Health, Social Care and Sport Committee
The Scottish Parliament
Edinburgh
EH99 1SP

Mansfield Traquair Centre
15 Mansfield Place
Edinburgh
EH3 6BB

17 June 2024

Dear Ms Haughey,

Follow-up to attendance at HSCS Committee, 4 June 2024

Thank you for your interest in our perspectives on Self-directed Support implementation for the post-legislative scrutiny of the Social Care (Self-directed Support)(Scotland) Act 2013. Please find my responses to your additional questions below.

Yours sincerely,

Dr Jane Kellock
Project Manager – Social Work Scotland SDS Project

National SDS Collaboration

What do you regard as the priorities for improvements to SDS?

We have a greater understanding now of what good looks like in Self-directed Support through the work of national and local stakeholders (as expressed in the SDS standards), and crucially we have a better understanding of what good implementation looks like, what the enabling and disabling context are for SDS, and what it will take to implement SDS as intended.

The SDS improvement plan was coproduced with national stakeholders through the National SDS Collaboration, and includes those priorities set out by the local authority SDS community of practice through a series of discursive events in summer/autumn 2022. We routinely revisit these priorities with Community of Practice members through our project work, and we are confident that they remain the foremost priorities. The SDS improvement plan forms the backbone of the seven Social Work Scotland SDS project workstreams, which focus on implementation activity for the social work profession.

The plan is based on the four categories of implementation drivers (drawn from implementation best practice):

1. supported person and carer's choice over their support

2. enhanced worker skills, practice and autonomy

3. systems and culture

4. leaders understand and help staff realise SDS principles and values

As noted, current priorities identified by the social work profession are included in the improvement plan. Other partners have contributed their own priorities from their own organisational perspectives. This is what makes the plan comprehensive.

However, as SDS doesn't exist in a bubble, but sits holistically within the wider enabling context of social work and social care policy and practice, there are many factors outwith the control of the SDS community which impinge on the delivery of SDS.

I have addressed these in my responses below, but fundamentally there needs to be a much more comprehensive understanding of Self-directed Support across all relevant policy areas and sectors. There remains a persistent misunderstanding that SDS is an 'add-on' rather than how we should all be delivering social care support to everyone who receives it. This needs to be driven nationally with local buy in.

The following needs to be included in engagement around the enabling resource context for SDS: access to care (to replace eligibility criteria), an understanding of population-level unmet need, a meaningful shift towards early help with investment in different models of care and support, and greater collaboration with other sectors like housing, health, communities.

What has been achieved by the National SDS Collaboration so far and in your opinion, what more needs to be done?

We have a strong and collaborative SDS community in Scotland because so many people believe in the potential of SDS if properly implemented. The National Collaboration, including the voice of lived experience, has developed a shared

pragmatic understanding of the SDS implementation gap, not an easy undertaking as there is potential for considerable strife due to current dissatisfaction in social care provision. The National Collaboration holds a space for regular information sharing, for coproduction in implementation, and a growing potential for influencing the national agenda.

Specific achievements to date include co-production of the national SDS Improvement Plan, inputs to related policy initiatives such as dementia strategy, learning disability and neurodiversity strategy, transitions strategy, engagement in the production of evidence and practice across the sector such as In Control Scotland Option 2 and Option 3 reports, Social Work Scotland SDS Standards, and the sharing of good practice such as recent inclusive communication developments.

The existence of the National Collaboration and the dedication and commitment of its members ensures that the grant funded projects can effectively and efficiently undertake project work co-productively with the full range of stakeholders. This enhances rigour, improves the quality of our output, and amplifies roll-out.

The National SDS Collaboration is a voluntary, informal collaboration, not a constituted organisation. It is jointly supported by SDSS (chair) and SWS (admin), but does not have dedicated resources.

The National Collaboration has a diversity of membership and consistency of attendance. Partners have developed strong relationships and opportunities for collective influence. What has been achieved so far speaks to the good will of organisations and passion of individuals. For the National Collaboration to continue to flourish, it needs a modest resource for admin and development.

Improvement Plan

Do you think the Plan can work given the current budgetary constraints and recruitment and retention challenges in social care?

While Social Work Scotland is fully committed to, and engaged in, the activities in the national SDS Improvement Plan, it needs to be understood that the full implementation of self-direction in social care will not be possible without sufficient resources, both financial and workforce, across the social work and social care sectors – these are basic ingredients.

There has been chronic underfunding in the social work and social care system since the inception of the Act, whose financial memorandum made an error in assuming a cost neutral position.

Subsequent years of recession, post-pandemic recovery, and a workforce crisis aggravated by an increasing care demographic means that the system is now perilously close to breaking point.

However, there is a strong forward momentum amongst SDS stakeholders and a strong commitment to the principles of the legislation. Collectively, we are demonstrating that we can achieve incremental improvement by addressing some of the key drivers.

To ensure future success, there needs to be constructive engagement between leaders in social work, community planning, local government finance,

commissioning and audit to shape national and local budgetary systems to support the principles of the Act and the financial duties of local authorities in Scotland.

Is the resourcing for the Plan (£7,547,000 in the last financial year) sufficient to embed identifiable changes in the system?

There is chronic underfunding at all levels of the system.

Intermediary support for local system change

The Social Work Scotland SDS project operates at an intermediary system level, undertaking work that will result in better consistency and usable innovation to be adopted at local authority level. We are working within a tight grant award and could work at a better pace with additional project officers and workstream activity budget.

Our core grant funding has been reduced since the inception of the project as follows:

- Between 2019-2022, annual award of £330,000
- In 2022-2023, award of £276,000
- Between 2023-25, annual award of £240,000

(We receive additional funding for 1 FTE project officer through the Fair Work division to work on specific outcomes related to the PA Programme Board; these outcomes are not reflected in the SDS Improvement Plan.)

Some of our workstreams are at an exploratory stage – where we work with local and national stakeholders to determine what will meet the gap in implementation in that topic area, and how to design specific innovations that are useful in practice. Undertaking subsequent implementation stages will require additional resources to support the installation of innovation in practice. Here are examples from just two of our seven workstreams (see annex A):

Workstream 7 is about improving SDS training for social workers. We are undertaking research currently to determine the implementation gap. We are in early discussions with the Community Brokerage Network about adapting their gold standard training to meet the needs of social workers. Future roll out of will require additional project resources for training delivery, as well as systems change that allows social workers to be freed up to attend training, and system support for a relationship-based practice model.

Workstream 3 is developing a self-evaluation and improvement framework for use by local implementers and leaders. This has been tested out with three local areas, and we are refining the framework so that we can test version 2 with another 3 to 5 local areas. To roll this out across Scotland will require local readiness and capacity for change, plus additional project resources to support learning for local implementers.

Local delivery level

In general, SDS and social care is not well resourced at the delivery level. The original financial memorandum assumed that the legislation would be cost neutral which was incorrect. Although the factors involved in this are complex, the basic line of reasoning is as follows:

It is not lawful for local authorities to withhold resources to individuals once it has been decided through an assessment of need that they should have them.

Prior to SDS, resources were provided mostly by direct provision (now referred to as option 3) or less frequently by a Direct Payment (option 1). Finite direct provision was managed by waiting lists. Prior to 2010, waiting lists were mostly manageable, however this became increasingly problematic as demographic pressures increased demand and costs savings began to bite as a consequence of the 2008 and more recently post-pandemic recessions.

SDS legislation provided greater flexibility as to how need could be met and greater choice and control for the supported person. This legal right, coupled with increased levels of need based on the changing population demographics, meant that local authorities could no longer rely on waiting lists to gatekeep in-house or commissioned services, as supported people were opting more frequently for direct payments under option 1, or asking for their choice of provider under option 2.

As social work budgets came under increasing pressure and became overspent, local authorities used the national eligibility criteria to raise the threshold for eligibility for service in order to manage their budgets. It is now the case that almost all local authorities operate under the critical risk level[1]. This does not allow for meaningful choice and control as, at the point of crisis, supported people just want a service to meet their basic needs.

In recent years, service availability increasingly drives local authorities' offer. We are seeing an increase in the use of direct payments (option 1) to pay for personal assistants to provide care and support (particularly to families with children with disabilities and/or support needs) due to a reduction in, or lack of, option 2 and 3 services/ providers in some local authorities (particularly rural areas). A direct payment may therefore not be the person's real choice.

As a further consequence, independent support organisations are reporting an increase in demand for their support to help people to recruit and employ personal assistants. For some people with very complex needs, managing teams of 4-6 personal assistants is effectively running a small business with a requirement to meet all employer statutory duties, manage rotas, fill in for absences, provide training and support for personal assistants. This may not be appropriate for everyone, and obliging people to take a direct payment without adequate support undermines the direct payment and personal assistant model of support. Direct payments are a tool to support independent living and should be the exemplar of Self-directed support choice and control.

In project workstream 4.1, SWS is working alongside the Personal Assistant Programme Board to develop a standard which supports local authorities in strengthening employers through providing sufficient direct payment to enable them to be a good employer of personal assistants and providing employer support through centres for inclusive living and independent support organisations.

For future success, investment in option 2 and 3 and different models of local care and support is required to ensure people can have real choice in the four SDS options.

[1] Critical Risk: Indicates that there are major risks to an individual's independent living or health and well-being likely to call for the immediate* or imminent* provision of social care services (high priority). Immediate means within 1-2 weeks; imminent means within 6 weeks.

Local system change

At a local authority level, transformational funding awarded to each local authority supports an SDS implementation lead. These officers are usually at a middle or frontline management status, and often sits outwith mainstream social work within the Health and Social Care Partnership development function. This means that they don't always have the influence and status that they need to make an impact.

Even if transformation funding is used for its intended purpose, we are hearing that in this financial year SDS leads have fewer colleagues to work with on SDS implementation, have additional portfolios themselves, e.g. carers policy, and are often firefighting day to day issues rather than addressing the change agenda.

In order to get the consistent and sustained visibility for SDS at a local level, we want there to be a directive that the SDS lead for each local council area is afforded formal access to their CSWO and, where relevant, the depute CSWO in adults services, in the same way as is afforded to child and adult protection and mental health officer lead officers. SDS is a legislative requirement and needs to be regarded as such.

Is there further work that your organisation would like to undertake, if more resource was available? Please provide further details.

We would progress the seven priority workstream priorities (Annex A) at better pace, and sustain work on each on a continuous basis (currently we must have some of the workstream in abeyance due to team capacity).

As explained in previous points, to move from the development of a useable practice development (innovation) to its implementation across 32 different local authority contexts requires additional project resources and investment in readiness at the local authority level.

With additional resource, we would include a workstream for the development of ethical commissioning of social care in HSCPs, in collaboration with the Social Work Scotland Workforce and Resources Standing Committee and Contracts and Commissioning subgroup.

Will all the outcomes be achieved by 2027? If not, what could prevent this from happening?

Because of the complexity of Self-directed Support as a social policy, it will never be possible to attribute the whole of each outcome solely to this plan's activities. This is acknowledged in the 'Dependencies' section of the plan. The plan is better understood as a substantial contribution to outcomes.

There needs to be an unequivocal understanding that the current climate is not conducive to full implementation of SDS - in fact many of those contributing to the recent review of the SDS Standards think we have gone backwards due to the social care and social work crisis.

In conjunction with Scottish Government SDS Improvement team and National Collaboration partners, we are developing a risk register as part of the monitoring and evaluation plan for the SDS improvement plan. These are the key macro-level risks that have been identified by Social Work Scotland to date:

- Lack of inclusion of SDS in sufficient nuanced detail in related policy areas, including NCS and Getting It Right For Everyone.
- Crisis in social care and continued cuts to local authority budgets.
- Adverse impact of care management model on social work practice, particularly in adults services.
- Performance management culture impeding the development of organisational learning culture required for implementation of complex social policy like SDS.
- Lack of professional autonomy of social workers.
- Lack of leadership capacity locally.
- Fragility of funding arrangement to deliver change at intermediary level (SWS SDS Team funding)
- Lack of local readiness for implementation.
- Transformation fatigue.

In the phase 1 report, the Health Social Care and Sport Committee has acknowledged the crisis in social care and social work recruitment and retention (bullet point 2). Below is an example of what we hear in the course of our project work relating to the lived experience of social workers trying to implement SDS..

We hear that the current situation is imposing ethical and moral dilemmas on social workers. We hear about social workers bending the rules to get the best out of the system for the people they support. Workers are under pressure to follow arbitrary financial rules that make no sense in actual practice. This might mean that workers take pragmatic decisions not to offer all four options when they know that these are not realisable, and steer supported people towards what they think are the best or in reality, only, meaningful choices.

One crucial factor that is thwarting the current system from operating well is the current reliance on the care management practice model, particularly in adult social work/social care. Social Work Scotland along with many other partners is calling for an urgent shift towards a relationship-based practice model which will much better underpin person-centred support, and is beginning work on this (workstream 5, annex A).

Do you have a funding commitment from Scottish Government for the lifetime of the Improvement Plan?

No, our funding is annual, and frustratingly is routinely agreed after the start of the new financial year in April. The process of applying afresh each year for grant funding starts usually in January, and each year the process has been different and takes considerable management time to complete. Project staff are not confident that their employment will continue year on year, and this causes anxiety towards the latter half of each financial year.

Do you (or the Collaboration) have clear indicators and an overall coherent framework of the success of the Plan?

We are working with the Scottish Government SDS Improvement Team and the National Collaboration to develop a robust approach to monitoring and evaluation of the improvement plan.

In line with implementation best practice, we are keen to develop a learning-based evaluation approach in line with our approach being taken to develop the self-evaluation and improvement framework for local authorities (workstream 3, annex A).

Whilst we are awaiting agreement on the monitoring and evaluation arrangements, the SWS SDS project continues to report progress on activities both to an internal SWS SDS project board, and through grant monitoring arrangements with Scottish Government (see Annex B).

Specific activities within the Plan

Which of the activities in the Improvement Plan deal with the fundamental issues with SDS delivery relating to local authority processes?

Below are the activities relating to local authority processes. Those activities that Social Work Scotland is grant funded to deliver are highlighted in yellow. All workstreams in the Social Work Scotland project (annex A) support local authority implementation of SDS.

1.2 Improving the availability and flexibility of SDS Options

1.2.1 Work to address key barriers to use of SDS Option 2 in Adults' and Children's services.

1.2.2 Support provider engagement with Option 2.

1.2.3 Develop and roll-out of tools and contractual models for Option 2 to increase workforce confidence and efficiency in offering it.

1.2.4 Work to increase flexibility in the provision of in-house and commissioned services when delivering Option 3.

1.3 Increase public information about SDS and improve its reach

1.3.1 Promote SDS using agreed common language reflecting good practice, including through information sessions.

1.3.2 Ensure SDS communications are in accessible formats. This includes communication about support planning and the promotion and signposting of appropriate tools and language services.

2 Enhanced worker skills, practice and autonomy

2.1 Improve SDS Practice Resources

2.1.1 Finalise, publish online and promote practitioner toolkit as a guide to SDS practice resources.

2.1.2 Update and roll-out of practice guidance to support implementation consistent with the refreshed SDS Statutory Guidance and revised SDS Framework of Standards. See also Theme 4.3 (Standards).

2.2 Social work education and incorporation of practice development for SDS

2.2.1 Ensure the principles of SDS are reflected in the emerging post-qualifying Advanced Practice Framework for Social Work, including describing the knowledge, competencies and skills required across the full breadth of social work roles (framework to be launched by OCSWA September 2024, followed by the development of a training plan).

2.2.2 Review of current SDS training at both local and national level, consistent with an alignment to the developing Advanced Practice Framework for Social Work (see above).

3 Systems and Culture

3.1 Improved involvement of supported people in planning.

3.1.2 Enabling flexible use of individual budgets in accordance with the supported person's choice, outcomes identified in their support plan and desired degree of control.

3.2 More ethical and equitable processes for commissioning, resource and budget allocation

3.2.1 Develop and share good practice on commissioning for SDS, and ensure processes align with the most up-to-date guidance and principles from the Adult Social Care (ASC) Ethical Commissioning Working Group.

3.2.2 Work to further develop the flexible use of budgets for short breaks for carers, for example promoting examples where positive outcomes have been achieved, and sharing learning about the flexible use of SDS budgets.

3.2.3 Supporting local review, good practice and improvement of Resource Allocation Systems, for example testing of calculation methodology, and sharing learning and good practice more widely.

3.3 Improving referral pathways

3.3.1 Work to improve referral pathways by embedding choice and control early in the hospital discharge process, including linking to community-based initiatives and support to facilitate early intervention.

3.4 Effectively mainstreaming SDS principles into relevant policies

3.4.1 Ensure that SDS is embedded into key national priorities including NCS, the Promise, Dementia Strategy, Ethical Commissioning and GIRFE themes as they develop, drawing on stakeholder evidence and expertise.

4 Leaders understand and help staff realise SDS principles and values

4.1 Supporting local authorities to ensure principles of SDS are incorporated into local planning and systems

4.1.1 Support local areas to embed SDS within relevant local policies and plans reflecting SDS as the way social care support should be delivered, including access to peer support to share learning.

4.1.2 Support Local Authority leaders across Scotland to innovate, embed, implement and sustain good practice to ensure that all care groups have access to SDS, incorporating good practice on self-evaluation and evidence on where challenges and opportunities exist.

4.2 Improved data and reporting on information, choice and quality of options to aid planning

4.2.1 Improve data-gathering approaches to better determine extent that individuals are accessing their preferred option and their personal outcomes are being met.

4.3 Ensuring leaders are supported through access to shared good practice

4.3.1 Review, refresh and promote the SDS Standards. The refresh will use the principles of Equalities Impact Assessment, Fairer Scotland Action Plan and Islands Community Impact Assessment to ensure that they cover all equality groups, care groups including informal carers, islands and diverse geographies.

4.3.2 Continue to support local areas to embed the 12 Standards. Where relevant and appropriate, support local authority implementation of SDS Framework of Standards in three priority areas:

4.3.2.1 Standard 3: Relationship- and strengths- and asset-based approaches across care groups and across all four SDS options.

4.3.2.2 Standard 8: Worker Autonomy (particularly in assessment, support planning and determining personal budgets).

4.3.2.3 Standard 12: Access to Budgets and Flexibility of Spend (including improving processes and approaches to approving personal budgets).

4.3.3 Consider and develop ways in which the SDS framework of standard may be adapted and used by ISOs to build on improvement of SDS across the whole system.

What issues would you identify with local authority processes in delivering self-directed support?

The issues are multiple, varied and nuanced, and go beyond mere processes to whether the values and principles of SDS underpin the local authorities approach. Because of the complexity, it is not possible to list the process issues, nor develop a list of 'solutions' that can be readily implemented. Exploring and understanding these issues are central to our project work. It should be noted that there are many examples of excellent practice of SDS across Scotland, as well as example of poor delivery.

Because the context for Self-directed Support is so complex, we categorise the implementation drivers for SDS in a graphic that aligns with the activity categories in the SDS Improvement Plan, and explain it in the new guide to the SDS Standards (p 8-9). Below, I have unpacked the explanation (italics) to illustrate some of the current issues.

Success looks like the supported person and/or carer living their life, the way they want to, in line with their human right to independent living (1).

This is not met consistently across Scotland, and is not met for many care groups such as mental health, older people, homeless people, substance use, care experienced children etc.

The person may have others who help them to articulate their views, and may have family and natural networks around them (2).

People's natural networks may not be well supported or protected when support is being planned.

The person has purposeful and meaningful conversations with a social work practitioner (3) to explore and develop their ideas and to reach a position about what arrangements and support is right for them to be able to live their life the way they want to.

There is a fundamental issue with the practice mode. Care management approach does not allow for relationship-based practice.

The social work practitioner's primary professional focus is on supporting the person's self-determination while balancing risk, and enabling them to live their life the way they want to (4).

This is the case, but social workers have an uphill struggle to achieve this within complicated local bureaucracy.

To be competent at this, the practitioner must be clear about what they are doing; have enough time with the person to understand their unique experience, views and needs and work together to develop a good support plan;

Workers are not afforded the time within a care management model.

be well trained and skilled in practicing Self-directed Support in line with other relevant areas of social work;

We are gathering evidence through research on SDS training for social work practitioners, which we anticipate is generally lacking across Scotland. This includes quality of training and inability of social work practitioners to access it because of not having protected time to learn, and there being no local budget for SDS training.

have good professional support;

We hear that supervision is often rushed and case related.

and be able to self-reflect and get feedback on how well they are practising (5).

We hear that workers have little time to do this in a meaningful way due to high caseloads and work pressure.

To realise the person's support plan, the practitioner must have the professional autonomy to interact with the complex systems of social work and social care (6).

We hear there are massive issues with lack of professional autonomy. Decisions based on finance often trump social work professional opinion.

For the practitioner to be able to do this, systems and culture within local government and partnerships need to be designed to make it easy for the practitioner to do their job efficiently and effectively (7) and for supported people to have their rights and needs met.

Systems and processes include access to budgets and flexibility of spend, recording, digital infrastructure, and commissioning and procurement procedures.

We hear there are significant process issues that affect workers' ability to practice SDS.

Engaging with these systems includes negotiating with other professionals such as health, finance, legal, commissioning and procurement.

Other professional groups have low understanding of SDS.

It is the role of leaders within local government and partnerships to ensure that local systems and culture support their social work workforce (8).

It is the job of leaders to understand the wider political and economic environment and to respond in a way that creates an enabling context for the progressive implementation of Self-directed Support.

This includes acknowledging and building capacity for supported people and carers to be leaders themselves in the improvement and implementation journey.

We hear of many issues affecting the capacity of leaders to lead from the front in the local development of SDS. These include leaders having multiple and competing priorities and pressures across the health, social work and social care agenda; SDS being poorly understood at HSCP level; SDS not being led by sufficiently senior leaders for it to have systemic impact.

Which of the activities in the Improvement Plan deal with the fundamental issues with SDS delivery relating to ethical commissioning processes?

With respect to the SDS Improvement Plan, section 3.2 is dedicated to ethical commissioning, and section 3.4 makes reference to it.

3.2 More ethical and equitable processes for commissioning, resource and budget allocation

3.2.1 Develop and share good practice on commissioning for SDS, and ensure processes align with the most up-to-date guidance and principles from the Adult Social Care (ASC) Ethical Commissioning Working Group.

3.2.2 Work to further develop the flexible use of budgets for short breaks for carers, for example promoting examples where positive outcomes have been achieved, and sharing learning about the flexible use of SDS budgets.

3.2.3 Supporting local review, good practice and improvement of Resource Allocation Systems, for example testing of calculation methodology, and sharing learning and good practice more widely.

3.4 Effectively mainstreaming SDS principles into relevant policies

3.4.1 Ensure that SDS is embedded into key national priorities including NCS, the Promise, Dementia Strategy, Ethical Commissioning and GIRFE themes as they develop, drawing on stakeholder evidence and expertise.

What issues would you identify with commissioning?

The principle of ethical commissioning is the direction that we should be aspiring to. SWS Contracts ad Commissioning subgroup has identified many issues in its delivery.

Section 3.2 covers two key areas – commissioning and procurement - that in practice are not often joined up. Social care commissioning arrangements within HSCPs are highly variable. This means that establishing a baseline or approach can be very problematic.

Social care commissioning is not recognised as a specific need within corporate commissioning in HSCPs, despite social care commissioning being the highest percentage of commissioning overall.

While social care commissioning sits with HSCPs, procurement usually sits within corporate procurement units, with contract monitoring and management again in HSCPs. Therefore, there is often a disjoin and a gap, with little social care representation in place.

HSCP contract monitoring seeks to achieve maximum flexibility within transactional contract arrangements. In some HSCPs who do have dedicated social care procurement, this is much more responsive and achievable.

Commissioning resources are critical in terms of ensuring a range of flexible service provision that in turn would allow budgets to be used creatively to achieve the best outcomes for individuals. Currently there is no formal or accredited training in social care commissioning. Learning comes from local culture and self-learning.

On the provider side, Scottish Care, CCPS, and IRISS have all invested heavily in ethical commissioning principles. In the public sector, expertise in social care commissioning held by Scotland Excel and Social Work Scotland needs more investment.

The nature of the relationship between strategic plans and commissioning function is also influenced by the above structures, and we know there exists several approaches and practices of how HSCP's fulfil their requirements in respect of SDS. At a local level, there is a significant lack of resources to ensure social care commissioning is fit for practice. It is our experience that often the commissioning voice not heard within Resource Allocation Groups or decision of policy development as this is often finance led.

A further review of the Procurement of care and support services: best practice guidance, Scottish Government, 2021 may be warranted, with work undertaken to determine what it will take to put in place local arrangements that achieve desired outcomes. Resources are needed for training and development, in guidance and worked practice examples, that reflect lived system experience.

In practice, there are tensions within the different options, based on considerations of risk enablement, risk reduction/management and duty of care.

Commissioning should be enabling, i.e. should enable the supported person to live their life the way they want it including taking the sort of everyday risks that we all need to take in life to help us enjoy life, grow in confidence and resilience. To do that, supported people need access to independent support, sufficient flexible resources and skilled and confident social workers.

Tensions might arise when the supported person is exercising their choice and control.

Under option 2, people can ask local authorities to commission specific services from providers that the local authority may have concerns about. There is mixed practice across Scotland as to how this is resolved. Some local authorities refuse if the provider is not on a framework or an approved list, but this is too blunt an instrument. We think there should be practice developed that give informed choice to the supported person, within a transparent consideration of risk and duty of care.

Another issue is the variable tiers of services and rates, which makes it difficult for supported people to flex their service. Local authorities routinely require supported people to pay an additional uplift to get their choice of provider if the local authority won't meet the actual cost.

Direct payments under option 1 are a tool to support independent living and to enable the supported person and/or their family to be the commissioner of their own support including employing personal assistants or choosing small local providers. This arrangement works best when there is a clear understanding by the supported

person and the social worker of the roles, responsibilities, duties, and risks around any arrangements. For the supported person to be a good employer or a commissioner it is essential that they have an adequate budget to meet all their employer responsibilities, a good relationship with their social worker and access to independent support to enable them to be a good employer understanding the law and HMRC regulations. Social workers need to have more expertise and confidence in this area.

Under option 1 commissioning, the local authority has less influence where there are issues of risk and duty of care in relation to specific providers. Legitimate concerns include when small providers don't have the capacity to deliver the level of support required, where arrangements may be fragile and of lesser quality. (We should stress here that small support providers are not the only providers that have capacity issues. We have acknowledged that greater investment in social care provision is essential.)

There are complicated requirements relating to employment law and HMRC regulations, where supported people may be put at financial risk, i.e. when buying in the services of a self-employed PA. There are challenges in this approach and more research is needed nationally. We should also acknowledge that people may be put at financial risk because they are being charged for care and support and the charges have not been made clear to them.

Is there anything additional that you would like to see included in the Plan?

At national level, we want Scottish Government to ensure that a nuanced understanding of the principles and practice of SDS is reflected in related national policies and developments, including but not limited to National Care Service, National Social Work Agency, The Promise, and Getting It Right for Everyone (GIRFE).

This could be achieved by setting an expectation that the SDS standards[2] and core components – our agreed position of what good looks like for self-direction – are embedded in each and every related policy area. An example of where this is working well is within the Fair Work agenda, where there is dedicated work to progress fair work conditions for Personal Assistants employed under SDS option 1.

Additional information

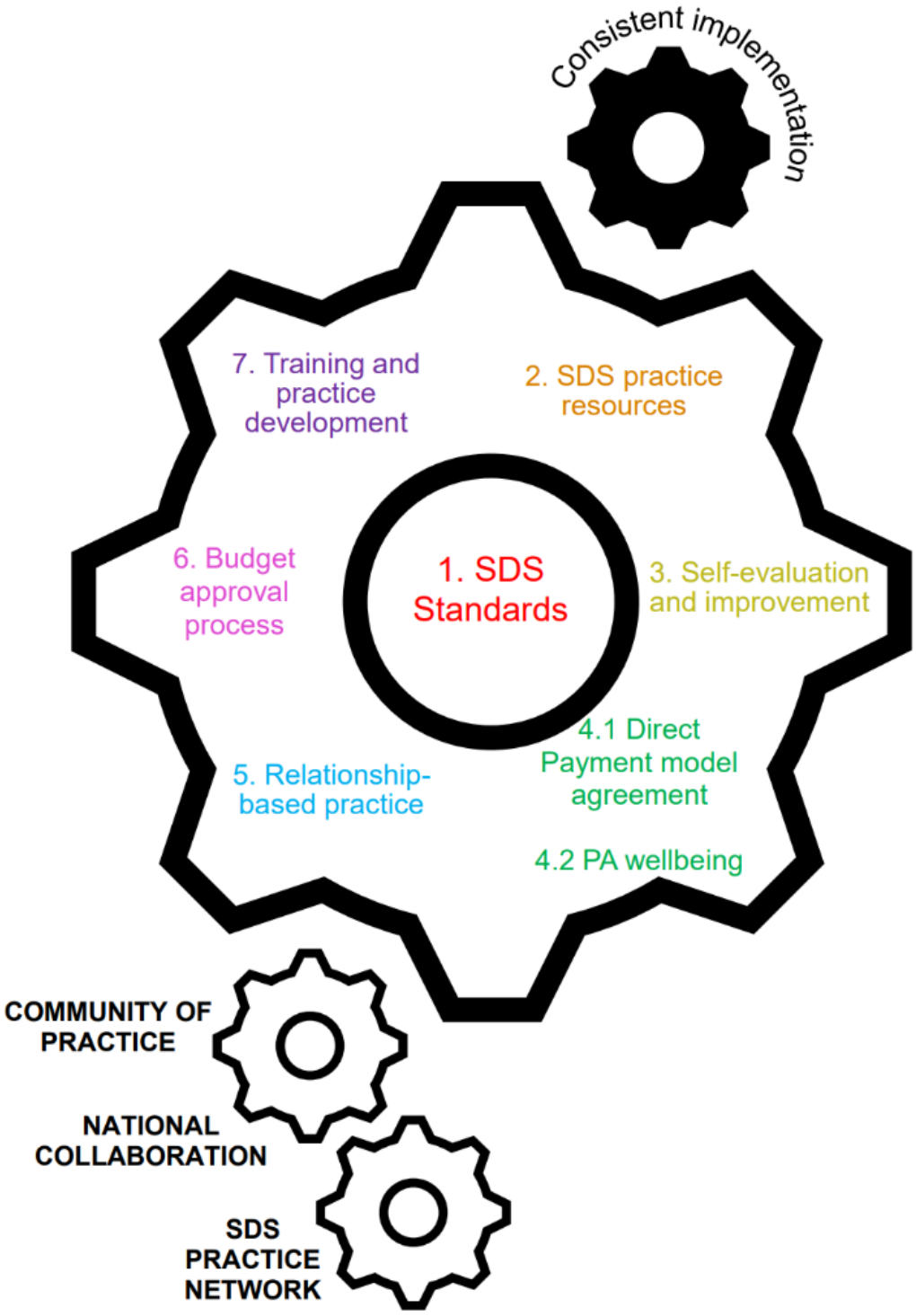
Is there anything further you would like to add about the Social Care (Self-directed support) (Scotland) Act 2013?

Given opinions expressed during the session around issues with implementation of the Act, misunderstandings associated with the interpretation of the legislation, and that understanding of SDS is required within other policy areas, the Committee would also welcome further thoughts on whether you feel the Act, or other relevant legislation, requires amendment to ensure the successful implementation of Self-directed Support?

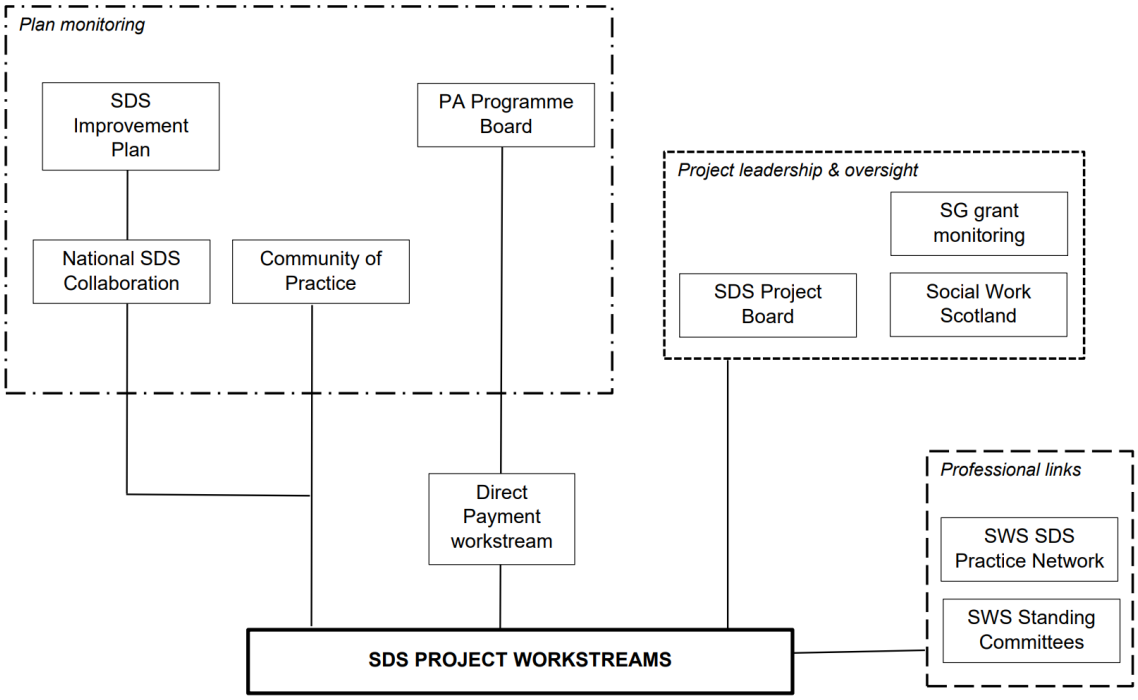
Nothing more to add.

[2] SDS Standards revised version was approved by SG and by COSLA on 10 May 2024.

ANNEX A


Consistent implementation
7. Training and practice development
2. SDS practice resources
6. Budget approval process
1. SDS Standards
3. Self-evaluation and improvement
4.1 Direct Payment model agreement
4.2 PA wellbeing
5. Relationship-based practice
COMMUNITY OF PRACTICE
NATIONAL COLLABORATION
SDS PRACTICE NETWORK

ANNEX B


Plan monitoring
SDS Improvement Plan
PA Programme Board
National SDS Collaboration
Community of Practice
Project leadership & oversight
SG grant monitoring
SDS Project Board
Social Work Scotland
Professional links
SWS SDS Practice Network
SWS Standing Committees
Direct Payment workstream
SDS PROJECT WORKSTREAMS