ESSS Outline

SDS brokerage in rural Scotland

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Introduction

This evidence summary seeks to address the following questions relating to approaches to self directed support:

1. *What are the challenges facing local authorities when seeking to implement brokerage models of self directed support in rural Scottish communities?*
2. *What are the best practices and resources needed?*
3. *How could a pilot be evaluated?*

About the evidence presented below

This summary draws on international evidence relating to self directed support in rural and remote contexts. The focus of the evidence included in this document specifically focuses on the ways in which the delivery of SDS may be impacted by factors caused by the rural or remote context of an area, rather than challenges to the delivery of SDS more generally.

There is a lack of published evidence about the specific impacts of rural and remote contexts and recommendations about overcoming the challenges posed, which indicates a need for further research and/or evidence generation from practice as well as evaluation of the outcomes of different models of SDS, including brokerage models, in different geographical and economic contexts.

In our search strategy we have included the Scottish Government's (2011) guidance around international terminology, including search terms such as personal assistance services programs, individualised funding, cash for care, consumer-directed care, individual or personal budgets, cash and counseling, and direct payments, in addition to terms used in Scotland including self-directed support, personalisation and brokerage.

Accessing resources

We have provided links to the materials referenced in the summary. Some of these materials are published in academic journals and are only available with a subscription through the The Knowledge Network with a NHSScotland OpenAthens account. The Knowledge Network offers accounts to everyone who helps provide health and social care in Scotland in conjunction with the NHS and Scottish Local Authorities, including many in the third and independent sectors. You can register here.

Background

Rurality and social care in Scotland

The Scottish Government Urban Rural Classification provides a standard definition of rural areas in Scotland. The classification distinguishes between urban, rural and remote areas within Scotland.

Pugh et al. (2007) report several obstacles to using and providing rural social care:

- Variability in provision and costs of services
- Access difficulties
- Isolation and stigmatisation
- Ignorance and neglect of minorities
- User expectations and satisfaction with services

Fraser et al. (2014) identify a number of ways in which working in health and social care in rural and remote areas differs to urban centres:

- Multi-skilling - combining roles
- Multi tasking - breadth of knowledge and experience required
- Lone working
- Lack of appropriate levels of qualified supervision
- Higher levels of autonomous clinical decision making
- Greater on call commitment
- Management responsibilities and confidentiality pressures
- No service when post holder on leave if a single-handed practitioner
- Travel time e.g. a single visit to an isles service user can take a full day

Self Directed Support

Self Directed Support (SDS) describes the ways in which individuals and families can have informed choice about the way support is provided to them. It includes a range of options for exercising those choices. The aim is to

increase individuals' level of control over how their support needs are met and who meets them (Scottish Government 2010).

The SDS Strategy was implemented in 2010 as a joint Scottish Government and COSLA initiative:

> In the first phase of the strategy, from 2010-2012, we developed information to promote understanding of Self-directed Support. The second phase, 2012-2016, was focused upon development of the Social Care (Self-directed Support) (Scotland) Act 2013, guidance, and supporting innovation. We have now reached the third phase (Scottish Government 2016)

Results so far have been mixed, with an Audit Scotland review (2017) reporting that SDS implementation stalled during the integration of health and social care services and that Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services.

Brokerage is one aspect of an independent support approach within SDS in which social services:

> Provide impartial information, advice and support for people to help them plan and organise their own support arrangements, and make maximum use of community resources and informal support, helping people find creative solutions to meet their needs. Evaluation Support Scotland (2014)

ESS (2014) outline the positive outcomes of Independent Support as an aspect of SDS, including that people:

- Access clearer information about SDS
- Are more aware of the support available to access and manage SDS
- Make more informed choices about SDS
- Achieve their personal outcomes and live the life they want to live are listened to

- Are an equal partner
- Have increased equality of access to SDS
- Gain confidence to demand an increased range of service options
- Have maximised opportunities for choice and control
- Experiment, make mistakes and find ways to correct them
- Contribute to local and national policy development

ESS (2014) also identify the following benefits for statutory services and care providers:

- Increase their capacity to support people
- Access additional information
- Provide holistic and person-centred solutions
- Build relationships with disengaged/isolated people
- Respond creatively and flexibly to people's needs
- Provide earlier interventions, therefore preventing crisis
- Learn about and understand best practice
- Work effectively together
- Ensure local and national policy makers understand the effectiveness and value of Independent Support

A particular challenge for service providers has been balancing flexibility towards service recipients and responsibilities towards staff, in a context of limited resources and recruitment and retention challenges:

> There are tensions for service providers between offering flexible services and making extra demands on their staff. At the same time, there are already challenges in recruiting and retaining social care staff across the country owing to low wages, antisocial hours and difficult working conditions.

Work in progress

Social Work Scotland has been asked by the Scottish Government to examine good practice in SDS and what the conditions are for enabling that practice and research based at the University of Edinburgh is currently underway. This

information will be used towards meeting the recommendations made in the Audit Scotland (2017) report and relevant findings will be published to support practitioners. The Care Inspectorate will be looking at SDS as part of their thematic inspections in 2018.

Challenges of SDS

We did not identify evidence relating to brokerage in rural communities specifically. General barriers to the implementation of SDS include:

- Lack of social work staff awareness and experience of SDS
- Staff reluctance to offer SDS
- Cost and complexity of implementation
- Difficulty integrating a variety of funding streams
- Councils struggling to move from pilot projects to mainstreaming SDS
- Not all councils including people with complex needs in SDS allocation
- Lack of accessible information on SDS and confusing terminology
- Lack of support organisations
- Volume and complexity of paper work involved
- Users/carers concerns about managing budgets and employees
- Difficulty in recruiting good-quality support
- Lack of support and training for personal assistants
- Risk of abuse
- Fear that SDS will could shift dependency from day centre to family care (with loss of jobs)
- SDS failing to account for the diversity of disabled people including their readiness for, or understanding of, self-determination (Harkes et al. 2012)

Challenges of SDS in rural areas

In addition to the general challenges identified above, specific challenges for delivering SDS and similar schemes in rural areas have been identified internationally. The key challenges identified in relevant literature are summarised below.

Advice and support systems

Rummery et al. (2012) highlight the importance of market capacity in rural areas:

> Local Authorities have given some thought to the increase in advice and support systems necessary to undertake an extension of SDS. One estimate was that 6% of the amount spent on DPs should be allocated to advice and support services. In the future, the function of contract managers will partly be to stimulate markets to ensure that sufficient market capacity is available. This will be particularly important in rural areas where providers are much less dense and transport costs therefore higher.

Service availability

Brown et al. (2011) found that geographical isolation is a key challenge for the Direct Service Workforce in Rural Areas of the US for several reasons, including that there are fewer direct service agencies available and that there is a "great size of service regions and distances between individuals in need of services and service agencies, resulting in direct service workers spending more time traveling to and from people in need of services and less time providing services".

In Scotland, a lack of social care supports in rural areas has been identified as a barrier to choice for young people using SDS (Mitchell 2015). Kettle (2015) also identified a lack of service availability as a problem:

> Provider availability was an issue for some SDS Leads. In some smaller and/or rural areas, or in pockets of larger local authorities there were simply no organisations willing or able to take on some of the tasks associated with SDS. "There are no local organisations who have said that they are interested in offering this" (SDS Lead). For people without strong family networks in places where there is

> a lack of innovative social enterprise initiatives, this can lead to a lack of choice and shortage of support.

Rurality has been found to limit the use of Option 2 choices in the Scottish SDS model:

> "We are a remote and rural area. There are very limited opportunities to exercise Option 2 choices locally. We will continue to encourage local third sector organisations to consider this, but they are reluctant to embark on business which will move them from use of casual staff to contracted staff. Island development trusts have considered becoming providers but baulk at the need to register with the care Commission and to train staff to required levels." (Kettle 2015)

The challenge of limited resources in rural areas is being addressed in the US through actions including the provision of mobile services and telehealth (Brown et al. 2011, p.6). In Scotland, Kettle (2015) identifies some interesting developments "in regard to micro-provision, particularly in response to acute local issues, and in some of the examples identified the contribution of providers was central to the success of the initiative".

In a study of people with disabilities in rural Australia and their access to therapy (physiotherapy, speech and occupational therapy services), Gallego et al. (2017) found that a lack of service providers including specialists, long waiting times and travel time were the most commonly mentioned barriers to accessing therapy. They also found that timely access prevented the escalation of problems: "timely allied health intervention prevented the development of more severe or complicated conditions that had a greater impact on carers, families, communities and the person with disabilities".

Advocacy for personalisation

In the follow-up evaluation of self-directed support test sites in Scotland, Ridley et al. (2012, p.19) suggested that the under-development of advocacy for personalisation identified may have in part been due to geographical factors:

> It appeared that the role of advocacy in regard to personalisation was emergent and re-active, and somewhat under-developed in Dumfries & Galloway. The lack of a user-led support organisation such as a Centre for Independent/Inclusive Living as operates in Glasgow was noted by stakeholders as a significant gap in Highland. In Dumfries and Galloway, Direct Inclusive Collaborative Enterprise (DICE) was established with Scottish Government funding to address this gap. In Highland, an SDS user network that was at an early stage of development at the end of the test site was said not to have progressed much in the following year. Reasons posited included the difficult logistics of remote rural areas with more people from Inverness participating than other areas: carers being unable to participate due to pressures of the caring role; and service users and carers not perceiving participation in such a network as valuable.

Workforce recruitment and retention

In an evaluation of self-directed support test sites across Scotland, Ridley et al. (2011) identified recruitment as one challenge in a rural setting:

> There were very real practical difficulties with implementing DPs in rural areas such as the small pool of potential Personal Assistants from which to recruit and concerns about privacy.

Similarly, Brown et al. (2011) found that a key challenge for the Direct Service Workforce in Rural Areas of the US is that there are fewer direct service workers available for agencies to hire in rural areas.

Rural home health agencies differ to urban agencies in several ways:

- Lower number of visits
- Smaller and more dispersed client base
- Smaller in size
- More likely to be non-profit
- Provide fewer services

These factors influence recruitment and retention, in addition to competition with other employers offering higher wages and benefits.

Additionally, changes in population demography in rural areas have a greater impact where the workforce is smaller, particularly relating to the ageing workforce. This has been identified as a major challenge for succession planning (NHS Scotland Remote and Rural Steering Group 2007).

Workforce training

Another aspect to consider in rural settings is workforce training:

> Maintenance of skills also poses challenges, whilst there is a requirement for a wide breadth of expertise; but skills will decay, where practice exposure is low. (NHS Scotland Remote and Rural Steering Group 2007)

Brown et al. (2011) identify specific challenges around workforce development in rural areas that limit career advancement and successful service delivery:

> In addition to general difficulties with direct service worker training, training in rural areas is difficult to execute because of geographic dispersion, lack of nearby education institutions, and smaller class sizes (thus less profit for training providers).

The authors suggest online training programmes as cost-effective methods of training delivery, and also identify collaborative partnerships between

public, private and third sector providers as effective models of training, such as the Healthcare Regional Skills Alliance of Northwest Michigan which provides in-person trainings for homecare workers across 12 rural counties.

Transportation

A lack of effective public transportation systems as well as seasonal road and weather conditions (Brown et al. 2011). Suggestions for improving transportation services for direct service workers include:

- Use alternative care sites and other settings such as senior housing facilities, assisted living facilities, and churches to deliver specific service
- To the extent state regulations allow, use community and family caregivers to minimize reliance on PACE staff
- Increase emphasis on home care as an alternative to day center attendance. Utilize advanced telecommunications technologies
- Build a coordinated network between multiple rural health care providers interested in sponsoring a PACE program and contractors necessary to operate a program

Partnerships between providers

“for small organisations in the BME and rural voluntary and community sector, groups are often competing with each other for funding and lack resources or lack access to funding owing to capacity and skills” (Carr 2014).

Resource allocation processes

In an evaluation of self-directed support test sites across Scotland, Ridley et al. (2011), resource allocation processes were identified as a weakness in one instance in a rural area:

> Several criticisms were aimed at the equivalency model tested in Highland from those closely involved in its implementation. The system highlighted the local authority’s poor information about service costs, and demonstrated a lack of sensitivity when applied

in a rural setting. It was reported that in some cases this had resulted in higher individual budgets than would have been achieved through an alternative. For example, if in the past an individual had travelled long distances by taxi to a day centre, for example, the equivalency model for their SDS package would have awarded an inflated amount when alternatives might not require such extensive travel.

Support for carers

The 2013 Act requires authorities to consider "whether the carer would benefit from some form of support to enable them to continue in their caring role" (Scottish Government 2014). Although there is a lack of research around family caregivers in rural areas (Ehrlich et al. 2017), there is evidence to suggest that there are key differences between urban and rural caregivers, for example around life-limiting illness:

- People are more accepting of death and less likely to intervene to delay death
- Support from friends and the community in rural locations played a more important rolethan in urban and suburban locations
- Caregivers tend to be younger and include friends as well as family and local support networks are important (Kirby et al. 2016)

Population migration trends indicate that younger generations are moving from rural to urban areas for employment and lifestyle, which presents a challenge of addressing "how family caregiving can be effectively provided at a distance" (Davis et al. 2011, p.20). The stresses of family caregiving in a rural context can influence older people's entry into nursing homes (Brown et al. 2011, p.3). Using evidence from previous research, Brown et al. (2011) suggest that access to training and support services, including attending a support group, may be beneficial to rural family caregivers.

However, Mitchell (2015) identifies a potential implication of relying on family networks for addressing service deficits for young people with disabilities:

> Strong family net-works in rural areas were seen as a solution to the lack of service providers in these localities, but there are dangers that bonding social capital in family networks that are deficit-focused and risk-averse could restrict informed choice for young people with disability.

Dal Bello-Haas et al. (2014) discuss a specific consideration for interdependent and interconnected rural services, describing how "close personal relationships or the relative intimacy of rural or remote life" can have an impact on people's experiences of services, particularly in terms of intertwined health professional-patient relationships. Familiarity in this context may be vital to developing trusting relationships and may need to be taken into consideration when identifying potential ways of providing services.

Demographic factors

Several differences between urban and remote and rural populations have been identified that may need to be taken into consideration for SDS development and identification of needs. For example:

- Higher suicide rates
- Higher incidence of alcohol related disease
- Higher number of accidents in rural areas: on roads, through climbing, farming, diving and fishing
- Proportionally higher palliative care workload (patients from remote areas often prefer to or are enabled to die at home)
- Seasonal fluctuation in population (NHS Scotland Remote and Rural Steering Group 2007)

There is generally a higher proportion of older persons in the total population in rural than urban areas (Giarchi 2006). Hafford-Letchfield (2015, p.159) argues that older people in rural areas are particularly at risk when local authorities not allocating enough money to account for the costs of service delivery across long distances in sparsely populated areas, as a result of the

combination of isolation and increased costs of rural life that negatively impact older people in these areas (Burtholt and Windle 2006). It may therefore be important to consider the compound disadvantages experienced by older people in rural areas when looking at SDS development in these areas.

The Commission for Rural Communities published a report on individual budgets in rural areas, experiences and expectations and lessons learned (Manthorpe and Stevens 2008) with several recommendations for how to 'rural proof' policies and programmes relating to the personalisation of adult social care for rural older people and their communities.

To 'rural proof' programmes, policy makers could:

- Consider whether their policy is likely to have a different impact in rural areas, because of particular circumstances or needs
- Make proper assessment of those impacts, if they are likely to be significant
- Adjust the policy where appropriate, with solutions to meet rural needs and circumstances (Manthorpe and Stevens 2008)

Additionally, Pugh et al. (2007) report that "the needs of some rural dwellers, especially those from minority ethnic groups, are often neglected".

Research and monitoring

Prior or alongside the development of SDS, Manthorpe and Stevens (2008) suggest it would be beneficial to consider the following issues as part of the 'rural proofing' of services:

- The long-term effects of the personalisation of social care need to be monitored and assessed to ensure equitable outcomes in rural areas and that it is fulfilling its promise of greater independence and well-being for older citizens.
- It will be important to carefully examine the impact of personalisation on rural premiums in social care as part of resource allocations, on

service commissioning and at the level of individual resource allocations.

- The effects on the workforce need to be considered both in respect of their current activities but also to consider the effects of personalisation on the rural social care workforce currently and in the future. Who will be able to act as mentors? What will be the effect on social care workers if they do not have the opportunities to build up employment and pension rights?
- Self-assessment and support planning for older people should be examined to see if there are significant urban/rural differences that give rise to inequalities or different outcomes.
- The impact of the personalisation of social care on community structures, businesses and social enterprises needs to be explored, by talking and listening to older people and considering the outcomes of the policy. We need to continue to assess the impact on providers, the workforce and older people's supporters, such as family, friends and neighbours.

Implementation

Manthorpe and Stevens (2008) also make recommendations around the implementation of personalised care for older people in rural communities:

- Older People's forums and other advocacy groups have an important role in transmitting the benefits of and reasons for the personalisation of social care. They need to be included in communication strategies developed by central and local government.
- Information, support and guidance need to be easily accessible to help older people undertake self-assessments and to be engaged in planning their own support.
- It will be important to foster and measure confidence in the benefits and processes of personalisation among older people who have community leadership roles.

- It will be important to explore links with the prevention and early intervention agenda, such as LinkAge Plus pilots, Partnerships for Older People Pilot Projects and housing services at district level. Voluntary and community sector groups should have a key role in monitoring the implementation of the personalisation of social care and in listening to and learning from individual older people's experiences. This will help them design accessible systems.
- Managing change, especially the move from block contracts to individual resource allocation, possible decommissioning of existing services, and the management of risk and viability, will need detailed discussion and negotiation with commissioners.
- The private sector will need to be involved in thinking through the implications for residential services and home care provision, in particular, and in developing new services for new and existing markets.
- Local councils will need to work in partnership with other agencies and to consult with rural interest groups as well as social care service user and carer groups in order to deal with market failure, to help business planning in social enterprises and to communicate the basis for change locally.
- Monitoring impact over the long term will need to be a commitment, not just to address budgetary implications but to establish whether or not the outcomes of improved quality of life are being achieved.

Approaches

Audit Scotland (2017) have identified some examples of good practice in rural Scottish areas:

> In some rural or remote areas, authorities are working closely with local communities. This is not necessarily to develop additional choices or preventative services, but to find ways of providing support to people who otherwise would have none. Individual, local

> solutions are being developed and greatly improving the quality of some people's lives.

A case study in their report gives examples from the Isle of Lewis, and Boleskine and Black Isle in Highland, of different kinds of activity and sector contributing to self directed support.

Remote and rural staffing model

Remote and rural contexts may require different staffing models to urban areas:

> Healthcare is currently delivered by a range of professionals, some working in isolation and others working in teams. Future models for healthcare delivery are based on integrated teams, demonstrating a range of competencies, defined by patient need. These competencies can overlap, between traditional professional roles, to the benefit of holistic care and utilises resources to better effect. Most of the team will be based within the remote and rural community, in primary or community care, within the hospital service or in combination, some team members will be based in the larger centre, with responsibility for supporting local delivery and providing a visiting service, where appropriate. (NHS Scotland Remote and Rural Steering Group 2007)

The Remote and Rural Steering Group has made a series of commitments, including: "This model of care for remote and rural communities, incorporating formal working links between remote and rural areas and those in larger centres, should be introduced."

The introduction of Rural Generic (health and social care) Support Worker (RGSW) roles is related to this staffing model. This model of health and social care delivery based on integrated teams demonstrating a range of competencies has been introduced in areas of Scotland including Orkney (Fraser et al 2014). Education and training is provided to ensure staff meet

the competencies identified within a predefined framework for integrated health and social care workers:

> A capability framework is a broad outline of what practitioners should be able to do in practice and are usually supported by discipline specific competency frameworks detailing levels of expertise required.

The conditions outlined by the Remote and Rural Steering Group (2017, p.19) for the emerging model of remote primary care echo the RGSW model:

> Four key pillars support this model of care: Workforce, including Education, Networks, Infrastructure and Community Resilience. Professionals within this model must be robustly trained generalists, with educational packages specifically designed for Remote and Rural Practitioners, have good supporting networks from larger centres, and, be supported by technology, transport and retrieval systems.

Grassroots approaches

Carr (2014) found that members of marginalised communities often utilise their own social network resources for support, and the grassroots mutual approach can build on this tendency and recognise it as an asset.

Pilotlight

Pilotlight was a five year programme funded by the Scottish Government as part of the implementation of self-directed support. The project has co-designed, tested and refined a model for successful power sharing, produced tools and resources and developed solutions for the implementation of self-directed support.

Building elder care networks

Many of the people providing voluntary support to older people in rural US areas are 'fictive kin' - "individuals who have strong interpersonal, social, and or geographic ties to the elder, but are not related by blood or marriage

(Jordan-Marsh and Harden 2005 in Davis et al. 2011, p.20). This is identified by Davis et al. (2011) as posing a challenge in ensuring elder care networks include these individuals. The authors draw on previous research to provide examples of how the strains resulting from geographical contexts influence family tensions, which community service providers should consider to develop "practice strategies that respond to elder care situations in ways that will strengthen families' capacity to address the needs of elder kin" and improve communication with health professionals when seeking to meet the needs of older people. The authors discuss implications for practice in supporting family caregiving in rural contexts, including encouraging the family as a caregiving unit, developing dynamic family caregiving plans and normalising family caregiving conflicts (pp.25-26).

However, it is also important to be aware that not all rural and remote areas have strong or positive networks (Bailey et al. 2013) and to avoid assuming or romanticising conditions and experiences of rural life.

Case Studies

There is a lack of case study evidence on good practice for implementing SDS in rural and remote areas specifically. Some of the case studies presented below therefore have a more general relevance.

- Evaluation Support Scotland (2014) Case study - Tagsa Uibhist in Support in the right direction: the value of independent Support (pdf)
- People Powered Health and Wellbeing programme (2014) Case study: co-designing a pathway to self-directed support for people who have mental health problems (pdf)
- Self Directed Support Scotland (no date) Self Directed Support Case Studies: Scottish Borders and Dumfries and Galloway (captioned videos with BSL)
- SUSE Scotland (2014) Self-directed support case-study from SUSE and Grampian Opportunities: Marie's Experience of self-directed support (pdf)

Approaches to evaluation

Evaluation of interventions is important to identify what changes have been made, and when and how they made an impact. Key to success is "developing plans from the outset to understand how activities, outputs and outcomes link and ensuring learning and feedback loops are in place" (Jeffcott 2014). The following references include several different approaches to evaluation that may be suitable for evaluating the impact and outcomes of brokerage models of self directed support in a rural community.

Ayling, R and Marsh, C (2014) Information, advice and brokerage: part 2: gearing up for change: practice examples from six councils that are developing their information, advice and brokerage services (pdf)

This report presents material gathered from six volunteer council sites, that are at different stages in implementing new information, advice and brokerage strategies. It includes learning and good practice examples, including some approaches to evaluation.

Contribution analysis

Contribution analysis uses a process of "logical argumentation" to understand the links between policy and practice activities, external factors and outcomes (Stocks-Rankin 2014).

- Armstrong, N et al (2018) Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement, not blame. *Social Science & Medicine*, in press (Available with NHSScotland OpenAthens login)
- Blamey, A and MacKenzie, M (2007) Theories of change and realistic evaluation. *Evaluation*, 13(4), pp.439–455 (Available with NHSScotland OpenAthens login)
- Lemire, ST, Nielsen, SB and Dybdal, L (2012) Making contribution analysis work: a practical framework for handlinginfluencing factors

and alternative explanations. *Evaluation*, 18(3), pp.294–309 (Available with NHSScotland OpenAthens login)

- Mayne, J (2001) Assessing attribution through contribution analysis: using performance measures sensibly. *The Canadian Journal of Program Evaluation*, 16(1), pp.1-24 (pdf)
- Stocks-Rankin, C-R (2014) Reflective literature review of contribution analysis. Iriss (pdf)

Iriss (2017) Outcomes & CO (website and toolkit)

Iriss have produced a toolkit to support practitioners and managers to reflect on their views, values and experiences around personal outcomes approach:

> Outcomes & CO provides a framework for open, honest conversations about personal outcomes. It does this by supporting reflective practice and building common understanding. It is flexible and can used or adapted for a range of audiences, including health and housing.
>
> This tool builds on a range of resources developed by Iriss and partners to support an outcomes-focused approach in the social services sector, in particular, the Leading for Outcomes series (Iriss, 2010-2013) and the Values and Principles Paper developed by the Personal Outcomes Collaboration. A list of other resources referenced in the tool are also available.

This tool could be used for evaluation. It may also be possible to speak to people who have already used the tool for ideas about how it could be applied.

- Miller, E (2012) Measuring personal outcomes: challenges and strategies. Iriss Insight 12 (website)
- Miller, E and Cook, A (2012) Talking points: personal outcomes approach. Joint Improvement Team (pdf)

Evaluation Support Scotland (2017) Evaluation methods and tools (website)

ESS has a long list of approaches to evaluation that may be applied to SDS programmes.

Evaluation Support Scotland (2014) Support in the right direction: measuring the difference Independent Support makes (pdf)

In this document, ESS provide guidance for how to evaluate work in order to:

- Find out what works
- Find out what doesn't work
- Measure what difference you are making (including things you didn't expect)
- Learn how to do what you do (even) better
- Give feedback to volunteers and staff
- Report to funders, commissioners, your Board, policy makers and the general public

It includes an evaluation planning template, examples of indicators and methods, a checklist and case studies of approaches services have taken to evaluation.

Other useful resources

SDS National Voice 2018 - survey for shaping the event

Responses to this survey will help shape the agenda for a National Self Directed Support Development Event.

Social Services Knowledge Scotland (SSKS) Open Badge: Self-Directed Support

Using the Self-directed Support portal and the introduction to self-directed support elearning resource available through SSKS, members of the social services workforce can earn a SSSC Open Badge.

Further reading

Bailey, C et al. (2013) Risky and resilient life with dementia: review of and reflections on the literature. *Health, Risk & Society*, 15(5), pp.390-401, DOI: 10.1080/13698575.2013.821460 (Available with NHSScotland OpenAthens login)

This paper discusses the ways in which local perspective and lifelong knowledge, particularly in rural or small communities can be a source of a positive sense of self and identity for people living with dementia in rural areas. It may provide relevant insight into managing risk in the context of SDS in rural and remote areas. It also highlights the diversity of experiences of people in rural and remote areas, stressing the need to be aware of "the danger of romanticising the existence of strong and positive rural networks".

Blackstock, KL et al. (2006) Living with dementia in rural and remote Scotland: diverse experiences of people with dementia and their carers. *Journal of Rural Studies*, 22, pp.161–176 (Available with NHSScotland OpenAthens login)

This paper explores the experiences of people using dementia services as patients or carers. It discusses the way in which participants linked their experiences to their spatial location in rural areas and emphasises the diversity of experiences of rurality and aims to help inform place and person centred policies.

Manthorpe, J et al. (2015) Embarking on self-directed support in Scotland: a focused scoping review of the literature. *European Journal of Social Work*, 18(1), pp.36-50 (Available through NHS Scotland Fetch Item service)

This article presents findings from a focused scoping review of the published literature on self-directed support. It was commissioned by the Scottish Government and focuses on literature around the facilitators and barriers to

SDS. It presents findings around reducing bureaucracy, available evidence about leadership and training to support the changes, and the use of specific transitional funding to ease the process of implementation. The review discusses the relevance of research to the implementation and practice of SDS, including the differences between pilot studies and mainstream practice.

NHS Scotland Remote and Rural Steering Group (2007) Delivering for remote and rural healthcare: the final report of the remote and rural workstream (pdf)

This report focuses on the steering group's response to the agreed objectives for the first phase of a project to develop a policy for sustainable remote and rural healthcare services.

Brown, DK et al. (2011) Strengthening the direct service workforce in rural areas: Appendix: Rural Resource Collection (pdf)

This article includes a list of innovative strategies and case studies in the US.

Rummery, K and McAngus, C (2015) The Future of Social Policy in Scotland: Will Further Devolved Powers Lead to Better Social Policies for Disabled People? *The Political Quarterly*, 86(2) (Available with NHSScotland OpenAthens login)

This article explores the ways in which Scotland has expressed a difference from the rest of the UK regarding disability policy, and examines to what extent this is the case in the context of devolution and whether this is likely to be beneficial for disabled people. The authors argue that the rhetoric around Scotland's superiority with regards to social justice in social care provision "does not bear empirical scrutiny" and consider the ways Scotland could create better social policies for disabled people, including approaches to end what they describe as the current "postcode lottery of social services".

Williams, I and Dickinson, D (2015) Going It Alone or Playing to the Crowd? A Critique of Individual Budgets and the Personalisation of Health Care in the English National Health Service. Australian Journal of Public Administration, 72(2), pp.149–158 (Available with NHSScotland OpenAthens login)

This paper analyses the assumptions that are inherent in personalisation and raises concerns over its ability to transform health-care services. At the heart of these concerns is the tension between appeals to tailored service provision and empowerment on the one hand, and promotion of a strong social contract, public trust in institutions, and collective identity on the other. Lessons are drawn for personalisation in other sectors and settings.

References

Armstrong, N et al. (2018) Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement, not blame. *Social Science & Medicine*, in press (Available with NHSScotland OpenAthens login)

Audit Scotland (2017) Self-directed support: 2017 progress report (pdf report and other appendices)

Ayling, R and Marsh, C (2014) Information, advice and brokerage: part 2: gearing up for change: practice examples from six councils that are developing their information, advice and brokerage services (pdf)

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