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Evaluation of Self-Directed Support Test Sites in Scotland

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EVALUATION OF SELF-DIRECTED SUPPORT TEST SITES IN
SCOTLAND

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LIST OF ABBREVIATIONS & ACRONYMS

ADSW	Association of Directors of Social Work
AP	Adult protection
ARC	Association for Real Change
BME	Black and minority ethnic
CIPFA	Chartered Institute of Public Finance and Accountancy
COSLA	Convention of Scottish Local Authorities
DP	Direct Payment
GCIL	Glasgow Centre for Inclusive Living
GSCPF	Glasgow Social Care Providers Forum
IB	Individual Budget
ILF	Independent Living Fund
ISF	Individual Service Fund
PA	Personal Assistant
RAS	Resource allocation system
SDS	Self-Directed Support
SPAEN	Scottish Personal Assistant Employers Network
SSA	Single shared assessment
SWIA	Social Work Inspection Agency

EXECUTIVE SUMMARY

Background

1. Promoting self-directed support (SDS) is part of the Scottish Government's wider programme to increase individuals' choice and control over their community care and support arrangements. Late in 2010, the Scottish Government and COSLA published a 10-year national Strategy to promote SDS as mainstream approach. Further, a SDS Bill was drafted and circulated for wide consultation at two stages in 2010 and 2011.
2. SDS is an approach to delivering care and support that is embedded within wider policy frameworks including that of social inclusion, participation and more recently, 'co-production'. As an umbrella term, SDS encompasses many concepts and practices in social care including Direct Payments (DPs), as well as Individual Budgets (IBs). DPs are payments in lieu of services provided directly to individuals assessed as being in need of community care services. IBs enable individuals to either purchase their own support packages to meet their assessed personal, social, and to a lesser extent, healthcare needs, or at least to determine how this budget will be spent on their support. The national Strategy has defined SDS broadly as support that individuals and families have after making an informed choice on how their Individual Budget is used to meet outcomes they have agreed (Scottish Government, 2010, p7).
3. Since the Community Care and Health (Scotland) Act 2002 it has been mandatory for everyone entitled to publicly funded community care services, with a few exclusions, to be offered the option of a DP by the local authority. While the early evidence base shows that those in receipt of DPs generally consider the benefits far outweigh the challenges (Homer & Gilder, 2008; Witcher et al, 2000), implementation has been slow in Scotland. Research has continued to highlight differences in uptake across community care groups: people with physical disabilities who are under 65 years are still more likely to be in receipt of DPs than any other group (Scottish Government Statistics, 2010).
4. As part of its activities to promote SDS, the Scottish Government selected 3 local authorities – Dumfries & Galloway, City of Glasgow and Highland – to act as test sites to trial targeting activities to address 3 themes in order to increase the uptake of SDS. The 3 themes – leadership and training; cutting red tape; and bridging finance – were based on previous research. The test sites were funded for 2 years and 3 months (January 2009 to end March 2011).

Purpose of the study

5. The main aim of the evaluation was to assess the development and impact of interventions implemented within the 3 local authorities test sites to improve uptake of SDS. The evaluation brief was to:

- Describe current SDS policy, activity, and practice in the test sites to generate baseline measures/data
- Develop tools and frameworks with project managers at each site to evaluate progress
- Examine the extent to which each site addressed the 3 key areas (bridging finance; cutting red tape; leadership and training)
- Assess the impact of the interventions at each test site in progressing SDS
- Identify the implications for policy and practice within wider Scottish context
- Disseminate to relevant stakeholders.

Methods

6. The evaluation had 3 main stages: Stage 1) establishing the baseline; Stage 2) evaluating process and impact; and Stage 3) reflecting on findings for wider policy and practice. Various methods were used to gather data at these different stages including:
 - Literature review
 - Collation and analysis of secondary information about SDS and community care services
 - Interviews with local stakeholders at each test site
 - Interviews with national stakeholders
 - Learning Sets – local stakeholders involved with the test sites
 - Monitoring framework – quarterly monitoring of test site action plans and collection of information about those receiving SDS packages during the test sites
 - Case studies – 30 individuals, their carers and assessors/care managers were interviewed
 - Evaluation stakeholder event in March 2011
 - Examination of all findings across the test sites.
7. Although a cost-analysis of the test sites was not possible for various reasons, interviews were conducted with finance officers in the 3 sites at Stages 1 and 2, to discuss their perspectives, especially about how CIPFA guidelines on introducing ‘light touch’ monitoring were being implemented by the test sites. Also, although not a key requirement of the evaluation brief, the relationship between Adult Protection (AP) and SDS was explored in very general terms.
8. While care should be taken in generalising the findings from the test sites to other areas, many of the issues they faced were similar to, and may reflect challenges other local authorities will face.

Key Findings

Stage 1: Start of Test Site Period

9. The following key findings at the start of the test site period are based both on interviews undertaken with a range of national stakeholders, and interviews with local stakeholders in each of the test site areas.
- The existing Direct Payments (DP) system was seen by national and local stakeholders as failing to deliver greater choice, control and flexibility as it was seen as overly prescriptive, bureaucratic, utilising 'old style' care management processes.
 - Implementation of DPs across Scotland was seen as highly inconsistent, with some local authorities adopting more enthusiastic policy and practice than others. SDS was seen as having the potential to address some of these problems in the current DP system by adopting a broader and more flexible definition.
 - Yet, despite SDS being defined as a spectrum of options that *includes* DPs, there was a prevailing view that what the test sites were doing was entirely different from established DPs. At this point, the lack of resources in the form of bridging monies was felt to be one of the main obstacles to more active promotion of SDS across Scotland.
 - Inadequate or non-existent support infrastructures for service users and carers across Scotland were seen as a further obstacle.
 - Particularly at local level, SDS policy had not enlisted sufficient input from service user and carer organisations and was in danger of seeming to be a professional-led concept.
 - There were concerns that SDS was being promoted as a cost-cutting exercise in the face of diminishing resources as opposed to a positive policy to promote independent living.
 - Up until this point, leadership to promote SDS via DPs across Scotland was seen as varying greatly and local authorities were not considered to have taken a particularly strategic or holistic approach to developing SDS, despite some notable exceptions.
 - A lack of consensus around what constituted good or effective leadership meant that the 3 test sites started their work without a clear steer or template on how to effectively lead the development of SDS, which was thus completely open to local interpretation and style.

Stage 2: Evaluating Process & Impact

- While test sites' operational definitions of SDS were broader than DPs and encompassed a range of options from DPs through to individually tailored local authority services, the majority of SDS packages involved a cash transfer, either as a DP to an individual or a 3rd party, usually family members.
- There was little evidence of support packages being funded from a range of sources other than Social Work and client contributions.
- Taken overall, people with learning disabilities were the main group to access SDS, although there were notable differences between the test sites. Those

groups who were less likely to feature in test site activity included people with mental health problems, older people and parents of disabled children.

- All 3 sites created a project lead/manager role; set up a dedicated SDS team; created a Project or Programme Board; and all sought to develop local champions.
- While this strategy might have worked well in relation to supporting the small numbers of service users and staff involved with new systems, it seemed to have limited the extent of system change achieved across the whole local authority in all 3 sites.
- Although significant activity was described as training in all 3 areas, it appeared that relatively small numbers of existing staff participated in any *in-depth* training.
- In relation to cutting red tape, the local SDS teams' efforts went into designing or re-designing new systems that were more 'fit for purpose'. Whilst some felt this was necessary in the short term, those participating in the evaluation felt test sites had tended to add to, not reduce, paperwork.
- On the whole, action plans and therefore activities were short on specifics regarding addressing the theme of bridging finance and therefore the impact of this theme was difficult to ascertain.

Individual Experiences of SDS

- Thirty individuals across the 3 test sites, their families/carers and assessors contributed to the evaluation by telling us about their experiences and views of the SDS assessment processes, and SDS options they had accessed through the test sites.
- While experience of the quality of assessment processes varied, on the whole, carers interviewed felt the assessment had been comprehensive and inclusive, and had been based upon what the individual wanted.
- There were differences between test sites in the degree of flexibility they allowed in terms of, for example, employing relatives, and in perception of appropriate activities that impacted on flexibility.
- SDS had expanded choice and control for the vast majority we interviewed. More flexible support was being offered under SDS than had been the case even with past DPs, which were often linked to purchasing specific activities or inputs rather than outcomes.
- However, while SDS was defined by all test sites as a spectrum of options *including* DPs, there were numerous examples where SDS was presented as, and understood by service users and carers as, an *alternative* to DPs.
- From these individual accounts, it was not always clear whether positive comments related solely to the model of SDS, or rather to the greater levels of support and local authority funding made available during the test sites, even though it had not been the intention for test sites to provide additional direct support monies.
- In this sense, the extent to which SDS test site monies had been used to meet previously unmet needs that had not been possible for either services or DPs to meet remains uncertain. This will have implications for the future roll-out of SDS across these and other local authorities.

Stage 3: Implications – Lessons from the Test Sites

10. Some general and specific recommendations emerge from the evaluation, which refer to the 3 key themes – leadership & training; cutting red tape; and bridging finance – and also to broader cross-cutting issues.

Pace of change

Recommendation 1 - Local areas need to gain agreement at senior level about the scope and extent of activity and what is reasonable to expect in a particular timeframe.

Recommendation 2 - Local authorities will need to allocate resources for taking SDS developments forward to ensure they have the capacity to design new systems or re-design existing systems, for example, for assessment and decision making around IBs.

DP and SDS

Recommendation 3 - A useful starting point for local authorities wanting to develop SDS would be a review of current DP systems, seeking to identify barriers to offering flexibility.

Recommendation 4 - To avoid duplication and confusion and to operationalise the broader ideal of SDS, more work needs to be put into integrating DPs and any new systems created to deliver SDS.

Measuring SDS

Recommendation 5 - When collecting information on SDS, local authorities may need to integrate different systems for recording DPs.

Recommendation 6 - A range of types of information (quantitative and qualitative) needs to be collected to capture how local authorities are implementing the full spectrum of SDS.

Impact of increasing knowledge about SDS

Recommendation 7 - Continued investment in increasing service users', carers' and staff knowledge and awareness about the range of SDS options available.

Recommendation 8 - Consistency of message and/or clarity about how decisions are made is needed and about how payments can be used.

Satisfaction with SDS packages

Recommendation 9 - A review of eligibility and funding criteria may be needed in order to ensure equitability of access.

Recommendation 10 - Continued funding of packages may be required at the level enabled during the pilot if local authorities are to see positive outcomes.

SDS and Adult Protection

Recommendation 11 - There is a need to consider joint training on SDS and Adult Protection, as well as integrated practice initiatives programmes

Leadership and Training

Recommendation 12 - Where a separate project team is set up to kick start developments it is important to ensure this is driven by a high level Project Board, and there is strategic consideration of the impact of the approach taken on wider implementation.

Recommendation 13 - Communication is needed from the start with all those involved including frontline staff carrying out SDS assessments with service users, especially about the 'nuts and bolts' of new systems.

Recommendation 14 - A multi-pronged training strategy is essential and needs to inform action by practitioners in parallel with driving culture change and knowledge and skills development on a wider basis.

Cutting 'red tape'

Recommendation 15 - In developing SDS assessment processes, local authorities need to take stock of existing systems and how these can be integrated with SDS.

Recommendation 16 - Developing a range of assessment approaches including supported self-assessment may be necessary, as well as ensuring access to independent advocacy to ensure people with complex needs have sufficient input into their care and support.

Recommendation 17 – Consideration is needed as to whether the SDS 'self-assessment' can address complex issues and inputs required from a variety of social care and health services to ensure a comprehensive and integrated response.

Bridging finance

Recommendation 18 - Local authorities need to be able to identify when and how much bridging resource will be needed to plan future service development.

Equal access

Recommendation 19 - A deliberate focus is needed to ensure SDS becomes an option for a wide range of individuals with varying needs, including those from BME communities.

Recommendation 20 - It will be important to apply equal opportunities monitoring to SDS uptake.

Mixed funding packages

Recommendation 21 - SDS monitoring systems need to find ways of recording access by [and outcomes for] people with complex needs ('dual diagnosis').

Recommendation 22 - There is a need to understand and overcome the barriers to utilising additional funding from other sources such as health.

Independent advocacy

Recommendation 23 - Commitment to promoting collective and strategic user involvement would seem essential if the perception that SDS is a professionally-led concept is to shift.

Recommendation 24 - Developing the capacity of local disability organisations should be recognised as a key aspect of SDS policy and practice implementation.

Conclusions

11. Given that some similar concerns emerged across all 3 test sites, it seems likely that these are not specific to the test sites but are more general challenges facing all local authorities attempting to make changes in the direction of SDS.
12. Specific conclusions in relation to the test sites can be drawn, especially about the longer term sustainability of the small but important changes that the sites were able to make. The implementation of SDS using a managerial rather than a strategic model, that is as a project or initiative with a designated team leading developments within authorities had limitations: a specialist SDS or personalisation team offered expertise and management of the 'SDS project' but also created the impression that SDS was separate from, and operated differently to, the local authority and other systems, such as DPs. There was a risk of these systems appearing to be working in parallel, which can mean unhelpful duplication and confusion. Unless senior managers take a lead role, there is always the danger that initiatives will be marginalised regardless of how committed those managing and involved in it are. Certainly by the end of the test site period, the 3 local authorities had resolved to move towards mainstreaming SDS with support from their senior management. An ambitious programme of SDS development in Glasgow involving external providers, for example, has far reaching consequences for future practice that we are unable to assess in this evaluation.
13. The new SDS processes created by the test sites worked extremely well overall for the selected individuals who benefited from SDS during the test site period offering increased choice, flexibility and control. The uptake of SDS and of DPs had increased as a result, and through the work of dedicated teams the local authorities found they could be more creative and innovative in the ways they worked with people. The key issue now is maintaining such innovation and flexibility for greater numbers of individuals. Clearly

involvement of service user and carer organisations and investment in the necessary support infrastructures are essential as well as continued availability of funding for the care packages themselves. In the foreword to the national Strategy, political leaders state that “more of the same will not work”. It will be essential therefore for all local authorities to grapple with the challenges faced by these test sites, and to find a way to implement this shift from service provision to greater involvement and co-production of care and support. The outcomes of this Strategy are worthy of continuing assessment.

1 INTRODUCTION AND BACKGROUND

Policy Background

- 1.1 Increasing individuals' choice and control over their community care support arrangements has been a key element of Scottish Executive/Government policy since the late 1990s and the introduction of Direct Payments (DPs). Self-directed support (SDS) is an approach to delivering care and support that is embedded within wider policy frameworks including that of 'personalisation', social inclusion, participation, empowerment, and most recently, 'co-production' (Scottish Executive, 2006; Pestoff, 2006; Hunter & Ritchie, 2007; Scottish Government, 2007; Leadbeater & Gallagher, 2008).
- 1.2 As an umbrella term, SDS encompasses many concepts and practices in social care including DPs as well as Individual Budgets (IBs) (Manthorpe et al, 2011). IBs enable individuals to either purchase their own support packages to meet their assessed personal, social, and, to a lesser extent, healthcare needs, or at least to determine how this budget will be spent on their support. Although IBs can be sourced from more than one funding stream, research in England has found that NHS resources have been rarely included and combinations of funding streams have been unusual with the exception of social care and Supporting People (housing support) monies (Glendinning et al, 2008).
- 1.3 Since the Community Care and Health (Scotland) Act 2002, implemented in April 2003, it has been mandatory for everyone entitled to publicly funded community care services, with a few exclusions, to be offered the option of a DP by the local authority. DPs are payments in lieu of services provided directly to individuals assessed as being in need of community care services. While the early evidence base shows that those in receipt of DPs generally considered the benefits far outweigh the challenges (Homer & Gilder, 2008; Witcher et al, 2000), implementation has been slow in Scotland. A study for the Scottish Parliament Health Committee (Riddell et al, 2006) identified several problems that slowed implementation, including:
 - A lack of shift in funds from traditional services into DPs and concerns about the impact on existing provision
 - Inadequate skills development and information about SDS for local authority staff
 - Anxieties about financial accountability issues and cumbersome bureaucracy
 - Concerns about the employment of unregulated personal assistants (PAs)
 - The influence of micro-cultures or organisational practice and beliefs that inhibit or support the development of DPs.
- 1.4 More recently, recommendations from another Scottish study (Homer & Gilder, 2008), which explored innovative work in areas with a good track record of delivering DPs, included the need for an effective support service for

DP recipients; local authority leadership; a dedicated team; 'light touch' financial systems; and better training for social workers.

- 1.5 Research has continued to highlight differences in uptake of DPs (and now IBs) across community care groups: people with physical disabilities who are under 65 years are more likely than people with learning disabilities, mental health service users or older people to be in receipt of DPs (Witcher et al, 2000; Ridley & Jones, 2003; Spandler & Vick, 2004; Riddell et al, 2006; Davey et al, 2007; Scottish Government Statistics, 2010).
- 1.6 At the start of this evaluation, the 3 local authorities who became SDS test sites showed wide variation in uptake of DPs: Glasgow had the lowest rate of 3.6 per 10,000 population compared to Highland with 8 per 10,000 population, and Dumfries & Galloway with 11 per 10,000 population (Scottish Government Statistics, 2009).
- 1.7 Since DPs have been introduced, policy and practice surrounding adult support and protection have also evolved, particularly in relation to decision making and mental capacity with the advent of the Adult Support and Protection (Scotland) Act 2007. Questions around risk, vulnerability and adult safeguarding or protection continue to emerge, and from the English experience, it would appear that policy and practice have travelled along 'parallel tracks' with developments in SDS generally occurring separately from developments in adult safeguarding (Manthorpe et al, 2009). The implication of this is that practitioners concentrating on SDS alone may miss the risks of exploitation and abuse/neglect, while those concentrating on safeguarding alone may try to over-control and so not take risks.

SDS - An Evolving Concept

- 1.8 A fundamental issue at the start of this evaluation was that what was meant by 'self-directed support' in Scotland was evolving, as was policy and legislation to ensure that SDS becomes the mainstream approach to care and support. At the start of the evaluation, SDS and DPs were referred to almost synonymously:

*“Self-directed support (SDS) policy (**encompassing direct payments**) provides individual budgets for people to buy their own support packages to meet their assessed personal, social and healthcare needs...The person is in control of their support arrangements using an individual budget that is usually sourced from more than one funding stream. Most people use the money to buy support from a service provider and/or to employ a personal assistant.” (Evaluation brief, 2009)*

- 1.9 There was much debate around the definition of SDS, as well about which model should be used, including whether or not the 7-steps model (or aspects

of this) developed by the organisation *In Control*¹ should be implemented by all the test sites. The consensus of opinion from early stakeholder interviews was that SDS refers to a spectrum of options ranging from the ‘sharpness’ or ‘purity’ of a DP at one end, to more individually tailored local authority provided services at the other. In other words, an individual might choose to directly control his/her social care allocation and employ his/her own staff via a DP, or instead choose to:

“...co-design the service, to talk about what kind of outcomes they want to achieve from the service, what they want their lives to be like – and they have a pretty good say, then, in how the resources for that service are directed.” (National provider organisation)

- 1.10 The key requirement, regardless of the mechanism used to deliver the support, was that the individual could exercise more choice and control over his/her social care than had previously been possible. During the lifetime of the research, the Scottish Government and COSLA published a 10-year strategy for SDS in Scotland (Scottish Government, 2010), which aimed to set out and drive a cultural shift around the delivery of support with SDS becoming the mainstream approach. This Strategy adopted a far broader definition of SDS than DPs, which had an impact on how SDS was operationalised by the test sites. The National SDS Strategy defined SDS as support that:

*“Individuals and families have after making an informed choice on how their Individual Budget is used to meet the outcomes they have agreed. SDS means giving people choice and control.
The process for deciding on support through SDS is through co-production . . .
The mechanisms for getting support through SDS can be through a Direct Payment (DP) or through the person deciding how their individual budget is allocated by the council to arrange support from a provider. . . Some people may choose to leave the decision on how their support is provided to the council.”
(Scottish Government, 2010, p7)*

- 1.11 Unlike DPs - which are easier to record as an individual (or a 3rd party on their behalf) either receives or does not receive it – measuring SDS is a more nebulous activity. At the start of the evaluation, the only aspect of SDS that was measured by official statistics was the uptake of DPs. As a result, reporting on and measuring the impact of SDS presented a number of challenges for the evaluation, and also for the Scottish Government in its collection of annual statistics on SDS. These challenges included:

¹ The *In Control* approach to service development and delivery, aligned with co-production involves 7 key stages – self assessment; plan support; agree plan; manage Personal Budget; organise support; live life; review and learn.

- How to measure the exercise of choice over how individual outcomes will be met;
- Gaining agreement with local authorities about the criteria to be used for monitoring implementation;
- Integrating monitoring with other systems such as single outcome agreements;
- Assessing the broad spectrum because choice and control are never ‘all or nothing’;
- Measuring choice and control when service provision stays the same and there is no cash transaction at end user level;
- How to consider longer-term outcomes.

1.12 The complexity of assessing the shift towards greater choice and control was exemplified by the challenge that care and support may be newly described as being more personalised, while, in practice, any difference can be hard to gauge. Given that the extent of choice and control will itself be experienced at the individual level, more nuanced ways will be needed to meaningfully capture the SDS process and its outcomes for individuals. In particular, any evaluation of SDS has to move beyond simply counting take-up of DPs. Therefore, towards the end of the evaluation, the Scottish Government started discussions with local authorities to consider better ways to capture SDS in its broadest sense as it was acknowledged that what has been recorded thus far did not reflect innovative practice and the real extent of SDS policy implementation.

Creation of SDS Test Sites

- 1.13 The Scottish Government selected 3 local authorities to become SDS test sites: Dumfries & Galloway, Glasgow, and Highland. The decision about the selection of local authorities was agreed between Scottish Government, COSLA and ADSW, and was based on a range of factors, including geography (covering urban, rural, and remote rural sites) and an assessment of the broad performance of the local authority according to the conclusions from inspections by the Social Work Inspection Agency (SWIA).
- 1.14 While there was support amongst most policy makers and senior managers interviewed at Stage 1 for the general rationale by which local authorities had been chosen, there was some suggestion that generalisation of findings across the rest of Scotland may be limited given that only 3 of the 32 Scottish local authorities were involved, and because there is known to be a high degree of diversity among Scotland’s authorities. It was also highlighted that there had been some disquiet about the decision among some of the other 29 local authorities, although on the whole, it was accepted there had been sufficient prior consultation.
- 1.15 Each site was funded over 2 years and 3 months (January 2009 to 31 March 2011) to put in place mechanisms to facilitate a shift towards SDS. At the outset it was agreed that each site needed to find ways to address 3 particular subjects that were seen as necessary to enable this change: bridging finance, cutting red tape, and leadership and training (refer to appendices for

further detail). These were identified as important themes by the Scottish Government from the research evidence on DPs and SDS.

- 1.16 The selected local authorities were to trial specific activities relating to these 3 themes in order to implement SDS. While the themes were pre-determined, according to one Local Government Organisation representative there was broad agreement amongst members of the national SDS Reference Group that these were the 'hot topics':

"Those were 3 elements that were constantly being discussed. So yes, I would say that the areas that are being looked at in the test sites very much come from the discussions around the country, people expressing their views on what the issues were."

(Local Government Organisation representative)

- 1.17 The 3 local authorities were invited to produce test site action plans specifying how they would implement the Scottish Government's agenda over a 2 year period. In practice, agreement between Scottish Government and local authorities on the test sites was not reached in some cases until March 2009, and so the original deadline was extended to March 2011. The Scottish Government's objectives for the test sites were that local authorities should consider how focusing on the 3 specific themes could contribute to increasing the 'uptake of SDS', and also to consider:

- How SDS can be used by all client groups and how it relates to carers and respite
- How SDS can be used for preventative care
- How SDS relates to other funding streams
- The role of advocacy and support services
- SDS packages that incorporate health monies, including support for palliative care
- "leap-frog" learning throughout the 2 years of the project and participation in an independent evaluation.

(Letter from Scottish Government to test sites local authorities; Evaluation brief)

- 1.18 Rather than direct how these themes should be addressed, Scottish Government invited the 3 local authorities to interpret the overall brief set by them in the context of local circumstances and to develop local action plans. Nevertheless, there was an expectation that the test sites would meet certain national commitments, for instance:

"...the very baseline is Manifesto commitments, each of the test sites must demonstrate increase in take up of direct payments as an absolute given so it's the Manifesto commitments. They must all have trialled something that looks like an IB one way or another..." (Scottish Government SDS Team)

- 1.19 Support to the test sites from the Scottish Government took 3 main forms: policy level support; financial support; and professional support. Throughout the life of the test sites, Scottish Government continued to promote SDS as policy through development of a national strategy for SDS with COSLA (Scottish Government, 2010), and latterly, through an SDS Bill, upon which it consulted widely during 2010/2011. Planned financial investment in 3 test sites totalled just over £3.5 million allocated to each test site as follows:

Table 1.1: Annual breakdown of financial support to each test site

Financial Year	Estimated budget (,000s) per test site
2008/09	£170
2009/2010	£510
2010/2011	£510

- 1.20 Professional support to the test sites came from a designated appointee within the Scottish Government SDS Team in the Adult Care & Support Division. Three part-time secondees contributed different knowledge and skills including experience of DP implementation, as well as of working in senior management positions in the voluntary and private sectors. Their key role was about sharing information and expertise, and keeping the Scottish Government informed of the implications of test site activity for policy development. Initially each test site was allocated a designated appointee, but later on this support was extended so that more than one secondee worked with each site.
- 1.21 Scottish Government expected sites to be in regular contact with the secondees and to receive updates on progress. This led to some uncertainty within the test sites and a perception that this was a form of scrutiny of their work, adding another tier of reporting to Scottish Government alongside the evaluation. Because these secondees were also employed by other organisations in other capacities, there were local sensitivities about some of the advice given and references made to 'how things are done elsewhere'. Similarly, it was considered unhelpful if experience in another capacity was seen to drive their contribution. Their input overall was generally perceived as constructive and helpful, although there were differences of opinion. We now briefly summarise the 3 test sites below.

Dumfries & Galloway Test Site

- 1.22 Becoming a test site served to progress and develop the local authority's existing plans for the transformation of social care service delivery. As a test site, the local authority aimed to test the applicability of the *In Control* method in a rural setting and across client groups, even though early plans focused on developing personalisation approaches in learning disability services. Initially, activities also centred around one geographical area. Expressly not wanting to implement personalisation as a top down policy, the test site took what they described as an organic or community development approach to promoting personalisation and building staff confidence in working in this new way. The work of the test site initially distanced itself from DPs in the Council, and its

action plan was described as *informed by*, but not driven by, Scottish Government's 3 themes for the SDS test sites.

Glasgow Test Site

- 1.23 The test site initially was developed in the East of the City with people with learning disabilities. It built directly upon an earlier Individual Budgets (IBs) pilot in Glasgow which aimed to achieve more personalised support for people with learning disabilities. The test site action plan was framed around the 3 test site themes, and stated that it would increase the number of IBs, wherever possible as DPs. To begin with, SDS was developed separately from the existing DP system. The local authority tested and refined information resources and operational systems (including a Resource Allocation System (RAS), and self-assessment) building on the *In Control* approach. It also increasingly used Individual Service Funds (ISFs). Partnership working has been a key element of the test site, as reflected in joint work with the Glasgow Social Care Providers Forum (GSCPF), which also received separate Scottish Government funding to promote SDS.

Highland Test Site

- 1.24 This test site aimed to promote SDS through directly increasing the number of people accessing DPs, although towards the end of the 2 years, this primary focus shifted to include ISFs. Test site activities concentrated on adapting self-assessment and other systems from an English local authority that had developed the *In Control* model. The test site aimed to recruit SDS champions within users/carers and staff members who would become exemplars. An existing local resource allocation system (known as the equivalency model) was tested for establishing IBs. At first the SDS test site was run as a separate initiative to DPs, with links explored later on. SDS was promoted mainly to young people in transition into adult services, commonly those with learning disabilities and/or autism, though one-off payments were made to a wider range of client groups. Plans to extend SDS to older people leaving hospital were tried and abandoned.

2 OVERVIEW OF EVALUATION

Evaluation Aims & Objectives

- 2.1 The main aim of the evaluation was to assess the development and impact of interventions implemented within the 3 local authorities test sites to improve uptake of SDS. The evaluation brief from Scottish Government was to:
- Describe current SDS policy, activity, and practice in the test sites to generate baseline measures/data
 - Develop tools and frameworks with project managers at each site to evaluate progress
 - Examine the extent to which each site addressed the 3 key areas (bridging finance; cutting red tape; leadership and training)
 - Assess the impact of the interventions at each test site in progressing SDS
 - Identify the implications for policy and practice within wider Scottish context
 - Disseminate to relevant stakeholders.

Evaluation Design

- 2.2 The overarching framework for planning the evaluation was adapted from Scriven's (2003) Key Evaluation Checklist (cited in Davidson, 2005), which accentuates the importance of process as well as outcome evaluation, and triangulation of data types and sources to support robust conclusions. The evaluation design was mixed method, gathering mainly qualitative information from a range of stakeholders (service users, carers, professionals) in each test site area through interviews, focus groups, learning sets, and reports.
- 2.3 Adopting an approach based upon the 3 interventions/themes as its overarching framework presented some challenges. One test site explicitly drafted an action plan around personalisation activities and not the Scottish Government themes. Also, the commissioned study was not an evaluation of IBs or DPs specifically, nor of SDS compared to traditional services. The evaluation design therefore attempted to capture information about the processes and changes as implemented by each test site according to their local operational definitions of SDS. The evaluation team worked with local project managers to tailor data collection to local circumstances, and different stakeholders were involved through learning sets and in a final stakeholder event in making judgements about the effectiveness of the 3 specific interventions/themes under study. While this design allowed some flexibility across sites, the same types of data were collected from all 3 sites.

Evaluation Methods

- 2.4 The evaluation had 3 main stages: Stage 1) establishing the baseline; Stage 2) evaluating process and impact; and Stage 3) reflecting on findings for wider policy and practice.

2.5 An initial plan to collect cost information on the test sites had to be scaled down considerably when it became apparent that none of the participant local authorities was gathering the data necessary to conduct a cost-analysis and that there was no standardisation of financial reporting to Scottish Government. Within the parameters of this particular evaluation therefore, it was not possible to produce a cost analysis. However, interviews were conducted with finance officers in the 3 sites at Stages 1 and 2, to discuss their perspectives, especially about how CIPFA (2009) guidelines on introducing 'light touch' monitoring were being implemented by the test sites.

Figure 2.1: Stages of the evaluation



Stage 1 - Baseline

2.6 Various methods were used to gather data to provide a 'baseline' or picture of events prior to implementing the test sites:

- **A literature review** of definitions of SDS, and the barriers and facilitators to SDS. A separate report is available (Manthorpe et al, 2011);
- **Secondary data analysis** of national DP and community care statistics;
- **Interviews with local stakeholders in each of the test sites** and gathering of local information to provide detail on SDS policy, practice and activity;
- **Interviews with national stakeholders** in Scottish Government, local government bodies, specialist SDS/DP bodies, and professional or special interest organisations to assess national policy and the rationale for the test sites;
- **Learning sets** involving various local stakeholders including project boards, providers, professionals, service users and carers. Although planned, this did not happen in Dumfries & Galloway due to delays in setting up the personalisation board.

Stage 2 – Process and Impact Assessment

2.7 The second phase of data collection gathered data about the processes and impact of implementing SDS within each site. Accepting the broad definition of SDS, the focus of Stage 2 was on capturing information about the extent to which the test sites were delivering SDS options across the whole spectrum. Analysis of information is organised, as far as possible, around the 3 overarching themes (bridging finance; cutting red tape; leadership and training).

2.8 Data collection for Stage 2 consisted of the following 4 key elements:

- **Monitoring framework** involving collecting quarterly information about outputs (activities and participation) in respect of each test site's action plan, and about service users in the test site and types of SDS options chosen;
- **Case studies** of 10 service users in each area (30 in total), involving interviews with the service users and/or their carer/relative, and the professional involved in assessment to explore experiences of new processes and procedures implemented during the test sites;
- **Learning sets** with relevant stakeholders in each test site area to reflect and identify key learning from local experience;
- **Key stakeholder interviews** with 10-12 individuals at each site (some of whom had been consulted at Stage 1) to understand new processes, the interface with adult protection, and perceptions of impact.

Stage 3 – Reflection on Policy and Practice Implications

2.9 The third and final Stage of the evaluation considered the findings from each test site at an aggregate level to make conclusions that are supported by information and evidence from other studies. The key elements of this Stage were:

- **Final learning set** in each area focussed on making evaluative judgements in light of the findings of the local evaluation, making an overall judgement about the success of the interventions both locally and in terms of their likely applicability in different locations;
- **Evaluation stakeholder event**, an event held in March 2011 where findings were presented to a mixed audience of 60 test site stakeholders and representatives from Scottish Government by members of the evaluation team, with discussion around perceived learning from the test sites;
- **Examination of all findings** in light of other information about implementation of SDS and IBs including consideration of statistical data, other research evidence, and interviews conducted earlier with a sample of local authorities about their experiences of SDS.

Adult Protection

2.10 Although not a specific topic for study within the research brief issued by the commissioners, the research team took the opportunity to explore 'adult protection' (AP) interface with SDS in very general terms through 2 sets of phone interviews with relevant lead officers in the test sites at the beginning and end of the study, as well as consulting individuals representing the perspectives of Scottish Government and national organisations.

Analysis

- 2.11 In the main, interviews and focus groups with service users, carers and professionals were digitally recorded and transcribed in full. In some cases, for example, where someone did not wish an interview to be recorded or the interview was with an individual with limited verbal communication, researchers took notes. The majority of group interviews or learning set discussions were noted in writing at the time or recorded on flipcharts.
- 2.12 Interview and focus group data were analysed using standard qualitative data analysis methods, beginning with the identification of key themes and patterns (Silverman, 1993; Coffey & Atkinson, 1996). The process of identifying themes was driven partly by the research objectives, key issues from the literature, and finally, from the team's interpretations, which were checked for accuracy and validity with the local test sites.
- 2.13 An evaluation team member acted as key contact and coordinator of data collection and reporting for each of the 3 test sites. The designated evaluation coordinator was responsible for analysing locally derived data, and for writing a local report and agreeing this with the local authority. Other data were coded using NVivo8 (a qualitative data analysis software programme). This report was written by the evaluation managers who retained a general overview of the test site programme (across the 3 sites), drawing on the 3 local evaluation reports. Feedback and comment from the team, the test sites and Scottish Government have been incorporated into this final report.

Ethical Approval

- 2.14 Ethical approval for the study was given by the Faculty of Health Ethics Committee at UCLAN. Advice was also taken from NHS West of Scotland Ethics Board on behalf of NRES, who advised NHS ethical approval was not required since the study was an evaluation. We took care not to identify participants and so some identifying features have been changed.

Study Limitations

- 2.15 In practice, the nature of the test site programme presented a number of challenges for the evaluation. First, the pre-test situation was difficult to measure given that at least 2 of the 3 test sites had already begun to make some changes to existing structures when the evaluation was commissioned. Also, their action plans stated that test sites were building upon pre-existing change programmes or pilots (such as the IB pilot in Glasgow). Thus, there was no clear 'before and after' SDS situation to evaluate, except in Highland where a new approach to DPs was implemented.
- 2.16 The evaluation was also hampered by the relatively short time period (2 years) and the delayed start of the test sites. As the first year was spent developing new systems and approaches, impact and outcomes were only able to be measured in a limited way. As there was less than one year to

measure impact, the funders have commissioned further data collection at the end of 2011, and this will be reported on separately.

- 2.17 Finally, our method of actively involving the sites with the evaluation presented additional challenges as well as advantages. Given the slow start up and its impact on developing the test sites' management infrastructures, it was not possible to involve local stakeholders to the extent originally anticipated. Additionally, some of the local authorities did not have a strong track record in engaging stakeholders such as service users and carers, or the independent sector. These stakeholders had often not been involved in development of test site action plans. The impact of this was that learning sets were unable to be set up as planned in the early part of the evaluation. Nonetheless, local test site project managers and others were consulted regularly by the designated evaluation coordinator for each site before finalising data collection tools, and at all stages of reporting.
- 2.18 These challenges must be taken into account as they limit the conclusions that can be drawn from the evaluation. To some extent, these will be partially addressed by the proposed supplementary assessment of the local authorities later in 2011 to capture additional impacts beyond the test site evaluation period.

Report Structure

- 2.19 The next chapter summarises findings from Stage 1 baseline interviews, including why the 3 themes were identified and perceptions of SDS before the test site was confirmed. Chapter 4 then looks at how the test sites defined SDS in practice, which service users accessed SDS packages, and how the test sites addressed the 3 themes. This is followed in Chapter 5 by findings from the case studies, providing an insight into individual service user and carer experiences in the test sites, and identifying key themes. Finally, Chapter 6 draws together key themes from the findings and makes some recommendations.

3 STAGE 1: BASELINE

Introduction

- 3.1 In this chapter, we use data collected from Stage 1 of the evaluation to provide baseline information, first about perception of the national picture, and second, to examine views about SDS in each of the selected local authority areas pre-test site. Interviews with a range of national stakeholders at Stage 1 (see appendices for detail) investigated the rationale for the selection of the test site key themes – leadership and training; cutting red tape; and bridging finance. Views about the themes are explored as well as stakeholders’ opinions about the importance of these particular themes. The views of national stakeholders about SDS policy and practice in Scotland are then discussed, followed by a summary assessment of SDS experience in the test site local authorities as gleaned from interviews with various local stakeholders and local documentation.

Leadership & Training

- 3.2 The national SDS Strategy which emerged during the lifetime of the test sites accentuates the importance of leadership at all levels, including citizen leadership (Scottish Government, 2010, p15). According to this Strategy, management leadership is essential, but so too is commitment across all levels and functions, including from elected members, finance directors, commissioners and social work managers, otherwise SDS will not be implemented effectively. The Strategy suggests that leadership can be achieved *“through champions who spread the vision, dedicated teams in each local authority and a national forum to share best practice”*, (ibid: p18). It includes a commitment to joint approaches and partnership involving all stakeholders, including those at policy and planning levels and with organisations that are led by and represent people who use services.
- 3.3 At the baseline, those interviewed from national organisations highlighted wide variations in the effectiveness of existing leadership in promoting SDS within Scottish local authorities. In principle, most identified leadership as a vital component of successful promotion of SDS, but they were usually less clear about what form this should take.
- 3.4 One element of leadership included promoting a change in culture and practice through training. In relation to training, the national SDS Strategy underlines the importance of training being delivered by people with experience of directing their own support. It also emphasises the importance of individuals and families who provide support being able to access information and training, especially on becoming employers. Furthermore, it highlights the need for training for staff at all levels in the values and principles of SDS, including senior and middle managers, finance and commissioning staff and front line staff. Stakeholders interviewed at the baseline stage concurred with the national Strategy, adding that staff/professionals at all

levels should act as pioneers in their particular field, whether finance, commissioning, front line staff or managers.

Cutting Red Tape

- 3.5 This theme sought to enable a local authority to cut non-essential 'red tape' surrounding SDS arrangements. Scottish Government envisaged this would enable front line staff to better concentrate on their core job and therefore improve service users' experience. This was expected to help increase demand for SDS as previous research has shown that the level of bureaucracy surrounding DPs has been off-putting for service users and carers (Manthorpe et al, 2011). At baseline, several national stakeholders suggested that current arrangements within local authorities for the assessment, monitoring and review of SDS (usually referring to DPs) tended to be overly time-consuming and complex:

*“SDS is a nightmare for social workers delivering care, due to the volume of paperwork and lack of clarity.”
(Representative of Specialist SDS/DP Organisation)*

- 3.6 Most national stakeholders felt the key issue here was local authorities' 'heavy handed' monitoring of individual arrangements typified by DPs. Monitoring arrangements varied across Scottish local authorities – with some thought to be more 'bureaucratic' than others. Only a small number of national interviewees pre-test site worried that monitoring was too 'light touch' (i.e. in relation to local authorities' legal responsibilities). Most agreed that local authorities' monitoring requirements were overly prescriptive and laborious. Such requirements were believed to be putting additional strain on service users, carers and front line staff, who often found the complexity of the process daunting and off-putting – to the point that some might disengage:

“Every penny has to be accounted for; there is a high level of scrutiny. Sometimes there is a lack of consistency of required accountability – it can change without warning, leaving people without the required accounts / receipts.” (Representative of Special Interest Group)

- 3.7 Interviewees agreed on the need to simplify monitoring requirements “so long as desired outcomes are met” (Provider Organisation), and to re-focus attention onto demonstrating that desired outcomes were being met:

*“What we're trying to do with the new CIPFA guidance is back off with the monitoring. I mean in my local authority we monitor people every month. We're in the process of developing a policy so that, for people who have established DPs and are managing it well, we'll do a spot check once a year, rather than doing what we're doing now.”
(Representative of Local Government Organisation)*

Investing to Save/Bridging Finance

- 3.8 In short, this theme was meant by the Scottish Government to refer to double funding or concurrent expenditure on buildings-based care within a local authority to enable remodelling of the service, while encouraging those who use the facilities to use other forms of social care support in the community. The availability of bridging finance was identified by national stakeholders to be the key to initial success. Lack of bridging finance was perceived as one of the main reasons why local authorities across Scotland did not appear to prioritise DPs and/or SDS. Its value lay in being able to continue to provide existing services whilst bringing about a change in service delivery:

“Bridging finance is needed while new models of care are being created. Moving to the SDS model will take time and money.”
(Representative of Provider Organisation)

“People cannot move on e.g. from day centres to IBs. Local authorities need to fund both; obviously they need finance for this.”
(Representative of Specialist SDS/DP Organisation)

- 3.9 Concern was expressed about the wholesale closure of day centres and the transfer of money from block contracts by some local authorities, which one representative argued might leave individuals with no services at all. Paradoxically, such policies, they argued, could undermine choice:

“For some people, what they’re saying to us is that our choice is to keep what we’ve got, and so you have to strike a balance.”
(Representative of Local Government Organisation)

- 3.10 While the availability of bridging finance was often reported as the top priority for local authorities, there was concern that the current economic climate would mean investment in test sites was a very temporary (and inadequate) solution to the wider issue of the under-resourcing of social care:

“Irrespective of what comes out...is [Bridging Finance] actually a deliverable concept? At a time when resources are diminishing at the level that they are now...is there going to be any scope whatsoever for bridging finance? – I have serious doubts about that I’ve got to say, even if the outcome [of the test sites] is extremely positive.” (Representative of Local Government Organisation)

- 3.11 This echoes recent research by the user-led Standards We Expect consortium (Joseph Rowntree Foundation, 2011). Similar concerns were also expressed by those interviewed in the local test sites. Another national stakeholder even suggested that there was a risk that bridging finance could be “a cushion that causes major problems at the end of the test sites”. This quotation implies that the process of service reconfiguration, which bridging finance aimed to facilitate, would be incomplete at the end of the test sites,

and might have negative rather than positive consequences. Those interviewed tended to suggest that the further development of SDS would take many years and was certainly beyond the timeframe of the SDS test sites.

SDS Policy in Scotland

- 3.12 Most national stakeholders were in agreement that SDS policy had to be flexible in order that local authorities could interpret guidance according to local requirements, and so as to respond to the diverse needs of service users. As one local government organisation representative argued, it was necessary to “develop a general policy that can then be individualised on a case-by-case basis”. However, whilst such a loose definition of SDS in policy terms had facilitated creative interpretations, it had also acted as a hindrance to implementation. Several national stakeholders perceived wide variation in practice and it was suggested by some that this had provided an excuse to local authorities to implement the guidance selectively, or at worst, to opt out:

“SDS is a mess. It has allowed a postcode lottery situation to develop. Local authorities have been able to pick and choose bits of the guidance.” (Anonymous)

“Policies are as prescribed by the local authorities in their interpretation of the legislation. There is no Scotland-wide policy. The local authorities (and within each local authority, each area Social Work team) all have their own take on it.” (Representative of Specialist SDS/DP Organisation)

- 3.13 One national stakeholder felt the ‘loose’ guidance had enabled a cynical interpretation of SDS:

“It has worked in complete separation from the new ways of tendering. SDS is used as a new way for service users to “buy” the service they are getting and in the process to reduce the hourly rate. This makes SDS look like a rationing tool. It has not been maximised as a tool for independence.” (Anonymous)

- 3.14 The national SDS Strategy for Scotland, which was out for consultation at the time of baseline interviews, was considered timely by many of those interviewed. The Strategy was expected to address the current confusion around the “boundaries between SDS and DP in policy terms” (Provider Organisation). This was compounded by the complex relationship between SDS and key legislation such as the Adults with Incapacity Act (Scotland) 2000, the Mental Health (Care & Treatment) (Scotland) Act 2003, and more recently, the Adult Support and Protection (Scotland) Act 2007. Some felt that SDS policy appeared to have been developed in isolation from key legislation, such as that concerning adult protection and developments in commissioning:

“Current policy is confusing and the language involved in it is confused. The current policy is too narrow, but the trend is moving in the direction we want to see... Policy is not ‘joined

up', [it's] not holistic and is not based on a rights-based approach" (Representative of Specialist SDS/DP Organisation)

- 3.15 Another national stakeholder felt that the original SDS policy had been developed with insufficient input from service user and carer organisations and was therefore ultimately professional-led, not user-led:

*"The whole thing is being confused by different models being developed without the involvement of disabled people."
(Anonymous)*

SDS Practice in Scotland

- 3.16 There were difficulties in defining a distinct pre-test site baseline regarding SDS in Scotland because local authorities (including the 3 test sites local authorities) had all, to different degrees, embarked upon change programmes to transform and modernise social care services in line with national agendas. Legislation had introduced DPs from the mid-1990s onwards, and there was general acknowledgement of the need for person centred services and individualised support. Interviewees from national organisations cited positive stories of people benefiting from SDS (referring usually to DPs), and of social workers who were committed to ensuring choice and control and who worked to overcome any obstacles. Even so, more weaknesses than strengths with practice were identified across Scotland.
- 3.17 A number of themes emerged from interviews with national stakeholders' about their opinions and experiences of practice in Scotland. These are now summarised.

Inflexible DP systems

- 3.18 A significant weakness of existing arrangements was identified as current DP systems. Ironically, given the underlying philosophy of DPs, national stakeholders perceived existing DP arrangements as restricting choice, control and flexibility. In contrast, SDS was perceived as offering greater flexibility and opportunity for personally directing support for a wider range of client groups. Their aspiration was that the test sites would promote wider and more equitable application of SDS, and that this would be broader than DPs.

Pressures on frontline staff

- 3.19 Increased workloads, problems with accessing social care resources, combined with new expectations to work differently were also hampering the capacity of frontline staff to promote SDS. At times, there was a discrepancy between the aspirations of senior management and the realities of frontline work:

"What we've got is Directors of Social Work and senior managers who completely buy into it, who are really committed

to it...and you've got people who are working really hard, burnt out, struggling to get enough resources to deal with what they've got...not able to...really think about how you take this forward.”
(Representative of Provider Organisation)

Professionally driven agenda

- 3.20 There was a perception among some interest groups that SDS was a professionally driven agenda. Indeed, as Beresford (2009) comments, while the rhetoric of personalisation is about involving service users and increasing choice and control, service users and their organisations generally have had little say in its shaping or development. One user organisation cautioned that its members were concerned about SDS meaning they had to become employers:

“How do you get rid of staff you don't like that have maybe been with you 2 or 3 weeks, how do you get rid of that person? Seems a lot of responsibility... (Representative of User Organisation)

- 3.21 A manager working for a national provider of social care argued that there was, for instance, *“not a huge groundswell [for DPs] in the mental health movement”*, and that pressure to increase uptake of DPs was coming from professionals not the service user movement.

Poor awareness leading to misconceptions

- 3.22 Many national stakeholders referred to a general lack of awareness and knowledge about SDS among staff, service users and carers. Also, there was often confusion about the different 'models' of SDS, or what options were possible under SDS. Clear and accurate information about SDS and how to administer schemes were said to be sorely lacking in many parts of Scotland. This had unhelpfully led to several misconceptions about what payments could be used for and how it should be administered:

“...the negative perception is created within the local authorities in a sense about all the complexities around payments and how it's all about being an employer and how...it's a lot of hassle and there's a lot of bureaucracy and it's no' worth it, and what you get off it at the end of the day is like £10 that you can't do anything with anyway” (Representative of Provider Organisation)

Problems with commissioning practice

- 3.23 Those interviewed identified block purchasing of social care services as a significant barrier to implementing SDS in Scotland, especially in the larger urban areas with well-developed service infrastructures. Block purchasing from large providers was perceived to be hampering development of more individualised options:

“...effectively the voluntary sector’s been wiped out in this area. For mental health, learning disability, physical disability, hearing impairment – private companies (have been) brought in on really big block contracts for like 1,000 hours each. The individuals concerned have had absolutely no say in any of that.” (Representative of Provider Organisation)

- 3.24 Such contracts were commented upon by members of the voluntary sector (who may or may not have had a conflict of interest) as restricting the type and quality of support available to purchase under SDS. Related to the issue of block commissioning was a different perception that Scottish local government culture had been more ‘protectionist’ of staff and practices than their southern counterparts. New arrangements were not only more threatening, but also potentially more expensive than either block contracts or in-house services and required fundamental shifts in organisational structure and culture. Scotland was perceived by some, though not all, to be more heavily committed to local authority provision and block purchasing than other parts of the UK.

Inadequacy of support infrastructure

- 3.25 Setting up and running SDS were seen as matters which could potentially put pressure on both service users and their support networks. A common weakness with current implementation highlighted by several national stakeholders lay in the inadequacy of existing support infrastructure. In the whole of Scotland for instance, there are only 2 Centres for Independent or Inclusive Living (1 each in Glasgow and Edinburgh). Yet these Centres are usually viewed by disabled people’s organisations as central to the success of Independent living initiatives (Barnes and Mercer, 2006). It was generally thought that there was insufficient independent support for those who might want to take up a DP, despite the presence of the Scottish Personal Assistant Employers Network (SPAEN).
- 3.26 The presence (and capacity of) such support organisations across Scotland was described as *“patchy”* by one representative of a specialist SDS/DP organisation. Some areas had small, and often “fragile”, independent support agencies. Smaller user-led organisations were seen as disadvantaged in the current commissioning and financial environment and suffered from a lack of central funding. There was also a perception that the few Independent Living Centres that did exist had limited capacity or expertise to support a diverse client group with more complex needs, including those with mental health problems or learning disabilities.

Problems with care management

- 3.27 One view expressed was that the system of care management introduced under Community Care legislation was now outmoded and unfit for purpose. Significantly, this was identified as constraining social workers’ ability to take the SDS agenda forward:

“Our current system has failed... what the care management system has done is made people task orientated, it's made providers volume dependent and risk averse and it's stopped us actually working alongside people to find out what it is that they would hope to achieve in their life and then think about how we can use the state's resources to help that person keep their life together and improve it...” (Representative of Provider Organisation)

Legal interpretations of capacity

3.28 Past flexibility in SDS guidance had resulted in local authorities using different legal interpretations of a person's capacity to consent to having a DP. One representative of a local government body observed that some local authorities were more willing to work with the notion of 'implied consent', while others were known to adopt far stricter criteria for consent, thus narrowing eligibility. This situation had reportedly contributed to differences in uptake of DPs and practice across Scotland. It was suggested by an interviewee from a local government body that where implied consent was not acceptable, the service users' carer or family members would have to apply for financial guardianship in order to receive (or continue to receive) a DP. This was said to be particularly off-putting for families of service users who had just turned 18 years old – an age at which consent becomes a legal requirement.

SDS in the Test Site Local Authorities

- 3.29 Local stakeholders from the test site areas were asked what they thought about the strengths and weaknesses of the test site local authorities' implementation of SDS before the test site. In short, few positive aspects about local implementation were identified by those interviewed from any of the 3 areas, and many comments were in relation to how DPs had operated locally rather than about SDS.
- 3.30 On the positive side, stakeholders in Dumfries & Galloway suggested that the authority had good procedures for quality assurance, and Glasgow based stakeholders had evidence of DP recipients in the area who had experienced positive benefits from directing their own support. The strengths of SDS tended to be expressed as potential rather than actual or demonstrable strengths. SDS had the *potential* for increasing choice and flexibility, as well as increasing user control over support arrangements. Some alluded to its potential to deliver positive outcomes for those with more complex needs, and others to the possibilities of combining funding streams with the NHS.
- 3.31 The catalogue of negative issues with SDS (usually DPs) pre-test site included:
- A lack of a strategic, holistic approach to implementation by local authorities;

- Poor, or even no, information about DPs and therefore low awareness among service users, carers, and staff in local authorities resulting in low numbers of DP recipients;
- Negative organisational cultures, lack of commitment or active promotion of DPs and SDS by frontline staff. Furthermore, some people had reportedly been dissuaded from considering DPs as social workers often emphasised negative aspects;
- Bureaucratic and burdensome administration of DPs that was off-putting for both service users and carers, and for social workers/care managers arranging their support. This included heavy handed monitoring systems that did not always appear proportionate to levels of cash payment awarded;
- DPs had not delivered the cultural change expected, and could potentially impact negatively on the sustainability of in-house services;
- Rather than delivering innovation, DPs had resulted in restricted models of support being set up and limited funding options;
- Limited reach of DP. The majority of DP recipients, except in Highland, tended to be people with physical disabilities with far fewer people with learning disabilities, mental health problems or older people accessing them. In Highland almost similar numbers of people with learning disabilities as people with physical disabilities were reported to be in receipt of DPs;
- Related to the above there was a sense of inequity and lack of transparency in DP support packages;
- Many service users and carers were not keen on the prospect of becoming an employer, and this seemed to be the only option open under DPs if they wanted to direct their own care;
- There were very real practical difficulties with implementing DPs in rural areas such as the small pool of potential Personal Assistants from which to recruit and concerns about privacy.

Interface with Adult Protection

- 3.32 Lead officers with responsibility for adult protection (AP) in the 3 local authorities interviewed at Stage 1 showed limited knowledge of the SDS test site and none had been actively involved in test site action plans. At the first stage interviews there had been no formal exchange between the lead persons in adult protection and the SDS test sites, though one interviewee commented they were both accountable to the same line manager, which was potentially a bridging mechanism. The raising of this question by the evaluators prompted interviewees to note that SDS was *implicit* rather than explicit in their AP procedures and training, and vice versa.
- 3.33 The national organisations consulted commented on the importance of cross-referencing these 2 policies but also acknowledged the delay in doing so, suggesting that SDS and adult protection policies were on “*parallel tracks*”, and further, that there is an inevitable tension between increasing choice and control and concerns for the safety of, and risks to, vulnerable people.

- 3.34 Joint training between SDS and AP teams was identified as a way of bridging the gap but plans to do so in any of the 3 areas were still *aspirational*. Various ambitions for training initiatives were described by the 3 AP leads; one intention was to plan a 4 day module covering all the legislation around SDS and AP; the development of a 3 day module on investigative training across the board of public protection and SDS; and an input on assessment of risk and on how SDS sits alongside protection plans.

Summary - Key Issues at Baseline

- The existing DP system was seen as failing to deliver greater choice, control and flexibility as it was seen as overly prescriptive, bureaucratic, utilising 'old style' care management processes.
- Implementation of DPs was seen as highly inconsistent, with some local authorities adopting more enthusiastic policy and practice than others. SDS was seen as having the potential to address some of these problems in the current DP system by adopting a broader and more flexible definition.
- Yet, despite SDS being defined as a spectrum of options that *includes* DPs, there was a prevailing view that what the test sites were doing was entirely different from established DPs. At this point, the lack of resources in the form of bridging monies was felt to be one of the main obstacles to more active promotion of SDS across Scotland.
- Inadequate or non-existent support infrastructures for service users and carers were seen as a further obstacle.
- Particularly at local level, SDS policy had not enlisted sufficient input from service user and carer organisations and was in danger of seeming to be a professional-led concept.
- There were concerns that SDS was being promoted as a cost-cutting exercise in the face of diminishing resources as opposed to a positive policy to promote independent living.
- Up until this point, leadership to promote SDS via DPs across Scotland was seen as varying greatly and local authorities were not considered to have taken a particularly strategic or holistic approach to developing SDS, despite some notable exceptions.
- A lack of consensus around what constituted good or effective leadership meant that the 3 test sites started their work without a clear steer or template on how to effectively lead the development of SDS, which was thus completely open to local interpretation and style.

4 STAGE 2: EVALUATING PROCESS AND IMPACT

Introduction

- 4.1 In this chapter, a range of data from Stage 2 of the evaluation has been used to assess the test site local authorities' progress towards increasing SDS against their action plans. Wherever possible, we explicitly reference the impact of any changes the sites made in relation to the 3 main themes (bridging finance; reducing red tape; and leadership training). The chapter begins by examining definitions of SDS in practice, and brings together data about the people who received SDS packages during the test site period. Test site activities are examined under the 3 themes, drawing upon a range of information sources.

Defining SDS

- 4.2 According to the test sites' espoused definitions of SDS, a range of options were possible under the umbrella of 'SDS' - from DPs to individually tailored local authority services. In practice, the majority of what was counted as SDS packages (see table 4.3) involved a cash transfer or DP. An underlying confusion about what should 'count' as SDS may have meant, however, that practice other than that involving a cash transfer was not fully captured. For instance, despite the evaluation team's efforts to design data collection around a broad definition of SDS, it is possible that more subtle changes to individuals' use of local authority and other managed services *did* occur but were not recorded consistently by the test sites.
- 4.3 In Dumfries & Galloway, SDS remained broadly interpreted, and was not used as a synonym for DPs. A variety of terms emerged, with 'personalisation' and 'SDS' used interchangeably. Few of those interviewed saw the test site as merely focusing on DP targets. Instead, there was a widely shared view about the potential of SDS to improve outcomes for people using services, as this parent carer stated:

“At the first meeting we went to...it was like instead of the Social Work running the budget now it was giving (my child) more right to do what they wanted and to .. the money that they got was to help them do things that they wanted to do in life and help ... it was more giving them a better outlook on life...”

- 4.4 The new Personalisation Panel in Dumfries & Galloway to approve SDS plans was felt to be well received locally. Its practice was perceived as promoting the view that SDS was about achieving better outcomes for service users and carers, and was not just about financial transactions (or who receives and controls the budget).
- 4.5 Although different definitions were in use at the start of the Glasgow test site, a consensus view soon emerged across the local authority and partner service providers that SDS is broader than DPs. SDS was taken to cover a

range of approaches to delivering outcomes based support, with individual budgets (IB) being allocated either via a direct payment (DP), an indirect or third party payment, or an individualised service fund (ISF).

- 4.6 In contrast, Highland tended to emphasise the promotion of personalisation/SDS for the most part through the increased uptake and use of DPs, that is, SDS always involved a cash transfer. It was only in the final stages that a broader interpretation of SDS and a range of mechanisms were embraced, including ISFs.
- 4.7 With this situation in mind, the evaluation explored *how* SDS was implemented by the test sites rather than assess their success in relation to limited and predetermined criteria (i.e. whether there has been an increase in uptake of DPs). Because of the evolving nature of definitions and understandings of SDS across the 3 sites, this part of the evaluation is primarily descriptive: in other words, we describe what happened during the test site period on the basis of what was recorded.

Detail of SDS Packages

- 4.8 From April 2010 to end March 2011 information was sought on a quarterly basis from the 3 local authorities about the characteristics of the service users engaged by the SDS test site. Information included whether clients were allocated an IB, type of SDS options chosen, and the funding mix of SDS packages. Information up to 31 March 2011 was received from all 3 test sites.
- 4.9 It is important to note that we are only able to report on information provided in these returns. Our assessment is therefore dependent upon both the quality and accuracy of the information provided, which in turn may have been affected by different interpretations of SDS in each site.

Number of SDS packages

- 4.10 Each local authority verbally reported that around 100 people at each test site had been assessed and received some kind of SDS package over the course of the 2 years. These were people who had experienced new processes and systems of assessment, resource allocation and support arrangements. However, the test sites reported on fewer than half this number of individuals in the cohort forms.
- 4.11 Dumfries & Galloway provided information regarding SDS packages with 35 people. In an email communication it reported that another 51 people were "*within the personalisation process*". However, on account of not being allocated an individual budget, the local authority did not include them in the cohort returns. Additionally, 13 people were said to have withdrawn from the test site process, or had not completed the process because of a change in personal circumstances. Therefore, while the test site appeared to have engaged with nearly 100 people over the course of the 2 years, the analysis that follows only includes those 35 people recorded as receiving an SDS package.

- 4.12 Glasgow provided data on 57 people who had an SDS support package, and stated that slightly more people were at earlier stages in the approvals process and had not been included in the detailed statistics. An additional 50 individuals were reported to have had an estimated SDS budget awarded and were awaiting contracts. No further information was given to the evaluation team about these packages. Hence, although Glasgow reported engaging with around 100 people during the 2 years, the analysis that follows is of the 57 individuals recorded in the cohort form as receiving an SDS package.
- 4.13 Highland provided information on 40 individuals who had engaged with new SDS processes, and were receiving an SDS package. Other information from this site suggested an additional 101 people had at some stage either sought information about SDS, or had been advised to consider SDS. These were mostly young adults in transition (the main target group) who, for various reasons, had not opted into the test site process. Nearly half were enquiries in relation to disabled school leavers, the core group targeted by the test site, but there is no further information to tell us why these individuals decided not to be part of the test site SDS process. Seven of those who did not pursue the SDS process are known to have accessed a DP through the traditional route in the local authority. The analysis that follows includes only the 40 individuals for whom we have information from the cohort form.

Service user type

- 4.14 Taken overall, people with learning disabilities were the main client group to utilise SDS across all sites, which is not surprising given the test sites' target groups. Both Glasgow and Highland, for instance, started with a focus on adults and/or young people with learning disabilities, resulting in 75% of Glasgow's total and 62% of Highland's total being people with learning disabilities. This compares with Dumfries & Galloway where just 46% of the cohort came from this client group.
- 4.15 Having started with people with learning disabilities as its primary focus in the East of the City, the Glasgow test site had begun by December 2010 to widen the range of needs addressed. In Highland, 2 main groups were targeted by the SDS test site: young people in transition to adult services and situations where people's discharge from hospital could be facilitated and accelerated through SDS. However, only 3 older people had an SDS package, while a quarter of the total was people with physical disabilities.
- 4.16 In contrast, Dumfries & Galloway seemed to adopt more open criteria for inclusion and subsequently the spread of people across different client groups was greater (possibly because of its geographical focus). Having said that, the largest group receiving SDS in Dumfries & Galloway were people with learning disabilities. It is likely that the work of the Association for Real Change (ARC) with self advocates in Wigtonshire in promoting personalisation and SDS with people with learning disabilities, may partly account for this.

4.17 Client groups who were less likely to feature in test site activities were people with mental health problems, parents of disabled children, and people defined as having ‘multiple and complex needs’. However, the individual case studies in each site, discussed in the next chapter, suggest that there were more people with more complex needs engaging with SDS than were actually recorded in the cohort forms. Again, there may have been under-recording of complex or multiple needs as a result of categorising people according to local authorities’ existing systems, which are often based upon a notion of primary or main presenting need.

Table 4.1: Comparison of service user type in each test site

Client Group	Local Authority				
	Dumfries & Galloway	Glasgow	Highland	Total	
				Number	Percent
Learning disabilities	16	43	26	84	64%
Physical disabilities	13	7	10	30	23%
Older people	2	5	3	10	7%
Parent (disabled child)	2	-	-	2	1%
Mental health problems	2	1	1	4	3%
Complex needs	-	-	1	1	1%
Not known	-	1	-	1	1%
Total	35	57	40	132	100

4.18 Drawing on the wider *potential* cohort it appears that the majority of people who did not finally engage with SDS in Dumfries & Galloway were people with learning disabilities (9 out of 13 people). In Glasgow those who were at an early stage of the process, but had not received an individual budget allocation, included a mix of people with learning disabilities (20); physical disabilities (10); children with disabilities (9); older adults (6); parents with disabled child (4); and mental health problems (2). In Highland, 44 of the 101 people who were offered the chance to take up SDS and did not, were disabled school leavers - the core group of young adults in transition targeted by this test site.

Gender of service users

4.19 Across the 3 test sites, almost the same numbers of women and men accessed SDS (see table 4.2 below). However, the proportions differed between test sites: while there were nearly twice as many men as women who accessed SDS through Dumfries & Galloway test site, the ratio was reversed in Glasgow. See table 4.2 below.

Table 4.2: Gender of people accessing SDS packages in the test sites

Sex	Dumfries & Galloway	Glasgow*	Highland	Total	
				Number	Percent
Female	12	34	16	62	48%
Male	23	18	24	65	52%

*The gender of 5 people in Glasgow test site was not recorded

- 4.20 Given that national statistics show the breakdown of DP recipients as 45% male: 55% female overall (Scottish Government, 2010), it might reasonably have been expected that more women than men would access SDS but this was not the case. Involvement of women in SDS packages however was clearly greater than these figures would imply: many were managed in partnership with family members and carers, the majority of whom were women.

Age of service users

- 4.21 The age profile of those accessing SDS through the test sites varied considerably between sites. In Dumfries & Galloway, where a broader range of needs were addressed, the age range was greater. Nearly half (47%) were aged between 26 and 60 years. Another 32% were under 25 years, and the youngest person was recorded as 8 years old (presumably the team were working with the parent of a disabled child). The oldest person receiving SDS was 96 years old.
- 4.22 This contrasts with Glasgow where 42% of SDS service users were aged 16-25 years, 35% were 26-54 years, and 23% were aged 55 or over. The oldest client in the Glasgow cohort was 71 years and the youngest, 17 years. The proportion of younger people receiving SDS was most pronounced in Highland, with 73% being under 25 years, and most of these were 18 years or under. This clearly reflects the primary cohort of young disabled people in transition targeted by this test site.

Ethnicity of service users

- 4.23 All those who accessed SDS through the Dumfries & Galloway and Highland test sites were recorded as being either white British or white Scottish. Unfortunately Glasgow did not record ethnicity where it might have been expected to capture a more diverse range of ethnicities. However, as none of the 10 case studies in Glasgow (reported in the next chapter) included any clients from black or minority ethnic (BME) backgrounds it is possible that no-one from a BME community accessed SDS through the test site.

Range of options in SDS packages

- 4.24 The range of SDS options included both DPs and Individual Service Funds (ISFs), as well as individually tailored local authority services, which is in keeping with the broad definition of SDS favoured by the test site local authorities. While ISFs were arranged with providers external to the local authority in 2 local authorities during the test site period, it was only in Dumfries & Galloway that an ISF with a local authority service was arranged or an individually tailored local authority service. Only a small number however appeared to have an SDS package that involved a mix of different options. The following table (4.3) summarises the SDS options across the test site cohorts.

Table 4.3: Type of SDS options in each test site

Local Authority	Type of SDS Option						
	DP Self	DP 3rd Party	ISF LA	ISF Provider	Tailored LA	Mixed Package	Missing
Dumfries & Galloway	24	1	2	10	1	3	1
Glasgow	39	3	-	14	-	-	1
Highland	8	32	-	0	-	-	-
Totals	71	36	2	24	1	3	2

4.25 DPs were clearly the most common SDS option across all 3 test sites with 107 DPs set up during the test sites: that is, 71 DPs managed directly by the individual and 36 payments managed by a 3rd party, usually family members. Highland stands out as having a greater proportion of DPs managed in this way. Further, the majority of its 40 DPs were one-off payments (25 out of 40 DPs). Whether or not this happened in the other 2 sites was unknown, as such information was not supplied to the evaluation team. Highland targeted its DPs involving regular or on-going payments at young disabled people, in particular those less than 21 years.

4.26 The second most common SDS option was ISFs arranged with external providers such as Enable (24 ISFs across 2 test sites). It was notable in both Glasgow and Highland that the numbers of ISFs increased towards the end of the test site period. In Highland, ISFs were in the process of being arranged for 4 existing service users of Leonard Cheshire Disability Services.

4.27 Few SDS packages involved more than one option other than in Dumfries & Galloway where 2 people had a DP and either one or 2 ISFs, and another had a DP and individual tailored local authority services.

Funding mix of SDS packages

Table 4.4: Funding mix of SDS packages in each test site

Local Authority	Type of Funding Stream					
	SW	Housing	ILF	Health	Client contribution	Other
Dumfries & Galloway	34	-	2	-	19	1 charitable body
Glasgow	57	-	1	-	35	
Highland	40	2	2	-	9	1

4.28 Social Work and client contributions (means tested payments) funded the majority of SDS packages across all the sites. There were some differences in the funding mix of SDS packages between sites: Glasgow had higher

numbers of people making client contributions despite the test site covering an area of severe deprivation, while Highland had fewest client contributions to packages of support. This may largely be accounted for by the young age group of this cohort. It is also perhaps indicative of a proactive income maximisation policy operating in the Glasgow local authority. It might also be speculated that some of those accessing support via SDS were doing so outwith the local authority's normal eligibility criteria in this early period.

- 4.29 As might be expected, given the restrictions on the national Independent Living Fund (ILF), this did not feature prominently, and was in fact only part of 5 people's packages across all 3 sites. Only in Highland did the Housing funding stream feature (presumably Supporting People Funding) and then only for 2 people. For one of these young people, the SDS package was funded solely from Housing monies. Health (NHS) funding was not recorded in any SDS packages and only 2 cases had involved accessing 'other' funding from charitable trusts.
- 4.30 Quarterly monitoring forms designed around each test site's action plan gave information about the activities implemented under the 3 themes. This information is now analysed below to provide an assessment of test site implementation. Again, it is important to note that we are only able to report on the information provided, which varied considerably in detail. Our assessment is therefore dependent upon the quality and detail of information provided by each test site. Interviews and learning sets with a range of key local stakeholders at Stage 2 provided confirmatory qualitative data about implementation and, to some extent, impact.

Leadership and Training

- 4.31 The test sites adopted slightly different approaches to how they addressed the **leadership** theme, although there were many similarities. Different strategies were used, and infrastructures created, to provide leadership within and across stakeholder organisations. Commitment to a joint approach with providers was evident, particularly in Glasgow where active links were made with the Glasgow Social Care Providers Forum (GSCPF). In other areas, partnerships with providers had grown more slowly.
- 4.32 Overall the work of the test sites could be seen as developing different relationships between those who require support and those who commission and those who provide it – the evidence for this is presented in Chapter 5. However, in terms of the collective engagement of service user organisations in developing policy and planning, test site activity was less evident, although in Glasgow there was investment in Glasgow Centre for Inclusive Living (GCIL), an independent user-led support organisation. This is not to deny what was achieved in developing individualised SDS packages, or the value of test sites enrolling individual service users and carers, as 'champions' to spread the word about SDS, or the importance of setting up local service user and carer networks to provide an opportunity for people with SDS packages to meet and share experiences. Such initiatives were clearly invaluable.

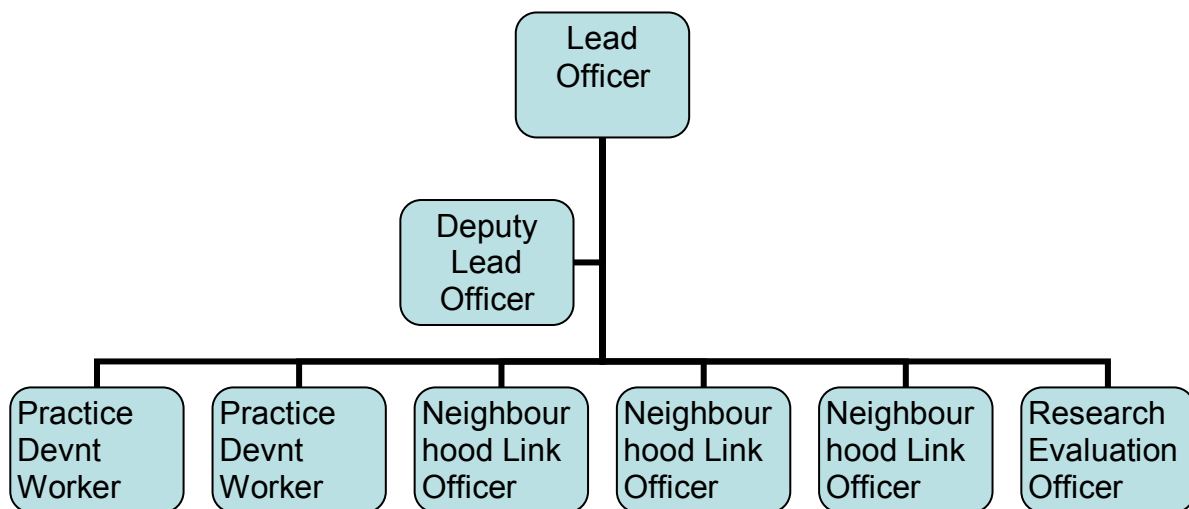
- 4.33 The test sites had translated the need for effective leadership into specific lead or management roles funded by the Scottish Government grant. Additionally, test site project managers or leads were variously linked into, and reported to, service change or modernisation infrastructures set up by the local authorities. Such programme boards and/or committees had not been set up as part of the test sites but were created to manage broader service development.
- 4.34 All test sites had sought to further promote SDS through 'growing' local champions who would spread the vision: both those receiving SDS packages (particularly in Glasgow) and the staff working with them (particularly in Highland) were considered to be potential champions. In reality, this was slow to develop as originally envisaged but was a key feature of the Dumfries and Galloway site. The test sites suggested that activity in this area demonstrated the power of individual stories in conveying the benefits of SDS, although we have no way of measuring this impact.
- 4.35 The most notable way that all the test sites attempted to grow expertise and provide leadership was through the development of SDS teams. Therefore, we describe this in a specific sub-section below.

Specialist SDS Teams

- 4.36 The test sites created specialist SDS teams to take developments forward and work with other staff. However, these teams were formed at different points, and comprised different roles. Glasgow was different initially in that it did not immediately set up an SDS team, but instead expected the SDS Manager to involve and develop the practice of area team social workers in one part of the City, and also to provide training on SDS to social workers in other area teams.
- 4.37 All the sites invested in a lead officer post to project manage the test site. They were variously termed the Project Lead or SDS Manager. Whilst these posts were appointed at various stages during the test site period, they all ended up heading up the SDS team. Only in Glasgow was this post in place from the start (January 2009). This was because the post was filled by 2 existing staff working as job sharers seconded from their post of Principal Officer (Learning Disabilities) who had previously led the Glasgow IB pilot. Project managers in the other 2 test sites had to be recruited and neither was in post until late 2009.
- 4.38 The 3 test sites experienced some problems appointing to temporary contracts and also with finding suitably qualified and knowledgeable people to take on the designated roles. For example, Highland Council's recruitment processes required approval from 4 bodies – Project Board, Vacancy Monitoring Committee, Resource Committee, and the Job Evaluation Committee - before any position could be advertised, and this inevitably caused delays in appointing to the SDS Team. All except the Project Manager post had to be re-filled at least once, and several posts were filled by agency or temporary staff.

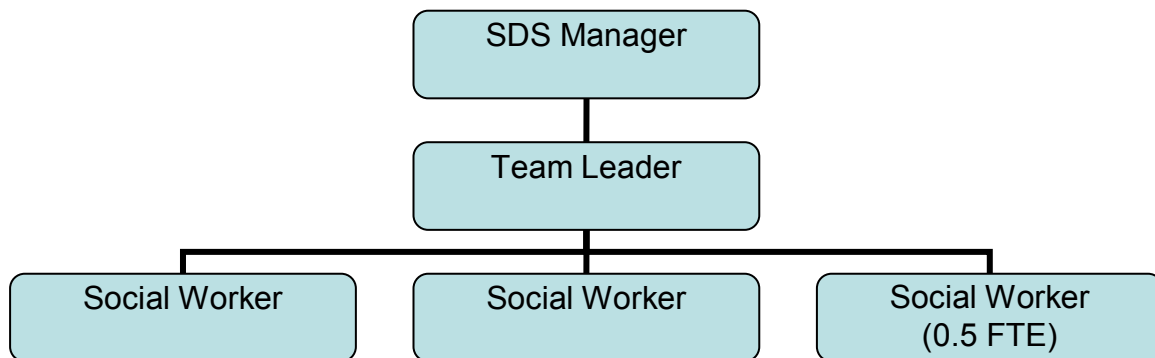
- 4.39 Project or Programme Boards that involved senior personnel from the local authority and other organisations were also set up as part of the test site. The efficacy of these in terms of promoting the wider development of SDS came in for some criticism. While the Project Board in Glasgow was generally seen as helpful in engaging key stakeholders in directing and supporting SDS managers and team, several stakeholders from Highland commented on a lack of shared vision among its members.
- 4.40 The following diagrams depict the composition of the SDS team set up in each site.

Figure 4.1: Dumfries & Galloway Personalisation Team



- 4.41 The full team complement in Dumfries & Galloway was not achieved until near the end of 2010, which obviously had an impact on what the team could collectively achieve within the timeframe of the test site. A barrier to recruiting to several posts within the team was identified by local interviewees as resulting from the short term nature of test site funding. Fundamentally, the local authority adopted a 3-pronged approach to leading SDS in that it set up a Personalisation Team (as above), a Personalisation Programme Board and a Personalisation Panel (senior social work managers who considered and approved personal plans). The team reported to the Head of Social Work as well as the Board.

Figure 4.2: Glasgow SDS team

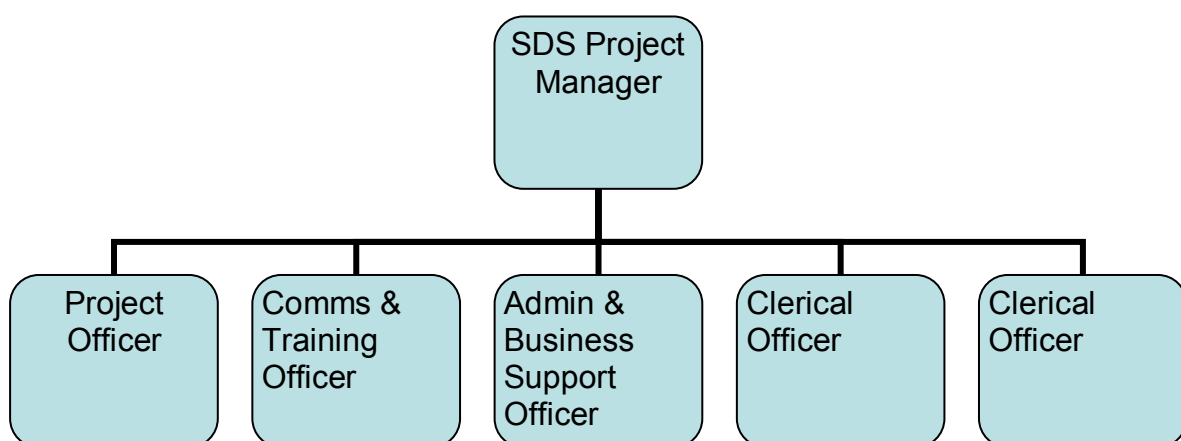


4.42 A dedicated SDS Team was established later in Glasgow (August 2010) when the local authority decided that to progress its agenda, there needed to be further dedicated SDS posts created. Its remit was to develop systems and engage and support care managers and other staff within East Glasgow as well as other areas as required. The team worked closely with finance section, and forged a close partnership with GSCPF and its work to promote SDS among providers.

4.43 Glasgow’s stated plan post test site was to appoint 3 dedicated social work staff in each of 3 new geographical areas to link with the centralised SDS team, with the aim of helping roll out SDS practice.

4.44 Despite originally planning to bring DP and SDS staff together in one central team in Highland, in practice, the SDS and DP teams were separate. There were plans for a unified team post test site. Again as elsewhere, the Highland SDS team did not start until late 2009 with the appointment of the SDS Project Manager in September, and consisted of the following staff.

Figure 4.3: Highland SDS Team



4.45 The test sites’ approach of setting up dedicated teams appeared to work well in relation to the specific service users they supported through new systems. However, at the stakeholder evaluation event held in early 2011, participants from all areas felt that the intention to bring about major cultural shift in

provision towards more personalised services had not happened despite the efforts of dedicated SDS teams.

- 4.46 The setting up of dedicated teams may have inadvertently resulted in limited engagement and change in the local authorities as a whole. An interview with a senior manager in another local authority (not one of the test sites) provided an opportunity to compare this with an exemplar of an alternative strategy to a project-based way of transforming social work services. The local authority in question had chosen to invest in “*a whole rich spectrum of support arrangements*” some of which could be described as SDS or DPs, while others were individual or personalised services. The authority had invested in supported employment, peer support and approaches that were best described as “community capacity building” but would not necessarily fit the model of SDS involving an IB. This approach was not in evidence in any of the test sites.

Training activities

- 4.47 Test sites activities recorded as **training** included 6 key strands of related activity as follows:
- **Information sharing events about SDS** – ‘numerous’ road shows and information events were organised around Dumfries & Galloway including at an agricultural show (number attending not recorded); 11 one-day sessions to 50 staff working for providers and 80 social work staff in Glasgow; transition road shows in Highland (100 staff and families), and 5 awareness raising events in March run by GCIL involving 170 people (service users, carers, social workers and providers) in Highland;
 - **Briefings on the procedures and processes of SDS** – briefing sessions with elected members in Dumfries & Galloway; 4 SDS briefing and awareness workshops for 70 social work staff in Glasgow; in Highland 57 social workers working with young people attended small group briefing sessions about SDS and its processes, and 34 social workers case managing young people in transition from children’s to adults’ services were briefed on the ‘nuts and bolts’ of new SDS systems;
 - **Training programmes in specific skills** – 25 participants in total in Dumfries & Galloway trained (across 8 sessions) in the *In Control* approach and person centred planning; in Glasgow 2-day training on outcomes-based support planning to 10 care managers; and in Highland 29 service users, social work staff and providers were trained in the *In Control* approach over 3 sessions;
 - **Mentoring and consultancy** – SDS team in Glasgow received mentoring and support from OLM Professional Services (consultancy, support and delivery focused on improving care sector) and *In Control*, and became mentors for social work staff;
 - **Online training modules** – Glasgow developed 3 online modules based on the *In Control* 7 steps which can be accessed by staff across the local authority;
 - **Participation in national training days** – Dumfries & Galloway funded 17 service users and staff to attend an *In Control* conference in Liverpool;

- **Strategic events** – the SDS team in Glasgow provided inputs at management meetings and development days held by provider organisations; in Highland, 31 senior social work managers attended a whole day event organised by the SDS team.
- 4.48 In addition to organising its own activities, Glasgow worked in partnership with GSCPF to deliver and participate in SDS workshops for providers. The importance of this strategy can be seen in contrast to the experience of Dumfries & Galloway where, at the end of the test site, it was remarked that several providers were neither engaged in, nor knowledgeable about, SDS.
- 4.49 From the information provided, relatively small numbers of existing staff were recorded as having participated in any in-depth formal training programmes through the test sites. Experiential learning or learning by doing, alongside support from staff in the SDS teams, was the main way that most care managers learnt about SDS, rather than through formal or informal training events. Obviously some staff would have received training and had opportunities to learn by doing.
- 4.50 However, whilst beneficial for some, this approach had its drawbacks. Knowledge of SDS and new processes was clearly uneven among care managers and others involved in assessment across the test sites. In Glasgow, this was particularly the case as the process widened out geographically and to more client groups. Some indicated that they had been “*fumbling through*”, and would have appreciated training early in the process. Key informants in Dumfries & Galloway commented that it would have been helpful to have had the formal training on the *In Control* approach *before* ‘going live’ with personalisation. Several care managers in Dumfries & Galloway felt that there had been insufficient information filtered down to front line social work staff to enable them to work confidently with the new system. One manager eloquently summed up the situation as:
- “Personalisation is like trying to put together a piece of flat pack furniture without any instructions. It’s a nightmare doing it but great when you have finished.”*
- 4.51 This may be another limitation of this ‘new project’ approach to implementation whereby expertise appeared to be primarily developed within specialist SDS teams. For example, although a large-scale training programme was originally planned in Highland, this soon became more tightly focused on staff involved with the test site’s target population for SDS. At the end of the test site, one Highland manager commented on the remaining challenge to move SDS from a centrally managed project to mainstream activity. Information sharing events in the other 2 sites had been more widespread.
- 4.52 The training activities that were provided across all the sites did not appear to reach large numbers and generated various levels of awareness and skill regarding SDS. According to the information from the sites, at times staff, service users and carers had sometimes been offered information or training

together, and it was unclear how well their different information and training needs were catered for through such activities.

- 4.53 In Highland, briefing and training events combined with a supportive SDS team, had meant that care managers on the whole felt able to complete processes adequately, though not without some glitches. Not surprisingly, in the early stages of the test site, views about training were less favourable than later:

“...was quite rushed, a lot of new info. Documents were in draft which created some concerns to the clients...” (Care manager, Highland)

Information about SDS for users and carers

- 4.54 By the end of the test sites, the needs of service users and carers for information about and support with SDS were beginning to be addressed through information sharing events; the development of specific website pages and promotional materials; and through specific support about becoming an employer. Highland, for example, had commissioned the national user-led Scottish Personal Assistants Employment Network (SPAEN) to deliver training on employment law to 49 social work staff, and was funding future sessions with service users on becoming an employer.
- 4.55 Glasgow published detailed guidance on SDS on its website outlining what service users might expect from the SDS process and how the money could be spent, and produced a user-friendly information leaflet. Similarly, Highland developed an SDS website that went live in February 2011, featuring illustrative examples of experiences and the benefits of SDS. The Highland SDS team was also in the process of further developing a subset of the High Societies online database of providers, and had produced new local SDS guidance and promotional materials including posters. In Dumfries and Galloway and Glasgow DVDs had been produced.

Training on adult protection

- 4.56 Matters of capacity to make decisions were said to be clear in the context of DPs and the Adults with Incapacity (2000) Act. However, the main issue identified by AP leads was that SDS workers needed to understand that SDS interventions would be subject to AP investigations as are other aspects of adult care. Therefore, adult protection was frequently viewed by the AP leads as a specific training need in relation to implementing SDS. In this respect, in all the sites, joint training initiatives were all very much in their infancy. Amongst the themes emerging from the interviews with AP leads was the lack of integration of procedures:

“SDS is still standing as a separate issue- we’re still talking about outcomes and needs separately...we mustn’t have parallel processes- but a single approach, to DP/SDS AP. We need to know there’s a fit.”

- 4.57 Such integration was to be achieved by what was referred to as holistic training so that personalisation/SDS workers would have the confidence to take this on. A priority in the training agenda was identified as the need to make the link between relevant guidelines, policy and procedures. It is not clear how far this was addressed in the training provided in the test sites.

Cutting Red Tape

- 4.58 Developing and implementing new systems to support SDS as well as attempting to reduce red tape were, to some extent, contradictory pursuits. All test sites did not so much set about analysing how bureaucracy or red tape could be reduced, as invest their teams' effort and time into designing or re-designing new systems. For example, drafting associated paperwork or computer systems related to the processes of assessment, resource allocation and monitoring were the necessary building blocks of SDS. New systems were, therefore, developed in addition to those that already existed under care management and DPs. As the following personalisation board member from Dumfries & Galloway observed:

“To be honest I have never heard of it [the priority to cut red tape]...I’ve got no reason to doubt what you’re saying...it may have been there but by the time I had caught up in the thinking, this was much more about us promoting a model of working about how we actually engage with people to provide and create better outcomes...”

- 4.59 In some areas of work this approach appeared to result in an apparent increase in red tape and bureaucracy rather than a decrease, at least in the short term, as there were dual new systems to navigate. Except, that is, in Dumfries & Galloway where initially there was no paperwork or written procedures and guidance beyond the *In Control* self-assessment and normal documentation. However, this was felt to be more disconcerting rather than liberating by some staff, especially administrative staff who reported problems with knowing what to record and file. In addition, the local authority's IT system had not been adapted to accommodate personalisation.
- 4.60 That the test sites had increased rather than decreased paperwork was the consensus of opinion at the evaluation stakeholder event in 2011. Some did not feel this was necessarily a negative development – that it might be a necessary stage in getting new systems in place. However, too much paperwork was still being raised as a challenge to staff at the end of the test site period. Staff in the SDS teams and others indicated that they had struggled with managing the drive for 'light touch' monitoring with accountability demands on the local authority, and the fact that some 'red tape' is perceived necessary as a protection against financial abuse.
- 4.61 Staff in all 3 sites still bemoaned the amount of paperwork involved with assessment and the problems with managing this within busy caseloads. One service user in Dumfries & Galloway described how *“a lot of people*

wanted to know about my problems”, suggesting that people were being asked to tell their story more than once and may experience this as excessive bureaucracy.

- 4.62 Some family carers felt that the only people able to give precise and accurate advice were those working on DPs. This may be because the DP systems were better established. While others (as we shall see in the following chapter), felt that SDS was a much easier process than DPs, though this may be related to the high level of support:

“X from Direct Payments has been the backbone to us. It’s that person that actually got it up and running now the personal assistant is part of it. It wasn’t [member of the personalisation team] it was [DP worker] that really got everything up. I’d praise her to the highest because she knows her job.” (Carer, Dumfries & Galloway)

- 4.63 Addressing this theme was generally perceived to have been the least successful of the test sites. This was partly because - as the following quotation illustrates - local authorities continued to run (unnecessarily in some people’s view) parallel systems for assessment throughout the test site, as well as parallel systems for SDS and DPs, thus potentially duplicating the amount of paperwork required to access support:

“...nobody’s confident about giving up on the old systems...it feels a wee bit like we’ve increased bureaucracy...because not everybody is involved in SDS at the moment you need 2 sets of systems running...” (Professional, Glasgow test site)

- 4.64 The following sub-sections will look at specific procedures which are necessary for enabling SDS but can be considered overly bureaucratic and time-consuming.

SDS Assessment

- 4.65 All test sites adapted some form of ‘self-assessment’ that had originated from *In Control*. Two test sites set up new decision-making panels to decide the allocation of resources and approve packages, while Highland referred SDS cases to its existing Resource Allocation Panel that dealt with DPs. All incorporated outcomes monitoring, even though review processes sometimes remained unchanged as in Highland. The latter process – monitoring and review - is largely outwith the timeframe of this evaluation given that most SDS packages had been in place for only a short time by the end of the test sites.
- 4.66 All test sites were running SDS and single shared assessment (SSA) processes in parallel: SDS teams had put into place new person-centred, outcomes-focused assessments but these were in addition to, rather than instead of, the SSA. In the case of assessment for one-off payments only, an

SDS assessment was undertaken in Highland. Reflecting on Highland's SDS assessment, one care manager commented:

“The self-assessment tool was ideal if the time was available and you would aspire to use this method...But because clients were in transition, this complicated and extended the process...due to current work pressures the paperwork was excessive.” (Care manager, Highland)

- 4.67 Towards the end of Highland's test site, a root and branch review of existing paperwork and processes was undertaken by a member of the SDS team with expertise in systems analysis, which resulted in the production of enhanced materials and guidance. However, this was implemented too late for the purposes of this evaluation to be able to assess any impact.

Resource allocation processes

- 4.68 Systems that were set up to discuss and approve SDS plans had delayed the starting of SDS packages according to some service users and carers in Glasgow and also in Dumfries & Galloway. There was some duplication in Highland of approval processes because SDS plans for on-going cases had often been considered both by the SDS team and separately by a resource allocation panel, adding what some felt to be an unnecessary stage in the process.
- 4.69 Resource allocation systems (RAS) (based on *In Control* models) were trialled in both Dumfries & Galloway and Glasgow. Highland had been asked by Scottish Government to consider an alternative such as adapting the Indicator of Relative Need (IORN) so that learning could be enhanced. In the event, Highland used its current system of allocation used for DPs known as an 'equivalency method'. In Glasgow's experience, the development of a suitable RAS was a highly complex process that involved the SDS team care managers, finance, commissioning staff and providers, and took them 2 years to complete.
- 4.70 Several criticisms were aimed at the equivalency model tested in Highland from those closely involved in its implementation. The system highlighted the local authority's poor information about service costs, and demonstrated a lack of sensitivity when applied in a rural setting. It was reported that in some cases this had resulted in higher individual budgets than would have been achieved through an alternative. For example, if in the past an individual had travelled long distances by taxi to a day centre, for example, the equivalency model for their SDS package would have awarded an inflated amount when alternatives might not require such extensive travel.

Monitoring systems

- 4.71 The difficulty of reducing red tape was not entirely the fault of local systems but arose from central government requirements for local authorities in terms of financial accountability, good governance and probity (CIPFA, 2009).

Ironically, CIPFA guidance on 'light touch' monitoring was viewed as overly bureaucratic by some of the financial officers interviewed.

- 4.72 Project managers and financial officers in all test sites concluded that implementation of CIPFA guidance on 'light touch' monitoring was not compatible with simplifying and integrating systems. For example, service users would still be required to have 2 separate bank accounts for ILF and DP transfers. Staff in Highland described the guidelines as "*useless*" and "*heavy handed*". However, having offered service users a 6-month reporting cycle (once trust was established), service users had requested a shorter 3-monthly cycle meaning that not all financial requirements are necessarily perceived as burdensome red tape.
- 4.73 Staff from Dumfries & Galloway had expressed similar views. One finance manager in Dumfries & Galloway reflected that they still had not worked out how to manage both the 'light touch' exhortation from Scottish Government and the CIPFA guidance, adding "*we're talking 'light touch' but then going on to micro manage the audit trail*". Further, the shift from "*detailing every penny and time sheets*", to less detailed requirements was described as "*quite a challenge to (the) mind-set*". This participant predicted that pressure for financial accountability would intensify as SDS rolled out with "*serious amounts of money*".
- 4.74 By way of making monitoring apparently less cumbersome for service users and carers, 2 test sites (Dumfries & Galloway and Glasgow) had considered use of an electronic purchase card, but not until the end of the test site. Glasgow Council decided to introduce a pre-loaded card system for future DPs as part of its post test site roll out. Interviews with staff involved with the development of the innovative Edinburgh Card in the Council's Funding Independence Team, suggested that such schemes have much potential in being able to considerably reduce the burden of paperwork for service users and carers. Major gains were also reported by staff from introducing the Edinburgh Card for individualised short breaks.

Bridging Finance

- 4.75 How the test sites had addressed the theme of bridging finance, indeed whether test site activities can meaningfully be assessed as fitting within the theme, was another challenge for the evaluation. Sites had not been asked by Scottish Government to implement specific models, and it was not always clear how the sites had interpreted this theme. On the whole, test site action plans were short on specifying particular actions under this theme, except Glasgow, and it was not clear what was actually implemented. Different stakeholders had conflicting views: some said that bridging finance had not been used while others were positive that this had been beneficial. Managers in Glasgow, for example, remarked on the benefits as being "*invaluable*" and claimed "*it's made a huge difference*". Some of the test sites stated that they intended to promote and increase the number of people accessing SDS packages by double funding services (such as day care and short break services), by increasing employability and routes to work (providing

alternatives to traditional day services), and through providing a wide range of flexible individualised options that would effectively offer alternatives to existing services. However, we were not provided with evidence to confirm that this occurred.

- 4.76 Of the 3 test sites, Glasgow was the most explicit about its use of test site monies for bridging finance. This test site did identify a number of explicit priorities for bridging finance in its action plan, including the re-provisioning of some day services, provision of palliative care at home, allocating resources to school leavers, increasing choice and range of short breaks options, remodelling supported living, early intervention and prevention support using neighbourhood networks and community support, and shortening the DP waiting list.
- 4.77 In practice, Glasgow found short break or respite services to be the least complicated to remodel. This supports the City of Edinburgh's experience in expanding use of the Edinburgh Card for people choosing flexible short breaks. The greater ease in re-commissioning this type of support was attributed by the test site to the spot purchasing nature of short break services, and the relative ease with which service users and families could identify alternatives. Close working with the care provider Enable had resulted in remodelled supported living arrangements as ISFs. There had also been some success with investing in developing community support via Neighbourhood Networks, although there had been some delays.
- 4.78 However, progress in developing alternatives to learning disability day services in Glasgow had been slow – just a quarter of its original target had been reached - which was attributed to the complexity of the process of identifying individuals who wanted alternatives; the work involved with assessment; and the challenge of finding community-based alternatives. Some opposition from carers to changing day services was reported. Plans to introduce palliative care at home for 6 people with dementia had not materialised, which was said to be due to the lack of a procedural framework, as well as of issues around decision making capacity for this group. This test site has highlighted some of the barriers, risks and uncertainties within local authorities and the NHS of extending SDS to people with advanced cognitive impairment.
- 4.79 Less activity in relation to bridging finance was discerned in the other 2 sites. Interviews with financial staff in Dumfries & Galloway confirmed that, as in Glasgow, funding from the test site had been used primarily to build the staffing, training, and IT infrastructure to implement SDS, and not specifically to double fund Council services. Early on, the development of personalisation in this local authority had become associated with day centre closure plans and this had been unhelpful in the development of SDS according to managers. However, in a more general sense, the focus on individualised packages had enabled a small number of people to access opportunities in the community rather than attend traditional day services. The use of test site monies to fund bridging finance in this site has therefore to be seen as part of the evolutionary approach adopted. Developing personalised approaches

was a stated Social Work priority and it was considering, in partnership with the NHS Board, using resource transfer in the future alongside other budgets, to ensure the delivery and sustainability of personalised approaches.

- 4.80 It is difficult to assess the impact of bridging finance spending in Highland because a clear strategy with targets and anticipated outcomes for the use of bridging finance was lacking. Whilst many of the young people in transition accessed SDS packages that enabled individualised choices in how they spent their days rather than attending day centres, these were ‘pepper-potted’ across Highland, and cannot therefore be equated with implementing change to specific services. That is not to say that the local authority was not considering service change, but that under the test site, bridging finance was not coherently brought to bear on advancing specific elements of a change programme. As one stakeholder involved with the change agenda in Highland commented:

“The issue of double running costs has not been addressed and is now becoming very delicate... Only now is SDS being brought forward as a an alternative option for users of services under threat...”

- 4.81 By not singling out services in this way, this local authority may have sought to avoid SDS becoming associated with controversial service closure, although such a move may only have side stepped the issue for the time being. Arguably, a longer term growth in SDS packages will necessitate a review of service provision, and will therefore affect a shift in spending as anticipated under bridging finance. Mainstreaming the SDS team costs that were met out of the test site monies was argued by interviewees to represent a shift in the Council’s resources that will be later achieved by making savings elsewhere.
- 4.82 In light of their test site experience, local authority managers in Glasgow proposed that rather than designated ‘bridging funds’, what local authorities need is a ‘change fund’ to facilitate start up for new support arrangements as well as for infra-structure. Certainly across the test sites, the learning on this theme would seem to be around the timing of such funds so to ensure they are the most helpful and to provide flexibility in their deployment to fit with local circumstances.

Summary – Test Site Implementation

- While test sites’ operational definitions of SDS were broader than DPs and encompassed a range of options from DPs through to individually tailored local authority services, the majority of SDS packages involved a cash transfer, either as a DP to an individual or a 3rd party, usually family members.
- There was little evidence of support packages being funded from a range of sources other than Social Work and client contributions.
- Taken overall, people with learning disabilities were the main group to access SDS, although there were notable differences between the test sites. Those

groups who were less likely to feature in test site activities included people with mental health problems, older people and parents of disabled children.

- All 3 sites created a project lead/manager role; set up a dedicated SDS team; created a Project or Programme Board; and all sought to develop local champions.
- While this strategy might have worked well in relation to supporting the small numbers of service users and staff involved with new systems, it seemed to have limited the extent of system change achieved across the whole local authority in all 3 sites.
- Although significant activity was described as training in all 3 areas, it appeared that relatively small numbers of existing staff participated in any *in-depth* training.
- In relation to cutting red tape, the SDS teams' efforts went into designing or re-designing new systems that were more 'fit for purpose'. Whilst some felt this was necessary in the short term, those participating in the evaluation felt test sites had tended to add to, not reduce, paperwork.
- On the whole, action plans and therefore activities were short on specifics regarding addressing the theme of bridging finance and therefore the impact of this theme was difficult to ascertain.

5 INDIVIDUAL EXPERIENCES OF SELF-DIRECTED SUPPORT

Introduction

- 5.1 The evaluation collected qualitative data during Stage 2 about individual experiences enabling us to look at how new SDS systems were impacting on people's direct experience of social care. Thirty case study individuals were identified from those accessing SDS across the 3 sites (10 from each). For each case study, where possible, interviews were carried out with the service user, his/her carers/families, and a professional who had been involved in the SDS assessment (e.g. a care manager, day centre manager, social care officer, SDS team member). Interviews were carried out between October 2010 and February 2011. Their views of the SDS process are brought together in this chapter. Participants were interviewed about their experiences and opinions of the new processes and SDS options accessed via the test site. All quotations in this chapter are anonymised, and any names used are pseudonyms. To protect confidentiality, the specifics of sites have only been reported where it seemed important to differentiate approaches or experiences.
- 5.2 Although it had been our intention to conduct separate service user and carer interviews, in practice the vast majority of interviews across all the sites were carried out jointly with service users and a carer/s (usually a family member and, occasionally, a support worker). This was either the individual's preference, because the person had limited verbal communication or there were other problems with the interview, such as ability to understand what was involved. Only one service user in each of the test sites was interviewed separately from either their carers or support workers, and although most service users were happy to be present at the interview, one person in Highland asked that we interview his carer instead of him. In addition, during most joint interviews with people with learning disabilities the family member/carers took a leading role in the interview. Where possible, their perceptions were cross checked with the service user present who usually concurred with the views stated.
- 5.3 Our initial assumption in planning the case studies was that care managers would be involved in assessment; this was not always borne out. In Dumfries & Galloway, and to a lesser extent in Glasgow, it was members of the SDS/personalisation team who led the assessment process whilst providing support to other professionals (e.g. care managers, Occupational Therapists, day centre staff, etc). For the Glasgow test site sample, day centre staff, social care workers, and staff from provider organisations as well as care managers were identified as the assessors.

Profile of Individuals

- 5.4 As far as possible within the selected sample of individuals, we aimed for variation in terms of characteristics such as gender, client group, age, ethnicity, and so on, and in terms of SDS options chosen. It did not prove

possible to select a sample in Dumfries & Galloway as at the time of arranging interviews (October 2010), only 10 individuals in total had accessed SDS packages, and so all 10 were invited and agreed to be interviewed. In addition, the intention had also been to interview individuals at least 3 months after their SDS support package had been in place. Again in Dumfries & Galloway most had only recently had SDS packages approved, or were awaiting the panel's decision. Therefore, in this site we were only able to report on early experiences of the assessment and decision making processes, and less about individuals' experience of actually setting up or receiving SDS support.

- 5.5 More men than women were interviewed: in both Dumfries & Galloway and Glasgow there were 6 men and 4 women interviewed, whereas 7 men and 3 women were interviewed in Highland. The ethnicity of all 30 individuals was white British or white Scottish. Overall, this reflected characteristics of client who accessed SDS across the sites (as identified in the cohort forms). Table 5.1 summarises the range of client groups included in the case study sample:

Table 5.1: Number of case study individuals in each site by client group type

Service User Group	Dumfries & Galloway	Glasgow	Highland	ALL
Learning disabilities	4	2	4	10
Physical disabilities (younger adult)	2	3	2	7
Older Person (over 65 yrs)	1	-	-	1
Person with dementia	-	1	-	1
Multiple disabilities	2	3	3	8
Mental health problems	1	-	-	1
Autistic spectrum condition	-	1	1	2
ALL	10	10	10	30

- 5.6 A more complex picture regarding individuals' needs emerges than was evident from the cohort forms as reported in the previous chapter: for instance, 8 of those interviewed had multiple and complex disabilities, including autism and physical disabilities and/or learning disability compared to only one person being recorded as such in the cohort form.
- 5.7 The case studies are not necessarily reflective of the full range of SDS options that were accessed through the test sites as detailed in the previous chapter due to the timing of interviews and the particular stage of test site development. However, during the interviews it became apparent that there was a greater degree of variation in SDS options than had been evident from collecting information through monitoring forms. All 10 case studies in Dumfries & Galloway involved employing support workers/PAs, and some also included existing local authority and other managed services. In Highland all 10 were receiving DPs (either one-off or on-going), although some also accessed existing services or a DP through the 'traditional route' alongside a cash payment through SDS, and thus had mixed packages. Most packages were focused on providing support to young disabled people in transition and were of varying levels of complexity. In Glasgow there was yet more variation: 5 people had a DP, 1 had an ISF, and 4 had mixed packages

involving DPs and local authority provided services. In most cases it was hard to ascertain whether they had an identified IB as most interviewees were not clear what this meant.

Provision of Information

- 5.8 Most service users and their families in Dumfries & Galloway reported a lack of information about the test site. This was in part because the test site approach did not encourage the production of standardised information. This is a more general point that applies across all sites. However, in relation to setting up the support, there were at least 2 examples in Dumfries & Galloway where the personalisation panel had apparently agreed the package but there had been some time before written confirmation had been sent out. In other cases, when initial payments were late due to a hiccup in setting up new systems, service users or carers had been forced to start the support package using their own money. As a result, some reported not being able to pay a PA in the first month or so of their employment. There were a couple of similar cases in Glasgow.
- 5.9 There was some difference of opinion among case study individuals from Glasgow about whether the level of information provided was sufficient for service users or carers to make informed decisions on SDS options. While about half felt they had sufficient information and it was explained well (some mentioning GCIL's input), the other half felt that information about SDS was not adequate. Perceived problems included: not being given adequate information about the range of options available through SDS; information being confusing especially the language used; lack of clarity about the difference between DPs, SDS, and IBs; and, as in the other test sites, a lack of clarity about how SDS money could be spent. A couple of individuals reported that they did not know what they were getting or what it was for. In addition, one person commented that they were getting just the same as before but it was now given a different name.
- 5.10 Many carers in Highland felt that they had had sufficient information about SDS (DPs) to make an informed decision, but some pointed out that they had been at an advantage as they themselves came from backgrounds in health and/or social care, or they were well aware of what was involved because of their experience of receiving DPs. This point was sometimes raised in the other sites. However, there was an additional sense in Highland that information about SDS was really information about DPs. Some felt they would have liked more information on available service options and not just be left to find this out for themselves. Others highlighted insufficient information being provided about the responsibilities involved in being an employer and on employment law. This information need was responded to in the Highland test site by investing part of the test site funding in bringing SPAEN into the area to provide information and support to those taking the DP option. A communication breakdown about whether funding for support would continue post test site caused some anxiety among service users and their families.

Experiences of SDS Assessment

- 5.11 Overall, comments from service users and carers indicated high levels of satisfaction with their involvement in the assessment processes they experienced across all sites. Most said they had had an opportunity to say what they wanted or that the needs of the person they cared for had been considered. For some, the SDS process felt more thorough and in-depth than their previous experience of applying for DPs. The assessment processes took varying lengths of time, depending on circumstances. Several service users or carers mentioned there had been just one or 2 visits from an assessor culminating in a written care plan they had then agreed to, whereas others had been engaged in a far lengthier process. For example, the care manager of a young man with long-term health problems, as well as physical and learning disabilities paid the family several visits and the whole process had taken about 5 to 6 months. As the care manager observed:

“It’s a process people have to engage in. They have to understand that and that takes some time to explain...It took us quite a long while to actually get Tom’s plan written or to get Tom to write the plan...”
(Care manager) (name of user anonymised)

- 5.12 Nonetheless, a very small minority of people felt that assessors did not consult with all those who knew the person well. In addition, another small minority in Dumfries & Galloway and Glasgow test sites felt disempowered by the decision that panels made not to award all elements of the self-assessment plan they had produced themselves. These individuals subsequently reported that self-assessment had encouraged them to have ‘false’ expectations of what was possible. For example, a disabled man in his 70s said:

“They (social workers) took everything into consideration that we were telling them and they wrote it down and then they checked it against what we had written down, the form we had filled in, and they seemed quite in agreement with what we needed and what we had self-assessed and then as I say it went away and sat in front of this Board (panel) for a year and when we got word back, everything had been cut, we only needed so many hours and ... in the morning and so many hours at night for getting ready for bed and whatever...”

- 5.13 In 2 case studies in Dumfries & Galloway service users reported being able to engage directly with the decision-making panel after completing the self-assessment process. In both these examples this experience was highlighted positively. For example, a young disabled woman had developed her own presentation, which she made to the panel with support from her parents. They commented positively:

“You do your pitch; it’s a bit like Dragon’s Den! You know, ‘this is what I’d like to do’, and they decide if they’re going to give you the money.”

- 5.14 In the other example, a young man with learning disabilities had also presented to the panel with support from his family. A relative commented:

“Initially we worked it all out...and when we presented it at the Board, quite surprisingly they turned round and asked if it was enough support, that we’d applied for enough and we were told basically what the rate would be and yes we’re very, very pleased with the outcome.”

- 5.15 It is worth noting that in both these examples the package they proposed had been subsequently agreed, so feedback may have differed if this had not have been the outcome.

- 5.16 In all 3 test sites there appeared to be at least 2 assessment processes occurring in parallel: self-assessment processes developed by the SDS test sites *and* single shared assessments (SSA). This was especially commented upon by service users and care managers in Highland. In one situation, assessment was said to have begun with the SSA and this was used to positively build up the outcomes statement for SDS. Other care managers in Highland resented the duplication of paperwork and the bureaucracy surrounding assessment, even though the self-assessment tool developed for the test site was *“ideal if the time is available”*. Another Highland care manager however was less critical, observing that working with both SSA and self-assessment forms provided *“more of an overview”* which she said was beneficial. A Glasgow care manager felt similarly about the dual approach.

- 5.17 Although some form of ‘self-assessment’ was always completed, how meaningful a term *self-assessment* was to describe the process was thrown into question by the finding that the great majority of SDS assessments were completed by professionals, and the main contributors were carers/relatives rather than service users:

“...it was out of his hands and he just kind of agreed to it but...I don’t think he made a decision really himself but she (autism nurse) certainly explained it to him what’s going to happen...I think decision making is quite hard for him...he’s not quite sure exactly what he needs at times.”

- 5.18 Another social worker from a different test site reflected:

“There are huge issues regarding ‘self’ assessment for people with learning disabilities and complex needs...in reality the main input is by the carer and the family members...it is not a fully self-directed assessment although every step possible is taken to ensure that their needs and wants are identified and considered.”

- 5.19 With this in mind it is worth noting that, while most families felt that service users had had sufficient input into the assessment process, this was usually because the families took a lead in the process (especially in the case studies of service users with severe learning disabilities). There appeared to be little evidence of innovation in relation to supported decision-making mechanisms for service users with less capacity to support self-assessment.
- 5.20 One service user from Dumfries & Galloway had felt sufficiently involved in the assessment but the process had been led by someone from the personalisation team and a care manager resulting in the service user lacking a sense of ownership of the plan - *“most of what’s on that sheet I didnae suggest it, it was them (the assessors) that wrote it”*. The care manager in this situation, who had not received training about new assessment processes, was unsure about the SDS paperwork and how to put a good case together for the panel. Despite the care manager suggesting what should be in the care package, it is worth noting that the service user reported being pleased with the outcome. In contrast, another care manager from this test site who had worked on a plan with an individual with learning disabilities showed how more user-friendly planning processes were being developed that seemed to find more creative ways of involving service users. The plan he referred to was written as *“a kind of narrative”*, and even though some people had felt this was *“over-simplified”*, he argued it had made the process easier for the service user to understand.

Nature of SDS Support

- 5.21 It was at times hard to ascertain from the interviews how individual support packages were comprised because funding appeared to come from a variety of sources and the individuals concerned were not always sure themselves how their packages were made up. This did not *necessarily* appear to be a problem, especially if the service user’s needs were being met. However, it did indicate a level of confusion that existed amongst many service users and carers, even for those who understood the system relatively well (because, for example, they had backgrounds in social care themselves and/or had previously used DPs or other social care systems).
- 5.22 Overall a wide range of SDS support packages was described in the case studies. Some involved a DP paying for a small number of hours support a week, for example, to pay for a supporter to drive a young man with autism to college in one site, or to pay support workers for 6 hours a week to sit in or go out with a woman in her 60s with mental health problems in another site so that she could get to activities in the community without always relying on her carer. This had made a *“huge difference”* according to her carer, and in her own words, had given her *“a lot of confidence”*.
- 5.23 Other SDS packages were more complex care packages of over 50 hours per week delivering intensive care and social support, sometimes every day of the week. The size of the support package, however, should not be seen as the most significant factor in assessing the impact of SDS on someone’s life. One

young man with learning disabilities had funding for just one day a week to support him to attend a place where he could learn outdoor skills such as gardening, as well as having one week's short break annually. One of his parents spoke about the major difference this had made to the family:

"It's made a big impact on our lives, you know before SDS was in place he was lying at home all day with virtually no social interaction, no friends, no jobs, no job experience, opportunities. It was affecting his mental health, our home. Family relationships were being affected to a huge degree."

- 5.24 There was some evidence of a broader concept of SDS being implemented than initially emerges from analysis of information from the cohort forms (described in Chapter 4). This included examples of the SDS package involving the service user continuing with the same provider but having more input about how the support was provided to them. In addition, complex and intensive support packages were arranged for some case study individuals, utilising different funding streams and consisting of a mix of options including day services and using DPs to employ support workers to enable the service user to get to community facilities. Examples of more packages being more complex were found in Glasgow and Highland test sites, as the following 2 examples show, while managers in Dumfries & Galloway acknowledged the need for personalisation still to be tested in relation to those with multiple and complex needs.

Box 1 (All names are pseudonyms)

Heather, a young woman with learning disabilities, lives at home with her parents. She attends traditional day service provision, has 20 hours support funded through ILF and additional SDS money which supports her social needs outside the day centre. The family report that this had enabled them to *"to feel more like a normal family"* and Heather was able to *"do things other young people her age do"*, independent of her family.

Mike, a young man who has autism and high support needs, lives with his parents. His SDS package consists of a DP paying for 55 hours a week support, enabling his parents who manage the DP to employ support workers, one of whom he has known for 15 years and who supports Mike with personal care and independent living, while other support workers help him participate in social activities, to attend music therapy and horse riding through *Riding for the Disabled*.

- 5.25 It was less common for SDS to be used to help someone moving home from hospital. At one test site a care manager commented that an SDS support package had enabled John, a man in his 50s with early onset dementia, to leave hospital with appropriate support in place. In her experience, the option of organising support via SDS had provided *"more choice and control"* to both John and his carer. According to the care manager, the support package under SDS was more flexible and individually tailored than would have been

possible under existing DP arrangements. SDS had enabled this man's wife to continue working:

"It works out perfectly...I don't know what would have happened...John would have been home but then day care is so limiting...I would have had to given up work then." (Carer)

- 5.26 A DP enabled John's carer to employ 2 PAs to support John from Monday to Friday. The support was also said to give him a sense of normality in his daily routine (as opposed to attending a day centre) and the opportunity to get out to places he wanted to go.
- 5.27 However, for some other individuals it was not always clear what was, or would be, different about SDS than accessing support via the traditional DP system. For example, in an area like Highland, where SDS was initially focused on young people in transition to adult services, most individuals appeared to be getting services (usually payments rather than managed services) for the first time. They were being offered SDS as an *alternative*, not only to directly provided services, but also to traditional DPs.
- 5.28 For a small minority, there did not appear to be any significant change in support, more than a change in terminology. For instance, a disabled woman had transferred her support package from a provider to a DP so she could employ her own PAs. She said she did not notice any perceptible change in the support she received, although clearly there had been. Another disabled woman from the same area did not feel the budget allocated to cover travel costs made all that much difference to her because, after her own contribution was deducted, the payment was very small.

Flexibility of SDS Support

- 5.29 The majority of people reported a change in their or their relative's support for the better. This was usually because of the increased flexibility and choice that SDS enabled, for example, being able to choose different facilities/agencies which, perhaps surprisingly, did not appear to have been possible under DPs. In turn, as we shall see, the examples of increased flexibility were partly due to the fact that SDS allowed users to pay for different and new activities or support. In addition, SDS support appeared to be more tied to 'outcomes', which *could* allow greater flexibility, although this very much depended on how this was interpreted by individuals themselves and the assessors. The following offer some examples of where the SDS test site had facilitated flexible support arrangements (See Box 2):

Box 2: Examples of flexible support packages from each of the test sites

Ian is a disabled teenager living in one SDS test site. At the time of the interview his SDS package had just been agreed. It was designed to pay another young person a couple of hours, twice a week to *“do activities with him, keep him busy, do games, read books, do stuff together and then maybe once a month at week-ends to go out and maybe have a walk or go to the café or go to the youth centre perhaps”*. Also there was an option of an activity short break. Previously, the family had paid for this support themselves because DPs did not allow them to employ young people less than 16 years old.

Phil is a young man in his early 30s who has learning disabilities and long term health conditions that severely limit what he can do. He sometimes has to spend weeks in bed. He lives with his mother who is his main carer. Through SDS, Phil’s support had recently changed for the better. He had wanted to move on from the day service because he had been going to the same centre since he left school. Now he participates in various activities geared around his hobbies and interests and has the chance to go on holiday. Phil says of the current arrangements: *“Oh brilliant, fantastic but what I had before that was rubbish, I wouldnae go back to that way again.”* Phil’s mother thought her son was happier and more outward going and had noticed an improvement in his self-confidence.

Gail is a young woman with learning disabilities in her 20s who lives with her parents. Her SDS package is more flexible than the social care she received previously and she can do more varied and ‘age appropriate’ activities (swimming, singing, art classes, horse riding), as well as having support at home. She can also use the budget to visit relatives and the rest of the family benefit from having time out from care. Her mother said Gail does not require sedation at night because no longer is she bored and falling asleep in the day. In interview her family reported that Gail is happier and more alert and her physical health has improved as she is able to walk more. This was said to benefit both Gail and her family.

- 5.30 However, there were also a small number of examples across the test sites where the flexibility of SDS was limited, particularly in respect of how a DP could be spent. For example, barriers were reported in relation to employing relatives or using the budget to support taking part in certain activities. In one example, being able to use the budget to support an older man attend bingo was prohibited as it was seen by local authority staff as gambling. In another, SDS was not able to fund the cost of moving into independent accommodation. In another example, an older disabled man who lives with his wife (also disabled) reported not being allowed to use the DP to employ family members as PAs to provide support they had provided previously. This was in contrast to other examples of SDS packages in the other test sites where friends and relatives were employed as PAs.
- 5.31 Clearly professionals make differential judgements about individuals’ needs in relation to these issues which often, in turn, relate to concerns about risk and independence and so on. However, greater clarity about these issues might help avoid confusion and misunderstanding – and in particular, clearer

explanations to individuals about the decisions that are made. Otherwise, decisions can seem arbitrary and inequitable to service users and carers.

- 5.32 There were also examples of SDS lacking flexibility in the other sites. For example, a family in one site wanted to pay a particular support worker whom they knew because they worked with the service user in local social care services. They wanted to pay her through the local authority so they would not have the burden of employing someone directly. However, they were told they could not do this – *“the Council can’t pay the Council”*. Others were deeply appreciative of SDS but in 2 of the test sites felt that flexibility was curtailed by the allocated budget, for example:

“I think my [relative] needs more help than what I’m getting...More funding not the personalisation, I think that’s brilliant but I would have liked a bit more funding.”

- 5.33 These, and other examples, make it clear that there are limitations to how far local authorities are able (or willing) to promote a broader definition of SDS and embrace a flexible, individualised approach to SDS as originally envisaged.

Relationships between SDS and DPs

- 5.34 In all 3 test sites there was a paradox at the heart of the SDS process. On the one hand, SDS was defined by all test sites as a spectrum of options including DPs. On the other hand, there were numerous examples of SDS being seen as an *alternative* to DPs, rather than DPs being seen as part of this spectrum *within* SDS. This in large part relates to the fact that the test sites created different administrative systems for SDS and, for most of the test site period, these operated in parallel to existing DP systems in the 3 local authorities. Some packages in Highland seemed to involve both SDS and a traditional DP, and although monitoring returns were sent to the same office, one family commented that payments were handled separately in the local authority and came to them at different times. This situation was confusing – for staff as well as service users and their carers.
- 5.35 Indeed, service users and carers distinguished between what they perceived to be social services and personalisation/SDS, sometimes seeing these as completely different rather than part of the same system. This meant that, for example, some carers were confused about where SDS funding came from and were under the impression that they could have funding either from SDS or the local authority. Therefore, integrating these systems seems to be an important issue to address – both at the monitoring level and at the operational level and may be one lesson to learn for any future pilots and general roll-out.
- 5.36 In one sense, the very existence of the SDS test site appeared to enable staff to work with people in more creative and flexible ways to support individuals having more say in how their support is delivered and what outcomes they aspired to achieving. This was related to greater time being available to users

from new and specialist staff in some areas. Most received an enhanced service in terms of assessment and support planning. In this way SDS was frequently contrasted to the existing DP system by service users, carers and professionals. As a relative of a young man with learning disabilities said:

“I’ve spoken to parents on DPs and just on social work and it sounds like what we’ve got is a thousand times better.”

- 5.37 Another family supporting a man with learning disabilities had previously received DPs for day care and felt that the SDS system was an improvement. Further, although the paperwork appeared to be the same as with previous DPs, communication with the SDS team was said to be better than that with the DP team. The carer of a young man with autism had previously tried DPs but found it “*too restrictive*” as it was only designed to employ a PA, which was not necessarily what was most helpful to him at the time. DPs were often linked to purchasing specific activities or inputs rather than outcomes. Adopting a more outcomes focus, SDS had seemingly offered greater freedom allowing people to decide what they wanted to do providing they could show how this met outcomes identified in the assessment.

SDS Meeting Unmet Need?

- 5.38 Numerous positive comments were recorded about the support available through SDS packages. Whilst this was often related to greater flexibility, this was itself sometimes based upon being able to access new or additional resources. SDS seemed to have been made available through the test sites to people who had been refused local authority services in the past, or support had previously been provided by relatives. Therefore, it was not always clear whether positive comments related to SDS as such, or rather to the greater levels of support and local authority funding that appeared to have been made available during the test site period, even though it had not been the intention for test sites to provide additional direct support monies.
- 5.39 For instance, in some cases local authorities’ usual eligibility criteria might have been circumvented in order to trial SDS. A care manager in one local authority had tried to access ILF and DPs for a service user, but had been told there was no funding and a waiting list for DPs, was advised to “go down the SDS route *instead*”. In another test site, a family who had been previously turned down for social work services related this experience:

“I never knew there was any help available apart from the social worker and she was absolutely no help at all. She said there was nothing they could do, she just filled in a form for a housing association for him and that was it.... And then this personalisation thing started and she [social worker] suggested that he [son] might be able to get some help.... So she put me in touch with [Personalisation Team Co-ordinator] and it turns out that there is quite a bit of help available but we never knew about it, for whatever reason I don’t know...”

- 5.40 It remains unclear whether the particular social worker was especially ineffective, or whether the SDS test site had enabled resources to be provided for previously unmet need – which was not possible in the mainstream system or via DPs. If support of this kind was not available via DPs it was not always clear to us why not; especially as eligibility criteria for services should presumably be the same, regardless of what type of support is utilised. Similarly, another family in the same local authority had been told by social workers that they were not entitled to services for their daughter who has physical disabilities because funding was only available for ‘critical need’, but the family now accessed support via SDS. A family in another test site whose son had learning disabilities had similarly been told there was no support available for their son except through SDS.
- 5.41 While SDS may have offered some selected individuals a more flexible service this begs the question of what happens when referrals increase, the social care budget is reduced, demand grows and SDS test site monies end. The equity and sustainability of SDS are therefore uncertain if, as it appears to have done, it relies on an injection of additional resources from Scottish Government. This issue was reflected across the test sites where individuals expressed concerns that their support or elements of it might stop at the end of the test site.

System Improvements

- 5.42 Whilst many service users and carers were mostly satisfied with their existing SDS support arrangements, they and the professionals involved in their assessments, suggested a number of system improvements as follows:
- Professionals such as care managers involved in assessment processes need training early on so that they feel confident with implementing new systems and so that the burden does not rest with a small team taking SDS/personalisation forward;
 - A central information and support point such as independent living centres would be helpful to service users and carers;
 - There was a general call for accessible information about SDS so that people who are eligible hear about it rather than having to find out by chance. This needed to include information about different SDS options and clarity about what cash payments can be used for (or why they can't be used);
 - There was some support for managing the processes of assessment and decision making about the budget ‘better’ and different elements of this have been covered above;
 - Increase eligibility for availability of SDS, including people with mental health problems, so that more people benefit, although such ambitions were not always framed within the resources available to local authorities;
 - There was a need to address restrictions placed on SDS packages (including DPs), especially on what the money can be spent, and investigate discrepancies between test sites in terms of what they were able to achieve under the umbrella of SDS to share good practice;

- While SDS had brought several improvements to some DP systems, there was not always a reduction in paperwork. Practitioners, carers and service users would like to see this addressed;
- It would be useful for local authorities to support, or continue to support, networks of service users and carers receiving SDS packages as they find these valuable;
- Service users and carers would find it helpful if local authorities were to coordinate different funding streams better as their separation was perceived to be confusing;
- There was a need to ensure families of young disabled people are aware of SDS at an early stage which would need better knowledge of SDS among children's and education services and their professional networks;
- There was a general view that integration of SDS and DP systems needed to happen following the test site period.

Summary – Individual Experiences

- Thirty individuals across the 3 test sites, their families/carers and assessors contributed to the evaluation by telling us about their experiences and views of the SDS assessment processes, and SDS options they had accessed through the test sites.
- While experience of the quality of assessment processes varied, on the whole, carers interviewed felt the assessment had been comprehensive and inclusive, and had been based upon what the individual wanted.
- There were differences between test sites in the degree of flexibility they allowed in terms of, for example, employing relatives, and in perception of appropriate activities that impacted on flexibility.
- SDS had expanded choice and control for the vast majority we interviewed. More flexible support was being offered under SDS than had been the case even with past DPs, which were often linked to purchasing specific activities or inputs rather than outcomes.
- However, while SDS was defined by all test sites as a spectrum of options *including* DPs, there were numerous examples where SDS was presented as, and understood by service users and carers as, an *alternative* to DPs.
- From these individual accounts, it was not always clear whether positive comments related solely to the model of SDS, or rather to the greater levels of support and local authority funding made available during the test sites, even though it had not been the intention for test sites to provide additional direct support monies.
- In this sense, the extent to which SDS test site monies had been used to meet previously unmet needs that had not been possible for either services or DPs to meet remains uncertain. This will have implications for the future roll-out of SDS across these and other local authorities.

6 STAGE 3 : IMPLICATIONS – LESSONS FROM THE TEST SITES

Introduction

- 6.1 In this final chapter, we outline some lessons from the experience of the 3 local authority SDS test sites, drawing across the evaluation findings. This evaluation faced several challenges, not least of which was that it was undertaken at a time when national and local SDS policy and practice were in a state of flux. Local authorities were undergoing local restructuring or modernisation of services, and public services generally were under pressure due to a change in the UK Government and the economic downturn. This evaluation report must therefore, be read in this context.
- 6.2 Also, while the SDS test sites were originally conceived of as addressing the same 3 themes – leadership and training, cutting red tape and bridging finance – how the Scottish Government’s brief was interpreted was left to the local authorities, resulting in 3 variations on the themes and one of the local authorities stated from the start that they were not following the 3 themes but rather, implementing personalisation in a broad way. The 3 sites did not adopt specific models of implementation which we could compare and contrast, and therefore the scope for systematic assessment of differential impact across the sites was limited. The definition of SDS changed during the course of the evaluation in response to the growing evidence that choice should be broadened, with a new national SDS Strategy published in 2010. The evaluation is thus mainly descriptive and process orientated.
- 6.3 Despite such challenges, the evaluation is able to offer some insights about how local authority processes need to change to enable SDS to become mainstreamed. This will add to the growing body of knowledge about SDS/personalisation. In this sense it is worth bearing in mind that the overarching policy aim of SDS is to progress systems *towards* greater flexibility, choice and control. The evaluation is thus concerned with a process on a continuum, rather than an ‘all or nothing’ assessment of whether the particular local authorities were able to achieve increased SDS or not. With these caveats, we now consider some general and specific lessons from the research overall.

General Lessons

Pace of Change

- 6.4 One general lesson relates to the rationale for the pace of change in implementing a major shift in service delivery. There was considerable Scottish Government investment in SDS test sites (over £3.5 million), and this evaluation found that over a 2-year period, this resulted in fewer than 150 new SDS packages being set up across 3 local authorities. While these numbers seem small overall, it should be acknowledged that development of policy and/or practice of this magnitude will of necessity take time, and investment in infrastructure for implementation may not translate into outcomes for

individuals in the first year or so. As stated in Chapter 4, the test sites were not up and running until well into their first year, which meant that the impact of the work of specialist teams was not fully realised within the timeframe (2 years and 3 months). This experience demonstrates that progress will very much depend on local areas getting agreement at senior level on the scope of activity and having dedicated resources in place to take this forward. The slow pace of democratic decision making within local authorities, coupled with time-consuming recruitment procedures for hiring to newly created posts, were significant barriers to the development of the test sites. This needs to be borne in mind by those considering implementing systems to increase SDS, especially given that the pace of change ultimately affects what outcomes can be achieved within the timeframe set.

Recommendation 1 - Local areas need to gain agreement at senior level about the scope and extent of activity and what is reasonable to expect in a particular timeframe.

Recommendation 2 - Local authorities will need to allocate resources for taking SDS developments forward to ensure they have the capacity to design new systems or re-design existing systems, for example, for assessment and decision making around IBs.

DP and SDS

6.5 At baseline, several flaws were highlighted by national and local stakeholders with existing DP systems and SDS was perceived as a new way for local authorities to increase choice, control and flexibility in support arrangements. DPs were perceived as restrictive and inflexible and focused on specified outputs. In all 3 test sites there was a paradox at the heart of the SDS process. Consistently we found a (mis)perception by staff, service users and carers of SDS as an *alternative* to, not only managed or direct services but also, DPs. Rather than the test site local authorities perceiving DPs as an option along the SDS continuum, new and parallel SDS systems to those delivering DPs were created, with subsequent attempts at integration occurring late on in the test sites.

Recommendation 3 - A useful starting point for local authorities wanting to develop SDS would be a review of current DP systems, seeking to identify barriers to offering flexibility.

Recommendation 4 - To avoid duplication and confusion and to operationalise the broader ideal of SDS, more work needs to be put into integrating systems.

Measuring SDS

6.6 Collecting information for the evaluation about how SDS was being implemented in the test sites provided an opportunity to compare information gathered through basic monitoring (cohort form) with qualitative information from interviews with service users, carers and care managers/assessors. The latter provided richer information that yielded a more complex picture about

SDS implementation and access than that provided by the cohort data. This confirms that gathering crude statistical indicators of SDS will only paint a partial picture and there is a need to capture data using different methods. Further, while there was an expectation that the test sites would increase uptake of DPs, which they did as the majority of SDS packages involved DPs (one-off or regular payments), such payments were not included in the local authorities' DP statistics. The need to develop more meaningful and accurate ways of capturing the SDS practice across Scotland is reflected in the national Strategy recommendations.

Recommendation 5 - When collecting information on SDS, local authorities may need to integrate different systems for recording DPs.

Recommendation 6 - A range of types of information (quantitative and qualitative) needs to be collected to capture how local authorities are implementing the full spectrum of SDS.

Impact of Increasing Knowledge

- 6.7 From the start, test sites argued for adopting a broad definition of SDS, apart from Highland who directly linked increasing uptake of SDS with uptake of DPs. Even so, the vast majority of SDS packages set up by the test sites involved some form of DP. This goes some way to dispelling claims that there is a lack of interest or low demand for DPs. Indeed, poor awareness and knowledge of DPs was identified as a barrier to uptake at baseline, and also by research studies examined in the literature review. Active promotion of SDS, including DPs, resulted in increased numbers of people opting for payments instead of direct services to pay for more flexible, individualised packages. However, the fact that some also opted for mixed packages, which included ISFs, also demonstrates that adopting a broader definition of SDS (beyond DPs), enables more people to achieve greater flexibility, choice and control in their support arrangements.
- 6.8 Lack of information and understanding of DPs and SDS had, in the past, led to misconceptions about what payments can be used for, and to variations in practice across Scottish local authorities. We found some differences between the test site local authorities and practitioners within them regarding interpretation of the law, for example, on the employment of relatives, and on understandings of what payments can be spent on. Such discrepancies had an impact on the flexibility of the SDS package and service user and carer satisfaction with SDS.

Recommendation 7 - Continued investment in increasing service users', carers' and staff knowledge and awareness about the range of SDS options available.

Recommendation 8 - Consistency of message and/or clarity about how decisions are made is needed and about how payments can be used.

Satisfaction with SDS Packages

- 6.9 The test sites increased the uptake of SDS for a relatively small number of people – that is, 132 SDS packages in total over the 2 years. Those that accessed SDS packages during this time were extremely positive about their support and very satisfied with the flexibility and choice that SDS had offered them. This indicates that where sufficient time and resources are put into developing SDS, service users (or their carers) are able to achieve a greater level of choice, control and flexibility. When the focus was on meeting defined outcomes, SDS was perceived positively, and this was frequently contrasted with what had been available before through DPs. While it is too early to tell whether this will ultimately result in better outcomes for these individuals, other research on IBs and personalisation suggests that this is likely to be the case.
- 6.10 We need, however, to be cautious in drawing conclusions about this because it was also apparent that some people had accessed new or additional resources through the test sites. Some positive comments about SDS therefore may have related more to receiving new or greater levels of support (in terms of professional support and/or actual funding) during the test site period than would otherwise have been possible. Test sites and other pilots may temporarily inflate the positive effects of SDS when promotion involves making new resources available.

Recommendation 9 - A review of eligibility and funding criteria may be needed in order to ensure equitability of access.

Recommendation 10 - Continued funding of packages may be required at the level enabled during the pilot if local authorities are to see positive outcomes.

SDS and Adult Protection

- 6.11 Whilst disappointing that cross referencing between SDS and adult protection (AP) remained in its infancy during the test sites, it is perhaps understandable in the broader context in which these policies were being rolled out. As SDS is being mainstreamed, and now that AP implementation has bedded down in Scotland, the challenge is to respond to suggestions that disproportionate focus on fraud prevention in SDS may dilute the focus on both positive risk-taking and identifying risk (Carr, 2010).
- 6.12 A related issue is the question of the registration of the social care workforce (Protecting Vulnerable Adults (Scotland) Act (2007)). Those interviewed expressed some concerns that Personal Assistants (PAs) were not subject to registration in the same way as those working in managed services. The national Strategy does not identify the registration of the PA workforce as an ambition, and indeed there are many who believe this interferes with the individual's right to determine who they wish to employ. Nonetheless, this workforce needs to have access to training and skills development, and those taking on the role of employer must take responsibility for accessing the

information available to them to ensure they do not employ a person barred under the PVG Scheme. Striking a balance between enabling and empowering individuals, whilst at the same time protecting those at risk, remains with the lead assessor. Positive leadership from middle and senior management is crucial in supporting staff to transfer power to individuals.

Recommendation 11 - There is a need to consider joint training on SDS and Adult Protection, as well as integrated practice initiatives programmes.

Addressing Scottish Government Themes

Leadership and Training

- 6.13 At baseline, leadership was identified by national and local stakeholders, as well as in the national Strategy, as a vital component. Scottish local authorities had already implemented various strategies with different results, but there was no consensus about the most effective form of leadership for the test sites to adopt. In the event, all 3 test sites invested in specialist SDS teams and project managers. The specialist SDS or personalisation teams were felt necessary to support the development of new SDS systems and tools, as well as to grow a body of practice expertise.
- 6.14 However, some service users, carers and care managers perceived SDS to be a new and *separate* service to Social Work or DPs, rather than being part of a major shift in service delivery overall. The local authorities may have placed disproportionate responsibility for change on local SDS Project Managers and teams which, in some cases, could have been mitigated by stronger project boards and leadership from senior managers. The Scottish Government recently (April 2011) allocated funding to all local authorities to build on the work and expertise of existing teams to support the development of SDS and delivery of DPs, to focus more specifically on implementation of the Strategy.
- 6.15 Despite extensive training activities reported by all 3 test sites delivered by the SDS teams and external consultants, we found that not all those who needed to receive training had done so. In addition, few staff had received what they considered sufficiently in-depth training. This underlines the importance of developing a strategic training and communications strategy both at local and national level, and also of considering training and support as on-going needs. By way of reinforcing this point, the National Implementation Group agreed an action plan that identifies communications and workforce development strategies as early priorities.

Recommendation 12 - Where a separate project team is set up to kick start developments it is important to ensure this is driven by a high level Project Board, and there is strategic consideration of this impact of the approach taken on wider implementation.

Recommendation 13 - Communication is needed from the start with all those involved including frontline staff carrying out SDS assessments with service users, especially about the 'nuts and bolts' of new systems.

Recommendation 14 - A multi-pronged training strategy is essential and needs to inform action by practitioners in parallel with driving culture change and knowledge and skills development on a wider basis.

Cutting Red Tape

- 6.16 At baseline, DPs were perceived by those interviewed and in the literature review as overly bureaucratic and, in some cases, processes were felt to be heavy handed and lacking flexibility. While 'cutting red tape' was a theme of the test sites, none were able to specifically reduce the paperwork involved. Instead, by concentrating more on designing effective systems to support SDS implementation, there tended to be an increase in paperwork and bureaucracy, at least in the short term. This was perhaps unavoidable given the approach the test sites took in that they were trialling new parallel systems and setting up new SDS teams. In many cases, SDS assessment tools were perceived as an improvement, which resulted in more comprehensive and inclusive assessment. It was uncertain, however, whether or not these would be adopted instead of established systems such as single shared assessment. This may change if new SDS systems are mainstreamed. There is still a danger that the social care system may become more, rather than less, bureaucratic and complex and perceptions of unnecessary red tape and bureaucracy increase if the *In Control* approach is left to run side by side with older assessment and care management systems.
- 6.17 One issue of note is that despite self-assessment being a key feature of SDS, many assessments were driven by carers and coordinated by professionals. Despite social workers being told to write self-assessments in the first person, several service users had very limited input due to complex disabilities and problems with cognition. This highlights the importance of being clear about what 'self-assessment' really means, and that different models might be needed to ensure that such assessments are recorded openly and honestly. Additional investment may be needed in independent advocacy and other supported decision-making mechanisms to ensure that people with complex needs are as fully involved in assessment as possible.
- 6.18 We are limited in what we can say about changes to monitoring and review processes and, therefore, about the impact of implementing 'light touch' monitoring systems. This is because of the early stage of development of the test sites when we collected information. Some of those interviewed concluded that the local authorities still had to work out how to manage both the 'light touch' exhortation from Scottish Government and the CIPFA guidance on financial accountability, good governance and probity. While test sites had explored initiatives such as the Edinburgh Card, an electronic purchase card, as a way of reducing red tape for service users and carers, this was only at the end of the test sites.

Recommendation 15 - In developing SDS assessment processes, local authorities need to take stock of existing systems and how these can be integrated with SDS.

Recommendation 16 - Developing a range of assessment approaches including supported self-assessment may be necessary, as well as ensuring access to independent advocacy to ensure people with complex needs have sufficient input into their care.

Recommendation 17 – Consideration is needed as to whether the SDS ‘self-assessment’ can address complex issues and inputs required from a variety of social care and health services to ensure a comprehensive and integrated response.

Bridging Finance

6.19 Despite an anticipation that bridging finance (defined by Scottish Government as double funding existing services while developing and providing new, more personalised, packages) would be a main focus of the test sites, in practice, test site activity was least focused on implementing this theme. Certainly only in Glasgow was there any evidence of strategic consideration of bridging finance, and there was learning in this test site about using bridging finance to remodel services. Where this test site was most successful was in reshaping its respite/short breaks service using bridging finance monies. The main conclusion from activities on this theme was that the critical issue is the timing of availability of funds to act as bridging finance or a change fund.

6.20 Investing to save is not a new issue - local authorities have been reviewing their investment in buildings based services for some years, partly through policy drivers such as institutional re-provisioning programmes, *The same as you?*, and partly through best value reviews. Other Scottish local authorities, such as one of those we consulted for the evaluation (not a test site), disinvested in the buildings-based model some time ago, when resources were more readily available. Those with largest investment in directly managed services will have the biggest challenge in releasing resources. One test site had some success with using bridging finance to reshape respite/short breaks services.

Recommendation 18 - Local authorities need to be able to identify when and how much bridging resource will be needed to plan future service development.

Other Themes

6.21 In addition to the 3 main themes, the test sites were asked to consider, among other things, equal access to SDS by all client groups, mixed funding packages including incorporating health monies, and the role of advocacy and support services.

Equal Access

6.22 Previous research has identified major inequalities in access to DPs, especially for people with learning disabilities, people with mental health problems and older people. The learning from the test sites about how to

promote SDS to all groups is limited. While access to people with learning disabilities (generally severe) improved as a result of the test sites, given this was the group most often targeted for inclusion, there was limited inclusion of, for example, people with mental health problems. An obvious gap in promotion, and a missed opportunity for the test sites, was ensuring people from BME groups gain access SDS packages.

Recommendation 19 - A deliberate focus is needed to ensure SDS becomes an option for a wide range of individuals with varying needs, including those from BME communities.

Recommendation 20 - It will be important to apply equal opportunities monitoring to SDS uptake.

Mixed Funding Packages

6.23 This theme was not really addressed by the test sites and, given that the cohorts included some people with complex and multiple needs, it is unclear why this was the case. There was no evidence of any pooling of NHS and social care budgets, which may have not been possible legally or, indeed, little evidence of specific use of other budgets in addition to social care. While, in theory, SDS presents an opportunity to address needs holistically, the extent to which support can be integrated across funding streams could not be assessed.

Recommendation 21 - SDS monitoring systems need to find ways of recording access by [and outcomes for] people with multiple and complex needs.

Recommendation 22 - Understand and overcome the barriers to utilising additional funding from other sources such as health.

Advocacy and Support

6.24 Inadequate or non-existent support infrastructures for service users and carers wanting to consider DPs was identified as a key obstacle to increasing the uptake of SDS at baseline. Test site monies were not, however, used by any of the 3 sites to invest in either capacity building of disabled people's organisations (such as independent living centres) that could offer user-led support on SDS/DPs, or independent advocacy to support individuals through the process. A recent study (Johnston et al, 2009) found that a pro-active approach to service user engagement is critical. Interviews with representatives of both service user and carer organisations at Stages 1 and 2 of the evaluation (where these could be identified) indicated only peripheral, if any, involvement of service users and carers in developing test site action plans. Given that citizen leadership and co-production, at both individual *and* strategic level, are central to the values and principles of SDS, this would seem an important omission.

Recommendation 23 - Commitment to promoting collective and strategic user involvement would seem essential if the perception that SDS is a professionally-led concept is to shift.

Recommendation 24 - Developing the capacity of local disability organisations should be recognised as a key aspect of SDS policy and practice implementation.

Conclusions

- 6.25 Given that some similar concerns emerged across all 3 test sites, it seems likely that these are not specific to the test sites but are more general challenges facing all local authorities attempting to make changes in the direction of SDS.
- 6.26 Specific conclusions in relation to the test sites can be drawn, especially about the longer term sustainability of the small but important changes that the sites were able to make. The implementation of SDS using a managerial rather than a strategic model, that is as a project or initiative with a designated team leading developments within local authorities, had limitations: a specialist SDS or personalisation team offered expertise and management of the 'SDS project' but also created the impression that SDS was separate from, and operated differently to, the local authority and other systems, such as DPs. There was a risk of these systems appearing to be working in parallel, which can mean unhelpful duplication and confusion. Unless senior managers take a lead role, there is always the danger that initiatives will be marginalised, regardless of how committed those managing and involved in it are. Certainly by the end of the test site period, the 3 local authorities had resolved to move towards mainstreaming SDS with support from their senior management. An ambitious programme of SDS development in Glasgow involving external providers, for example, has far reaching consequences for future practice that we are unable to assess in this evaluation.
- 6.27 The new SDS processes created by the test sites worked extremely well overall for the selected individuals who benefited from SDS during the test site period offering increased choice, flexibility and control. The uptake of SDS and of DPs had increased as a result, and through the work of dedicated teams the local authorities found they could be more creative and innovative in the ways they worked with people. The key issue now is maintaining such innovation and flexibility for greater numbers of individuals. Clearly, involvement of service user and carer organisations and investment in the necessary support infrastructures are essential, as well as continued availability of funding for the care packages themselves. In the foreword to the national Strategy, political leaders state that "more of the same will not work". It will be essential, therefore, for all local authorities to grapple with the challenges faced by these test sites, and to find a way to implement this shift from service provision to greater involvement and co-production of care and support. The outcomes of this Strategy are worthy of continuing assessment.

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8 APPENDICES

Appendix 1: Detail of Research Samples

Table 8.1: Local stakeholders interviewed in the 3 test sites at Stage 1

Dumfries & Galloway	Glasgow	Highland
<p>SDS Project Manager</p> <p>Lead Officer Personalisation</p> <p>Head of Strategic Planning, Commissioning & Performance</p> <p>Senior Finance Officer</p> <p>Group session at the Visioning Event with:</p> <p>SDS Project Manager; Head of Strategic Planning, Commissioning & Performance; Director of SW; User & Carer Involvement Officer; Local Area Coordinator; Joint Planning & Commissioning Manager (Learning Disability); Turning Point Scotland; Acting Senior SW Manager (Annandale & Eskdale); Senior Finance Officer; Senior SW Manager (Wigtownshire); Scottish Government Project Manager</p>	<p>SDS Project Manager</p> <p>Social Work Head of Service Modernisation</p> <p>SDS Principal Officer</p> <p>Principal Officer (Older People and Physical Disability)</p> <p>Focus group with 3 Care Managers</p> <p>Director, Glasgow Social Care Providers Forum</p> <p>Chief Exec, Glasgow Centre for Inclusive Living (GCIL)</p> <p>Inclusive Services Manager, GCIL</p> <p>Group discussion and participant observation at meetings of SDS Stakeholder Forum involving a range of service providers.</p>	<p>SDS Project Manager</p> <p>Head of Children's Services (Test Site Sponsor)</p> <p>Team Manager (Younger Adults)</p> <p>Service Manager (Service Planning & Modernisation)</p> <p>Direct Payments Support Officer</p> <p>Senior Finance Officer</p> <p>Health & Happiness Co-ordinator/Manager and SDS Project Board member</p> <p>People First (Learning Difficulties Self Advocacy Group) Development Worker</p> <p>Focus group with Highland Community Care Forum including Director; Information Coordinator; Senior Carers Advocacy Worker; Carers Advocacy Coordinator.</p> <p>Telephone interview with Highland Users Group (HUG) representative.</p>

Table 8.2: Category and organisation of interviewees at national level interviewed at Stage 1

Category	Organisation Name
Scottish government	3 Seconded Project Managers group interview 2 Senior SDS Team Members
SDS/DP Specific	SDS Scotland SPAEN In Control Independent Living in Scotland
Service User Group	Voices of Experience 2 People First
Local Government	2 COSLA ADSW Sub Group on SDS
Interest Group	SCLD Carers Scotland
Providers	Community Care Providers Scotland Thistle Foundation Alzheimer Scotland Scottish Care at Home
Union	Unison

Table 8.3: Local test site stakeholders interviewed at Stage 2

Dumfries & Galloway	Glasgow	Highland
<ol style="list-style-type: none"> 1. Test Site Manager (Scottish Gov) 2. Personalisation Lead Officer 3. Senior Social Work Manager 4. Social Work Team Leader Older People & Physical Disabilities 5. Social Work Team Leader Learning Disabilities 6. Senior Finance Officer 7. DP Coordinator 8. ARC Manager 9. Peer Project Manager 10. Stranraer Skills Station (2 Managers) 11. Turning Point Union Rep 12. Senior Commissioner 13. Adult Protection Lead 	<ol style="list-style-type: none"> 1. SDS Project Manager 2. Head of Adult Services 3. Test Site Manager (Scottish Gov) 4. Principal officer, Disability Commissioning 5. Head of Mental Health 6. SDS Team Leader 7. Senior Finance Manager 8. Care Managers (x 3) 9. Glasgow Social Care Providers Forum Manager 10. Providers (x 7) including managers in: Inclusion Glasgow C-Change Community Lifestyles, Alzheimers Scotland Enable Scotland Mungo Foundation Quarriers and Consultant working with providers 11. Glasgow Centre for Inclusive Living (GCIL) (2 managers) 12. Partner organisation in an SDS Project (Housing Association Manager) 13. Service user organisation clients - focus group of service users (x 8) 	<ol style="list-style-type: none"> 1. Director of Social Work (HC) 2. SDS Project Manager (HC) 3. Head of Children's Services (HC) 4. Director of Community Care – NHS Highland 5. Co-ordinator, Health and Happiness 6. CEO Highland Community Care Forum 7. Principal Accountant (HC Soc Wk) 8. Test Site Manager (Scottish Govt) 9. Head of Community Care (HC) 10. Programme Manager – Modernisation and Quality Assurance (HC) 11. DP Officer (HC) 12. Provider (1) 13. Commissioning Lead (HC) 14. Adult Protection Lead (HC)

Appendix 2: Test Pilot Themes

The 3 themes were defined as:

Investing to save

This theme will seek to double fund buildings-based care within a local authority to enable remodelling of the care facilities, while encouraging those clients who use the facilities to adopt other forms of social care in the community, in particular, self-directed support. One of the obstacles to the uptake of self-directed support that has been repeatedly identified is the difficulty that local authorities have in releasing money that is tied up in building-based services, as self-directed support has historically been regarded as a cost neutral option. Local authorities have argued that additional funding is required to “double fund” facilities to enable the transition from buildings-based care to more personalised care.

Cutting red tape

This theme will seek to enable a local authority to cut non-essential red tape surrounding self-directed support provision. This would allow more front line staff to concentrate on their core job and therefore improve the user experience, which we expect to help drive demand for self-directed support. A local authority would be expected to cut its inward and outward focussed bureaucratic processes and to apply a “light touch” monitoring process. The work will focus on implementing fully the forthcoming CIPFA Guidance on DPs but provision would also be made to encourage local authorities to consider wider bureaucratic issues that impact on the self-directed support agenda.

Leadership and training

The leadership and training theme would seek to develop a means of increasing awareness, knowledge and confidence about promoting self-directed support on the part of front-line staff, social work middle and senior management and local authority finance officials. The test sites will consider different means of promoting self-directed support internally throughout the local authority and enable evaluation of the effectiveness of these, with a view to the practices being spread throughout Scotland.

(Source: Letter to test sites from Deputy Director (Adult Care and Support) Primary and Community Care Directorate, December, 2008)

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