6. Policy development and plans to support improvement in services

The partnership commissions services that ensure supported people have a range of choice and control over their social care and support.

Summary

Outcome-focussed commissioning had not been a focus for the partnership. Approaches to support flexibility, choice and control for people using services were at an early stage of development. Commissioning in the partnership was weighted towards traditional services with little evidence of innovation. With most services still provided directly by the council and significant levels of services under block contracts[2] there was little flexibility, choice and control for supported people. We saw some use of spot purchasing resulting in more personalised support for people in learning disability services but not elsewhere. There was an increasing awareness of the issues and the gaps in the partnership's current provision and a recognition that their commissioning direction needed to change. Steps had been taken to increase the range of providers available and for provision to be more in line with self-directed support. Work had started on changing the shape of the market in care at home and respite services. The partnership was in the process of appointing a commissioning manager to bring more focus to their change in direction.

Evaluation: Weak

The services provided in West Dunbartonshire were traditional and not consistent with the principles and values of self-directed support. The chief officer was leading a review and refresh of their approach but this was at an early stage.

The partnership's service delivery was predominantly through block contracts. Partnership staff at all levels recognised that the existing model of block contracts hindered choice and control. There had been some use of spot purchase[3] and this was supportive of innovation and tailored support for some people. A few examples of this were given in relation to supported people with learning disabilities.

In the partnership, there was still a reliance on council-provided service delivery. Eighty per cent of services were provided directly in this way. Corporate and political decisions in the council had directed the shape of service delivery to a great extent. There had been a commitment to retain as many services as possible within the council as this was seen as a way of supporting local employment. This had restricted innovation and the development of alternative care models. The level of in-house provision for care at home clearly limited choice. In practice, the majority of people had to accept council services. The senior management team felt strongly that a culture change was needed in the provision of services and that this could be done without impacting on the council's commitment to support local employment.

[2] Block contracts are payments made to a provider to deliver a specific, usually broadly defined service

[3] Spot contracts are when a service is purchased by a partnership as and when they are needed for a supported person. They are purchased on an individual basis for a single person.

The partnership had begun to work on shaping the market. There had been a minor shift of some care at home provision to external providers and the partnership was looking at new models of care using reablement. It was also seeking to increase respite provision and the range of respite opportunities. The partnership was keen to encourage small and medium-sized providers and had highlighted this in their market facilitation plan. They recognised that this would give more choice to individuals, increase choice and grow the market. However, there was no clear strategic plan in place for the partnership to continue enabling and growing the market.

The partnership had established a market facilitation consortium which included partners from across the statutory, independent and third sectors. The consortium aimed to make the best use of the resources across local communities. The consortium principles were described as *'*a comprehensive partnership approach across all sectors providing health and social care services; a commitment to provide enhanced delivery of service to individuals and communities and a need to create diversity within the marketplace based on population needs[4]*'.* This initiative was a positive one and borne out of a commitment to partnership working at locality levels. It was, however, not clear how this was to be translated into locality developments. The approach was developed in 2015 and there was little evidence that this approach had resulted in any real diversity within the marketplace. There was no evidence that it had been updated and linked into their strategic needs assessment, strategic plan, commissioning plans or locality planning forums.

While expenditure on self-directed support Options 1 and 2 in the partnership had increased[5], the partnership had a higher percentage of people opting for Option 3 compared with other partnerships. The partnership felt that high satisfaction with the partnership's social care services meant that people were less motivated to take up self-directed support direct payments or individual service funds options. The high number of people choosing Option 3 did not necessarily mean that this was not the right option for them. Within the partnership however, supported people did not necessarily have real choices open to them across all four options. The partnership did not routinely engage supported people or staff in getting feedback after options had been chosen so it was impossible to evidence that people were happy with their option choices.

Commissioning needed to be more creative and responsive. While there was still a requirement for traditional services for some supported people, it was clear that new models of care needed to be explored. Some staff recognised that due to the majority of services being in-house, people were steered towards taking services under Option 3. Staff felt they had ideas to offer about options that would support more innovative service, save money and improve outcomes.

[4] West Dunbartonshire Market Facilitation Consortium Paper September 2015
[5] From 1.39% of the overall adult social care spend in 2013/14 to 2.16% 2017/18

Service managers were very clear about the need to move to an outcome-focussed approach to commissioning. Procurement was predominantly corporately based. While the service managers worked closely with procurement services, there was a task ahead to educate their corporate partners as to what they wanted to achieve as they embedded the self-directed support approach, and how corporate partners could support them in doing this.

The commissioning of services was led by service managers. While all the managers had a good knowledge and understanding of self-directed support this was not reflected in their commissioning practices and the services commissioned. The partnership recognised the issues and risks around the current approach to contracts and commissioning. They were developing a commissioning manager post for the partnership. The partnership stated that this would clarify the responsibilities and roles of strategic commissioning and contract management within the health and social care partnership alongside the council's procurement team. The commissioning manager's role was to consider how primary and secondary health services could support the implementation of self-directed support. The partnership wanted this approach to lead to the embedding of self-directed support across all social care and health planning and ensure that the corporate approaches taken reflected the self-directed support ethos. They hoped this approach would support a streamlined and consistent contract monitoring approach across the partnership.

The Carers (Scotland) Act 2016 places additional demands on the partnership's budgets at a time of continuing financial austerity. The potential implications of the Act, including the financial impact of waiving of charges for carers, had not as yet been fully quantified. Finance staff had some concern about the financial impact of meeting carers' needs via self-directed support. The senior management team members were more confident. At the time of inspection, carers' needs were mostly being met through universal services. There was little use of self-directed support and budgets therefore it was having little financial impact. There was no evidence that the partnership was monitoring services to carers to ensure that needs were being appropriately met or forecasting need for newly commissioned services and ensuring any financial impact from that would be met. A detailed financial plan was to be developed over the next year to ensure a robust financial framework for the delivery of the priorities of the Act. The position of having no eligibility criteria for carers would be reviewed at that point.

The development of the partnership's approach to planning and commissioning services to support flexibility, choice and control was at a very early stage. There was no overarching commissioning plan which explicitly showed the self-directed support improvement actions.

Recommendation for improvement
The partnership should engage with supported people, carers and frontline staff to inform the development of new models of care focussed on delivering positive outcomes.

Recommendation for improvement
The partnership should take steps to increase local choice of provider and flexibility in the delivery of services to ensure people have genuine choice and control over how their support is delivered.

7. Management and support of staff

The partnership empowers and supports staff to develop and exercise appropriate skills and knowledge

Summary

Training, supervision and management support was not being used effectively to promote self-directed support. There had been an investment in training at the time of self-directed support implementation in 2014. This had not been maintained. There was no existing training for current or new staff including those moving into management roles, nor was any training extended to external providers. The partnership had begun to refresh their self-directed support guidance and had begun to develop continuous professional development material. The specifics and timescales for implementing these were unclear.

Evaluation: Weak

There had been a strong focus on self-directed support awareness raising and training in the early years of self-directed support. The partnership had delivered training to staff across social work, health and the third sector in 2014. This included creating champions or peer mentors. The direct payment team was also established at that time to support implementation within the learning disability team. This team was recognised by staff and managers as being knowledgeable and confident in working with supported people and staff around self-directed support.

The self-directed support team and guidance co-produced with the Royal National Institute of Blind People (RNIB) "*My life My choice; A Guide to Planning My Support*" were identified as helpful sources of information about self-directed support and for awareness raising amongst both staff and the wider community.

There was no ongoing training for new or existing staff at frontline and first line management level. There was a need for awareness raising and training about self-directed support to be refreshed and undertaken on an ongoing basis.

The senior management team acknowledged that they need to be confident that all stakeholders, including external providers, are working with a self-directed support ethos but they had no plans to offer any training to the third sector.

The partnership had recently released a practitioner from frontline work to develop new guidance and continuous professional development (CPD) material on self-directed support but there was no clearly articulated work plan to deliver the material.

Supervision for social work staff took place routinely on a six-weekly basis, with case file audits on a quarterly basis. Staff had the opportunity to attend practitioner forums although many staff told us that operational pressures often stopped them from attending. These were potential opportunities for staff to reflect on self-directed support within these forums but there was no evidence to suggest that this was happening.

In older adults' case records we saw that most interventions were positive and person-centred. However, much of this was done from a deficit-led approach to assessment and was process driven. This did not fit with the principles of self-directed support. Training, supervision and management support could have been used more successfully across all service groups to support staff to shift their practice to a more self-directed support, strengths-based approach.

The partnership indicated an intention to develop established practitioner forums and identify champions to get frontline staff more meaningfully engaged in the agenda. They were looking at ways that they could evaluate the effectiveness of these new initiatives.

Recommendation for improvement
The partnership should take a strategic approach to the development and delivery of self-directed support training for staff at all levels across the partnership.

Recommendation for improvement
The partnership should consider the training and development needs of all partners.

8. Leadership and direction that promotes partnership

Senior leaders create conditions that enable supported people to experience choice and control over their social care and support.

Summary

Some staff expressed doubt about the degree to which leaders in the organisation were committed to self-directed support. The senior management team had seen a number of senior staff retire or move onto other promoted posts. This led to a change of leadership. At the time of inspection, there were still temporary positions within this team. This had led to difficulties in driving the changes required to deliver self-directed support and maintaining a consistent approach to its implementation. The partnership's focus on health and social care integration over recent years had diverted their attention away from self-directed support. New members of the senior management team were committed to ensuring that self-directed support would be a significant and central activity for the whole health and social care partnership over the next year. They felt that once all senior managers were in post, they would have the opportunity to start a cultural shift in how they approached the delivery of all of their services. They recognised the need to develop a common understanding and direction around self-directed support across all partners including external providers. They had taken some steps to put the required foundations in place to reinvigorate this agenda. They needed to develop more robust plans to take this forward.

Evaluation: Weak

In the partnership's annual public performance report 2017, there was a large section on self-directed support which reinforced their commitment to meeting the requirements of the self-directed support legislation. The partnership had not yet met the commitments set out in this report.

The newly appointed senior management team articulated a commitment to reinvigorate full implementation of self-directed support. They had taken important initial steps, including the establishment of the self-directed support review group. All service managers were part of this group which demonstrated their commitment and their ownership of the agenda. This group was in the process of producing practitioner guidance during our inspection. The senior management team had overseen early progress on developments in training, tools and processes. Within a relatively short period of time they had also overseen a number of specific actions demonstrating their commitment to change.

Senior managers recognised the limitations in care at home and care home provision in supporting the delivery of self-directed support by the third and independent sector and were keen to develop their partnership with providers. They were developing plans to progress this. They recognised the importance of improving their approach to commissioning and planned a review of procurement and commissioning procedures. They were developing a commissioning manager post to address this.

It was evident that statutory partners across health and social care were starting to look at how they could work together to create a cultural change which would support innovative practice in line with the values and principles of self-directed support. Their stated intention was to use self-directed support as the approach that they would take in delivering all services. To ensure this cultural shift, the senior management team recognised that all leaders across the statutory partnership and all other stakeholders had to be more meaningfully engaged. Health leaders in particular had to be more visible and active in this agenda. A paper on self-directed support had gone to the integration joint board in November 2017. This board needed to be more actively involved in leading and supporting the changes that self-directed support required.

The senior management team recognised that the third and independent sector had to be more fully involved. While this was stated in the market facilitation plan, there were no plans as yet to show how this would be achieved.

While leaders had taken initial steps to progress self-directed support, we saw no overarching plan which brought together all the various improvement actions into one place. We saw no evidence of the use of evaluation and performance information to inform how they moved forward in developing and embedding self-directed support. While the senior management team could articulate their vision about where they needed and wanted to be, there was a lack of robust planning to support this. There were no clear timescales, pathways or plans in place to achieve their vision.

Finance staff had a very good understanding of self-directed support. There were constructive relationships between the senior management team and finance managers. They offered a supportive role to operational services. While driven by best value and the recognition that embedding self-directed support had to be done within the confines of decreasing resources, finance staff were committed to the ethos of self-directed support. They were advocates of transparency and equality of spend across care groups in relation to self-directed support and understood the principles of choice and control. This was important in preparing for the partnership to expand access to self-directed support across all care groups.

To embed self-directed support the partnership recognised that it has to more closely align to other factors such as its charging policy, its eligibility criteria and the implementation of the Carers Act. It had not yet assessed the impact of full implementation of self-directed support on its finances. This was a key risk yet they had not formally logged any identified any risks around this in the partnership risk register.

Staff completing our survey and those we met expressed significant levels of doubt about the degree to which leaders in the organisation were committed to self-directed support and how they facilitated and supported creativity and innovation. Senior managers and leaders were keen to stress their confidence that this perception would change in time, as a result of the changes that had more recently taken place at senior management level. It was too early however to say how effectively this would be progressed.

Recommendation for improvement
The partnership should accelerate its progress in embedding self-directed support and set clear timelines for full implementation of self-directed support across all care groups.

Recommendation for improvement
The partnership should develop a robust strategic plan for self-directed support aligned to its other partnership plans. The strategy should be underpinned by detailed action plans setting out how the partnership intends to fully implement self-directed support for all care groups across the partnership.

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