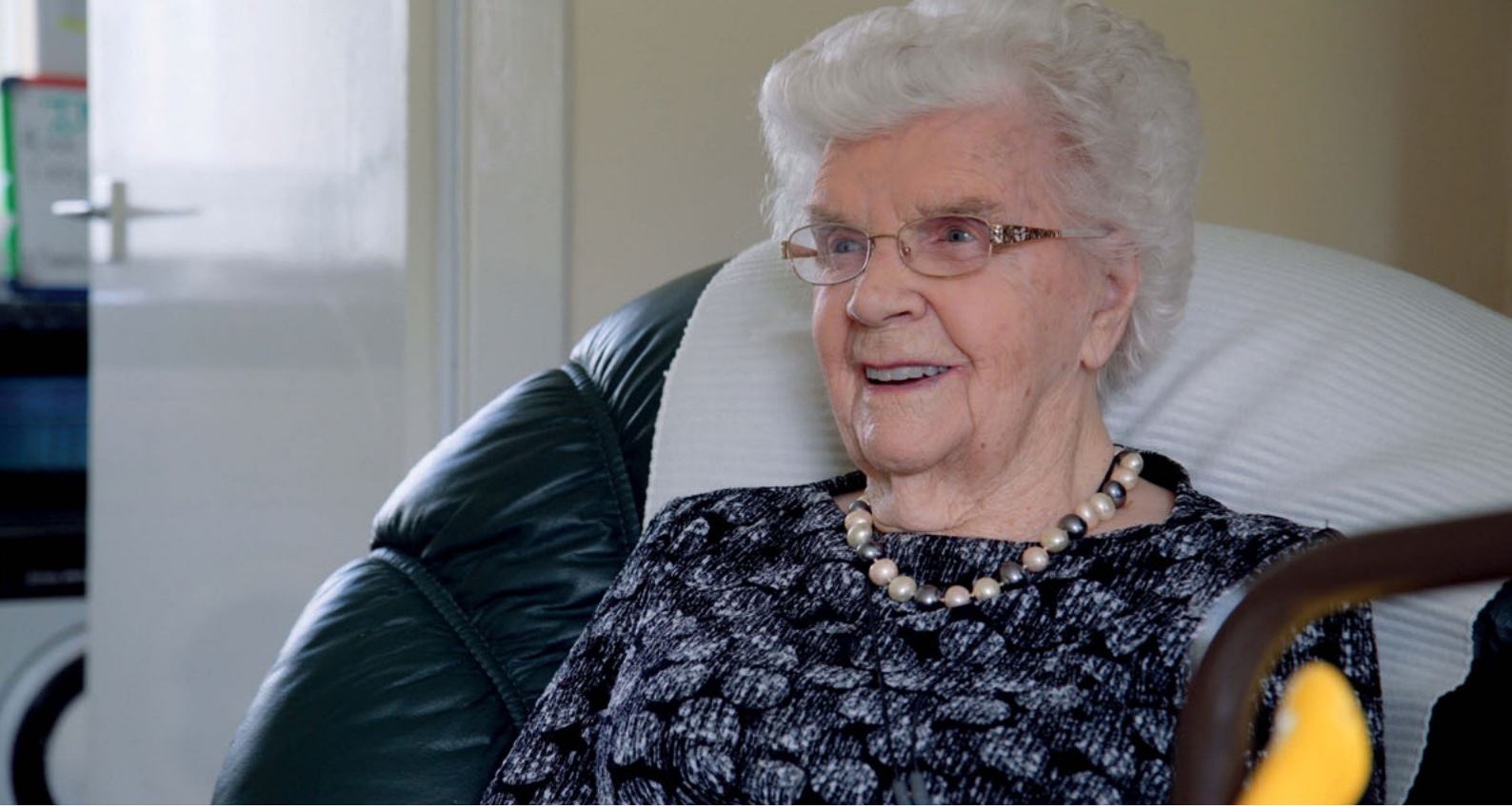
Scottish Care
Voice of the independent care sector

A HUMAN RIGHTS BASED APPROACH TO SELF-DIRECTED SUPPORT FOR OLDER PEOPLE

An analysis of the Scottish Care Getting it Right for/with Older People Project, January 2016-June 2017

CONTENTS



PREFACE

One of the strongest advocates for human rights was the late Nelson Mandela. In 1998 he said:

"A society that does not value its older people denies its roots and endangers its future. Let us strive to enhance their capacity to support themselves for as long as possible and, when they cannot do so anymore, to care for them."

There is an undeniable thread between the value we place upon older age and the extent to which we advance and support the human rights of older people.

Scottish Care is grateful that the Scottish Government funded a project for 15 months which helped to advance the rights of older Scots seeking to receive self-directed support packages of care. This report reflects on the lessons learnt, the potential of human rights for achieving systemic change, and the distance we still have to travel. In no small part the positive outcomes achieved in this project have been due to the work and leadership of Carlyn Miller whose passionate advance of human rights I applaud.

Self-directed Support is essentially about the rights of individuals, regardless of age, to be given informed choice, control and involvement in their care and support. Changing structures and systems to enable all that to happen is not easy and this report reflects some of that struggle.

I hope as you read it you will consider the way a robust embedding of human rights can become the enabler of the change which must surely happen if we are to create a future centred upon the dignity and rights of our older citizens.

Dr Donald Macaskill

Chief Executive, Scottish Care

SECTION 1

Introduction

In 2016 Scottish Care received funding from the Scottish Government to undertake a 15 month project examining Self-directed Support (SDS) for older people. The primary focus of the piece of work, titled Getting it Right for/with Older People, was to explore the application of a human rights based approach, consistent with the statutory principles within the SDS Act, in the operational delivery of older people's care and support.

Section 1 of this report outlines the background, methodology, structure, policy fit and desired outcomes of the project. Section 2 explores how the outcomes were met in each area using a human rights based approach and adhering to the principles and values outlined in the Social Care (Self-directed Support) Scotland Act (2014). Section 3 reviews some of the critical barriers to Self-directed Support implementation through case studies and Section 4 offers reviews and recommendations.

This piece of work is not intended to be an exhaustive project report, those exist separately. Nor is it intended to be a qualitative or quantitative analysis of Self-directed Support implementation. Instead the focus is on human rights; what they are; who is bound by them and how they coexist with Self-directed Support.

The crucial aim of this paper is to leave the reader with an understanding of how a human rights based approach, through a combination of the FAIR and PANEL models can be used to address identified challenges and ensure that human rights are promoted and protected in the delivery of health and social care in Scotland.

Scottish Care

Scottish Care is a membership organisation which represents the largest group of Independent Health and Social Care providers across Scotland. Independent in this context refers to both private and voluntary organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations.

These member organisations deliver a wide range of registered services for older people and those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems. These services include but are not limited to; residential care, nursing care, care at home, day care, housing support, respite, intermediate, step-up and step-down care.

Scottish Care is at the forefront of the national policy agenda and was closely involved in the development of the Self-Directed Support Act and its Statutory Guidance. Scottish Care as an organisation, led by Dr Donald Macaskill, is committed to ensuring that the principles of participation, involvement, collaboration, informed choice, dignity and respect which lie at the heart of the Self-directed Support Act are embedded in provider practice across Scotland. Scottish Care promotes the principle that for rights to be real for people, they have to be the starting point for those delivering services.

Identified issues for older people and Self-directed Support

From 2012-2015 Scottish Care ran a project called, “People as Partners” which was designed to build the capacity of the independent care sector to be responsive to the emerging Self-directed Support policy and Act. That project focused on increasing provider awareness of the principles of control and choice at the heart of personalisation, as well as examining organisational and cultural barriers to the implementation of the forthcoming Act. In particular it addressed issues of workforce readiness and risk enablement.

The majority of services supported by Scottish Care members are delivered to older people and following directly from the People as Partners project, one year after the implementation of the Act, Scottish Care undertook two pieces of research to ascertain the relative uptake of and experience of Self-directed Support for older people in Scotland. Scottish Care continues to articulate that for Self-directed Support to result in the desired change in practice and experience of supported individuals, it has to become an effective model of delivering social care and support for older people.

This research was conducted from the perspective of older people’s support providers and, whilst not claiming to be exhaustive, nevertheless provided an indication of the scope and challenges facing the implementation of this key Scottish Government strategy.

Detailed research findings are available on the Scottish Care website. In brief, this piece of work evidenced a disturbingly low level of allocation of personal budgets to older people; a lack of awareness on the part of providers as to whether their clients have personal budgets and the complete absence of individual budget allocation for those being supported in residential care.

At the time of research from May-July 2015; 28% of respondents indicated that their Local Authority was still developing a framework for Option 2, 12% said that their local authority was not actively encouraging Option 2 for older people and over 60% indicated that they had not been informed or were unaware of their Local Authority practice. Given the statutory principles of involvement and collaboration outlined in the new legislation these responses suggested a lack of robust engagement with stakeholders. They also highlight that although Option 2 was seen as the real creative heart of Self-directed Support, one year in it was not being taken up as an option for older people.

Crucially, the research brought to light that older people themselves were largely unaware of Self-directed Support and what the Act could do to ensure that their human rights in receiving care and support were protected and promoted. The national picture derived from these research projects highlighted a fragmented and disappointing reality for older adults across Scotland in the implementation of Self-directed Support. Specifically, this work highlighted the need for:

- More structured and focused work to be undertaken with older people's groups at community level to make individuals and their family carers more aware of their rights under the Self-Directed Support Act;
- More work of a collaborative nature with colleagues in COSLA, Scotland Excel and the Joint Improvement Team to develop models of commissioning and procurement which were specifically sensitive to the needs of older people in communities across the country;
- More work with social work practitioners and others to develop more appropriate, person centred models of assessment which are a better fit for older people;
- More work with all stakeholders to articulate a clearer and more age appropriate Older Person's Supported Pathway;
- More investment to build the capacity of the older people's care and support sector to meet the potential of Self-directed Support. This is in part a recognition of the reality that this sector is further behind in such capacity building compared to the learning disability or physical disability sector.

What was the Getting it Right for Older People Project?

In response to these findings and with the desire to make Self-directed Supported an effective model of care for older people, Scottish Care put forward a proposal for a new project which would work as a partnership approach between Scottish Care, two Local Partnerships and other relevant stakeholders in an older person's social care journey. The primary focus of this piece of work would be to explore the application of a human rights based approach, consistent with the statutory principles within the Self-directed Support Act, in the operational delivery of older people's care and support.

The project methodology, structure, policy fit and outcomes are summarised below. As stated, this report is not intended to be an exhaustive writing up of the research or activity achieved through Getting it Right for/with Older People but instead seeks to present the necessary information to set the context for the latter part of this report, which models how a human rights based approach was used to meet these outcomes and address barriers to Self-directed Support for older people. It is here, we believe, that any lessons for the mainstreaming of a human rights based approach to Self-directed Support may be evident.

Methodology

The project was funded by the Scottish Government for a total of 15 months from January 2016 to March 2017. This was later extended until June as the initial three months of scoping meant the budget could be stretched to allow for a longer implementation and dissemination stage. The project set out to be a partnership between Scottish Care and two Local Partnership areas as well as other local stakeholders such as independent support providers and community groups.

A full time human rights practitioner was employed to lead across both project areas and two Local Development Officers employed on a 2 days per week basis in each area.

What was envisaged was an intensive, short term practice orientated project which would allow for the testing of new models of support planning for older people centred around human rights and the principles within the Self-directed Support Act; involvement, informed choice, collaboration, participation and dignity. The Getting it Right Project aimed to ensure that these human rights principles were embodied and embedded in action at all stages of work and development.

This modelling of human rights in action and practice also set out to contribute to Scotland's National Action Plan for Human Rights as well as address a number of national outcomes and policy objectives including meeting some of the National Health and Wellbeing outcomes, namely:

- Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer
- Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected
- Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Outcome 5. Health and social care services contribute to reducing health inequalities
- Outcome 7. People using health and social care services are safe from harm
- Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Outcome 9. Resources are used effectively and efficientlyt in the provision of health and social care

Structure

The initial stages of the Getting it Right project involved identifying the two Local Partnerships we would collaborate with, employing local development officers and then working in collaboration in each area to explore current Self-directed Support practice and models. This process involved widespread engagement with statutory officers, care providers, older people and carers. This engagement was crucial to ensure that the project evidenced key human rights principles of engagement, collaboration and involvement.

The central part of the project involved working with a representative Steering Group in each area to examine the research gathered and work through the 'quick wins' identified by stakeholder groups. It was the job of each local Steering Group, made up of Directors, Senior Management, Self-directed Support teams, Local Integration Leads, Community Connectors and Care Providers to prioritise the focus of the project based on the intelligence gathered and presented from older people, carers, providers and practitioners. The reason for working to a "quick win" scenario instead of a whole system change approach is a consequence of the short term nature of the project. Getting it Right for/ with Older People had 15 months to recruit Local Partnerships, employ staff members, develop stakeholders, achieve and collate meaningful data, identify tests of change, trial these interventions and then disseminate the results. This was clearly an intense programme of work, not least in the project's desire to evidence collaboration, engagement and involvement at every stage.

The latter stages of the project involved testing the identified 'quick win' changes in each area, gathering feedback from those involved and sharing that widely in final project reports and Steering Group meetings.

A project timescale document for one of the areas is detailed in Appendix 1 (p30).

Outcomes

The project identified both short and long term outcomes in the proposal for funding. After a period of stakeholder development these outcomes were put to Steering Groups. Action planning by participants narrowed down the specific focus in each area which would enable the largest number of the outcomes to be met.

The identified outcomes are listed below and section 2 of this report will evidence how each of these outcomes were met using a human rights based approach of participation, accountability, non-discrimination and equality, empowerment and legality alongside the Self-directed Support principles achieved.

Short term outcomes

- We understand the current situation for older people receiving care and support in both local areas and the challenges involved in embedding SDS in practice.
- We know more about effective models for independent support and care for older people, and how to overcome barriers.
- Existing innovative practice will have been identified and shared, and where appropriate, developed further prior to dissemination.
- Older individuals who access support from social care providers engaged in the project will be better informed, more aware and empowered to exercise their rights under SDS.
- Each local authority and partner organisations will be able to evidence SDS principles at work in older people's assessment and support planning processes to the best of their capacity to deliver.
- Care providers engaged in the project will be more informed and able to exercise their duties under SDS.

Long term outcomes

- More older people are aware of SDS and what choice and control mean for them.
- More older people will be aware of the full extent of choice available under each of the four SDS options and their distinctive features.
- More older people will be confident in accessing and using personal budgets within the context of their preferred SDS option choice, whichever that may be.
- Social care provision for older people will be flexible and creative and focussed on personal outcomes.
- The workforce has skills and confidence to ensure care meets personal outcomes.

SECTION 2

Human Rights

This section of the report examines human rights, what they are; who is bound by them; how they coexist with Self-directed Support and how a human rights based approach, in the form of both the FAIR and PANEL models can be used to address identified challenges in the implementation of Self-directed Support for older people.

Human rights are the rights that we are all entitled to, simply by virtue of being human. These rights guarantee the dignity and worth of all human beings, the autonomy to make our own choices, the freedom to live without discrimination and the support to participate equally in society. Human rights, if protected, set the conditions in which each of us can live fulfilling lives regardless of nationality, place of residence, race, age, gender or any other status. They seek to ensure that everyone will be able to live free and autonomous lives. Human rights are guaranteed in the UK by the European Convention on Human Rights (1953), the Human Rights Act (1998) and devolved in Scotland through the Scotland Act (1998). All public bodies and those carrying out public functions have to comply with this legislation; this means the courts, police, local government, hospitals and care providers. These rights are derived from international legislation, importantly the United Nations Declaration of Human Rights (1948) and its subsequent treaties; the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic Social and Cultural Rights (ICESCR, 1966).

Human rights are often divided into civil and political rights, and economic and social rights. Civil and political rights include; the right to freedom of expression, to freedom of conscience and religion, to vote and the right to privacy. Economic and social rights include; the right to adequate food, water and sanitation; to an adequate standard of living; to health and to education. They all relate to and depend on each other, for example, without the right to adequate food and water, an individual cannot enjoy the right to health.

It is important to note that some rights are absolute, such as the right to life and the right not to be tortured or treated in an inhumane or degrading way. Others have limits to ensure that they do not unfairly infringe upon other people's rights. Restricting an individual's right must be done in a way that is legal, justifiable and proportionate. For example, if a public authority was to decide to restrict an individual's right to freedom of expression, that authority would have to first of all prove that there were legal grounds

to do this, that the restriction was justified in that it would not restrict someone else's right and that the action taken was proportionate.

They are in their very essence, universal. They apply to everyone equally, however, certain groups can find it more difficult to claim their rights. In response to this, the United Nations created additional treaties which seek to protect the rights of women, children, disabled people and racial and ethnic minorities. The Convention on the Rights of the Child (UNCRC, 1990) and the Convention on the Rights of Persons with Disability (UNCRPW, 2006) seek to protect vulnerable groups and keep our society fair, just and equal. At present there is no United Nations Convention on the Rights of Older People. In 1991 the United Nations General Assembly adopted the Principles on the Rights of Older People which are not legally binding but which encourage Governments to incorporate the following principles into national programmes; independence, participation, care, self-fulfilment and dignity. Scottish Care, Age UK and other organisations continue to lobby for a separate UN Convention for older people. Demographic shifts mean that the population is ageing and instead of viewing this as a threat or a health care challenge that cannot be met, there needs to be a shift to thinking of older people as valuable individuals: as employees, volunteers, carers, parents, grandparents but most importantly as rights' holders with aspirations, experience, knowledge and potential. A UN Convention would not only ensure that older people's rights are enshrined in law but could drive a culture shift on how society views older people. This would help reduce discrimination, improved health and social care practice and lead to more fulfilling and dignified lives for older people in Scotland and across the world.

Human Rights and Self-directed Support

There are a wide range of human rights which are potentially at risk in the delivery of health and social care. The move towards Self-directed Support and personalisation was seen as an opportunity to embed a human rights based approach, ensuring principles of human rights law such as self-determination, autonomy and participation were central to someone's care. The Social Care (Self-directed Support) Scotland Act came into force on 1st April 2014 and places a duty on Local Authority Social Work departments to offer individuals a range of choices as to how they receive their social care. By law, a person must be supported to make their own informed choices about what their care looks like and how it is delivered.

Implementing the Self-directed Support Act successfully for supported people requires a two-pronged approach. Firstly, one of choice and control in the form of the four options which must be offered to the individual. These four options, detailed below, should be offered to a person after the initial assessment stage when it has been established that there are eligible needs which cannot be met by natural supports, personal strengths or community resources. Each local Partnership has a mechanism for determining how much funding will be allocated to the individual. The practitioner needs to inform the person about how their support will be costed prior to exploring the four options.

The legal duty to offer these four options since 2014 gives wider choice and control than previous options of traditional care or direct payments. These four options apply to everyone receiving support, although at present with some limitations on those living in residential care.

The 4 options provided under the 2013 Act are:

Option 1

The making of a direct payment by the local authority to the supported person for the provision of support.

Option 2

The selection of support by the supported person, the making of arrangements for the provision of it by the local authority on behalf of the supported person and, where it is provided by someone other than the authority (a provider), the payment by the local authority of the relevant amount in respect of the cost of that provision.

Option 3

The selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority (possibly from an external provider) and, where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.

Option 4

The selection by the supported person of Option 1, 2 or 3 for each type of support and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

Professionals have a legal responsibility to ensure that the supported person is fully informed of the opportunities, responsibilities and consequences in each of the options. It is therefore crucial that professionals are fully aware of the nature and extent of local services and how they might contribute to meeting a supported person's needs.

The second prong of the approach, to successfully and lawfully implement Self-directed Support, is one of values and principles. It is equally important and must exist alongside the provision of the options explained above. The person providing support must ensure that their practice is guided by Sections 1 and 2 of the Act which sets out the 5 principles of Self-directed Support. These principles are not simply aspirational statements but are the legislative grounds which should guide practice at each stage of a person's care journey whether they are eligible for support or not. This is where it becomes crucial to explain that Self-directed Support is more than simply offering an individual four options, it is a way of working which if put into practice can ensure that an individual's human rights are met.

The five principles under Sections 1 and 2 of the Act are detailed below:

Involvement

The supported person must be as involved as they wish in both the assessment and then the provision of care and support.

Collaboration

Those supporting the person and the individual receiving support must collaborate in the provision of any support identified to ensure that it meets and continues to meet the person's outcomes.

Informed Choice

The supported person must be provided with any assistance that is necessary to assist them to express their view about their support. This means that an individual must be given all of the information they need in a way that works for them in order to make an informed choice. This might involve access to an independent advocate, an interpreter, translator or communication aid.

Participation and Dignity

This is about the relationship between the person receiving and those delivering support. That relationship must be centred on promoting human rights and ensuring that decisions are made together which help the individual to lead a dignified and fulfilling life, free from discrimination and degrading treatment.

The duty to offer the four options and follow these principles throughout an individual's entire care journey is intended to result in care and support which is inclusive, collaborative and which promotes human rights through autonomy and self-determination. This is a holistic approach which should be driven by good conversations with the individual or those seeking support on that individual's behalf. Self-directed Support emphasises the importance of helping people to think about their life, the challenges they face and the natural, community and social networks which could help that person to lead a more fulfilling and dignified life.

Human Rights Based Approach

A human rights based approach is about ensuring that international human rights standards and principles are embedded in policy and practice and that the dignity of the individual is at the centre of decision making. In every setting a human rights based approach is about participation and making sure that people work together in coming to decisions that impact their human rights. This approach seeks to protect vulnerable groups; to understand why rights are at stake and to redress and then to review these imbalances.
In a health and social care setting, applying a human rights based approach empowers the individual receiving care and support to know and claim their rights whilst at the same time increases the ability and accountability of those responsible for protecting and fulfilling those rights. Decisions are taken every day that affect human rights and although the Self-directed Support Act is a positive development, evidence from projects like this one depict that there is more to be done to assure and not assume that these are being delivered in practice.

This section of the report will outline two different models developed to support the delivery of a human rights based approach. The first of these is called PANEL and details a set of principles as a mechanism to determine how far human rights have been embedded in any given scenario. The second of these is the FAIR Model; a flow chart to guide an individual or organisation through implementing a human rights based approach.

This report argues that the challenges to Self-directed Support implementation are endemic through every part of the system and neither of these models is likely to promote change when used in isolation. However, as will be depicted through project case studies, these models when taken together can support a process which identifies barriers and offers human rights based solutions.

PANEL

The PANEL principles are a way of breaking down what human rights mean in practice. The approach can be used in two ways, the first of which is to use the acronym to ensure the actions taken in projects, organisations and service delivery go beyond the minimum legal requirement and embed human rights at every stage. These are set out below:

Participation: People should be involved in decisions that affect their rights.

Accountability : There should be monitoring of how people's rights are being affected, as well as remedies when things go wrong.

Non-Discrimination : Nobody should be treated unfairly because of their age, gender, ethnicity, disability, religion or belief, sexual orientation or gender identity. People who face the biggest barriers to realising their rights should be prioritised when it comes to taking action.

Empowerment: Everyone should understand their rights, and be fully supported to take part in developing policy and practices which affect their lives.

Legality: Approaches should be grounded in the legal rights that are set out in domestic and/or international law

The second approach, referenced in the following section, is as an evaluation tool to evaluate to what extent human rights were infringed in a given case.

Further information about the PANEL principles can be found on the SHRC website.

How the Getting it Right Project used PANEL

The following two tables depict how the Getting it Right for/with Older People project utilised the PANEL approach to identify and evidence how human rights were embedded in practice when achieving each of the project outcomes. The tables are separated into short and long term outcomes. Note that for PANEL to be effective, each of the principles must be evident at every stage. For the purposes of this report and to avoid repetition, there is simply one principle listed per outcome achieved.

Short term out-come	*How it was achieved*	*PANEL Principle*	*Self-directed Support Principle/Value*
We know more about effective models for independent support and care for older people and how to overcome barriers.	Widespread engagement with older people receiving support, carers, providers and practitioners which provided an insight into the barriers and enablers to Self-directed Support. Understanding, collating and sharing this engagement with Steering Groups which allowed for consultation on what the barriers are and how the project could address these.	**Participation**: older people involved in discussions and decisions that affect their rights.	**Involvement** of older people and carers in discussions about their care and support.
Existing models for understanding the assessment needs of older supported individuals will have been explored and any new models developed and trialled.	Practitioner forums held in both project areas with older people's teams specifically as well as wider forums with all practitioners to encourage shared learning and discussion. Individual interviews held with older people who have undergone the assessment process to establish what this process felt like for the individual. In both areas, Steering Groups decided that any new assessment models would take into account the research produced but given the timescales would be developed internally, separate from the project.	**Non-discrimination:** all forms of discrimination must be prohibited. The project ensured equal access for all. This meant visiting each older person at home or providing accessible transport and venues to enable attendance at focus groups.	**Collaboration** with practitioners and older people in exploring current assessment processes.
Older individuals who access support from social care providers engaged in the project will be better informed, more aware and empowered to exercise their rights under self-directed support.	Engagement and Self-directed Support awareness raising events held in both areas for older supported individuals as well as "coffee mornings and conversation," open to those who are not currently receiving support. Feedback from these awareness raising events evidenced that those who attended felt they were more informed about social care afterwards. A Self-directed Support information leaflet co-produced with older people was developed and opened for consultation by stakeholders. A short video about older people and Self-directed Support was developed which seeks to raise awareness that older people must not be discriminated against in access to Self-directed Support. This video will be used in community roadshows public engagement and staff training.	**Empowerment**: older people and carers were empowered by supporting them with the knowledge and awareness to claim their rights under Self-directed Support.	**Informed Choice** as older people involved in the project are now aware of the different Self-directed Support options open to them and their families.

Each supported local authority able to evidence that they are more effective at supporting individuals to achieve their personal choice as well as evidencing self-directed support principles at work in older people's assessment and support planning processes.	Staff training developed by practitioners and Self-directed Support teams. Practitioner forums gave staff the voice to express what they required in new training to support older people more effectively. This training was then developed and tested. Feedback from the training was collated by the Project Development Officer. The project Steering Groups held quarterly ensured that there was dedicated space and time for evaluation and planning around Self-directed Support on the agendas of those leading and directing at Partnership level. This ensured that culture change was being driven from the top down as well as the bottom up. At a time of budget cuts and recent integration, without this project and the Self-directed Support Leads pushing this agenda, it could easily slip down the list of priorities.	**Empowerment** of staff to speak up about the changes and training they need to ensure that older people's aspirations and out-comes are achieved.	**Dignity and respect** for older people will be a consequence of each local Partnership being able to evidence Self-directed Support principles at work.
Care providers engaged in the project will be more informed and able to exer-cise their duties under self-directed support.	Provider forums held to gather information about what would help providers to support older people better under Self-directed Support. These forums led to provider training ses-sions which covered Self-directed Support in its entirety as well as human rights. A provid-er FAQ sheet was developed and shared. The local Partnership was present at the training, allowing for crucial relationships to develop.	**Empowerment** of providers to come forward with innovative plans to make Self-directed Support work for people. Training through the project empowered providers to understand Self-directed Support and to work with the local Partnership to get the best outcomes focussed care for the individual. Providers learned that they must be confident to set their support out in clear terms as to what they can offer a person; costs, times etc.	**Informed Choice**: If care providers set out exactly what they can offer a person, that person will be more able to make an informed choice about their care and support.
Existing innovative practice will have been identified and shared, and where appropriate developed further prior to dissemination.	Individual interviews held with older people to record their care journey in search of good practice which could be shared. Working collaboratively with organisations also working to support the implementation of Self-directed Support. This included AILN, Outside the Box and IRISS, ensuring that innovative practice was shared and that there was no duplication of work.	**Participation**: This part involved speaking to older people about how much choice and control they had in decisions about their care and support.	**Collaboration**: if all stakeholders across health and social care work together, not in silos and with older people participating at every stage of decision making- the outcomes for the individuals will be improved.

Long term out-comes	*How we achieved this in each area*	*Human Rights Based Approach*	*Self-directed Support Principle*
More older people are aware of Self-directed Support and what choice and control mean for them. **More older people will be aware of the full extent of choice available under each of the four Self-directed Support options and their distinctive features**	Engagement events with older people and carers increased their knowledge and awareness of Self-directed Support and how social care has changed since 2014. Self-directed Support literature in the form of a leaflet and video co-produced and involving older people developed. Training for professionals developed and trialled together with practitioners reported to have increased their knowledge and understanding, which will be transferred to the older people they support. Provider forums and training increased their knowledge and awareness and their ability to support an older person through a Self-directed Support journey.	**Legality**: staff and provider training ensures that duty bearers are aware of their legal duties under the Self-directed Support Act.	**Informed Choice:** the leaflet and video created by the project details the choices a person has under the Self-directed Support Act. If these are disseminated widely they will increase informed choice.
More older people will be confident in accessing and using personal budgets within the context of their preferred Self-directed Support option choice, whichever that may be.	Awareness raising, engagement and training over the 15 months with older people and the stakeholders who support them will in the long-term lead to more older people using personal budgets. The projects also included support services such as the Community Brokerage Networks, Voluntary Action and Dosh who can help older people and providers to manage budgets in training and awareness raising sessions. If more older people, carers and practitioners are aware of these services and how they can support older people, in the long term, more older people will be confident to direct their own care and support through whichever option they choose.	**Accountability:** raising awareness with older people and those who support them means that if choice and control are not made a reality, someone can be held to account. Without knowledge and awareness of what a person is entitled to, it is impossible to hold anyone to account.	**Collaboration:** the interventions achieved through the project increase the chances of an older person collaborating with practitioners and providers in directing their care and support**.**

Social care provision for older people will be flexible and creative and focussed on personal outcomes	The project took a holistic approach to involving all stakeholders who have a role to play in the provision of older people's care and support. These forums, training sessions and Steering Group discussions identified the current barriers to flexible and creative support for older people. The project then targeted some of these barriers and trialled interventions in both areas to address the barriers which the Steering Group agreed would be most appropriate under this project and within the timescales. It is the hope of the project that the learning from this process will go some way towards improving personal outcomes for older people.	**Participation:** working with older people at every stage of the project ensures that the barriers are identified and the Partnerships can work towards addressing these to ensure provision is flexible and creative.	**Collaboration:** for this outcome to be achieved, all stakeholders across health and social care need to collaborate with each other and with older people.
The workforce has skills and confidence to ensure care meets personal outcomes	Training for the frontline workforce was developed in collaboration with practitioners and was then trialled and tested. Human rights training and awareness of older people's personal outcomes was undertaken for providers. Discussions at leadership level to enable the culture change that will support staff to put through creative care plans for older people.	**Empowerment:** empowering the workforce to understand their legal duties and to stand up against systematic barriers to the implementation of the Act and the assurance of human rights for older people.	**Informed Choice:** if the workforce are aware of their duties under Self-directed Support then they in turn will support older people to have informed choice.
Older people's support providers have systems in place to support personal outcomes	Engagement, awareness raising and training with older people's support providers.	**Empowerment:** older people are empowered by the support they receive from trained providers and practitioners.	**Informed Choice:** if older people's support providers have the systems and relationships in place which outline how they can support an individual and practitioners are aware of these services, informed choice will be increased.

FAIR Model

The Scottish Human Rights Commission developed a flow chart to guide an individual or organisation through implementing a human rights based approach. When confronted with a situation where human rights could be at stake, the FAIR model aims to act as a guide towards a proportionate and justified resolution.

The FAIR model and training kits can be found on the SHRC website:

Facts:

What is the experience of the individual? Are they being heard? What are the important facts to understand?

Analysis of rights at stake:

What are the human rights at stake? Can the rights be restricted? What is justification for restricting the right? Is the restriction proportionate?

Identify shared responsibilities:

What changes are necessary? Who has responsibilities for making changes?

Review actions:

Have the actions taken been recorded and reviewed and has the individual been involved?

SECTION 3

Application of FAIR model and PANEL principles

This section of the report will use FAIR alongside the PANEL principles as a joint model which can be used to successfully implement a human rights based approach. Using these models together allows the user to identify the experience of the individual, the rights at the stake, to establish who is responsible, implement changes and ensure that this is followed up by a robust review procedure.

The case studies below evidence barriers to Self-directed Support which are then worked through using a merging of two human rights based approaches.

It is important to establish that this report does not seek to be an exhaustive breakdown of all the barriers to Self-directed Support for older people. The intention is to highlight some of the key barriers identified across two project areas and evidence how a human rights based approach was used to push change. The case studies cover the following challenges:

- **Knowledge, awareness and understanding of Self-directed Support**
- **Lack of services, reablement, capacity to review and ownership and collaboration**
- **Processes and timescales**

Again, it's crucial to note that within each of these barriers there exists diversity and difference in how they are experienced both across stakeholder groups, depending on whether you are a carer, a supported person, a practitioner, a senior manager or a provider as well as across two different Health and Social Care Partnerships and further differentiated again within each locality area. When applying the model to each of the three barriers identified, the paper will draw from one specific case where the barrier stood in the way of human rights and evidence how this was addressed through the project. The following seeks to be an example of how to use a human rights based approach to address barriers to Self-directed Support for older people, it is not intended to be an account of the nuances and details of each challenge.

Case Study 1: Knowledge, awareness and understanding of Self-directed Support

F*acts*

What are the key barriers in the realisation of human rights in Self-directed Support for older people?

The first of these barriers, identified in both project areas was **knowledge, awareness and understanding.** This was highlighted as an obstacle to Self-directed Support by all stakeholder groups consulted during the process. This heading is broad and it should be reiterated that the specific areas where knowledge and awareness were missing were not the same across all groups involved and differed not only in each Partnership area but further still with each locality therein.

The example below focuses on practitioner knowledge and awareness in one project area. Practitioners here reported that gaps in their knowledge and awareness exist around the navigation of the process behind each Self-directed Support option. Practitioners expressed their desire to support people to have choice and control but stated that they felt disempowered to do so as the processes were unclear and inconsistent, guidance around the process was underdeveloped and training for practitioners irregular. Specifically, in this location, practitioners reported gaps in their knowledge and understanding of the Option 2 process and how it could help older people to meet their outcomes. This is evident in the fact that only 11 people are reported to have chosen this support option across the whole authority.

A*nalysis of rights or self-directed support principle at stake*

Which human rights are at stake? Is any restriction on the rights justified?

In terms of human rights, if we use the PANEL approach to assess this scenario it would look like this:

Participation: The supported person cannot participate fully in support planning if they are not equipped with the full knowledge to do so.

Accountability: In this example, neither the Partnership nor the individual practitioner is held to account for being unequipped to perform their legal duties.

Non-discrimination and equality: The older supported person is experiencing inequality as they are not being offered the same level of choice and control as another person in a different area, supported by a practitioner who is fully knowledgeable, aware and able to discuss all four options and their potential risks and benefits.

Empowerment: The older supported person is not empowered to truly direct their support as they are not equipped with the knowledge and awareness to do this. The practitioner is also not empowered to do their job in a way that meets legal requirements as they have not been equipped with the knowledge, training, guidance and processes to do so.

Legality: The practitioner is in breach of the Social Care Scotland Act (2014) by not offering the supported person each of the 4 options specified under the Act.

The example above also highlights the violation of the Self-directed Support principle of informed choice, a practitioner is not able to give the older person all of the information they require to make an educated decision about their care and support. In this case, the practitioner does not fully understand how Option 2 works or could be used to help a person to meet their outcomes, the practitioner is then not able to pass this information onto a supported person meaning they cannot exercise true choice and control.

Identify responsibilities

What changes are necessary? Who has responsibilities for helping to make these changes?

The changes necessary were identified by the Health and Social Care Partnership through the Steering Group established by the project. The Partnership was proactive in identifying the changes required and acting on them with funding and support from *Getting it Right for Older People*.

Change Required	Action taken
• Widespread awareness raising to empower people to know and claim their rights under the Self-directed Support Act.	• Engagement and involvement of Community Connectors in the project who directly provide information and support to people in the community. • An awareness making film produced which talks through each Self-directed Support Option and focuses specifically on older people. • Self-directed Support to be incorporated into Community Roadshows. • New Self-directed Support leaflet produced which explains the 4 options to the general public.
• Increased practitioners' knowledge and awareness.	• Practitioner forum established • Consultation on what new training and guidance was required. • New practitioner training developed and trialled in one locality area with the decision that this will then be rolled out further when considered fit for purpose by practitioners. • New Option 2 guidance developed and distributed. • Awareness raising video made which will be used in staff training.

Recall and review progress

Have the actions taken been recorded and reviewed and has the individual been involved?

The actions taken were recorded in the final report which has been shared with the Partnership and with the Scottish Government Self-directed Support Policy Team. A review of the training was conducted with staff who took part and shared with the Partnership and in overall project reports. Further recall and review procedures lie with the Partnership Self-directed Support Team as the Getting it Right Project funding has come to an end. It is important to note that for this part of the FAIR model to be fully closed, an assessment would need to be conducted to ascertain the impact on the supported person and whether or not their awareness level has increased.

Case Study 2: Availability of services and Ownership and Collaboration

F*acts*

What are the key barriers in the realisation of human rights in Self-directed Support for older people?

The second barrier this report would like to address is one of availability of services. This was a barrier which was raised in both project areas but more dramatically in the larger, more rural area. The reality for many of the older people interviewed is that they have had little choice and control over the provider who sends staff to them on a daily basis. True choice and control cannot exist when there is not a choice to be had. This is something which has been raised across many Self-directed Support forums, research and publications in the last three years. There are now social enterprises like the Health and Wellbeing Cooperative, amongst others who have come into existence to fill the identified gaps and provide a personalised service in areas where there is a lack of service provision.

The case below which was gathered through individual interviews goes further than a lack of services and contradicts all Self-directed Support principles. Mrs Jones' situation is not unique and was confirmed in engagement with the provider organisation and the Social Work team involved. Mrs Jones gave permission for her story to be shared however an alias has been used.

Mrs Jones had received Option 3 - traditional care provided by the NHS - for 4 years. She was happy with the care and support and had developed an important relationship and friendship with her two carers. Mrs Jones was admitted to hospital for a routine procedure and her discharge was delayed by 10 weeks due to a lack of service provision in the area in which she lived. When she arrived home she was met by new carers. Her care was now being provided by a voluntary provider, commissioned by the NHS. On paper, the individual is now receiving care through Option 2 but no reassessment had taken place, or no process that the individual remembered. Mrs Jones did state that a social worker visited her in hospital and explained that she was doing all that she could to get Mrs Jones back home but there was no conversation about the change in her support.

A*nalysis of rights or self-directed support principle at stake*

Which human rights are at stake? Is any restriction on the rights justified?

Participation: The older person in this example has not participated in the decision to change her care and support. She was unaware of who was now providing the care, simply that the carers were not her usual carers and that since her return from hospital they now arrived at 9.30 am instead of at 7.30 am, the time she had been used to for the past 4 years.

Accountability: This specific case was raised at a project meeting with the Local Partnership and there was no acceptance of accountability. It was explained that a reassessment had occurred in hospital and Mrs Jones may have been too stressed to remember.

Non-discrimination and equality: Human rights exist to protect the most vulnerable. In this example, Mrs Jones has suffered inequality and discrimination in her ability to exercise choice and control in the reassessment process as a result of being admitted to hospital.

Empowerment: Mrs Jones was disempowered. In her interview, she was reluctant to complain, however her eyes filled with tears when she spoke of her previous carers. She didn't know the name of the organisation who was now providing her care and wasn't aware of who she could contact for a conversation about this. She felt completely powerless.

Legality: The case sits in direct violation to the legal duties, principles and values set out in the Self-directed Support Act.

In terms of a violation of the principles of Self-directed Support Mrs Jones has been denied her right to involvement, to collaboration and to informed choice. She waits in her bed from 7am until 9.30am before her carers arrive to support her to get up, to use the bathroom and to eat her breakfast: a violation of her right to dignity and respect.

Identify responsibilities:

What changes are necessary? Who has responsibilities for helping to make these changes?

Change required	Action taken
• The changes required here are larger than the project. The scaling back of NHS care services sits in a much wider context and assigning responsibility is not within our capacity. • However, small changes around the journey of the individual can be addressed through a human rights based approach.	• This case study was raised as a priority at the following Steering Group meeting with the local Partnership. • A meeting was then arranged with the senior manager of the social work team involved and the care provider to create a space for dialogue about how they can work together to empower the individuals caught up in service cuts and pressures on providers. Prior to the project, there had been no dialogue between the two parties. • Both agreed that something needed to change and discussions began around the possibility of testing out a new scenario where the care provider conducts the assessment and support planning for the individual. For Mrs Jones this would mean that when she returned from hospital, she would be able to have a good conversation with someone about what was important to her and the provider could then try and accommodate her wishes. • Time periods between reablement and reassessment were raised by practitioners as a barrier to Self-directed Support. It was suggested that someone should be employed to occupy the role of reviewing officer. However, this wasn't something within the project's reach given funding and timescales.

Recall and review progress:

Have the actions taken been recorded and reviewed and has the individual been involved?

The actions taken have been recorded in project reports and meeting minutes. The individual has agreed for us to share her case study and was invited to attend the end of project coffee morning. Ideally in the process that is now underway between the local NHS team and the provider organisation, Mrs Jones and other older people will continue to be heard. The project Development Officer has agreed to keep Mrs Jones up to date with the process in as far as is possible after the end of a funded project.

Case Study 3: Processes and timescales

F*acts*

What are the key barriers in the realisation of human rights in Self-directed Support for older people?

The final case study this report would like to draw on is one around processes and timescales for care planning and budget sign off. Again, this was a barrier which came up across the board in our engagement. Practitioners and team managers in project forums reported that for them, the biggest barrier to implementing Self-directed Support for individuals is the senior management sign off process which sits above them. This was the case in both areas but took slightly different forms. In area one, practitioners reported that Option 3 can be signed off by their direct line manager almost immediately. Option 1 or Option 2 are sent to more senior management for approval and the processes behind these are unclear and inconsistent.

Practitioners stated that they were unsure when the request was added to a waiting list and timescales for sign off could be anything from 3 weeks to 3 months. There was little clarity or communication and practitioners, as the face of the provision of care and support, felt their job of explaining to an individual why they had been waiting so long when a neighbour received care within a week, caused stress and a demotivation to put through either of these Options regardless of how they could improve the lives of the person receiving support: "If someone needs support and I know Option 3 will be in place in the next week and I have no certainty over when an Option 1 or 2 budget would be signed off, I'm more likely to push that person towards traditional care to ensure that their needs can be met quickly and they are not left to struggle. It's a hard decision that we all have to make."

A*nalysis of rights or self-directed support principle at stake*

Which human rights are at stake? Is any restriction on the rights justified?

Participation: The older supported person may have been able to participate in the assessment but not with full involvement or informed choice. The practitioner in the case above is more likely to direct an older supported person to an Option 3 to ensure that care arrives quickly though at the expense of person centred planning.

Accountability: The accountability here appears to lie at senior management level where processes are timely and inconsistent. Practitioners reported that they were not able to contact anyone directly about the person's budget and instead had to wait for sign off without explanation.

Non-discrimination and equality: The older person in this locality is suffering inequality in the length of time spent waiting for budget approval for an Option 1 or 2 budget. An individual should not be discriminated against in the timing of their care as a consequence of their preferred option.

Empowerment: The practitioner doesn't feel empowered in the process and is therefore unable to empower the older person.

Legality: The demotivated practitioner is at risk of avoiding his/her legal duties to offer all four options when faced with a long wait for sign off and the pressure to get care to an individual quickly.

The Self-directed Support principles at stake are involvement and informed choice on the part of the individual.

Identify responsibilities

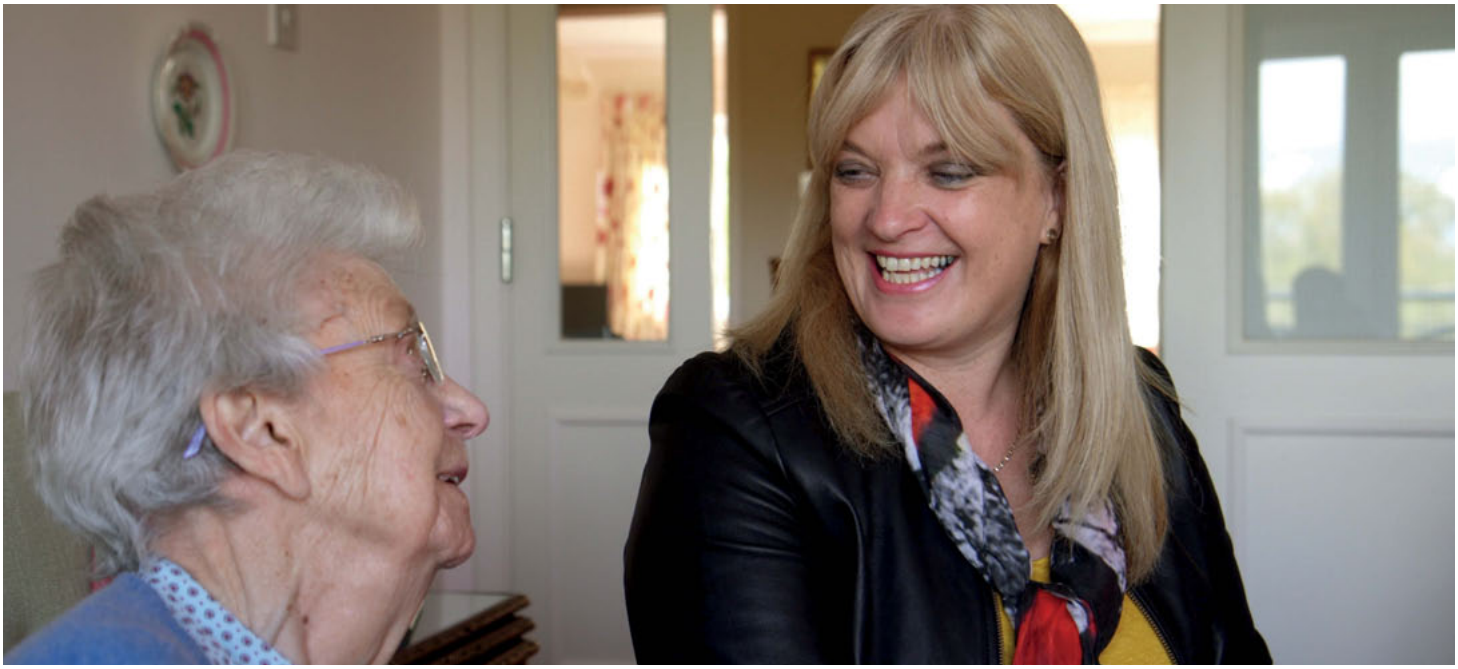
What changes are necessary? Who has responsibilities for helping to make these changes?

Change required	Action taken
• Changes are required in the internal systems and processes of this Local Partnership. The systems in place which require a frontline worker to submit an individual's budget to a centralised authority for signing off and to potentially then have to wait months for approval are not conducive to a system that empowers either workers or the people they support.	• The Steering Group agreed that internal processes for sign off were part of a much broader system change that needed to be tackled separately from the project. However, the project was supported to embark on a process of culture change from the top down. • The Director of Health and Social Care instructed the Steering Group to reissue the Partnership's policy statement on Self-directed Support to increase awareness and draw attention to the legality of the Act. • The feedback from practitioners was shared by the project at Steering Groups, forums and project reports making sure that their voices were heard.

Recall and review progress

Have the actions taken been recorded and reviewed and has the individual been involved?

The actions taken through the project have been recorded and reviewed and will be shared nationally in the publication of this report. However, the real change has to be undertaken directly by the Partnership involved and must include both supported people and practitioners in that process. The Self-directed Support team have set up a practitioner forum which takes place quarterly and is an opportunity for practitioners to express their views and for updates to be provided around any internal changes in process.



SECTION 4

Review and Call to Action

Knowledge and information communication

As a barrier to Self-directed Support, this project highlighted that gaps in knowledge, awareness and understanding are evident across all levels of the health and social care system. The case study above is a specific case from practitioners in a particular area and is cited in this report for the purpose of evidencing how a human rights based approach can be used to address barriers.

The experience of this project is that poor practice results and negative outcomes occur where there is muddled thinking around how Self-directed Support principles should permeate through social care practice and systems. In addition it is clear that there is a lack of thorough awareness of where Self-directed Support legislation sits alongside existing social care policy and legislation on the part of those who commission services for older people, especially where there remains the practice of commissioning services on a spot purchased, time and task framework.

A further issue relating to knowledge and communication affects providers who themselves don't understand how to put forward their services in a way that promotes individual choice and control and instead follow instruction on what time and how often support has to be delivered, sometimes without a conversation with the supported person.

It is the individual older person whose human rights are at stake and who, as a direct consequence of the gaps in knowledge and understanding listed above, are unable to explain how they have had any choice and control in their or their family member's care journey. Such gaps and the failure to resource knowledge are a contravention of both the Act and the Human Rights Act.

Call to Action:

Further attention needs to be given to the accessibility, availability and quality of information on Self-directed Support for all stakeholders, be they practitioners, commissioners, providers or supported individuals. The Act has been in place for 3 years and yet evidence from this project and many others highlights quite dramatically that there is there is still no shared understanding of what Self-directed Support is, or how it is delivered in practice.

There is a lot of information which has been produced nationally as well as locally by Health and Social Care Partnerships, providers and other organisations. This is perhaps why people working in Self-directed Support are often reluctant to undertake more awareness raising but the reality is that Self-directed Support is still misunderstood across the board and a new approach needs to be adopted.

A collaborative communication strategy led from the top which utilises a human rights based approach could go some way to getting the sector to a place where good conversations and genuine choices are at the heart of service delivery in Scotland.

We recommend a new, national communications strategy be developed utilising human rights principles. This would ensure that:

- The next chapter of implementation is **participatory**: Including all stakeholders who ensure consistent and effective messaging about Self-directed Support and that any change in messaging is intertwined with the new Health and Social Care Standards
- Duty bearers are **accountable** and no-one is **discriminated** against in access to good quality Self-directed Support information which makes sense to them.
- Citizens are **empowered** by being engaged, informed and included at all stages.
- The messages being delivered make it clear that Self-directed Support is the law, it is not an add on or an optional way of delivering social care and is the only **legal** way to deliver social care in Scotland.

Ownership and collaboration

The scaling back of NHS care and support and the viability of independent care providers to act in their place under current contracts is a worrying barrier to true choice and control. The provider in case study two was overstretched and despite a real desire to be flexible, the workforce was unable to meet Mrs Jones' preferred time of care.

This evidences issues of lack of services as well as ownership and collaboration, the legal duty to ensure that the person has been offered all four support options lies with the assessor. However, the responsibility to embed Self-directed Support principles and values must lie with everyone in an individual's care journey.

Call to Action:

If we see Self-directed Support as simply the duty of the assessor and not as a whole system change in the way we support people to flourish then we will never get to a place where people are truly exercising choice and control. We recommend the use of a human rights based approach to create spaces for dialogue, collaboration and the forming of relationships between all parties involved in supporting an individual.

A human rights based approach puts the focus on the person and moves away from shifting blame and control along a chain. Implementing Self-directed Support needs to be done collaboratively and we need a push both nationally and locally to create the space and time for these crucial relationships to grow.

We also need leadership and bravery to test new ways of working that emerge from these inclusive conversations with Health and Social Care Partnerships, providers, community groups, supported people and carers.

Resistant processes

The research has also highlighted that even where practitioners are enthusiastic and positive about enabling choice and extending control, inconsistent sign off processes can have the effect of halting creative care planning and demotivating practitioners as well as care providers.

In the case study evidenced above we can see that bureaucratic barriers and timescales prevent practitioners from promoting Option 2. Again, this was just one example selected from one area for the purposes of this report. We also came across practitioners who were demotivated because after time, energy and dedication had been put into creating a person centred care plan for someone, it was declined by the management level above. Practitioners in this area were then reluctant to think outside of the box during their next assessment.

There is no part of the legislation which instructs local Health and Social Care Partnerships to assign budget sign off to a certain level of management. This is a reflection of ingrained culture and systems where control over budgets and resources has traditionally resided in the centre: a way of operating which is now, in some areas, proving to stand in the way of Self-directed Support implementation.

Call to Action:

Systems and processes are created by people, and these can change if the will is there. Part of this is about culture change and convincing the people leading these systems to be brave and try doing things differently. We understand that in the current climate, budgets are tight and there is a belief that allowing people to direct their own care costs more. What would be helpful therefore would be some myth busting by sharing the cost analysis of support budgets.

This analysis could be successfully undertaken through the FAIR and PANEL models which would provide the structure for an analysis of a person's life before and after a Self-directed Support assessment, putting the emphasis on the facts and figures, the rights at stake and the changes made which redressed any rights violations and improved the person's quality of life.

A specific area in older people's care which would be useful to review from a cost benefit point of view would be reablement. This project highlighted the number of older people who had been in a period of reablement for up to 18 months, a worrying reflection of the case load realities of professionals who are stretched beyond capacity. A cost analysis of the resources used for unreviewed reablement versus the support a person might have needed had a good conversation occurred 6-12 weeks after hospital discharge or crisis scenario would be hugely beneficial. We believe that this analysis would depict that Self-directed Support and ensuring consistent reviews would not only lead to better outcomes for the person but less dependency on services and resources.

CONCLUSION

This report has explored Self-directed Support for older people through the lens of the Getting it Right for Older People project. In doing this the focus has been on a human rights based approach. The different sections of the report evidence the benefits of combining both the FAIR and PANEL models in addressing barriers to Self-directed Support implementation and achieving both individual and project outcomes. The report ends on a final review of the current barriers facing stakeholders in the implementation of Self-directed Support and human rights for older people and puts forward three calls to action:

1. We need a collaborative communications strategy led from the top and utilising a human rights based approach to ensure participation, accountability, non-discrimination, empowerment and legality in the dissemination of consistent and clear messaging about Self-directed Support for all.

2. We need to create spaces for dialogue and the articulation of the challenges faced by people, workers and organisations in the implementation of Self-directed Support. Further, we need to ensure that flexible systems are put in place which address these differing requirements and prioritise the protection of the individual's human rights.

3. There needs to be more work done into the cost benefit analysis of Self-directed Support versus 'business as usual' in order to win the hearts and minds of budget holders and open up systems and processes which put the control into the hands of the person and the worker supporting them.

The Getting it Right project evidenced the number of challenges faced when making Self-directed Support a reality for older people. The potential of the Act to change the way social care is delivered has not been fully realised and we need to work collaboratively to address barriers and move towards a reality where social care empowers people to have choice and control and to know and claim their human rights.

APPENDIX

0-3 months January - March 2016	**Project development, awareness raising and research** Worked with COSLA to create the Getting it Right for Older People project description and letter of invitation to local Partnerships. Project information sharing and scoping exercises of current SDS projects; their challenges and successes. Early desk analysis of human rights based projects in Scotland and the rest of the United Kingdom. Raising awareness of the project on national groups and local forums. March 8th – official invitation of interest sent out by COSLA.
4-5 months April - May 2016	**Partner identification and capacity building** Meeting with interested local Partnerships to identify possible opportunities for development identified in the project proposal. Two local Partnerships identified associated with capacity building work; considering local alliances with health and social care partners; capacity of older participants and the needs of the workforce/organisations the project seeks to engage. Local Development Officers recruited. Steering Groups established.
June –September 2016	**Discovery and modelling** Exploring current practice and models of Self-directed Support for older people through a multi-facetted engagement strategy. This part of the project allowed for an evaluation of the key strengths, weaknesses and areas for development in both Partnership areas and across organisations. This engagement, included older people, carers, providers and statutory officers and ensured that the key human rights principles of participation, collaboration and involvement were upheld.
September-November	**Pilot area identification and action planning** This part of the project involved collating and sharing the data which highlighted potential areas of development and working with local Steering Groups to prioritise these. It was decided at this stage, in both Partnerships that it made sense to trial and implement on a smaller scale within the locality. Work was then undertaken to identify the areas which would give the project the best chance of meeting the outcomes. The exact focus of each project was left to local parties and discussions included work on new commissioning models which would include the older supported person; new models for older people's assessment; approaches to support planning around outcomes for older individuals; workforce development; provider development; modelling new approaches to risk for older individuals, especially those with challenges related to capacity; awareness raising and literature development specifically for older people. 'Quick wins' were identified and action planning by Steering Groups finalised.

December-May	**Implementation and testing** This period of time focused entirely on testing and trialling interventions identified in the action planning stage. These included but were not limited to awareness raising; workforce development; provider training and literature coproduction.
May-June	**Evaluation and dissemination** This stage sees the completion of the project, the publication of key lessons and the wider dissemination of the results and findings. This stage also includes the publication of a report analysing the effectiveness of a Human Rights Based Approach to Self-directed Support for older people.

Report written by Carlyn Miller

Photography credit: Michael Rea and Duncan Cowles

If you would like to discuss this report or its findings, please contact:

Scottish Care
25 Barns Street,
Ayr, KA7 1XB
01292 270240
Co. SC243076