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Self-directed Support Implementation Study 2018. Report 4: Summary of Study Findings and Implications

HEALTH AND SOCIAL CARE

social research

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1. Introduction

Background to the report

The purpose of this report is to summarise research that the Scottish Government commissioned into self-directed support. As well as this overview, there are three reports, which separately detail the main components of the study. These and the study objectives are outlined further below.

The implementation of self-directed support (SDS) in Scotland has led to a major shift in how social care and support are conceptualised and how related services are delivered. SDS is now the mainstream approach to social care delivery in Scotland. At its core are the principles of choice, control and flexibility for supported people to pursue personal outcomes they have identified through open, informed discussion with professionals. It demands a new approach to providing support in a way that focuses on the needs and priorities of supported people. The Scottish Government needs to understand what progress is being made to ensure that the principles of self-directed support are fully embedded in practice and reflected in experience. It is important that there is evidence about: the short, medium and long term consequences of the policy for individuals, the workforce and services; ;, changes in service procurement and the care market; the costs and benefits involved; and the impact on – and implications for - the wider system. 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, which will contribute to and help to shape ongoing national monitoring and evaluation. This short report summarises the key research findings from this study.

Context

The Scottish Government launched *Self-directed Support: A National Strategy for Scotland (SDS Strategy)*[1] 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. The Health and Social Care Standards, which came into effect in 2018, also reflect the personalisation of care.

Self-directed support represents 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 than those seen as traditional solutions in the health and social care services. This has entailed a significant cultural shift for some support services, from making decisions **for** supported people to making decisions **with** people.

[1] https://www2.gov.scot/Publications/2010/02/05133942/0

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.

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, and which self-directed support option they wish to pursue.

"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."[2]

Transforming Social Care: Scotland's progress towards implementing self-directed support, 2011-2018"[3], published in August 2018, further describes the wide-reaching implications of self-directed support and the significant investment of finance, time and effort which has already taken place.

Audit Scotland also published a progress report on self-directed support implementation in 2017.[4] The report noted 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 the implementation "progress" at a national level. The report did find that many people are being supported in new ways, although more information and guidance are needed to help individuals make informed decisions.

[2] https://www2.gov.scot/Resource/0051/00510921.pdf

[3] https://www.gov.scot/publications/transforming-social-care-scotlands-progress-towards-implementing-self-directed-support/

[4] http://www.audit-scotland.gov.uk/report/self-directed-support-2017-progress-report

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

Audit Scotland also identified that the integration of health and social care has likely further slowed the pace of self-directed approaches being mainstreamed.[5]

The research project

The purpose of this study was to contribute to improved understanding of the impact and effectiveness of self-directed support at a national level, with a focus throughout on engagement with users of social care, their families/carers, and the people responsible for frontline delivery. It will inform the Scottish Government's plans for future monitoring and evaluation of the policy.

Due to the differences in the extent to which self-directed support has been fully embedded in practice across the country, and some inconsistencies across the social care data collated nationally from local authorities, the project focused on understanding the current situation and certain topics in more detail rather than being a full evaluation of self-directed approaches.

The project was delivered through three inter-connected parts:

- 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.

The Evaluability Assessment was initiated by conducting Theory of Change (ToC) workshops to create the SDS Change Map. This provides a simple outcomes framework for major changes that need to happen to move towards self-directed approaches being fully implemented as the mainstream approach to social care delivery.

After building the SDS Change Map, an assessment of existing evidence helped to create a revised set of research questions for future monitoring and evaluation as well as looking at how to evidence and understand economics/resource implications of self-directed approaches. The final part of the study involved case studies from six areas that consider the local context and individuals' and providers' experiences of self-directed approaches in practice, with a focus on Option 2.

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

Research outputs

Four papers have been produced to detail the methodology and findings of the Self-Directed Support Implementation Study 2018:[6]

- Report 1: The SDS Change Map;
- Report 2: Evidence assessment for self-directed support;
- Report 3: Self-directed Support Case Studies; and
- Report 4: Summary of Study Findings and Implications (this report).

[6] All four are published on the Scottish Government's main website: www.gov.scot

2. Research findings: SDS Change Map

Theory of Change for self-directed support

A key aspect of this work was an Evaluability Assessment of self-directed support. To achieve this, an SDS Change Map was created based on Theory of Change (ToC) workshops with participants from local authorities, providers, carer organisations, national bodies and disabled people's organisations; and refined through further discussions with the Research Advisory Group (RAG) for this project.

In creating the outcomes, the participants were asked to ensure that they were clear; concise; related to the Implementation Plan for 2016-18[7], the Social Care (Self-directed Support) (Scotland) Act or the guidance; and that the outcome could feasibly be evidenced either through monitoring or evaluation.

The SDS Change Map (Figure 1 below) provides an outcomes framework for major changes that need to happen in the journey towards self-directed approaches being fully embedded as the mainstream approach to social care. The Scottish Government will use the map as a basis for ongoing monitoring and evaluation of implementation and it offers a useful conceptual framework for planning, designing and reviewing social care provision. The map complements and reinforces the outcomes and statements set out in the national Health and Social Care Standards.[8]

The SDS Change Map is discussed in more detail in Report 1.[9] It consists of three tiers:

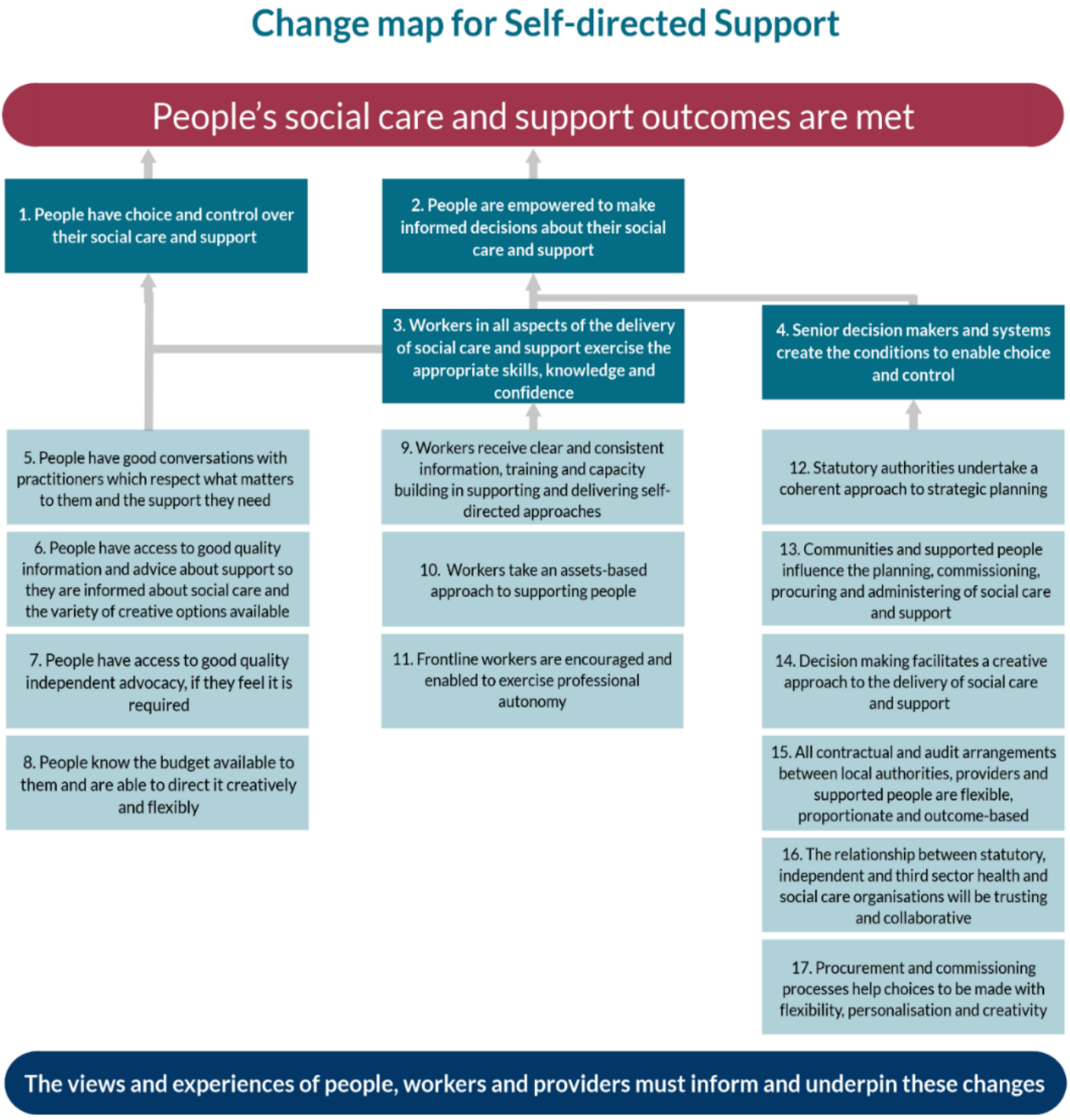
- the overall vision (**people's social care and support outcomes are met**);
- the four key outcomes (numbered 1 to 4); and
- a set of intermediate outcomes (numbered 5 to 17) that need to be in place for the key outcomes and overall vision to be achieved.

[7] https://www.gov.scot/publications/self-directed-support-strategy-2010-2020-implementation-plan-2016-2018/

[8] http://www.newcarestandards.scot/

[9] This can be accessed through the Scottish Government's main website: www.gov.scot

Figure 1: The SDS Change Map



The first two key outcomes in the SDS Change Map relate to supported people. They reinforce that the discussions during the initial assessment for social care and regular reviews should form the foundation of an effective approach to social care. This engagement process should follow the accepted 'good conversation' model detailed in ''Talking Points: Personal outcomes approach"[10] which identifies what

[10] Ailsa Cook and Emma Miller (2012) "Talking Points: Personal outcomes approach":' http://www.ccpscotland.org/wp-content/uploads/2014/01/practical-guide-3-5-12.pdf

should be discussed, how the conversation should be conducted, who should be involved and what should happen.

The third key outcome focuses on workers who are involved in any aspect that affects the delivery of self-directed approaches to social care. To achieve outcome 3, workers must have the skills, knowledge and confidence to engage with and support people effectively and in a clear and consistent manner. Crucially they must be enabled to utilise these skills for decision-making with autonomy.

The final key outcome (4) has a series of intermediate outcomes that will help to create the conditions in which supported people can exert choice and control over their social care and support.

It requires the commitment of senior managers and leaders to change a number of systems and processes that influence how self-directed support is experienced. The systems need supportive and proportionate procurement and commissioning approaches, which are:

- flexible - able to respond to the changing needs and situation of supported people;
- proportionate - the administrative time and effort is proportionate to the scale of cost; and
- outcomes-based – focusing on the outcomes to be achieved for the supported person as opposed to a process that people or workers should follow.

In order for the social care and support providers and workforce to deliver the best possible care and support, discussion and involvement in decision making across all sectors is crucial. Although there may be elements of competition involved – which may become more noticeable if funding reduces – the need was identified for the changes to be reflected in cross-sector relationships that are stronger in terms of trust and collaboration.

Use of the SDS Change Map

The SDS Change Map, which will evolve over time, provides a simple outcomes framework to articulate major changes that need to happen in the move towards self-directed support being fully embedded as the mainstream approach to social care delivery.

The outcomes in the SDS Change Map shaped the discussions in the area case studies (see Report 3) and informed the evidence assessment for self-directed support (see Report 2).

3. Research findings: Evidence assessment for self-directed support

After creating the SDS Change Map, an assessment of existing evidence helped to create a revised set of research questions for future monitoring and evaluation, as well as looking at the economics/resource implications of self-directed approaches. The assessment of existing evidence (fully documented in Report 2)[11] included:

- a literature review of other evaluations of similar programmes;
- a review of current data collections in Scotland that potentially relate to self-directed support; and
- the production of case studies to explore the various ways self-directed support is being implemented across user groups and the potential for scaling up and replicating.

Literature review[12]

To help inform the options appraisal we undertook an ambitious, international literature review to highlight approaches that could inform evaluation of self-directed support in Scotland. Given the wide range of terms that are used to describe models for social care where personalisation, choice and control are core, a broad search strategy with high sensitivity and low specificity was developed and applied to local, national and international systems. These searches retrieved 6,120 unique records, which were analysed for relevant evaluations of existing schemes at a national level, pilot programmes, and local evaluations of national policies and programmes and local pilots.

The review sought to identify methodological approaches and limitations from these evaluations, and revealed a number of challenges in designing effective evaluation. It highlighted the additional challenges involved in economic evaluation of approaches like self-directed support due to an inability to identify suitable comparator cohorts in pilot studies or no comparator being possible where changes are system wide. Collecting costs on the time taken to actually undertake assessments or undertake processes associated with choice and control was rarely undertaken or the information was not robust when collected. Outcomes in social care – especially when personalised – can be difficult to capture, monitor and analyse at an aggregate level and as such was rarely attempted.

Only six studies were identified that attempted to address any aspect of economic impact, with four of these only looking at the costs of delivering individual budgets or direct payments with no exploration of outcomes. One study did calculate the

[11] "Report 2: Evidence Assessment for Self-directed Support"

[12] References and descriptions of the literature reviewed are include in Report 2.

cost per satisfied family (as judged by a survey) but this was without any form of counterfactual.

Only the sixth study could be considered a full economic evaluation of costs and benefits, with cost-effectiveness ratios calculated based upon responses to the General Health Questionnaire (GHQ) and the Adult Social Care Outcomes Toolkit (ASCOT). Whilst the methodology is not directly replicable in the current context in Scotland, as it was an evaluation of a pilot project, it highlighted how a holistic high-level outcomes tool, such as ASCOT, could be used in an evaluation of choice and control and personalised outcomes.

No evaluation attempted to provide evidence on how to evaluate or monitor a "good conversation". However, a number of pilot evaluations did seek to use existing tools to measure high-level outcomes in social care and health– such as the ASCOT, GHQ-12 or EQ5-D, and bespoke survey questions.

A key theme arising from the literature review was the challenge in ensuring that self-directed support approaches as a means of social care delivery is working across highly diverse groups. Any ongoing monitoring or evaluation in Scotland must therefore capture the characteristics of supported people and carers to ensure that social care is working for everyone. In addition, as almost all published reports were audits or ad hoc evaluation, the review found little information on undertaking ongoing national evaluation or monitoring.

Current and proposed data collections

Data is collected on aspects of self-directed support as part of the Social Care Survey and the Health and Care Experience Survey. An initial SDS User Experience Survey has also been undertaken. As part of the research, an assessment was made of the effectiveness of using evidence from each of these collections for monitoring and evaluation against the SDS Change Map.[13]

Social Care Survey (Scottish Government national survey)[14]

Strengths: An established, annual census gathering information from local authorities . The survey questions include the self-directed support option chosen, gross budget and who contributes to it, and what it is spent on. The data is read-through indexed which means that it can potentially be linked to other data sources, such as health data (subject to approval).

Weaknesses: As highlighted by the case studies reports, there are differences in how self-directed support is delivered across the country so it can be difficult to compare data across Scotland. The survey does not cover the extent to which supported people have 'good conversations' during their assessment.

[13] The Care Inspectorate does not routinely collect evidence that could directly feed into evaluation of self-directed support. However, research should involve the Care Inspectorate to identify relevant evidence available at that time.

[14] https://www2.gov.scot/Topics/Statistics/Browse/Health/Data/HomeCare

Health and Care Experience Survey (Scottish Government national survey)[15]

Strengths: A large scale, bi-annual survey that gathers information about health and care service users' experience of care, including their awareness of the help, care and support options available to them, whether they had a say in how their help, care or support was provided, and whether they felt treated with respect and compassion.

Weaknesses: The survey is not targeted specifically at people eligible for social care and does not ask people directly about social care. The sample is drawn from all adults in Scotland registered with a GP practice. As a blanket survey there is a chance of self-selection bias.

SDS User Experience Survey (SDSS)[16]

Strengths: Contains quantitative data about whether supported people are having their options explained to them and qualitative data about users' views of the conversations they have had with social care workers.

Weaknesses: This was a survey originally piloted with a sample of supported people from three local authority areas (in 2018-19 being repeated in eight authorities). In the pilot, the low response rates meant that insufficient data was collected to enable statistically significant conclusions to be made about supported people's experiences across Scotland.

Summary of current evidence against the SDS Change Map

The Health and Care Experience Survey and the Social Care Survey currently collect limited information that directly evidence, or provide proxy data for, the SDS Change Map. In the SDS user survey, there were questions that, in their current form, would provide evidence against outcomes 5, 6, 7 and 8 in the SDS Change Map. For Outcome 9 – Outcome 17 there are no questions in any of the current surveys that could be used as proxies for impact against those changes.

Evidence from the Case studies

As part of the wider research conducted around self-directed support, thirteen case studies were produced to highlight how self-directed approaches were working in practice across a sample of six local authorities in Scotland.

The case studies were not intended to be evaluative. In the process of their design and delivery, they have provided useful context and information that have implications for any future evaluation.

[15] https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey

[16] http://www.sdsscotland.org.uk/wp-content/uploads/2016/09/SDS-User-Experience-Survey-Report-Full-version-2-4.pdf

Case study approach as an evaluation activity

The aim was to undertake case studies exemplifying social care, accessed under the four options, across a diverse population. This ambition was tempered slightly by the ability to identify and secure participation in the primary data-collection.

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 of social care. The involvement of supported people, their families/carers, social workers and providers provided detailed insight into people's experiences and, if this had been an evaluation, the case studies would help to understand the extent to which self-directed support is meeting its policy outcome in this small number of cases.

Case studies could be a valuable option for evaluation of specific aspects of social care, but the resource intensity required to do them thoroughly means they would be difficult to include as part of ongoing evaluation and monitoring.

Local authority engagement

Whilst some local authorities were keen to engage with the research, in other areas this was challenging and the researchers required considerable effort to gather sufficient information. The case studies were voluntary, not designed to be evaluative and did not require the level of challenge and evidence as evaluation would. It was difficult to obtain sufficient information for some of them, largely because it was not easily accessible or in some cases not available at all. This highlights how difficult evidence gathering and engagement for evaluation may prove to be.

Variation of delivery between and within local authorities

As expected, implementation of self-directed support had not been uniform between the case study areas. A national evaluation would account for such variation, especially if the approach were based upon a robust change map. What is potentially more challenging is variation in practices within local authorities.

In some areas, this variation was because choice, control and personalisation were more readily available to some groups, such as younger adults with disabilities or parents of children with disabilities. A full evaluation would need to take account of and explore local variation in experience for different groups.

The individualisation, choice and control a supported person experiences is shaped by their social worker's practice and how they can operate within the system.

An evaluation needs to have sufficient depth to be able to unpick issues of variance in the offer of choice and control that may both explain and be masked by aggregate statistics.

The need for review and changing circumstances – evaluation considerations

Several of the case studies highlighted how changing circumstances altered not only the support needed for individuals to achieve their outcomes, but also which outcomes they wanted to achieve, the priority of those outcomes and/or how much responsibility they wanted in terms of managing their support. Several case studies highlighted how circumstances in terms of funding available and priorities for funding can change rapidly within an authority. The changes that can take place for individuals and in authorities indicate the importance of regular monitoring, and point to the need to consider longitudinal studies with regular monitoring points with a cohort of individuals followed over time.

Sufficient supply and ensuring quality of supply – evaluation considerations

Challenges in the social care market in terms of the supply of care workers are well documented. The case studies provided further evidence of the impact of supply of the care workforce on the outcomes individuals are trying to achieve. Even where individuals had a budget to recruit a personal assistant (PA), it was not always possible to find someone suitable. It is potentially concerning that non-traditional methods of recruitment are being used and it is unclear how appropriate checks on the quality of care a PA can provide (as opposed to basic safety through criminal records checks and registration with the Scottish Social Services Council) are being undertaken. It is not clear how people employed through Option 1, or in some cases Option 2, receive ongoing training and support to ensure the quality of support they offer. The case studies reinforced the importance for evaluation to gather information on how local care markets are developing and being managed, and on how quality and stability of provision are assured.

Evaluating the economics of self-directed support

Understanding the difference in local authority 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 the additional administrative and social work resource needed is predominantly in the assessment process and in resource allocation panels. Ascertaining resource use in either panels or in the assessment process proved difficult to gather, with only one site providing information that allows the costs of both the assessment and allocation process to be estimated.

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. 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 local authority was already engaging in practices to support choice and control and personalisation.

Furthermore, any attempt to evaluate whether 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 can be provided to achieve an individual's personalised outcomes. 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 .

The case studies therefore reinforced how challenging it will be to undertake an economic evaluation of self-directed approaches to social care.

More details of the case studies' findings about experiences of self-directed support element are summarised in the next chapter.

4. Research findings: Case studies

The case studies aimed to explore some of the various ways that self-directed approaches are being implemented and the potential for scaling up and replicating good practice. In addition to providing evidence for Option 2 in practice (which had been under-explored), these case studies can also help inform the assessment of the economics/resource implications of self-directed support.

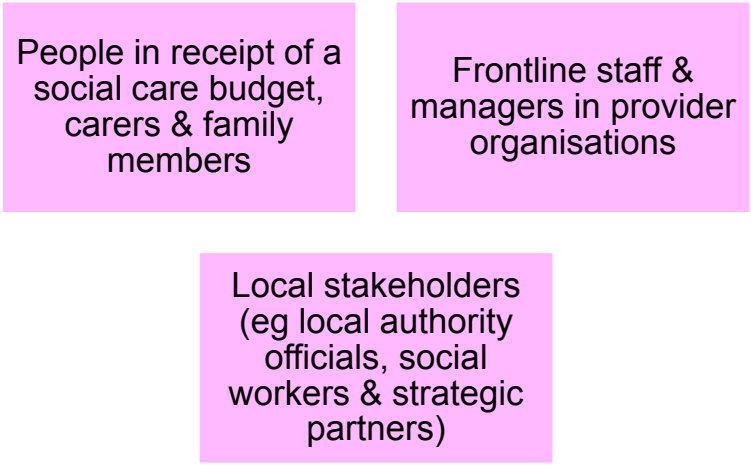
Case study areas

Six local authorities took part, selected to provide a range across areas of deprivation and urban and rural geography: Dumfries & Galloway; Edinburgh; Highland; Midlothian; North Lanarkshire; and Eilean Siar (Western Isles). Case study examples were requested from each area. It was easier for some areas than others to work with their social workers to identify cases and then secure informed consent from individuals and providers. At least one case study in each of the six local authority areas was completed.

Case study contributors

Figure 2 details the range of contributors, involved in or supporting the delivery of social care, who participated in the research for the case studies.

Figure 2: Range of contributors



In most cases, we carried out face-to-face interviews with participants along with follow-up telephone and email correspondence to confirm details.

Discussions with case study participants

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 local approach.

In order to understand the resources needed and to assist in understanding the economic implications of self-directed support, the local authority officials in each area were sent follow-up questions about the resource allocation system and time spent on key activities. Two areas provided all this information, which is included in their case study and discussed in more detail in *Report 2: Evidence assessment for self-directed support.*

Appendix 1 includes one of the infographics that summarises an individual case study and "Report 3: Self-directed Support Case Studies" includes full details of the case studies.[17]

Case Study Reflections

The case studies were not designed to be representative of the degree to which self-directed support has become the mainstream. Rather they were intended to capture diverse instances of how individuals and their families, communities, and providers have been negotiating the self-directed principles and formal options, to enable individuals to meet their personal outcomes.

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 before the legislation was implemented. They echo other evidence of the pace and means of implementation varying across the country.

Local authority resource and cost implications

Understanding the difference in local authority resource use and costs associated with implementing self-directed support requires an understanding of the difference between current resource use and previous social care practices. The case studies highlighted that the additional administrative and social work resource needed for choice and control is predominantly in the assessment process and in resource allocation panels.

The scope of any economic evaluation of self-directed support will necessarily be limited.

Resource allocation panels

Local authorities with resource allocation panels saw them as a crucial part of their approach to enable supported people to direct their social care and support. These panels involved both social workers and budget holders and met at least fortnightly.

[17] This can be accessed through the Scottish Government's main website: www.gov.scot

There were two main reasons for their use: to ensure that overall budgets for social care were not being exceeded at a local authority level; and 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 for the supported person.

Panels require considerable investment in social worker and management time to attend. Resource allocation panels identified in the case studies predominantly considered social care support under Option 1, 2 or 4. It is unclear whether there would be sufficient capacity to hold such meetings for every assessment that identifies the need for support. The lack of local authority capacity for such panels may influence how self-directed support is implemented across all groups of supported people in that area.

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 Options they choose). Social workers are required to be proactive in 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 personal outcomes and support needs have changed.

Sufficient supply and ensuring quality of supply

Challenges in the social care market are well documented [18].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 all impact on the social care workforce skill requirements and supply.

The case studies provided further evidence of the impact of supply issues - e.g. some people's outcomes required traditional caring, but with a high degree of flexibility, and others needed support that existing care providers did not routinely offer. Even where individuals had a budget to recruit support workers or Personal Assistants, it was not always possible to find suitable people who could deliver that support. In addition, the Option 1 case studies highlighted that there may well not be any training and support for their role. It is important to introduce training and support to ensure the quality of support they can offer is at a minimum maintained and ideally improves over time.

[18]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/

Does the use of the four self-directed support options reflect intended policy outcomes?

The case studies highlighted the different ways that local authorities interpret, deliver and record the four self-directed support options. As noted elsewhere, there is an inconsistency in what is recorded and why, from area to area, and this has been recognised at Government-level. Some local authorities only record as using self-directed support individuals who have been through an assessment, 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 recorded accordingly. This has significant implications for the collection and comparison of high-level statistics on self-directed support implementation from local authorities in Scotland. This has been a significant issue routinely commented on by authorities in relation to published statistics

Although the four options are explained within the legislation, translating them into practice has varied. Within the case studies, there are examples where: Option 1 does not offer a similar extent of choice and control in different places; or Option 1 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 appeared to be similar to the personalisation, choice and control under Option 3 in another area, where creative contracting provided more flexibility.

Ultimately, the options for self-directed approaches to care should be understood as a means to deliver the values and principles of self-directed support. The options should not be treated as if synonymous with self-directed support itself. The case studies highlight that the options can be a real focus for genuine change in some areas, but it also appears that there can be an over-emphasis on a local authority demonstrating an increase in the use of a particular option. Similarly, in the case studies, staff and supported people tended to talk about the hours or nature of support received rather than the outcomes being pursued, suggesting that there is still a cultural shift required to fully embrace self-directed support as mainstream social care.

5. Conclusions and future implications

The SDS Change Map provides a simple outcomes framework to articulate the main changes that need to happen to embed self-directed support fully as the mainstream of social care in Scotland. It provides a conceptual and practical basis for mapping, tracking and learning from major policy and service; for visually representing the logic or theory of change that underpins self-directed support; and for checking whether and how actions are contributing to intended changes and outcomes.

The assessment of the evaluability of self-directed support looked at published previous evaluations of similar system-wide policies and data currently collected in Scotland. The case study research also identified potential evaluation design challenges.

The evidence from the literature review highlighted that evaluation of similar policies has been challenging - particularly economic evaluation - and almost entirely qualitative. The literature review found no evidence that anyone had ever evaluated the equivalent of the “good conversation” which is central to the delivery of self-directed support. Several of the evaluations identified highlighted the need to be able to monitor change over time for individual supported people, their carers and families, and service providers and the need for longitudinal research.

Current routine data collections are not sufficient to monitor or evaluate against the SDS Change Map, so it is recommended that:

- longitudinal research is undertaken with people receiving social care starting from the time of initial assessment;
- a survey is undertaken of workers across social work and providers who deliver social care;
- a slightly expanded version of the Self-directed Support User Experience Survey is used to include a high-level question on social care outcomes;
- a survey is conducted of independent and third sector organisations who hold service contracts with statutory services; and
- a reporting requirement should be introduced for local authorities to evidence and self-assess their approach to strategic planning and how they are facilitating creative solutions to achieve individualised outcomes.

Economic evaluation will remain a challenge with no quantitative counterfactual[19] possible and as such should focus on the time taken by staff in local authorities to enable choice and control, which could provide information to consider alongside outcomes data collected in an expanded SDS User Experience Survey.

[19] That is, data that compares the outcomes of those having benefitted from a service or programme with those of a group similar in all respects but who have not received the service (a control group).

The case studies revealed many of the same issues as the literature review, notably the challenge of economic evaluation and the need for longitudinal research. The case studies provided a depth of information that would be valuable to the evaluation of specific aspects of social care, but the resource intensity required for case studies means they could be difficult to include as part of ongoing evaluation and monitoring.

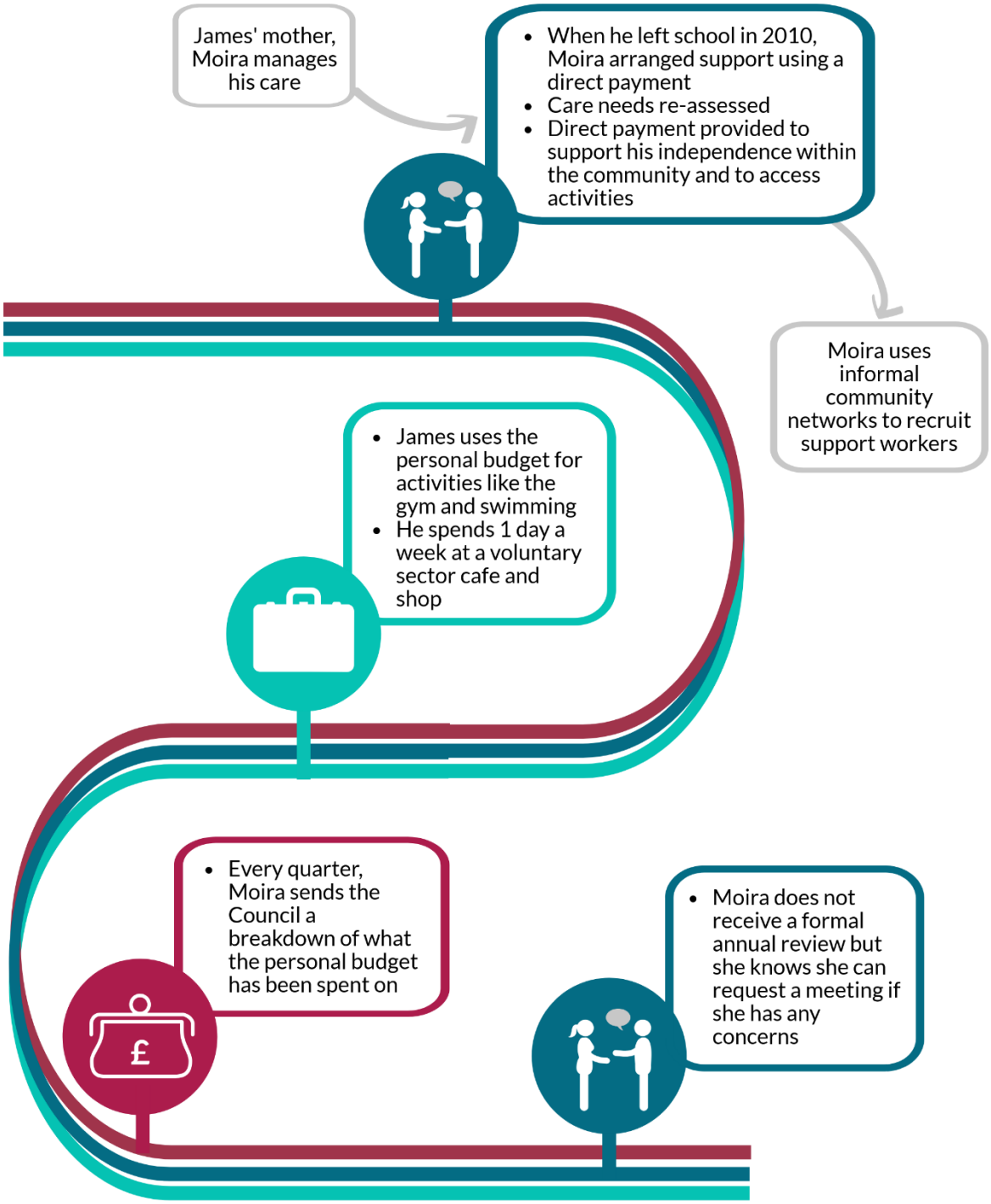
The case studies identified that uptake of the four options in a local authority is not a suitable proxy for full and genuine implementation based on the fundamental principles of self-directed support. Although the four options are a gateway to choice and control, what is potentially more important is:

- the quality of the social care assessment and reviews, including a genuinely "good conversation";
- the degree to which there is a focus on the supported person's outcomes;
- budgets being available to meet these outcomes;
- the availability of local providers and other resources ; 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, alongside cost-effectiveness, in order to understand whether and how the principles of self-directed support in Scotland are being realised in local practice and delivering the intended outcomes of the policy and legislation.

Appendix 1: Case Study 13 Summary Infographic

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.

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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