

Self Directed Support:

practitioner guidance



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Preface

The Self Directed Support (Scotland) Act 2013.

"to make legislative provisions relating to the arranging of care and support in order to provide a range of choices to individuals as to how they are provided with their support"

Scottish Government

Self-directed support is about assisting individuals who may need support to have maximum choice and control over how this support is planned and provided.

It is a matter of national pride that the principles and values that underpin best practice in this field are to be enshrined in statute. We have a real opportunity in Scotland- at government, professional, community and individual level- to work together to achieve our ambitions for a quality life for everyone.



Sandy Riddell, President of ADSW

We are all challenged by the impact of an economic downturn. Resources are scarce and must be used to best effect. We are all concerned to ensure that the advances in health and social care that have resulted in increased life expectancy are matched with advances in professional practice that ensure living longer means, as far as possible, living well.

This document aims to provide practical guidance and support to practitioners tasked with bringing Self Directed Support legislation and policy objectives into everyday practice. It is at this level of the organisation that transformation in approach is most crucial, backed by necessary supporting IT, resource allocation and financial systems. Every practitioner has a key role and responsibility in the process to provide people who need support with the information and assistance they need to make real choices. These practitioners, in turn, need to be empowered by their organisation to shift control within the system towards people who need our support. It is this change in organisational practice and culture that will be most challenging in the context of our changing relationship with key partners.

The new Act provides a framework for transparency and clarity in how partnership and collaborative practices can be effective in supporting practitioners to work creatively and resourcefully. It is the natural policy progression from 'Changing Lives' (2006) which stated,

"tomorrow's solutions will need to engage people as active participants, delivering accessible, responsive services of the highest quality and promoting wellbeing."

It is a policy position supported by the direction of the Christie Commission report. Most importantly, it is what we would want for ourselves and our loved ones. There can be no better affirmation of the value of this approach.

Sandy Riddell, President of ADSW

Introduction

People, Policy & Legislation

"We are people first. The outcomes we want include having power and control, being able to take risks & contribute to society. This means that there needs to be a shift in power away from people who commission & provide services to users and carers..."

(User & Carer Panel: Report of the 21st Century Social Work Review: 2006)

The Social Care (Self-directed Support)(Scotland) Act 2013, due to be implemented on 1st April 2014, is a key building block of public service reform. It's an approach that has its origins in the Independent Living Movement- sharing the core values of inclusion, contribution and empowerment through real choice and respect. The Act creates a statutory framework around the activities already underway across Scotland to change the way services are organised and delivered- so that they are shaped more around the individual, better meeting the outcomes they identify as important. So individuals are seen as 'people first' – not service users.

This simple but powerful statement from the User and Carer Forum should sit in the hearts and minds of staff from across the sectors as the justification for change. Legislation, policy and guidance will assist with understanding what is expected. However, it is an understanding of humans and their ambitions that will lead to an appreciation of what is needed.

Achieving better outcomes for individuals is complex. It requires a whole system change within and across organisations that supports the best intentions and abilities of individual workers and the people receiving support.

Practitioners across social care will have a pivotal role in delivering this reform in partnership with health colleagues. In Scotland, for example, during 2011/12, 684,000 hours of home care were provided in a week; 211,000 weeks of respite were supported in the year. The challenges will be many and come at a time of reduced resources and growing demands. There is a general acceptance that 'more of the same (type of service delivery) won't work'- but this reform goes deeper than economic issues. It's about making people's lives better.

The Christie Commission Report emphasised the importance of:

"Working closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance, and build resilience."

To drive forward this work, the Scottish Government has developed a 10 year Self Directed Support strategy with partners, stating the intention as -

"..delivering better outcomes through focused assessment and review, improved information and advice, and a clear and transparent approach to support planning. The strategy is part of a wider reform agenda, and reflects the common goals of current health and social care policy to deliver better

outcomes for individuals and communities. These include recent developments in Reshaping Care for Older People, Caring Together, and the National Dementia Strategy. Implementation will also bring a focus to the development of self-directed support for children and young people alongside GIRFEC."

The wider policy context, including the Public Bodies (Joint Working) (Scotland) Bill, evidences a move towards the integration of health and social care and provides a context for working in partnership to meet outcomes. Self Directed Support places people who use services right at the heart of this partnership.

Many staff experienced in this approach say that it reaffirms their core purpose - namely improving outcomes for people through utilising their strengths and assets. 'It's why they came into the job'.

Purpose and Scope of Guidance

- to provide a guide for all practitioners who have responsibilities under the new legislation on how to effectively deliver on the new duties and responsibilities with people who need, or may need support.
- this is one of several pieces of guidance provided or commissioned by the Scottish Government- namely- Statutory Guidance and Regulations; guidance for people who require support; guidance for carers.
- to offer practical examples of how the new Act will translate into practice, including explanation of where new duties apply; a broad "how to guide" in relation to complex assessment and support planning.
- the new duties of the Act sit with local authorities. This guidance, therefore, is primarily aimed at local authority practitioners. However duties also apply to those to whom the authority has delegated responsibility for providing information, assessment and support planning activities / to multi-professional teams where practitioners, especially in NHS, who undertake assessment and support planning activity.
- when a person has health and social care needs, there is a clear expectation that partner agencies will work collaboratively to meet these needs. The guidance will support this practice.
- to assist with identifying some of the key considerations for local authorities in their implementation of Self-Directed Support.
- this guide cannot offer detailed explanation as to the mechanics of delivering the 4 options under Self Directed Support - as local implementation arrangements will differ and are at varying stages of development. Practitioners, therefore, have a responsibility to be knowledgeable of any local policies and systems in place designed to help support the process.

- the guide highlights relevant, existing legislation that will continue to direct practice alongside the new duties. New challenges around risk versus self-determination are considered.
- a guide for providers will be produced in late 2014/early 2015.

Terminology

- where the term 'person' is used, it applies to all adult groups, carers, children, and young people unless otherwise specified.
- where 'practitioner' is referred to, this applies to all professionals undertaking activity described in guide.

Principles & Values

Self-directed support is a policy driven by the recognition that when people have more control over how they live their lives and any support they may require, they are likely to achieve better outcomes.

Principles

Sections 1 and 2 of the Act specify five general principles that guide practice.

Involvement	This requires that the supported person must have as much involvement as they wish in both the assessment and in the provision of any support agreed on completion of the assessment.
Collaboration	Practitioners must collaborate with the supported person through assessment and in the provision of any support identified and agreed on completion of the assessment.
Informed Choice	The supported person must be provided with any assistance that is reasonable to assist them to express their own view about the options available to them and to make an informed choice about their preferred choice.
Participation & Dignity	This applies to both the initial assessment stages and to the provision of choice as part of wider planning.

Values

The Act is underpinned by the following values that are underpin good social work practice:

	Having due regard for the feelings, wishes, or rights of others.
	A reference to the individual, not the group or society at large; providing unbiased information about the choices available/ treating people in a manner which befits and benefits their individual circumstances.
	People are supported to maximise their aspirations and potential. Support focuses on the prevention of increasing dependence and enablement, or re-ablement.
	Have a choice.
	Individual is supported to feel safe and secure in all aspects of life, including health and wellbeing; to enjoy safety but not be over-protected; and to be free from exploitation and abuse.

The Act introduces four options that require the identification of allocated financial resources. This aspect of the legislation has attracted considerable attention as our organisational systems often do not readily support a shift in resource allocation in the manner and scale required to make this aspiration a reality. This attention has led some to believe that Self Directed Support 'is all about money'.

Self-Directed Support is, in fact, about people, their strengths and assets, their right to live fulfilling lives, their right to be included as active citizens, their right to be full participants in assessing their own needs and also their right to exercise choice and control over any support provided.

Legal duties

The Act, implemented on 1st April 2014, enshrines in law the key principles that already inform best practice. From that date, practitioners must 'have regard' to the following principles when engaging with all individuals who are assessed and those who then require support. These form new legal duties:

- involvement
- informed choice
- collaboration
- dignity
- participation

Successful implementation of the new Act will be dependent upon practitioners keeping these values and principles central within their practice.

The new duties summarised:

- A person must have as much involvement in the assessment process as they wish to and in the provision of support services. It is built into the Act that people must be enabled to participate in their own assessment. This includes NHS partners.
- The local authority and those delegated must collaborate with the individual in relation to the assessment of the person's needs for support or services and the provision of support or services for the person.
- When a person has been assessed as eligible for support there is a duty to offer 4 choices in relation to how that support will be facilitated. There is also a duty to ensure these choices are informed through consideration of impact and implications.
- A person must be provided with any reasonable assistance to enable them to express any views they have about the options for self-directed support. This will require consideration of, for example, advocacy, interpreter or other communication support.

The duty to offer the 4 options is a specifically a duty for the local authority. They are explained in detail in "The four options" section. They are:

1. A Direct Payment
2. Directing the available support
3. Services arranged for the person by the authority
4. A mixture of the 3 above.

When a person is eligible to choose one of these four options, the authority must give the person:

- information on how to manage the support

- information about where else to get information and help about managing the support

If the authority considers that the supported person is ineligible to receive direct payments the authority must notify the supported person of:

- the reasons for refusal
- the circumstances in which the authority must review this decision.

If a person is not considered eligible for any of the 4 options this requires to be explained in writing.

At each review the four options must be offered formally again, even if there are no changes.

Adult Carers – a new duty in the Act is that the authority must consider the assessment and decide whether the adult has needs in relation to the care they provide, or intend to provide, to the person that is cared for.

Duties for Local Authorities

Local authorities must take steps to promote the availability of the options for self-directed support.

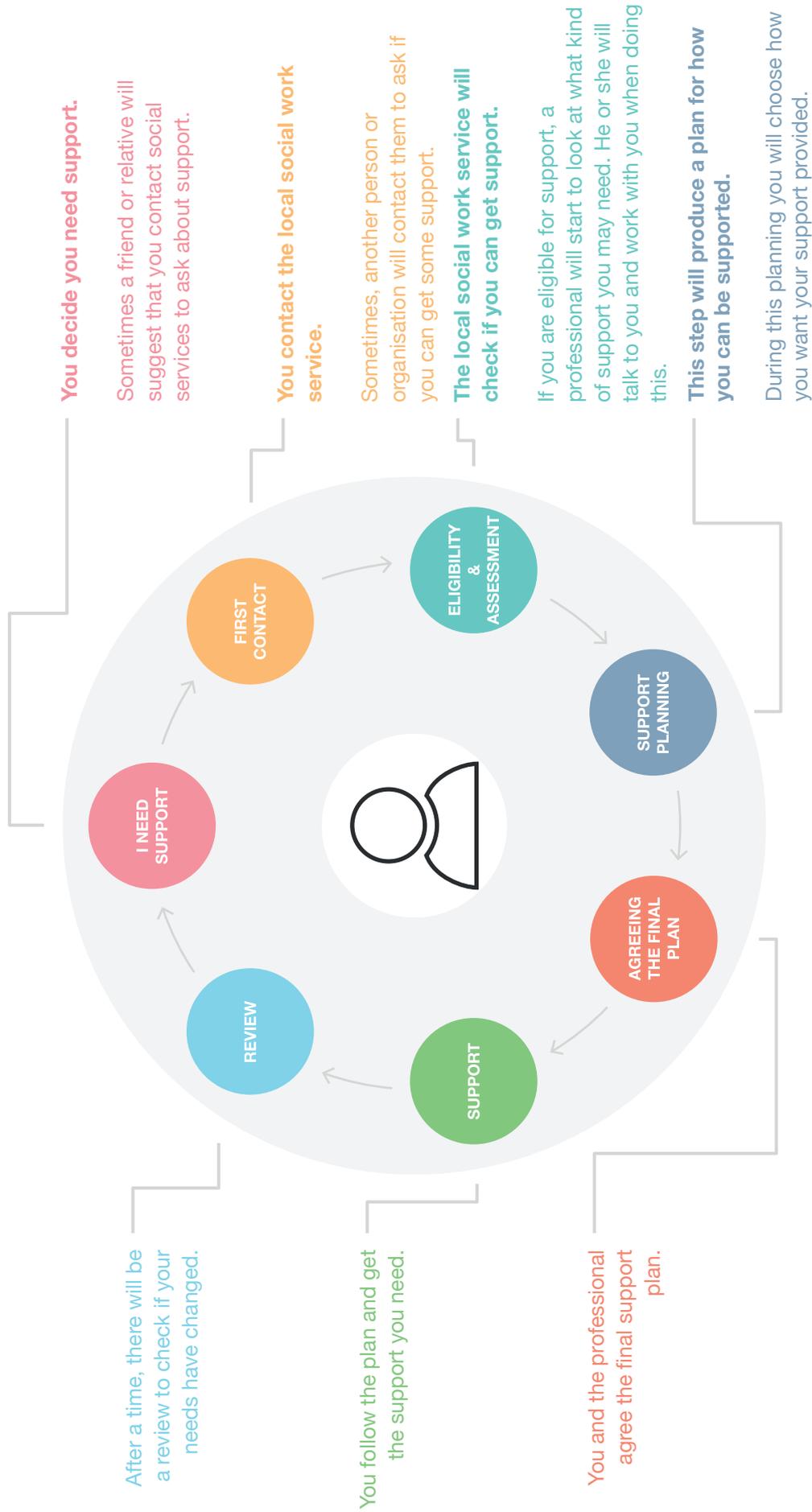
Local authorities must, in so far as is reasonably practicable, promote a variety of providers of support and a variety of support.

In addition, NHS partners should consider where collaboration in support planning can extend to sharing resources. The closer integration of health and social care encourages the pooling of resources to meet joint health and social care needs. This means that NHS partners should work with councils in a collaborative way in relation to their role in self-directed support.

(Risk in relation to these new duties is addressed the sections on assessment; eligibility; support; planning; the 4 options and, risk)

The Person's Pathway

There are different steps to getting support. The steps are called the Person's Pathway. Here's how it might work for you.



Assessment

The Act is clear in relation to individual's participation in their assessment. This is more than 'consultation'. Whilst assessment is currently a legal duty for local authorities, this duty involves enabling people to co-produce their assessment if they so wish. This also extends to NHS partners involved in the assessment or who are contributors to the assessment and plan.

Legislative framework that guides practice around assessment.

- Section 12a of the Social Work (Scotland) Act 1968 - provides the legal basis for all community care assessments for adults.
- Section 22 of the Children's (Scotland) Act 1995 – provides the legal duty to safeguard and promote the welfare of 'children in need'.
- Section 23 of the Children's (Scotland) Act 1995 – provides the legal duties in relation to children affected by disability.
- Section 24 of the Children's (Scotland) Act 1995 – provides the duty to conduct carers assessment for carers of disabled children.
- Section 12aa of the 1968 Social Work (Scotland) Act states we have a duty to offer assessment to carers.

Exploration of the person's needs and outcomes under Self-Directed Support – background information

Assessment presents an opportunity to engage the individual and other key people involved in reflecting on what matters to them in their life, and also why these things are important (the outcomes) as well as challenges faced and opportunities to address these. The main focus in assessment until recently has been on individual needs. As needs are usually linked to eligibility criteria, which are used to determine whether the person's needs call for provision of services, there is still a requirement to identify needs as well as outcomes. There can be a challenge to make this distinction. Often a factor identified by an individual as being important to them can be understood as both a need and outcome. However, the outcome should always answer the 'so what' question.

Although distinguishing needs and outcomes can be challenging, it may be necessary to do so in the context of eligibility criteria. In this context, it might be helpful to understand outcomes as clarifying direction and purpose, while needs can be interpreted as barriers to achieving those outcomes. An example might be that an individual wants to feel more confident about spending time with their peers (outcome) but they have lost confidence due to difficulty with walking following a car accident (barrier or need). It may be that the individual is beginning to experience symptoms of depression due to isolation and that failure to support the outcome of spending time with peers may exacerbate deteriorating mental health (risk).

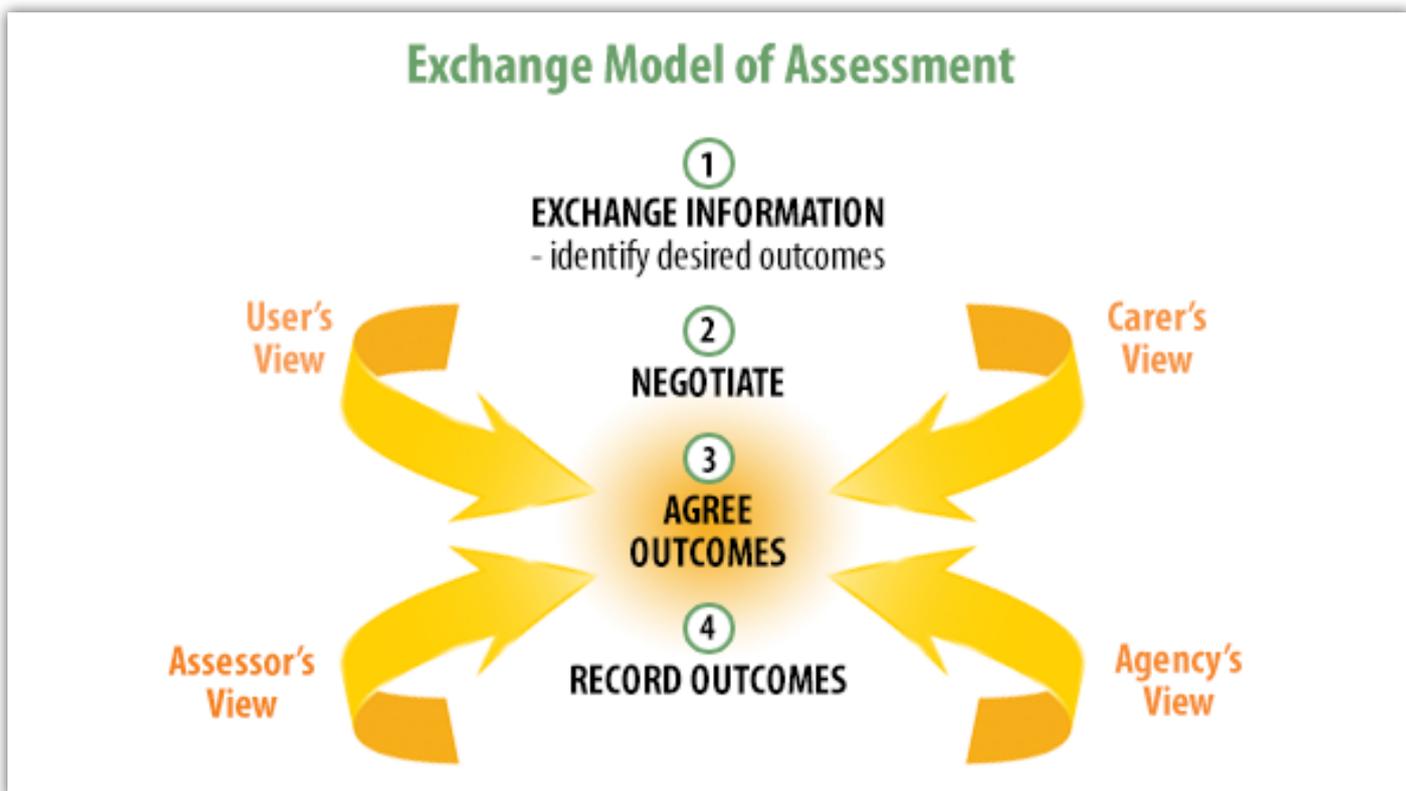
In almost all cases, the assessment provides an opportunity for individual participation in decision-making and should involve consideration of the role the individual wants to play as well as the role of other people, supports and services. In

adult services, the focus on outcomes is therefore consistent with a range of health and social care policy drivers which promote participation and support independence, including recovery, re-ablement, an assets approach and supported self-management. For children and young people, this approach is consistent with GIRFEC and the SHANARRI wellbeing indicators. For unpaid carers, it is consistent with the Carers Strategy.

Assessment may act as the starting point for development and improvement in an individual's life. Alternatively, it may support a person to maintain the "status quo", to slow the rate of deterioration or to ensure that any decline in a person's situation is well managed. Individuals' needs and outcomes can change over time, even over relatively short timescales. The assessment should respond to changing circumstances and needs, and changes during the course of the person's life.

Good assessment practice and personal outcomes

An outcomes focused assessment is in tune with the general principles within the 2013 Act. It also fits with relationship based practice in particular and with the "exchange model" which emphasises the collaborative nature of assessment, showing how the views of the person, carer, assessor and agency are brought together to negotiate, agree and record outcomes. The agency perspective acknowledges the need to operate within statutory, governance, duty of care and budgetary factors. Otherwise, while the range of individuals whose views are included may vary, it is critical within this model that the person's views are represented. Although developed in relation to adult services, some of the principles apply to children and families, including the need to use the best possible sources of information available, and to consider the views of key people involved, to negotiate and identify outcomes. Although not emphasised within the model this should involve the views of other professionals as appropriate, particularly with reference to GIRFEC. It may not always be possible to agree on all outcomes. Recording differences can help with clarification and can support reflection and negotiation in the longer term. See Figure 1 below for an illustration:



An outcome is generally understood as a result or effect of an action. However, it is also critical that the individual is involved from the outset in identifying the outcomes that are important to them. There are different understandings of outcomes in operation. For example there are national outcomes such as 'we live longer, healthier lives' and there are organisational outcomes which could include 'improved ability to self-manage.' Personal outcomes are the things that matter to the supported person, and require an understanding of why these things matter to them.

New duties - assessment processes

Referral

People engage with services for a variety of reasons and circumstances. For some, they will be seeking advice and information that can be best supported through good initial communication, information and signposting. Often, referral for social work support will not be initiated by the person themselves. Clear information needs to be given to both the person and the referrer about the purpose of any involvement as well as the legislative framework which is guiding involvement in someone's life.

The duty to provide information at this stage currently exists under Section 12 of the Social Work (Scotland) Act 1968 and the NHS Community Care Act 1990.

Dermot's Story

Dermot, aged 51 has had a long history of recurring depression and anxiety for which he receives medication. When Dermot was feeling unwell he abused alcohol. Eventually, his health deteriorated further, was admitted to hospital and formally diagnosed with schizophrenia. Dermot was later discharged to the Community Mental Health Team and allocated a Mental Health Officer. At this point, he was encouraged to consider support as there were concerns about him refusing his medication and abusing alcohol. Initially Dermot did not like the thought of having a Mental Health Worker and the thought of any further 'assessment' for support heightened his anxieties as he knew it might mean being asked very personal questions about his personal life and family. The Mental Health Worker recognised this fear and established a relationship through fully explaining the purpose of her involvement, being sensitive to his situation, and going at a pace that Dermot felt comfortable with. Through on-going conversations, Dermot felt reassured by this. He was also assured by her knowledge and experience of working with people who experience poor mental health.

Dermot found it hard to make decisions or even think about his future, it was something he found very hard to think about in any shape or form, let alone on an aspirational level. Dermot had spent many years just trying to survive so the concept of identifying personal outcomes was difficult. Dermot's Mental Health Officer understood this and supported him to take small steps, firstly by giving him choice about when and where they would meet, moving on to talking about the things that were important to him but small manageable chunks and at Dermot's pace.

Following many conversations Dermot started to recognise that there were important things that he hadn't been able to think about for a long time. Dermot wasn't really sure about what having support meant or what it would look like so time was spent fully explaining this, how it would be planned and who else might need to be involved. The Mental Health Officer advised of how Dermot's support could be something he could have choice and control over himself and fully explained some options. It took Dermot some time to get his head around this, however, he felt safe to ask questions about what different options might look like and mean. He also found it helpful reading through

information about how to direct your own support, particularly examples of people's stories about how they planned and used support. Through on-going conversations, Dermot identified that he wanted a hobby, make contact with his family, and be able to go out of his house with confidence. (Personal outcomes) He decided he would like his Mental Health Officer to arrange his support, as he wasn't ready to take the step to handling a budget. However, he still wanted to be fully included in all aspects of the support planning – identifying an agency to provide a support worker.

Dermot was able to advise on the kind of personality and qualities he valued in a support worker. Dermot was able to identify small goals and work through how these might be achieved and who could help. Dermot found it helpful to know that whilst his plan was agreed and the support put in place, it didn't have to be 'set in stone' and if things did deteriorate he could ask for it to be looked at again.

The assistance and information given to Dermot at a level and pace he understood was crucial in helping Dermot feel more in control about the process and help him develop confidence to make choices important to him. Dermot was also aware that if things did move on in terms of his recovery that he would consider thinking about the agency holding the budget for him or even eventually managing his budget himself.

Initial screening assessment

This concerns the process of determining how to action a referral and what priority is afforded to it. Self-directed Support requires skilled practitioners to take a holistic approach to screening, working in partnership with the person to help explore their existing resources and natural and community networks. There are many ways of exploring alternative solutions at an early stage. For example, providing information and helping the person to identify personal and community assets. NHS policy mirrors this approach of self-care and community resilience. Skilled assessment and screening processes may often enable a person to remain independent of formal services.

Self-screening also has an important role, for example accessing website information, thereby enabling informed choice as to whether or not to continue. This applies to both individuals and families. The principles of participation and dignity underpin all assessment and screening processes.

Duties in relation to assessment

1. To undertake an initial assessment with the person, ensuring they are involved in the development of the assessment along with those who matter to them.
2. Where it is identified as needed, ensure the person is supported to participate as fully as possible at this stage of assessment.
3. The principles of participation dignity and collaboration apply, along with the stated values.
4. The right to participate in society and community and to live with dignity may guide to other solutions.

Issues of choice vs safety will guide decisions re further assessment or crisis engagement.

Holistic Assessment

Social work is based on the premise that people can change and that social workers are agents of change. Health and education, along with others, are key partners in ensuring the person remains at the centre of all decision making.

Holistic assessments consider the person's assets and wider supportive network, leading to creative solutions that can delay or negate the need for formal intervention. This promotes opportunities for early intervention and preventative solutions through jointly created and alternative means.

- the new Act emphasises the importance of the assessment being undertaken in a manner that ensures the individual feels they have helped shape the assessment rather than been a passive party in the assessment.
- the importance of assessment based on personal outcomes is acknowledged, identified through genuine partnership.
- people should be considered experts in their own lives- therefore staff need to work in partnership to explore and agree solutions and to mitigate risks together.
- where there is risk, the principles of Self-Directed Support still apply but must be explored from a protective perspective. When providing a service/support for children, protecting them from harm remains the paramount concern. However, there is a need to understand and balance any risks and consequences of proposed actions.
- crisis situations can present challenges in considering the consequences of various options for the delivery of Self-directed Support. It should also be remembered, however, that change can be more possible at times of crisis. As with all cases, professional judgment should be applied.
- when a person is considered not to have capacity/capacity is diminishing-appropriate information and support should be provided to enable participation, with due attention given to risk factors in the assessment and planning activities.

The '**Talking Points**' Approach developed by Miller and Cook 2012, (<http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/>) suggests it is helpful to explore the following areas during assessment.

- being as well as possible
- improved confidence
- having friendships and relationships
- social contact
- feeling safe
- living independently
- being included

When undertaking assessments with children, practitioners should be guided by the Wellbeing Indicators (Often known as SHANARRI):

Safe • Healthy • Achieving • Nurtured • Active • Respected • Responsible & Included

Barbara's Story

Barbara is an Independent single woman who in mid-70's was working as a volunteer in university.

She has no family but lots of friends and church activity, as well as a volunteering role and in adult continuing education.

In a fall, she sustained a severe brain injury; this resulted in -loss of capacity, loss of daily living skills, loss of mobility, loss of choice.

All of this was confirmed in a traditional deficit based assessment in hospital which led to a care home placement plan. This was entirely appropriate, eligibility clear, but not what Barbara had ever thought would happen and this impacted on her motivation and sense of self.

Barbara's Hospital Report

- Barbara mobilises with a walking frame but has no recall on how to use her walking frame as a result of cognitive impairment
- Barbara requires supervision from staff to ensure that she is using a walking frame safely as she is at risk of falls
- Ward staff advised that there are times during the night when Barbara gets up to go to the toilet and forgets the location of the toilet or her bed.
- Barbara has expressive dysphasia
- Barbara requires support with speech, reading and writing
- Barbara requires prompts with all activities of daily living

An outcomes focussed assessment using Talking Points themes to guide it, developed an alternative and longer term goal which in turn changed the support plan.

Outcomes support planning using a talking points themed conversation had an immediate impact on helping Barbara feel there was something now worth working toward. Her outlook changed and it was identified that Barbara wanted the chance to try to move back home eventually .This took time and skill-communication skill and support of practitioners and advocate.

A team approach was identified using collaboration and joint planning-MHO, SW, Nurse, OT, Physio, advocate, care home staff. All worked together on a rehabilitation programme, this was monitored and where risks were identified they were explored, explained and planned around.

First stage was mainly around regaining strength and mobility, and learning again basic communication skills.

Gradually care home staff stopped doing for and stood back while Barbara was encouraged to relearn self-care skills and eventually cooked her own meals.

9 months later

Barbra went back to her own home. Her capacity is being monitored by MHO – this is the only formal service. She has a full life with support and encouragement

of friends and is learning new skills to help her manage her changed circumstances.

There are no other services –other than a brief intervention when support was requested to assist with house move to a new flat.

Outcomes

For Barbara

- Chooses to live with some risk.
- Is independent,
- Is in control
- Has regained a sense of well worth
- Managing her own life and decisions-attached calendar and diary

For authority

- Positive example of team working.
- Risk is managed

Short term; resource intense- longer term; resource light.

Assessment in relation to Carers

The majority of support provided in communities is undertaken by unpaid carers- usually, though not always, by family members. It is good social work practice to work with the person who may require support and their carer(s) to identify intended outcomes and agree how needs will be met. Beyond this, carers have legal rights to have their own needs independently assessed and they may require information, advice and support in their own right. Very often this will be a combination of agreeing what the local authority can provide or facilitate and what support a carer is able and willing to provide.

Evidence suggests that key areas to consider/address with carers in this context are:

- the quality of life of the carer; maintaining health and well-being: opportunities to follow own interests; relationship with the person cared for; freedom from financial hardship.
- the quality of life of the cared for person.
- managing the caring role - choices in amount of/type of caring undertaken; ensuring the carer feels informed/skilled/equipped; satisfaction in caring; positive partnership working with services & practitioners.
- the carer feeling valued/respected and their expertise recognised.
- having a say in services that are flexible and responsive to changing needs.

New duties relating to assessment of all carers

1. Involvement and collaboration.
2. The opportunity, information and support to jointly produce their assessment.
3. Ensure language, format and arrangements are appropriate to ensure participation is confirmed.
4. Identify personal outcomes and goals; determine if these can be achieved through natural supports and solutions created in partnership with others (agencies, family, informal networks).
5. Ensure the principles of participation in society and community are guiding and help carers retain or regain independence when required.

Assesment: Considerations for:

all Practitioners

- assessment remains core to the social work task.
- the person or their family should have a clear understanding of the assessment process and knows what happens next.
- the level of assessment undertaken should be proportionate to the needs, circumstances and risks presented.
- the assessment should be informed through personal outcomes and the Wellbeing Indicators (SHANARRI).
- all reasonable measures should be taken to ensure full participation in the assessment including consideration of any assistance required including, if appropriate, access to advocacy, translation support or the use of communication aids.
- the practitioner has a primary role in guiding the conversation.
- it should clearly identify what matters most to the person being assessed and why, thus providing a clear signal as to how the assessment will shape and inform future planning
- an individual or family's own strengths and assets will be explored to enable community or family based solutions.
- assessments should clearly evidence the process of collaboration and that thorough networking and information gathering has taken place. Most importantly, it needs to demonstrate that the person's perspective is reflected and valued.
- the person should ideally have a copy of their assessment and this should be in a helpful format and language.
- NHS practitioners should have an awareness and understanding of the principles of Self-directed Support in relation to assessment in order to promote collaborative working.

Organisations

- Do your initial screening systems support good early assessment including exploration of risk and, when appropriate, is there clear signposting to other informal solutions?
- Do assessment processes encourage an outcomes based approach?
- Do practitioners have the opportunity to reflect on outcomes based approaches within supervision and within the wider team?
- Do you have information systems that enable you to record intended outcomes and connect them to the subsequent review process?
- How will your pathway or process to self-directed support ensure there is evidence of collaboration with the person?
- Do your current assessment support planning and care management procedures and processes support the requirements of the Act?

Capacity and assessment

The law assumes capacity for any adult over 16 years unless otherwise assessed. The emphasis should be on the presumption of capacity, providing support and assistance to enable the person to make informed choices. In some instances the supported person would benefit from receiving additional support and assistance to contribute to their assessment. The SDS Act requires practitioners to take reasonable steps to identify people who can assist the supported person, and, if the supported person agrees, to involve the relevant people in assisting the supported person with their assessment. There are a number of organisations, aids, equipment and natural community and family supports that may be able to assist the practitioner in this task.

Incapacity can only be confirmed by an assessment from a medical professional. It is important, during assessment, that practitioners are alert to the potential that someone's capacity may be impaired. If such concerns arise, there is a legal requirement to consider if statutory measures need to be applied and action taken to protect the persons welfare, property and financial interest. Families should also be provided with information and guidance in relation to Power of Attorney.

When someone lacks capacity, it is important to remember that this does not necessarily impact on all their decision making. It is crucial that the person is supported to make full use of their abilities in shaping their care and support. Careful consideration requires to be given to a person's capacity at all stages of the process to properly inform judgments about the extent they are able to make decisions about their own needs and support.

There is some concern that the implementation of the Act could lead to an unintended increase in applications for welfare guardianship for adults in order to be supported to participate in assessment and, if eligible, to access one of the 4 options. Therefore a clear understanding of duties under the Adults with Incapacity (Scotland) Act 2000 is important for all practitioners undertaking assessment and support planning where issues relating to capacity may be present.

Practitioners should refer to established local procedures and seek the expertise within their organisation.

Eligibility

The 1968 Social Work (Scotland) Act recognises the central role of the local authority in determining where there is a need for the provision of community care services and how such need should be met. The legislation, as amended in 1990, describes assessment as a two-stage process: first the assessment of needs and then, having regard to the results of that assessment, the local authority shall decide whether the needs of that person call for the provision of services (12A of the Social Work (Scotland) Act 1968). The use of eligibility criteria applies to this second stage of the assessment process; they are used by councils to determine whether a person assessed as needing social care requires a service to be put in place in order to meet those needs.

National eligibility criteria for social care were agreed by the Scottish Government and COSLA in 2009 and while originally developed for older people as part of the response to Lord Sutherland's report on free personal and nursing care, the criteria were explicitly designed to apply consistently across all adult care groups (see para 1.5 of the [eligibility guidance available here](#)).

It is recognised that the use of eligibility criteria as a means of managing demand for social care is imperfect and unless properly deployed can result in resources being narrowly focused on individuals with acute needs or on specific client groups. There is also evidence that inappropriate application of eligibility criteria can hinder the person centred and outcome focused assessment and support planning that is essential to deliver Self Directed Support.

To that end, further work is being undertaken by the Scottish Government and COSLA to assess how eligibility criteria are being applied in practice and consider whether further work is required to ensure criteria support the SDS approach. Each LA will have their own clear locally agreed eligibility criteria that should be referred to by managers and practitioners as part of the assessment process.

Self-Directed Support Strategy

In 2010, the Scottish Government and COSLA published a Self-Directed Support Strategy for Scotland. This strategy put forward a host of recommendations, including one on access to care and support and the use of eligibility criteria. Specifically, the Strategy recommends that:-

"The Scottish Government in conjunction with COSLA and the National SDS Implementation Group will review the application of the national eligibility framework in order to establish the need for national eligibility thresholds for all adults with social care needs."

In developing the Self Directed Support Strategy it became evident that a key concern amongst people who use services is the fact that provision can vary between council areas in Scotland and that there is not sufficient clarity as to the application of eligibility criteria and the operation of thresholds.

National Eligibility Framework

The national eligibility framework employs a four criterion approach, categorising risk as being critical, substantial, moderate or low.

- **Critical Risk:** Indicates that there are major risks to an individual's independent living or health and well-being and likely to call for the immediate or imminent provision of social care services
- **Substantial Risk:** Indicates that there are significant risks to an individual's independence or health and wellbeing and likely to call for the immediate or imminent provision of social care services.
- **Moderate Risk:** Indicates that there are some risks to an individual's independence or health and wellbeing. These may call for the provision of some social care services managed and prioritised on an on-going basis or they may simply be manageable over the foreseeable future without service provision, with appropriate arrangements for review.
- **Low Risk:** Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.

In these definitions, the risks do not refer only to an individual's current independence, health and wellbeing, but also to the risk that she or he may not be able to gain these outcomes without support.

As part of the overall policy discussion on Free Personal Care, it was agreed that older people who had been assessed as being at critical or substantial risk would be provided with services within a maximum of six weeks of the confirmation of need.

Section 12 (1) of the 1968 Act indicates that "It shall be the duty of every local authority to promote social welfare by making available advice, guidance and assistance on such a scale as may be appropriate for their area, and in that behalf to make arrangements and to provide or secure the provision of such facilities....as they may consider suitable and adequate".

While the advent of Self-Directed Support requires a broad interpretation of the legislation – it is not necessary for the local authority to provide a service in response to assessed need – it remains the case that local authorities should operate eligibility criteria to determine whether or not an individual assessed as having a social care need can access formal support and if so, which of their needs are to be met by that support.

Self-Directed Support, as an approach, does not negate the need for the application of eligibility criteria- rather is a further evolution of relationship and partnership approaches with people and with families and heralds an expansion of choice in how support is delivered. This approach works within the context that social care support is not now, nor has ever been, an entitlement. Rather, it remains linked to a sound assessment of need.

Most people in society live most of their lives independent of formal services. There are people whose need for formal support will be short term, or variable. There are,

however, many individuals who require lifelong support. All these groups deserve support that is flexible and creative in nature, and responsive to change. However, it is the latter group that is most likely to benefit from Self- Directed Support.

Key issues:

- the Self-Directed Support Act 2013 requires transparency in decisions on allocation of resources. Experience from legal judgments in England reinforce the explicit need for those systems to be fair, equitable and transparent.
- should a person fall below the threshold of eligible need (and therefore access to an individual budget) this does not mean they don't have needs that can be met in other ways- e.g by the provision of information and advice; signposting to community resources or through a wide range of limited interventions.
- knowing the amount of resources available to meet their intended outcomes is a key component in maximising a person's choice and control. The section on support planning describes this in more detail.
- where an adult over 65 years is entitled to free personal care to meet specific needs, this should be built into planning and those elements made clear. A creative plan can be built around the elements that won't be charged for to enhance the support experience.

The SDS Act is not prescriptive as to the means by which resources should be allocated. Regardless of whatever system is being developed locally, the following points are critical and will be included in the carers and service users' guides:

- local authorities should have a system of deciding a budget that is fair and clear to everyone.
- practitioners should be able to advise the individual how much money is available under each of the 4 options.
- the amount of money allocated for support should be enough to meet the eligible needs and agreed outcomes that are agreed in the assessment.
- before deciding how much money is allocated, the local authority must take into account the view of the professional who has worked with the individual and agreed needs and outcomes.
- where people do have a requirement for formal support because their support needs can't be met in other ways, the design and shape of that support is developed as a partnership.
- resources should be provided flexibly and be personalised around the individual, making use of natural networks, with support focused on specific goals and personal outcomes.

Eligibility: Considerations for:

Practitioners

- there is an obligation to inform people of the eligibility criteria that operates locally.
- to make this accessible, practitioners need to be clear about the criteria and be able to express this in different ways or formats to meet different communication needs.
- once a local authority determines a person's needs fall within its eligibility criteria, it has a duty to meet those needs, always recognising that there are many and varied ways to 'meet a need'. The act encourages creativity and collaboration to widen the scope of support received.
- eligibility criteria should not shape the identification of "presenting needs" but it may influence which needs can be met through local authority or partnership funding.
- it is important that assessments are focused on personal outcomes and that a strengths based approach to assessment is adopted.
- a need should not automatically be seen as a deficit that requires funding or a service.
- in determining eligibility, practitioners need to take full account of how a person's needs and risks may change over time, the impact of failure to access support and whether this would lead to more support being required in the future.
- if, after assessment, it is determined that a person does not meet the eligibility for funded support or services they should- minimally- be provided with information and advice about alternative forms of possible assistance.
- there may be a requirement for limited or ongoing involvement with some people even if their needs fall below eligibility criteria thresholds.

Organisations

- Is there clear guidance available about current eligibility at a local level and are practitioners aware of it?
- Whilst councils have different ways of doing so, they are required to have systems of allocating resources that are demonstrably fair, equitable and transparent. Local eligibility criteria should, therefore, be clear, published and accessible for anyone to access.
- Self- Directed Support challenges local authorities to find appropriate ways of matching need to available resources. Neither the Act nor the accompanying regulations make comment on this, other than to acknowledge local authorities are permitted to seek a charge or contribution from the recipient of an individual budget, regardless of how it is accessed.
- Financial and IT systems should be in place to support the allocation and monitoring of individual budgets.

- Is there a joint commissioning strategy that promotes preventive or alternative approaches as well as access to more formal services? Practitioners should be clear about their responsibilities if a person's needs fall below eligibility criteria.
- A focus on co-production and locality based approaches will reduce pressure on formal services through prevention, early intervention and ongoing support to people in communities.
- There has been a number of legal challenges to the amount awarded to meet an assessed person's needs and the resulting judgments provide a helpful guide to the responsibilities of a local authority.

Support Planning

Having identified and analysed a person's strengths, needs, risks, capacity and aspirations during the assessment process, the development of a support plan enables the practitioner, in collaboration with the individual (and relevant others), to consider how these needs can be best met and any potential challenges or conflicts of interest addressed.

The Act requires that support must be available to ensure an individual is able to communicate their views questions and concerns. This will ensure and evidence that choice is informed.

In the past, people assessed as being eligible for support have sometimes been expected to 'fit' into existing services and care planning tended to be 'resource led'. The principles of the Act facilitate a move towards an outcomes focus- where the individual is central to the planning of their support. It enables a focus on an individual's goals rather than on what services can provide.

Key issues

- planning for outcomes focused support with a person requires creativity and imaginative thinking to ensure the wider resources available are recognised and valued.
- these resources should start with the individual's own personal assets, which could be their experiences, their resilience and motivation, their circumstances and life history, their family and community supports- partnered with the professional's experience, skills and knowledge of systems and potential sources of support.
- this can also involve other agencies using support planning to develop shared and joint plans with clear roles and responsibilities.
- planning activity also needs to take account of proportionality and of opportunities for time limited or time specific interventions based on the aims and objectives agreed.
- support planning also takes place in specific statutory contexts. As the new Act sits alongside other guidance and legislation- such as Adult Support and Protection- it gives practitioners an opportunity to enhance effectiveness and adapt practice in order to ensure the best possible outcomes for each person.
- good practice suggests a "one person – one plan" approach. Practitioners should therefore aim to minimise duplicate planning and streamline existing processes.
- professional judgement needs to be applied when determining how to engage with people whose capacity is impaired. It is important to support the application of principles of participation and choice to promote the least restrictive option that is of most benefit to the person.

The safety of individuals remain the paramount concern when assessing risk. In circumstances where concerns or possible conflict of interests arise around roles within family or in other key relationships e.g. where a child or adult may be considered to be at risk, the Self- Directed Support principles can still apply- but there needs to be full consideration of the child and adult protection guidance and procedures when assessing risk and working with the supported person and their family.

There is some apprehension that the development of Self Directed Support approaches, processes and the transferring of power may increase risk for some of the more vulnerable people who engage with services. There is however increased recognition that practice based on sound relationships with the supported person, their families and wider support networks may, in fact, support greater safety and risk enablement opportunities. Helping to identify more creative solutions of support may in many circumstances lead to reduced levels of risk and harm.

Children:

In relation to the Act, a child over 16 has the right to make decisions about their own support and the choice of the 4 options. Below the age of 16 the person with responsibility for a child, the "appropriate person" should be involved in decisions about a child's support and the choice of the "4 options". However a child's age, stage and maturity needs to be considered. Children over the age of twelve years have the right to make decisions unless it is shown that they are unable to do so. Even in that event, all attempts should be made to seek the child's view, include them in the process and keep them at the centre of decision making about any support arrangements.

An effective support plan should:

- demonstrate how the principles of the Act have underpinned the planning and guided practice throughout.
- demonstrate how identified outcomes can be achieved within available resources.
- demonstrate a shared understanding of the outcomes, objectives, tasks and decisions.
- outline clear timescales and date of review.
- explore and take account of a person's existing strengths and supports and how these can be enhanced.
- outline the roles of each person and agency involved, the part they play in effective support, and their responsibility for supporting change.
- clearly identify how areas of risk will be managed or supported and by whom.
- be reflective and responsive to changing circumstances where possible.
- demonstrate how to link the individual's eligible needs and their agreed outcomes and show how creativity and lateral thinking are effective in meeting need

- demonstrate how the supported person has a good understanding of the process and the agreed priorities.
- outline information about any services provided.
- be written or communicated in a format that the supported person understands (considering - age, communication, language, ability etc...).
- describe arrangements for what happens within a crisis situation – consider what may need to happen if things go wrong - a contingency / back up plan.
- allow for a sufficient degree of flexibility, allowing for reasonable adjustment over time and in response to the “real world”.

The Act requires that, for people to make informed choice and be involved, the support planning and decision making processes must be clear and understandable to each person.

- describe arrangements for what happens within a crisis situation - consider what may need to happen if things go wrong - a contingency/ back up plan.
- allow for a sufficient degree of flexibility, allowing for reasonable adjustment over time and in response to the “real world”.

The Act requires that, for people to make informed choice and be involved, the support planning and decision making processes must be clear and understandable to each person.

There are a wide range of templates or formats used to guide and facilitate both the individual and practitioner through the support planning process. Whatever method is used it must be accessible and reflect the needs of the individual, and it must encourage and support an outcome-based rather than “tick box” led approach. Consideration needs to be given to age, disability, culture, communication method, ethnicity, language etc.

Agreeing the support plan:

Local arrangements for agreeing level or type of resource should be followed. Local authorities’ duty of care means that it can refuse to agree to any element of a support plan where the support would:

- unreasonably endanger any person and put their safety at risk
- support an illegal act
- involve gambling or financial investments
- fund health care that should met by the NHS unless budgetary arrangements have been put in place between agencies to permit this
- pay for anything that other sources of income should normally cover
- not contribute to the agreed outcomes within the support plan.

This applies to all of the Options under the Act.

Tom's Story

Tom is a young man who just after graduating from university sustained a brain injury following an operation on a brain tumor which has left him totally blind with no light or shade. Following discharge from hospital he moved into his own accommodation. He now lives alone in his own tenancy with support 3 times per week amounting to 15 hours. He had his own flat after university and wished to continue to live the life of a young man though had to give flat up when in hospital. He has had to make huge adjustments, the career dreams he had, the plans he had for adventures with his friends and the aspirations of his family all had to be adjusted.

His one surviving parent, his mum who was widowed when Tom was a child, lives nearby. She has recently had a crisis in her own health which has long term implications and she now and suddenly is not able to support Tom physically. She still provides emotional and social support through email phone and of course when he visits her home.. Mum is concerned that she's not able to support her son as she'd expected this has had profound impact on her own emotional wellbeing and her sense of being a parent and carer. She wanted the best for Tom and before her own health crisis, she ensured the support that Tom got was as good as it could be, using community and other resources to enrich Tom's life and choices and to envision a future that was positive and safe and made the best of the circumstances . She was a powerful advocate but this role has been compromised through her own ill health.

It has taken time and effort for the family to get through each challenge step by step. Tom's support arrangements were set up before SDS and at the time, most of the arrangements were set up to enable discharge from hospital.

Tom is required to be offered the 4 options at his next review after 1st April. He likes the arrangement he has, but this is still a new experience for him and circumstances have changed since it was set up. Tom's carers are his life, and part of his routine and he would not manage without them.

Now that he has had time to adjust to his new way of living, what would an outcomes focussed review enable him to say?

What matters most?

That his family feel he is managing so they can focus on his mum .One very visible sign of this is shaving. A seemingly small thing, he is by shaved by female carers most of the time-passable but not great. He is aware his mum feels he looks unkempt at times, and this becomes a source of argument, about the quality of his carers and if he defends them then his personal priorities are questioned.

He can cope but if there is a special occasion like visiting his mum, or other relatives and friends a sign to them of him managing is to look groomed. The only way he feels properly clean shaven is on the rare occasions he is taken to a Turkish barber-(he is totally blind and has to rely on others to escort him.)

He would feel more independent if some of his support was turned into escort to a Turkish barber, and flexible enough for shaving before family gatherings not just a Monday Wednesday or Friday, but weekends when parties happen and families gather. Then he knows and feels he is groomed.

The outcome for him, is he can trust that his appearance is how he would like to look if he could see, and secondly he feels this is one less worry his mum has and he feels less of a worry for her, the time they spend together therefore has more quality.

Option 1 a DP for unpredictable escort to a Turkish barber.

What else matters?

Tom likes most of his carers but wants them to remember it is his life and he wants to have friends round-for meals, coffee, film nights with carry out food and drink. He attempts to wash his dishes, but can't see how clean the plates are, and he doesn't mind anyway. He would prefer that one of his his carers does not scold him for leaving plates used by others for her to wash. He wants to remind her this is his home. But he needs her support. His involvement in designing his support would enable him to make this clear at the outset, there are other tasks he would be happy to do without so that he could have friends round and live his life as normally as he can.

Outcomes; Tom feels just like any other young man leaning to live as independently as he can, and to enjoy a normal life with friends

SDS Duties confirmed . Involvement in designing support. Collaboration More effective use of own resources and networks. Choice and control Support designed around him with small adjustments.

Support planning: considerations for:

Practitioners

- the support plan must evidence the involvement and participation of the individual and highlight that collaborative approaches have been taken especially with person, with other agencies and people who are important.
- the practitioner, where they consider it appropriate, should provide the individual with information about independent advocacy services. Independent advocacy services provide a unique role in terms of helping people navigate and make their choices.
- the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 require consideration of independent advocacy when people are subject to duties under these acts.
- when support planning for a child or young person, the GIRFEC approach must be adopted (this will be further supported within the new Children and Young People Bill).
- the individual should have an understanding about the choices they have made and what this means for their support arrangements, now and in the future, pending review.
- the person is clear about how the plan will be monitored and reviewed and how this will support their agreed outcomes.
- the plan should make use of natural networks and other community resources where possible.
- there should be clear evidence of the person's full involvement within the process.

- capacity can be variable, this needs to be built into plan.
- clear timescales are identified and outcomes are broken down into manageable chunks. This helps make it measurable and easier to see progress if there are milestones identified along the way.
- the person should be clear about what supports are going to be provided to them, by whom, when, how and every other detail of the support plan arrangements along with how these will be managed and everyone's role within this process.
- the support plan should focus on what the person wants to achieve as well as openly discussing and recording any risk factors to the person or from the person to others.
- the support plan should consider the importance of the principle of minimum intervention- as the least restrictive options should be used.
- use of assistive technology can deliver discreet support that enables people to retain independence and dignity and this should be considered.

Organisations

- decision making and budget setting processes should be transparent regardless as to what system is adopted to determine a person's personal budget
- practitioners need to be supported by supervisors and managers to ensure individuals are at the heart of all assessment, planning and decision making.
- the requirement to evidence involvement and choice will require coherent support plan recording methods
- practitioners will require guidance and support in relation to a range of new procedures, structures, policies, and resources to allow them to feel clear and confident about this stage.
- these will vary across local authorities and partnership arrangements, but must be fit for purpose to ensure practitioners carry out their duties in relation to the Act.
- opportunities to contest decisions should be known to all parties (e.g. appeal or complaints processes)

For carers

There are 2 specific areas relating to carers in addition to those listed above:

1. they are to be fully involved in developing a support plan in their role as a key partner.
2. when support is to be provided to enable the carer to continue in role, the support plan is to be developed jointly and highlight which areas are for the supported person and which are for carer in their own right.

A Carer's Story

A carer looks after her father, who lives alone, is getting older and more frail and starting to need a bit of help around the house. The carer does the more heavy-duty housework such as vacuuming and mowing the lawn, as well as going to the supermarket and running errands.

Her father has a stroke and is taken into hospital. He is in hospital for three weeks and during this time his daughter has a carer's assessment, organised by the hospital social worker. It establishes that although his daughter was able to support him before the hospitalisation, the care required when he leaves hospital will be more substantial than what has been done before, including some personal care, and it is not known how long the more substantial care will be needed for as rehabilitation following a stroke can be variable.

The carer will not be able to cope with this level of caring as she works full time and has two teenage children. In addition, she does not want to provide personal care for her father and he would prefer to receive it from paid care workers. She is still able to visit regularly, and helps with the housework when she visits, as well as picking up shopping, running errands and supporting him when the occupational therapist and physiotherapist visit. She is also referred to the local carers' centre, and is able to meet with other carers who are in similar situations.

Her father is offered support from the local authority, and after talking with his daughter about how the support will fit in with the care she can provide, he decides to take an individual budget, and asks the Council to arrange care from a private care agency who can come and help him with showering, dressing and cooking at times that suit him. The care agency is very flexible and will come along in the mornings and evenings to provide personal care and help with making meals. The care workers have shorter visits at weekends and on days when his daughter is not at work, as she is able to help her father with meals then and so the care workers only have to help him wash and dress.

A key safe is installed to make it easier for the care workers to access the property. It also means that the eldest grandchild can visit if required when the carer is not available. The flexibility of the agency care workers is very important as his daughter's days off are not on a specific schedule. Likewise, if the carer needs a break, the agency uses the hours that have been 'saved' to provide extra support with shopping and household tasks.

Learning points:

The carer has been caring for a while but has only had a carer's assessment after reaching crisis/emergency. It has been recognised that her caring limit had been reached and support must be provided for her to be able to continue to care.

The cared for person is provided with support due to his condition, but this support also benefits the carer. It will be detailed in both plans. He is able to choose support that suits him and also has the help and support of the carer when choosing.

The flexibility of support suits both the carer and the person receiving care, as it allows the carer to maintain their own life, remaining in employment and having a break from caring. Neither of them wanted a direct payment, but do want some choice over who provides care, so option 2 was the best choice for them as they can 'bank' the hours they don't use for extra support when it's needed.

Risk

When discharging duties under the Act, consideration of risk needs to remain central to the process. Risk should be considered at the support planning stage and across all four options. Effective risk assessment is a core requirement and is equally important to arranged service provisions as it is to a direct payment arrangement.

Effective risk assessment and management is fundamental to achieving the right balance between protection and empowerment in current and new duties. Risk is an everyday part of life; it is the skill and professional judgement of the practitioner that helps people balance risk, protection and freedom of choice.

This guidance acknowledges the tension between individual rights and the wider needs of society, including the need for public protection. The ongoing challenge for practitioners is how to identify and manage risk in genuine partnership with the supported person and others.

When we hear the word "risk" we tend to think of something to be avoided. However, risk is present in every life.

The duty within the Self-Directed Support Act 2013 to offer "4 options" (described more fully in the next section) for the delivery of support, has highlighted this debate around risk enablement. In particular, the debate has focused on concern over the person's ability to manage a direct payment, to use the budget as agreed to achieve intended outcomes or that the practitioner believes the person will be placed at increased risk of exploitation by others. There may be particular risks associated with a direct payment arrangement. Similarly, there may be risks associated with services arranged on the person's behalf by the authority. Practitioners need to be able to openly discuss all potential risks with the person and their own local authority throughout the various processes involved.

The balance between care and control is a defining feature of statutory duties and influences practice, workload, priorities and public perception of the role. The implementation of the Self-Directed Support Act does not change this.

Assessing risk is a highly skilled and complex task- made even more complex when faced with complicated family dynamics, when people are in crisis or where a person's capacity may be impaired. Collaboration and partnership allows for exploration of risk factors and clearly identifying where responsibility lies for supporting or diminishing that risk. This is a key element in the support planning process.

Risk and direct payments

There are a range of steps that the practitioner should take in order to ensure that risk is identified and managed. Good risk identification/management should act as an aid to supporting the direct payment option and "making it work" for the person. For example, the direct payment can only be agreed after a full assessment and agreement on how the money should be used have been negotiated. The local authority has a responsibility to ensure that public funds are used in line with assessed need. Equally, the supported person should be able to expect the appropriate amount of support and advice from their authority to help them to actively manage risk on a day to day basis. Local monitoring arrangements need to

be robust but proportionate. It should be clear to both the supported person and the practitioner how the main risks will be managed.

A variety of strategies and agreements on how a Direct Payment is paid can be explored if there are concerns about the management of large sums. The aim is to find ways to achieve this safely and not to avoid the direct payment option simply because it is perceived as being "too risky".

"there is no current evidence that direct payments holders are experiencing greater abuse in contrast to recent abuse scandals in traditional settings. Empowering people can in fact reduce their vulnerability to abuse..."
(Fox 2012 pp15-5)

Risk: the main things to consider

Whilst adults have the right to make their own decisions about risk, this must be balanced with the authorities' duty of care. The local authority should feel confident in challenging particular forms of support or particular decisions under the person's desired Option. If, after assessment and detailed discussion with the supported person, they identify risks that cannot be safely managed in these circumstances the Local Authority has the authority not to support the person's preferred option

- risk enablement needs to be based on detailed, shared discussions (the 'skilled conversation') not only with the individual but also with other key family members, carers and professionals involved.
- assessment through co-production recognises the capacity, capability, strengths and personal assets people possess, which in turn informs risk assessment and, where appropriate, risk enablement.
- supporting positive risk taking requires the ability to effectively balance the benefits and positive outcomes against the potential negative outcomes of having measures in place that restrict or seek to avoid risk.
- shared agreement about what constitutes risk will not always be possible. They often have 'personal' or 'organisational' elements that have been built up over time. Practitioners should be aware of their own values and assumptions and the impact these have on others.
- a shared understanding of the views of all those affected is important, however, articulated through efficient and relevant case recording and available for scrutiny and review.
- different organisations and sectors operate within different cultures. This in turn affects thresholds of risk. These differences will require to be carefully navigated and will undoubtedly be assisted by effective communication and sharing of values –both on behalf of the individual and on a wider, ongoing basis.

Risk- considerations for practitioners

- positive risk taking or risk enablement is central to the philosophy of self-directed support but practitioners are still required to balance empowerment for the individual whilst fulfilling their statutory duties

to protect from harm and to ensure rights are safeguarded. The exercise of professional judgement is a key factor.

- evidence suggests that an effective relationship built on trust with the supported person is required to both promote risk enablement as part of self-directed support as well as detect and prevent harm as part of safe guarding duties. Risk enablement and safe guarding in relation to self-directed support involves supporting people to contribute to the assessment of the impact of risk and explore ways to minimise and manage risks, assessing if they are acceptable.
- a more person centred and collaborative approach to managing risk is crucial in helping to move away from inappropriate risk averse policies and procedures.
- in all our practice, we need to be confident that the decisions and actions to support risk are appropriate. Practitioners need to ensure their decisions are sound and relate to the assessed needs of the person and they need to ensure that the reasons for decisions are evidenced appropriately.

Risk- considerations for organisations

- practitioners need to be supported by an organisational culture that enables and values best practice. This should recognise the need for sufficient time to be spent with the person so that a good working relationship can develop.
- Self-Directed Support and protection policy need to be re-enforced and aligned through planning, training and briefings, to further explain where duties work together.
- local authorities and social care providers need to foster a culture of positive risk taking which supports practitioners to work in a risk enabling way. This requires a culture of supportive learning not least from serious incidents, from reflective supervision and an emphasis on evidence based practice.

The Four Options

Under the Self-Directed Support (Scotland) Act 2013 local authorities have new duties that require them to offer greater choice and control to people who, following assessment, have eligibility for funded support.

Social work services aspire to promote independence not dependence. One measure of success is that people are enabled to live positive lives beyond the requirement for continued support.

Whilst Self-Directed Support undoubtedly represents an important change in social care, it is important to recognise that the offer of the 4 options apply to the provision of long-term support following a formal social care assessment. Practitioners need to consider the wider supports that are available to people beyond their formal social care provision and they need to consider how to integrate this into any formal support.

There are also regulations accompanying the Act. The Regulations provide additional safeguards in relation to the direct payments – safeguards for the authority and for the supported person. This is to recognise the unique nature of a direct payment and to support practitioners and individuals to choose the direct payment option.

The formal offer of the 4 options does **not** apply when :

- a person is presenting in crisis (though self-directed support may represent a sustainable approach to help prevent crisis or help a person with longer term needs manage a crisis if it occurs).
- when it is premature to make an assessment about a person's longer term need for support, typically before every attempt has first been made to maximise their capability e.g. through reablement.
- when it is necessary to arrange support ahead of more considered planning to meet future needs e.g. to facilitate discharge from hospital.
- when a person's chaotic lifestyle requires stabilising before their longer term support needs are identified and addressed.
- when a person's outcomes can be best achieved through a relationship with a practitioner, access to universal services or community resources rather than through access to support that requires an individual budget.

This does not mean that the provision of greater choice and control for individuals should not be considered for people in some of the above circumstances- rather that other interventions may be more appropriate to timeously meet presenting need. That does not preclude emergency financial assistance being made available in keeping with existing legislation, practice and professional judgment.

If it is evident through assessment, or at a later stage, that longer term support or intervention is required to meet eligible need, then the duty to meet assessed needs applies and the 4 options should be explored.

Lack of capacity is not a reason in itself to exclude people from self-directed support. 'Capacity' is NOT an absolute concept. Indeed, someone deemed to lack capacity is likely to have longer term needs. They are also less likely to be able to maximise choice and control over their life if self-directed support is not used. Careful consideration is obviously required to be given as to which of the options will apply most helpfully in such circumstances.

It should be noted that people in long-term residential accommodation remain ineligible to receive a direct payment (though the Scottish Government are planning to pilot a different approach in a small number of local authority areas.)

The offer of the 4 options applies when a person has longer term, relatively stable and predictable needs for support for example needs associated with:

- frailty
- cognitive impairment e.g. dementia
- learning disability
- some long term conditions
- physical disability
- a person has needs that may be episodic but their recurrence has a degree of predictability e.g. mental health problems
- a child with disabilities requiring longer term support.

The 4 options will be offered after an outcomes focused assessment has been completed in partnership with a person (and, where appropriate, their representative/s) and where the assessment suggests there are eligible needs that cannot all be met through natural supports, personal strengths or through community resources.

Community resources could include accessing existing services and approaches - such as rehabilitation through collaboration with partner agencies such as NHS.

The law requires local authorities to provide clear information on all the four options available when a person is eligible for support. This may be in the form of access to independent advocate, translation, an interpreter, or support that may involve a communication aid or method that supports the person to make their views known.

Local authorities will have a local mechanism for determining how much funding will be allocated as the relevant amount. The practitioner needs to be able to inform the person about how their support will be costed prior to exploring the four options, supporting the principle of informed choice.

Practitioners have a responsibility to ensure the supported person is fully informed of opportunities, responsibilities and consequences in each of the options.

Local authorities should have a system of deciding a budget that is fair and clear to everyone.

Practitioners should be able to advise the individual what resource is available under each of the 4 options.

The amount of money allocated for support should be enough to meet the needs and agreed outcomes that are agreed in the assessment.

Before deciding how much money to allocate, the local authority must take into account the view of the professional who has worked with the individual and agreed needs and outcomes.

4 Options and risk: considerations for practitioners

- ensure the person is eligible to access the 4 options (section on Eligibility).
- ensure alternative solutions have been explored.
- consider how the person will best understand the information, and how it can be made as accessible as possible.
- have the implications of personal capacity been considered?
- are there any risks or concerns about the person's ability to manage any of the options and if so what can be done to minimise or support the risk?
- if there are significant concerns about outcomes not being met by the choice of a particular option then this needs to be explored fully with the person, the organisation and the person's representative.
- ensure that reasons for not being able to access any or all of the 4 options are explained to person and that this is put in writing.
- evidence suggests that an effective relationship with the supported person is required to promote risk enablement as part of self-directed support as well as detect and prevent harm as part of safe guarding duties.
- the skills required for risk enablement and safe guarding include the ability to support people to assess the impact of risk and explore ways to minimise and manage risks.
- supporting a more person centred and collaborative approach to managing risk is crucial in helping to move away from inappropriate risk averse policies and procedures.
- in all our practice, but particularly around risk, we need to be confident that the decisions and actions to support risk are proportionate. Practitioners need to ensure their decisions are defensible and the reasons for decisions are evidenced appropriately.
- practitioners need to be supported by their organisations to incorporate safeguarding and risk enablement in their relationship based, person centred work.
- effective, consistent, trusted relationships and good communication are particularly important for self-directed support and supporting risk.

- practitioners may encounter situations where their professional assessment will recommend it not appropriate to explore a particular form of support under one of the Options. It is the practitioner's discretion, as part of the collaborative approach, to raise this with the supported person and come to a solution that provides the appropriate flexibility to the individual and meets assessed needs.
- positive risk taking or risk enablement is central to the philosophy of self-directed support but practitioners are still required to balance empowerment for the individual whilst fulfilling their duty of care.
- research shows that risk management dilemmas are an inherent part of social work practice and existed well before the development of Self Directed Support. Therefore, there will always be a role for professional judgement when exploring risks around the choices on offer through Self Directed Support.

Option - 1 Direct Payment.

- this is an existing duty but the Act retains it as an established option. The supported person may choose option 1 to purchase appropriate support to meet their agreed outcomes.
- practitioners need to explore the implications of capacity with regards to direct payments and a part of this consideration will involve an understanding of the person's natural supports and the level of understanding that he person has about the choices and their implications.. Clearly a Direct Payment involves additional responsibilities.
- If a person is formally assessed as 'lacking capacity' under the AWI Act, then they will only be suitable for a Direct Payment, after being assessed and found to be eligible, if they have a formal legal guardian who is able to speak for them. Otherwise, the choice would default to Option 3.
- if a person doesn't lack capacity in the legal sense (under the AWI Act) but needs significant assistance to make and manage decisions, then the local authority has a duty to support them in this decision making and to assist them with the management of their decision thereafter. This' management' may be provided directly by a third party, depending upon the option chosen.
- Practitioners, therefore, need to be confident, knowledgeable and be able to give accurate information on the risks and responsibilities that come with a direct payment arrangement.
- If a person cannot choose the direct payment, or cannot manage their support under the direct payment even with additional support, then the authority retains its duty to provide services under Option 3.
- the supported person may use a direct payment to purchase support from a provider including those not on local authority approved frameworks- provided the authority's assessment is that the support will meet a person's intended outcomes safely and appropriately .
- if a person prefers to employ a personal assistant to meet their support needs, they must use Option 1 to do so. In this event, practitioners must signpost a person to the appropriate information and advice to ensure they are able to meet the ensuing responsibilities. There are a number of such

organisations who provide this service and there is an obligation for a local authority to provide information in this respect.

- this information needs to include the need for PVG, arranging holiday cover and having clear contingency plans, since that responsibility does not then lie with the local authority.
- the test for a local authority in relation to making a direct payment for the employment of a personal assistant is no different to that set out above i.e. that the support will meet a person's intended outcomes safely and appropriately

Option - 2: Directing the available support

- the person, in partnership with the practitioner, can identify a 3rd party or local authority to oversee/administer their agreed budget. Effectively, it is an individual budget that is administered on behalf of a person with eligible support needs. They can direct the local authority to make payments on their behalf for services or for the purchase of key items that will meet their outcomes, or a combination of both.
- the budget can be held by an identified provider who works in partnership with -and takes direction from - the supported person on how they wish their support to be delivered.
- the 3rd party will oversee the administration of the budget and provide and/or arrange for the flexible support to the individual as and when agreed- to meet identified needs.
- this option should allow for the supported person to stay in control without the additional responsibility of managing a Direct Payment.
- practitioners need to explore the implications of capacity with regards to direct payments and a part of this consideration will involve an understanding of the person's natural supports and the level of understanding that he person has about the choices and their implications.. Clearly a Direct Payment involves additional responsibilities.
- if a person is formally assessed as 'lacking capacity' under the AWI Act, then they will only be suitable for a Direct Payment, after being assessed and found to be eligible, if they have a formal legal guardian who is able to speak for them. Otherwise, the choice would default to Option 3.
- if a person doesn't lack capacity in the legal sense (under the AWI Act) but needs significant assistance to make and manage decisions, then the local authority has a duty to support them in this decision making and to assist them with the management of their decision thereafter. This 'management' may be provided directly by a third party, depending upon the option chosen.
- Practitioners, therefore, need to be confident, knowledgeable and be able to give accurate information on the risks and responsibilities that come with a direct payment arrangement.
- if a person cannot choose Option 2 or manage their support under Option 2, even with additional support, then the authority retains its duty to provide services under Option 3.
- the person should be supported to take a lead but be made aware of any implications.
- consideration of intervention using Section 13za of the Social Work (Scotland) Act to access option 2 should be considered- for example if the supported person has some capacity to understand the options and has a good, supportive network.

Option - 3: Services arranged for the person by the authority

- the person may choose/decide for the local authority to continue to select and to make arrangements for the appropriate support that will meet their agreed outcomes.
- there are a number of reasons why a person may choose option 3 and this choice is as valid as other options in the self-directed process.
- the local authority will have responsibility for identifying and commissioning (or providing) appropriate support and making payment of the relevant amount to the identified provider/service.
- it is important to note that when an individual chooses option 3, the principles of being provided with information, offered choice and having some control still apply.

Option - 4: A mix of the first 3 options for different aspects of support

- this may be a useful choice for someone wishing to have a taste of managing a budget e.g. a young people in transition or moving beyond care who may wish to have an opportunity to direct a small part of their budget whilst being supported to develop skills and confidence to use this more widely.

The Four options: Case Examples

James' Story

James is a 92 year old retired college lecturer who has lived his life as a socialist. This ideology impacted at times in various ways, his choice of house tenure, how money was spent, a concept of community and belief in role of state. His wife and 3 sons found ways of living with this, embracing and challenging in equal measures the consequences at times. His wife Sheena has been a pragmatic partner, accepting that he has strong views, is independently minded and strongly self-motivated.

He had university potential, but as eldest son had to leave school at 14 and get a trade, working as an engineer following apprenticeship. He later gained social sciences degree through Open University and an art degree at Glasgow School of Art through evening classes.

He is a well-known figure having been involved in various political campaigns and local elderly forum, and as guest speaker in schools through his local history knowledge.

James has become more forgetful, but the strong dominance of his character has made this a challenge for him and his family particularly his wife. He is distressed at losing any kind of control, especially his independence of thought and self-determination.

His wife is adjusting to working around the new challenges, and has approached local Alzheimer's group for advice and options for future. There is family support but sons do not live nearby. They are articulate and knowledgeable but sensitive to parents continuing need for independence and respectful of their life style choices. James in many respects will benefit from the new approach offered through SDS, enabling him and his wife to feel they still have some control over decision making .As his condition deteriorates he will become eligible for formal support to enable him to manage as

will Sheena in her own right as carer. For James it will be to assist with his personal care, dressing and enabling involvement in activities that help him remain part of his community and support his dignity. For his wife it will be her emotional and physical strength as she adjusts to being a carer at 85 years of age. The couple will continue to use support of son's more flexibly and for other types of activity- social activity, shopping trips etc. POA is in place.

Option 1

Given the couple's belief that the state knows best, and due to the stress dementia has caused this will not be a preferred option. While it gives more control, the couple have not engaged in many aspects of financial management, this would cause additional stress at a time when managing the emotional impact of change will be at its most intense.

The couple would not wish to manage a budget either for James or for Sheena as a carer with needs in her own right. At review Option 1 might be reconsidered. This will be guided by how effectively and flexibly chosen option has delivered.

Option 1 might be considered if POA for any unforeseen reason has to be activated and sons feel able to manage this on behalf of father.

Option 2

Council manages budget but couple choose support and provider.

This option may be more openly explored at a later stage but the change for a couple previously independent with no services. It is not at this time of stress and change something they would feel comfortable about directing as a first step and good assessment will identify that. Assessment will also identify that once trust and evidence of new approach gained, this option could be reconsidered through feeling informed through actual experience.

Good assessment skills will ensure that couple are clear about this option and how it might work and will identify where natural support are, and where there are gaps.

At review

Option 2 may well become the ideal balance between having control and having security of council involvement as a safety net. It will take time for people to adjust to the implications of choice.

Option 3

Council decides and makes agreed arrangements to meet the agreed goals and outcomes.

The new act will ensure that couple are well informed about the level of support they will receive and will ensure that this is provided as flexibly as is possible.

For the couple, local authority and NHS support are what they have been used to- (they seldom see GP, and keep well generally so see the state as a benign safety net). This will be their instinctive place of comfort based on what they know from relatives, friends and family. Of note local authority was not their first port of call when considering support, it was Alzheimer's they went to for advice at time of diagnosis. Given the demands of council services for James this may not be as flexible or responsive to him as at first anticipated.

Will this arrangement take account of family and community support?

For Sheena , she may find options for support to her as a carer are less creative. However to settle into a new way of life for both this would be preferred choice.

At review

The couple are more likely to feel comfortable at exploring again the 4 Options based on their new and growing experience.

James changing capacity will be an ongoing factor, but will not limit his choices, given assessment information and knowledge of that his preferences would be . Sheena may now be more open to exploring other ways of helping her continue in role.

Option 4: A mixture of all

At initial stage this may not be seen as likely to be most effective, it may feel too complicated at first, unless there are gaps in local provision. However through time experience and with information about amount of support to be offered, and a trusting relationship with assessor and through team work with others involved such as CPN and GP , it may be that this is ultimately the most effective option at review stage. The choice of this option will depend on good and clear information, and involvement in how the support may be shaped , what it will look like. This will require a very detailed support plan to enable the couple to make best use of manage this.

Rachael's story

Rachel is 11years old and lives with her family. She has cerebral palsy and requires to use a wheelchair. Rachel has significant personal care support needs but attends mainstream school and lives life to the full. She currently receives support from social work in the form of homecare 2x per day to assist with getting showered, dressed and ready for school and bed. She also receives a sitting service one evening per week to allow her parents some time away from their caring role. Due to insurance issues with the care provider the sitter is unable to take any responsibility for Rachel's siblings or friends who may want to visit. Rachel's family is also assessed as being eligible for 2 weeks respite per year at a local respite unit for young people with physical disabilities. During the school holidays Rachel is able to access the local play scheme run by the local authority for children with disabilities.

Let's consider how Rachel's support plan could look by applying the 4 options.

Option 1

Rachel's parents opt to take a direct payment for her assessed support. With this system they chose to employ a neighbour (Angela) who Rachel has known most of her life. Angela is 22 and currently undertaking her nursing degree. They employ Angela as a Personal assistant(PA) to support Rachel with her physical care needs in the morning and in the evening. This frees up Rachel's parents to get themselves ready for work and younger children off to school and does not leave them exhausted with the physical care needs on a daily basis enabling them to spend more quality time as a family. Rachel and her Family use a specialised payroll agency to help them manage their employer responsibilities.

Angela is also employed to support Rachel one evening per week, to allow her parents a break, Angela is not restricted by employer insurance issues and therefore is able to accompany Rachel and her friend to the local bowling alley, driving Rachel's Motability vehicle. Rachel enjoys this as she gets to spend quality time with her friends without her parents needing to be there. This works for Rachel as she looks up to Angela and is not embarrassed about her supporting her the way she is if her mum is at the bowling with her.

Instead of Rachel using the residential respite unit in her local area, she and her friend who also has a respite budget choose to pool their budgets and employ a support person to help them access 3 short breaks per year, Rachel and her friend spend time finding out about places they wish to go and have been to see their favourite band ID in Manchester, staying at a hotel and going shopping with Angela's support.

Option 2

Rachel and her family identify a support provider who are willing to be flexible and recruit 2 dedicated workers to support Rachel. Rachel and her family are involved in the advertising locally and interview candidates. It is important to Rachel that her supporters are "young and trendy and have similar interests to Rachel" The support provider are able to recruit two college students who are undertaking an HNC in Social care, they live locally to Rachel and can be flexible with their support. The Local authority gives over the annual agreed budget for Rachel's support and together they are able to help Rachel and her family develop a support plan that works for her. The budget can be used creatively as long as Rachel's outcomes are being met. Rachel's social worker meets 4 x yearly to review and monitor the support plan and this is done in a person centred manner with Rachel deciding who she wants to be there, Rachel is supported to engage in the process by developing a visual pathway of her achievements etc.

Option 3

Rachel and her family chose to continue to use the services provided by the local authority. Rachel's SW works in a co-productive manner and encourages the homecare service to provide Rachel with consistent workers who are young and full of energy. After discussions with the sitter service there is an agreement that the sitter is able to take Rachel out with her friend (Rachel's friend's parents are part of this discussion and happy for this to happen and are clear that the sitter is in no way responsible for their child).

Rachel continues to use the respite resource in her local area but works with the team there ensures that her breaks coincide with a friend from the play scheme so they can be there at the same time and spend quality time together, Rachel and her friend are consulted prior to their stays on the outings activities they wish to be supported to do.

Option 4

Rachel uses a mixture of all the options. Her parents take a Direct Payment to pay for Angela to become Rachel's PA and support with daily personal care and use the payroll agency. Rachel still uses the respite unit but only for 1 weekend per year when her friend is also going and has 2 weekend breaks with Angela and her friend to

attend their favourite concerts in London and Manchester, the girls again pool their respite budgets to fund this. Rachel with the support of her SW source a care provider that can provide sitter service that is happy to support a community outing for Rachel and her friends to the bowling, they work with Rachel, her family and friends to develop safety strategies that allow Rachel to be less reliant on the support worker when she is accessing the bowling which is hoped that as Rachel gets older will help her develop skills to enable her to access her community with minimal support from workers. Rachel still accesses the council run play scheme because she loves it and has lots of friends there with similar experiences and interests.

Vera's story

Vera is a 46 year old woman with diagnosed personality disorder. She lives alone in a local authority house but has a history of homelessness, eviction and experience of domestic violence. She has a number of health issues and her mental health fluctuates. Vera's lifestyle could be described as chaotic and she has been assessed as needing support to manage her tenancy including support to manage bills and correspondence, maintain relationships with neighbours and others and keep on top of her housework. Vera also needs support with getting to health appointments and taking her medication.

Vera currently has daily support from a care provider but relationships can be difficult and she often decides not to engage with their support, this increases her vulnerability and risks as she often does not eat, wash or take her medication. Vera's home is in a poor condition due to levels of self-neglect and a number of animals kept in the property.

Option 1

During assessment the social worker and Vera explored whether she could manage a Direct Payment and employ her own team of personal assistants.

Some of the risks identified included:

- Vera would struggle to manage any payroll responsibilities,
- she would struggle to remain professional when dealing with her staff if difficulties arose and would likely threaten to sack them
- Issues of capacity arose. Vera struggled to manage her on weekly budget and was often in financial crisis and she had no-one in her life able to support her with this.

The option of a Direct Payment is not made available to Vera as she lacks capacity to really understand the full responsibilities and consequences of becoming an employer. This decision was fully discussed and agreed with Vera and reasons given in writing. Vera was then supported to explore and make a decision between the other options.

Option 2

Vera is supported to engage with a number of local providers and ask them to explore with her how they could assist her to live her life the way she wanted. The provider's pitch their ideas to Vera based on a brief overview of what she wants from life. It is important to Vera that the people who come into her house appreciate some of the choices she makes and that they support her to help look after her pets. Vera also wants flexibility around her support times and it is important she can contact the provider in times of crisis and they can respond.

With support from Social work and her community nurse Vera is able to identify a provider she feels can support her flexibly, she is involved in picking a core team of

workers who will form a consistent team. The Local Authority agree to provide the care provider with the budget that has been agreed and they take responsibility for overseeing this on her behalf. Vera is clear about how much her personal budget is and how she can direct the spending of this in negotiating with the provider and her social worker. Vera has chosen people to support her that she is comfortable with and feels she can develop positive relationships. The team are supported to understand how Vera diagnosis impacts on her behaviour and her ability to maintain relationships and this enables Vera and her team to develop a robust support plan that helps achieve her outcomes. Regular team meetings including Vera help to ensure Vera has a forum to raise any concerns and steps can be taken to adapt and tweak her support to suit. This also give the support team to have honest discussions with Vera about some of her behaviours that they find challenging and solutions sought to overcome any issues. Vera continues to be supported to manage her health needs and maintain relationships with neighbours. Being a responsible pet owner is critical for Vera and she is supported to do this and explore being a volunteer and their local cattery. Having independence and control is important for Vera and she appreciates being able to negotiate from week to week the support she needs, at what time and to do what as this often changes for Vera depending on her priorities at the time. This approach and understanding from the team about what is important has reduced the number of times Vera makes complaints to the department and contacts to GP surgery and other services she would contact in times of distress and frustration.

Option 3

Vera choices to remain with the support provider that the local authority has commissioned to provide the service. The services is allocated on an hourly basis and a designated amount of hours has been committed to support Vera. This does not provide the flexibility Vera desires and there continues to be times when Vera declines to engage with the support because she is not ready to when the workers arrive or she is less comfortable with the workers who are sent to provide support. This means there are often times when Vera does not receive support but the local authority still requires to pay for it. The social worker continues to try to negotiate a, more flexible service that can respond to Vera in a more individualised way but as they are commissioned and block funded this can at times prove difficult. Due to the number of people the support the provider cannot guarantee a consistent team and sometimes less familiar staff are sent to support Vera.

Option 4

Vera could chose to have a mixture options 2 & 3. She could continue to access the services of her current care provider or homecare for some of the key practical tasks she needs support with ie medication prompts, personal care tasks such as showering and meal preparation but choices to access a smaller portion of her budget to purchase support from a bespoke provider that can offer her tailored support in relation to her mental health and social inclusion. Vera may also chose to use some of her budget to pay for weekly massage therapy sessions as she feels this helps to maintain her mental health and reduces her levels of anxiety. She also purchases a cat and enjoys spending time caring for it and this again has therapeutic benefits.

Adam & Sheena story –Young Carer

Adam is 14 years old and lives at home with his mother Sheena. Sheena has a diagnosis of multiple sclerosis (MS) which affects her mobility and ability to carry out some tasks like cooking, ironing, washing, shopping and dispensing her own

medication. Adam has been her main carer for the last 3 years. The family have no other family support and Adam is determined to continue to support his Mum at home and undertakes a number of the daily household chores that Sheena is unable to manage, He takes responsibility to cook their meals when Sheena's health is poor and also helps Sheena with taking her medication etc. Sheena has been assessed for her own needs and receives daily support from the local homecare team to assist with her personal care needs as she is determined that this is not an area that she wishes Adam to support her with. She also receives a weekly shopping service and attends a local club for people with physical disabilities once a week with transport arranged by the local authority. Due to the complexities of his Mum's needs Adam has been assessed as a young carer with needs in his own right. It is felt Adam needs time away from his caring role and the opportunity to explore his feelings around the impact his caring role has on his family life.

Option 1

Adam chooses to take a direct payment to support him to meet his outcomes. His Mum helps him manage the direct payment. Mum and Adam open a separate bank account and the local authority pay his personal budget into this account regularly. Adam chooses to use his budget to meet his agreed outcomes which are to enjoy some free time away from his caring role and has opportunities explore his feelings around being a young carer and ensure he has quality time to spend with his friends. Adam has used some of his budget to pay for his music lessons. Adam has also used his budget to pay for a computer which enable him to stay connected with friends through social media even if he is at home caring for his mum. He also uses it to link with an online forum of young carers.

The success of the direct payment and the flexibility it offers to Adam supports his to remain positive about his caring role without needing to be labelled or link with more traditional supports. He feels in control and appreciates that people have listened to him and to what would make a difference. It has also encouraged Sheena to consider choosing to receive her own support through a direct payment and explore employing a personal assistant which might provide greater flexibility. Sheena would also like to access a computer to allow her to take charge of her shopping through online shop and delivery services rather than rely on the councils shopping service. This could be purchased through her personal budget and enables her to remain in control of managing her family shopping.

Option 2

Adam wants to be able to spend some time away from his caring duties but does not really want to attend the local young carers support group, He does not really want to talk about being a young carer and be labelled as such by the attendance at the established group. Through discussion he also confirms that he has an older cousin who he is very close to and can talk to him about any worries about caring for his mum. During conversation with Adam he talks about his passion for music, he has had some guitar lessons at school and is really keen to progress but cannot afford further lessons despite a local musician offering some tuition at the local community centre. After discussion with Adam and his mum it is agreed that he can use a small personal budget to support him to access the music lessons. The local authority make arrangements to pay for the lessons on a quarterly basis. This helps support Adam to maintain his caring role for his mum but also meets his agreed outcomes of having some time away from his role. Adam also advises that learning music has increased his confidence and helps him cope with any worries he has as a young carer. He finds playing music very therapeutic and Adam's mum is pleased that he has some time away and is able to enjoy his passion for music and just be a teenager.

Option 3

Adam is linked in with the local carer's service who run a weekly support group for young carers. Adam accesses this on a weekly basis where he gets the opportunity to meet other young people who have a caring role for someone in their family. The group supports the young carers to access lots of activities such as ice skating, bowling and trips to the cinema as well as the opportunity to talk freely and share their experiences of what it's like to be a young carer. Adam has made some good friends through this club and his mum is pleased that it is a fun filled evening where Adam can enjoy being a teenager, without having to worry about her.

Option 4

Adam chooses a mixture of the other options. He receives a small budget to help him purchase a computer which helps him stay connected to friends through social media. Adam also asks the council to pay for his attendance at the music lessons 2x monthly but he still likes to join the local young carers groups on a monthly basis as he has close friendships with other young carers and enjoys sharing their experiences and having fun. Adam also helps my mentoring some of the younger carers who attend this group and he takes this responsibility seriously and likes that he can support others in this way.

Considerations for children & young people

'Self-Directed Support', as defined within the legislation, reinforces the principles and values that underpin work with children in need and their families under Sections 22 and 23 of the Children (Scotland) 1995 Act i.e.:

- participation and dignity
- involvement
- informed choice
- collaboration.

The Self-Directed Support Act 2013 supports the policy values of **Respect • Fairness • Independence • Freedom • Safety** and therefore sits comfortably with the Wellbeing outcomes (SHANARRI - That children and young people are Safe; Healthy; Active; Nurtured; Achieving; Respected; Responsible and Included), wellbeing indicators and approach.

The development of children's legislation has been driven by the same values:

- **Children (Scotland) Act 1995** – which incorporates the 3 key principles of the United Nations Convention on the Rights of the Child (UNCRC) - i.e. non-discrimination; a child's welfare as a primary consideration; and listening to children's views.
- **GIRFEC** – which ensures that positive outcomes for children and young people are at the heart of decision making.
- **Curriculum for Excellence** – which ensures children and young people are at the heart of learning.
- **Additional Support for Learning Act 2004** – where children and young people are provided with the necessary support to help them work towards achieving their full potential.
- **Children's Hearings (Scotland Act) 2011** - where the voice and experience of the child or young person is at the centre of every hearing as well as highlighting their right to advocacy where appropriate.

When can a child/young person make decisions about their support?

A young person over sixteen has the right to make decisions about their own support, unless questions of capacity have been identified- in which case they should be encouraged to contribute their view as much as possible.

Below the age of sixteen, the person with responsibility for the child (defined by the Act as the 'appropriate person') should normally be involved in decisions about the child's welfare and support. A child's age and maturity needs be taken into consideration. A child who is aged 12 or over is presumed to be of sufficient age and maturity to express a view and this should be taken into account. Regardless of age, the child's view is central to assessment, planning and decision making.

Support should be provided to ensure this is possible with regard to age and stage of development.

Section 22

The duty of care remains the paramount factor in all work and it is a priority to fulfil statutory responsibilities in relation to child protection. The 2013 Act should be seen as strengthening the value based framework for engaging with children and young people and their carers, including those subject to compulsory measures of care. Many interventions under Section 22 are time limited; the identified issues are typically addressed through the relationship between the individual their family and the allocated worker, the intervention is part of a continuous process of social worker input to the family and there is little or no financial element to the resolution. In such circumstances, it is not the policy intention that the four options contained in the Act should be made available. What the Act does facilitate, however, is application of the options where there is professional judgement that long-term support is required, where there is a legal duty to provide that ongoing support and where this support can be converted into a service and/or financial resource that can be directed by the individual.

There is an emerging evidence base that creative use of specific funding can lead to better outcomes, such as an avoidance of residential care.

The Self-Directed Support Act 2013 can benefit practice across the services by further emphasising the importance of placing the child at the centre of decision making. Creative, individualised use of monies at an early stage to prevent a child from being accommodated, for example, may lead to better outcomes and more efficient use of resources in the longer and shorter term. It is important to note that this practice is already permitted under current legislation and does not actually require the offer of the 4 options which are designed more to meet longer term needs.

Plans for young people leaving care, for example, may be co-produced along self-directed support lines. The monies allocated within local authorities for supporting their transition into the community may be viewed more widely as meeting quality of life outcomes, not solely meeting practical needs.

Many such practices already exist across Scotland but are not 'badged' as 'self - directed support'. They provide an opportunity for a 'quick win' in terms of increasing staff's skills, improving outcomes and understanding of the application of self-directed support within a children and families setting. Embedding co-produced, preventative solutions within practice inevitably requires skilled leadership across organisations so that they become a real option for individuals and practitioners.

The Scottish Government intends to give further attention to the wider application of the 4 options over time and further guidance will be developed.

Sarah's story

Sarah is a lone parent to Jamie and Fraser aged 2 and 4. There have been ongoing concerns about Sarah's ability to ensure the children's needs are met. Sarah has no support from family or friends and, is unable to provide any structure or routine at home, struggling to manage both boys' behaviour. The boys don't sleep well at night, which contributes to Sarah's stress levels. She has limited cooking skills

and relies on fast food and ready meals. Sarah has been advised to attend a local parenting class and both boys have been offered a place at the local nursery. Sarah finds group settings difficult and unhelpful but conversations with her social worker outline what it is she would need to help get things 'back on track'. Sarah is given a small Direct Payment which is managed through a pay roll agency. With this, she is supported to employ Agnes, a local experienced grandmother and retired homemaker for 10 hours per week. The initial agreed outcomes are focussed on getting the boys into a routine, as this will allow Sarah to feel more in control and less stressed. Sarah would also like to spend less money on ready meals and give the boys a healthier diet. When the boys are at nursery, Agnes teaches Sarah to cook, plan weekly shopping and establish a manageable house work routine. The 1-1 relationship with Agnes who is supportive, nurturing and encouraging, builds Sarah's confidence as a mum as well as her self-esteem. Sarah, Agnes, the social worker and health visitor meet regularly to talk about how things are going. The nursery have noticed a positive change in the boys behaviour and Sarah advises they are even sleeping better, which means she is getting more rest. Despite there being child care concerns, Sarah has been supported to stay in control and make choices that suit her and her family. The outcome is that Sarah is able to make the necessary changes and learn new skills to care for her sons effectively thus reducing risk and further social work intervention.

Section 23

When a child or young person has longer term support needs, a balance between recognition of carer responsibility and the rights of the young person to shape their plans is essential.

Identifying best individual outcomes from identified and eligible needs can present challenges for all parties when the young person is preparing for leaving school and growing into adulthood. Being actively involved or supported to be actively involved as partners is seen as invaluable by families and young people and this is key to planning for better long term outcomes.

Local authorities must determine what needs it deems eligible to meet within available resources. In a Self- Directed Support context, this includes determination of criteria to access an individual budget however it is enacted. In framing local systems for the allocation of resources, local authorities will require to reflect on what is age and stage appropriate for a child e.g. all young children require constant supervision but clearly consideration should be given to the requirement for support of children with additional support needs and their family carers.

For a child, young person or their parent/carer whose needs determine they are eligible for additional support, the following considerations are essential:

Information- to ensure the young person or the person making decisions on their behalf are kept informed about the process and what might be possible within the 4 options. The information must be explained in a manner and format that is appropriate for the child - taking into account their age and capacity to understand. If another appropriate person is taking decision on behalf of the child, the principles still apply **and** attempts must be made to explain matters to the child where possible.

Collaboration – to ensure that the child or the young person is supported to design or describe what their support should look like and to have a say.

GIRFEC -named person and lead professional will need to take these duties into account when fulfilling their role.

Transition - when a child has additional support needs, (disability; learning difficulties; emotional; physical or social; is looked after and accommodated etc.) transition is commonly referred to as the time when they start to prepare for leaving school and adult life in general. It is recognised as a challenging time for children, young people, and families and indeed challenges agencies co-operative practices. The flexibility which self directed support approach promotes is more likely to develop creative, collaborative plans for young person's independence and social inclusion.

Children and young people: considerations for

Practitioners

- one child, one plan - If the child/young person has more than one agency involved it must link into the child's plan (GIRFEC) /'co-ordinated support plan' (Education (Additional Support for Learning) Act 2009. (These should already be in one plan, unless the young person, parent / guardian has made a decision to have them separated due to individual circumstances).
- assessment and planning should follow the duties set out by the named person or lead professional (GIRFEC and the forthcoming Children's and Young People Bill).
- if Self Directed Support principles have been applied in children's services, the move to adult services should be a lot smoother for everyone involved.
- the principles and values which underpin the 2013 Act continue to promote the best practice that is already established within children's legislation and policy. The importance of the role of professional skill and judgement cannot be underestimated.
- balancing the principle of choice alongside duties to protect and compulsory measures of care is an essential requirement.
- keep the child and young person's needs at the centre of planning- whilst giving importance to effectively engaging with informed parents and carers.
- ensure access to independent advocacy where appropriate, enabling individuals to have sufficient input into their own care and support and be helped with make decisions if required.
- if the young person has a Co-ordinated Support Plan, it may be helpful to be aware of the good practice guidance concerning the Additional Support for Learning Act and transition.

Organisations

- effective self directed support implementation will require engagement of partners who have responsibility for children and their families and for them to be fully versed in the duties of the Act.
- clear transition arrangements are important.

- opportunities for families to pool resources to increase their capacity or to be merged with community based resources might be areas for further examination.
- strong leadership is important to ensure organisational practices support practitioners in transforming practice so it is more creative and empowered.
- the development of co-production alongside other organisations is required to ensure there is access to less formal services.
- the continued development of connected services is important to ensure staff have ready access to experts on adult support and protection; mental health etc which will support an informed, risk enabled approach.

Mary's story

Mary is almost 15 and has been living with foster carers Rosie and Bob for the last 3 years. Mary doesn't have a lot of contact with her family, as there are concerns about her mum's drug misuse. Mary gets on well with her foster carers but eventually would like to move into her own accommodation in a couple of years. As part of this transition, Mary's social worker and Rosie are supporting Mary to take more responsibility - in manageable steps- as preparation. For example, It has been agreed Mary will get weekly, then eventually monthly, money for her bus fares to college rather than daily - to see how she manages it. Her social worker was worried that Mary would be pressurised into giving her mum money when they met up, however, this was fully discussed and Mary decided the best way to prevent this was to buy a weekly ticket rather than carrying money around. Mary advised this would also prevent her from spending the money on other things like mobile top ups and clothes! At the start, Mary did find it tempting but knew that if she spent the money on other things she might risk missing college and worse still - go back to daily money! Mary likes how people trust her with the money. She also likes coming up with her own solutions and feels her ideas are getting better and better each time. Mary gets on well with her social worker - she says she is a great listener but most of all she feels she has faith in her!

Use of Direct Payment to employ family members

In the past, local authorities have had limited, discretionary powers to make direct payments to family members to undertake some caring duties that would otherwise have been purchased from a provider. It is not the intention of this approach to pay family members for undertaking family caring duties that are usually provided as part of the carers existing role. Typically this situation has arisen due to issues of rurality (e.g. where more formal support may be difficult to access because of geographical remoteness) and ethnicity (e.g. where a person's specific cultural needs require to be met by someone with a comprehensive understanding of those needs, and that person may be a family member). These are not the only circumstances where family members have been paid by a local authority to care within their family but they are more common examples.

The **statutory regulations** that accompany the Act define the circumstances where a local authority may agree to a family member providing paid support where this is requested by the supported person.

A direct payment to a family member can be considered where:

- the family member and direct payment user and local authority agree to the family member providing the support.
- the family member is capable of meeting the direct payment user's needs and
- any of the factors below apply.

The factors are:

- there is a limited choice of service providers who could meet the needs of the direct payment user.
- the direct payment user has specific communication needs which mean it will be difficult for another provider to meet the needs.
- the family member will be available to provide support which is required at times where other providers would not reasonably be available.
- the intimate nature of the support required by the direct payment user makes it preferable to the direct payment user that support is provided by a family member.
- the direct payment user has religious or cultural beliefs which make the provision of support by a family member preferable to the direct payment user.
- the direct payment user requires palliative care.
- the direct payment user has an emergency or short-term necessity for care.
- there are any other factors in place which make it appropriate, in the opinion of the local authority, for that family member to provide the support.

The regulations define an “exception to the family members rule” where local authorities may not agree to a family member being employed if:

- the local authority determines that either the family member or the direct payment user is under undue pressure to agree to the family member providing support; or
- the family member is a guardian, continuing attorney or welfare attorney with power to make decisions as regards the support to be provided through the direct payment.
- and includes a person, granted under a contract, grant or appointment governed by the law of any country, powers (however expressed) relating to the direct payment user’s personal welfare and having effect during the direct payment user’s incapacity.
- if the arrangements do not meet the person’s needs then the local authority does not have to agree (exemption already exists in existing legislation).
- if the arrangements place the person at an unacceptable risk then a duty of care takes precedence.

Paid support by family members--: considerations for practitioners

- regulations have binding legal status so cannot be ignored.
- crucially the local authority, as well as the family member and direct payment user must agree to the family member providing the support. The ultimate decision lies with the local authority to retain the power to decline to fund this arrangement and must be made explicit to the person as to why this decision has been made. This means that the authority, as well as the supported person and prospective employee, must agree to the arrangement in order for it to be allowed under the Regulations. There are a number of reasons as to why an authority may disagree where the arrangement. For instance, the arrangement may not in fact meet the assessed needs of the supported person. Or the authority may be aware of other factors, for instance, the authority may be aware of potential exploitation issues.
- it is important to ensure that enough information is provided (that includes potential consequences) to enable informed choice.
- best practice indicates that this discussion is best located at the support planning stage of the self-directed support process when the ways of meeting a person’s needs and intended outcomes are being explored and described.
- there may be advantages and disadvantages to paying a family member. It may help to resolve a long-standing difficulty in relation to meeting the person’s support needs. On the other hand, families often have complex dynamics. Inevitably, paying for support changes the nature of the relationship between the person with support needs and the family member providing the support. This change in relationship may have an effect on the support needs of the individual. In all

cases, the practitioner should weigh up the specific circumstances and they should do so alongside the individuals involved.

- it is important to explore the extent to which both parties are comfortable with the arrangement. Some considerations are likely to be around the nature of the arrangement, which often involves the person becoming the employer of their family member. In these circumstances it is important to assess how easy would it be for the supported person to raise concerns about the quality of the support provided? How easy would it be for the person to dismiss the family member if the need arose? Would employing a family member inhibit the choices and lifestyle of the person with support needs? How would you monitor the quality of support provided? What are the risks of such an arrangement and what steps can be taken to mitigate them?
- the above factors should be explored with the person and family member(s) to ensure the implications of such an arrangement are fully understood and the choice a well-informed one.
- an alternative that is sometimes deployed is for the person to use a direct payment to fund a provider organisation to employ their family member, which can help remove some of the challenges associated with the employer-employee relationship.
- a good support plan will address such issues (and some of those questions apply to a wider range of provision e.g. employment of an unrelated personal assistant).
- ultimately the regulations state that a family member must be “capable of meeting (a person’s) needs” so practitioners must satisfy themselves that a person’s intended outcomes can be met in this way, as with every other option.
- if a worker believes such a payment is not appropriate in this context, it will be important to evidence the reasons why e.g. where a practitioner believes a person is under “undue pressure to agree” there would be a reasonable expectation from all parties that this is documented and explained.

Douglas’ story

Douglas is in his late 30’s and has a long history of substance misuse, his wife is also a drug misuser and both lived very chaotic lifestyles. Douglas’s wife Anne is a particularly angry and verbally abusive individual though not physically abusive. The tenancy is vulnerable due to anti-social behaviour reports to housing.

Douglas was diagnosed with Motor Neurone Disease a few years ago and this is increasingly having an impact on the couple. Their lifestyle had already compromised and damaged their relationship with family and neighbours and as Douglas’ condition worsened they became more isolated.

A Direct Payment was put in place to enable flexible support in an isolated area where options were limited and community networks not an option.

The circumstances were described to a support agency, they started to provide personal and other key support to Douglas, though Douglas's ambivalence was at times challenging for carers and arrangements were monitored.

This was monitored very closely and Adult Support and Protection featured frequently. The couple have strong antipathy toward authority in general and social work services and resent the increasing need for support. However they do trust their GP.

Regular multi agency meetings are held including representatives from police housing and GP and AS& P plan in place.

The agency lost some staff to a rival agency, which meant a change to regular support arrangements. The couple struggled with this, and new carers found the attitude of the couple difficult, so they have notice to withdraw.

Douglas at time expressed to his sister that he did not trust the care provided by Anne who was by now main carer. Anne frequently put her own needs above her husband's wellbeing, and carers increasingly had no money to buy food for Douglas nor the means to provide personal care with dignity or safely.

Anne left, and the situation settled but a mutual dependency brought the couple together again. Douglas has the capacity to make decisions and clearly wished his wife to remain in his life and in their home.

In light of providers' withdrawal, a plan was developed whereby Douglas's sister would take on the role of Personal Assistant and would with her brother's permission provide some aspects of the support, while Anne took on the more personal aspects.

This was considered appropriate because Douglas's sister provided a protective factor, she was the last relative willing to engage with the couple, She also recognised her brother's choices were becoming restricted as his condition worsened and felt to provide support would help the couple stay together which in turn helped her brother stay out of institutional care, the last thing he or she wanted.

An outcome of this arrangement is that Anne has experienced a productive team work approach that does not judge her, and as a result she is more trusting and more able to compromise and is certainly less confrontational. Douglas is confident and reassured that his personal choices are respected. Prognosis is poor but this arrangement has enabled Douglas to remain in his own home which was his goal for as long as is possible.

Monitoring and Reviewing

There is a duty on the practitioner to offer the person the four options for all new presentations of eligible need and for those due to be reviewed from April 1st 2014. This review will require to consider risk, capacity and any changes which impact on current support plan.

In order to ensure practitioners discharge their duties under the Self-Directed Support Act, monitoring and reviewing processes must be guided by the statutory principles:

Participation & Dignity; Involvement; Informed Choice; Collaboration.

Local authorities have a duty to undertake reviews where support is provided to meet eligible need and as a response to a significant change in circumstances. Frequency will be guided by risk and other factors.

Monitoring

- monitoring of the support plan is essential to ensure the plan is being implemented as agreed and to allow for any minor adjustments to be made as appropriate.
- the amount of contact required with the individual, their family, carer or any other organisations will be determined by the level of need and risk and contribute to the on-going process of assessment and analysis. This will have been openly discussed and agreed at the support planning stage.
- monitoring informs the review process so that the information contributes to an understanding which can support people to make the best use of the resources available to them.

Reviewing

- review of the support applies to all four options under the SDS Act. Review involves re-evaluating whether the plan is achieving the agreed goals and outcomes set out in the support plan.
- it should focus on the agreed outcomes and consider with the person and other involved parties including the provider the extent to which the support has achieved the outcomes.
- the views of the person with regard to such issues as - the support provided; feeling safe in their home and local community; their level of social inclusion; their personal development; and/or any caring roles they undertake - should all be explored and changes to the support plan discussed and agreed.
- when the supported person is a child/young person, the well-being indicators (SHANARRI) should be used as a framework for monitoring and reviewing.
- the Act makes it clear that the local authority and the supported person have the right to request a review of their selected Option

under the SDS Act if there is a change in the supported person's circumstances/if there is evidence that outcomes are not being met as anticipated.

At each review, the four options must be offered formally again, even if there are no changes required. How this is evidenced, it must be considered by the practitioner and included in local review recording process. It may be helpful for the practitioner to see reviews as a natural extension of support planning. At any time, the supported person can ask to change their option (which should be dealt with by the same process as they made their previous choice) or they may ask for their assessment, support plan, or budget to be reviewed.

Monitoring and Reviewing: Considerations for -

Practitioners -

- monitoring of the support, its purpose and aim (ensure outcomes are being met) should be clearly understood by all and evidence active participation (this should be referenced within the support plan).
- the level of monitoring should relate to the scale of the support and the complexity of the outcomes identified. Reassure people –it is ok not to get the plan right every time; professionals need to adapt and change too!
- the supported person and contributors to the plan should be clear about how to raise concerns, give feedback if the plan is not progressing or highlight concerns.
- for many, a goal will be to enable an individual to become less dependent on formal support and more engaged in and part of their communities. The monitoring and reviewing process should help to explore this on an ongoing basis.
- the monitoring and reviewing process is as important as the assessment and support planning stages and requires the same principles and approach applied as with the initial pathway.
- practitioners should continue to adhere to local policy, procedures and guidance in relation to monitoring and reviewing.
- preparation – ensure you have planned sufficient time to engage and seek the views of those involved within the support plan.
- the most up to date support plan needs to form the basis for the review; the review should be responsive to the inevitable change and fluctuation that exists so that support can be offered more flexibly and proportionally.
- some issues shouldn't wait for a review to be addressed.
- along with independence and choice comes responsibility – it is reasonable for practitioners to ask people to account for how they have spent their money in achieving their support plan outcomes, but to do so in a sensitive way. During this process individuals and professionals may need to question the quality of support and information, or their level of funding or explore the choices that are being made and for both parties to develop a

refreshed plan of support. The development of a good working relationship with all involved will allow for constructive, open and honest conversations to take place as appropriate when this topic requires discussion.

- who else needs to be involved in the review – this should be considered under the guidance of the person where possible? If other professionals need to be involved – for example within a child’s plan – the reasons for this should be fully explained to all involved.

Organisations

- Is review data influencing service design and commissioning strategies given that it reflects the views of people who use need support?
- Have you got systems that schedule reviews and prompt when timescales approach?
- Are payments made in accordance with required legal and procedural guidance adopted locally?
- Is there a policy for review?

Evelyn’s Story

Evelyn is 23 years old and lives with having fragile “X” syndrome. This affects her in many aspects of her life and means that she can struggle to achieve a level of independence without support. Evelyn can struggle with communicating and developing relationships, her co-ordination is poor which can result in accidents. She finds sequencing tasks and problem solving difficult without guidance and support from others. Evelyn is extremely vulnerable to exploitation by others and she is unable to identify risks and is extremely susceptible to coercion from others.

Evelyn lives at home with her parents who both have significant health needs themselves and despite their commitment to continue to provide care and support for Evelyn the family have been assessed as requiring support to help maintain Evelyn in the family home.

Evelyn had been assessed as requiring some weekly support to promote social inclusion and this had been provided by local agency who receives block funding from the council to provide this kind of support. Evelyn had also been assessed as eligible for respite and had visited a number of local respite units but Evelyn and her parents felt this was not appropriate for Evelyn. Using an SDS approach to planning we were able to agree that Evelyn could access a flexible budget to support short breaks that would meet the families need for respite. For a period of time this worked well and Evelyn went on a number of short breaks with a family friend and also with support from a support worker from the care agency that she was linked with. Evelyn would with support identify a break and was fully involved with planning this. Her budget was held by the Social work department and administered to the family or to the travel company when required to purchase the break. Evelyn’s aunt provided her support by accompanying her on her trips and all her accommodation and expenses were paid for using Evelyn’s respite budget.

During a review the success of the support plan revealed that the provider agency were not able to provide the flexibility that Evelyn required, they often cancelled support or sent an unfamiliar person to support Evelyn. There were also restrictions about the activities they could support Evelyn with and with the use of their car for activities further afield which limited Evelyn’s choices. In partnership with social work Evelyn and her mum were supported to explore Option 1 (Direct Payment). This gave them the opportunity to employ 2 personal assistants. Evelyn and her mum were fully involved in the recruitment of 2

women of similar age to Evelyn with similar interests who could support her to achieve her goal of social inclusion. Evelyn's Mum helps oversee the financial responsibility and receives good support from the local authorities Specialist SDS team. They also use the services of a local payroll agency and are extremely pleased with the flexibility this arrangement has given them. Evelyn and her mum feel very much in control and directing her own support.

Evelyn has used the support of her personal assistants to help her gain confidence in using public transport, visiting friends, taking up classes in her local area and securing 2 volunteering roles in her local community. Evelyn continues to use her personal budget to help her to achieve her agreed outcomes and Evelyn has developed unintended skills from the process i.e. planning and organisational skills as well as increased confidence and IT and literacy skills. Her Mum has also grown in confidence in her role in overseeing the Direct Payment and her own self esteem has improved as a result.

Summary

This guide, developed by ADSW, confirms the new duties in the Act for practitioners. The objective is to affirm the value of current best practice in outcomes focused assessment and support planning and to show how the new duties enhance the opportunities to practice within a clear value base which is supported through statute.

This practitioner guidance has been developed reflecting the views and experiences of people who use services and guided by operational practitioners working in various frontline contexts. This was a condition laid down by the Scottish Government. It is a testimony to the value with which frontline views are held and their central role in turning the rhetoric of self-directed support into a reality.

It is recognised that the local arrangements which provide the framework for the delivery of self-directed support will vary considerably- from screening processes; how and when budgets are agreed; the type and range of options available especially in rural and remote areas and so on. In light of this, the guidance has taken a broad overview to provide enough scope for tailoring advice to specific requirements.

Some elements of the statutory guidance and regulations will not be in place until nearer the implementation date. It is not anticipated that this will compromise the usefulness of this document. However, it has meant that some elements of Self-Directed Support practice requirements cannot be fully explained. More guidance will be provided once options within residential care are explored and when aspects of children in need, under S22, are further considered.

The document is broad in its scope and will require to be amended as the elements of the approach are tried and tested. This is particularly pertinent in relation to procurement and commissioning arrangements and how individual service funds will work in practice.

The online version of this guidance will be the vehicle for reflecting progress through updates and additional case examples. This guidance is one of a suite of planned, supportive documents that includes guidance for users and carers and providers and also national training modules. The SSSC, supported by the Scottish Government, is also driving change through the new 'Workforce Development Strategy' in partnership with councils, providers, carers & user organisations which will run until 2015.

Together - nationally and locally, across and through the organisations and sectors - but most importantly in partnership with people who may need support and their carers - we can make a better future for Scotland.

Glossary

Act	Self-Directed Support Act 2013	
Action Plan	A record of agreed objectives and actions that are set against timescales with indications of who is responsible for what.	
Active citizen	In relation to engagement with public services a person with rights views and expertise.	
Advocate / Advocacy	Independent and trained person usually attached to an organisation who provides an objective voice on behalf of an individual.	
Assessment	Assessment is the ongoing process of gathering, analysing, interpreting and reflecting on information to make informed and consistent judgements with a view to determining what, if any, intervention can assist in meeting positive outcomes and change.	Talking Points: A personal Outcomes Approach Practical Guide & Summary briefing www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/
Authority	Local authorities who have duties relating to arranging care and support in community care and children's services.	
Budget	A defined amount of money set aside for a particular purpose.	
Care programme approach	The Care Programme Approach ("CPA") was developed originally for use at local level in Scotland for people with severe and enduring mental illness as a means of co-ordinating support.	http://www.scotland.gov.uk/Publications/2010/06/04095331/4
Changing Lives Report	The 21st Century Social Work Review that involved extensive consultation across Scotland with those who use social work services and those who plan, deliver and commission services. Three over-riding conclusions were: <ul style="list-style-type: none"> • Doing more of the same won't work. • Social work services don't have all of the answers and need to engage with people as active participants. • Social workers' skills are highly valued and increasingly relevant to the changing needs of society but need to be adapted. 	http://www.scotland.gov.uk/Publications/2006/02/02094408/0 Summary report – http://www.scotland.gov.uk/Publications/2006/02/02094718/2

'Child in need' (Section 22)	<p>Section 93 (4) Children (Scotland) Act 1995 defines a child in need as: being in need of care and attention because;</p> <ul style="list-style-type: none"> • s/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him/her services by a local authority • his/her health or development is likely significantly to be impaired, or further impaired, unless such services are so provided • s/he is disabled • s/he is affected adversely by the disability of any other person in his/her family. 	<p>Children (Scotland) Act 1995 Guidance and Regulations http://www.scotland.gov.uk/Publications/2004/10/20066/44707</p>
Choice	<p>Fundamental principle of self-directed support. Choice means having options, alternatives, and opportunity to express preferences.</p>	
Christie Commission Report	<p>The Christie Commission was established by the Scottish Government in November 2010 to develop recommendations for the future delivery of public services. The Commission, which was chaired by Dr. Campbell Christie CBE, operated independently of government. Key theme-the workforce must be able to provide effective services and support that are designed with and for people and communities and not delivered top down for administrative convenience.</p>	<p>http://www.scotland.gov.uk/Publications/2011/06/27154527/0</p>
Collaboration	<p>Statutory principle of the SDS Act - to work together, join forces, partnership and co-production.</p>	
Commissioning	<p>The process by which authorities contract with providers of services, both internally and externally.</p>	
Control	<p>A principle of new act, people having influence and having a say in, for example, how support is shaped.</p>	
COSLA	<p>Convention of Scottish Local Authorities-the representative voice of local authorities.</p>	
Co-ordinated Support Plan (Child or Young Person)	<p>The co-ordinated support plan is a statutory document for children and young people with additional support needs. (There is specific criterion to establish who is eligible for a CSP).</p>	<p>http://www.scotland.gov.uk/Publications/2004/06/19516/39190 http://enquire.org.uk/</p>

Co-production	<p>“co production involves the public sector and citizens working together in an equal and reciprocal fashion. It is more than asset based community development and service user design; more than consulting; goes beyond partnership, co-operation and collaboration. It can be all these things but it is more than the sum of its parts. Efficiently delivered and useful services rely upon both professional expertise and the assets and efforts of citizens. Co –production requires us to engage with the ‘core economy’ – ie all the resources and assets that are available to citizens in their every-day lives – wisdom, knowledge and skills from learning in its widest sense; relationships and capacity and emotion- to name a few. Effective services must be underpinned by co- production with individuals, family, community and civil society.” ADSW</p>	<p>https://youtube.googleapis.com/v/n5K44phGP-g8?rel=0&rel=0&autoplay=1</p>
Cultural Change	<p>Change that transforms individual and organisational attitude, value base and belief system to support the purpose of that change.</p>	
Direct Payment	<p>A cash payment, paid directly to the individual (or to a third party). It is:</p> <ul style="list-style-type: none"> • A self-directed support mechanism that allows a person an alternative to community care services • Money for a person to arrange their own support • By paying staff, purchasing services (from agencies or local authorities) buying equipment or a combination of these • Increased Choice, Control and Responsibility • No advantage or disadvantage in terms of “amount” of service. 	
Duty of Care	<p>Fundamental duty to promote welfare and protect from harm within Section 12 1968 Social Work Scotland Act.</p>	
Early Intervention	<p>Preventative engagement and involvement in relation to children, a collaborative approach to improving a child’s life chances.</p>	<p>http://www.scotland.gov.uk/Publications/2008/03/14121428/0</p>

The Education (Additional Support for Learning) (Scotland) Act 2004	<p>The Education (Additional Support for Learning) (Scotland) Act 2004 came into force in 2005 and was amended in 2009. The law sets out how pupils should be helped to get the right support to become successful learners and explains how parents can make sure this happens. Additional support for learning means giving any child in need of help or support so they can get the most out of their education and reach their fullest potential.</p>	<p>A summary</p> <p>http://www.scotland.gov.uk/Publications/2004/06/19516/39190</p>
Eligibility Criteria	<p>Specific requirements set out as thresholds for accessing specific services.</p>	
Equivalency Model	<p>A model being developed for determining budget allocation.</p>	
Empowerment	<p>Enabling, feeling permitted and self-determined.</p>	
Funded Support	<p>Support that can be costed and purchased, usually in social care and does not include the use of professional skill and time, for example, physiotherapist, social worker, occupational therapist nurse.</p>	
'Getting It Right For Every Child' (GIRFEC)	<p>The GIRFEC approach is a Scotland-wide programme of action to improve the well-being of all children and young people. Its primary components include: a common approach to gaining consent and sharing information where appropriate; an integral role for children, young people and families in assessment, planning and intervention; a co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the Well-being Indicators; a Named Person in universal services; a Lead Professional to co-ordinate and monitor multi-agency activity where necessary; and a skilled workforce within universal services that can address needs and risks at the earliest possible point.</p>	<p>http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright</p>
Human Rights and Equalities legislation	<p>Self-directed support and all public services are subject to Human Rights and Equalities legislation.</p>	<p>http://www.scotland.gov.uk/Topics/BuiltEnvironment/Housing/16342/management/socialhousingaccess/allocations/Guide/legislativeframework/dataprotectionequality</p>

Independent Living	<p>“Independent Living means all disabled people having the same freedom, dignity, choice and control as other citizens at home, at work and in the community. It does not mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life” - Independent Living in Scotland (ILiS)</p> <p>This applies to all people.</p>	<p>http://www.sdsscotland.org.uk/show.php?contentid=124#sthash.Cp1xKKFe.dpuf</p>
Independent Service Fund	<p>Where someone wants to use their individual budget to buy supports from a provider:</p> <ul style="list-style-type: none"> • The money is held by the provider on the individual’s behalf • The provider is accountable to the person • The person decides how to spend the money • The provider commits to only spend the money on the individual’s service and the management and support necessary to provide that service. 	
Individual budget	<p>Individual budget is the actual allocation of funding for self-directed support given to people after an assessment. The agreement of the budget should be a transparent process that demonstrates compliance with community care and other legislation. The money can be combined from several funding sources that can be used to design and purchase support to meet eligible needs, from the public, private and voluntary sector.</p>	
Informed Choice	<p>Statutory Principle of SDS Act – ensuring individuals have access to or are given enough information in an understandable format to enable them to make decisions and express choice.</p>	
Integrated services	<p>The term used to describe jointly resourced and managed services between organisations (such as health and social work) in order to achieve better outcomes for service user and best value.</p>	
Involvement	<p>Principle of the Act; participation and taking part in assessment and support design.</p>	
Joint Improvement Team	<p>The Joint Improvement Team (JIT) was established in late 2004 to work directly with local health and social care partnerships across Scotland.</p>	<p>http://www.jitscotland.org.uk</p>

IRISS	IRISS – Institute of Research & Innovation for Social Services The Institute for Research and Innovation in Social Services (IRISS) is a charitable company who support social services by providing research, information and resources.	
My World Triangle	As part of the GIRFEC “practice model” for assessing risk and need, the My World Triangle is provides a starting point for considering what risks might be present in a child’s life. It focuses attention on the three dimensions of a child’s world: the child themselves; their family; and their wider environment.	http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright
Outcomes	Personal outcomes – Defined by the person as what is important to them e.g. It is the difference or positive impact any support plans or intervention have on a person. Definitions from ‘Talking Points’ – Personal outcomes approach. Joint Improvement Team.	http://www.jitscotland.org.uk
Outcomes Focused Assessments	Assessments that engage with people through skilled conversation in what matters most and why, and highlights what needs to change and why	
Person	Adult, Child, Young person or Carer.	
Personal Assets	What a person brings through life experience, skills, knowledge, motivation, ideas and their own networks of support and capital.	
Personalisation	“Personalisation enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive.” - Scottish Government (2009) ‘Personalisation: A Shared Understanding’	http://www.sdsscotland.org.uk/resources/terminology.php#sthash.LsW1uHiW.dpuf
Person Centred	Keeping an individual at the heart of any process that involves or impacts on them.	
Power of Attorney	A power of attorney is a document appointing someone to act on and make decisions on the individual’s behalf, for someone anticipating permanent incapacity or to deal with periods of temporary incapacity. This could be relevant to someone with a fluctuating condition. Powers of attorney can deal with financial and/or welfare matters.	http://www.publicguardian-scotland.gov.uk/whatwedo/power_of_attorney.asp



Practitioner	A worker, (usually but not always a professional) who will undertake Self-Directed Support Act 2013 responsibilities, which could include colleagues from partner agencies who are delegated by local authorities.	
Re-ablement	One way of describing rehabilitation, improving mobility or self-care skills.	
Resource Allocation System	A Resource Allocation System is a means(under development), of deciding how much money people are entitled to, to be able to purchase the support they need.	
Risk Enablement	Promoting positive risk taking	
Screening Assessment	The process of deciding how to action a referral and what priority is afforded to it.	
Self-Directed Support	The 2013 Act; to ensure people are involved in their assessment and supported to make informed choices and collaborate in the design of their support.	
Support Planning	The complex process whereby information gathered through assessment, and involving individual, using their personal outcomes and choices to help define what is going to be most helpful. It will define how goals will be agreed and how people and agencies can work together to achieve them.	
SPRU	Social Policy Research Unit ;University of York	https://www.york.ac.uk/inst/spru/aboutspru.html
Statutory Regulations	The national guidance and rules which guide the Self -Directed Support Act 2013 implementation in authorities.	
Transition	In public service- defines the move from children to adult services.	



Additional reading

Statutory Guidance & Regulations 'The Social Care (Self-Directed Support) (Scotland) Act 2013' – Scottish Government <http://www.scotland.gov.uk/Publications/2013/11/3923>

Understanding and Measuring outcomes –Institute of Research and Innovation for Social Services (IRISS)

<http://www.iriss.org.uk/resources/understanding-and-measuring-outcomes>

Wellbeing a Guide to Measuring Meaningful Outcomes: Scottish Government

<http://www.scotland.gov.uk/Topics/People/YoungPeople/gettingitright/background/wellbeing>

The Knowledge Network (NHS) 'Carers assessments' and 'Engaging with Carers and Young carers'

<http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/practice-guidance.aspx>

The Carers Trust - Scotland

<http://professionals.carers.org/social-care/articles/policy-documents-scotland,4436,PR.html>

National Guidance on Supporting Carers – Scottish Government

<http://www.scotland.gov.uk/Publications/2003/03/17023>

Getting it right – Assessment for black and minority ethnic carers and service users Institute of Research and Innovation for Social Services (IRISS)

<http://content.iriss.org.uk/bme/>

Scottish Independent Advocacy Alliance (SIAA) <http://www.siaa.org.uk>

Adults with Incapacity (Scotland) Act 2000: Communication and Assessing Capacity: A guide for social work and health care staff. Scottish Government

<http://www.scotland.gov.uk/Publications/2008/02/01151101/0>

Powers of Attorney and Guardianship- Office of the Public Guardian (Scotland)

<http://www.publicguardian-scotland.gov.uk/>

Mental Welfare Commission for Scotland – Good Practice Guides

<http://www.mwscot.org.uk/publications/good-practice-guides/>

Self-Directed Support in Mental Health Capacity Building for the 3rd Sector Providers

<http://www.mentalhealth.org.uk>

Current eligibility for adults in Scotland <http://www.scotland.gov.uk/topics/health/suphttp://www.careandhealthlaw.com/Public/LawDatabaseCasesDesc.aspx?IndexType=2&Id=171port-social-care/support/older.people/free-personal-nursing-care/guidance>

Cutting the cake fairly CSCI review of eligibility criteria for social care

<http://www.scie-socialcareonline.org.uk/cutting-the-cake-fairly-csci-review-of-eligibility-criteria-for-social-care/r/a11G00000017vOTIAY>



Belinda Schwehr – Legal judgments for England that can support SDS delivery in Scotland
<http://www.careandhealthlaw.com/Public/LawDatabaseCasesDesc.aspx?IndexType=2&Id=171>

Personal Outcomes Plan – guidance to staff. Joint Improvement Team Scotland
<http://www.jitscotland.org.uk/search/>

The keys to life - Improving Quality of Life for People with Learning Disabilities: Scottish Government
<http://www.scotland.gov.uk/Publications/2013/06/1123>

SCIE Guide 17: The participation of adult service users <http://www.scie.org.uk/>

Further planning tools can be found at:

<http://www.scie.org.uk/>

<http://www.pcpmn.cswebsites.org/>

<http://www.inclusive-solutions.com/pcplanning>

<http://www.iriss.org.uk>

Reshaping care and support planning for outcomes – IRISS (Institute of Research and Innovation for Social Services)
<http://content.iriss.org.uk/careandsupport/assets/html/info.html>

Child protection and the needs and rights of disabled children and young people: A scoping study – University of Strathclyde – Glasgow <http://strathprints.strath.ac.uk/27036/>

Learning to Live with Risk: Skills for Care <http://www.skillsforcare.org.uk/risk>

Nothing Ventured, Nothing gained: Risk Guidance for people with dementia. Department of Health
<https://www.gov.uk/government/publications/nothing-ventured-nothing-gained-risk-guidance-for-people-with-dementia>

Self-Directed Support Scotland
<http://www.sdsscotland.org.uk/>

A Guide to Receiving Direct Payments (Scotland) NHS
<http://www.sehd.scot.nhs.uk/publications/grdps/grdps-01.htm>

Disability Rights UK
<http://www.disabilityrightsuk.org>

In Control Scotland
<http://www.in-control.org.uk/>

Self-directed Support Scotland – frequently asked questions
<http://www.selfdirectedsupportscotland.org.uk/directing-your-own-support/frequently-asked-questions>

National Guidance on Self-Directed Support – Section 5: Employing staff: personal assistants and close relatives Scottish Government

<http://www.scotland.gov.uk/Publications/2007/07/04093127/10>

Statutory Guidance and Regulations 'The Social Care (Self-Directed Support) (Scotland) Act 2013' – Scottish Government <http://www.scotland.gov.uk/Publications/2013/11/3923>

Children's (Scotland) Act 1995 – Guidance and regulations

<http://www.scotland.gov.uk/publications/2004/10/20066/44707>

Getting It Right For Every Child – Scottish Government <http://www.scotland.gov.uk/girfec>

Getting it right for every child: Guidance on the Child's or Young Person's Plan

<http://www.scotland.gov.uk/Publications/2007/01/22142141/0>

Scottish Parliament Information Centre (SPICe) Briefing: Children and Young People (Scotland) Bill <http://www.scottish.parliament.uk/help/Research.aspx>

National Risk Assessment Framework – Children and Young People

<http://www.scotland.gov.uk/Resource/0040/00408604.pdf>

Getting It Right For Every Child – Guidance: Scottish Government

<http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/national-practice-model/planning-action-review>

Integrated Team Working - The effectiveness of different models of integrated team working – Institute of Research and Innovation for Social Services (IRISS)

<http://www.iriss.org.uk/project/integrated-team-working>

Recording Outcomes in Care and Support Planning and Review (E.Millar & E.Cook) Joint Improvement Team Scotland

<http://www.jitscotland.org.uk/search/>

Guidance for Completing Talking Points Annual Review Plans (Day Service) Joint

Improvement Team Scotland <http://www.jitscotland.org.uk/search/>

