REPORT OF THE JOINT FUTURE GROUP

Contents

November 2000

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JOINT FUTURE GROUP

CHAPTER 1

INTRODUCTION

1.1 Susan˚Deacon, Minister for Health and Community Care, set up the Joint Future Group (JFG) chaired by Iain˚Gray, Deputy Minister for Community Care, to:

- agree a list of joint measures which agencies need to have in place to deliver effective services, and to set deadlines for that;
- advise on the balance between residential and home based care;
- advise on options for charging for care at home; and
- advise on how to identify and share good practice.

The Group s remit is set out in full in Appendix˚2.

1.2 Modernising Community Care: An Action Plan[1] had set the agenda, not only for joint working but also the organisation and delivery of services within agencies. It had sought specifically:

- quicker and better decision-making, through delegated decision-making and financial responsibility;
- more flexible and better quality home care services, including a shift in the balance of care towards these services; and
- agencies working in partnership in localities, through better operational and strategic planning, joint budgets, joint services and joint systems.

Context

1.3 When the Scottish Executive came into being in May 1999 it was clear that the principles of Modernising Community Care were accepted, but progress on the ground was mixed. As is the case today, there were many examples of good practice in pockets, pilots or projects. But the

[1] Scottish Office, (1998) *Modernising Community Care – An Action Plan*

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positive outcomes, especially as a result of joint working, were not available consistently. At the seminar of leaders of councils, health boards and NHS trusts in November 1999, Ministers made clear that they were not seeking structural change, but that the status quo — in terms of joint working — would not do. A new lead was needed. The Joint Future Group was charged with providing that lead.

1.4 At the same time the expected shift in the balance of care for older people towards more care at home, first expressed in Caring for People[2] and subsequently reaffirmed in Modernising Community Care, has not materialised. Indeed, it could be said that the balance has got worse. A number of factors have combined to undermine this long -standing policy objective, as discussed more fully in Chapter 3.

1.5 Community care is now far more organised than prior to 1993. But as the origins of the Group suggest, there is a long way to go if people across Scotland are to receive consistently high standards of care which match their rising expectations. We recognise that many areas of Scotland have made considerable progress, and our approach reflects that. The task for the future is to ensure that these higher standards are achieved more uniformly.

Policy Context

1.6 Community care does not stand still. The policies introduced in 1993 have been updated, expanded and refined as community care as a whole develops and improves. Modernising Community Care (together with its companion The Housing Contribution)[3] remains the cornerstone of how we want agencies to work together. But there are also major new policies, which need to be read alongside it. The Framework for Mental Health Services in Scotland, the Learning Disability Review and the Carer s Strategy all advance significantly the way people should be supported both within and between agencies. And the development of national standards will define what users should expect from services, and influence outcomes. We have had regard to that changing agenda as we went about our work.

1.7 Planning and financial systems are also changing. Community planning offers an opportunity for comprehensive area-based planning, and to rationalise the range of plans currently produced. More generally,

[2] Department of Health et al, (1989) *Caring for People – Community Care in the next Decade and Beyond.*
[3] Scottish Office, (1999) *Modernising Community Care – The Housing Contribution.*

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the Scottish Executive s 21st° Century Government Agenda will focus much more on outcomes, on which development work is currently being progressed through pilot studies.

1.8 Best Value, which aims to secure sound governance and continuous improvement in the way agencies perform, both individually and together, is also part of the context. So too is the thinking emerging from the Strategic Issues Working Group of a new resourcing framework for local government, focusing more on the relationship between new resources and outcomes, and measures to gauge performance.

The Joint Future Group s Role

1.9 Our task was specific. It was not to develop new policy, but to identify ways of making existing policies work better. The task was short-term and focused, and principally about statutory agencies working better together. That does not diminish the roles of or the need for joint working with the voluntary or private sectors or, indeed, people who use services and their carers.

1.10 The seminar in November° 1999 underlined that responsibility for the success of community care is shared. It rests with local authorities, usually through their social work and housing departments, with health boards and NHS trusts, and with Scottish Homes. The interfaces between parts of the system - for example between acute hospital services for older people and services in the community - are often critical.

1.11 We have drawn up an action plan, mostly for the short to medium term, with timescales for implementation. In accordance with our remit, some measures relate only to services for older people; some are based on older people but extend equally to other care groups; and finally those on joint working apply across the board. We aim to make these distinctions clear in this report.

1.12 Our recommendations will deliver a step change. We have identified a challenging but fair agenda. Many of our proposals are not new: they already exist in parts of Scotland. More importantly, they have been proven to work. That is one of the strengths of our work. The measures should make a real difference to people who use services. People now deserve access to the essential services we recommend to see for themselves the benefit of joint management of services, more focused assessments, and better organised equipment services.

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1.13 We believe the climate is right to offer a strong lead on some of the most important aspects of community care. We now want agencies to grasp the opportunity to make real progress, not based on theory but on sound, effective approaches that will make a real difference.

1.14 Our membership was drawn from a range of backgrounds. But in building for the future we concentrated on what is best for community care. We achieved broad consensus on our chosen way forward and presented our findings accordingly to the consultation seminars towards the end of September.

1.15 We note that the Minister for Health and Community Care s statement on older people on 5˚October included the Executive s intention to implement a number of the Group s recommendations, as follows:

- more intensive care at home;
- rapid response teams in every local authority area;
- free home care for the first 4˚weeks after discharge from hospital;
- a shopping/home maintenance service in every area;
- more short breaks;
- joint resourcing and joint service management of services for older people.

The statement also indicated that the Executive would provide new resources to support change.

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CHAPTER 2

RECOMMENDATIONS AND TIMETABLE FOR IMPLEMENTATION

REBALANCING CARE OF OLDER PEOPLE

Intensive Support and Care Schemes

2.1 Every local authority area should have in place a comprehensive, joint hospital discharge/rapid response team, by mid 2001-02.

3.15

Intensive Home Support/Augmented Care Schemes

2.2 Every local authority area should have in place a comprehensive, joint intensive home support team, by mid 2001-02.

3.18

Short Breaks

2.3 Each year, agencies should provide both more short breaks (to reduce the number of carers providing most care, without a break), and more breaks at home.

3.22

Practical Shopping/Domestic/Household Maintenance Service

2.4 Every local authority should identify the need for a practical shopping/domestic/household service, and arrange it comprehensively, by mid 2001/02.

3.27

A Service Development Centre for Older People

2.5 The Executive should, in 2001, set up an older people s service development centre to champion the development of good and innovative community care services, promote training and assist implementation of the Group s proposals.

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IMPROVING JOINT WORKING

Single Assessments

2.6 Agencies locally should have in place single, shared assessment procedures for older people and for those with dementia by October 2001, and for all client groups by April˚2002.

4.12

2.7 Agencies locally should have in place by October 2001, a single shared assessment tool for older people and people with dementia. Local agencies should either adapt existing systems or develop systems to achieve the outcomes specified in the report, or adopt Carenap D &˚ E .

4.12

Intensive Care Management

2.8 The Scottish Executive should redefine care management as Intensive Care Management , which will be for people with complex or frequently changing needs.

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2.9 Care managers should be trained in Intensive Care Management throughout 2001-2002. Only those who have undertaken such training should carry out Intensive Care Management .

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Information Sharing

2.10 The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration.

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2.11 Locally, the arrangements for single shared assessments should include specific proposals for the necessary sharing of information between agencies, by obtaining explicit client approval.

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Equipment and Adaptations

2.12 To modernise and improve equipment and adaptation services, the Scottish Executive should establish a strategic overview, and set out a programme of change that will require agencies locally to integrate equipment and adaptation services with the rest of community care services, and put in place a number of specific measures that will result in a better-focused and more effective service for the user.

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Occupational Therapy Services

2.13 To target occupational therapy services more effectively, agencies need to modernise equipment and adaptation services, and to remove duplication between hospital and community based occupational therapy services wherever practical. For community care services that reoganisation needs to begin as soon as possible, followed by the rest of health and social care within the context of the wider agenda for joined up health, housing and social care services.

4.51

PLANNING, FINANCIAL AND SERVICE MANAGEMENT FRAMEWORKS

National Planning and Financial Framework

2.14 The Scottish Executive should set up a programme planning and financial framework, beginning with services for older people in 2001.

5.15

Joint Resourcing and Joint Service Management Locally

2.15 Local authorities (that is social work and housing), health boards, NHS trusts and Scottish Homes should draw up local partnership agreements, including a clear programme for local joint resourcing and joint management of community care services collectively or for each care user group individually.

5.15

2.16 As a step towards that, and recognising current progress on the ground, every area should introduce joint resourcing and joint management of services for older people from April 2002, and in

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preparation for that introduce shadow arrangements in the course of 2001-02.

5.15

CHARGING

2.17 COSLA should develop guidance on charging policies to reduce the inconsistencies in home care charging.

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2.18 The Scottish Executive should consider introducing:

- free home care for up to 4 weeks for older people leaving hospital

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- free home care for older people receiving extended home care , (though they would still pay for ordinary services)

7.19

GOOD PRACTICE

2.19 The Scottish Executive should, by mid˚2001-02, identify measures to improve the collection and dissemination of good practice by linking together the bodies in the field in a more cohesive structure, using the benefits of networking and information technology.

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CHAPTER 3

REBALANCING CARE FOR OLDER PEOPLE

Context

3.1 All the evidence points to most older people wanting care at home whenever possible. That is what the research says; that is what older people continue to tell us; that is what the policy aims for; and that is what agencies say they are aiming to do. One of the issues therefore is to understand better the paradox of that strong commitment, both nationally and locally, towards home based care and the patterns of expenditure and services, which seem to move in the opposite direction.

3.2 Between 1994 and 1999:

- Long-stay geriatric beds decreased by 2,500 (33%);
- Nursing home places increased by 5,000 (34%);
- Residential home places decreased by 1,200 (11%);
- LA home care clients reduced by 15,000˚(17%), partly on redefining the role of the home help service; but staff increased by 1,300 (13%), meaning more people got intensive packages of care;
- Older people seen at home by community nurses rose by 8,000 (3%), but the number of home visits fluctuated and eventually reduced at a time when 100,000˚more older people were discharged from acute hospitals; and
- Local authorities expenditure on home care services rose by £7m, but that on residential and nursing home care increased by £65m (both 1995-99).

3.3 A number of factors influenced these outcomes. Reducing the number of long-stay hospital places dominated the agenda. But the emphasis was much more on using services such as nursing homes which were readily available in increasing numbers, rather than on providing care at home. And the DSS transfer, despite its intention of assisting the balance of care, tended to perpetuate existing patterns. Partly that may have been affected by increases in demographic pressures and life expectancy, resulting in lower than expected turnover

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of existing residents. Community care as a whole was also under financial pressure — sometimes as a direct consequence of shifts in the balance of care - and often needed firmer and more focused leadership, both nationally and locally. Finally, home care services have taken time to become more flexible and respond to the challenge.

3.4 In practical terms there is also the eternal bridging question: how to place people appropriately in residential care or nursing homes, and at the same time develop better and more flexible home care services, with due regard to Best Value.

3.5 These factors alone do not explain the imbalance between policy aspirations and reality, but they clearly influenced the outcome. Evidence is now emerging through SCRUGS[4] of a significant number — perhaps as many as one in five - of residents in nursing homes capable of being looked after at home with appropriate support. There is also evidence that interventions from occupational therapists can sustain people at home, who otherwise would be in residential care.

3.6 There are also many positives. Although the alternative to hospital care was not home care, the significant reduction in inpatient beds for older people is one part (from hospital to community services) of the balance of care shift. And there is considerable innovation in both services and in partnership working. But much of this good work is found in pockets, in pilots or in projects. The resulting impression is of agencies ability to innovate, but an inability to convert that innovation into mainstream services. To see where the future should lie, we do not need to re-invent the wheel . There are already many innovative and effective approaches; but they need to be applied more generally. Using what works well is fundamental to our proposals. We want to raise the standard to that of the best.

The Way Forward

3.7 It was not appropriate for us to draw up the ideal balance of care. That should be a matter for local determination within the broad policy framework which already exists. Rather, we identified 2˚complementary, practical approaches to support rebalancing services for older people:

- key services which must be in place to support people properly at home; and

[4] Scottish Care Resource Utilisation Group

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- new national and local financial, planning and service management frameworks.

3.8 These frameworks are, however, about much more than rebalancing care for older people. They are also part of the new joint working agenda. To include them in a chapter about one or the other would be inappropriate. Our proposals are therefore set out separately in Chapter˚5.

Key Services to Look After Older People at Home

3.9 To achieve the desired rebalancing of care, home care services need to be integrated, robust and focused on sustaining people at home. Home care services have to change to achieve that. This is not just about social care and health services. Housing s expertise operationally and strategically also has a part to play.

3.10 Change is also required in service priorities and ways of working. There is scope, for example, for discharge arrangements to be better co-ordinated; and rehabilitation services developed to support actively people s independence and inclusion, as opposed to reacting to changes in their circumstances. This calls for a more concerted approach, with more multi-disciplinary inputs, including from occupational therapy.

3.11 Older people need access to a range of services — a continuum of care - if they are to be properly supported at home. We were particularly conscious of critical gaps, and identified 3˚key services to which every older person who needs them should have access. They are:

- intensive support and care schemes;

- more flexible and comprehensive short break services; and

- a practical, low level shopping/domestic/household maintenance service.

What characteristics of these services do we value?

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Intensive Support and Care Schemes

3.12 We recognise the need for two types of scheme:

- hospital discharge/rapid response teams; and
- intensive home support/augmented care schemes.

3.13 Hospital discharge/rapid response teams support early or timely discharge from hospital or prevent inappropriate admissions by providing short periods of intensive home-based support. Teams need to be multi-disciplinary, comprising a mix of health and social care and, where appropriate, housing professionals, have devolved budgets and clear service goals. Some schemes can also be ward or condition-specific, and some divert older people who present at accident and emergency departments. That broad effect makes joint resourcing a prerequisite.

City of Aberdeen Rapid Response Team

The key characteristics of the scheme are that care is short-term and intensive, available quickly (within 24˚hours), and the service is time limited (max of 14˚days). It has a dedicated joint budget (via the Council, the Primary Care and Acute NHS Trusts) to purchase services (including access to independent home care providers), or simple equipment and adaptations and install them quickly.

The team comprises a social worker/care manager, dedicated home carer/access to independent providers, home care organiser, district nurse, physiotherapist, occupational therapists, and an occupational therapy technician/assistant.

The majority of users are supported successfully within the scheme s planned timescale. It handles about 60˚cases a month, 80% of whom are supported for less than two weeks and sometimes for as little as one day. 40% of interventions enabled early discharge, and about 17% prevented admissions in the first place. The scheme supports people successfully and cost-effectively across the spectrum of care, including interaction with the acute sector.

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3.14 The key factors which makes these schemes successful are:

- the speed of response to referrals;
- joint resourcing;
- dedicated and flexible resources; and
- the multi-disciplinary team providing co-ordinated, targeted care and support.

3.15 **We recommend**:

> **Every local authority area should have in place a comprehensive, joint hospital discharge/rapid response team, by mid 2001-02.**

Intensive Home Support/Augmented Care Scheme

3.16 In contrast, these schemes provide longer-term support for people becoming frailer to enable them to return to or remain at home, rather than enter long-term residential or nursing home care. These schemes provide personal care of a higher level of intensity and need, more flexibly and for longer periods of the day than mainstream services. They also provide support for informal carers, usually spouses.

3.17 The key factors which makes these schemes successful are the skilled response from a multi-disciplinary team, the flexible and intensive care, and a positive relationship with users.

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Augmented Care at Home (South Ayrshire)

Augmented Care at Home is a joint scheme run by the Health Board and the Council to provide intensive and flexible home care services for, mostly, physically frail older people. It aims to maintain them in their own home; enhance their quality of life; support carers; co-ordinate care delivery; and inform the future development of home care services.

Care is provided by a team of trained home care support workers who carry out any task that a caring relative might perform. These teams work: the evaluation identified the importance of the closely managed team, the flexibility of the service offered, the satisfaction of users and the good relationships formed between home care support workers and users.

Similar schemes have also been developed in Falkirk, North Ayrshire, North Lanarkshire and West Dunbartonshire.

3.18 **We recommend that**:

Every local authority area should have in place a comprehensive, joint intensive home support team, by mid 2001-02.

Short Breaks

3.19 Previously known as respite services, we recognise firstly the continuing levels of unmet need. Of an estimated 150,000˚carers who provide more than 20˚hours a week of care, half have not had a break for more than two days since beginning to care. We also need more effective and personalised short break services — at home - to widen choice as part of a continuum of care. Improving these services is already part of the National Carers Strategy, the Learning Disability Review and the Social Justice Report. And almost every policy or strategy document locally recognises that short break services do not meet needs, and are probably not sufficiently flexible or focused. A particular problem is responding effectively to emergencies. Much of the current service is directed to carers rather than users needs. The term short breaks , however, applies to both.

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3.20 Short breaks should provide choice: of location (either at home or in other settings), and of frequency and duration (weekends or evenings, or in more substantial blocks). To be effective, certain key elements need to be in place. Resources need to be dedicated to short break supports and not to any specific provider, such as a residential care or nursing home. Though emphasising breaks at home, we recognise that some people want or perhaps need a break in a different setting, such as a residential care or nursing home. Users themselves and their carers are often best placed to advise agencies on the criteria for short-break services.

3.21 We cannot realistically resolve these problems overnight. Agencies need therefore to increase incrementally both the level of short break services and the proportion of short breaks available at home. The Group s thinking, though founded in older people, is translatable across all care groups, and should be interpreted as such.

Share Project (South Lanarkshire)

The Share Project provides a supportive, caring, flexible respite service within the community for older people, older people with dementia and their carers. The service can support individuals either in their own homes or in the homes of registered family-based carers.

The registered carers offer blocks of time from two to five hours, in mornings, afternoons or evenings. Where appropriate, overnight services are also available. This initiative provides an alternative short break service within the community and offers older people and their carers a positive choice.

3.22 **We recommend**:

Each year, agencies should provide both more short breaks (to reduce the number of carers providing most care, without a break), and more breaks at home.

A Practical Shopping/Domestic/Household Maintenance Service

3.23 A number of studies point to many older people and disabled people being unable to do key daily living activities without assistance. For those living alone or without close natural support this is a particular issue. Alongside that, in some areas of Scotland older people not

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requiring personal care cannot get assistance with meal preparation, shopping, cleaning or other tasks. These are not daily needs, but are usually intermittent.

3.24 To address these needs we want local authorities to arrange a low intensity, practical shopping/domestic/household maintenance service. It can help older people retain their independence at home and prevent further deterioration; ensure they live in a healthy and safe environment; and reduce potential exclusion. (The service may operate alongside the low intensity advice and support which help people sustain tenancies, funded at present through Housing Benefit and from 2003 under Supporting People [5]).

3.25 This service can be provided in a more structured way than under the former home help service. We envisage a new style service with a focused approach, separate from personal care services, and which could be provided by local authorities but more likely through the local voluntary or independent sectors. This is the kind of service we think authorities should charge for. Some places already have these types of service. Again, the issue is making them available consistently across Scotland.

3.26 Changing times offer changing solutions. We live in an electronic age, and agencies need to look at the role of, for example, home delivery of food stuffs, telephone ordering services and, indeed, the Internet.

Skye and Lochalsh Handyperson Project

Skye and Lochalsh Community Care Forum s Handyperson Project carries out small repairs/tasks for older/disabled people, and also offers advice and information. The project provides semi-skilled assistance and general help which users otherwise find very difficult to access. Dealing effectively with small tasks (such as hanging curtains, changing light bulbs, doorbells, re-routing and extending telephone points, fixing taps) greatly increase comfort and independence.

[5] *DSS (1998) Supporting People: - A Policy and funding Framework for Housing Support*

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3.27 **We recommend**:

Every local authority should identify the need for a practical shopping/domestic/household service, and arrange it comprehensively, by mid 2001/02.

A Service Development Centre for Older People

3.28 We recognise that there is a huge change agenda surrounding older people. It is not just about rebalancing care and improving joint working in areas that affect them, but also in recognising the contribution that older people can make more generally. We considered at length whether or not a dedicated centre should lead and support change, to ensure that older people can in future access better quality services more consistently. On balance, we concluded that a centre was necessary, which our consultation seminars broadly supported.

3.29 A centre for older people s services would be a focal point for change management, not just for rebalancing care but also more widely, and for advice to those at the coal face . It would provide a lead on:

- winning the hearts and minds for the change agenda and for its implementation;

- supporting the change agenda by identifying champions and enabling them to support and encourage others, and sharing good practice generally;

- addressing quality co-ordination, by helping develop good and consistent quality services;

- promoting older people s involvement in service planning and delivery;

- supporting the organisational and cultural changes facing staff in a number of agencies;

- developing multi-disciplinary and advanced training for care managers and other professionals across the care spectrum.

- broader issues such as the application of Better Government for Older People ;

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3.30 The centre would also become a source of expert advice on service and organisational issues, on good practice and on research and information on older people. It would also have a role in ensuring quality services are in place in hospitals, in the community and in people s homes by working alongside those responsible for standards and monitoring.

3.31 Without in any sense making direct comparisons, such a centre would perform a similar function to the Scottish Dementia Services Development Centre, the Scottish Development Centre for Mental Health and the proposed Centre for Learning Disabilities. Indeed one of its tasks would be to address interrelated questions with these other sources of expertise.

3.32 Most people recognise the need for a centre; but some are concerned that resources which could be applied to services would be tied up in infrastructure costs. We do not see this as a new structure per˚se. It could be attached to an existing facility or facilities — almost virtual in its physical presence, but far from it in effect. Costs should not therefore be significant, but the value substantial.

3.33 **We therefore recommend:**

> **The Scottish Executive should, in 2001, set up an older people's service development centre to champion the development of good and innovative community care services, promote training and assist implementation of the Group's proposals.**

Summary

3.34 Older people have not been able to access the services they need to support them at home. We address that. Our proposals to rebalance care for older people require more services focused on care at home. The Framework for Mental Health Services and The same as you? do the same for people with mental health problems and learning disabilities respectively.

3.35 Our approach to rebalancing care for older people focuses on putting in place within set timescales 3˚key services. Investment in these services — which are flexible, responsive and joint - will strengthen agencies ability, together, to care properly for older people in their own homes. To underpin these measures, we recommend new planning/

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management systems focusing initially on older people, as set out in Chapter˚5. The new national planning and financial framework will identify the collective new resources available for improving services for older people, and set priorities for action locally. And local joint resourcing and joint management of services will improve the way services are organised and delivered on the ground.

3.36 In making these recommendations, we recognise that one size does not fit all. Every area must put in place each service we recommend. But agencies locally will decide for themselves how to organise any particular service to suit their own circumstances. In particular, while urban areas may use the opportunity to employ more specialised staffing, rural areas may look for more multi-skilling and multi-tasking.

3.37 The key services we have identified are already in place in some areas, and have been proven to make a difference. They now need to be available across Scotland, and everyone who needs them should have access to them. The task facing all agencies is to reconfigure their services locally to focus on sustaining people at home. This may not be easy, but some have risen to that challenge and are already doing so successfully. Our combination of measures will enable many more people than at present to be cared for at home — properly and appropriately - and thereby reverse the trend since the community care policy came into being. That is what older people in Scotland want.

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CHAPTER 4

JOINT WORKING

4.1 Despite the continuing emphasis on and improvement in joint working since the community care policy was fully implemented in 1993 there remains, as indicated in Chapter˚1, a long way to go. We want to use the positive developments in many parts of Scotland to overcome instances of resources not being used to the best effect, of systems and services not delivering for either users or agencies, and of professional skills not being properly utilised. We want to raise standards and achieve greater consistency.

4.2 Many of our proposals for rebalancing care will also improve joint working. Our task on joint working was to identify a set of measures which must be implemented. We may have wanted to do that across the whole of community care but in practice focused on a few key areas where better joint working will make a real difference. The 3˚areas are:

- assessment and care management;
- sharing information; and
- equipment and adaptation services.

4.3 They are all at the heart of community care. Assessment and care management and sharing information are key processes which can contribute to effective outcomes. Equipment and adaptation services need modernisation. They have a large user base and a significant effect, but are often marginalised, fragmented or disjointed. Each will be more effective if more joined up.

4.4 Our approach to improving joint working — across all care groups - restores the person to the centre, and uses proven systems and practices, against a backdrop of joint resourcing and joint management of services as set out in Chapter˚5.

Assessment and Care Management

A Single, Shared Assessment

4.5 There is widespread acknowledgement that assessment arrangements need to improve. Too often people are visited by several different

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professionals and require to repeat the same basic personal information. And because individual agencies do not accept others assessments the whole process is often repeated. The experience in Perth & Kinross, as described in the Patients Journey , of 37˚steps in the assessment of an older couple - with the health and social care professionals meeting first at step 25 - illustrates the need to do better. Assessment has to focus on the needs of the person and should be organised to do this efficiently˚- not to suit professionals or agencies.

4.6 There is also scope to make fuller use of self-assessment for lesser needs, as suggested in Modernising Community Care. Thinking needs to be more about how best to get effective outcomes for people, not about how to get them into systems (sometimes unnecessarily and with limited effect). Reducing unnecessary bureaucracy allows scarce resources to focus on those cases with greatest needs.

4.7 We aim to reduce that bureaucracy and duplication in assessments. We propose that there should be a *single,* shared assessment. For complex cases**,** different professionals with special expertise need to contribute (either from a multi-agency team or from a more specialist background). Housing professionals have an important part to play too, especially where housing is an issue. And through local protocols and training, the outcome of the assessment must be accepted by fellow professionals, irrespective of the lead professional. Responsibility for the assessment and ownership of the outcome will therefore be shared.

4.8 We expect single, shared assessments:

- to promote a structured exchange between the user and the assessor about perceived needs, including where relevant the views of informal carers. A separate assessment of the carer s needs should also be offered.

- to be undertaken by **one member** of the multi-agency team (the most appropriate lead professional), drawing on contributions from other members of the team as necessary. Contact with the service user for assessment purposes should be through the lead professional. If the assessment points to the need for specialist opinion, this should be sought, building on the basic information already collected.

- to be a passport to the full spectrum of community care services, with no subsequent reassessment necessary unless needs change.

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- to include a financial assessment completed by the assessor (which recognises this being an integral part of the assessment).

- to be available to the person, and with their consent the main informal carer, together with the agreed care plan to meet their needs.

4.9 The single, shared assessment creates a single gateway or point of entry to the multi-agency team and community care services. It also presents a logical opportunity to seek the explicit consent of the person being assessed to sharing of information between agencies to help them respond holistically and efficiently to need.

4.10 Effective assessments have to be underpinned by an effective assessment tool. Some agencies have or are developing single, shared assessment tools. Further work may, however, be needed to meet our objectives.

4.11 We reviewed the Care Needs Assessment Packages (Carenap) for Dementia (D) and the Elderly (E) and their associated databases. We believe that these tools offer significant promise and with some refinement would meet our vision of a single, shared assessment tool. We understand that the Scottish Executive aims to support that refinement in partnership with the developers, and also enable more systems integration between primary care and local authorities.

Carenap E Pilot (Govan)

Carenap E was developed to reduce duplication of core assessment details. The tool has now been used in more than 460˚assessments of older people, and has proved highly reliable. Assessors have begun to access services across professional boundaries using Carenap E as a form of service passport . In general, assessments have been well accepted by service providers. The level of reassessment by other professionals has reduced, as has duplication. These are the outcomes users want. Because Carenap E focuses on need (met and unmet) it also brings direct benefit to service planning and provision.

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4.12 **We recommend that:**

Agencies locally should have in place single, shared assessment procedures for older people and for those with dementia by October 2001, and for all client groups by April 2002.

Agencies locally should have in place by October 2001, a single shared assessment tool for older people and people with dementia. Local agencies should either adapt existing systems or develop systems to achieve the outcomes specified in the report, or adopt Carenap 'D' and 'E'.

4.13 Our proposals will change markedly both the role of professionals and their participation in assessments. Two steps seem essential - firstly, through joint protocols agencies need to secure agreement locally on the systems for and ownership of assessments; and secondly, to train staff jointly in assessment practice. Putting these in place has to be an early priority.

Intensive Care Management

4.14 Care management was introduced in 1992, but has not developed uniformly. Like many parts of community care, it lacks consistency. It is not always clear who should receive care management; its meaning is interpreted differently; and while in some areas only social workers carry out care management tasks, in others a range of professionals are care managers. A recent conference referred to over 600˚models of care management in the United Kingdom.

4.15 There is a need to refocus care management so that it is clear:

- what needs require care management;
- what tasks are involved;
- who carries it out; and
- what skills and knowledge care managers need.

4.16 Our first step is to change the title to reflect its purpose. For the purposes of this report, we suggest Intensive Care Management . The

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second is to define its scope. It is for people with complex needs, or frequently or rapidly changing needs.

4.17 Most referrals for community care services can be dealt with by the provision of a straightforward service immediately, or following a brief assessment. To help, a number of screening tools are available (as set out in the 1998 circular[6]). For more complex cases, intensive care management will co-ordinate and deliver services in a way that is tailored to meet these people s needs.

4.18 The care manager can be a social worker, community nurse, occupational therapist or other similar professional. In integrated services, professionals lose their label and assume a more corporate role. The key qualities are their skill to judge the person s and any carer s needs, the knowledge and skill to secure and co-ordinate the full range of services, the skill to assess and manage inter-personal relationships between the person cared for and the carer; and the ability to manage a devolved budget. Research shows that better results emerge where care managers have devolved budgets - ultimately to individual professionals - and access to a wide range of resources from different services. Care managers need that flexibility if they are to respond to individual circumstances. Concerns about resource management and control of devolved budgets need to be addressed through systems development and training, rather than inhibiting the scope of care managers.

4.19 Local authorities and the health service must provide the organisational framework to support effective care management. We expect care managers to work in a climate of multi-disciplinary, multi-agency teams with joint resources, shared objectives and agreed priorities. Care management also needs to be more user-led; greater use of direct payments could, for example, be one of the results.

4.20 As a consequence of these changes, we envisage individual care managers being responsible for the long-term support of up to 40-45˚people at any one time. Broadly speaking, this model of intensive care management parallels that developed in Kent[7], which has been evaluated extensively and proven to be successful.

[6] Circular SW 10/98: Community Care Needs of Frail Older People.
[7] *PSSRU (1992) Care in the Community: Challenge and Demonstration.*

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4.21 Some people attending the seminars were concerned that the emphasis on care at home could result in very expensive care packages for older people, and suggested that there should be some form of cost limit. That is clearly not within our remit. But it is a matter for individual authorities to consider.

4.22 To redefine and reinvigorate care management, staff from different agencies will need training. We propose a new initiative to strengthen and develop the skills and knowledge of care managers - on a joint basis. It would be aimed at post-qualifying level, but the underlying concept also needs to be part of qualifying training across the respective professional groups. The outcome would be that only suitably qualified persons would act as intensive care managers.

4.23 **We therefore recommend:**

The Scottish Executive should redefine care management as 'Intensive Care Management' which will be for people with complex or frequently changing needs.

Care managers should be trained in 'Intensive Care Management' throughout 2001-2002. Only those who had undertaken such training should carry out 'Intensive Care Management'.

Information Sharing

4.24 We want to see our thinking on the joint management of services, more joined up assessments, etc. underpinned by a culture of information sharing which, in turn, seizes the opportunities for information systems integration. But we also need to reassure service users that personal information will be treated sensitively and stored securely in accordance with the law.

4.25 To support person-centred services, we need person-centred information systems. They need to extend beyond the starting point of sharing information between mainly statutory agencies in social care and health, to include housing, education, the voluntary sector and the Benefits Agency. That is the intention of e-government generally.

4.26 These issues are heavily influenced at the moment by action nationally. Firstly, the NHS Programme Information Management & Technology Board will take the lead in developing a strategic overview

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on how modern technologies can support community care services. It will report by October 2001.

4.27 Secondly, the Confidentiality and Security Advisory Group for Scotland (CSAGS) will take the lead in specifying the principles for information sharing to be incorporated in agencies local protocols, to meet the requirements of the Data Protection Act (1998). It will report by April 2001.

4.28 Thirdly, the Social Work Information Review Group (SWIRG) will take the lead in identifying the information needs for community care, and its exchange. It expects to report by mid-2002.

4.29 In its short life, the Joint Future Group has been successful in ensuring that the separate health and social work information developments under the Programme Board and SWIRG respectively now cut across the wider community care information spectrum and take account of e-government s focus on the citizen, not agencies.

4.30 At a local level, while the developments above will bring their influence to bear in due course, enabling the transfer of information about a user by obtaining their consent must be an integral part of the assessment tool described earlier in this Chapter. This approach can indeed be implemented now, through specific agreement with the user.

Personal Record of Care (East Ayrshire)

To address apparent overlaps in the care of people with complex needs, a multi-disciplinary group developed a protocol to clarify agency/professional roles. As a result, multi-disciplinary care planning was consolidated in the user s personal record of care. The record is held in the user s home, as a communication tool for professionals, and clients and their carers. The record is therefore the common bond and commonly owned. The arrangement is supported by joint training and clear guidance on when and how to use the record.

4.31 **We therefore recommend:**

The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration.

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Locally, the arrangements for single, shared assessments should include specific proposals for the necessary sharing of information between agencies, by obtaining explicit client approval.

Equipment and Adaptation Services

4.32 Equipment and adaptation services can make a very positive impact if they are organised and managed effectively. Demand in this area represents 25-45% of all referrals to social work departments, and adaptations are also a significant part of the work of housing agencies. We benefited from a detailed analysis of the problems facing equipment and adaptation services and their users. Our generic recommendation below is underpinned by a series of specific measures to achieve the desired outcomes. Our starting point was obviously joint working but our interest spread to related issues such as the role of occupational therapists who currently carry out most of the work in this area.

4.33 **We recommend:**

To modernise and improve equipment and adaptation services, the Scottish Executive should establish a strategic overview, and set out a programme of change that will require agencies locally to integrate equipment and adaptation services with the rest of community care services, and put in place a number of specific measures that will result in a better-focused and more effective service for the user.

Strategic Direction

4.34 To give equipment and adaptation services a much needed sense of direction we believe it is necessary to set up a national Strategy Forum — not necessarily a permanent feature — to be led by the Scottish Executive but with its membership drawn from leading players and users. It will review existing services and how they interact, develop a programme for change that will identify minimum service standards for information and self selection of equipment, and suggest research on the effectiveness of equipment and adaptation services and rehabilitation services. **The Scottish Executive should set up a Strategy Forum by the end of January 2001.**

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Informed Choices

4.35 One of the weaknesses in equipment and adaptations services is a lack of good and accessible information for both potential service users and for professionals. We see this being addressed in 3 inter-related, ways:

- Firstly, **local agencies need to produce information for the public on existing equipment and adaptation services, by June 2001**. This can be in the form of booklets but could also use the opportunities afforded by IT.

- Secondly, the **Strategy Forum will produce guidelines on core information requirements for service users and assessors, by Autumn 2001**.

- Thirdly, we need local advice and demonstration services to help people make better choices by having a much better understanding of what is available and being able to try out potential solutions. A few facilities already exist, usually in the form of Disabled Living Centres, but a range of flexible and innovative services will be needed across Scotland. They can be developed in tandem with IT solutions or existing facilities such as one stop shops, healthy living centres, etc. In rural areas they may need to be mobile. The Strategy Forum will provide a lead. **Local agencies should put these services in place, in response to the Forum's guidance, across Scotland by April 2002**.

Joint Equipment and Adaptation Services

4.36 Developing more joined up services will be helped considerably by our recommendations in Chapter 5 on joint resourcing and joint service management. A joint approach will increase access across the often artificial boundaries between equipment and adaptations funded and supplied by the NHS, local authorities (social work or housing) or other agencies. It should also improve the efficiency and cost effectiveness of procurement, storage and distribution, and enable better access to stock through IT networks and other systems. Alongside these structural changes, we need to encourage recycling of equipment no longer required.

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Recycling of Used Equipment (Lothian)

The joint store in Lothian in one year had 23,000 items with a value of £0.9m returned for cleaning, refurbishment and ultimately re-issue. In the same period 63,000 new items were issued at a value of £1.4m.

4.37 North Lanarkshire Council reviewed its adaptation services between social work and housing in 1996. Many authorities across Scotland have used the resultant practice document. East Ayrshire Council has taken this further and developed a detailed service specification on work quality, timescales for completion and providing information to users, all with built-in penalties for default. These more specific purchasing criteria resulted in twice as many adaptations for half the cost. From a joint resourcing perspective, the housing department also transferred its adaptation budget to the social work department.

4.38 **Agencies should jointly resource and jointly manage equipment and adaptation services, by April 2002, and should consider the benefits or combined storage facilities as soon as possible thereafter**.

4.39 We were impressed by the contribution of care and repair schemes to sustaining people in their own homes, and welcome the commitment nationally to establish care and repair schemes in all areas of Scotland. But we also saw a need for agencies to be better informed of the level of adapted properties in their area (on which Scottish Homes issued guidance in 1999); for, in the light of initiatives on common housing registers, a single point of access to housing services; and for greater consistency in the allocation of tenancies.

Housing Registers: Disabled Person's Housing Service

The Disabled Person s Housing Service (DPHS) facilitates, through provision or advice and information, the welfare of people with disabilities with housing needs. Its Disabled Persons Housing Register matches disabled people with suitable available housing.

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4.40 **All local authorities should create, with their partners, (Scottish Homes, registered social landlords and the private sector) registers of adapted properties, by mid-2002**.

4.41 **The partner agencies (local authorities, Scottish Homes and registered social landlords) should have one point of contact for applications and a more joint approach to allocations through consistent and shared allocation arrangements, by 2002**.

Simple Solutions

4.42 We want to reduce inefficiencies and improve user choice by enabling users to decide for themselves on simple equipment and adaptations. A number of studies show this is feasible and effective, if good information and advice is available. This is obviously related to our proposals in that field.

Self-selection: (Cornwall)

This study showed most people with modest needs — 80% of the total — were able to identify needs for themselves. They gained little from interventions of nurses, occupational therapists or social workers. Many required only minimal services/interventions to continue living independently. But rapid responses were vital to sustain self-confidence and a sense of independence. Effective outcomes resulted from good advice combined with opportunities to try out equipment.

4.43 Unqualified staff already offer advice on simple solutions under the guidance of qualified occupational therapists. Other staff could do this if appropriately trained in disability awareness, equipment and adaptation options, and sources of information, advice and demonstration.

4.44 The Strategy Forum is to draw up guidance on self-selection arrangements, and for training of staff, with the training itself co-ordinated by the proposed Centre for Older People (Chapter˚3). Thereafter, **local agencies should put in place, by Autumn 2002 self-selection arrangements for "simple" solutions and training of staff by 2002/03**.

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Occupational Therapy Services

4.45 Proposals for joining up and improving equipment and adaptation services will inevitably impact on the work of occupational therapists. As demand for equipment and adaptations grows they are often seen as rationers of a limited resource. And inflexible organisational boundaries can mean both hospital-based and local authority occupational therapists being involved in one case. There are also questions about how the occupational therapy service should be organised, in the context of more joined-up health and social care services, to maximise the use of occupational therapy skills and enable other workers, qualified or otherwise, to play their part in providing equipment and adaptation services.

Using Occupational Therapists More Effectively

4.46 We recognise the need to change the role of occupational therapists so that they are not seen as the sole route to equipment and adaptations. Rather they should contribute to care solutions more generally by training and supporting others in managing simple solutions, developing complex packages of equipment and adaptations, and becoming more widely involved in intensive care management. They should have a pivotal and equal role in joint, co-ordinated hospital discharge arrangements; and be an integral part of intensive support services and multi-disciplinary community-based rehabilitation services (as indicated in Chapter 3).

4.47 Studies in Nottingham (McCloughry & Murphy 1998) show that 12 out of a sample of 21 people identified by social workers as requiring residential care were able to remain at home following occupational therapy intervention. And of 56 people receiving home care, half did not require the level of service being received when assessed by an occupational therapist (McCloughry & Lowe, quoted by DOH 1999).

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Kensington, Chelsea & Westminster Commissioning Agency and Westminster Social Services

Victoria Project: Community Occupational Therapy Rehabilitation Service

Grant from King s Fund to explore how health and social care can be purchased more effectively to meet older people s needs. Success based on combination of occupational therapy care management alongside rehabilitation, that resulted in significant reductions in care services.

Not all financial outcomes are available, especially on health care; but evidence shows a positive impact on reducing admissions and dependency, and on more appropriate use of health services. 92% of users showed significant functional improvement and health gain. Social care saved £65k through positive rehabilitation, rather than reacting to circumstances, and £14k on equipment and adaptations.

Organising Occupational Therapy Services

4.48 Current demarcations between health and social care occupational therapists are not helpful. There is a logical progression from accessing one another s services across organisational boundaries, to integrating certain services or parts of them (for example hospital discharge teams), and potentially to full service integration.

4.49 We recommend a staged approach. Firstly maximising co-ordination in community care services and then moving towards an integrated occupational therapy service within the wider context of the agenda for joined up and multidisciplinary health, housing and social care services.

4.50 Pointers to achieving these goals include commonality of boundaries, the right mix of specialist and generic skills, addressing issues related to pay and conditions and professional development and accountability, and consideration of the wider change agenda in community care.

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4.51 **We recommend:**

To target occupational therapy services more effectively, agencies need to modernise equipment and adaptation services, and to remove duplication between hospital and community based occupational therapy services wherever practical. For community care services that reoganisation needs to begin as soon as possible, followed by the rest of health and social care within the context of the wider agenda for joined up health, housing and social care services.

Summary

4.52 This chapter sets out in some detail our proposals to improve joint working. They apply to all care groups. We have focused our attention on 3˚important areas where improvement is clearly possible. The measures we propose are, as said elsewhere, of proven standing and testimony to those who have already addressed change. There will be organisational benefits for health, social work and housing services from more streamlined systems, more joint involvement and ownership of systems and, in the case of equipment and adaptation services, a much needed joint approach to service organisation and delivery. But the ultimate goal is the positive effect on users of changes at the heart of community care. They should notice a real difference as a result of our proposals. Putting them in place must be a priority.

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CHAPTER 5

NEW FINANCIAL, PLANNING AND SERVICE MANAGEMENT FRAMEWORKS

5.1 This chapter introduces structural changes to underpin the service and operational recommendations in previous chapters on both rebalancing care for older people and on joint working. Some will apply nationally, some locally, and some to both. These planning, financial and service management frameworks all have one thing in common: they will contribute in their own way to improving outcomes for people who use services.

National and Local Financial and Planning Frameworks

5.2 As suggested in the Introduction and in Chapter˚3, the financial and planning systems for community care have not necessarily helped the balance of care. Planning locally is increasingly joined up but resourcing less so; and nationally, priorities may not be linked formally to the allocation of resources. National and local planning and financing must be more integrated. The Strategic Issues Working Group has been considering a number of options for changing the funding of local government. We wish to apply some of their thinking, but to a wider pool of resources, across community care. We advocate a new approach of a partnership between the Scottish Executive and local agencies, focusing on all the new resources for community care — both capital and revenue - across social work, the NHS (including relevant acute services) and social housing; and deciding in partnership what to target these resources on and what outcomes to expect. That approach will bring a much needed and clearer link between resources and priorities.

5.3 A further critical issue is to underpin the new arrangements with stability of funding. The Minister for Finance announced the introduction of 3˚year budgeting in his statement on 20˚September 2000, starting in 2001.

National Programme Planning Group

5.4 We envisage this agenda being taken forwarded by a National Programme Planning Group. That group s role is not to develop policy. Rather, it will provide a strong lead and set targets for implementation of priorities that will ensure consistency and fairness across Scotland. The group will consist of key stakeholders including Ministers, elected and

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appointed members, senior managers and professionals from local authority, social work and housing departments, housing agencies and the NHS, and user representatives. It should:

- set development priorities and targets for local partners.

- monitor and assess local partnership agreements, and measure performance against such agreements.

- review financial arrangements at national and local level and ensure that they support integrated management of resources between partners. In particular, it should identify the relevant revenue and capital funding streams for acute and primary health care, residential and home based social care, and social housing; and advise on any reconfiguring to support the development of joint working and the achievement of priority service developments in community care.

- In a less formal way, we think it should also advise the Scottish Executive on ensuring that the legal and accountability arrangements for partners locally and nationally do not impede flexible partnership working, and on the extent to which national and local arrangements for performance measurement and management reflect and promote joint working. Lastly, it can disseminate good practice and reflect it in the development priorities and targets set.

5.5 We are very conscious that one alternative to our preferred approach would be more hypothecation of finance, and prescription of implementation mechanisms nationally. We clearly see that as second best. But to ensure that the Programme Planning Group can deliver, particularly on greater consistency across Scotland, it should have a degree of authority. It should, for example, be able to challenge local partnership agreements, and examine and advise on improving the existing financial, legal and performance frameworks for community care. Its precise ways of working can be developed more fully in the light of this report.

5.6 It may be asking too much to introduce these arrangements across the whole of community care. A staged approach seems appropriate. Services for older people take up the largest part of expenditure, offer considerable scope for changes of direction and are currently a priority. Early attention should therefore be directed to this care group, with others building on that progress.

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Local Partnership Working

5.7 Moving from the national to a local perspective, Modernising Community Care proposed both more joint use of resources and more joint services locally. In their responses, agencies said they could do more within existing powers. There has been progress. Most people will be aware of the Care Together initiative in Perth and Kinross. And Glasgow has introduced joint management and joint resourcing of its learning disability services. The models are similar, as described briefly later.

5.8 These initiatives are very significant, but somewhat isolated. We know that some agencies still have doubts — at the margin at least — about their ability legally to have fully fledged pooled budgets. We also acknowledge the practical issues that creates. But like many of those at the seminars, we do not wish these doubts to get in the way of progress. We believe that a new lead is required, not just on bringing together agencies resources, but also on the management of services.

5.9 We are looking for an approach which reduces barriers, is practicable and deliverable, and provides better results for users. We believe jointly resourced and jointly managed community care services, either in the round or for each care group, achieves that. In future, that should be the norm. These arrangements give members the opportunity to take joint decisions on a bigger pool of resources, and opportunities to break down negative cultures, for mutual learning and, most importantly, to organise and deliver services in a more concerted way to the benefit of the person using the service.

5.10 To explain what we mean, joint resourcing is about the resources at agencies disposal— their staff, their buildings and their money, and how they use these resources jointly. As in other settings, we envisage relevant parts of health, social care and housing forming the nucleus of the local joint resource. The jointness is mainly in the use of these resources. As the models illustrate, decisions are taken by a joint body/single manager as appropriate. This approach is therefore not as advanced as pooled budgeting, but is more practicable at this point in time. And it is deliverable reasonably quickly. It is beginning to happen now. Pooled budgeting, in which resources are freely interchangeable in the pool and accountability joint may, however, be the Executive s longer-term aim.

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5.11 Joint resourcing and joint management of services go together. Joint management brings health, social and housing services, as appropriate, under a single manager — of either community care services in the round, or of individual care groups. The manager can come from either a health or social care background. At the outset social and health care services, together with relevant elements of housing, may be separate entities under a common manager, but over time we expect progress towards joint services, facilitated in part by the growing use of joint teams and generic workers. As indicated earlier, there are existing models of joint resourcing and joint service management.

Glasgow: Joint Learning Disability Service

The joint learning disability service operates under a joint sub-committee of the Health Board, Council and NHS Trust, with member/officers drawn from each agency. The sub-committee has delegated authority to plan and manage services and, in turn, delegates that to an executive group of senior officials. They oversee a joint general manager who has responsibility for joint commissioning and joint management of learning disability services. This is a single, joint commissioning team which pools the collective resources and commissions all health and social care from the one pot . At the moment it does not include a housing component.

On service management, Glasgow is about to move to integrated area learning disability teams with integrated single management, integrated care management, shared assessments, shared resources, and shared premises. Health staff will remain employed by the NHS Trust and social care staff by the Council. Individual team managers — of whatever discipline - will remain employed by their present employer but will have joint management responsibility for the whole team. The teams will have shared budgets.

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Perth and Kinross: Community Care Services

The Board, Trust and Council s model for joint organisation and delivery of care revolves around a joint board comprising members and officers of the 3˚bodies. The joint board will have delegated powers and resources, and will operate within the current legal responsibilities of the respective organisations, but without the administrative barriers. The joint board will appoint a general manager, and has operated in shadow form from 1˚October 2000. Staff will be officers of the joint board but will retain their existing pay and conditions.

The joint board s responsibilities will cover the resourcing and management of all relevant social and health care services for adult community care clients. That includes the Trust s secondary and intermediate care services but for the moment that covers only community services in the Local Health Care Co-operative. General Medical Services are not at present included.

Local Partnership Agreements

5.12 To consolidate this joint approach, we believe local agencies should draw up local partnerships agreements . In due course, they will have regard to the lead and targets given by the National Programme Planning Group. The agreements will both inform communities about proposed service developments and allow scrutiny by the National Programme Planning Group. It is important to stress again that we do not see local partnership agreements as new policy statements, and thus a new layer of planning. Rather, they are action plans distilled from existing policy expressed in community plans, community care plans, HIPs and TIPs and housing plans. A local partnership agreement should include:

- the joint development priorities and targets for a 3 year period, covering the key community care client groups and carers, in the light of the lead from the National Programme Planning Group;

- developments in joint service management and joint resourcing proposed to support the stated development priorities and targets;

- the performance management framework to be used to monitor progress, evaluate impact, and guide corrective action if necessary.

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(This is likely to include local performance indicators, timetabled targets, user and carer feedback, service level pledges, etc. It should also include proposals for assessing outcomes.)

- the governance and accountability framework for the partnership agreement, straddling a number of local agencies. This could be a joint board, or joint programme commitments, or joint management arrangements with clear empowerment and reporting lines to parent agencies. (We would not wish to be prescriptive at the outset but the National Programme Planning Group will analyse proposals and ensure that robust frameworks for governance and accountability are in place.)

5.13 We envisage partnership agreements being updated annually in the light of performance, feedback and financial circumstances. They should be part of existing plans (eg community care, HIPs etc).

5.14 Local partnership agreements will therefore set out the arrangements for setting up joint resourcing and joint management of services across the board. But in concert with our thinking elsewhere in the report, we believe it is important to make an early start on services for older people, with full implementation from 2002. Local partners who believe they can move faster on either older people or any of the other groups are encouraged to do so.

5.15 **To improve financial planning nationally and the financing and management of services locally, we therefore recommend:**

The Scottish Executive should set up a programme planning and financial framework, beginning with services for older people in 2001.

Local authorities (that is social work and housing), health boards and NHS trusts, and Scottish Homes should draw up local partnership agreements, to include a clear programme for local joint resourcing and joint management of community care services collectively or for each care user group individually.

As a step towards that, and recognising current progress on the ground, every area should introduce joint resourcing and joint management of services for older people from April

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2002, and in preparation for that introduce shadow arrangements in the course of 2001-02.

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CHAPTER 6

HUMAN RESOURCES ISSUES

6.1 We have identified a mix of organisational, structural and practical measures to rebalance care and to improve joint working. But we acknowledge that people, not just structures, create and support change. We need to help staff across agencies overcome barriers to change. We commissioned a helpful presentation from Human Resources/Personnel Managers from local authority and health settings.

6.2 As services move closer to the user and at the same time social care and health services become more joined up, added importance attaches to breaking down traditional cultures, the more rigid employment practices, differing terms and conditions, etc. in both health and social care. This calls for strong leadership locally and greater emphasis on joint training and development, within a partnership framework which gives staff appropriate security through involvement and support, and at the same time enables them to address change positively. We recognise that a more structured approach to human resources issues generally will pay dividends in terms of improved joint working, determining joint visions and reducing divisions between staff groups and between their employers.

6.3 The presentation identified, amongst other things, a number of recommendations which could form the agenda for a national network group on human resource issues across the community care spectrum, as follows:

- joint service provision requires to be more systematically supported by organisational development programmes, which help form strategic alliances and partnerships;

- the competencies required for leaders in the NHS and local authorities require to be integrated, based on personal development planning;

- a more structured approach to secondments of senior staff between health and social work would increase understanding of differing cultures and working arrangements;

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- discussion with education providers is needed to ensure that professional training reflects the need for joint provision of services centred around individuals and based on effective teamworking;

- joint training requires a systematic approach and commitment at a strategic level to support joint community care plans;

- a staffing framework should be agreed by the NHS, local authorities, the trade unions, and the voluntary and private sectors ;

- opportunities should be sought to achieve where possible alignment of the varying terms and conditions and pension arrangements;

- regulatory bodies need to be sufficiently flexible to accept dual registration or to accept transfer between regulatory bodies, and recognise the continuing professional development requirements of other bodies.

6.4 We endorsed these vital issues but recognised that addressing them was both outside our direct remit and our tight timetable. We resolved therefore to refer them to the NHS Human Resources Directorate in the Health Department. It, in turn, is setting up a network group, comprising a wide range of trade union, professional and management interests across health and social care to take forward these issues, within the wider modernisation/partnership agenda more generally.

6.5 Our recommendations throughout our report hinge on the quality, training and flexibility of, particularly, front line staff. Selecting, training and retaining staff to deliver the desired outcomes in a changing environment will undoubtedly be one of the challenges for the future. Joint training - of managers, professionals and front line unqualified staff˚-˚has to be a prerequisite.

6.6 Although we did not make a formal recommendation on human resources issues, that does not diminish the importance we attach to them. As this chapter makes clear, human resources will be central to the progressive development of community care. People s ability to move from one employment field to another, across agencies and across sectors, and to have joint training with colleagues are important examples of our vision for the future. But a more systematic and holistic approach to the range of human resources issues is required to achieve that.

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CHAPTER 7

CHARGING FOR HOME CARE SERVICES

7.1 We were invited to offer advice on charging for home care services. Local authorities have considerable discretion on what charges, if any, they make and on how they set these charges.

7.2 The task had two elements. The first was to consider steps to reduce the inconsistency in charging for home care services between areas of Scotland. Our proposals are set out below in paragraphs 7.3 to 7.5. The second was to consider any new policy on charging in the light of, amongst other things, the Royal Commission on Long Term Care s[8] recommendations on free personal care. While recognising the principles which underpinned the Royal Commission s recommendations, we preferred approaches to charging that not only helped older people financially, but also supported community care more directly. Our proposals are set out below from paragraph 7.6 onwards.

Improving Consistency

7.3 Charging for services is an integral part of the funding of social care. Practice has evolved often as a consequence of financial pressures. As a result, the levels of charge and charge construction vary considerably from authority to authority. Greater consistency is clearly required. The Convention of Scottish Local Authorities (COSLA) has been looking at this since before the JFG was set up. We support their initiative.

7.4 **We recommend therefore:**

COSLA should develop guidance on charging policies to reduce the inconsistencies in home care charging.

7.5 COSLA is now consulting on a number of approaches authorities might adopt to improve consistency. These include setting common income thresholds above which charges would apply; an agreed minimum for the treatment of capital, with no maximum; housing, mortgage and council tax payments to be disregarded; and a standard disregard for dependent children. The objective is that local authorities should take a more strategic view of charging policy and its relationship

[8] Royal Commission on Long Term Care (1999) *With Respects to Old Age*

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to overall plans and objectives. The desired effect is greater consistency in charge construction, and users of services being left with sufficient money to have a reasonable quality of life. The role of benefits is obviously pivotal. COSLA s proposals include a benefits check as part of any proposal to charge and, secondly, that an individual s resources left after any charge should exceed the level of Income Support and any premiums.

Charging Policy

7.6 Our starting point was to consider whether home care services should be provided free of charge. We concluded that providing free home care services as a whole would be unaffordable, would give rise to inconsistencies with the benefits system and would do nothing to develop better community care services. We explored a number of options and focused on two:

- free home care for older people for up to the first 4˚weeks after hospitalisation; and

- free personal care for those older people receiving most care, who might otherwise be in residential, nursing home or hospital care. (For reference purposes, this group of people are described as requiring extended home care).

Up to 4˚Weeks Post Hospital Care for Older People

7.7 Our proposals aim to facilitate an individual s discharge/ resettlement and to benefit them financially, for a limited period. They also support both rehabilitation and the initiatives to speed up discharge. We want older people to receive care at a critical time, possibly more intensively than needed for the longer term, and get back on their feet without worrying about the cost of their care.

7.8 For these purposes we define older people, as men over 65 and women over 60. The extension would follow discharge from in-patient acute hospital care. It should be limited to a maximum of 4˚weeks in each case. For these purposes home care means personal care or other social work services, including equipment, provided in the home within the maximum 4˚week period.

7.9 Local authorities will therefore have to decide, just as they do at present, how long a person needs support following discharge. Four

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weeks is not a norm. It is a maximum, only for charging. We recognise some people will not need 4˚weeks, but others may need more. The limit will cover the vast majority of cases. Setting a time limit gives a clear message about duration, and reduces incentives to prolong the initial level of care unnecessarily.

7.10 We also considered - but rejected on practical grounds - offering relief from charges to stop people going into hospital in the first place. It has been suggested that under our proposals professionals and users could collude to engineer a stay in hospital so as to secure free post hospital care. But we do not believe that is realistic.

7.11 Some councils already operate home from hospital schemes. Some charge, some do not. Our proposals would mean that <u>all</u> older people would get a free service for up to 4˚weeks.

7.12 **We recommend therefore:**

free home care for older people for up to 4 weeks after leaving hospital.

<u>Extended Home Care</u>

7.13 We recognise that a small number of home care users receive very high levels of home care, usually provided by both health and social care services to sustain them at home. Without that level of help, these people would almost certainly be in residential, nursing home or even hospital care. This is therefore effective community care.

7.14 Charging for these services is a recognised part of the financing of local authority services. Moreover, the benefit system provides resources, with a dependency differential, to help individuals meet the added cost of frailty or disability, including paying for care.

7.15 We believe that people who need substantial levels of care should not have to pay a premium, just because they are more infirm than others. In hospital, they would not pay at all, and in residential or nursing home care their care costs would be met wholly by the state if they had limited resources; partly by the state if they had modest resources; and if they were better off they would have to pay the whole cost themselves. Because of local authorities discretion, people paying for home care are currently treated differently from area to area, though

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only a few pay the full costs. Nevertheless this can, depending on the levels of local disregards, make care at home financially unattractive.

7.16 We are told that charging for social care can be an impediment to developing joint packages of care, especially where agencies are working towards or already have generic workers or other blurring of professional roles. We would want charging to support joint working wherever possible.

7.17 Our approach aims to support joint working, and the home care policy generally. It also recognises the contribution which benefits can make to an individual s ability to pay for care. Moreover we believe that people who use services will understand that getting greater levels of care should not necessarily result in a greater charge.

7.18 We propose to provide relief for the additional cost of care of those people who receive extended home care . Extended home care means a range of specific tasks to be defined, provided by both health and social care staff. The crux, however, is their intensity. To secure relief from the charge would require at least 4˚such interventions a day. To maintain a link with the benefits system, the person would, however, continue to pay for ordinary home care or other services. How to measure both extended home care and ordinary services will be discussed with COSLA.

7.19 **We recommend therefore:**

Free home care for older people receiving "extended home care", (though they would still pay for 'ordinary' services).

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CHAPTER 8

GOOD PRACTICE

8.1 Our task is to set a new direction for identifying and sharing good practice. As this report makes clear, much of our work is founded in good or innovative practice. We were struck both by the number of good practice examples in Scotland and the growing number of players in the development and dissemination of good practice.

8.2 We attribute that increasing interest to a combination of factors: the Government s greater emphasis on service quality, Best Value, organisational learning and standard setting, as well as broader social trends such as life-long learning, advances in information technology and the growing involvement of service users and their carers.

8.3 In considering options for the collection and dissemination of good practice, we want to minimise re-inventing the wheel locally, with all the effort and wasted opportunity that can generate.

The Current Picture

8.4 Our analysis of the current arrangements for sharing good practice identified 3˚broad categories of activity. The first comprises organisations whose role is to drive, gather, evaluate and disseminate good practice as a core function. In Scotland, this includes the Nuffield Community Care Database, the Designed Healthcare Initiative, the COSLA Website to showcase good practice (under development) and the Scottish Inter Collegiate Guidelines Network (SIGN). Bodies in England include the Idea and Development Agency, Evidence Base 2000 and the NHS Learning Network (to be subsumed into a Modernisation Agency). In addition to their common focus, this group of bodies is distinctive because of the interactive methods used to share good practice, such as networking and interactive databases.

8.5 The second category focuses on those organisations associated with the development, dissemination and monitoring of standards. They identify good practice as a by-product of standard setting, review or inspection. Examples in Scotland include the Clinical Standards Board, Scottish Homes, Best Value Groups, Audit Scotland, Social Work Services Inspectorate, the Scottish Health Advisory Service and the forthcoming Commission for the Regulation of Care.

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8.6 The third category is characterised by more focused activity such as centres of expertise, professional bodies/development units and those engaged in academic activity or consultancy. The Scottish Development Centre for Mental Health and the Scottish Dementia Services Development Centre are centres of expertise driving change in a specific client group. And professional bodies such as the Royal College of Nursing, the British Association of Social Workers, the College of Occupational Therapists, and the Chartered Institute of Housing all engage with their membership on issues of professional good practice. Academic activity and research is sponsored in part by the statutory sector and includes the Nuffield Centres, the NHS Research and Development Fund and the work of the Scottish Executive Central Research Unit.

8.7 We concluded that the links within and between these categories of organisation are incomplete. As a result good practice is not spread on the widest possible basis. The existing knowledge base is not being maximised. We want to develop a culture of inter agency knowledge management and learning. We also considered recent research by the Office for Public Management[9] into the dissemination and uptake of good practice. A variety of approaches will be necessary to achieve our aim, to cover different types of knowledge, the range of bodies and the geography of Scotland. We need to harness information technology, but recognise that while technology makes sharing more practicable, it does not of itself make it happen.

The Way Ahead

8.8 As a result of our analysis we recognised the need to:

- encourage those who develop good practice to disseminate it more widely;

- encourage more face to face exchange of more complex good practice through multi-agency networking;

- linking as many as possible of the bodies to maximise the information available and the number of recipients in community care; and

[9] The Office of Public Management (2000): The Effectiveness of Different Mechanisms for Spreading Best Practice.

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- make better use of information technology, particularly the use of interactive databases.

8.9 We looked at 2˚approaches. The first would involve central co-ordination of good practice activity under the auspices of a Scottish centre, linked to the range of bodies above and with a specific role to lead and develop good practice in Scotland. The second would encourage the linking of current bodies into a network without disturbing their separate identities, using the advances of information technology. This will bring greater cohesion and maximise the considerable public resource already invested in many of their activities. We concluded that greater benefit would lie in linking existing players to achieve better co-ordinated activity and to develop effective systems to co-ordinate and disseminate their outputs.

8.10 Improving good practice is a longer term objective. But work to set in train the desired outcomes needs to begin shortly.

8.11 **We therefore recommend that**:

The Scottish Executive should, by mid 2001-02, identify measures to improve the collection and dissemination of good practice by linking together the bodies in the field in a more cohesive structure, using the benefits of networking and information technology.

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CHAPTER 9

IMPLEMENTATION

9.1 The Group reports formally to Susan Deacon, Minister for Health and Community Care. It will be for Ministers to decide to accept the report, in whole or part. We envisage, however, a short period of consultation with interested parties. This would include referral to the Health and Community Care Committee which is nearing the end of its Community Care Inquiry.

9.2 In proposing change, we have not had to be radical. Much of what we recommend is already there, in part at least. Our proposals will, however, build key measures into the fabric of community care, across the board.

9.3 The changes we recommend should not be optional. We believe that agencies, their management, professionals, and indeed users and carers all realise that implementing these changes, quickly, is essential if community care in Scotland is to be more effective. Ministers will decide how to do that.

9.4 We recognise in our recommendations the need for closer links between resources˚-˚especially new resources made available nationally˚-˚and delivery of outcomes against them. Possibilities to achieve that might include:

- working under the financial proposals set out in Chapter˚5, if they are introduced quickly;

- agencies submitting joint proposals to achieve our goals against new resources. This might be termed a change fund approach; and

- directing agencies.

9.5 The consultation seminars suggested a willingness on the part of agencies to implement our proposals. A number did however express concern that a directive/prescriptive approach might not sit well with the partnership approach being advocated in at least some of our recommendations. The Executive s statement on older people proposed discussions with the Convention of Scottish Local Authorities on how to achieve the desired outcomes, and we welcome that.

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9.6 We have produced a strong set of recommendations at a time when a new lead is required. This is a great opportunity for Ministers, for all the agencies involved in community care and their staff to accept and run with the challenge we present. We believe there is a strong will to do that. It is now down to all concerned to make that happen. We look forward to our recommendations being acted upon, both locally and nationally, in a sense of partnership.

Resources

9.7 We recognise that some of our recommendations will have resource implications. On the other hand, some will result in better use of existing resources and better service outcomes. Agencies need to look very carefully at the way they resource existing services and systems, and identify the scope for their better use.

Conclusion

9.8 This is the beginning, not the end. Individual agencies have very different starting points, but we hope our recommendations will bring to the vast majority of people using community care services better quality services, better systems and as a result better outcomes available more consistently across Scotland. We expect the Scottish Executive to look for demonstrable progress by agencies on delivering our recommendations.

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APPENDIX 1

HOW WE WENT ABOUT OUR WORK

1. Susan˚Deacon, the Minister for Health and Community Care, announced the setting up of the Group at the end of December 1999. We met first in February, and then on 5˚subsequent occasions.

2. We drew on the knowledge and understanding of individuals within the Group and on advice from officials in the Scottish Executive. We also received presentations from the then Invest to Save Project Team in Perth and Kinross, now known as Care Together ; Directors of Human Resources and Personnel in local authorities and the NHS; and the Nuffield Centre for Community Care Studies on its good practice study. We are grateful for the quality and concise nature of these presentations.

3. Towards the end of September we held 4˚regional consultation seminars to bring the general thrust of our proposals to the attention of leaders of councils, health boards and NHS trusts, their senior management, and representatives of providers and users and carers. These seminars endorsed our general direction of travel; but we received many requests for additional information or clarification, which we hope this report now provides.

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APPENDIX 2

JOINT FUTURE GROUP

REMIT

1. The main aim of the Group is to find ways to improve joint working in order to deliver modern and effective person-centred services.

2. Its primary task is to agree a list of joint measures which all local authorities, health boards and trusts should have in place to deliver effective services, and to set deadlines by which this must be done. It will also act as a Steering Group for a short series of regional seminars to take forward the themes from the 5 November 1999 seminar at a more local level.

3. The Group will advise on:

- the balance between residential and home based care; having regard to the opportunities for flexible home care services, smart technology etc;

- options for dealing with charging for personal care delivered at home (including the relevance of the Royal Commission s recommendations);

- how to identify and share good practice.

4. Within these broad parameters, the Group will have extensive scope. Its aim is to produce sound practical proposals which can make a real difference, some hopefully with early effect. It must, however, have regard to costs of and speed of implementation, and recognise that some proposals could ultimately require legislation.

5. The Group should report formally on the balance of care and charging issues by the end of June, and on the other matters by the end of September. It may, however, announce milestones as its work progresses.

6. In managing its business, the Group may co-opt or invite others to participate in meetings; can commission work; and would want particularly to recognise the interface with users and carers, housing, and the voluntary and private sectors.

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APPENDIX 3

JOINT FUTURE GROUP: MEMBERSHIP

Iain Gray, Deputy Minister for Community Care (Chair)

Oonagh Aitken, Chief Executive, COSLA
Tim Davison, Chief Executive, Greater Glasgow Primary Care NHS Trust
Colin Mair, Scottish Local Authority Management Centre
Councillor Rita Miller, South Ayrshire Council
Dr Linda Pollock, Director of Nursing, Lothian Primary Care NHS Trust
Jacquie Roberts, Director of Social Work, Dundee City Council (as from 2˚June)
Heather Sheerin, Chairman, Highland Primary Care Trust
Margaret Wells, Director of Housing & Social Work, Aberdeenshire Council
Jenny McNeill, Scottish Executive, Joint Future Unit (Secretary)

Scottish Executive Officials in Attendance

Rosemary Bland, Community Care Team, Social Work Services Inspectorate (to 28˚August)
Stephen Gallagher, Joint Future Unit
Liz Lewis, Community Care Division (to 28˚August)
David Meikle, Joint Future Unit
Gill Ottley, Assistant Chief Inspector, Community Care Team, Social Work Services Inspectorate (to 28˚August)
Susan Scott, Community Care Team, Social Work Services Inspectorate
David Pia, Assistant Chief Inspector, Social Work Services Inspectorate (as from 2˚October)
Thea Teale, Community Care Division (as from 28˚August)
Dr Kevin Woods, NHS Management Executive (to 26˚June)

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