ACCOUNTS COMMISSION

PERFORMANCE AUDIT

SELF-ASSESSMENT HANDBOOK

Commissioning community care services for older people

Applying a Best Value framework

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Accounts Commission

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- following up issues of concern identified through the audit, to ensure satisfactory resolutions
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Commissioning community services for older people – applying a best value framework

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1. Introduction

Commissioning community care services for older people is an important local authority function which impacts directly on the quality of people's lives. It is a challenging task however – resources are limited and there is an increasing number of older people with significant needs.

1.1 The context

1.1.1 Community care expenditure

In 1993 local authorities were given lead responsibility for community care under the NHS and Community Care Act 1990. Since that time expenditure on community care services has doubled – from just under £410 million in 1993/94 to £832 million in 1998/99[i]. However, much of this increase is due to the transfer of responsibility for funding places in independent sector residential and nursing home care from the Department of Social Security to local authorities.

1.1.2 Demographic changes

There is an increasing demand for community care services because of changes in social policy and because people are living longer due to improvements in public health and medical advances. Older people are major users of community care services and the number of people over 65 years of age is projected to rise to just under 858,000 in the first 12 years of this century, an increase of 72,000 (Exhibit 1).

Exhibit 1: Projected rise in population of people aged 65+ (000s)

Age	Year				
	2000	2003	2006	2009	2012
65-74	438.4	439.7	439.9	451.5	478.5
75-84	261.4	271.2	273.4	275.7	282.3
85+	86.0	83.1	88.8	93.3	97.0
Total (65+)	785.8	794.0	802.1	820.5	857.8

Source: Registrar General for Scotland, 1996 based projections.

Most significantly, the number of people over 75 years of age is set to rise to just under 380,000, a 9% increase in the group of people likely to have the highest needs. A recent survey showed that half of all people over 75 report a limiting illness, health problem or disability. This compares with one in ten people of the 16 to 24 years old population reporting similar health problems[ii].

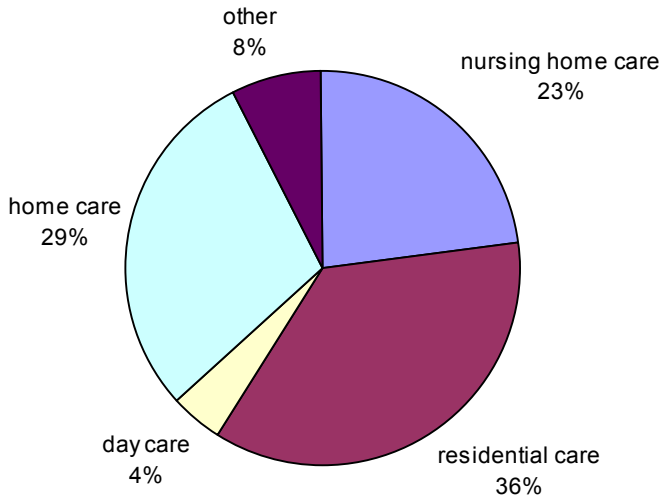
1.1.3 Balance of community care services for older people

> "We expect to see major changes in the home care service. We want a modern, flexible care service, which can meet a wider range of needs and provide support when it is needed. The service may be provided directly or brought in."
>
> Source: The Scottish Office, Modernising community care, 1998.

Excluding the costs of care management, councils spent in the region of £540 million on community care services for older people in 1998/99[iii]. A significant proportion of this is spent on residential and nursing home care (Exhibit 2).

Exhibit 2: The balance of community care expenditure for older people

Over half of current expenditure is on residential and nursing home care.



Source: CIPFA, Personal Social Services Statistics 1998-99 Estimates

Note: For the purposes of this comparison we have allocated 85% of councils' total expenditure on home care, meals and equipment and adaptations to older people's services, although these are categorised as generic. This represents the proportion of these services used by older people.

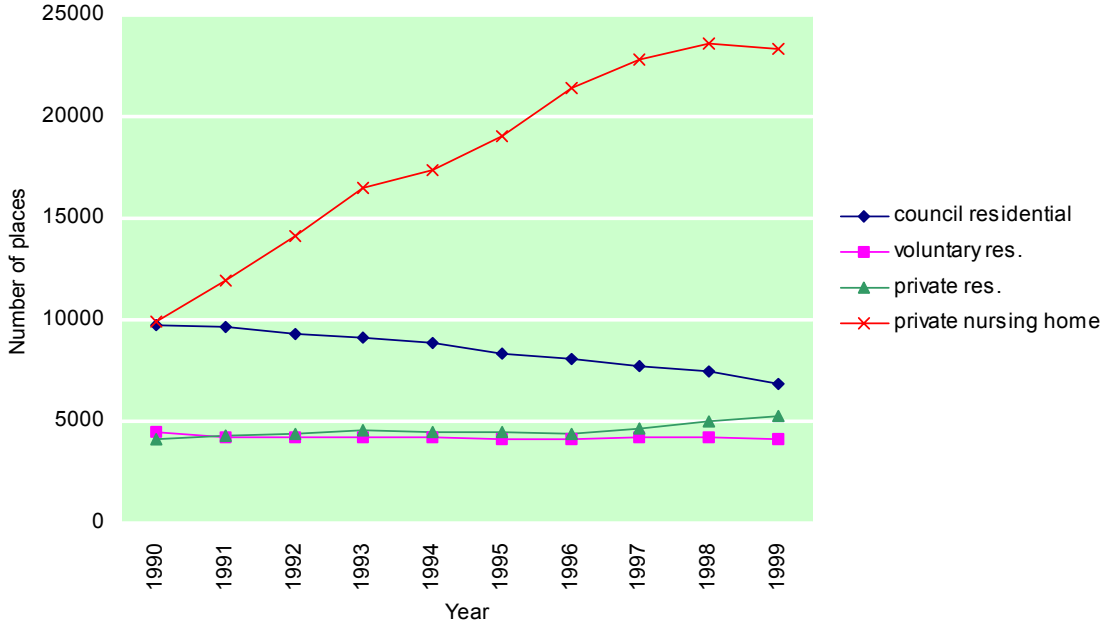
The community care policy, and more recently the Government's modernising community care agenda[iv], stresses the importance of maintaining people in their own homes or, where this is not possible, in as homely a setting as possible. The current distribution of services, in line with the expenditure patterns shown in exhibit 2, shows that there is still a bias towards institutional forms of care for older people needing intensive forms of support (Exhibit 3).

Exhibit 3: Distribution of services for older people needing intensive support

Source: The Scottish Executive, Vacancy Monitoring Report and Home Care Services, Scotland, 1999

Approximately 34,000 older people live in residential or nursing homes. The number of residential care places in the local authority and voluntary sectors has been dropping since 1993 but has increased slightly in the private sector over the past two years. Nursing home places continued to grow between 1990 and 1998 although they are now beginning to reduce very slightly (Exhibit 4).

Exhibit 4: Residential and nursing home places

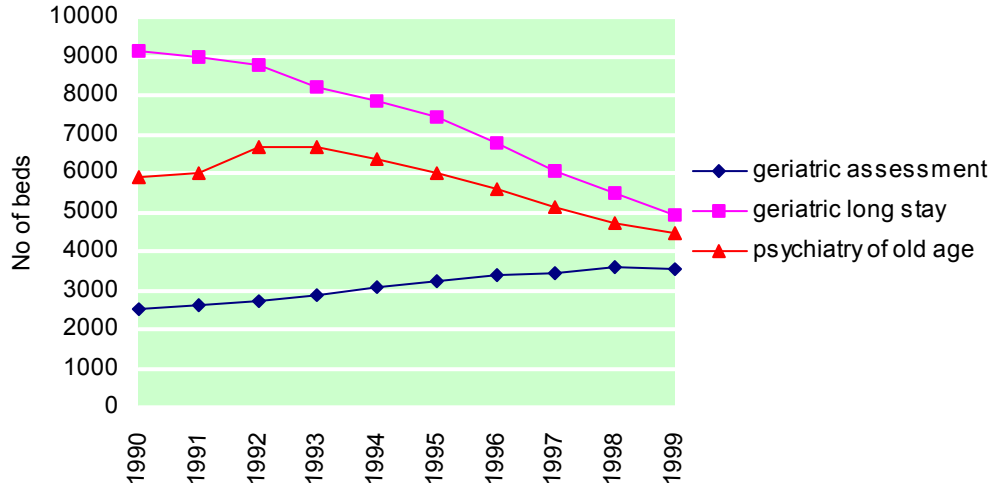


Source: The Scottish Executive, Vacancy Monitoring Reports and Information and Statistics Division of the NHS in Scotland, Health Service Statistics, 1999

1.1.4 Trends in the health and housing sectors

There has been a steady reduction in the number of long stay NHS beds for older people with a consequent transfer of responsibilities for the care of older people from the NHS to local authorities. In the ten years from 1990 to 1999 over 4000 long stay NHS beds for older people and nearly 1500 long stay 'psychiatry of old age' beds, primarily for people with dementia, were closed. Over the same time period there has been an increase of 1000 geriatric assessment beds (Exhibit 5).

Exhibit 5: NHS long stay care of the elderly, 'psychiatry of old age' and assessment beds



Source: ISD Scotland, 1999

These NHS long stay bed closures create a significant challenge for local authorities in commissioning alternative services in the community. Community based local authority and NHS services must meet the needs of the people who occupied those beds. They must also be flexible enough to provide for a future population who may have been admitted to long stay NHS care in the past but who will need alternative services in the future.

Alongside these long stay bed closures social care services are playing an increasing role in helping to avoid unnecessary acute hospital admissions, and managing discharge arrangements more effectively. These home-based services are highly valued by older people, but can create further pressures on existing resources.

There are also developments in the housing sector with just over 38,000 units of sheltered and very sheltered housing for older people. This equates to 49 units per 1000 people who are 65 years or over, although the number living in very sheltered housing is still relatively small – less than 0.5% of older people in Scotland. When the additional categories of 'amenity' and 'other dwellings with alarms' are taken into account, the total figure for special housing provision for older people is over 95,000[v].

1.1.5 Role of informal carers

Carers, whether they are family, friends or neighbours, play a key role in supporting many older people in the community. Current estimates suggest that around 360,000 people in Scotland are caring for someone over 65, nearly a third of whom are caring for someone who is over 85[vi]. An estimated 96,000 carers are over 65 themselves.

Around 45,000 carers of older people provide more than 20 hours of care per week, with some providing in excess of 50 hours care per week. This contrasts with the 1800 clients who receive more than 20 hours of local authority commissioned home care services and is a significant amount of care provided on an informal basis.

Many carers have their own distinct needs and an essential component of community care is to provide adequate support for them. There is evidence to suggest that dependent people with a carer living in the same household are less likely to receive support from social care services than people whose carers live elsewhere.

1.1.6 The commissioning challenge: matching resources to growing needs

The situation is therefore one of growing need, limited resources, pressure to change the balance of care for older people. The commissioning and delivery of services for older people must be well managed if it is to meet these demands effectively and efficiently. Not only is this an area of relatively high expenditure but also more importantly getting commissioning right has significant quality of life implications for a growing number of older people and their carers. Getting it wrong can lead to an inappropriate and inequitable distribution of services, which fail to meet the individual needs of older people. To prevent this happening councils need to have a clear idea of:

- the type and volume of services they require now and in the future
- what the quality and price of services should be
- how current services can be subject to continuous improvement plans with appropriate rewards for innovation and ability to change in line with changing needs
- how 'failing' services can be improved or decommissioned.

1.2 What is commissioning?

"…councillors and officials will need to focus on the key factors for success:
- a strong focus on people
- effective corporate working within authorities
- effective partnership working with other agencies
- a rigorous search for cost effectiveness."

Source: The Scottish Office, Aiming for excellence, 1999.

Commissioning is a term that can mean different things to different people. For the purposes of this handbook commissioning is defined in its broadest sense. It includes:

- strategic planning and shaping of the local care market to meet the current and future individual needs of older people
- consulting with older people, carers and the public
- involving older people in planning how to meet their individual care needs
- working in partnership with other agencies and providers where appropriate
- responsive care management systems
- managing limited resources and matching to local needs (which may involve setting clear eligibility criteria)
- using best value mechanisms to improve the quality of care
- using contracts and purchasing arrangements to specify, secure and monitor services
- being accountable to local communities and users by providing information on services and performance.

1.3 Structure and use of the handbook

The handbook is intended for all those involved in the commissioning process as defined above. The structure of the handbook uses a framework for commissioning based on the best value performance management and planning audit:

- how do we know we are doing the right things?
- how do we know we are doing things right?
- how do we plan to improve?
- how do we account for our performance?

Inevitably in applying such a structure to the complex and complicated task of commissioning there are times when issues that are addressed in one section could be covered equally well elsewhere. There are a number of key messages that run through the handbook including the need to:

- place older people and their carers at the centre of the commissioning process
- use commissioning as a key mechanism for improving the quality of care
- work jointly with other agencies for the benefit of older people
- pay due attention to equity and value for money issues.

Each section of the handbook includes related questions aimed at assisting councils in evaluating their own commissioning practice. These questions cover a broad range of activities including consultation, planning, working with other commissioning bodies and providers, care management, using the results of service reviews, contracts, finance and accountability.

The handbook is not intended as a definitive guide to commissioning, but rather as a constructive contribution to the debate on how to apply best value principles to commissioning. Key to the best value agenda is the establishment of clear standards and targets for activities – Chapter 4 provides a suggested framework for measuring the effectiveness of the commissioning of community care services for older people.

Where relevant we provide case studies from a sample of local authorities that were visited during our research. We hope that these will generate interest and discussion at a local level. Some of these practice examples will be council specific but others will have elements that can easily transfer or be adapted to local circumstances.

2. How do we know we are doing the right things?

New approaches are needed to develop flexible community based services, which are responsive to the needs of older people. Best value places a strong emphasis on consultation – both with the users of services and with the general public – as a way of informing service plans, priorities and developments. In order to commission the most effective patterns of care local authorities must also work with a range of different partners.

2.1 We understand the needs, expectations and priorities of all our stakeholders

Modernising Community Care calls for better practice in commissioning to achieve a shift from institutional to home based care. Different participants in community care may have different needs, expectations and priorities. For example, many older people prefer to stay in their own homes but carers may worry about their parent who is staying at home alone; nursing home owners may see their investment threatened; social work departments may find individual care costs increasing and over-stretching budgets. Effective commissioning must therefore involve active consultation with a range of stakeholders in order to ensure that the local care market can adapt to suit changing needs and priorities.

2.1.1 Consulting with older people and their carers

The importance of listening to users' and carers' views on their needs and on services is well accepted. Better links now need to be made between the views of older people and the decision-making processes that influence the provision of care. This needs to be achieved through:

- the planning process, specifically by creating appropriate opportunities for consultation and funding to facilitate involvement
- involving older people in planning their own care (primarily through the care management process).

⇒ See section 2.2 for ways of improving the effectiveness of care management

2.1.1.1 Common problems with consultation

Most local authorities have made considerable efforts to ensure appropriate consultation with key stakeholders across the whole spectrum of council services[vii]. However, the Accounts Commission found a number of common failings in their consultation exercises, including:

- lack of clarity on the purpose of consultation
- no criteria for assessing the effectiveness of the process
- no clear recommendations for service improvement or development arising from the consultation exercise
- lack of co-ordination with other parts of the authority.

It is important that these are guarded against when consulting with older people and their carers so that the consultation exercise directly informs the development of local community care services.

Principles of good consultation

Whatever the approach to consultation, the same principles apply:

- the purpose should be clear to both those consulting and those being consulted
- the approach or methods should suit the purpose
- the target population to be consulted should be identified, and a representative sample included in the consultation exercise
- the methods should be appropriate to the target population
- arrangements should be made to enable participation including offering transport and respite support for carers if appropriate
- the way in which information from consultation is to be analysed and presented should be stated with the methodology
- other consultations should be recognised, to avoid duplication and help prevent 'consultation fatigue'
- commitment to acting on the results of the consultation which will contribute to the empowerment of older people and their carers.

2.1.1.2 The role of consultation in community care planning

> "…we expect people who use services and their carers to be central to all decisions made about themselves and the service planned."
>
> Source: The Scottish Office, Modernising community care, 1998.

Most service users and carers will have little or no involvement in planned consultation exercises but their views on needs and services could be the most significant. Consultation will be most effective where a range of methods are used to maximise participation, and where consultation is ongoing in service development and not used merely to inform the community care plan.

All authorities have mechanisms for involving users, carers, and the public in the development of their community care plans. These include focus groups, user and carer groups, search conferences and workshops. As community planning develops this will also provide a broader community perspective for consultation.

Case study 1 - Consultation document from search conferences

Search conferences were held in local areas across Highland Council, the results of which informed local sections of the joint community care plan. Users and carers, together with representatives of statutory, voluntary and independent agencies were invited to take part. Participants attended local workshops to identify:

- what is valued and not valued about living in the area
- a common vision statement
- the main local community care issues
- what services/developments have priority in a budget scenario of
  - new money
  - same money
  - cuts.

Consultation with older people in different settings has been actively used in best value service reviews; for example the City of Edinburgh Council ran a number of focus groups for local residents of council and independent sector homes to identify quality measures from a user perspective. These have been used to evaluate services and follow up groups have been held with participants to measure progress against these user-determined standards. Fife Council, through its local Age Concern network of Users' Panels, also has been more successful than many other authorities in including the most frail and dependent older people.

In order to ensure consultation is as representative as possible people from minority ethnic groups and those in residential settings or with special needs, such as sensory deprivation, dementia and learning disabilities - those most likely to be receiving care management – should be included.

Consultation through traditional means such as surveys by postal questionnaire and requests for comment on draft plans and proposals often give a poor return. While they do allow specific information to be collected, they can be time consuming to undertake, analyse and to complete. It is likely that older people will not find them user friendly and they are more likely to generate responses from older people's organisations than from service users or potential users. They are not suitable where barriers to communication are likely. Such approaches will be more worthwhile if the topic is of direct interest to the potential respondents, the questionnaire is simple and in plain language, and appropriate action on the findings is assured.

Case study 2 - Influencing the development of home care services - survey of users' views

Research commissioned by Fife Independent Disability Network and undertaken in 1999, with support from Fife Council, examined users' views of the home care service. It drew on lessons learned from earlier research in 1997. The methodology included a postal survey of users. Questionnaires were designed in consultation with users' groups and distributed with assurances of independence and confidentiality, and a free post envelope for return. The response rate was high for this sort of survey, at around 40%, explained mainly by the care taken in planning and carrying out the exercise. The survey of individual views identified issues that were followed up with focus group discussions involving service users. The reports from the study have informed Fife Council's planning of its home care service.

Social work departments have large numbers of staff who are in daily contact with service users. A sampling system and a few simple questions put by familiar staff could generate valuable information on preferences and effectiveness of services, at little cost and with little inconvenience to users. However, care must be taken to prevent or minimise the bias that may come from a lack of independence and the understandable reluctance of vulnerable users to criticise a service to the provider of that service.

2.1.2. Assessing the needs of the population

In *The Commissioning Maze* the Accounts Commission highlighted that most councils do not have simple and effective systems to record and analyse information and access national data. Assessing the community care needs of the older population requires a range of information:

- population data
- health statistics
- housing information
- socio-economic data (with explicit links to councils' corporate anti-poverty and social inclusion strategies)
- information on service usage
- aggregated information from individual care plans.

It also requires staff who have the necessary skills in data collection, analysis and interpretation.

2.1.2.1. Population data

Consulting with older people and carers affords a perspective on their current needs and preferences and how well these are matched by services. In addition, a broad understanding of the older population is necessary for good planning and resource allocation at a strategic level.

Community care plans are expected to include an assessment of the aggregated needs for each care group. Local authorities refer in community care plans to information on older people from the Office of Population, Census and Statistics (OPCS) and the General Register Office Scotland (GRO). These sources give demographic profiles and population projections and help in predicting prevalence rates of disabling conditions. Authorities may supplement this standard information with data derived from epidemiological studies, notably EURODEM prevalence rates for dementia.

Such information provides a baseline for needs assessment but national prevalence rates are not always reflected in local populations and prevalence rates do not necessarily correlate with levels of need. Local information should be sought to confirm prevalence rates and levels of need.

Case study 3 - Survey of carers

Perth and Kinross Council has drawn on the findings of a survey of carers in Tayside in 1995, jointly undertaken by social work, health and the voluntary sector. Information from questionnaires completed by 229 adult carers in Perth and Kinross indicated a number of differences in the circumstances of carers comparing the local with national data. The survey gave valuable information about the location of carers, their characteristics and the effect of caring on their health and lifestyle, and the caring tasks they carry out.

2.1.2.2. Local health services data

Health boards hold information on:

- morbidity rates
- hospital admission and discharge
- use of hospital and community health services.

Some authorities make use of these local health services data in community care planning. In general, however, they remain an under-used source of information in community care needs assessment.

At some GP practices the number of patients with particular conditions and the prevalence per hundred patients can be identified and compared with national prevalence rates, through the computerised General Practice Administration System for Scotland (GPASS). The relatively new local health care co-operatives (LHCCs) provide ready-made groupings of GP practices that should facilitate locality needs assessment.

2.1.2.3. Housing information

Appropriate housing is a key factor in helping older people achieve good community care. The main sources of information on housing are:

- local authorities' housing plans and house condition surveys
- Scottish Homes
- the Scottish Executive Housing Statistics Unit.

Unitary authorities and combined social work and housing departments take away some of the organisational barriers to the sharing of information. However, community care plans are variable in the attention they give to housing needs.

Barrier free housing with additional support on site, as found in sheltered and very-sheltered housing schemes, can provide viable alternatives to residential care. Many authorities have been successful in developing such schemes in partnership with housing associations and others. Experience shows however, that these require significant time and planning to ensure a successful outcome. They also require 'joined up' working between social work and housing departments in order to synchronise local community care and housing plans.

2.1.2.4. Socio-economic data

Socio-economic factors will be one of the main reasons for variations in need between older populations. Social deprivation indices, such as Jarman's index or the Scottish Deprivation Measure (DEP), can be applied to local population data to highlight differences between groups or across geographical areas.

2.1.2.5. Information on service usage

Knowing how many older people are in particular categories and circumstances is a starting point in assessing population needs but is not enough by itself. An analysis of community care plans suggests that, along with prevalence data, current patterns of service usage are what local authorities most depend upon to give a picture of need.

Information on service activity, numbers of users and people on waiting lists, generated for internal purposes or for the Scottish Executive, yield quantifiable data that is being used in planning service provision. Service usage can be compared with prevalence rates to indicate potential or unmet need. Comparative information from Scottish Executive and Accounts

Commission or Audit Scotland reports allows authorities to compare their performance and patterns of provision against others. The requirement, under best value, for authorities to benchmark with each other suggests that this is likely to become a more common approach in needs assessment.

Some care is needed in the use of such information. It may tell more about services than needs or unmet needs, particularly where assessment and care management are not needs-led in approach. It is possible that the current use of services could reflect their availability and inequities in provision rather than provide information on user preferences or the effectiveness of services. Furthermore, those who make most use of services are not necessarily those in most need. Planning that is founded predominantly on patterns of service usage is likely to result in more of the same provision rather than a strategic view of service development.

2.1.2.6. Aggregated information from individual care plans

The aggregated information from assessment and care management can provide valuable quantitative and qualitative data on:

- the needs of older people and their carers
- patterns of service usage
- whether current services are satisfactory in meeting needs
- the need for service developments.

This should inform community care planning for both commissioners and providers.

There is limited evidence of use being made by local authorities of aggregated details from individual assessments of need and unmet need. It is not acceptable that some authorities do not record unmet needs for fear that they may be required to provide for them.

2.1.2.7. Making a wider use of needs assessment information

The results of population needs assessment are not just for planners and commissioners. Older people who do not yet use services, users and carers, purchasers and providers have an interest in the findings. The information gathered can be presented, in suitable ways, through the consultation process. This can help to inform people's views on needs and services, and enable them to consider options for the future that go beyond more of the same provision to meet increasing levels of need.

Exhibit 6: Approaches to needs assessment

Approach	Advantages	Disadvantages	Methods/Sources of Information
Population Analysis	• Wide range of demographic data available • National and local data • Current and projected data • Abstracts and CD-Rom	• Census data out of date	• OPCS – Census Information • Registrar General for Scotland – Population Data – Standard Mortality Ratio
Epidemiological Studies	• Information on broad range of conditions and prevalence • Indicate potential unmet need	• Local prevalence may vary from expected • Mostly relates to health needs	• OPCS Surveys • Scottish Needs Assessment Programme • Research studies
Comparative Studies	• Local service provision set against other areas or national norms • Basis for equalising provision	• Not necessarily a correlation between provision, use of services and needs	• Accounts Commission reports • Scottish Office/Executive reports • SWSI Reports • ISD Reports • Best Value – benchmarking
Individual assessment of need	• User-focused • Participatory • Information on needs, priorities and preferences • Qualitative and quantitative Information can be aggregated	• Retrieval of information may be difficult so synthesis and analysis may not be feasible	• Community care assessments • Self assessments • User and carer interviews or surveys • Personal housing plans

Approach	Advantages	Disadvantages	Methods/Sources of Information
Stakeholder consultation	• Broad range of qualitative information • Participatory – involving wide range of interests • Helps priority setting	• May not be representative • Synthesis and analysis of information may be difficult over range of sources	• Surveys by questionnaires and interviews • Focus groups • Advocacy groups • User and carer groups • Conferences etc.
Community involvement	• Local focus • Participatory – involving wide range of interests • Brings community dimension to community care	• Risk of loss of focus to breadth • May not be representative	• Surveys • Search conferences • Participatory rapid appraisal • Citizen juries • Action planning

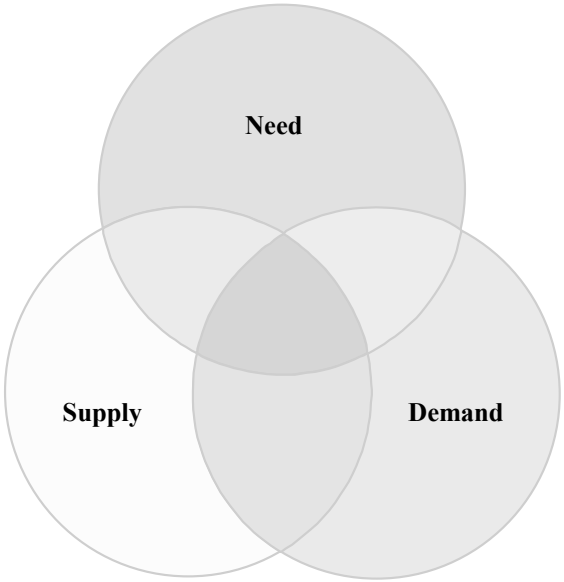
2.1.3. Understanding and 'managing' the market

2.1.3.1. Mapping need, demand and supply

The relationship between need, demand and supply of social care services is complex and shifting particularly because of the range of statutory and independent sector providers in the market place. Nevertheless, the aim is to maximise the match between needs, demand and supply by understanding and 'managing' the market (Exhibits 7 and 8).

Exhibit 7: Identifying a match between need, demand and supply

Maximising the match between need, demand and supply is fundamental to managing the market.



'Managing' the market means influencing the supply of services to achieve strategic objectives in commissioning. Since the aim is 'doing the right things' to meet need, a good understanding of need and demand is fundamental. Shaping provision in order to meet need requires an understanding of available services, and factors that influence supply and the potential for service development. 'Mapping' the market will provide comprehensive information on need, demand and supply; the relationship between these; and the factors influencing them (Exhibit 8).

Exhibit 8: Dimensions of mapping the market – making links between need, demand and supply

Need and Demand	Demand and Supply	Supply and the local authority
By area or locality, authorities should ask: • How many people are receiving which services? • What are the characteristics of service users? • Which needs are being met by which services? • What levels of service are being provided? • How long do users remain with services? • What are users' and purchasers' views of services? • What are the perceived shortfalls in current services? • What are the perceived gaps in provision? • What are the reasons for population variations in need for services? • How are needs and demands changing?	Authorities also need to understand the capabilities and constraints of providers. Information will be available from service directories, authorities' contracting and purchasing services, Registration and Inspection reports, funding applications and agreements, and agencies' annual reports and promotional materials. More specific questions may have to be asked directly of providers. For each area of the market details on supply should be available to tell: • Where do referrals/requests for service come from? • What is the range of needs that can be met? • Does location of provision meet patterns of demand? • Is there over-capacity or under-capacity in services? • Are providers reliable? • Do providers meet quality standards – and whose? • Are service costs competitive? • What are the unit costs and special rates? • What are the gaps in the range of services required? • Is there potential to meet gaps in provision? Authorities should be asking the same questions of in-house services as they are of independent providers. Availability of local authority provision has a direct bearing on the care market and the potential supply through the independent sector.	A commissioning strategy must take account of the potential effect of that strategy on supply and will need answers to questions about the local authority's relationship to the market. • What is the balance between sectors –continuing health care, local authority, voluntary, private – across areas of provision? • What are the sources and levels of funding across areas of provision – residential care, nursing homes, day care, home care etc.? • Who are the major suppliers – what is their share of the market – how are they funded? • Who are the key suppliers of specialist services – what is the level and source of funding? • What are the weaknesses in supply – in terms of availability and vulnerability – and what accounts for these? • Does supply reflect the current commissioning strategy and stated purchasing intentions.

2.1.3.2. Changing the focus of services to meet need

There are many examples across Scotland of active planning to cut services, which are not effective, efficient or achieving policy objectives, in order to release resources for more appropriate investment. Most notably this has happened where authorities have proposed the closure or disposal of their own residential homes to improve existing provision or release resources for alternative forms of care. The public and political opposition to such proposals makes changes that involve cutting existing services a difficult option. This will be easier to justify when done on the basis of need, cost effectiveness and priority rather than in response to budget overspends.

It is not in the interest of users, purchasers or providers if the range of provision is reduced. Authorities should expect to engage in open dialogue with providers about their place in the market. This would encourage good providers to look at how they might re-shape their services to secure their market position.

In order to make the best use of resources, authorities will have to consider criteria for changing services based on information about need, demand and supply. Specifically they will need answers to the following questions:

- what do population projections suggest as areas of changing need?
- what are the policy and practice decisions in health and social work that are affecting commissioning?
- what are the priorities in maintaining supply?
- what shifts in provision will be required?
- are there opportunities to change and reshape existing provision?
- where is the potential for developing new services?
- which services should be discontinued as ineffective, inefficient or inappropriate?

An explicit commissioning strategy is needed, which:

- is based on a sound understanding of the local market and its capacity to develop and change in line with the changing needs and priorities of older people
- evaluates a range of options to determine how best to meet need, ensure equity and provide value for money
- sets clear priorities.

Developing this strategy will involve explicit questions about the potential for reconfiguring services in line with needs. These will most likely challenge historical patterns of provision that may no longer offer the best way of meeting need. In developing a commissioning strategy authorities should take account of the effect of resource allocation on supply. Local authorities are major, sometimes sole funders of independent providers, through grants and purchasing arrangements. Therefore, changes in policy and practice can have a significant impact on the confidence and stability of this sector. Failure to 'manage' the market can result in scarcity or over-capacity.

⇒ See sections 2.2.3, 2.2.4 and 3.3.1 for further discussion of working in partnership with other agencies and contracting arrangements.

2.1.4. Responding to national policy objectives

> "Without good information we cannot properly plan or manage social work services --- Without good information it will be very difficult for you to begin to tackle Best Value."
> --Few authorities seem to have adequate systems in place at present. This is in many ways the most serious problem we face."
>
> Source: Sam Galbraith, ADSW Annual Conference, May 1998.

Since *Caring for People* and the *NHS and Community Care Act, 1990*, central government has set the agenda for community care based on principles of:

- flexible services tailored to the needs of individuals
- care at home or in homely settings
- value for money
- a mixed economy of care.

Modernising Community Care reinforces these principles and emphasises the necessity of greater changes to the commissioning and provision of community care in order to achieve them. The scale of the task for authorities will vary with the extent to which they have made progress already in achieving the key objectives in community care. The action plan expects better and faster decision-making; people to be cared for at home wherever possible; and a new emphasis on working better in localities.

For local authorities the challenge is to strengthen the commissioning process to achieve the changes necessary for modern, effective services. There are two major barriers to this:

- authorities' relatively limited progress towards developing a commissioning culture
- poor information.

A commissioning culture, in its broadest sense, is needed to secure the change from a 'service' driven to a 'needs led' approach; from rigid, 'traditional' services to flexible 'modern' services; from doing things to people to doing things with and for them; and from 'processes' to results[viii]. That is the focus of this handbook.

In addition, a commissioning strategy that is not founded on good, reliable information about 'needs, priorities, and expectations' is unlikely to result in the delivery of best value services. The collection, analysis and flow of information needs to be managed as part of an information strategy that recognises the link between information management and effective commissioning and service delivery. There is potential for better sharing and co-ordination of information between local authorities, and between authorities, health boards and other agencies. This should be considered as a key component of any information strategy.

Case study 4 - Joint management information strategy

Scottish Borders social work department and Borders Health Board are committed to "agree on policy and specific requirements for the sharing of information which satisfy standards of confidentiality". Complementary information strategies will include:-

- development of a network link between the social work department and the NHS;
- seeking agreement on access to view social work department and NHS client indices by either party, subject to necessary permission and security protocols;
- investigation of the use of NHS client number in the social work department computer system, to enable more effective cross reference of data;
- joint working to establish, maintain and develop a definitive data set for sharing between the social work department and NHS;
- investigation of the feasibility of information on NHS and Scottish Borders Council intranet and web sites.

The ongoing work of the Social Work Information Review Group in producing a statement of Local and National Information Requirements and best value key performance indicators, with the aim of achieving a national minimum data set for social work, should provide a sound basis for authorities' information strategies. In the meantime, processing of information remains a weak link in the commissioning cycle.

Self assessment checklists

2.1 Do we understand the needs, expectations and priorities of all our stakeholders?

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
2.1.1. Consulting with older people and their carers		
We have user and carer groups for older people, with which we regularly consult.		
The views of users and carers are collected systematically to identify gaps in services, and service improvements.		
We make an effort to include representation of all older people in our local communities, including people who traditionally have been less consulted (frail older people, people from minority ethnic groups, people with sensory deprivation).		
We provide support to people to participate in local consultation exercises, including transport and respite care.		
We provide information to participants about the purpose and intended outcomes of the consultation exercise.		
We use a range of methods to consult with older people. These are chosen to suit the intended purpose.		
We make a commitment to follow up feedback obtained through the consultation with action. Where this is not possible we explain why changes will not be implemented as a result of the consultation process.		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
2.1.2. Assessing the needs of the population		
We are clear about the limitations of the data sets we use and take action to fill gaps in data.		
We have matched population and prevalence data against local data		
We make use of data collected by our commissioning partners – health, housing etc.		
We make use of a range of quantitative and qualitative data.		
We aggregate information from assessment and care management on unmet needs to inform community care planning.		
We use the findings from population needs assessment to inform consultation exercises.		
2.1.3. Understanding and managing the market		
We have a documented commissioning strategy, which: • has been agreed with local health and housing agencies • sets priorities • is based on the needs of users rather than organisational constraints • incorporates a thorough understanding of the market • evaluates a range of options to determine how to deliver services to meet needs, ensure equity, and achieve value for money		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
• has been discussed with providers • takes a long term view of where the authority wants to be • has targets and outlines a way of monitoring whether these have been achieved • sets out purchasing intentions for independent sector providers.		
Our commissioning strategy includes financial modelling to assess likely spending implications and matches these to estimated resource projections.		
We have identified the areas of current activity, which need to be decommissioned to meet our objectives. Elected members have agreed these.		
We have up to date information on providers: number, location, and quality.		
We have a clear idea of how we compare with other similar authorities in terms of: • expenditure on different service types • expenditure on different sectors • proportion of resources on assessment and care management against spend on provision of services.		
We know what proportion of our expenditure is accounted for by our 3 largest independent sector providers in: • home care • residential and nursing home care.		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
We know what proportion of the local market we represent in: • Residential care • Home care • Respite care • Day care.		
We use market management and pricing strategy to influence the local market in the areas of: • improving quality • encouraging new providers in areas where the limited number of providers threatens adequate competition • encouraging innovation and the development of new services to meet identified need.		
We analyse the source of our referrals to get a clear picture of where demand is coming from.		
We have plotted current location of services against population need.		
We collect information on the quality of services.		
We collect information on the cost of services and compare these on a regular basis.		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
We know how many older people are currently supported in all types of services, and we have a user profile by age, gender and ethnic group.		
We have length of stay data on older people in different service types.		
We have access to length of stay data in health settings.		
We have a clear idea of current levels of unmet needs, gaps and shortfalls in provision and these are used to inform the commissioning strategy.		
2.1.4. Responding to national policy objectives		
We are complying with the requirements to provide information in line with SWIRG's Local and National Information Requirements.		

2.2 We have decided on the best ways to meet these needs, expectations and priorities

2.2.1. Making commissioning more user-focused

Research shows that the priorities of the majority of older people are to retain their independence and remain at home in their own community. Promoting independence at home is a broad aim for community care, and the commissioning of services needs to reflect this explicitly at all levels from strategic planning through to care management.

2.2.1.1 Independence through prevention

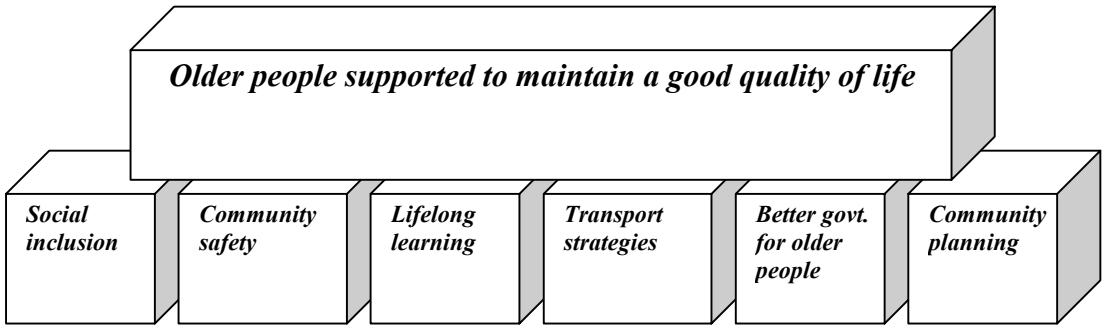
Services may compensate for loss of independence but they may also prevent or delay the onset of conditions that lead to this loss. Research into the importance of preventive services to older people has revealed their value in helping people to help themselves and to exercise the choice and control that gives a sense of independence[ix].

In looking at the possibilities for preventive approaches in community care, commissioning should look beyond the needs of current service users for social and health care services and consider with older people what they need in order to maintain their independence and a good quality of life in their community. However good they are, health and social services alone will not keep older people at home. An inclusive approach to the older population, through the sorts of methods outlined in section 2.1, is important if preventive strategies are to prevent or delay the need for more intensive health and social care services.

2.2.1.2. A new partnership with older people

A wider view of care in the community by influencing provision in other areas of service is therefore needed (Exhibit 9). Independence and choice should be aims set for all services for older people– not just community care provision.

Exhibit 9: The range of other policy initiatives that impact on older people's quality of life



The Better Government for Older People project has identified 5 key areas which commissioning strategies for older people's services need to address explicitly[x] :

- combat age discrimination
- effectively involve and engage with older people
- improve decision-making
- better meet the needs of older people
- tackle the barriers that prevent a strategic and joined-up service.

This requires a corporate response to older people's services, and older people's strategies are now being developed on both a corporate and multi-agency basis. At their best these can encourage:

- joint commissioning between agencies and across local authority services
- the involvement of local communities in community care
- initiatives that older people run themselves.

Case study 5 – Better Government for Older People

South Lanarkshire Council has been one of the better government for older people pilot sites. Over 100 older people attended the council's 'You and your money' event organized by the sub-group on finance and older people, which has also developed partnerships with the Benefits Agency and Inland Revenue to improve their user-friendliness.

Case study 6 – Edinburgh's 'A city for all ages': towards a city plan for older people 2000 – 2010

The Policy and Resources Committee approved this initiative in March of this year. It involves a ten year 'vision' statement and a five year draft action plan for better services and opportunities. This is out currently for consultation with older people, key organizations and city partnerships.

The action plan covers a range of council services from leisure, recreation and lifelong learning through to housing developments using 'smart' technology and social care services. Funding has been allocated to priority tasks.

Case study 7 - Consulting and involving citizens

A multi-agency community development project in rural Aberdeenshire used a community conference to consult with local people on the issues and needs in the area and their priorities for development. Two of the main issues identified by participants were the need to develop local services for older people and improve local transport. The project followed through on the conference with initiatives to involve local older people and interested organisations in specifying needs and planning ways of meeting them, linking this to consultation for the Council's Older People's Strategy. Action arising from consultation has resulted in new resources and services to the area. Community involvement and action is at the heart of the approach resulting in wide support for local community care initiatives.

2.2.2. Improving the effectiveness of care management

"..statutory organizations should delegate decision-making to the lowest effective level, and set challenging but fair targets for key decisions."

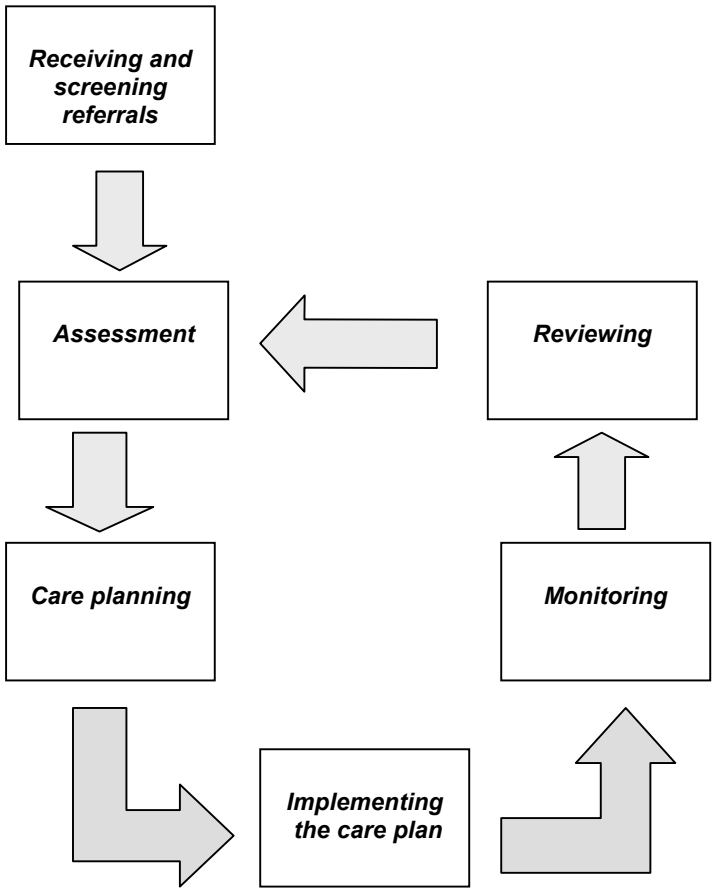
Source: The Scottish Office , Modernising community care, 1998.

Care management with its emphasis on needs led care, is founded on principles of participation and choice and should be the vehicle for ensuring that users' needs are met. Care management should:

- help people express and understand their own needs and their priorities and hopes for meeting them
- assist them in making choices by providing information about the provision available
- ensure that care arrangements are what people need and want both now and for the future. This implies a level of monitoring and reviews, which is not always in evidence.
- ensure that unmet needs and people's views on services are recorded.

Whilst all authorities have systems in place for care management, organisational arrangements differ and the terminology to describe care management varies. For the purpose of this handbook, care management is defined as the process of tailoring provision to meet individual needs. This involves a number of core tasks (Exhibit 10).

Exhibit 10: The care management cycle



Receiving and screening referrals - This should determine who receives a service through care management, based on eligibility criteria.
Assessment - The key to good care is an holistic assessment that involves users and carers in determining their needs and priorities and preferences for meeting them, and responds to changing needs. A written assessment or statement of need should result and unmet needs should be recorded and reported. Financial assessment is part of this, where appropriate, for purposes of charging for services and maximising users' income.
Care planning - The care to be provided should be decided in consultation with users and carers with regard to offering choice and with consideration of the available budget, cost of services and social work policies. This should result in a written care plan.
Implementing the care plan - This involves making care arrangements and securing and co-ordinating services to meet needs, as set out in the care plan, and in accordance with any contractual agreements the authority may have with providers.
Monitoring - Proactive monitoring and fine tuning of care arrangements are essential to ensuring that users' current and changing needs are met, and that providers fulfil their obligations. Users, carers, providers and other relevant parties may be involved as well as the care manager.
Reviewing - At regular intervals it is necessary to reassess needs and the effectiveness of care arrangements with a view to changing the care plan, if necessary, in conjunction with users and carers.

Authorities' arrangements for care management broadly follow two models – role or task (Exhibit 11).

Exhibit 11: Models of care management

Role model	Task model
Professional staff are employed as care managers to undertake, or with responsibility for, all the elements within care management. The purchaser / provider split is well defined in this model.	Care management is itself a task or function carried out by particular staff in addition to their other duties, usually as service providers.

Within these models there are further differences over which staff operate as care managers; whether the same worker undertakes all the elements of care management; and whether the service is generic or specialist.

However, the most significant difference between authorities is not in the model of care management adopted but the extent to which they have removed the barriers to care management as an effective means of commissioning. The main problems are with:

- lack of clarity over who care management is for, resulting in poor targeting of specialist resources
- lack of delegated responsibility to care managers, resulting in delays in implementing care plans
- inadequate information to support care management
- extending the care management role into other agencies.

2.2.2.1. Clarity on the targeting of care management

There is a cost to the provision of a care management service that adds to overall care costs. It should therefore be used where it can be most effective in ensuring a co-ordinated response to older people's changing and complex care needs.

The demand for care management skills is likely to increase in line with the growing number of people with complex care needs being provided for at home. Care management will need to become increasingly focused on monitoring and reviewing care in response to changing needs – essential care management tasks if services are to be used to best effect.

At a local level, managers need to ensure that care management resources are used efficiently and effectively (Exhibit 12).

Exhibit 12: Balancing needs and resources in care management

Managing care management resources requires that:

- eligibility criteria for care management are clearly stated and followed
- eligibility criteria reflect levels of need and demand on services
- the deployment of care managers reflects population need
- care managers' workloads permit them to respond to changing needs
- arrangements are in place for monitoring and reviewing care packages
- performance targets are set (and being met) for all elements within care management.

⇒ See also section 3.1.2 Eligibility criteria

2.2.2.2. Delegating responsibility in decision-making

In care management decision-making should be at the level of the care manager in conjunction with the user and carer. Within the care management process the degree of responsibility and autonomy given to care managers varies at 3 key stages:

Screening decisions are most likely to be made by team leaders. With well-defined eligibility criteria there is no reason why individual care managers could not make these.
Care managers invariably carry out **assessment of need and care planning** in liaison with users, carers and other relevant parties. However, their involvement in monitoring and reviewing care needs differs according to authority.
Commitment of resources is where there is most variation, and the way in which this is managed can directly impact on the types of care packages offered to individual people. Once assessments and care plans are agreed and services need to be commissioned or purchased, care managers may find that they lack the authority to commit resources or that they may do so only for in-house services or within narrow limits that restrict choice. Users can face delays in getting services while permission is sought from team leaders or resource managers to implement or revise the care plan.

Central government has encouraged the devolution of budgets with a view to stimulating more responsive and innovative services through flexible purchasing. Users, carers and care managers will be aware of resource constraints and are arguably in the best position to decide how the available resources can be used to meet the individual's needs and take account of user choice.

The examples given in Exhibit 13 illustrate some current variation in setting levels of budget delegation and restrictions on choice of provider. They highlight the impact that this has on developing flexible care packages for older people and care managers' ability to influence the balance of care in line with national and local objectives.

⇒ For more on managing devolved budgets see Section 3.4.1

Exhibit 13: Variation in delegation leading to different levels of flexibility in developing care packages

Authority 1 – needs-led assessment and service-led provision resulting in very little shift in the balance of care from institutional to home based services	**Authority 2 – different treatment of in-house and independent sector provision resulting in limited home care developments**	**Authority 3 – more decisions made at a lower level and developing more home based care**
The purchasing budget for community care is managed centrally. Expenditure is set annually by type of service and on an area basis, according to historical patterns of spend. There is no capacity for virement but within service budgets it is possible to shift resources between area teams. For older people area-based community care teams are given a resource allocation that includes local authority services, voluntary sector provision which is mostly day care secured through block contracts, and a number of nursing home beds per month. Teams have in addition a small 'flexible' budget to purchase services that would not be available to them otherwise. One area team described decision–making thus - Social workers undertake care management and are expected to carry out a needs-led assessment. But care ends up being service led. ⇓ A written request by pro-forma for a package of care is put for approval to the senior social worker who is the team leader. The cost of care packages approved by the senior is limited to the cost to the authority of a nursing home place. ⇓ Beyond this limit, approval is sought at the centre from a senior manager. The flexible budget allows some spot purchasing and the care manager checks invoices for payment. Administrators log expenditure monthly. In this system the senior has an overview of the use of local resources and what is spent from the budget, but not of budgets overall. Care managers have 'no idea' of	The purchasing budgets for community care is devolved to the area social work manager, on the basis of historical spend. The community care team and specialist provider teams access this single budget. Care managers may arrange in-house residential, day and domiciliary services to the cost to the authority of a nursing home place. There is no shadow costing for these services and no unit costs are available. ⇓ The senior social worker may authorise purchase of independent sector services up to £100 per week per user. ⇓ The assistant area manager may authorise expenditure up to £200 per week per user on independent services. ⇓ The area manager takes decisions to purchase services over £200 per week per user. High–cost care packages are those above the cost to the authority of a nursing home place. There is no set limit of time or cost on them but they are reviewed regularly by the care manager, senior and area manager. Usage of residential and nursing home care is high. In-house services are expected to be the first choice for care managers and the range of independent providers of domiciliary care is limited. External providers are used for more specialist services or where in-house	The purchasing budget is devolved to care management teams led by a senior care managers Care managers commit in-house residential and day services through negotiation with providers. They purchase local authority home care services. Care managers purchase the full range of services from the independent sector, up to the cost to the authority of a nursing home place. ⇓ The senior care manager approves care costs beyond nursing home levels up to £500 per user per week. ⇓ Costs beyond £500 per week are referred to the social work manager for decision. There is no limit of time or cost of packages over the nursing home rate but they are reviewed three monthly. More of these are purchased through local authority home care than through the independent sector. Care managers keep commitment records and a new client information system holds detail on care packages and costs and will inform financial systems. Purchasing care is on the basis of need and the balance is shifting from residential to home based services, with new domiciliary providers and the closure of local authority homes.

Authority 1 – needs-led assessment and service-led provision resulting in very little shift in the balance of care from institutional to home based services	Authority 2 – different treatment of in-house and independent sector provision resulting in limited home care developments	Authority 3 – more decisions made at a lower level and developing more home based care
budgets overall and a 'rough idea' of individual care costs, but do not know the true costs of high-cost packages. They are aware of the hourly rates of domiciliary providers but not the unit costs of in-house services. In this model staff expressed concerns about the limited range of provision; lack of choice; inflexibility of resources; and the impossibility of stimulating development or shifting the balance of care. Care managers did not see the benefit of devolved budgets. They were concerned at the workload implications, that they might have to manage scarce resources and that they would lose the main focus of their work – assessing need. They thought it enough that the senior knows what is spent from the budget. The senior wanted more flexibility, the possibility of virement, more local planning and less centralised systems. In another area of the same authority the community care team is making changes to its structure to achieve better targeting of care management. The team faces the same frustrations with resource allocation as the previous team. They are keen for budgets to be freed up to allow more local purchasing and believe that since they do not use their nursing and residential care allocation that budget should come to the team. The team leader has been looking at systems for devolved budgets and is looking at commitment recording and ways of identifying unit costs. This team sees local control of budgets as the way to more responsive services. **A more coherent council-wide approach to commissioning is needed.**	services cannot provide. This authority plans to devolve budgets to community care teams with any staff taking on a purchasing role. There are proposals for joint teams with health. **Better financial and management information systems will be needed to support devolved budgets. The inequitable treatment between in-house and independent sector services will need to be addressed.**	This authority is planning an evolutionary change from the purchaser / provider arrangement of care management to primary care teams, bringing together social work, health and housing on a locality basis, with purchasing responsibility through pooled budgets under the overall responsibility of a single manager. **Better financial management systems may be needed for pooled budgets, but the cultural shift has been made to delegate decision making.**

2.2.2.3. Information to support care management

Irrespective of whether they manage a budget or not, care managers need reliable information about local services. They also need to understand their authority's commissioning strategy and how their personal decisions in developing individual care packages can influence the local market. If devolved budgets are in place, good financial and management information is also required.

Information on local services

In order to make decisions based on objective comparisons and to help users make informed choices, care managers need the following information about *all* providers, including in-house services:

- the quality of services
- the unit cost of services and any special terms or negotiable rates
- the contractual arrangements that are in place.

This information is available from a number of sources: their own caseloads; local registration and inspection reports; the work of contracts officers; and increasingly best value in-house service reviews. All of this should be made available to care managers in an easy-to-use form, which can be discussed with potential users and carers.

Implementing commissioning strategies

Care managers must understand their authorities' commissioning strategies if they are to contribute to achieving local and national policy objectives. They can also help inform these strategies, through locality planning or by other mechanisms which link central and local decision-making, as their work with individual older people means that they are well placed to identify need and unmet need.

Specifically care managers need to understand:

- How policy and strategic objectives in commissioning will influence purchasing, and how they can contribute to, or inhibit, shifting the balance of care.
- How their care planning decisions may be shaping the market, and on what basis they and service users are exercising preferences about services and providers.
- Their role in identifying unmet need and developing local services.

⇒ For a discussion of information to support devolved budgets see section 3.4.1

2.2.2.4. Extending Care Management

Finally, the potential for extending the care management role to suitably qualified staff in other agencies is being actively addressed in a number of authorities. This is being done through staff such as district nurses, in a key worker role, taking on aspects of care management in shared cases. In joint projects or teams they might take on the whole function where it is in the interest of the user and compatible with their professional role. Consideration needs to be given to joint training and appropriate support but there are clear benefits in avoiding duplication of work, making good use of skills and resources, and offering continuity to users.

For example, South Lanarkshire Council and North Lanarkshire Council are working with local health bodies on a pilot project on developing joint assessments. East Renfrewshire Council has been participating in a pilot on the use of a common assessment tool – Carenap E – in a multi-disciplinary team based in a medical centre.

Case study 8 – Perth and Kinross

Perth & Kinross Council, Tayside Health Board, and the new Tayside Primary Care NHS Trust have joined together in a project that will investigate how they can create a fully integrated and flexible health and social care services for the whole of the adult population of Perth & Kinross.

In order to achieve the objective of a single agency approach, integration at 2 levels is being worked upon:

- **At the Planning, Commissioning and Financial level.** This will require the bringing together of the present responsiblities of the Health Board and Perth & Kinross Council under the control of a Joint Commissioning Body.
- **At the service delivery level.** This will require the amalgamation of the Primary Care Trust Services in the Perth & Kinross area and the Council's Adult Care Services who would be charged with responding in a holistic way to assessing needs and providing and/or arranging health and social care services to meet those needs within the limits of approved policy and agreed service levels.

The agencies are aiming to provide:

- a single visible identity for health and social care
- a one-stop reception and assessment service
- an integrated and flexible range of services
- complete joint working between all disciplines and staff
- a new financial infrastructure.

The partnership is funded by £1,000,000 from the Government's new "Invest to Save" budget, awarded to schemes aimed at bringing public bodies together and making resources available now to deliver more efficient services and provide a better deal for people using them.

Case study 9 - Key features of care management in Aberdeenshire

Approach…	role model; task model for joint health and social care 'old age psychiatry' teams
Organisation..	care management teams led by senior care manager linked to Primary Health Care Teams or GP practices.
Staff…	social workers, occupational therapists or nurses.
Referrals…	from all community care groups from any source with client or carer agreement directly to care managers for action on basis of eligibility criteria.
Budgets…	devolved to teams or individual care managers commitment recording through weekly spreadsheets to keep track of spend monthly financial reports with detail of spend and commitment projected to year end.
Purchasing..	according to need from any sector to the limit of the cost to the council of a nursing home place high cost care packages approved by social work manager.
Supported by..	contracts officer finance officer.
Performance..	guidance material on procedures and standards performance indicators for each element of care management.

See also case studies 23 and 30 for further information on eligibility criteria and financial information available to support care management in Aberdeenshire.

Case study 10 - A partnership approach to care management in Scottish Borders

Pilots of new care management arrangements were run in 3 locations during 1999, with funding from the Scottish Executive. This came out of the Better Government for Older People initiative in the Borders. In addition to social workers, community nurses and occupational therapists can assess need, arrange services, and access resources directly from the Social Work Department via team seniors.

The aims of the approach were to:

- improve access to services
- avoid duplication of assessment
- provide more timely services
- make the best use of resources
- set quality standards for care
- develop strong partnership working.

The external evaluation of the pilot identified 3 key components in managing the successful implementation of a partnership model of care management:

- managing and maintaining multi-agency commitment
- creating and reinforcing the appropriate culture through developing shared values and a set of quality standards
- providing appropriate practical support to staff.

The value of allowing organizational flexibility was particularly highlighted as it had led to benefits for users and carers through faster response times and opportunities for combined health and social care assessments.

2.2.3. Working in partnership with other commissioning bodies

Local authorities have the lead role in commissioning community care services for older people. However, they cannot work in isolation and joint working with other key bodies is essential in order to achieve change. The principal partners in commissioning community care - social work, housing and health - are collaborating on a number of levels (Exhibit 14).

Exhibit 14: Collaboration in developing community care for older people

Working together is needed at a number of different levels – commissioning is at both the strategic and operational level.

Applicable at all levels

- listening to what older people say they want, as a basis for planning services
- commitment to social inclusion for older people.

Strategic

- population needs assessment to map health, social care and housing services and identify needs
- co-ordination between health, housing and community care plans to extend the range of services including housing and housing with care options
- development of the enabling and brokering functions of local authority housing services
- involvement of older people and relevant agencies in planning and tendering for services

Operational

- understanding of the roles and responsibilities of agencies and staff
- joint development of procedures and protocols for sharing information, assessment of need, including consideration of housing options, allocation of housing, improvement and adaptations
- joint training in areas of mutual concern
- information for users and carers on health, housing and care services in appropriate format

Individual

- joint assessment to ensure housing, health and social care needs can be expressed, with regard to confidentiality
- collaborative working arrangements to devise, implement, monitor and review care plans
- commitment to offering choice in housing and care arrangements
- understanding of the roles and responsibilities of staff in different agencies and services available

All three partners are charged with responsibilities for caring for more people in their own home. Their success in achieving this will depend on recognition of their mutual dependence, openly addressing the pressures that this is creating and working together to re-shape provision (Exhibit 15).

Exhibit 15: Principles for partnership working in commissioning community care for older people

Successful partnerships have common features. Typically they:

- take place when appropriate
- set clear objectives for joint working
- identify needs
- agree the level and source of funding or resources to meet those needs
- reach agreement on the respective roles and responsibilities of the different agencies involved
- communicate in an open and transparent way
- involve other key stakeholders as appropriate.

2.2.3.1. Joint working with health

Health and social work services face similar pressures arising from:

- a growing population of older people who are living longer due to improvements in public health and medical advances
- the increasing pressure from central government and users of services to speed up the move from hospital and institutional care to community or home based care for older people
- a growing requirement to demonstrate cost effective services through best value and clinical governance.

It is important, therefore, that they plan and work together, particularly as many of their services for older people are inter-dependent, and making changes to one service can have a direct knock-on effect on others (Exhibit 16).

Exhibit 16: inter-relationship of policy and practice in health and social care services

Policy and practice changes and pressures in health care have a direct bearing on the demand for social care, and vice versa.

Health ⟷ impacts on ⟷ Social care	
Health bodies have: • an increasing number of older people being admitted to hospital • earlier discharge from the acute health sector • a reduction in the number of long term and continuing care beds for older people • limited health care options between acute and long stay care, such as convalescence and rehabilitation services • additional responsibilities in primary care.	Social work may have: • lack of affordable alternatives to nursing home care • unmet demand for nursing home places, resulting in some older people staying in hospital longer than necessary • an increasing number of older people requiring high levels of care, including health care, in community settings.

There has been less progress in joint commissioning for frail older people than there has been for other client groups. Long stay 'geriatric' bed closures have tended to be more piecemeal than some of the larger scale resettlement programmes for people with mental health problems or learning disabilities. Consequently, strategic planning for older people's services has tended to be weaker making it harder to identify ways of resourcing alternative services to hospital and nursing home places.

Many areas are beginning to develop better joint commissioning arrangements for older people's services. The development of Local Health Care Co-operatives (LHCCs) and joint working at locality level should facilitate this.

At the most basic level, good information on services, policies and procedures is needed in order to ensure that the inter-face between health and social care operates efficiently; that older people can receive integrated health and social care packages; and that opportunities to develop community based services are identified.

Case study 11 - Bed forecasting, 1998 to 2006

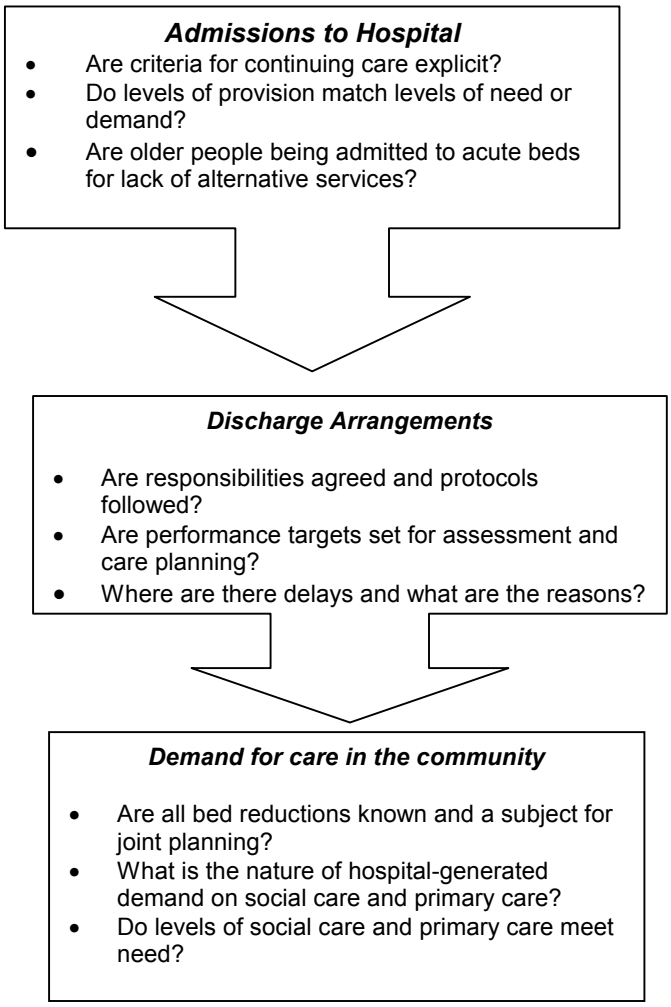
Scottish Borders Council and Borders Health Board worked together to identify future need for residential and nursing home beds and "new care packages" over an 8 year period. Predictions were made from the analysis of information from a number of sources: population projections and mortality rates applied to each area of provision; placement rates and commitment records; number of private placements; a residential and nursing home survey; the Health Board's continuing in-patient survey; and bed occupancy figures.

Two scenarios were developed for the balance of care between residential and nursing home places and new care packages comparing the forecasts for 2001 and 2006 with the 1998 position and applied on a geographical basis. Funding sources were projected across each sector including resource transfer. From this exercise detailed data is now available to inform Scottish Borders' commissioning strategy and their plans for shifting the balance of care.

The aim of the sort of mapping illustrated in exhibit 17 is to produce the information that will allow social work and health to:

- highlight intra and inter-organisational issues that need to be addressed
- establish the balance of provision that is needed between NHS continuing care beds, nursing and residential home places, and home-based care
- identify gaps in provision as a basis for:
  - agreeing common priorities
  - sharing procedures
  - re-shaping and planning alternative services.

Exhibit 17: Jointly mapping information on services, policies and procedures in 3 key areas



Case study 12 - Moving forward together on best value reviews

East Renfrewshire Council and Argyll and Clyde Health Board are carrying out a joint best value service review of all health and social care services for older people.
They are sharing information on needs, existing services and resources in order to:

- consider the local balance of care
- identify areas for service development
- identify areas where joint working can benefit the older person, for example in joint assessments
- minimise duplication of care between the agencies
- make a more effective use of joint resources.

Achieving a shift in the balance of care while responding to on-going demand will not be easy. Where there is a high use of nursing and residential homes alternative community provision is likely to be lacking in both health and social work. In those authorities where current demand for funding for nursing home places cannot be met and older people are having to stay in hospital longer than necessary, maneuverability will be particularly curtailed. Service users will suffer the consequences of inappropriate care.

Changing the balance of care

There are two areas of provision where joint commissioning could begin to change the direction of care:

- prevention of admission through **developing home care services**
- faster and better planned hospital discharge through **rehabilitation.**

Developing home care services

Home care services face a number of challenges:

- extending provision
- providing preventive services
- meeting the personal care needs of the most frail users, including support to allow health care needs to be met
- helping to meet social care needs of older people living on their own, thereby enhancing their quality of life.

Since the community care reforms of the early 1990s the boundary between health and social care services has been steadily shifting with many services previously provided by the NHS, such as help with bathing, being defined as ‘personal care’ and now being provided and commissioned by local authorities. This has led to some charging anomalies where a service provided by health staff is free but the same service provided by the local authority is likely to be means tested. This was highlighted by the Royal Commission on Long Term Care and has funding implications for local authorities.

Some authorities have made considerable progress in developing home care and have well established personal care services. Others are re-shaping traditional home help services to meet changing demand. Whatever the state of current provision the shift from institutional care can be achieved only if comparable levels of care can be provided in people's own homes. This requires a joint approach from health and social work, which avoids demarcation and unhelpful distinctions between services, while clarifying respective responsibilities.

The 'grey areas' between health and social care, such as bathing, medication and nutrition, can cause disputes about who should do what. These, therefore, provide a good starting point for joint approaches particularly for those users who need intensive health and social care. Here the principle of shared care should be adopted, with home care staff supported and trained by health professionals. For users the aim is an integrated service that meets their needs in a coherent way irrespective of who is providing the care.

There are many enhanced or augmented home care projects set up by health and social work. These have been developed to allow earlier discharge from hospital or to prevent admission. A few schemes are well established and permanent with joint funding, others operate on a temporary basis with short term funding from health to relieve pressure on acute beds over the winter months. These initiatives vary in the services that they offer, in the staff involved and their operational arrangements but there are lessons to be learned from them in planning a joint approach to home care.

Case study 13 – Health and social care partnership in Dundee

'The principle of choice is central to the partnership – the choice to be cared for at home and the opportunity to make choices for day to day living.'

A partnership scheme between Dundee City social work and Dundee Healthcare NHS Trust offers home based care as an alternative to nursing home or long stay hospital to suitable frail and functionally dependent older people. Care can be provided intermittently throughout 24 hours, every day of the year by a team of community care assistants, employed by social work. These staff undertake personal, domestic and social care tasks. Training is provided jointly by health and social work and is ongoing. An occupational therapist with the team offers help to maximize independence and GPs and community nurses provide care as needed. The team manager has a community nursing background and is employed by Dundee Healthcare. There are good links with the district nursing service.

Each user has a named community care assistant and is linked to the community alarm scheme. To facilitate joint working a shared care record is kept in each user's home which includes an individual care plan drawn up with the user, the family and the relevant agencies. Users are given as much choice as possible in their daily routine.

A combined Care at Home Scheme to prevent unnecessary acute hospital admission and an Early Supported Discharge Scheme are also run collaboratively between social work and the trust.

The benefit of rehabilitation services

> "A postponement of the onset of dependency could reduce long-term care costs or assist in ensuring that they were at a lower level".
>
> "Preventative strategies are supported by two arguments; firstly that by delaying the onset of disability and dependency they prevent, or at least postpone, the need for more costly forms of care; and secondly that they improve the well- being and quality of life for older people."
>
> Source: With respect to old age; report by the Royal Commission on Long Term Care. 1999

Many older people are admitted to a nursing home following a prolonged stay in hospital. For many this may be premature. There is evidence that shortage of rehabilitation provision can lead to older people:

- becoming more dependent
- having more frequent and longer stays in hospital
- being admitted to residential and nursing homes earlier than might have otherwise been the case
- needing more costly care packages at home, with family members taking on heavy caring duties[xi.]

There are positive findings for the clinical effectiveness of rehabilitation[xii,] and the development of rehabilitation services is likely to lead to reductions in the demand for nursing home care (largely funded through local authorities) and the number of 'blocked' in-patient beds (funded by the NHS). More fundamentally, rehabilitation can directly improve older people's quality of life.

Reviews from the King's Fund recommend joint action by health and local authorities to:

- clarify the purpose of rehabilitation and channel resources appropriately
- bring together professional teams with different skills
- reshape current services to invest in primary and community care
- introduce comprehensive assessments and adapt services to circumstances
- support innovation in rehabilitation and evaluate new services.

A national development initiative by the King's Fund is promoting the development of rehabilitation through joint action by health and social care agencies with a Rehabilitation Development Network for information exchange[xiii.]

Case study 14 - The client's choice project - rehabilitation in Scottish Borders

This is a joint initiative between health and social work, which aims to maximise older people's independence following a hospital admission and divert people away from nursing home care.

Older people admitted to Kelso Community Hospital are eligible to joint the project if they:

- meet criteria for NHS continuing care or social work criteria for nursing home care; and
- are keen to return home or to a less institutional setting.

Continued rehabilitation is offered to three patients at a time. Discharge planning is multi-disciplinary and, in addition to users and carers, involves all relevant services, including home care and professions allied to medicine.

The project is small scale but in its first year of operation it has enabled 11 out of 18 older people who had suffered major strokes and were likely to be admitted to nursing home care to return home or to residential care.

Work is ongoing in evaluating the cost effectiveness of the project.

Case study 15 – Community rehabilitation service in Edinburgh

This service has been developed and funded jointly by the City of Edinburgh Council's social work department and Lothian Health Board. It is available for older people and adults in north and south Edinburgh. The aim is to provide active, time-limited rehabilitation which restores the patient to previous levels of functional ability and independence, or to reach whatever modified potential is possible following a hospital admission. The main desired outcomes of the service are a reduction in the length of stay in hospital and the avoidance of admission to residential and nursing home care.
Planning the service required a number of key issues to be addressed including funding, agency responsibilities, employment and management of staff.

⇒ For more on joint planning between social work and health see section 2.3

2.2.3.2. Working with Housing

> "The principle of community care makes it harder to justify tying resources to property rather than people. Sheltered housing must accordingly re-invent itself as provision for older people who prefer the presence of a supportive community, or it must re-think the levels of need it is able to support. If it does not it will face serious questions about its relevance in a system which can deliver high levels of support in ordinary housing."
>
> Source: Audit Commission, Home alone, 1998.

Appropriate housing is a basic requirement in ensuring that people are able to live satisfactory lives in the community. Partnership working between social work, health and housing is becoming the norm facilitated by unitary authorities, the bringing together of social work and housing services and working links with housing associations, Scottish Homes and private house builders.

The majority of older people who need care receive it in their own home. As the number of people cared for at home increases, relative to the number who move into residential care, authorities will have to plan for increased demand for:

- home adaptations
- care and repair schemes
- community alarm systems
- tenant support services
- home care provision.

Developing sheltered housing

Another group of older people whose care needs may increase but who will want to remain in their home is that group which has opted for sheltered housing. This generally brings the security of alarm call systems and warden services. However, attention has been drawn to the need for sheltered housing to adapt to meet the requirements of care in the community for non-residential care[xiv].

Some authorities are responding to this by developing joint initiatives with health and housing. They have introduced dedicated teams of home carers, which offer continuity of care, on-site provision of meals and laundry services. In addition, wardens are providing increased support. However, traditional options of ordinary or sheltered housing with care provided as it becomes needed are unlikely to be cost-effective long term alternatives to residential care for the most dependent users, particularly when overnight services are required.

Joint initiatives between social work and housing associations in developing purpose built extra-care or very sheltered housing look more likely to provide a real alternative to residential care. These offer the benefit to tenants of the privacy of their own home in suitable accommodation combined with the availability of 24-hour support if needed. For social work and health they allow some economies of scale in the planning and delivery of services, without detracting from the needs of people as individuals. The costs of 24-hour warden services are passed on to tenants as part of the service charge and at the present time are eligible for housing benefit. Proposed changes to the housing benefit system may have an impact on the affordability of such provision in comparison to residential care.

Case study 16 - Very sheltered housing in Moray

Cameron Court in Forres is a development of accommodation for older people by Hanover Housing Association in partnership with Moray Council. Local care managers and Hanover staff worked together to identify and prioritise suitable applications for very sheltered housing. Tenants have the privacy of their own home with access, as required, to a range of community and on-site facilities. On-site facilities are covered by a service charge in addition to the rental charge. They include meals in the dining room, laundry, hairdressing and assisted bathing facilities. Cameron Court day care offers a range of activities for tenants and others in the community. There is a specially designated suite for people with dementia, short respite breaks are available and a guest suite allows tenants to have visitors. The aim is to provide housing and support for people unable to remain in their existing home who might otherwise need long term residential care, and provide support to help others remain at home.

The development of these housing with care models require that authorities who will be purchasing and providing care and housing agencies, responsible for the dwellings and some support services, co-operate to ensure that resources are used effectively and needs are met. This will mean:

- the development of joint criteria of eligibility
- collaboration in needs assessment
- agreed protocols to clarify respective responsibilities in the delivery of services.

Case study 17 - Housing, care and support provided for people with dementia

East Ayrshire Council, Ayrshire and Arran Health Board and Bield Housing Association have together developed an innovative tenancy based model to support people with dementia living in the Cumnock area.
Eleven barrier free flats suitable for older people with dementia have been provided by the housing association with funding from Scottish Homes and private loaned finance. The flats have been let on assured tenancies giving full tenants' rights to people who have been selected jointly by health and social work using community care and health needs assessments. Tenants offered a tenancy have been assessed as requiring, or are about to require, a residential or nursing home place. To date the project has enabled eleven people either to remain in their own community or to return to the community from a hospital setting.
Bield provides housing support and meals to tenants. The council provides personal care and support including 24 hour waking cover from a dedicated staff team. The local NHS trust has dedicated community psychiatric nursing staff. Partnership working between agencies and with carers – who participate in staff selection - has been central to the success of the project.
There has been an ongoing review of the project, which found that initially there had been a tendency for staff to operate the principles of a residential model rather than a tenancy model. This was in part due to the original design of the building, which had been for a residential unit with 24 hour staff cover, on-site health staff and office accommodation. The partnership was strong enough to tackle this and review, challenge and re-establish objectives by:

- clarifying roles and responsibilities of staff
- removing home care management and health cover from the site
- revising operational practices to ensure that links with the local community could be fostered.

The project has been evaluated by Stirling Dementia Centre, which highlighted the following key areas of good practice:

- **choice** and **equity** of treatment – the opportunity for people with dementia to remain in their own community with appropriate levels of support and to be treated as ordinary tenants with the same rights as others.
- **multi disciplinary working** and **inter-agency collaboration**, which collectively provide the necessary services, required to support tenants in their own homes.

Planning for the Future

Whilst changes can be made in the short term to develop sheltered housing with varying degrees of support, authorities and housing bodies must also look to the medium and longer term. Universal design ideas suggest that barrier free and lifetime homes, and smart and assistive technologies should be the way of the future. These, combined with more flexible home support services, would reduce the need for 'special needs' housing for older people.

Scottish Homes' housing design guidance includes barrier-free standards for mainstream housing. Communication technologies are in wide, if limited, use with personal and community alarm systems, and automated devices assist people with disabilities. There is enormous potential for the development of 'tele-care' with the use of sensor devices to assist people to maintain their health, their lifestyle and their environment. Staying in the safe environment of your own home could become a real option for even the most dependent people when unsuitable accommodation is removed as a barrier to providing a wider range of social and health care at home. All such developments raise ethical issues about intrusion on people's privacy that should be considered but, with the consent of users and carers, parameters can be set on the application of technology.

Case study 18 - 'Opening Doors for Older People' in West Lothian

West Lothian Council wanted to support older people as they became more frail either in their own homes or in new homes or in new barrier-free flats on a 'homes for life' basis. It developed a major strategic plan to shift resources by closing 3 of its out-dated residential care homes and using the resources to develop new housing, smart technology in people's homes and a new form of 'gentle care'.

The Opening Doors for Older People Partnership, which includes the council, housing associations and Lothian Health Board is working towards achieving this project by 2002, with a capital budget of £9.1 million.

The Partnership outputs will include:

- independent living for at least 94 people within new build, barrier free homes which have individual tenancies and smart technology
- support through a wide variety of smart technology in their own (existing) homes for at least another 50-75 people
- a broad range of individual care arrangements supported by smart technology and social work home support teams.

The houses are set up so that they use smart technology to provide safety and security. For example, the smart house can communicate with support staff in the hub building if an older person wakes in the night and does not return to their bed within a reasonable time or leaves their home in the night.
In addition, staff have developed a new form of 'gentle care' in which they work together with clients to assist them in doing what the clients used to do, what they like doing and what they say they want to continue to do, whether it is gardening or hovering. Mary, in her late 70s, said 'I came out of a residential care home yesterday. I'd been in it for 20 years and today I hoovered my own rooms'.

Case study 19 - Making housing design dementia friendly – Glasgow 1999 UK City of Architecture and Design

'*Just another disability: making design dementia friendly'* is a collaborative series of projects led by Glasgow City Social Work Department. The projects bring together architects, designers, care professionals, people with dementia, and their carers and families to create a comprehensive guide to making design dementia friendly.

Key elements include:

- the customisation of three facilities:

  - a unit within a local authority residential care home

  - a council flat

  - a hospital ward.

- an information pack giving guidance on creating a positive environment for people with dementia in their own homes or in group settings
- preparation of a strategic brief for dementia friendly design
- an audit tool for dementia friendly design.

Glasgow City Council and Greater Glasgow Health Board specify design requirements in commissioning dementia services.

Self assessment checklists

2.2 Have we decided on the best way to meet these needs, expectations and priorities?

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
2.2.1 Making commissioning more user focused		
We have an authority-wide strategy for older people's services.		
Our commissioning strategy has considered the role of preventive services for older people, and how these may be provided.		
2.2.2 Improving the effectiveness of care management		
We have in place a system of care management based on principles of needs led care, partnership and choice.		
Care managers are able to commission services from the provider(s) that will best meet an older person's needs, and are not restricted in this choice.		
We know what care managers do. We have information on their workloads and the different activities in which they are engaged.		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
All older people in residential / nursing home care receive regular reviews (at least 6 monthly).		
All older people with home care packages have their care plans reviewed (at least 6 monthly and more often if necessary).		
We have clear eligibility criteria for care management that targets resources on those who will benefit most from a care management approach.		
We have an overall information strategy for commissioning at all levels of the organisation.		
We have delegated decision making in care management to the lowest appropriate level.		
We provide care managers with accessible information on: • The quality and unit cost of services • Contractual arrangements with providers • The impact of their purchasing decisions on the market.		
The costs of all service providers (including in-house services) are included when determining the cost of packages for financial limit purposes.		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
2.2.3 Working in partnership with other commissioning bodies		
We work in partnership with health and housing bodies to develop community-based services for older people. This has led to the joint commissioning of some services.		
We have agreed with health and housing colleagues the balance of provision in our local area between NHS beds, nursing and residential care places, housing with support and home based care.		
We have identified gaps in provision and are actively planning to fill these.		
We have a joint approach to delivering home based care. This has involved us in: • clarifying our respective agency responsibilities • identifying ways of coordinating care • sharing care plans and timetables to rationalise visits and approaches.		

Current good practice	✖/✔	Action required: What? Who? Time scale? Resources identified?
We are working with our health colleagues to: • clarify the expected outcomes for rehabilitation services • identify resources to develop rehabilitation schemes • develop an approach to evaluating the success of rehabilitation in enabling older people to return to home following hospital admission.		
We are working with our housing colleagues to: • develop joint eligibility criteria for housing with support services • assess need • agree protocols to clarify responsibilities in the delivery of services.		
We are keeping up to date with new technical developments that may enhance older people's quality of life and enable more people to stay living in their own homes.		

2.3 We have detailed plans for achieving our goals and our plans are clearly based on the resources we have available

> "Local authorities and their partner agencies need to introduce arrangements which develop a joint strategic view of goals and intended results. They then need to make sure that joint spending and other decisions achieve these goals."
>
> Source: The Scottish Office: Modernising community care, 1998.

2.3.1 Co-ordinated local planning

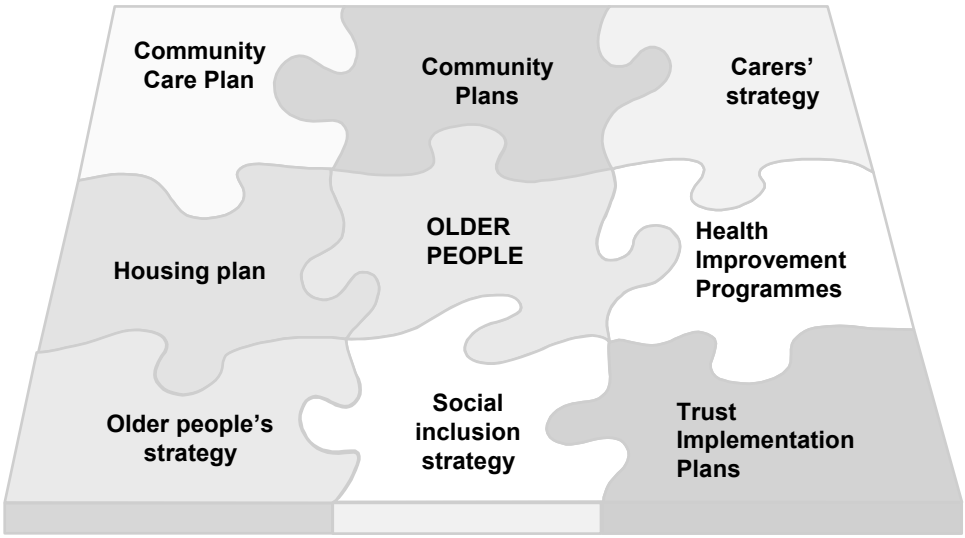
As the previous two sections demonstrate, planning for change is a complex task and there is a need for local authorities, health and housing bodies to:

- share information on the needs (including unmet needs) of older people
- outline current services in all sectors and agencies to meet those needs
- make a commitment to manage the market specifically at the interface of health, housing and social care
- agree priorities in commissioning to give direction to change and a focus for joint working
- be transparent about current levels of expenditure and resources committed to older people's services.

These requirements should come together in local plans and strategies. Irrespective of lead agency local plans for older people's services should complement each other (exhibit 18). Given the multiplicity of planning, care must be taken to minimise the risk of parallel planning where agencies move in the same general direction but do not properly integrate their activities. This runs the risk of duplication of services and missed opportunities for re-configuring care across organisational boundaries in the most effective way for older people.

Exhibit 18: Planning for older people's services

Plans for older people's services should be integrated and complementary.



In order to be useful working documents all plans that relate to older people's services should include details of:

- the level of current and projected resources and activity
- the need for services
- the level of joint action required to shift the balance of care for older people from hospital, residential and nursing home care to care delivered at home or in the community
- clear purchasing intentions to assist local providers in planning for a reconfiguration or development of their services.

Case study 20 - Joint Community Care And Health Improvement Programme For Dumfries And Galloway 2000 – 2005

Working Together for a Healthy Community is a joint community care plan and health improvement programme produced by Dumfries and Galloway Health Board, Social Services and Housing Services. It is seen as one of the building blocks of the Community Plan which in turn will become the 'umbrella' for joint planning.

There were some challenges to meet in producing the joint plan:

- client groups for community care planning and clinical priority areas for health improvement programmes do not all overlap
- different timescales set by government for production and publication
- different planning cycles: 3 years for community care plans and 5 years for health improvement programmes
- separate sets of guidance and legislation for community care planning and health planning.

To provide the detail for implementation, Social Services has produced a Social Services implementation plan (SSIP) to complement the local trusts' implementation plans (TIPs).

Transparency on resources

Joint commissioning strategies and plans should be the way forward in developing more responsive community alternatives to institutional care. These strategies will depend on good information about need and demand and absolute openness and transparency between commissioning partners over resource use and allocation.

Resource transfer is one mechanism of shifting the balance of care to community health and social care provision and for local authorities and health boards to agree priorities for development. In relation to older people's services savings arise not just from bed closures but also from the re-designation of beds, reduction in the use of hospital services brought about by earlier discharge and avoidance of inappropriate admissions to hospital. Thus joint commissioning strategies and plans need to be informed by more than bed closures, particularly as the money released from these will have largely been directed towards the nursing home end of the spectrum of care. Progress is being made with resource transfer agreements but there is still wide variation in the levels of funding made available across health boards[xv].

Case study 21 - Resource transfer agreement in the Scottish Borders

Scottish Borders Council and Borders Health Board have in place an overarching resource transfer agreement for the balance of services for older people. This agreement supports national and local objectives:

- to transfer appropriate patients from long term NHS care to case in the community; and
- enable people to live as independently as possible in their own homes or in homely settings.

The agreement:

- complies with agreed principles of resource transfer
- is for five years
- specifies the services agreed appropriate for transfer
- provides indicative transfer amounts
- states payment arrangements and conditions
- notes other arrangements for the provision of specialist health care services
- states arrangements for review, including consultation
- sets the requirements for an annual report by the council to deal with accountability
- specifies arrangements for resolving disputes.

Three schedules to the agreement set out the detail of:

- service objectives and timetable of resource transfer
- funding and payment arrangements
- information to be included in the annual report.

Some additional funding has become available from central government. Much of this is short term and targets particular developments in pursuit of specific national objectives. Undoubtedly, external awards of short term development funding have resulted in initiatives that might have been hard to achieve otherwise, but care is needed to ensure that bids are compatible with local priorities and objectives. The cost of submitting bids in terms of staff time can be considerable, there is a danger that it can distract from core services and local priorities, and some authorities have had difficulties in redirecting resources to maintain funding. Thus local commissioning strategies have an important role to play in ensuring that the benefit of time limited funding is maximised through:

- setting clear priorities and linking funding to specific local objectives
- finding opportunities for pooling resources
- finding cost effective alternatives to more traditional services.

The benefits of an explicit de-commissioning plan should be apparent, allowing planned changes to existing provision that will release resources, in health and social care services, to maintain new initiatives.

2.3.2. Setting measurable targets in plans

Local authorities and other commissioners should monitor plans to ensure delivery against stated objectives. In order for this to happen plans need to provide detailed information about:

- how services will be reconfigured or developed, and the cost implications of this
- time scales for completion
- which agency or who is responsible for ensuring that any action outlined in the plan is completed.

Elected members have a key role to play in this as they will want to be reassured that strategic objectives are informing planning processes, and that there is a mechanism for checking that progress is actually being made towards achieving the objectives.

Local authorities' action plans for *Modernising Community Care* are a starting point. These now need to provide more specific details on how major changes in service delivery are to be achieved, how new services are to be financed, and the time frame within which these changes are to happen.

⇒ For more on identifying and developing performance measures for commissioning see chapter 4 *'How do we plan to improve?'* and Appendix 1 '*Developing performance indicators for commissioning community care services for older people'*

Self assessment checklists

2.3 Do we have detailed plans for achieving our goals and are our plans clearly based on the resources we have available?

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
2.3.1 Co-ordinated local planning		
We share information on needs of older people with our planning partners.		
Our plans outline clearly: • level of current and projected resources and activity • need for services • joint action required to shift balance of care for older people • clear purchasing intentions to assist local providers in planning for a reconfiguration or development of services.		
Local plans for older people's services are complementary.		
Local negotiations over resource transfer take account of bed closures; bed re-designations; the impact of early discharge and schemes for managing people's ill health in the community rather than hospital.		
Bids for time limited funding are directly linked to local commissioning strategies.		

2.3.2 Setting measurable targets in plans		
Our plans have measurable targets against which progress can be monitored.		

3. How do we know we are doing things right?

Evidence is needed to show that best use is being made of available resources, and that these resources are managed effectively. Contracts play a major role in ensuring that the right services are being delivered in the most appropriate way, but there is a need to consider how these can be used to encourage a joint approach between commissioners and providers in driving up standards.

3.1 We make best use of our available resources

3.1.1 Benchmarking cost and quality of commissioning

In order to achieve best value in commissioning, authorities should ensure that they have the organisational capacity to implement their commissioning strategies – that is, staff should have the right skills, knowledge, resources and time. In order to assess the management of resources in this area, authorities should have a clear idea of the costs and quality of the commissioning process, and make judgements about the right balance to be achieved between the two.

As this handbook shows, commissioning is a complex task and there are different commissioning models adopted by local authorities. Assessing the use of commissioning resources will therefore be more difficult than in direct service provision. Nevertheless, there are distinct activities involved in commissioning, such as consultation, planning, contracting, financial management and care management where financial and staff resources can be quantified and compared both internally and with other authorities.

Case study 22 – comparing assessment practice between area teams

The in-house provider of home care in Glasgow City Council, Direct and Care Services, are working in partnership with Social Work Services purchasers, on developing trend information by area team. Comparative information of average hours of home care per service user has been used to identify possible differences in assessment practice, or application of the home care eligibility criteria, between teams. The analysis has shown that there is considerable consistency across the city, adjusting for vulnerable older people in each area. Similarly matching the percentage of out of hours home care provided to the proportion of vulnerable older people within each area team's population can give an indication as to whether services are being commissioned equitably.

It is possible to assess the efficiency and comparative costs of commissioning activities, although care will be needed to ensure that like-for-like activities are being compared. In addition a meaningful comparison of transaction costs involved in contracting will need to:

- Break down the different processes involved– contract preparation, negotiation and monitoring for instance – so that it is clear where the differences lie. An authority may put a lot of resources into preparing the contract documentation but little into contract monitoring. This distinction could be hidden if a simple cost comparison is made.
- Differentiate between contract type - spot, block, cost and volume – as these may explain some of the cost differences.

Benchmarking, with its emphasis on the review of management processes, goes beyond a simple use of comparative data[xvi]. The purpose is to see, by learning from others, how it is possible to improve commissioning processes. It involves the comparison and measurement of specific commissioning processes against similar processes in another authority, and can be used to develop continuous improvement targets. Some authorities - such as the City of Edinburgh, which is carrying out a best value review of purchasing and contracting - are beginning to apply best value principles to commissioning and are actively looking to benchmark on specific processes.

It is essential that authorities measure also the *outcomes* of commissioning against their overall strategic objectives. For example:

- Examining the proportion of older people who are discharged home over time would give an indication of the effectiveness of discharge planning in returning people home rather than directly to residential or nursing home care.

- Monitoring expenditure on residential care, nursing home care and home care will indicate whether care planning and local purchasing decisions are achieving the desired effect of maintaining more people at home.
- Surveying users on the extent to which they played a part in the assessment of their own needs and care plans will provide quantitative evidence of user involvement.

This is an essential part of evaluating the effectiveness of commissioning in delivering strategic objectives, and provides valuable information for reporting to key stakeholders.

⇒ see Chapter 4 for an approach to developing performance indicators for commissioning

3.1.2 Eligibility criteria

As the population of older people requiring care increases and financial resources are becoming more stretched the trend has been towards greater targeting of provision on the most elderly and frail, usually with services that are seen to compensate for loss of independence. In shifting the balance of care from residential and nursing home care to more community based provision this trend is likely to continue. In order to ensure an equitable allocation of resources, needs assessment and decisions about care packages must be done on a consistent basis throughout the local authority area – this requires clear and open eligibility criteria. The development of these criteria is possibly the hardest task in the commissioning process as it is where people's needs and the resources available to meet them come together most explicitly.

Typically eligibility criteria for residential or nursing home care are based on a combination of factors including symptoms such as dementia, the ability to carry out tasks and a risk assessment on the ability to cope at home. These specific criteria are helpful to staff in making decisions and can help ensure equal treatment. Another example of good practice is where authorities have included within their eligibility criteria clear guidance on when residential care can be accessed for assessment, trial periods, rehabilitation and respite. This can encourage staff, users and carers to think flexibly about the use of these resources. It may, for example, be possible to prevent or delay long term admission if these resources are used as part of an intensive rehabilitation care package, which enables an individual to move from hospital to home in a safe and planned way. The least helpful criteria tend to be based on broad statements about a person's needs being 'best met by a residential care placement'.

Some authorities using relatively broad eligibility criteria, have 'inherited' these from the previous regional councils. These may need to be brought up-to-date given the significant policy developments over the past few years, and the increasing demands on services. In a few authorities, although the same criteria are being used, definitions have become tighter due to financial constraints.

Many authorities operate eligibility criteria for older people's access to home care services based on a system of priority levels, although the content of each level varies between councils. For instance, some people who would rate as a high priority for home care services in one authority would fall into the lowest priority in other areas. Other authorities, such as Fife Council, prioritise needs on 3 levels according to assessment and the degrees of risk identified and apply these across most community services. This has the advantage of consistency, ease of use and conciseness.

Details about eligibility criteria should be made widely available to users, carers and the wider public in user-friendly formats. Some authorities, such as Moray and Fife, have taken this process further and consulted user groups when developing or amending the criteria. However, some authorities do not make them available routinely. This means that older people may not know the basis on which resource allocation decisions are made.

Case study 23 - Indicators for referral to care management in Aberdeenshire

A care management team screening referrals, according to broad eligibility criteria set by the council, identified the clients who were benefiting most from a care management approach. This became the basis for devising indicators for referral to care management – in other words converting broad criteria into more specific ones for operational purposes. These indicators help care managers make decisions about referrals. They have been issued to Primary Health Care Teams and GPs who are the main referral sources to care management.

User:

- requires or at risk of admission to institutional care
- requires resettlement from institutional care
- is at risk of harm through lack of care or attention or self care/attention
- has lost or is in danger of losing main carer
- has experienced a breakdown in care arrangements or a dispute over them
- is suspected of or is being abused
- has 'challenging behaviour'.

Carer:

- is no longer able to maintain an adequate level of care
- is suffering from physical or mental health problems or has a disability
- is experiencing stress arising from the caring role or other responsibilities
- is suspected of or is being abused
- is under 18 years
- is over 75 years.

Case study 24 - Presenting eligibility criteria in a user-friendly way

Moray Council have combined their community care plan with 'The Moray Guide to Community Care Services'. For each client group this clearly outlines who is eligible for the services in a 'question and answer' format under the following headings:

- Which services are currently available?
- Can I have this service?
- Will I have to pay for this service?

Services include both health and social care ones available in Moray. Information is also provided on contacts for benefits advice, support groups, housing and transport.

Self assessment checklists

3.1 Do we make best use of our available resources?

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
3.1.1. Benchmarking cost and quality of commissioning		
We know the cost of commissioning and its component activities.		
As part of our commitment to continuous improvement, we collect information on commissioning processes for comparison and benchmarking with other local authorities.		
We measure the outcomes of commissioning and match against our strategic objectives.		
3.1.2 Eligibility criteria		
We have in place clear eligibility criteria which are current and reflect our commissioning strategy and the available resources.		
Eligibility criteria are applied consistently across the authority.		
User groups have been consulted in the development of eligibility criteria.		
The criteria are available to all users, carers and the public in user-friendly formats.		

3.2 We make best use of our people

3.2.1. Developing commissioning skills

All staff involved in commissioning need good communication and organisational skills and increasingly will need to be computer literate. In addition, specialist skills are needed in the key areas of:

- planning
- contracting
- care management.

3.2.1.1 Skills for planning

Planners of social care are primarily, although not exclusively, from a social work background. They are likely to have an understanding of users' needs and services but may have to acquire new skills in their planning role (Exhibit 19).

Exhibit 19: Skills for planning

Key tasks	Required skills
Determining population needs: • Consulting with stakeholders • Sourcing information on needs • Collating and analysing data • Mapping demand • Working with other agencies	• Communication and inter-personal skills • Research skills including: ▪ data analysis and interpretation ▪ numerical skills • Verbal reasoning
Planning the pattern of provision: • Mapping the market • Modelling costs • Analysing budgetary information • Consulting with stakeholders • Working with other agencies	• Communication and inter-personal skills • Capacity for logical thinking • Financial acumen • Business awareness • Negotiating skills • (Potential for) leadership skills
Producing community care plans and contributing to other plans: • Consulting with stakeholders • Working with other agencies • Interpreting and presenting information	• Communication and inter-personal skills • Negotiating skills • Ability to write in plain English for a number of different audiences • Ability to present financial and activity information in a user-friendly format

3.2.1.2 Skills for contracting

The development of contracts is an important part of the commissioning process – used well contracts provide a key means of ensuring that financial resources are used as efficiently as possible, and that the best possible standard of care is delivered. It has been estimated that 7% of the value of a contract is spent on contract preparation[xvii]. It is important, therefore, that this investment is managed effectively and that contracts staff are appropriately trained. This is recognised by ADSW, which has set up a Training Working Party specifically to examine the core competencies and training requirements for staff who have a contracting role[xviii.]

Across Scotland, contracts staff are located in different sections of the organisation including finance, planning and specialist contracts units; vary in the scope of the work they undertake; and differ in their level of experience and qualifications. A few authorities do not have dedicated contract officers and their function is split between other 'commissioning' staff. Whatever the model adopted, there are key skills involved in developing effective contracts in line with strategic corporate objectives (Exhibit 20).

⇒ See section 3.3 for a further discussion of the role of contracts in meeting strategic objectives.

Exhibit 20: Skills for contracting

Key tasks	Required skills

Securing the contract:
 	
• Consulting with stakeholders
• Negotiating with providers
  • Assessing quality
  • Agreeing terms and conditions
• Working with other commissioning colleagues in social work
• Working with other agencies
	
	• Communication and inter-personal skills
	• Negotiating skills
	• Knowledge of social care issues
	• Understanding of the local social care market
	• Knowledge of local standing orders and national guidance for procuring services

Specifying the contract:
 	
• Consulting and working with stakeholders, including:
  • users and carers
  • providers
  • care managers
• Developing service specifications, including quality standards
	
	• Communication and inter-personal skills
	• Financial and business awareness
	• Understanding of legal and technical framework for contracts
	• Negotiating skills
	• Ability to write in plain English and differentiate between inputs, outputs and outcomes
	• Ability to develop standards which are capable of performance measurement

Monitoring the contract: • Consulting with stakeholders • Working with other agencies, including Registration and Inspection Units • Interpreting qualitative and quantitative monitoring information • Taking action when services fail to meet contract requirements	 • Communication and inter-personal skills • Negotiating skills • Ability to interpret financial and activity information • Administrative and organisational skills in setting up inspection systems and procedures • Ability to write in plain English • Skills in conflict resolution

3.2.1.3 Skills for care management

Most care management staff are social workers, with some qualified in occupational therapy or nursing. All these professions require good inter-personal and communication skills, essential for delivering effective care management. However, additional skills in financial management, priority setting and other management tasks are needed. Authorities need to ensure that care managers are equipped to undertake the tasks being asked of them – this is particularly the case with the move to devolved budgets and faster decision making advocated in *Modernising community care* (Exhibit 21).

Exhibit 21: Skills for care management

Key tasks	Required skills

Assessing and reviewing needs:
• Working with others:
  ▪ users and carers
  ▪ other professionals in a range of agencies
• Risk assessment
• Collecting information
	• Communication and inter-personal skills
	• Negotiating skills
	• Capacity to work across professional and organisational boundaries
	• Ability to write clearly and succinctly
	• Ability to think strategically (in highlighting individual needs for strategic planning purposes)

Care planning and co-ordination: • Communicating with users and carers and ensuring their views are represented in, and inform, the care plan • Judging eligibility and setting priorities with authority criteria • Matching needs and resources • Choosing providers • Specifying services (in liaison with contracts officers) • Negotiating with providers	• Administrative and organisational skills • Communication and inter-personal skills • Negotiating skills • Capacity to analyse and interpret information • Business and market awareness • Ability to write for different purposes • Decision making skills
Monitoring care delivered: • Consulting and communicating with users, carers and service providers • Collecting information • Judging quality of services • Negotiating with providers where services fail to meet the specification	• Communication and inter-personal skills • Capacity to analyse and interpret information • Skills in negotiation and conflict resolution
Budget management: • Purchasing in accordance within budget/spending parameters • Working with finance staff • Recording spend and other budget information • Monitoring budget commitment	• Ability to understand and present financial and other relevant information • Numeric skills • IT skills

As the above shows, a skilled workforce is crucial to the effective commissioning of community care services. However, some authorities, the smaller ones in particular, may have difficulties in ensuring that they have enough appropriately trained staff. In order to make the best use of staff resources there are some tasks, such as planning or contracting, which can be shared among authorities or among authorities, health boards and other planning partners. There are several examples of Scottish authorities and health boards jointly funding strategic planning posts, either on a time-limited basis, as a secondment or as a permanent arrangement. In addition to making an efficient use of limited resources, these can help break down organisational boundaries and improve joint working.

Self assessment checklists

3.2 Do we make best use of our people?

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
3.2.1 Developing commissioning skills		
We have reviewed the skills we need for commissioning at local and central levels.		
Appropriate training has been provided for planning, contracts and care management staff to fill any identified skills gaps and equip them to undertake the complex tasks required.		
We have considered sharing tasks with other planning partners, or other authorities, where this would make a better use of resources.		

3.3. We monitor and control our overall performance

3.3.1. Securing, specifying and monitoring services

> "[the key objectives of the white paper are]… to provide effective and efficient social work services, based on the best available evidence of what works, that maximize individual choice and autonomy, demonstrate best value; and allocate resources to needs in a transparent and equitable manner."
>
> Source: The Scottish Office, Aiming for excellence, 1999.

Contracts and service level agreements are the means by which authorities secure, specify and monitor services and are an important part of the commissioning process. The way in which contracts are managed can directly influence an authority's ability to develop services to meet local needs. Authorities vary in their contracting arrangements, and their use of approved providers' lists, accreditation schemes and requirements to tender. In the main, however, in-house services are funded centrally and tend not to be subjected to the same contracting requirements as external providers, whilst spot purchasing contracts are commonly used for the independent sector. Neither of these necessarily demonstrates a best value approach to contracting.

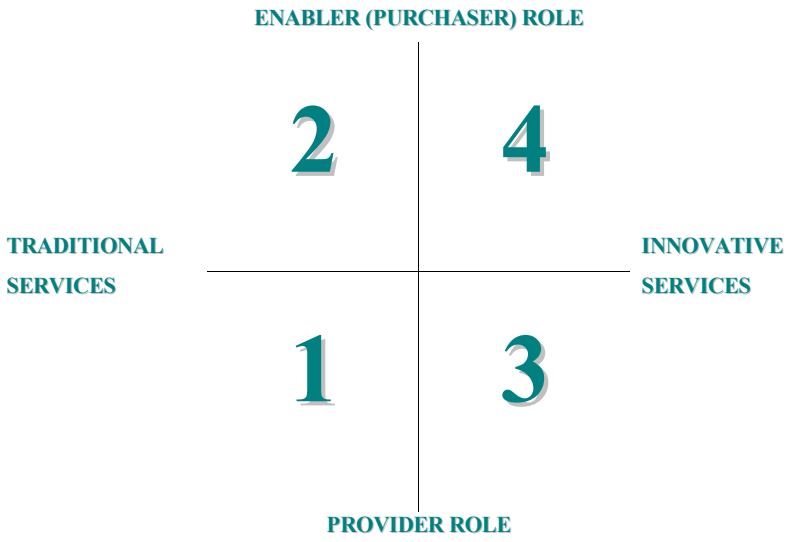
3.3.1.1. Working with the independent sector

The independent sector – private and voluntary - is a major provider of community care commissioned and purchased by statutory agencies. Authorities need to work with the sector to develop services and change the pattern of care, secure best value services, and provide users with a choice of services and providers in a mixed economy. In doing this they need to reconcile their position as providers, potentially in competition with the independent sector, with their role as commissioners and purchasers.

Exhibit 22 expresses the relationship of the local authority as provider and enabler (or purchaser) with the pattern of provision in social care. The bulk of provision for older people sits in quadrants 1 and 2 of this grid. In 1 are found traditional local authority services, residential homes, day care and home help or home care. In 2 are mainly private sector residential and nursing homes and voluntary provision in residential and day care.

These services will continue to have a place in meeting the needs of older people and will need to be flexible and responsive. The main challenge is to develop more innovative solutions to keeping people at home - to shift resources and develop services in quadrants 3 and 4.

Exhibit 22: Changing the pattern of care



Securing services for older people that better meet their needs is most likely to be achieved by a collaborative and open approach with independent sector providers. A number of features are necessary for successful purchaser – provider relationships, the most important of which are accountability, openness, trust and sustainability (exhibit 23).

Exhibit 23: Developing constructive relationships

Purchaser ...	Key attributes of a good relationship	Provider ...
is clear in specifying service needed	⇐ Accountability ⇒	is responsive to the services wanted
ensures that the process and reasons for selecting providers are clear	⇐ Openness ⇒	is realistic about the services that can be provided
honours commitments and pays on time	⇐ Trust ⇒	takes responsibility for monitoring service delivery
takes action to secure services for the future and encourages development	⇐ Sustainability ⇒	is willing to invest in and develop quality provision

Case study 25 - Improving services by working with local private and voluntary residential and nursing homes

East Ayrshire social work department has worked in partnership with the 25 private and voluntary residential and nursing homes in its area to agree improvements in standards above registration standards.
For the past two years the department has supported providers to train their staff to SVQ levels II and III in social care by accessing European Social Fund money for them and liaising with a local college.
Quarterly meetings are held with representatives from the Ayrshire Care Homes Association, and officers from the social work department meet with all 25 providers annually.
The department has actively encouraged joint registration and over the past four years the number of nursing homes with joint registration status has risen from 3 to 8 out of 16 providers.

3.3.1.2 Contracts fit for purpose

Authorities need to use contracts for older people's services in a way that matches their overall commissioning strategies:

- a broad range of contract types are used which take account of local needs
- a greater emphasis is placed on quality standards and outcome measures
- competition is encouraged, where appropriate, through open and transparent tendering processes.

Many authorities in commissioning services for other client groups, such as people with learning disabilities, have adopted this more strategic approach successfully.

The purpose of contracts is not necessarily about getting the cheapest price possible for a particular service - instead it is about achieving the optimum balance between cost and quality in line with best value. There are potential advantages and disadvantages to all contract types - the skill is in deciding which contract best suits the authority's commissioning strategy. For example, block contracts are likely to be better than spot contracts for sharing financial risk when developing a service; spot contracts may better suit the purpose where needs are difficult to predict or are variable (Exhibit 24).

The financial pressures on authorities may tempt them to look to the short-term advantage of using their purchasing power to keep prices low and place the financial risk on providers through an over reliance on spot contracts. This may not be an effective strategy in the longer-term, as it will limit the willingness or capability of some providers to work with authorities to develop better quality services. It is also likely to involve higher transaction and monitoring costs.

Exhibit 24: The pros and cons of different contract types

	Potential advantages	Potential disadvantages
Block contract	• Shares the risk between purchaser and provider • Gives the provider security to plan for service developments and innovations • Protects and helps encourage smaller providers to enter the market • Less potential for service disruption for users • Creates an environment which allows for the development of partnership working in improving quality • Lower financial transaction costs • Could be used to get lower unit cost overall • Lends itself to market testing approach to improve services and/or reduce costs.	• May reduce the number of providers • Could reduce user choice if not properly managed • Puts local authority at risk of accusations of 'doing deals' and skewing the local market • Requires a detailed and sophisticated understanding of the local market • Could lead to unused services if not carefully used • Market testing and tendering can be an expensive and time- consuming way of achieving cost and quality improvements.
Cost and volume contracts	Similar advantages to block contracts. In addition: • Keeps a competitive element to improve productivity / reduce costs • Gives potential to negotiate marginal rates above a certain volume of activity.	Similar disadvantages to block contracts. As they provide less security to providers this may hinder service developments.
Spot contracts	• Users' needs may be met flexibly • User choice facilitated • No purchasing of services which are not used • Competition between providers has the potential for reducing prices (although conversely prices may increase to cover provider uncertainty).	• Highest financial transaction costs of all contracting approaches • Little or no security for providers providing minimal incentive to invest in the service or staff with potential knock-on effect on quality of service, for example: • high turnover • low skilled staff • Limited use in enabling the authority to take an active role in developing local care market • Difficult to develop mature partnerships with providers • Requires very good financial control systems • Potentially increases the cost of the service being purchased. • Care managers need good purchasing skills.
Funding in-house services from central budget	• No financial transaction costs • Secure supply • Easier financial controls.	• Limits user choice • Could lead to higher cost, unused services if not carefully managed • Open to accusations of failing to provide a 'level playing field' between in-house and independent sector providers • Less incentive to engage in continuous improvement and service developments • Less accountability.

Adapted from: Audit Commission, Take your choice, 1997.

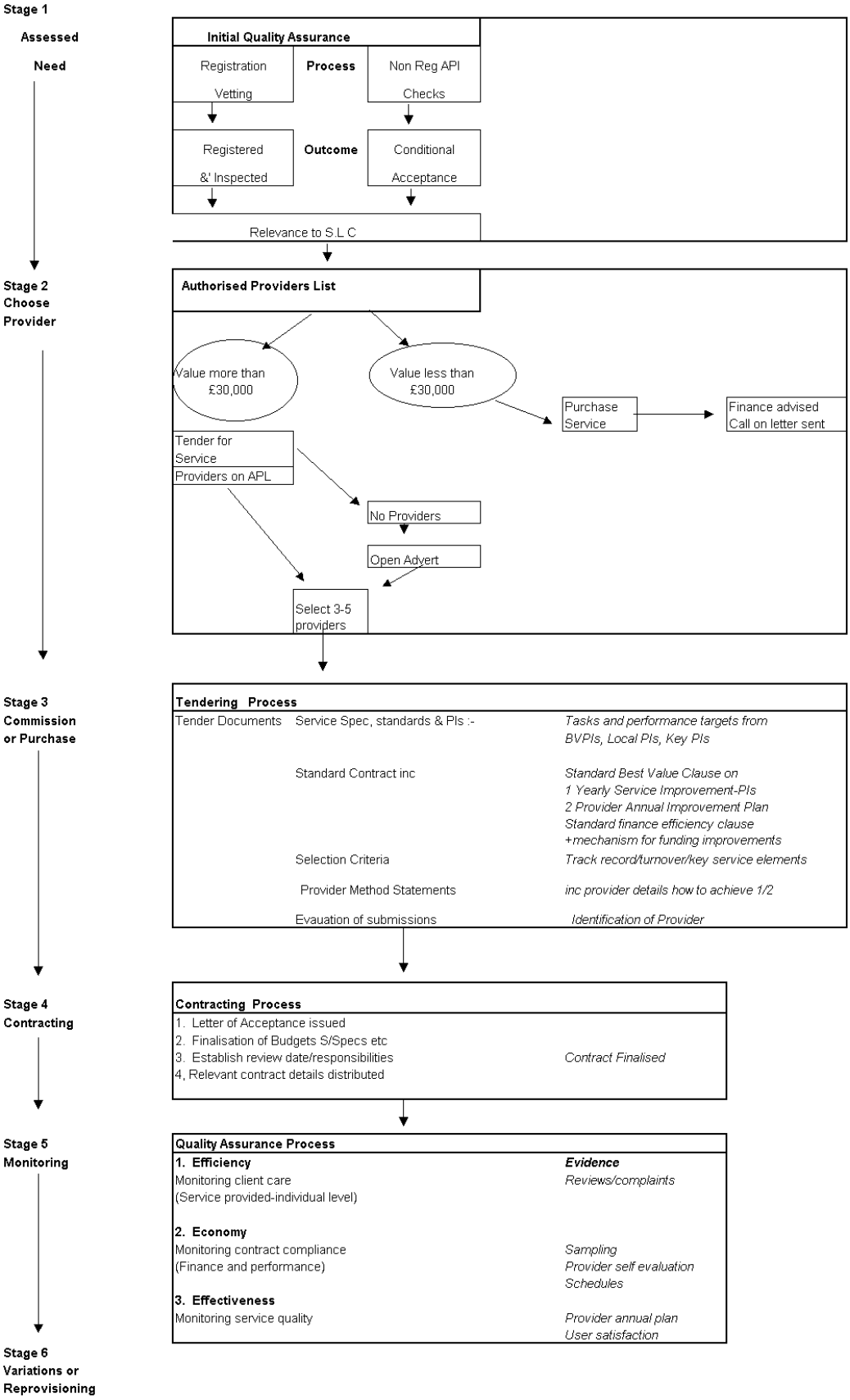
It is also important to give consideration to the appropriate length of contracts. They should not be so short that providers are discouraged from investing in services. Neither should they be so long that authorities have a long term financial commitment in a service where needs and demand can change over time. In addition, long contracts may act as a deterrent to new providers entering the market.

Although paperwork is necessary there is a danger that this can become overly bureaucratic and concentrate on the procedural at the expense of the quality of the service. Authorities can add to independent sector costs with excessive information requirements for contracts and approved providers' lists, invoicing requirements and delays in payment[xix]. In recognition of this, the ADSW Contracts Officers Group has standardised some aspects of the contracting process to make it less onerous on providers who contract with a number of different authorities.

Case study 26 - Clarifying processes for contracting and tendering

As part of its best value review of external purchasing, South Lanarkshire Council has developed a framework for contracting, tendering and monitoring. This includes a strong emphasis on the inclusion of user and carer views consistent with the council's policy on stakeholder involvement.

See overleaf for flow chart illustrating South Lanarkshire's approach.


Stage 1
Assessed
Need
Initial Quality Assurance
Registration
Vetting
Process
Non Reg API
Checks
Registered
&' Inspected
Outcome
Conditional
Acceptance
Relevance to S.L C
Stage 2
Choose
Provider
Authorised Providers List
Value more than
£30,000
Value less than
£30,000
Purchase
Service
Finance advised
Call on letter sent
Tender for
Service
Providers on APL
No Providers
Open Advert
Select 3-5
providers
Stage 3
Commission
or Purchase
Tendering Process
Tender Documents
Service Spec, standards & PIs :-
Tasks and performance targets from
BVPIs, Local PIs, Key PIs
Standard Contract inc
Standard Best Value Clause on
1 Yearly Service Improvement-PIs
2 Provider Annual Improvement Plan
Standard finance efficiency clause
+mechanism for funding improvements
Selection Criteria
Track record/turnover/key service elements
Provider Method Statements
inc provider details how to achieve 1/2
Evauation of submissions
Identification of Provider
Stage 4
Contracting
Contracting Process
1. Letter of Acceptance issued
2. Finalisation of Budgets S/Specs etc
3. Establish review date/responsibilities
4, Relevant contract details distributed
Contract Finalised
Stage 5
Monitoring
Quality Assurance Process
1. Efficiency
Evidence
Monitoring client care
(Service provided-individual level)
Reviews/complaints
2. Economy
Monitoring contract compliance
(Finance and performance)
Sampling
Provider self evaluation
Schedules
3. Effectiveness
Monitoring service quality
Provider annual plan
User satisfaction
Stage 6
Variations or
Reprovisioning

3.3.1.3 Placing emphasis on quality standards and outcome measures

The primary purpose of contracts is to secure high quality, cost efficient services in line with the local commissioning strategy. National care standards are being developed currently which will be used for registration and inspection purposes and should complement local contracts. Some authorities are developing contracts aimed at adding value to these standards in areas such as quality assurance, performance reporting and user involvement – that is developing quality standards in contracts against which performance can be monitored and improvements in service measured.

Effective monitoring requires:

- clear and focused service specifications based on proven effectiveness and good practice
- good quality standards including where possible valid outcome measures
- a co-ordinated approach.

Defining objective outcome measures for social care is not easy, as much will depend on the individual user's relationship with the care provider. Authorities may need to use proxy measures of quality based on the key factors that users define as important in providing care. These could be developed locally with users, or derived from national research such as the user-defined quality indicators for home care developed by the Nuffield Institute and UKHCA[xx].

Authorities need to ensure that they monitor contracts effectively otherwise all the effort put into the contracting process could be wasted. They need to bring together feedback from all available sources including:

- registration and inspection units
- care managers
- providers' own monitoring systems and results of best value service reviews; and most importantly
- users and carers themselves as they are best placed to comment on the quality of care provided.

Monitoring information should be available routinely to care managers and service users to help inform their purchasing decisions and choices. It should also be fed back to providers as a way of encouraging continuous improvement. A major implication of best value is that services in both the independent sector and in-house should be subject to the same requirements and criteria.

Case study 27 – Using quality standards for home care services in West Lothian

In 1997 West Lothian Council developed quality standards for home care and have used these for a variety of purposes:

- quality assurance for external and internal home care services
- as an integral part of the local registration and accreditation process for the council's approved providers' list
- contract specification and tendering
- contract monitoring and compliance
- as a reference point in the complaints procedure
- part of the assessment and care management process.

Ownership of the standards was achieved by developing them with all providers in an interactive format using checklists. New providers wishing to be approved by the council are required to demonstrate that their services meet 10 key quality standards. The council then works with them to develop an action plan with clear timecsales for meeting the remaining standards.

The council moved away from spot purchasing to block contracts for home care to encourage new providers and reduce their dependence on one provider which was in the position of monopoly supplier. The standards are used to specify the service and are monitored through annual reviews. The standards have reduced disputes about what the council wants and has enabled providers to focus on continuous improvement.

The quality standards are made available to users and carers and have helped manage expectations of the service and provide reassurance about the council's ability to handle complaints.

3.3.1.4 Using competition

Competitive tendering can be a useful strategy - amongst others, such as working with providers through benchmarking - for developing services, improving quality and managing costs more effectively. If used, the process must be open and transparent with clarity about the desired outcomes. Social services are exempt from European Community tendering requirements but it is good practice to adhere to the principles and transparent processes involved.

Authorities should:

- Make the decision to tender in line with their commissioning strategies.
- Comply with the corporate requirements set out in financial regulations and standing orders.
- Use a market testing exercise if new services are involved and little information is available on the likely response of providers.
- Provide full information to all potential bidders at the 'expression of interest' stage.
- Be transparent in the short-listing process using key criteria of financial stability, technical competence to provide the services and the existence of internal quality control procedures.
- Ensure that the specification strikes a balance between enabling the tenders to be objectively evaluated and making too big a demand on providers. Although authorities are legally entitled to negotiate the detailed specification with a chosen provider, parameters should be set about affordability and how far the specification can be altered before it needs to be opened up again to other providers.
- Evaluate tenders on an equal footing.

Case study 28 - The use of a market testing approach for residential care in the Scottish Borders

Scottish Borders Council owns and manages 6 residential homes for older people. Through 1998, as the first stage of a process to enable the Council to determine which option for running the homes offered best value, it undertook a market testing exercise. This was to establish the:

- level of interest from the independent sector in managing the homes
- quality of service that the independent sector would provide
- technical competence of independent providers in meeting purchasing and service delivery requirements
- price over 10 years the Council would have to pay to purchase accommodation and care in the independent sector.

The Council provided prospective providers with:

- a comprehensive information pack outlining the process and giving background and supporting information
- a seminar on the market testing process
- a detailed pro-forma with instructions for completion for making submissions
- the criteria against which submissions were to be evaluated
- the opportunity for short listed providers to tender for the management of any or all homes
- strict confidentiality throughout the process.

Tenders were presented to the council alongside a submission from the in-house provider. Confidentiality had to be strictly enforced so as not to advantage the council's own in-house service. Externalisation was ruled out in favour of the in-house provider's submission, which offered the best value.

3.3.1.5 Using best value to hold in-house services to account

Independent sector providers have criticised authorities for:

- the lack of a 'level playing field' with preferential treatment given to in-house services which have not been subject to the same cost constraints as the independent sector
- the lack of clear service specifications for in-house services, and less transparency about the quality of this provision.

Best value, with its emphasis on cost and quality, requires authorities to address these concerns directly. The results of service reviews should be used to challenge and improve the delivery of in-house services and to inform the commissioning process. As section 2.2.2 has already illustrated, in-house services are often treated as 'free goods' by care managers when in fact they bear a cost to the authority and should be included in the total cost of care packages.

Authorities should put their commissioner – provider relationship on a more formal basis by applying the same standards to both external and internal providers, and monitoring these in the same way. Involving internal and external providers in developing quality standards can be an effective mechanism for demonstrating that services are treated equally (see case study 26).

There will be some circumstances where developing a mixed economy of care is not practicable and the authority is best placed to provide the full range of social care services. This can be the case in some of the most remote parts of the country where provision by the independent sector, unless perhaps on a monopoly basis, is unlikely to be viable and where fragmentation of services would compromise quality and add to costs. Where this is the case, the authority still needs to demonstrate continuous improvement.

Case study 29 - Developing community care units in Highland

The Highland Council tackles the problems of providing community care services to more rural and remote areas through its five community care units, which provide a range of services on a locality basis.
Telford Centre in Fort Augustus is a purpose built unit and is the hub of provision to the surrounding area. The nearest residential or nursing homes are 32 miles away. The Centre aims to keep people in their own home to avoid dislocating them from their community.
The centre has ten self-contained flats - four for respite and six for permanent residents, with additional communal facilities. A day service also operates from the centre open to residents and people in the community. Laundry services, a bathroom with specialist equipment, hairdressing and library facilities and regular shopping trips and excursions are available. Support workers from the centre provide an outreach service. Services are co-ordinated by the Centre Manager who has a wide ranging role in assessing need, arranging care, organising the home care service, and liaising with specialist services, other agencies and local communities. Health and social work staff work closely together.

Self assessment checklists

3.3 Do we monitor and control our overall performance?

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
3.3.1 Securing, specifying and monitoring services		
We work in collaboration with the independent sector to develop and secure best value services and choice for users.		
Negotiations with providers focus on both quality and price.		
We recognise the concerns of the independent sector providers and take them into account in a way that benefits both parties when undertaking contract negotiations.		
We take account of providers' needs in terms of ensuring information requirements are not too onerous or costly to compile.		
We have a clear picture of the activities and costs of in-house services from best value reviews. This information has been used to develop continuous improvement action plans for in-house services.		
We make use of a range of contract types, including where appropriate cost and volume and block.		
We produce clear and focused service specifications, based on proven effectiveness and good practice.		

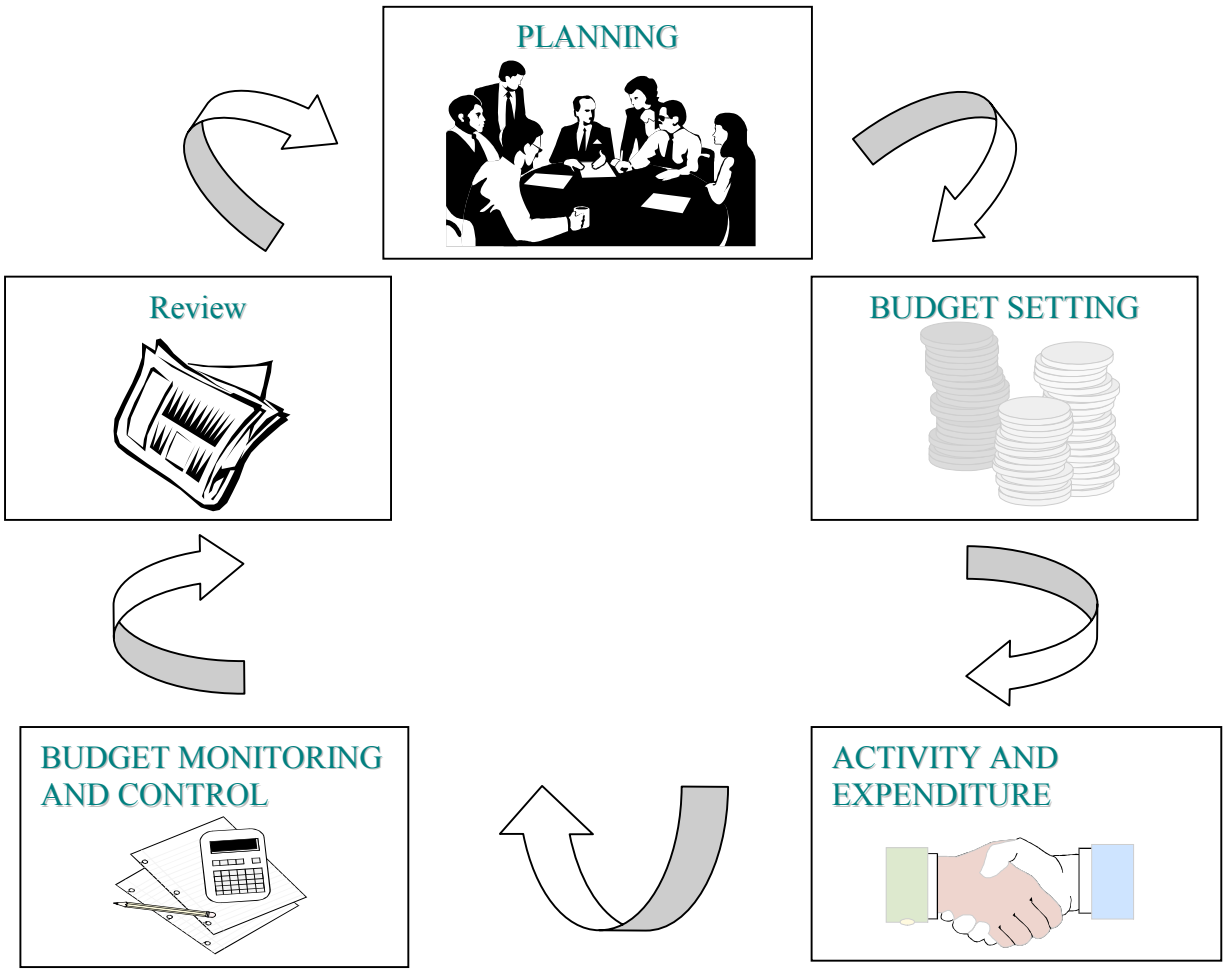
Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
We are actively working towards longer-term relationships with selected providers to develop services and improve care standards.		
Our approach aims to minimise the financial transaction costs of purchasing services.		
We have an effective quality assurance system, which enables us to feel confident that all providers are delivering services to an acceptable minimum standard.		
We have a clear idea of what represents quality and have specified standards in contracts for: • home care • day care provision • residential and nursing home care • respite care.		
We co-ordinate the work and input of older people as service users, care managers, contracts officers, inspectors and providers in monitoring contracts.		
All major providers, including in-house services, are monitored using the same criteria and measures to enable comparisons of performance for the purposes of ensuring best value.		

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
We monitor and report on areas of major concern to our providers, such as: • number of days notice given to providers before services are due to start • the length of time before payment.		
We provide monitoring information to care managers to help inform their purchasing decisions.		
We provide monitoring information to users to help inform service choices.		
We have an open and transparent system for competitive tendering which provides full information to all potential bidders.		

3.4 We have sound financial control and reporting

The effective management of financial resources is crucial to the success of community care. Authorities need to manage overall expenditure and monitor the use of resources in meeting objectives. There are five key elements in effective financial management (exhibit 25).

Exhibit 25: Stages in achieving effective financial management



Adapted from CIPFA, *Managing the Money*, 1992.

Financial management is not a separate activity, the province of accountants and senior managers, but an integral aspect of the process of commissioning that involves a range of staff. Different staff may be involved at each stage in this cycle and will need appropriate skills and information to fulfill their responsibilities effectively (Exhibit 26).

Exhibit 26: Staff involvement in financial management

	Activities	Potential staff involvement
Planning	Setting clear objectives and performance targets	• Senior managers • Planners • Finance staff
Budget setting	Agreeing the level of resources for planned activity	• Senior managers • Planners • Finance staff
Managing activity and expenditure	Specifying and purchasing services	• Contracts and purchasing staff • Finance staff • Care managers (individually or at team level) • Senior managers
Budget monitoring and control	Collecting information about actual performance compared against plans and budgets	• Senior managers • Planners • Finance staff • Care managers
Review	Re-examining plans to make improvements	• Senior managers • Planners • Finance staff

3.4.1 How far to devolve budgets?

Given the tight financial circumstances in which social work bodies operate, and the inadequate management and financial information systems that many have, it is not surprising that some have kept a central control on spending and not made significant progress towards devolving budgets. However, central government clearly expects authorities to act on delegating decisions to the 'lowest effective level' – including financial decisions[xxi.] The aim of this approach is to stimulate more responsive and innovative services through flexible purchasing which better meet the needs of older people.

Few authorities have achieved this and the situation remains much as it did when the Accounts Commission reported on commissioning in 1997[xxii]. The majority of authorities have devolved limited budget responsibility to team level. A few have delegated responsibility to individual care managers for all purchasing to agreed limits. In these authorities high cost care packages are agreed at a level above that of care manager.

Hierarchical and centralised arrangements for decision-making are often defended on the basis that:

- managerial control is necessary in deploying scarce resources over the financial year to prevent overspend
- this is in the interest of achieving equity for users
- they avoid burdening care managers with resource allocation decisions that may conflict with their role in needs-led assessment.

Section 2.2.2.2 demonstrates that an over-centralisation of financial decision making can have a detrimental effect on the ability of local staff to respond flexibly to users' needs resulting in more of the same services rather than a needs-led approach to provision. It can also separate managerial and financial responsibility for the commitment of resources. This can encourage care managers to overstate needs to secure resources. Instituting resource panels and operating waiting lists may provide some form of financial control but they can quickly become inefficient and bureaucratic and are not effective long-term solutions.

The extent to which budgets can be devolved will depend on local circumstances and the availability of good management and financial information. It should only be attempted where authorities are confident that they have good financial systems, controls and skills in place. Where this is not the case, authorities must develop appropriate systems and invest in staff training and development to enable them to meet the 'modernising community care' agenda.

Authorities need to find the right level of devolution that best suits their situation – for some this may be to team or local manager level, for others it could be to individual care manager level within set parameters. This latter model is the most likely to be able to involve older people and their carers in decision making about their own care needs, within available resources.

Delegating financial responsibility will require some authorities to make fundamental changes to their commissioning strategies, including an overhaul of the way in which budgets are constructed. Such changes would need to take place on an incremental basis to avoid serious disruption to service provision.

Other authorities already have potentially more flexible budgets. Allowing care managers to purchase up to institutional care costs across sectors, for instance, could begin to create demand for a wider range of services and encourage new providers (see Exhibit 13).

Having made the decision to devolve to a given level of management the practical steps involved are detailed and need careful planning and review (Exhibits 27 and 28). Even if devolved budgets are in place this model can be used to review existing arrangements and ensure that proper controls are in place and adequate information available.

Exhibit 27: Managing the devolution of budgets

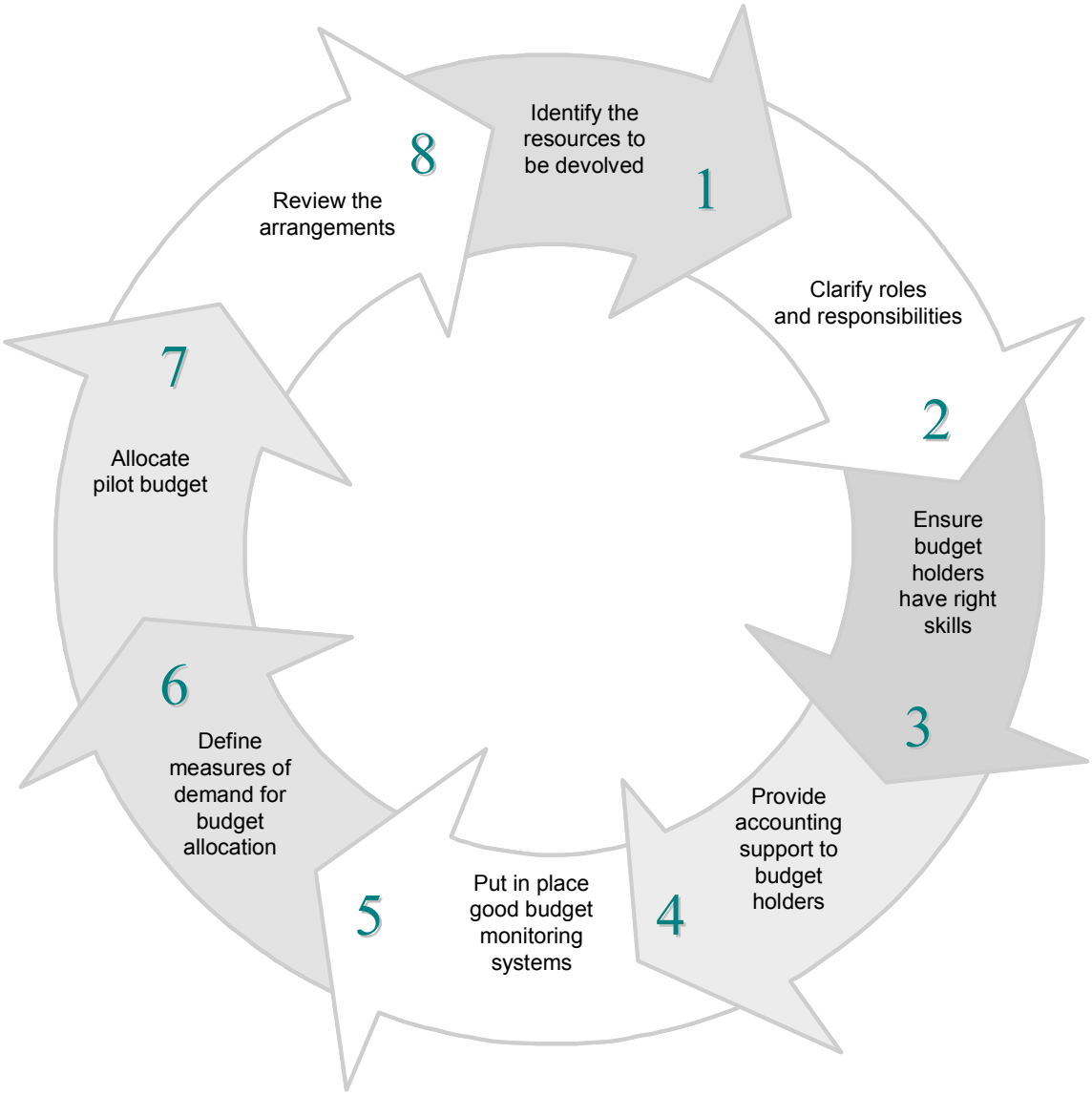


Exhibit 28: Stages in managing the devolution of budgets

Stage in planning	*Task*
1	**Identify resources to be devolved ...** good information is needed on current service use and expenditure patterns. A partial devolution of resources could be useful but authorities would need to guard against creating perverse incentives.
2	**Clarify roles and responsibilities ...** clear lines of reporting and responsibility must be outlined. Formal guidelines are needed setting out duties and responsibilities for all budget holders.
3	**Ensure budget holders have right skills ...** training in financial management skills will be required.
4	**Provide accounting support to budget holders ...** even with training budget holders will need support from finance staff, and systems must be in place to ensure that this is available.
5	**Put in place good budget monitoring systems ...** these should be locally available, timely and user friendly. There will need to be a central system for aggregating local budget information so that managers can monitor overall expenditure and hold budget holders to account.
6	**Define measures of demand for budget allocation ...** although historic patterns of spend may provide a starting point for budget allocation this is an inadequate measure. Other information such as the number of older people, levels of deprivation and dependency measures are more likely to help match budgets to need rather than service use.
7	**Allocate pilot budget ...** this will vary between authorities as care management is organised differently.
8	**Review the arrangements ...** Piloting is essential to ensure that the risks associated with changes in financial control responsibilities are minimised. Reviews should highlight any problems with issues such as over-spends and inequitable resource allocation.

Adapted from Audit Commission, Take your choice. 1997

3.4.2 Maintaining financial control of devolved budgets

Devolving budgets does not mean losing central control of overall expenditure. Control can be maintained by ensuring that staff who make spending decisions are also held accountable for them; and that

- staff with budget responsibilities operate to clear guidelines
- staff have the financial and management information they need
- systems are in place to monitor expenditure.

3.4.2.1 Guidelines for managing budgets

Against a background of Standing Orders and financial regulations staff with devolved budget responsibilities need clear parameters to guide their purchasing decisions. These could include:

- priorities for service provision
- eligibility criteria for services and levels of service
- indicative targets for average spend per client or cost limits on individual care packages
- criteria and procedures for accessing care beyond cost limits
- rules for use of contingency funds, if any
- use of compensatory savings (under-spends offsetting over-spends)
- the range of services and providers
- the range of prices that may be paid.

3.4.2.2 Financial and management information and monitoring expenditure

Social work managers (including care managers) operating devolved budgets need good working links with finance staff as it is in this area of responsibility that they are most likely to lack skills, knowledge and confidence initially. For the purposes of monitoring expenditure they will need:

- to know what the budget is and any commitments or restrictions
- to understand what is required of them individually and collectively in managing the budget
- a system for recording and reporting commited expenditure in a timely manner that is easily maintained and processed regularly
- clear, up to date reports on actual spend, committed and projected expenditure and activity data
- budget profiling to highlight any likely variations in anticipated expenditure
- analysis of variances - overspends or under-spends – highlighting where corrective action is needed.

⇒ See previous section 3.2 for meeting the financial training needs of social work staff

Case study 30 - Management information available to care managers in Aberdeenshire who have budget responsibilities

Care managers responsible for devolved budgets in Aberdeenshire keep track of and report their spend through weekly spreadsheets that record new commitments and any changes in existing commitments. They receive, in return, monthly spreadsheets that detail their spend and its effect on their own and overall budgets. The devolved budget can be closely monitored through this system.

Information reported *by* care managers

- client identifier
- source of funding (code)
- care type and cost code
- provider (codes)
- start and end dates
- gross cost per week
- client contribution per week
- one-off costs.

Information reported *to* care managers

To team and care managers

- budget allocated
- % budgets committed
- total budget committed for year
- total committed for next year.

Spend by care managers on each client with:

- care type
- care provider
- start date
- gross cost
- client contribution
- external funding
- L.A. contribution
- commitment for year.

For team

- Cross tabulated spend by service and user group.

Self assessment checklists

3.4 Do we have sound financial control and reporting?

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
3.4.1 How far to devolve budgets?		
We have, or are working towards, financial systems that provide adequate information to support devolved budgets and maintain control of spending.		
We have identified resources to be devolved; and these are matched to assessments of local population need not historical patterns of expenditure.		
We have clarified roles and responsibilities for managing devolved budgets.		
We have effective budget monitoring systems in place so that managers can monitor overall expenditure and hold budget holders to account.		
We have piloted and reviewed budget devolution prior to implementation.		
Care managers / team managers have the flexibility to purchase tailored packages of care.		

Current good practice	✖✔	Action required: What? Who? Time scale? Resources identified?
3.4.2 Maintaining financial control of devolved budgets		
Care managers / team managers are directly responsible for ensuring purchasing budgets are not overspent.		
Staff with budget responsibilities operate to clear guidelines.		
Budget holders have easy access to financial advice, and have received training in managing budgets.		
Budget monitoring information is timely and accurate. It includes detailed information on activity to improve financial planning.		

4. How do we plan to improve?

Best value provides a framework which commissioners can use to achieve better quality services whilst also managing costs more effectively. Service reviews are beginning to provide invaluable information about the cost and quality of services. Performance information on commissioning, which can be used to evaluate its effectiveness, is now needed although this will be harder to develop.

4.1 We actively support continuous improvement

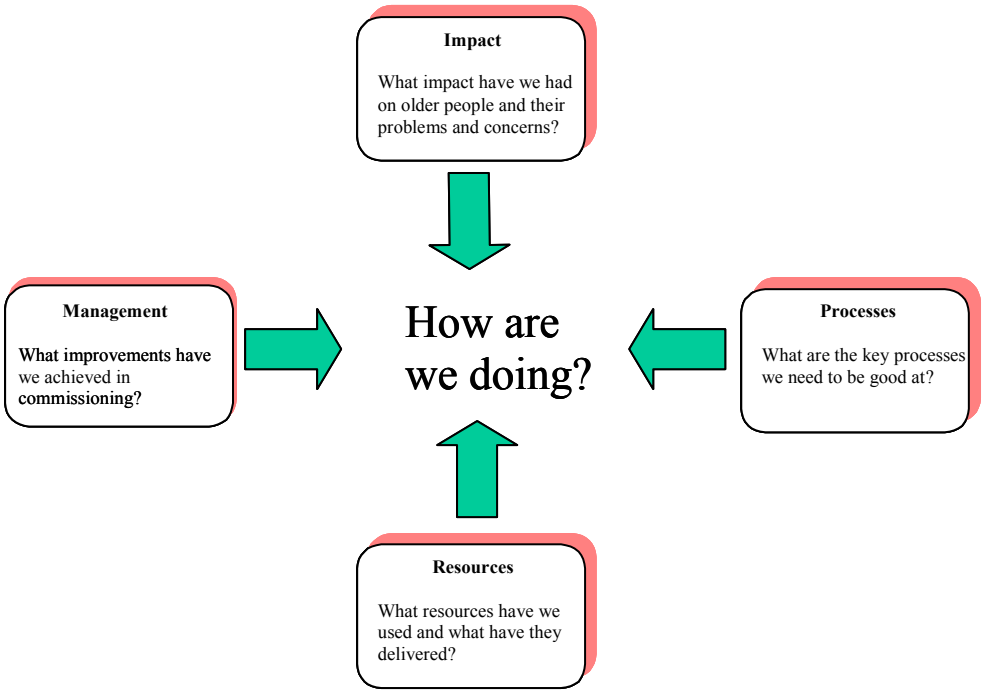
4.1.1. Achieving continuous improvement in commissioning

Continuous improvement is a central requirement of best value - equally applicable to commissioning as it is to service provision. However, performance information on commissioning is harder to develop, and there is very little comparative information on the cost and quality of commissioning available at a local or national level. This needs to be addressed if authorities are to improve performance in commissioning using internal comparisons of performance over time, or through benchmarking with other authorities.

The commissioning of services for older people must be linked directly to the overall commissioning strategies and community care plans of the authority. These in turn will derive from the overall direction that has been set. This means that the selected performance indicators need to be linked to the overall strategic priorities and actions - they need to be measuring the right things in the right way.

The Accounts Commission has published details previously of the Balanced Scorecard approach to performance measurement[xxiii]. The scorecard is intended to be an agreed set of performance measures that provide managers with a comprehensive, but timely, view of performance. It can also serve as the basis for meeting the performance information needs of key stakeholders. With adaptation, this can be used to help develop a core set of commissioning performance indicators (PIs). The scorecard has four interrelated perspectives of performance (exhibit 29).

Exhibit 29: Scorecard perspectives of commissioning community care services for older people



Impact ...	is concerned with the effects commissioning has had on older people. These can be linked directly to the strategic goals set by the authority: for example increasing the number of people supported at home rather than admitted to residential or nursing home care.
Processes ...	are concerned with looking at how commissioners (in the broadest sense as used in this handbook) achieve things - the efficiency and effectiveness of how things are done.
Resources ...	looks at the resources devoted both to commissioning and the services commissioned. Is commissioning delivering value for money in its own activities and in the services it secures?
Management and improvement…	is concerned with how well the commissioning process is managed and identifying the improvements achieved.

These four perspectives provide a balanced measurement focus and, collectively, an overall view of performance. Within each perspective, using some of the key themes discussed in this handbook, authorities can consider the key areas in which they want to measure performance and secure continuous improvements (exhibit 30 overleaf).

Exhibit 31 gives, as a starting point, some examples of PIs for each of the scorecard perspectives. Authorities may wish to build on these in order to identify opportunities for improving performance.

Case study 31 – Using a balanced scorecard approach in Angus

Angus Council's social work department is developing critical success factors for each the main service areas, including community care. These factors have been identified in terms of 4 perspectives: customer, continuous improvement, internal processes and finance. They cover statutory performance indicators, national policy objectives, local policy objectives (corporate strategy), local performance information for best value purposes, and needs assessment information for strategic planning and commissioning. Targets have been agreed and an implementation plan is being developed.

Underpinning this is a performance management system that integrates qualitative information (such as feedback from users and carers) and quantitative data (on service level and activity), and co-ordinates financial and non-financial information. This provides a reporting framework, which will deliver valid and reliable management information for all levels in the organisation.

⇒ Appendix 1 outlines the key steps in developing performance indicators.

Exhibit 30: Areas where performance indicators could be developed for commissioning community care services for older people

IMPACT ***What impact have we had on older people's:***	**PROCESSES** ***How well do we:***
• quality of life • maintenance of personal lifestyles • home environment • independence • ability to exercise choice • involvement in the local community	• respond to individual need • respond in a timely fashion • involve users and carers in care planning • provide adequate information for older people to make informed choices • make use of best value service reviews in maximising the cost effectiveness of services • maintain a trained and 'expert' workforce • link care management and strategic commissioning • work with providers to develop services
MANAGEMENT AND IMPROVEMENT ***How well do we:***	***RESOURCES*** ***How well do we:***
• agree overall priorities and plans • consult • assess the needs of the population • understand and manage the local care market • work with partner bodies to develop services to meet need • provide a co-ordinated approach to service delivery • match our community care plans with the national policy agenda • adopt best practice in commissioning • tell the community how we are doing	• make best use of our resources in: ▪ commissioning ▪ purchasing cost effective services • maintain financial controls in a complex financial environment • provide timely budgetary information: ▪ centrally ▪ to care managers

Exhibit 31: Illustrative performance indicators for commissioning community care services for older people

Some of these can be used for in-house comparisons over time; others would be best used in benchmarking with other authorities.

IMPACT	PROCESSES
• % of older service users who get 1st choice in residential or nursing home • % of older service users with intensive home care packages (> 20 hours per week) • % of older service users of home care who are supported to retain links with local community • local purchasing matches strategic aims (e.g. respite care increased by *x* hours over set time period; *y*% reduction in service users admitted to nursing home over set time period) • trend information on spend on home care as a % of total spend for the past 3 years	• number of carer assessments against population estimate of carers • % of user satisfaction with different commissioning processes (through consumer survey) • % users aware of complaints procedures • % users provided with copies of own assessment and care plans • % staff receiving relevant training (to be determined depending on tasks carried out) • number of joint best value service reviews with external provider involvement
MANAGEMENT AND IMPROVEMENT	***RESOURCES***

• all published plans have complementary action plans detailing time scales, resources and person responsible for action
• unmet needs collated from care plans
• number and range of consultative events with evidence that these have informed plans, priorities and service developments
• joint assessment documentation in place for all users in receipt of social and health care services in their own homes
• number of potential users on waiting list for a given service for more than *x* months
	• cost per assessment
	• average cost of a home based care package
	• % budget for older people's services spent:
	  • in-house
	  • spot contracts
	  • block contracts
	• transaction costs per contract (by type of contract and to include monitoring costs)
	• care management cost as % of overall community care budget

Self assessment checklist

4.1 Do we actively support continuous improvement?

Current good practice	X/√	Action required: What? Who? Time scale? Resources identified?
4.1.1 Achieving continuous improvement in commissioning		
There are clear links between the commissioning of services for older people and core strategic objectives of the authority.		
We are developing performance indicators for commissioning, which can be used over time and in comparison with other authorities, to demonstrate performance improvements to key stakeholders. These PIs cover cost, efficiency and quality.		

5. How do we account for our performance?

The community care budget for older people is significant - over £500 million. To ensure councils are publicly accountable and can demonstrate that they are achieving best value they must provide information about the quality and cost effectiveness of services. High quality, accessible information is also needed on services and charges for users and potential users.

5.1 We provide our stakeholders with the information they need about our services and performance and listen to their feedback

5.1.1. Information about services

Most users and carers will have had no experience of community care until they are in need of care themselves. They may have a limited view of the services available, have low expectations of what should be provided, and have no clear idea of how it is possible to meet their full range of needs. It is unlikely that they will have any knowledge of care management and its importance in matching their needs with resources.

Local authorities must support older people to take an active role in determining ways of meeting their own needs, by providing:

- Accessible and user-friendly information on the range of services available, eligibility criteria and charges where relevant. This should be made available in a range of formats to meet the needs of people with special needs.
- Copies of individual assessments and care plans.
- Information on expected service standards and the complaints procedure so that users, or their advocates, can challenge or complain about an unsatisfactory service.

Providing information about the range of local services helps users and their carers exercise choice about services and providers from an informed position. For example, the provision of a comprehensive directory of local residential and nursing homes helps users short list care homes, which meet their own criteria. This, combined with access to registration and inspection reports, facilitates real choice and saves time in visiting unsuitable or poor quality homes. There is no reason why this approach could not be extended to cover daycare and home care providers. The latter could be very useful particularly for those people who do not meet authorities' eligibility criteria and who need a starting point to select a home care provider as a private arrangement.

Case study 32 - Aiding choice through the provision of good information

East Ayrshire Council has developed, in collaboration with local providers, a directory of residential and nursing homes to assist individuals in making choices about care homes. This is updated annually and amendments are made based on feedback from providers and service users. This is not a brochure with pictures but a factual information directory with an accompanying leaflet with helpful questions to think about.

Case study 33 - Working with local user groups to produce user-friendly information on services

Fife Council has produced a simple but informative booklet on home care services. It is highly accessible, covers everything a user would wish to know – including eligibility criteria and charging information - is written in plain English and is printed in a large typeface. The council consulted with the Dunfermline Forum on Disability and local Age Concern users' panels to ensure that it was user-friendly and met their needs. Reference was also made to general guidance issued by Fife Society for the Blind, which has led to black on yellow user-held care plans being printed.

Case study 34 - Collecting information on user choice in Aberdeenshire Council

A care management team employs a simple form for users to sign confirming that they have been offered a choice of care homes and whether they have been placed in a home of their first choice. Where users have not been able to choose the home they move into, the user's representative or the care manager gives an explanation.

The team now has information on user choice, which can be aggregated and used as a simple performance indicator on the percentage of users who live in the home of their first choice. This has been useful in answering a number of complaints that the Council was not referring older people to particular care homes.

It is widely accepted that users should be involved in the assessment of their needs and in developing their own care plans, and that they should be given copies of these two documents. This should be monitored to ensure that users, and their carers where appropriate, are actively involved in care planning including:

- setting their own desired outcomes from the service intervention
- agreeing individualised service specifications where the care to be provided differs from standard contract terms
- having a role in evaluating the quality of care delivered.

Where an older person is being admitted to residential or nursing home care and funded by the local authority, some authorities, such as Angus Council, have developed tri-partite contracts which outline the terms and conditions of care, and the responsibilities of the resident. A copy is signed and kept by the resident, which is good practice. The Office of Fair Trading found that only one in four residents or their relatives had ever had a copy of their contract, and that the awareness of the contents of the contract was very limited[xxiv].

A low level of complaints does not necessarily mean a high quality service is being delivered. It may indicate that people do not know how to complain; are reluctant to complain for fear that services will be taken away; or their expectations may be so low that any provision is regarded positively. However, even within these constraints the pattern, distribution and type of complaints can usefully inform monitoring and quality assurance of contracts and service level agreements. Information on complaints, action taken and user satisfaction with the outcome should be available to the contracts section to help them in monitoring services. Similar information on complaints should also be routinely collected from providers.

5.1.2. Information about performance

> "It is important that elected members in particular see their role as ensuring that services are delivered in as efficient and effective a manner as possible, and with full recognition of their responsibility for the protection of…vulnerable adults."
>
> Source: The Scottish Office, Aiming for excellence, 1999.

Accurate, timely and up to date performance information is essential to inform decision-making and demonstrate accountability to the authority's key stakeholders. Without this information:

- Elected members will find it difficult to make informed judgments about the success of the commissioning practice to deliver strategic objectives.
- Managers will be unable to identify areas where commissioning practice is ensuring older people's needs are being met, and where there are problem areas that need corrective action.
- Users and carers will not be able to judge whether the authority is meeting their needs in the most effective way.
- The public will not be able to assess whether the authority is delivering best value in older people's services.

Performance reporting is the least developed aspect of the best value agenda. Auditors, in reviewing performance management and planning in local authorities, found that whilst many council services have identified performance measures, fewer than half report their performance to key stakeholders on a regular basis[xxv]. This is an area which all local authority services, including social work, need to address in the context of demonstrating best value.

Case study 35 - Keeping senior managers and elected members informed

The City of Edinburgh Social Work Department has a clear well established process for reporting progress on each of its best value reviews:

Each best value review group reports every 2 months to the Departmental Best Value Project Implementation Team, outlining progress made against agreed targets.

Selected reviews (6 per year) are presented to a Scrutiny Panel of Senior Officers from across the council, who assess the progress made towards achieving best value services.

All best value reviews are included in the work programme of the Scrutiny Committees of Elected Representatives, created under the council's new management arrangements.

⇒ See Chapter 4 for an approach to developing performance indicators for commissioning which address different stakeholder requirements.

Self assessment checklist

5.1 Do we provide our stakeholders with the information they need?

Current good practice	X/√	Action required: What? Who? Time scale? Resources identified?
5.1.1 Information about services		
We provide information to users and carers on services, eligibility criteria and charges (where relevant). We make this information available in a range of formats for people with special needs.		
We provide information to users about how the care management process works.		
We have a directory of local care homes which reflects the key factors influencing user choice such as geographic location, accessibility of local facilities etc. The directory provides objective indicators of service quality.		
Inspection reports on care homes are available to users and potential users and are in a user-friendly format.		
All users and carers get a copy and explanation of their: • assessment • care plan or timetable • financial assessment and calculation of their contribution.		
We record the service providers offered to users and the choices made.		
Users are involved in determining the most appropriate care to meet their needs, and in evaluating the quality of care delivered.		
We undertake regular reviews of the responsiveness of our complaints procedure, and the outcomes of complaints made.		
We actively and systematically use complaints information to inform commissioning.		

Current good practice	X/√	Action required: What? Who? Time scale? Resources identified?
5.1.2 Information about performance		
We have identified the performance information required for all our stakeholders and agreed a reporting timetable.		

Appendix 1: Developing performance indicators for commissioning community care services for older people

> "The first step is to measure whatever can be easily measured. This is OK as far as it goes. The second step is to disregard that which can't be easily measured or to give it an arbitrary quantitative value. This is artificial and misleading. The third step is to presume that what can't be measured easily really isn't important. This is blindness. The fourth step is to say that what can't be easily measured really doesn't exist. This is suicide."
>
> Source: Charles Handy, The empty raincoat, 1994.

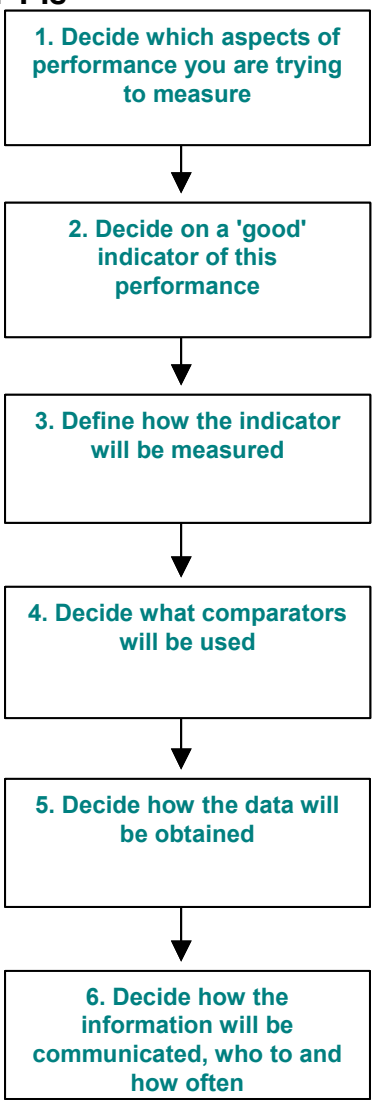
Deciding how to measure

It is important to distinguish between performance measures and performance indicators:

- A performance *measure* is an unequivocal statement of performance linking what we did to what was achieved - *We did X which resulted in Y.*
- A performance *indicator* is an indicator of performance we need to interpret - *We did X and Y happened.*

Virtually all our 'measures' of performance will actually be indicators, which will require interpretation, judgment and context. PIs will rarely by themselves tell you how you're doing. Rather they will *indicate* where performance appears adequate and where performance merits investigation, as it appears to be falling short of what is required.

Steps in producing 'good' PIs



1. Decide which aspects of performance you want to measure

When constructing PIs for each of our scorecard measures we need to be mindful of which aspects of performance we are actually trying to measure: economy, efficiency or effectiveness or the broader strategic issue of 'impact'.

Economy

Economy is about measuring the resource costs of some activity or service with the focus being on ensuring that we want to do it as economically as possible (i.e. at the lowest attainable cost). For example, the cost per community care assessment would be an economy PI.

Efficiency

Efficiency is about measuring the outputs obtained in some activity and the inputs used in that activity. Efficiency is always a ratio or percentage. For example, an efficiency PI might be the percentage of assessments completed within 5 days of receipt of a referral; or the number of care plan reviews carried out by individual care managers.

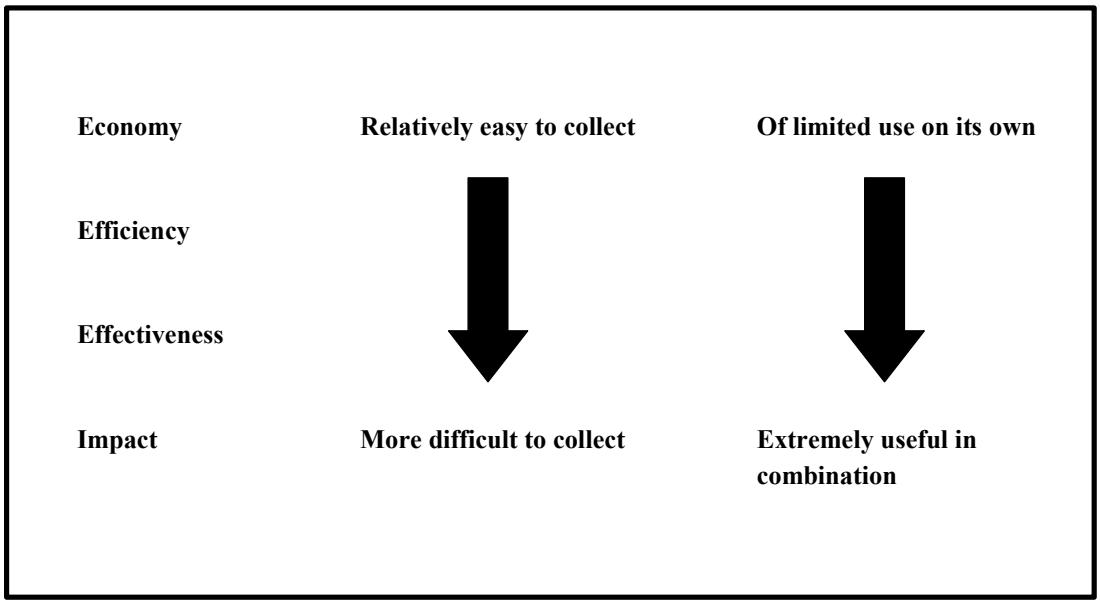
Effectiveness

An effectiveness PI is focused on assessing the extent to which our activities have achieved what we set out to achieve. Whereas efficiency PIs tend to focus on the outputs of some activity, effectiveness focuses on the outcomes. For example, consider the provision of home care services. By definition we are not interested simply in the outputs (e.g. the number of people provided with home care within existing resources). We are providing home care for a purpose: we are trying to achieve something by doing this activity - we may be trying to maintain people at home rather than them being admitted to residential care. An effectiveness PI might then be the number of clients assessed as needing intensive support who are maintained at home for a given period.

Impact

In addition to the 3 E's, we need to consider also impact. This can be defined in different ways for different service areas but is basically concerned with assessing the wider effect of our actions or activities. We may try to measure user satisfaction, customer perceptions of the quality of services, equity, quality etc.

Clearly, we are likely to end up with a mixture of PIs across these different categories. PIs measuring economy are relatively easy to collect but are of limited use on their own. PIs on wider policy impact are, arguably, of much more interest and use but equally much more difficult to collect and use. We should, however, resist the temptation to collect and use only the 'easy' PIs.



Similarly, the focus within the different scorecard perspectives will vary. In the Impact perspective our interest is likely to be on Impact indicators. In the other three dimensions our interest will largely be on some combination of the 3 E's. From the process perspective we are likely to be interested in the efficiency and effectiveness of our key processes. From the management and improvement perspective our interest will be largely on effectiveness indicators. From the resource perspective our interest is likely to be mostly on economy and efficiency.

2. Decide on a 'good' indicator

Whichever PIs we decide are appropriate such indicators should be QUEST PIs wherever possible:

- **Q**uick - to obtain and use
- **U**nderstandable - by those who will use them
- **E**ffective - at showing how we're doing
- **S**imple - to use and understand
- **T**imely - to obtain, to use and to report.

3. Define how the indicator will be measured

Make sure there is an unambiguous definition of the indicator. For example, we may have set ourselves a target of responding to all referrals within two weeks, unless they have been flagged as being urgent assessments in which case we should respond within 48 hours.

So, we may have two indicators:

1. the percentage of standard assessments completed within the 2 week target
2. the percentage of urgent assessments completed within 48 hours

We then need to define what we mean by:

- **Referral:** receipt of a request for an assessment (letter, phone, personal caller)
- **2 weeks:** 10 working days excluding weekends and public holidays with the first day being the date of receipt and the end day being the day assessment carried out
- **48 hours:** 2 working days including weekends and public holidays

4. Decide what comparators will be used

PIs by themselves are generally of little use. Knowing, for example, that 67% of people assessed as needing nursing home care wait less than 4 weeks for a placement is of little help either to us as commissioning managers or to our stakeholders with an interest in our performance. The main value of PIs comes from comparing them with something else and forming a judgement about our relative performance. Such comparison may come from:

- **an internally set target**

As part of the service planning process we might have established some target that we want to reach. If the target, for example, had been 70% we would take a very different view of our performance than if the target had been 60%. Targets should be seen as achievable but also as stretching.

- **over time**

Trend comparison can be very useful although, naturally, they may take some time to establish with a new PI.

- **other organisations**

Part of the challenge of Best Value is to ensure that your commissioning practice is "competitive" through comparing yourself with others. Clearly, this has implications for PIs. Looking good in isolation is unlikely to be an option. Performance comparison between your authority and other organisations will be needed.

- **external standards**

Finally, the comparison may be against some externally set standard of performance - set by central government or by a professional body.

5. Decide how the data will be obtained

- What data sources are already available? Statutory PIs? Internal PIs? Council 'families'?
- Will these meet our needs?
- If not, what other sources might be cost-effective? For example, should we consider sampling?
- How frequently will we collect and publish the data? Will this meet our stakeholders' needs?

6. Decide how the data will be communicated, who to and how often

- Who needs to see the PIs? – which stakeholders will have an interest?
- In what format will they want this data? – for example, report, tables, charts, pamphlet, advert, web site?
- What mechanisms do we have in place to assess whether what we provide is what our stakeholders wanted?

Whilst all of this may seem a daunting task, it is about ensuring you are trying to develop a suitable way of measuring your commissioning performance that will meet your needs and those of other stakeholders interested in your performance information. Much of the information you identify will already be available and may just need collating; other information may need more thought as to how it should be collected and on what basis.

Performance measurement is not an exact science. However, that by itself is not an excuse for not trying to provide the best performance information we can realistically obtain. Best Value is not just about providing the 'best' commissioning practice we can, and being committed to continuous improvement. It is also about demonstrating this to our key stakeholders.

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