanne has substantial personal and social care needs that increased over time. Initially these needs could be met by support from the local early onset dementia team, but this support had to increase when it became clear that Joanne needed some support throughout the day, even after they had moved into a bungalow that was a more suitable residence as her motor skills declined.

The personal care was provided through the locality team for about six months at which point she was re-assessed and self-directed support options were discussed. Whilst David is able to partly meet Joanne's needs, the self-assessment made it clear his work commitments mean that personal assistants are required to ensure she has the level of assistance she requires.

During the guided self-assessment process, beyond meeting her personal care outcomes, it was clear that the outcomes that mattered to Joanne were around being able to continue to do some of the activities she enjoyed – such as going to the cinema – but mostly related to her son and family. Joanne wanted to be able to still spend quality time with her son.

Discussing the four options with their social worker, Joanne and David wanted control over their support and so initially chose Option 2 with the Council's resource allocation system estimating a budget of around £19,760 per year.

Whilst local providers were happy to help, it proved a struggle to find providers who could offer the support required because the provider and direct staff had to be registered to look after both adults and children (Joshua being at home when David was at work). In the end support was found but, due to the complexities of the situation, for only 22 hours a week. This would have meant that David could no longer work full-time which would have placed significant financial strain on the family, so was not an option.

Whilst reluctant to take on the responsibilities of employment that come with Option 1, Joanne and David realised that Option 1 was the best way that they could achieve the outcomes Joanne had identified in her self-assessment.

With the budget available, they managed to employ two personal assistants through advertising on Gumtree (after no success advertising at Job Centre Plus) for 34 hours a week over weekdays with a schedule that suited them and left Joanne and David with enough of the budget to fund two weeks a year of 24/7

support so the family could go on holiday. Whilst David found becoming an employer challenging, he used some of his budget to pay for the Scottish Personal Assistants Support Network's (SPAEN) fully managed service to help with the administration and payment of their personal assistants.

As a degenerative condition, Joanne's personal care needs have increased over time, in some areas quite rapidly. At the same time, Joshua has grown older and his needs have changed. David missed being able to spontaneously do activities with his son (like take him to the park or out on his bike) as it was proving increasingly difficult to prepare Joanne to leave the house and she could no longer be safely left home alone.

On reviewing the level of support provided, North Lanarkshire agreed that the personal budget should be increased by £6,240 for ad hoc care or support over the weekend. However, whilst he has been trying for some time, David has not been able to find anyone to employ in this capacity, so the extra hours have not been filled.

The current personal assistants cannot take on any more hours due to the impact it would have on their own financial circumstances and their benefit entitlement and, whilst they do on occasion work more hours for no payment to help David and Joshua have time together, this is not a situation that is sustainable or allows any sort of routine to develop.

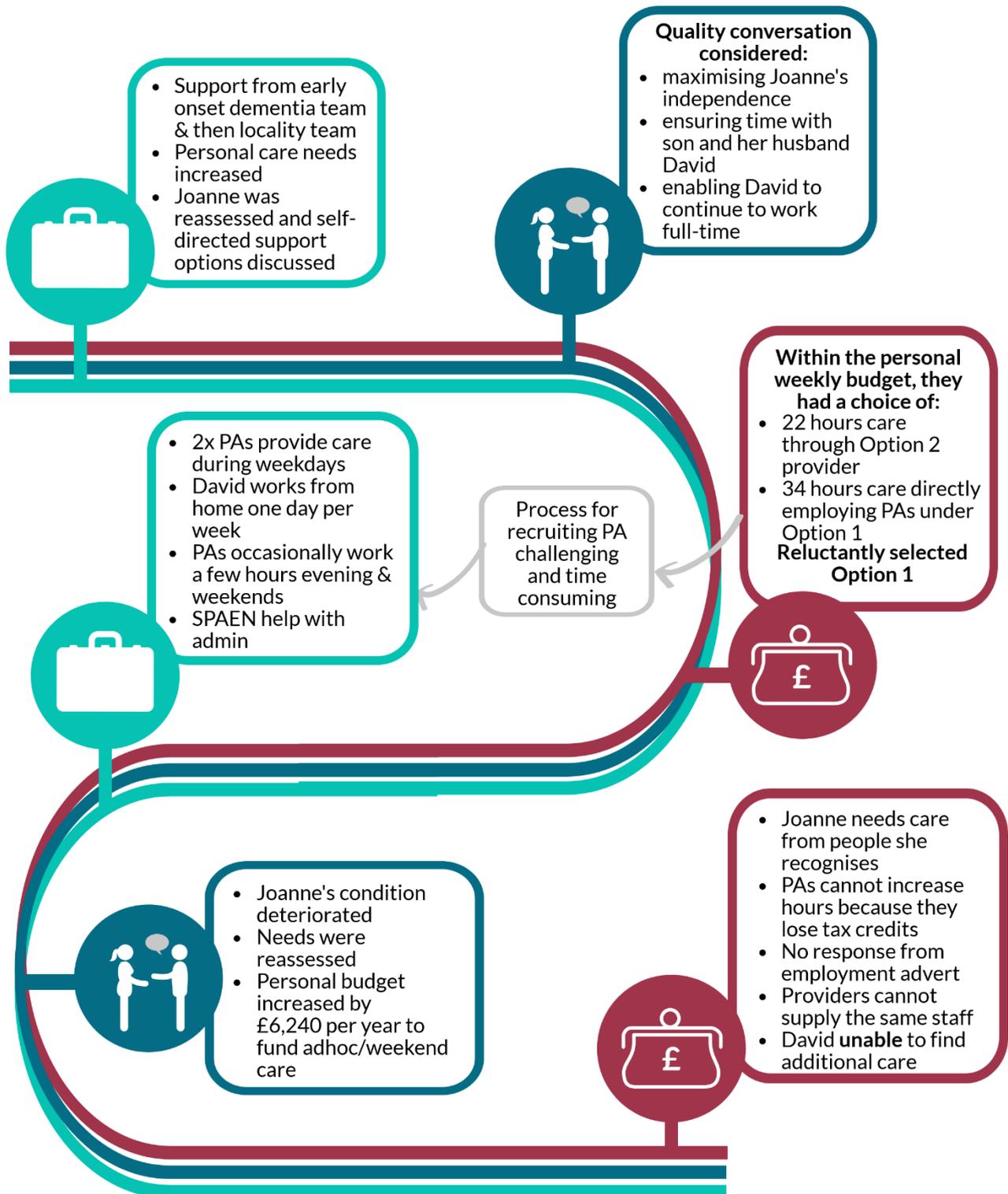
As Joanne needs consistency in the people supporting her, a third-party provider cannot offer the flexibility required without sending different people at different times and so is not an option. This is putting additional strain on David who is increasingly worried about not being able to spend quality time with his son.

Until recently, Joanne's outcomes have been met through Option 1. Whilst the system has been flexible enough to adapt – in terms of funding – to the family's changing requirements, the local care market has been found wanting in terms of its ability to supply the services that are now required.

Joanne's situation highlights that supply in the market is not only constrained by the physical ability of potential providers to offer the care required, but also by the financial constraint imposed by a 'benefits trap' (benefit entitlement can depend on how many hours of paid work you do per week) that is likely to exist for many low paid workers such as personal assistants, artificially lowering the potential supply of services available.

Figure 5: Summary infographic - Case Study 10, North Lanarkshire

Joanne is 41 years old. She is married and has a 6 year old child. She has a rare degenerative neurological disorder.



The self-directed approach has adapted to Joanne's changing needs but the local care market is unable to fully meet them.

## Case Study 11: Graham, North Lanarkshire

Graham is in his 40s and has recently left long term care in a hospital for a brain injury. His story illustrates how a local authority can work together with the individual, their family and the local care market to develop a package of support to meet complex needs whilst maintaining an individual's independence in their own home.

After an accident four years ago, Graham was left with neurological impairment. Following a substantial time in an acute hospital, Graham had been resident for 2.5 years in the Robert Ferguson Unit, the national specialist NHS brain injury unit in Edinburgh.

The medical team at the Robert Ferguson Unit advised that a care home would be the best residential environment given his support needs and without self-directed support it can be assumed that he would have been ultimately discharged into residential care. Social workers did not think that residential care would produce the best outcomes for Graham and suggested to his cousin and niece – who act as his advocates and have power of attorney – that it would be better for Graham if he could be supported in a home of his own. However, his family had concerns about this because of both advice from the medical staff and Graham's lifestyle and choices before the injury.

Whilst respecting the family's concerns, social workers agreed to scope out the options available to Graham should he be discharged to his own home. They then explored how to reassure the family. The local authority found suitable accommodation and asked three trusted providers from the 24 on the North Lanarkshire framework to meet the family and tender for the support required for Graham to live as independently as possible. The family appointed Turning Point.

Six months before he was discharged from hospital, the staff from Turning Point started to visit Graham three times a week. This was to help Graham to get to know the staff, to allow the staff to work in partnership with the health professionals to understand his needs and to work with him to redevelop basic life skills and define his own personal outcomes.

Turning Point offer a range of services to people in receipt of a social care budget, from intensive at home care to limited daily support to help with personal care, taking medications, or support to help participate in social activities. They provide support through a keyworker system that ensures consistency and predictability. These are important elements for the support Graham needs as he has a tendency to wander and to engage in activities that could potentially expose him to harm. It is important that he is carefully monitored and supported by people he knows and trusts and who also know Graham well.

Having seen the support Turning Point can offer, Graham's advocates/relatives with power of attorney agreed that he could be discharged into the accommodation found by the Council. At the moment, his family still make all the decisions about the support provided but they and Turning Point are hoping in the future that he will be able to become increasingly involved in the decision making process.

Turning Point are currently providing 24-hour support to Graham to maintain his independence but keep him safe. In planning the support for Graham and keeping in mind his support needs and the concerns of the family, they have introduced door alarms and a GPS watch. By exploring what activities he likes, they are using music-based activities to reintegrate him in the community and going on daily walks to build up his stamina. The work they did whilst he was in the hospital is continuing and increasingly he is able to do more around the home.

Graham's needs and abilities will change over time so his support needs are reviewed every 6-8 weeks through discussions with the family, provider and social worker. The worker and senior social work practitioners who will attend Local Enablement Group meetings to establish how Graham's support requirements are changing and how the support provided needs to change.

The North Lanarkshire approach has created flexibility in the support that Graham has received. Without this flexibility, Graham would undoubtedly have been discharged into residential care.

As a result of the introduction of self-directed support, the Council has played an active role in developing the local care market encouraging greater flexibility in the way it joins up support offered by providers and enabled providers to develop innovative and bespoke support solutions. This has been through the LEG meetings and the close contact the local authority keeps with all its providers. A quality assurance team works with new providers to meet the standards required to achieve a place on the Council provider framework and ensure that existing providers continue to fulfil requirements to remain on the framework.

The way social care operates in North Lanarkshire has also shaped the way Turning Point as an organisation works, working closely with the Council to look at where services are required, and consider how their service could address these needs.

There are still challenges in the market, notably around recruitment especially now the Scottish Living Wage has levelled the playing field with care providers and alternative employment such as in retail or catering. There is also competition from people using Option 1. This is because they can often pay more for support workers than providers can, with organisations such as Turning Point trying to distinguish themselves from other potential employers through their conditions of service and training opportunities.

## Case Study 12: Joyce, North Lanarkshire

Joyce is 66 years old and married to Barry. Her story illustrates the continuity in care that self-directed support is able to provide that can be important when an individual requires substantial assistance in their own home.

In 2010, Joyce – who had recently taken early retirement - had a major stroke which left her with significant mobility problems. At the time, she was assessed by the Council as eligible for homecare, but the support offered did not match what Joyce and Barry needed in terms of the flexibility of times. In addition, it was especially important for both of them to know and trust the person coming into their home. This carer would be there for many hours each day and would be responsible for key aspects of Joyce's personal care.

Joyce and Barry heard about Option 1 from a friend who suggested that this may be a route for them. The Council assessed the level of payment that would be available, but initially Joyce and Barry felt that this was significantly below what should have been expected, given the level of support Joyce needed. Working with the Council and through reassessment and evaluation, Joyce and Barry were able to access a budget more suitable to her situation.

Under Option 1, they employed a local care worker, Claire, who has now been working with Joyce for eight years and is involved in all aspects of her care. Option 1 allowed Joyce and Barry to employ a care worker they felt comfortable with. It has also allowed them to maintain continuity of staff over eight years. There has been no change in care workers nor any requirement for multiple care workers as would have been the case with an agency or local authority provided services.

## 7. Eilean Siar (Western Isles)

### Local context

The area covered by Comhairle nan Eilean Siar (the Western Isles Council) has a population of 26,950.

Although Option 1 has been established for some time, preparations for the implementation of self-directed support did not begin in earnest in the Western Isles until 2014 when the Act came into force. At this point, the Council used Scottish Government implementation funding to employ a Service Improvement Officer (SIO) for self-directed support along with an administrative member of staff.

There is no formal preferred provider framework in the Western Isles because there are only four organisations registered with the Care Inspectorate: the local authority, Crossroads, Alzheimer Scotland and Action for Children. There is a close relationship between the Council and the other providers, and developing a formal framework is not considered necessary. Members of the Council commissioning team meet with providers regularly to ensure that outcomes are being met and to discuss contractual arrangements.

The SIO's role now covers a wider social care remit. It is supported by two staff who: administer Option 1; assist social work staff with financial queries; support people with the administration of the payment and invoicing, and liaise with providers on behalf of Option 2 supported people.

### Implementation of social care and support in Eilean Siar

The approach to social care in the Western Isles is based on a 'good conversation' and a strengths-based approach when planning care packages. The authority estimates that it takes anywhere between 5 and 7 hours of a social worker's time to undertake a social care assessment at a cost of between £215 and £301.<sup>14</sup>

Although the data shows that take up of Option 2 in the Western Isles is broadly in line with Scotland as a whole (14% among supported people aged 18 to 64 and 5% among those aged 65 and over), the local authority's self-directed support lead feels that they are unable to offer this option in its "true spirit" because of the limited number of care providers in the area's remote and rural communities.

Option 3 is the most popular option (taken up by 47% of supported people aged 18 to 64 and 81% of those aged 65 and over) and this is viewed as especially appropriate for supported people, particularly older people, who want care at home but do not want to take on the responsibility of a direct payment via Option 1 yet want some control over their care.

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<sup>14</sup> Based upon a cost of an hour of social worker time of £43 from PSSRU: Unit Costs of Health and Social Care 2017

The lead officer explained that, in some cases, supported people who would prefer to be on Option 3 have to choose Option 1 because of the limited capacity across the local authority social care team and the small number of other care providers. This means that taking up Option 1 to employ a personal assistant from the community can often be the only option for achieving their personal outcomes.

All budgets and care plans are agreed at a weekly resource allocation panel meeting. This involves a Strategic Commissioning Manager, Social Work Services Manager and two Service Improvement Officers. This approach helps to ensure equity in the allocation of time for each supported person, regardless of the option they choose. The panel was established partly in response to an issue identified early in the implementation of self-directed support, when social work practitioners designing Option 1 and 2 packages included inflated numbers of hours in care packages, which was unsustainable. All supported people choosing Option 1 or 2 are informed of the budget available to them.

The self-directed support lead feels that this approach to approving care plans could be improved and made more systematic, and the local authority is considering introducing an Equivalency Matrix model<sup>15</sup>. It is also exploring how to make the assessment process easier for staff and more conducive to the self-directed approach, for example by reviewing the outdated single shared assessment forms.

The lead officer also recognises the importance of continuing to promote an open and dynamic procurement and commissioning system with community involvement, and now, with the funding of an independent brokerage service through the Support in the Right Direction Fund, supported people will have more information and support when making choices about their social care.

One case study was undertaken in the Western Isles where Moira uses Option 1 to design a flexible package of care for her son.

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<sup>15</sup> Under this model, a practitioner uses their judgement to decide what support they would normally provide to a person with social care needs and then use the monetary value of that service to calculate an indicative budget for the supported person (Learning Disability Alliance Scotland (2014), 'Self-directed Support: The Start', <http://www.ccpscotland.org/wp-content/uploads/sites/3/2015/01/The-Start-SDS-report-January-2015.pdf> )

## Case Study 13: James, Eilean Siar

Moira's son, James, is in his twenties and has a condition that causes learning disabilities and other health problems. Their experience shows how Option 1 can be used to create a flexible package of care delivered by local people from within the community.

Moira said that, although James can write well, he finds it difficult to express himself verbally, and he requires support to access activities in the community. Once James left school in 2010, his care needs were re-assessed and Moira receives Option 1 to support his independence within the community and access activities. James attends college for two days per week during term time.

The local authority pays the budget directly into a bank account set up by Moira for the direct payment and Moira then makes the relevant payments to those providing support. The Council calculates a direct payment based upon an hourly rate of support of £14.35 with £7.20 per week for administration costs. This approach is consistent with the Comhairle's plans under consideration to introduce an equivalency model of resource allocation for all options.

James spends one day per week at a local voluntary sector café and shop with staff and volunteers. Moira described this as an important social opportunity for James: "[It's] really great that he can socialise independently of his parents."

James and Moira use Option 1 in various ways. This includes support workers who take James to activities of his choice including the gym, swimming pool and music shows, as well as providing overnight care if his parents need to stay off the island. The support workers are students and young people who Moira and James identify via their local networks in the community, rather than from a social care provider. This approach is sometimes a necessity for families in the Western Isles, given the number of providers in the area and their limited capacity.

Moira explained that this approach allows the family to choose the individuals who they want to support James. She said that, "James can be very particular about who he likes," so it is important that they "can select people who work well with James." Moira likes "the flexibility of picking and choosing" from people she knows in the community, and she prefers this approach to selecting from a list of suppliers provided by the Council. This process is made easier because Moira has strong connections with the other families who live in the area and this provides reassurance that the people recruited are suitable to work with James.

Harris Voluntary Service (HVS) helps the family with their responsibilities as the support workers' employer. HVS looks after the books and informs the family how much they have to pay HMRC in income tax, which Moira finds very helpful.

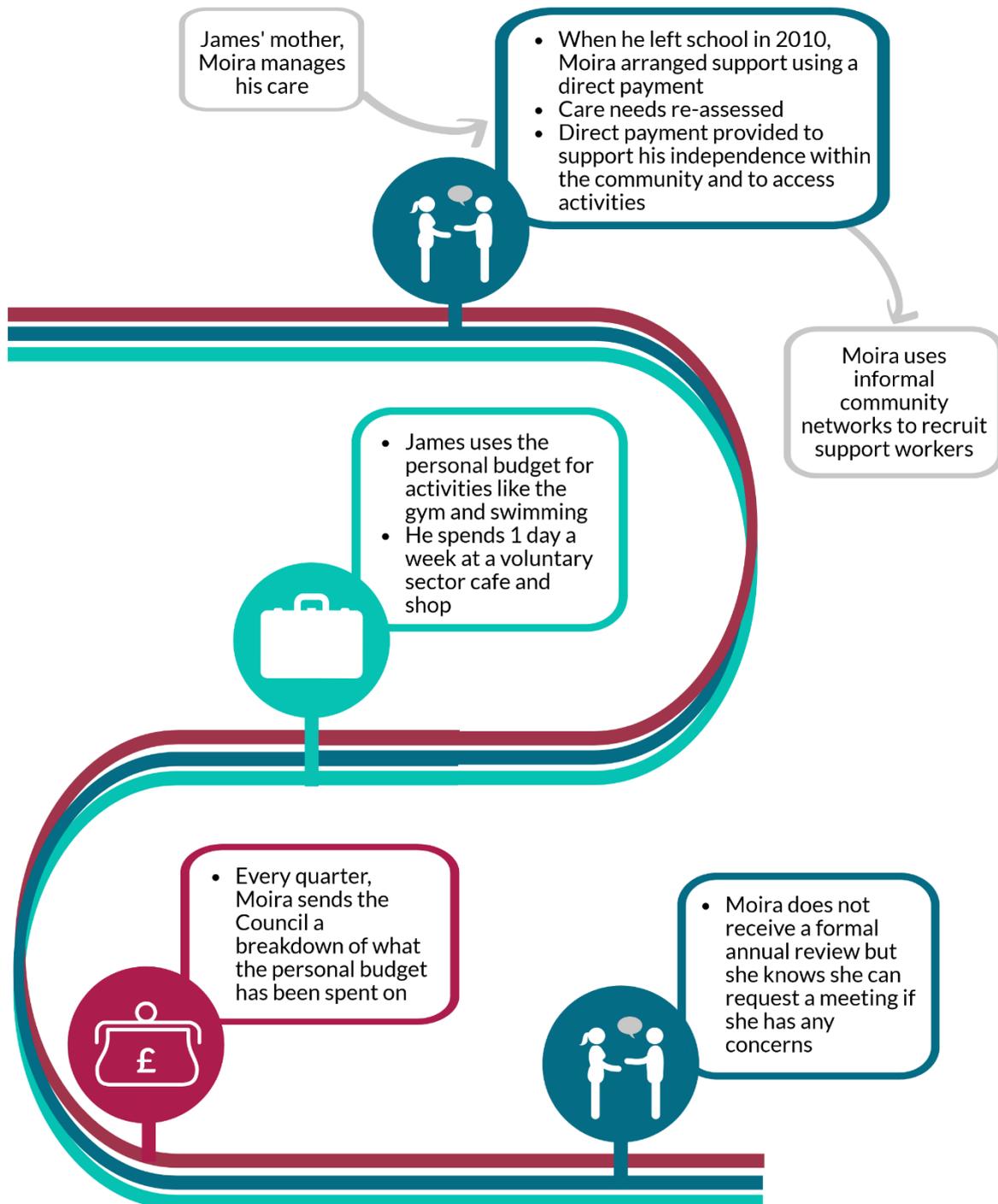
Moira described the budget as adequate and the family sends the local authority a quarterly breakdown of what the direct payment has been spent on. The budget is often underspent and the money is returned to the Council. Moira is not aware of any formal regular reviews, but she knows she could ask for a meeting if the family had any concerns or if "anything was amiss".

Overall, the family is happy with Option 1, particularly as it allows them to flexibly access community networks to choose people who James gets on well with and who can support him to access the activities he enjoys.

James' experience shows the benefits of supported people being able to design a package of support that meets their individual needs and addresses their personal outcomes, and it highlights the importance in remote rural locations of being able to recruit workers from the supported person's local community.

## Figure 6: Summary infographic - Case Study 13, Eilean Siar

James is in his 20s and has a condition that causes learning disabilities and other health problems.



The flexibility of the direct payment enables a varied package of support for James provided by local people and organisations within the rural setting.

# 8. Reflections

## Introduction

The case studies within this third report, alongside Report 1 (the SDS Change Map) and Report 2 (the Evidence Assessment) provide insight and some understanding about self-directed support as a policy and the implementation of the legislation. Together, they will support the Scottish Government to make better-informed decisions about the ongoing national monitoring and future evaluation of social care.

This research did not set out to gather case studies that were representative of the degree to which self-directed support has become the mainstream approach, across the country for enabling individuals to have their social care support needs and outcomes met. The case studies were not intended to be fully evaluative, looking in-depth at social care outcomes for an area and how they were being delivered. Instead, they were exploratory studies to capture some of the many ways self-directed approaches are being implemented and to consider the potential for scaling up and replicating documented approaches.

## Case study approach as an evaluation activity

The aim was to undertake 13 case studies exemplifying social care, accessed under the four options across a diverse population; this ambition was tempered slightly by the time it eventually required to identify and secure participation (of individuals using social care and families, and social care staff). The people accessing social care within the case studies are predominantly older or middle-aged people with degenerative diseases, neurological conditions, people who experienced a life changing critical incident and some individuals with a genetic disorder.

Undertaking the case studies was resource intensive and took several months to complete, which is important to be aware of when considering a case study approach as part of future research and evaluation. Each case study involved; gaining initial co-operation of the local authority; working with Council officials to identify individuals and gaining informed consent; then liaison with the individuals, their families/carers, their social worker and providers to arrange the fieldwork, which was in the form of face-to-face and telephone interviews. The discussions were followed up with further email exchanges or telephone calls to clarify facts and details and for participants to check and confirm that they were happy with the written case study account. The involvement of all these contributors provided detailed insight, through multiple first-hand perspectives, into self-directed support. The case studies also throw light on the extent to which self-directed support is meeting its policy outcomes in this small number of cases, although conclusions about policy implementation would require fuller evaluation.

This project shows how a case study approach (perhaps with a wider set of research questions and participants) could be a valuable component of any future, larger evaluation of self-directed support implementation.

## **Emerging themes**

The timescale and size of this project meant that it could not reflect all of the diverse approaches to implementing self-directed support across Scotland. There are, however, clear, recurrent themes across the local authorities that were part of this case study research.

The case studies were intended to capture diverse instances of how individuals and their families, communities, and providers have been negotiating the self-directed principles and options. They were also designed to document a range of fairly typical examples of individuals using social care. It is also clear from the case studies that the local authorities started from different baselines in terms of their existing approaches to social care and the extent that personalisation, choice and control featured in social work practice prior to the 2010 strategy and subsequent legislation. They echo other evidence about the pace and means of implementation varying across the country.

## **Local authority resource and cost implications of implementing self-directed support**

Understanding the difference in Council resource use and costs associated with implementing self-directed support requires an understanding of the current difference in resource use compared to previous social care practices. The case studies highlighted that additional administrative and social work resources associated with delivering choice and control lies predominantly in the assessment process and in resource allocation panels. Ascertaining resource use either in panels or in the assessment process proved difficult to gather, with only one site (North Lanarkshire) providing information that allows the costs of both the assessment and allocation process to be estimated. The Western Isles provided partial costings as well.

A full evaluation of the economic and resource implications of self-directed support would ideally include a comparison of current estimates of local authority resource use on assessment and allocation activities compared to previous practice. In the absence of any established system for recording relevant data, such a comparison would require research into time spent on assessment and allocation processes before 2014 and an understanding on a case-by-case basis of how much the Council was already engaging in practices to support choice and control and personalisation. It is likely to be challenging to involve councils in such work and they may not be in a position to provide the necessary data.

Researching resource use and costs in the past would be extremely challenging.

Furthermore, any attempt to evaluate whether the shift to self-directed support has led to health and social care system-wide costs and benefits will inevitably run into potentially intractable difficulties, not least those arising from the range of services and support that contribute to an individual's personalised outcomes and well-

being. In addition, compared, for example, to many medical interventions or narrower service interventions with less diverse target populations, it is extremely difficult to monetise social care and social care outcomes or estimate returns on investment – and this has become even more so the case with the move to self-directed support.

The scope of any economic evaluation of self-directed support implementation and policy outcomes will necessarily be limited. This is further discussed in “Report 2: Evidence assessment for self-directed support”.

### **Resource allocation panels**

Resource allocation panels were not in use by all authorities but where they were, they were seen as a crucial part of the approach to enable supported people to direct their social care and support. In the case study areas with panels, these involved both social workers and budget holders and meet at least fortnightly. There were two main reasons for their use. First, to ensure that overall budgets for social care were not being exceeded at a council level. Second, the panels were seen - particularly in North Lanarkshire - as a means to test and develop creative solutions to people’s needs and provide social workers with the confidence to move from a ‘good conversation’ to a care plan that was truly bespoke to meeting an individual’s outcomes.

The constraint with such panels is time. They require considerable investment in social worker and management time to attend. Currently, resource allocation panels identified in the case studies predominantly consider social care support under Option 1, 2 or 4. It is unclear whether there would be sufficient capacity to hold such meetings for every social care assessment which identifies the need and eligibility for support. An example of this is in North Lanarkshire home care for the elderly where a significant proportion of all social care is provided under Option 3 and so does not currently go to the resource allocation panel. There are indications that the lack of local authority capacity for such panels may be limiting how self-directed support is implemented for all groups of supported people in an authority.

### **The need for review and changing circumstances**

Several of the case studies highlighted how changing circumstances altered the support needed for individuals to achieve their outcomes, which outcomes they wanted to achieve, the priority of those outcomes, and/or how much responsibility they wanted for managing support (partly translated into the Options they choose). This is highlighted in Case Study 8 when Gerry moved to Dundee to study and changed contractor and the option under which his care package was provided. Social workers are required to be proactive in both maintaining ongoing relationships with supported people and addressing changing circumstances as they arise. Equally important is for individuals to be able to request reviews where they can speak freely about how support needs and personal outcomes have changed. In Case Study 2, Alastair’s needs have been met by the same care provider for almost ten years and the opportunities to discuss alternative provision have been limited.

## **Sufficient supply and ensuring quality of supply**

Challenges in the social care market in terms of the conditions and supply of care workers are well documented and reported<sup>16</sup>. The complex provision and changes in delivery of services, the challenges within rural and urban areas, the financial environment and resource constraints, and the impacts of social and technological change are placing demands on the social care workforce skills requirements and supply.

The case studies provided further evidence of the impact of supply issues on the outcomes individuals are trying to achieve. Some of the outcomes required traditional caring but with a high degree of flexibility, others called for support that was not routinely offered by existing care providers. Even where a budget (and sometimes other practical help) was provided for individuals to recruit support workers or Personal Assistants, it was not always possible to find suitable people who could deliver that support, as seen in Case Study 10 with Joanne struggling to recruit additional support. In addition, the Option 1 case studies highlighted that there may well not be any training and support for their role (for example those within the local community providing support to James in Case Study 13). It is vital to introduce training and support to ensure the quality of support they can offer is at a minimum maintained and ideally improves over time.

### **Does the use of the four self-directed support options to access social care reflect the intended policy outcomes?**

The case studies highlighted the different ways that local authorities interpret, deliver and record the four self-directed support options. Some local authorities only record as having self-directed support those individuals who went through an assessment (including the good conversation), a resource allocation calculation and then a decision process on the care package from a range of provider options. In other areas, essentially anyone accessing social care or support is assumed to have made an 'informed choice' and is recorded as accessing self-directed support. This has significant implications for the collection and comparison of high-level statistics on self-directed support across local authorities in Scotland. This has been a significant issue routinely commented on by authorities in relation to published statistics on self-directed support. There is an inconsistency in what is recorded and why, from area to area, and this has been recognised at Government-level.

Although the four options are explained within the legislation, translating them into practice has varied across local authorities and within the case studies there are examples where Option 1 does not offer a similar extent of choice and control in different places. This contrast can be seen between Case Study 3 where Linda and

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<sup>16</sup>National health and social care workforce plan: part two  
<https://www.gov.scot/publications/national-health-social-care-workforce-plan-part-2-framework-improving/pages/2/>

William need to use the pre-paid (All Pay) payment card that not all providers accept and Case Study 13 where Moira can use the personal budget for a range of support and care activities for James. The case studies also exemplify where Option 1, as seen for Joanne in Case Study 10, reflects a restriction of choice for individuals who do not want to manage their own care but for whom this option maximises their personal budget.

The boundaries between the options were not always clear across the different authorities. Option 2 in one area, like Case Study 2 of Linda and William in Edinburgh accessing homecare, appeared to be similar to the personalisation, choice and control under Option 3 for Jane in Case Study 3 in Dumfries and Galloway, where she 'banks' unused hours and so this creative contracting provides the flexibility needed.

Ultimately, the four options are a means to ensure the realisation of the values and principles of self-directed support. The case studies highlight that the options are a real focus for change in areas but that there can be an over-emphasis on a local authority demonstrating an increase in the use of a particular option. Similarly, there was a focus in the case studies for staff and supported people to talk about the hours or nature of support received rather than outcomes they were being supported to achieve, suggesting that there is still a cultural shift required to fully embrace and embed self-directed support as Scotland's approach to social care delivery.

## **Conclusion**

Whilst the four self-directed support options are a gateway to choice and control, the case studies provide evidence that what is potentially more important than the available options in an area is:

- the quality of the social care assessment, including a genuinely 'good conversation';
- the degree to which there is a focus on outcomes;
- the budgets available to meet these outcomes and the availability of local providers able to deliver the support required; and
- the enabled creativity and authority of supported people, social workers and the care market to find solutions to meet those outcomes.

Any future evaluation will need to focus on these elements, along with the cost-effectiveness, in order to understand whether and why self-directed approaches to social care in Scotland are being realised, whether the principles are being upheld, and whether the intended policy outcomes are being achieved.



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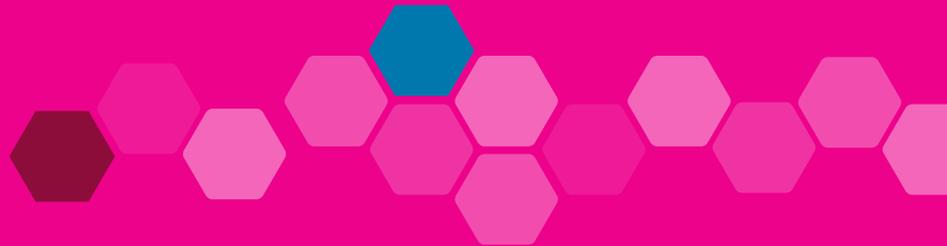
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