Introduction

Scotland’s health and social care landscape is changing. The most profound reform to social care since its legislative inception in 1968 is beginning to be implemented across the 32 Local Authorities. Self-directed support lays the foundation for a new relationship between the state and those who require support to live independently in the community. Stemming from campaigns for the personalisation of outcomes for people who are disabled and those living with long term conditions, fronted by the disabled people’s movement, self-directed support is the mechanism through which choice and control over one’s life can be exerted.

The Social Care (Self-Directed Support) (Scotland) Act 2013 places a duty on local authorities to offer those who are eligible for social care services four options of self-directed support, ranging from control over a direct payment, through control of an individual budget held by a local authority or third party, to the retention of statutory-arranged services to meet individual needs, or a mixture of all previous options. This is a profound shift towards autonomy for individuals requiring social care.

For two decades, Health Boards and local authorities have been gently prompted to work together for the attainment of joint outcomes of those who require support from both. However, without budgetary integration, divisions continued to hamper common objectives and people remained caught in the middle of services fighting over spending. The Public Bodies (Joint Working) (Scotland) Act is an attempt to remedy such separation by legislating for full collaboration in the design, commissioning, and delivery of support.

The ALLIANCE’s round table event, ‘The person, the whole person, and nothing but the person’, brought representatives of health boards, Local Authorities, the Scottish Government and the third sector together to consider the implications of combining both reforms in order to embed an integrated model of self-directed support throughout the health and social care partnerships in Scotland.
Context

‘The person, the whole person, and nothing but the person’, held on the 20th of June 2014 at the Dome Room in Edinburgh, aimed to bring self-directed support to the forefront of health and social care integration. Speaking at the event, representatives of the Scottish Government, local authorities and the NHS gave their account of joining up self-directed support to achieve better health and social care outcomes for people who are disabled or are living with long term conditions.

The policy context of self-directed support

Allie Cherry is the Professional Advisor leading the Scottish Government’s Self-Directed Support team programme on engaging health in the implementation of self-directed support. Her work demonstrates that there is an appetite to map out the opportunities to combine the Scottish Government’s strategy for self-directed support and health and social care integration. Allie set out the context in which self-directed support sits by describing it as being “the culmination of multiple strategies intended to increase the independence and autonomy” of people who are disabled or are living with long term conditions.

To this end, self-directed support is entrenched in the principles of being outcomes focused, person centred, self-managed, informed and co-produced. All of which is encapsulated in the social model of health, which promotes the concept of enabling people with long term conditions to manage their conditions. Self-directed support, therefore, sits alongside a range of legislation and strategies aimed at the greater involvement of individuals in the management of their own conditions. As Alex Neil, Cabinet Secretary for Health, has affirmed, “self-directed support cannot be seen in isolation from integration and we cannot see integration as isolated from the person-centred strategy. It is all part of the same plan to improve the quality of service delivery”. 1

Since the Community Care and Health (Scotland) Act 2002, health boards have had the authority to transfer funds to local authorities in the provision of securing health outcomes for individuals with health and social care needs. While this has had limited usage, Allie demonstrated that self-directed support could be extended into an integrated health and social care landscape with relative transferability.

While there is no legislative basis for giving people direct budgets for the health service, the other options of self-directed support are practically applied through the various delivery mechanisms in the NHS. The advice given for extending self-directed support into this framework, from Allie’s perspective, would be that self-directed support is more applicable the less acute the service for which it is being used. However, at present there is no intention from the Scottish Government to legislate for direct payments to be extended to health.

Stemming from recent pilots, which have taken place in NHS Lothian and Fife\(^2\), the Scottish Government is taking forward scoping exercises to ascertain the possibility and scope for implementing self-directed support within a health context, the aim being to map out the future of self-directed support in an integrated landscape.

Speaking at the ALLIANCE’s third sector engagement event on the Public Bodies (Joint Working) (Scotland) Bill, Cabinet Secretary for Health and Wellbeing Alex Neil MSP highlighted the opportunity to apply the principles of SDS within the wider context of health and social integration.

Full presentation available at Appendix A.

**Practice**

Inspiring a fresh way of integrated working between health and social care colleagues, Lee McLaughlin (Self-Directed Support Lead, East Ayrshire Council) gave an enlightening overview of the pilots conducted with people who had diverse health and social care outcomes. Based on the approach taken by Diversity Matters\(^3\), to build a collective ownership of self-directed support, East Ayrshire Health and Social Care Partnership have trialled integrated budgets for people with a social care and/or health care support need.

Lee highlighted two examples from the trial; a person recovering from substance misuse with a budget of just £250 and a mother who had had a stroke requiring personal support on a budget of around £20,000.

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\(^2\) Blake Stevenson – Self-Directed Support test site evaluation: http://www.alliance-scotland.org.uk/download/library/lib_5012b7ae88324/

\(^3\) Diversity Matters: http://www.diversity-matters.co.uk/index.htm
These examples showed that the outcomes achieved demonstrated a major shift in the perception of required interventions. Rather than prescribing treatments and therapies according to a medical perception of successful outcomes, the trial found that more holistic approaches improved people's overall wellbeing.

Important to the theme of the day, Lee spoke of the learning to have come from the process involved in the trials. Firstly, for those who participated, outcomes pertained to the recovery model of health, whereby each of the people exemplified had the intended goal of returning to their lifestyles, or improving them.

For example, the participant who had had a stroke wanted to ‘regain her role as a wife/mum, return to work, and self-manage her after-stroke condition’. This had implications for both health and social services in enabling her to realise her intended outcomes through adapting their mode of service delivery to reflect her needs.

“Self-directed support was the light at the end of the tunnel, as it allowed me to be mum again and bring my family back together where they belong.”

To enable the pilot to be a person-centred, integrated experience for each of the participants, the East Ayrshire Health and Social Care Partnership (HSCP) adopted a joined up model of self-directed support. Through the learning to stem from the pilot, the HSCP found that the approach had direct and indirect consequences for people who use support and services, the services themselves, and the wider community.

These included:

- participants having fewer admissions to primary care
- less need for social care intervention
- services embracing self-directed support as an enabler to organisational partnership
- community capacity being developed through participants’ inclusion

In conclusion, it was felt that integrated self-directed support was an opportunity to ‘think differently’ about meeting outcomes.

Full presentation available at Appendix B.
Delegates were asked for their views on what they had heard so far. Many delegates were cautiously optimistic about the agenda:

- The discussions that took place mainly pertained to the conflicts between the focus on improving outcomes through joint support packages, which delegates seemed to be supportive of in principle, and the lack of an infrastructure able to facilitate such an approach.

- Noting the apparent low take up of direct payments in social care, comments were made about the lack of aspiration for individualised commissioning of care which could signal that there is less demand for personalised services in Scotland than in other parts of the UK.

- A noticeable concern for NHS representatives was the impact of delegation; the notion that joined up self-directed support packages could enable people to employ Personal Assistants to undertake medical tasks (i.e. gastrostomy care, catheterisation). While this possibility has been available under Direct Payments since their inception, and more formally established through delegation of NHS funding under the 2002 Community Care (NHS) Act, there was concern that self-directed support could lead to health professionals being at risk should their medical tasks be delegated.

- Though self-directed support incorporates four options of support delivery, for a health service that is publicly funded and budgeted on a care delivery model, the idea of Direct Payments being initiated in a health setting caused concern amongst NHS representatives. The point was later raised that health services already deliver options two, three and four of self-directed support by providing in house health care and outsourcing services to subcontractors.

- Since the inception of direct payments in social care, markets have evolved to include representation from the third, independent and statutory sectors, while in the provision of health care there is no appetite to transfer this approach to the NHS. However this restricts the perception of health care to being strictly about medical treatment.
Personal outcomes through combined approaches

Too often commissioners of healthcare can be fixated on the financial implications of transformation, when in practical terms it all starts with a conversation. Alison Linyard, project manager of Personal Outcomes for Older People (SHINE) in Fife, demonstrated the power of changing the conversation between practitioners and people who use them. Identifying the current context in which older people’s services are operating in Scotland, Alison pointed to the fact that there is an increasing demand for public services to support people with multiple long term conditions in old age.

While it is common for such services to focus on maintaining health, the Personal Outcomes for Older People (SHINE) project has approached these challenges through changing their response to reflect individual outcomes.

In the same way that self-directed support has shifted the philosophy of social care to one that focuses on empowerment, the Personal Outcomes for Older People (SHINE) project takes a collaborative approach to healthcare by enabling staff to have outcome-based conversations with the people they support. This is a profound transformation to the traditional dynamic that once saw health professionals as being the authoritative figure on health management and recovery. Instead, by focusing on the relationship between staff and individuals, solutions to meeting individual outcomes can be cooperatively developed and implemented in a way that supports each partner. For example, professionals working with the Personal Outcomes for Older People (SHINE) project reported:

“*When working in the hospital, you just don’t think that way at all. It made me think outside the box. Before, I think I’ve always thought in terms of what people will be able to do, rather than who they’ll be able to be.*”

This approach is further supported through the collaboration with micro-providers who can offer home support to people of older age in a way that reflects a person centred model of healthcare. By striving towards the same vision, the NHS, social care and micro providers can together enable individuals to be empowered to reach outcomes made possible by health services centred on supporting living rather than just sustaining it.
Professionals also reported:

“I was referred a very elderly lady who had dementia and was told to ‘keep her ticking over until we can find her a place in long term care’. However, through conversation and taking an interest in the lady’s life, her self-esteem and confidence grew, she began to talk more about things she enjoyed doing and her anxiety about leaving the house reduced. The lady’s outcomes had therefore changed significantly: on a day to day basis they centred on finding meaningful things to do. In the longer term her wish to live at home had become a real possibility.”

This mode of working reflects a truly integrated model whereby all agencies and actors involved in the care and support of individuals have an equal stake in the embedding of a person centred approach to healthcare.

At the heart of this, it was stressed that the conversation between professionals, pulling on their knowledge and individual assets, and individuals is key to changing the model of health care towards the coproduction of positives outcomes. Concluding, Alison Linyard asserted that “this approach offers a free route to integration”. By combining the personal outcomes approach with a self-directed support model of health and social care, the transformation of care can achieve a bespoke response to meet individual outcomes.

Full presentation available at Appendix C.

**Engaging solutions**

By applying a personal approach to a macro issue, the ALLIANCE promotes an approach to joined-up health and social care self-directed support that is founded on achieving the best outcomes for individuals. To explore the potential solutions that could be attained through this approach delegates were posed scenarios with fictitious personal circumstances that could be improved through integrating self-directed support between health and social care.
The personas included:

Jean

Jean is a 75 year old widow living in her family home in a small village. Since retiring, she continues to be very active in the community, volunteering and is a member of the church council. She has never needed any assistance and continues to drive and live independently. However, recently she has had two falls resulting in trips to A+E. During her last visit to hospital she had an eye test, which revealed deterioration, following which she is no longer able to drive and her falls have been linked to the onset of arthritis.

Calum

Calum is 49 years-old, he is a qualified accountant, used to exercising a high degree of control over his life. He lives at home with his wife and son. He has a progressive neurological condition; diagnosed five years ago, which has subsequently resulted in complex needs, including health needs and overnight support needs.

Dominic

Dominic is a 25 year-old man who lives alone, is at college part time and is seeking work. He lives in the area he grew up and has lots of friends. He has a good relationship with his parents and sister who also live nearby. He has a spinal injury and sometimes suffers from chest infections and needs nebuliser support. He does not want to go into hospital when this happens and there was concern about the health risk involved when he is unwell.

All of the responses to these scenarios highlighted the need to ascertain each of the individual's aspirations and outcomes. The discussions centred on the social cultural context in which the people could contribute if their health and social care needs were met in a person centred way.

The main solution to be drawn from the exercise was the suggestion that there needed to be one point of contact for individuals to be assessed and their outcomes to be supported by health and social care services. A full list of the suggested solutions to each of the personas is included in Appendix D.
Next steps:

As the integration of health and social care begins to be implemented across Scotland, the ALLIANCE will work with partners to take forward the recommendations from ‘The person, the whole person and nothing but the person’, to advance the opportunities for people to use a joined up model of self-directed support.

- The ALLIANCE will produce a think piece on self-directed support in an integrated landscape.

- The ALLIANCE will work with the Scottish Government and third sector partners to map out the potential opportunities of self-directed support within a health context.

- The ALLIANCE will approach an HSCP to consider joint working to trial integrated self-directed support.

About Creating the Connections

Creating the Connections accompanies the Changing Support Changing Lives consortium⁴, aiming to build the capacity of providers to deliver self-directed support. The ALLIANCE aims to promote its delivery within health and social care. We believe that through directing your own support and managing your own conditions, people who are disabled or living with long term conditions can live more independently and determine their own future. By working with the Scottish Government we will influence the direction of health and social care integration to advance the self-directed support agenda across Scotland.

About the ALLIANCE

<table>
<thead>
<tr>
<th>The ALLIANCE vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 600 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.</td>
</tr>
<tr>
<td>The ALLIANCE has three core aims; we seek to:</td>
</tr>
<tr>
<td>• Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.</td>
</tr>
<tr>
<td>• Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.</td>
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The ALLIANCE would like to thank all contributors to ‘The person, the whole person and nothing but the person’ for sharing their experiences and examples of joined up self-directed support in practice, and for their candidness in discussing the future of self-directed support in an integrated health and social care landscape.

Contact:

For more information please contact Colin Young, Senior Policy and Outcomes Officer (Self-Directed Support), the ALLIANCE by email colin.young@alliance-scotland.org.uk

Visit the Health and Social Care ALLIANCE Scotland website for more information: www.alliance-scotland.org.uk

July 2014
Appendix A

The Ethos of SDS in Health

20 June 2014

Allie Cherry
SDS Policy Team

The Scottish Government
Self-directed Support is...

- Outcomes focused
- Person centred
- Self-management = Social model of health
- Informed choice
- Co-production

Scotland’s national outcomes

- We have improved the life chances for children, young people and families at risk
- We have tackled the significant inequalities in Scottish society
- We live longer, healthier lives
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it
- Our public services are high quality, continually improving, efficient and responsive to local people’s needs
“Self-directed Support cannot be seen in isolation from integration and we cannot see integration as isolated from the person-centred strategy. It is all part of the same plan to improve the quality of service delivery.”

Alex Neil, Cabinet Secretary
| SDS & Integration | Jointly Funded Care Packages | Health Only Packages | SDS included in Statutory Guidance |

**The Scottish Government**

- **SDS in Health: What's in Scope?**
  - Which areas of health?
  - Delegation of healthcare interventions
  - Duty of care / Risk
  - Joint protocols & procedures
  - Identify & address barriers to SDS in health

**The Scottish Government**
Appendix B

Self Directed Support
Making it Happen in East Ayrshire

Lee McLaughlin  SDS Lead Officer
East Ayrshire Health & Social Care Partnership

What makes a good life for you?
Follow us  Twitter: @eacthinkdiff

SDS – Community Engagement

- 6 Everyone Together Learning events across East Ayrshire 2013/2014
- Attended by over 350 people who use health & social care services, family carers & Health & Social Care Practitioners.
- 2 Focused Events March / April 2014:
  - SDS in Addictions
  - SDS for Allied Health Professionals

Learning Themes

- What makes a good life for you?
- It's the little things that matter?
- The bottom line....
- Power and Control and Right Relationships
- SDS Pathway in East Ayrshire
Self Directed Support – Making it Happen

- Young people leaving care.
- Adults with drug/alcohol addiction
- Adults with health and/or social care needs (Linked to AHP’s)

Personal Outcomes  Individual Budget

Positive Impact in their lives
Capacity to Self Manage
Workforce Development
Transformational Change

Self Directed Support – Strategic Links

<table>
<thead>
<tr>
<th>AHP Delivery Plan 2012 -15</th>
<th>ADP Strategic Aim 2011-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Recognising the contribution that AHP’s can have on delivery of national policy.”</td>
<td></td>
</tr>
<tr>
<td>“Demonstrating the value of preventative approaches in enabling people to live well and for as long as possible in their own homes and communities”</td>
<td>“To ensure people with alcohol and drug problems have the capacity, with support from well targeted, integrated and informed services, to pursue more rewarding and enriched lives beyond their use of alcohol/drugs.”</td>
</tr>
</tbody>
</table>
SDS in East Ayrshire – Stories so Far

Maggie

What would you like to achieve?
- Spend more time in the garden
- Grow my own vegetables/flowers
- Have a nice garden - pride!

Goal/Outcome
- Maintain Recovery
- Time Out – Feel Relaxed
- Focus my mind – feel positive
- Self Management

£250
Option 1

How will you know it worked?
- Maintained Recovery
- Develop garden and my skills
- Share photos of my lovely garden
- Less reliant on addiction services

How will you do it?
- Purchase Green House
- Purchase plants and seeds
- Get stuck in...

SDS in East Ayrshire – Stories so Far

Angela
- Aged 37 years old
- Lives at home with her husband and 3 children (11, 8, 2)
- Discharged from hospital in 2013 following a stroke

• Regain her role as a mum/wife
• Focus on recovery
• Self Management
• To feel listened to
• To get back to work
• Confidence / Improved Mood
# SDS in East Ayrshire – Stories so Far
## Angela’s Support Plan

<table>
<thead>
<tr>
<th>Agreed Personal Outcomes</th>
<th>Support Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>promoting independence</td>
<td>Natural Supports from family and friends</td>
</tr>
<tr>
<td>feeling safe and secure</td>
<td>Driving Licence / Car</td>
</tr>
<tr>
<td>normal family life</td>
<td>Personal Resilience</td>
</tr>
<tr>
<td>regain control and identity</td>
<td>Personal Motivation</td>
</tr>
<tr>
<td>self management / recovery</td>
<td>Individual Budget</td>
</tr>
<tr>
<td>SHANARRI wellbeing indicators for children</td>
<td>Personal Assistant</td>
</tr>
</tbody>
</table>

> “Self Directed Support was the light at the end of the tunnel, as it allowed me to be mum again and bring my family back together where they belong”

## Organisational Learning

- People are the experts in their own life / shifting the power
- Risk Enablement – Self Management - Recovery
- Commitment and willingness to embrace SDS
- Less reliance on primary care / social care services
- Common values and vision
- Evaluation – Did We Get it Right – 5 must do with me

## Wider Outcomes

- Citizenship – Building Community Capacity
- Peer Support – Self Management
- Employment Opportunities
  - Community Brokerage Network
  - Everyone Together

## Processes/systems

- Finance
- Shift in resources required
- Health and Social Care Integration – Opportunity to Think Differently
The power of good quality conversations: co-creating personal outcomes for older people

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joates@brag.co.uk

The Challenge

• Health and social care systems are struggling to adapt to the changing patterns of demand placed on them.
• More people have complex multi-morbidities, combined with general frailty and cognitive decline.
• They are not well served by services providing episodic care, designed around individual disease pathways and focused on specific tasks.
• Instead, an emphasis on personal outcomes, quality relationships and co-creating solutions building on community assets is needed to support recovery, long-term care and end of life care.
The Response

To find ways for older people to not simply survive, but thrive at home. We did this by:

• Training staff to have personal outcome-based conversations with patients and their families using a validated method (Talking Points);
• Supporting staff to implement this approach in practice by peer-based action learning and instigating review visits;
• Diversifying the range of solutions available with a particular focus on small scale solutions that are safe, legal and sustainable;
• Working with regulators and statutory agencies and local commissioners to unpick bureaucratic hurdles and nurture small scale providers.
Staff feedback

- "The penny did drop. We usually write down the problems that someone has, and the goals will have been set with the person, we do start with what they would like to get back to, what's important to them, but then it is: right, here's what 'we' are going to do. That was quite sobering."

- "I think I practice in a very holistic person-centred way, but when I then look at our documentation, I couldn't hear the voice of the person. We have to share notes, and I first thought, well that is not what 'the system' prioritises. But it was more than that. I had made a lot of assumptions."
Staff Feedback

- “When working in the hospital, you just don’t think that way at all. It made me think outside the box. Before, I think I’ve always thought in terms of what people will be able to do, rather than who they’ll be able to be”.

- “It changes the relationship. I now put more of me into the conversation. I am a daughter, a wife, a friend, a mother. I just happen to work as an OT. People are now thanking me for listening and talking to them at a personal level and I am thanking them in return. It is a more enjoyable way of working, of relating to each other.”

An OT’s Perspective: The Subtle Side of Prevention

“I was working with one lady who had been in hospital. I was there to help her with kitchen tasks to ensure she was able to make herself something to eat and drink safely. And through conversation, boiling the kettle, making a cup of tea, she talked about her friends and their support while she’d been in hospital. Sitting safely in the kitchen drinking a cup of tea from a spill-safe beaker on her own really wasn’t what she wanted. She wanted to be able to make a pot of tea and serve it to her friends in her living room. She wanted to reciprocate. It was important for me to support that. We looked at how she would normally do things and together we worked our way through the various obstacles.”
Who are the Microproviders?

How we support them?

- Guidance Pack
- Bespoke training packages
- Peer Support Group
- One to One
- Work with the Care Inspectorate
- Link into Direct Payments (SDS) Team
- Quality Assurance – Award
- Community Consultation Events
- Small Grants Programme
Micro-providers

• A network of twenty-one small-scale providers (including 6 new start-ups) has been identified and supported

• Between them they are supporting over 700 older people on a weekly basis.

• All of these providers have gone through a Gateway Level, and one provider a Silver Level, Quality Mark.

The Micro Provider Perspective

‘I was referred a very elderly lady who had dementia and was told to ‘keep her ticking over until we can find her a place in long term care’. However, through conversation and taking an interest in the lady’s life, her self-esteem and confidence grew, she began to talk more about things she enjoyed doing and her anxiety about leaving the house reduced. The lady’s outcomes had therefore changed significantly: on a day to day basis they centred on finding meaningful things to do. In the longer term her wish to live at home had become a real possibility.'
Drawing upon the Community Capacity Building Projects, Local Co-ordinators and Micro-providers

- "I'd been speaking to one lady who was living at home with her husband in a fairly rural setting. It emerged, through the conversation, that she's really missing female company. Normally, I wouldn't have responded to that, well not beyond acknowledging it, not directly. But we had a chat about that and what sorts of things might interest her and the possibilities. I was aware that the befriending service is extending out to the villages in Fife (one of the new change fund projects) and that was of interest to her."

- "I was recently surprised to discover that one lady I was working with was feeling very socially isolated. She had downsized to a nice new flat, but found people in the development kept to themselves and she was lonely. I would not have opened up that sort of conversation before. But after some discussion about what she might like to do, I referred her to MyBus (one of the micro-providers being supported by SHINE). It was a little bit of extra work, but with big gains for her."

- "Through speaking to one lady about her life and interests, I found out that she was keen to volunteer. She had quite a good family support system, but it was important to her to give something back. I told her about the Local Area Co-ordinators and she was interested to hear what was available, so I referred her. She is now volunteering at one of the day centres and loving it. That took very little time. We are much more aware of the range of supports and possibilities, even if we don't know all the details, and having the co-ordinators there is great."

Integration with others

Lots of cross sector working and sharing of practice and learning with others at local and national levels including:

- Community sector and Local Area Co-ordinators
- Self-directed Support
- Providers Forum/Senscot/Co-production network
- Care Inspectorate
- Dementia co-ordinators and national pilot sites
- National person-centred collaborative
Discovery

• A different approach is needed to produce a different result
• These different conversations are the key to increasing wellbeing
• Professional expertise is still important – just deployed differently
• Re-motivates and energises staff
• This outcomes approach offers a route map to integration – for free
Appendix D
Personas – ‘The person, the whole person and nothing but the person’, 20 June 2014

Jean – Group 1
• Outcomes – living at home independently; getting out and about; involved in church council and local community.
• Falls prevention – volunteer classes in local village hall; trained volunteer with self-management/ home exercises.
• Hospital admission (prevention) – Red Cross 1st Responder/home alarm local responder (first line); front door at A&E/have appropriate assessment and community support (second line). Full assessment with immediate/acute need.
• Assess eyes (any treatment?), arthritis (any treatment/home/adaptation etc.). Improvement?
• Future planning – links within her social circle i.e. church. Lifts; admin support to sec.: seat in church identified e.g. chair with arms. iPad to enlarge print for hymns.
• Therapeutic input – right person, right place, right time. Built around the person, not the service following the person where they need it.
• Need national guidance around SDS.

Calum – Group 1
• The right conversation – “What do you want to achieve?”
• Family and Calum – what do they want to achieve?
• Conversation with one person Calum has chosen – highlighting his assets.
• Building on existing assets.
• Overnight care? Think more creatively. Could family offer this with support to do other tasks? Influenced by the conversation. Which are the bits you want us to deal with?
• Retaining control and independence.
• Breaking down barriers of eligibility criteria.
• Avoiding healthcare worker coming to do one bit and a social care worker coming into the house to do another bit. Negotiation and discussion within integrated teams. Avoiding two visits. Jointly agreed and integrated packages – PRAG. ‘Who chips in what’.
• Drawing on a combined resource.
• Self-management resources offered.
• Equipment and health economics assessment of staff involvement. Equipment and adaptions bought by integrated team.
• Advice from across health and social work. No one person has the money. Bringing people in at the right moment.
• Post-support being put in place. Assessing the outcome against the goals in the conversation early on.

Dominic – Group 1
• What matters to me?
• Values.
• Integrated team would engage Dominic, his family and friends in conversation.
• Conversation about whole person, preferred solutions for Dominic including risk enablement.
What would good outcomes be for Dominic?
- Less hospital admissions.
- Hospital admissions when required – “What matters to me?” Improved patient experience.
- Sustainable, rewarding employment.
- Telehealth, telecare.
- Meaningful friendships and family support.
- Awareness of relevant legislation e.g. reasonable adjustments at work to support employment.

Jean – Group 2
- We would have a conversation with Jean.
- Natural supports – assets; friends, family, community.
- The little things that matter to Jean.
- Clarify – Jean’s personal outcomes; Jean’s perspectives about what next; provide information.

Calum – Group 2
- Single point of contact – trusted person to coordinate needs and wishes of Calum and family.
- Young carers for son/carers support for wife.
- What does Calum want?
- What are overnight support needs? How can this be delivered? Family? Equipment? Social care/health professionals?
- Employer support – reasonable adjustments.
- Community facilities/projects.
- Financial impact – contribution to care; loss of income; benefits.
- Advocacy.
- Explanation of SDS options.
Dominic – Group 2
- Start by listening to the person and respecting his expressed wishes.
- Work through with him potential solutions that would maintain his dignity and independence as a young man.
- Could nebuliser support be provided by a non-hospital person if trained specifically to do this?
- Could nebuliser be available at home?
- Alternative provider paid through a personal budget or part of what existing support workers can do.
- Retainer payment for emergency support.

Jean – Group 3
- Talk to Jean about what matters to her.
- What she values in her network of community assets now?
- What she would like for the future.
- Check that pathways of care focus on Jean.
- Explore options for care and introduce SDS into conversation.
- Organise multidisciplinary team meeting with Jean to explore how her personal outcomes could be achieved.
- Support Jean to decide if she wishes to coordinate her own care or nominate someone else to do that with her.
- Partnerships should support and enable staff to have these personal outcomes-focused discussions with people using services.