

# Commissioning community care services for older people

Prepared for the Accounts Commission and the Auditor General for Scotland

July 2004



## Commissioning community care services for older people

Prepared by Audit Scotland on behalf of the Accounts Commission and the Auditor General.

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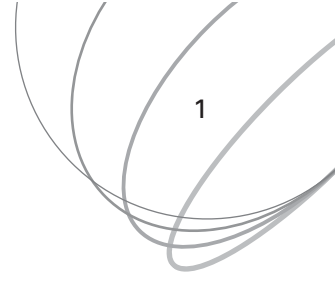
### Acknowledgements

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Jane Kennedy managed the study, under the general direction of Angela Canning. Andrew Reid provided consultancy services.

**Audit Scotland** is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Executive and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

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## Part 1. Introduction



The environment for providing community care services to older people is challenging.

***“Our aim is clear. Care delivered at home, not just in care homes. A fundamental shift in emphasis in community care. Care based on individuals receiving continuous support that reflects their changing circumstances – but also reflects their rights, their feelings, their homes and their families.”***  
**(Deputy Minister for Health and Community Care, 2000)<sup>1</sup>**

## Background

**1.** As people get older their health may deteriorate and they may become more frail. Living independently can then become difficult. Many older people depend on support provided or organised by their council and its local partners to help them live in their own homes. This can be anything from help with getting dressed and washing, to cooking meals, shopping and taking medication. Often this support is bought from the voluntary or private sectors rather than provided directly by a statutory body like a council or the NHS. Councils and their partners also provide support services aimed at preventing older people being admitted to hospital or remaining in hospital longer than necessary.

**2.** Current community care policy promotes independent living for older people. Councils are encouraged to work with their partners to provide services to older people in or close to their own homes, and to move away from an over-reliance on care homes. Policies to support this balance of care in favour of more care at home have increased in the last five years

with the introduction of free personal care, direct payments and rapid response services.<sup>2</sup>

**3.** Councils have to consider the sustainability of the care services they commission for older people. Not only do services have to meet the needs of individuals now, they also have to be commissioned with the future needs of the older population in mind. Councils and their partners therefore need to know what type and level of services they must have in place now for their local older population, what services they will need to meet the needs of older people in the future, and then jointly plan how to work towards meeting future capacity.

**4.** Spending on community care services for older people in Scotland was around £558 million in 2001/02.<sup>3</sup> This represents about 64% of total community care expenditure (£876 million) and about 41% of total expenditure on social work services (£1.3 billion).<sup>4</sup> It is difficult to quantify health expenditure as older people use services across the NHS both in the community and in hospitals.

## Our study

**5.** This report sets out the findings of our national review of how councils commission community care services for older people in partnership with the NHS (aged 65 and over). The key messages from our review are:

- Councils and their NHS partners need to plan now for the likely increase in demand for community care services for older people and the expected shortage of carers.
- There has been some shift in the balance of care for older people from care home provision to more intensive care packages delivered in their own homes.
- The Scottish Executive needs to ensure it collects information about the implementation of policy. This is essential to enable the impact of its policies to be monitored and evaluated.
- Almost every council has a waiting list for care home places and two-thirds have one for home care. But monitoring how long older people wait for services to be provided is patchy and inconsistent.
- Councils and their partners need to use the information they have on older people's needs when planning services. The balance of contracts needs to support strategic planning to ensure value for money and the sustainability of services.

**6.** Our review follows up the Accounts Commission self-assessment handbook on commissioning services for older people.<sup>5</sup> We focused on councils as they have the lead role in planning community care services for older people. Recognising the increasing involvement of health bodies in this

<sup>1</sup> Scottish Executive news release SE2645/2000, October 5 2000.

<sup>2</sup> Rapid response services are multi-disciplinary teams which work to support older people either to stay out of hospital after a fall or illness or to support their discharge from hospital as soon as possible after they are well enough to leave. For further information see [www.scotland.gov.uk/health/jointfutureunit](http://www.scotland.gov.uk/health/jointfutureunit)

<sup>3</sup> This is an estimate because national statistics on expenditure do not provide an overall figure for expenditure on older people's services.

<sup>4</sup> *Scottish Community Care Statistics 2002*, Scottish Executive, 2003. These figures relate to net expenditure.

<sup>5</sup> *Commissioning community care services for older people: applying a best value framework*, Accounts Commission, 2000.



role, through community planning and the Joint Future Agenda, we also comment on how councils are working with their local health partners when considering future demand, capacity and models of service delivery.

**7.** We looked at the performance of all 32 Scottish councils in three key elements of commissioning:

### Planning

To plan community care services effectively, councils need to know the needs and expectations of older people and their carers,<sup>6</sup> and involve them in the planning process. Each council should also be aware of its current levels of unmet need and the potential future needs and expectations of older people. This should be undertaken jointly with local health partners.

We looked at the information councils gather on their older service users and the older population in general. We also reviewed the ways in which councils engage with older people and their carers in order to inform service planning and development. Our findings are outlined in [Part 3](#).

### Commissioning

Councils purchase care from a variety of providers under different contractual arrangements. Councils need to put care packages in place quickly and also ensure that purchasing arrangements are sustainable. This requires an understanding of the local care market and an appropriate use of different types of contract.

[Part 4](#) looks at the types of contracts councils most commonly use to purchase services.

### Reviewing performance

In order to meet the needs of older people, service performance should be monitored and reviewed, and changes made where necessary.

[Part 5](#) looks at waiting times for community care services, best value reviews and ways in which service performance is monitored. We also look at how councils and their partners are working together to manage community care services for older people.

### Study methodology

**8.** The review was developed and led by a team from Audit Scotland's Performance Audit Group. We collected data from 32 councils about how they commission services. Councils' external auditors then validated these data through interviews with key council staff and reviewing local documentation.

**9.** We also used other community care data currently collected and analysed at a national level by the Scottish Executive and the Accounts Commission.

**10.** Each council received a report from their auditor with an action plan containing recommendations for improvements.

<sup>6</sup> 'Carers are people who care for a relative, partner or friend, or for a child with a disability. They care, unpaid, for people who cannot manage without help because of disability, illness or frailty,' The Princess Royal Trust for Carers, [www.carers.org](http://www.carers.org)

## Part 2. Community care services for older people



### Key messages

- Councils and their partners need to plan now for the likely increase in demand for community care services for older people and the expected shortage of carers.
- There has been some shift in the balance of care for older people from care home provision to more intensive care packages delivered in their own homes.
- The Scottish Executive needs to ensure it collects information about the implementation of policy. This is essential to enable the impact of its policies to be monitored and evaluated.

### Population projections

#### Scotland's older people

**11.** The result of the 2001 census confirmed predictions about a large change in the demographic profile in Scotland over the next 23 years. The number of older people is predicted to rise by 46%, from 812,000 in 2002 to almost 1.2 million in 2027. Further analysis reveals even higher predicted rises in the 'very old' population (aged 85 and over), from 88,000 to 174,000 over the same timeframe.<sup>7</sup>

#### Local population projections

**12.** The older population predictions vary from council to council, with the percentage of the population who are aged 65 and over expected to increase in almost every council area ([Exhibit 1 overleaf](#)).

**13.** The overall increase in the older population will affect future service provision. Having more older people in the population will generally mean

an increase in demand for community care services. But the anticipated growth in over 85s will place more pressure on these services – the rates of physical disability and dementia are significantly higher for this age group leading to a need for more specialist care.

#### Carers

**14.** The predicted population changes in Scotland over the next 23 years will have a significant impact on the number of people available for caring roles. It is estimated that one in ten people in Scotland provide unpaid care to a relative or friend living at home (about 500,000 people).<sup>8</sup> At present carers looking after older people save the state an estimated £4 billion a year in Scotland.<sup>9</sup>

**15.** More than two-thirds of carers in Scotland are between 35 and 64 years of age. By 2027 this age group is expected to have decreased as a proportion of the total population from 40% to 38%. With the older

<sup>7</sup> GRO Scotland 2001 Census.

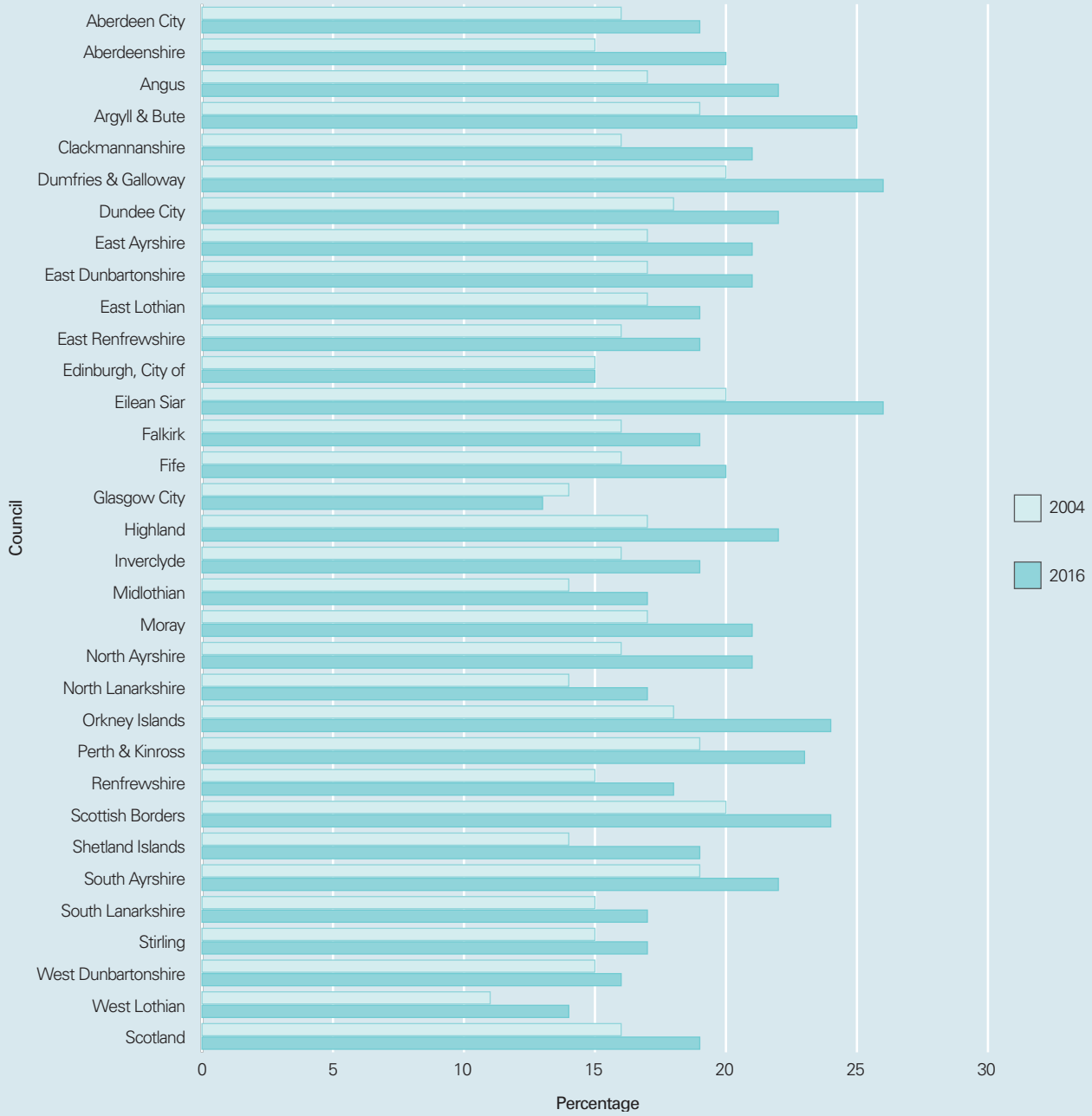
<sup>8</sup> Information on whether the person who is cared for is elderly is not available.

<sup>9</sup> Based on information from the following fact sheet: *Facts about Carers*, Carers UK April 2003, [www.carersonline.org.uk](http://www.carersonline.org.uk).

## Exhibit 1

Older population of each council as a percentage of the total council population, 2004 and 2016

The percentage of the population aged 65 and over is expected to increase in 31 councils.



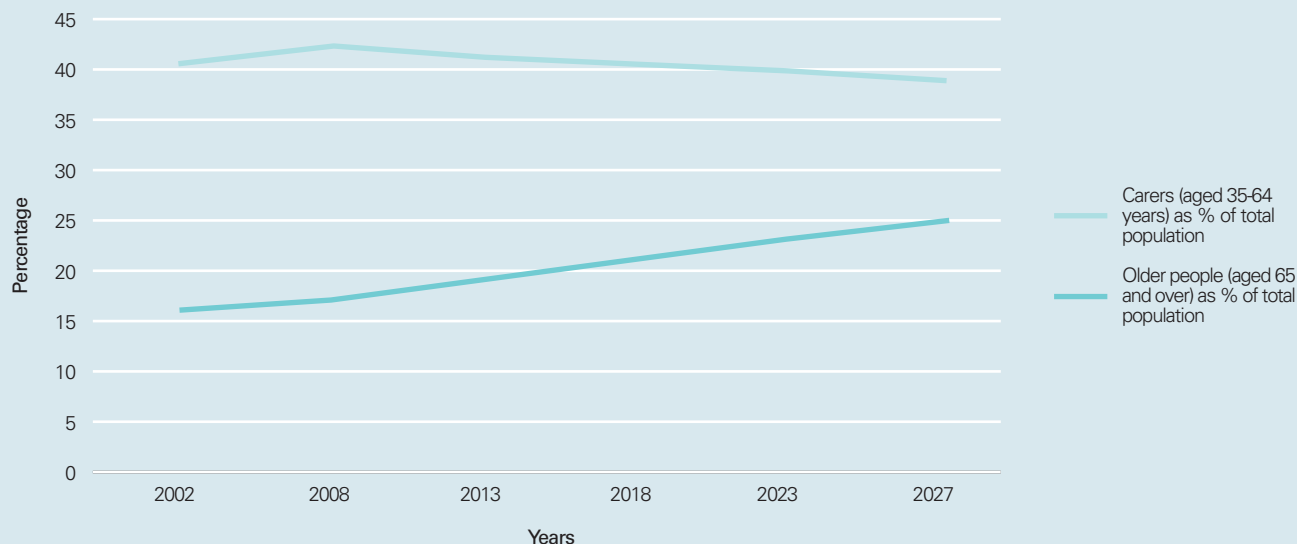
Source: General Register Office for Scotland, base year 2001. (At the time of reporting, population estimates for each council were only available for the period 2004–2016)



## Exhibit 2

### Population projections for older people and their likely carers, Scotland, 2002 - 2027

As a percentage of the total population, the 65 and over age group will grow while those most likely to care for them (35-64 years) will decrease.



Source: Based on data from General Register Office for Scotland

population increasing from 16% to 24% there are implications about how this 'care deficit' of more older people depending on less carers will be met (Exhibit 2 above).

**16.** Older people themselves are also care providers. Around 15% of care is provided by the over 65 age group.<sup>10</sup> It seems reasonable to assume that a number of people in this age group care for a spouse or partner. By 2027 it is predicted that the older male population will increase by 60%, with the older female population increasing by 38%. Information from the census suggests that women provide three-fifths of care.<sup>11</sup> Therefore a smaller rate of growth in the older female population will also have implications for care services.

**17.** Depending on the population make-up in each council, some councils could face a deficit of carers in the future. As well as having to meet the care needs of an increased

number of older people, councils and partner agencies may also have to provide care for a group of additional people who formerly would have relied on family, friends or neighbours. Similarly, the predicted decline in the working age population will also affect the pool of people available for employment in local services as paid carers.

**18.** Councils and their health partners must therefore consider the predicted age and gender profile of their local populations when planning for older people's services. This will help them to support carers: all carers are entitled to an assessment of their needs in terms of help with the person they look after and/or respite help for themselves.<sup>12</sup> The information from carers' assessments should also assist councils and their partners to quantify any future deficit in carer provision and plan services accordingly.

### Recommendation

- 1.** Councils and NHS partners should collect information about carers in their area, for example, number of carers, hours and type of care provided, support received by carers from the council. They should use this information to inform service developments for carers and to prepare for any future decline in carer numbers.

### Balance of care

**19.** Older people prefer to stay in their own homes and within their own community.<sup>13</sup> Many feel that moving to a care home or moving out of the area can lead to isolation, loss of control and a lower quality of life. Over recent years there has been a move in the balance of care towards more care at home. This is evident in a number of ways: levels

<sup>10</sup> GRO Scotland 2001 census.

<sup>11</sup> GRO Scotland 2001 census.

<sup>12</sup> Community Care and Health (Scotland) Act 2002.

<sup>13</sup> *Attitudes and aspirations of older people: a review of literature*, Boaz et al 1999.

## Good practice example 1

Dumfries and Galloway Council, NHS Dumfries and Galloway and partners

Dumfries and Galloway launched 'A Strategy for Carers' for in June 2001. The strategy was developed by Dumfries and Galloway Council, NHS Dumfries and Galloway, Carers National Association and the Princess Royal Trust for Carers.

Carers across Dumfries and Galloway Council were identified and a range of services developed to meet identified need. These services include:

- a comprehensive information booklet for carers
- a region wide service for young carers
- a training prospectus for carers
- a carers development worker located within Dumfries and Galloway Royal Infirmary
- the appointment of a carers development worker in the Acute Psychiatric Units across Dumfries and Galloway
- a project to support carers whose partner has either died or been admitted to residential care
- funding for a project to provide transport costs for carers to visit the cared for-person in hospital settings across Dumfries and Galloway.

Source: Dumfries and Galloway Council and NHS Dumfries and Galloway

of expenditure; the intensity of home care that older people receive in terms of the number of hours provided; and when care is provided.

**20.** Over the period 1999/2000 to 2001/02 there was some shift in the percentage of expenditure on non-institutional<sup>14</sup> forms of care from 32% to 36%. Over the same period, the percentage spent on institutional care<sup>15</sup> fell from 50% to 48% (**Exhibit 3 overleaf**).

**21.** The situation in individual councils varies (**Exhibit 4 overleaf**).

**22.** The shift in the balance of care is also reflected in the rise in the number of home care hours per client, the increase in intensive home care packages and the more flexible way in which home care services are delivered (**Exhibit 5 page 12**):

- the number of home care hours per client increased from 5.6 hours in 2000 to 7 hours in 2002<sup>16</sup>
- the number of older people per 1,000 population aged 65 and over receiving intensive home care (10 or more hours of care each week) rose from 14.6 in 2000/01 to 18.8 in 2002/03<sup>17</sup>
- the proportion of older people receiving home care outside normal office hours is also growing.<sup>18</sup>

**23.** But the number of older people getting home care has fallen by more than 9,500 since 1999.<sup>19</sup> This would indicate that the focus on more intensive home care may have affected the number of older people receiving lower level, preventative care services.

**24.** Moving the balance of care in favour of care at home is not easy and a range of factors can affect the types of services councils and their partners provide. It can be difficult to reduce dependency on care homes if councils are tied into inappropriate block contracts creating incentives to fill places (**see Part 4 page 23**).

**25.** But there are steps councils can take to get to know the needs of their older population better and make sure they provide appropriate services. A key step is to ensure that the older people moving into care homes actually need to be there. Evidence has shown that a significant number of older people are inappropriately placed in residential homes and could be looked after in the community. Data reported by SCRUGs<sup>20</sup> shows that 56% of older people in residential homes and 18% of older people in nursing homes were assessed as being of low dependency. As many of these people may have no need for complex care,<sup>21</sup> their needs, and preferences, could perhaps have been better met in the community. Providing adequate home care services for this group of people in future may help avoid, or defer, placement in a care home.

**26.** There is not a perfect balance of care that applies to all councils in Scotland – each council is different. Joint capacity planning between councils and the health service will help these partners understand the local care market, project future needs, and work together to develop models of service delivery aimed at ensuring an appropriate balance of care for their older population. These discussions should involve local

independent providers where appropriate since capacity planning must also be concerned with what services can be provided across the full spectrum of providers – public, private and voluntary.

### Recommendations

2. Strategic planning for and investment in future community care services for older people should be developed in line with the policy on achieving a balance of care in favour of maintaining people in their own homes where possible.
3. Councils should ensure that older people are appropriately placed and that older people do not move into care homes unless their needs require it.
4. Councils and NHS partners should assess local services, including capacity, and monitor progress in shifting the balance of care towards care at home.
5. Partners should involve their local independent providers in discussions about the future development of services, eg, capacity of care services and models of service delivery.

### Community care policies

**27.** The profile of older people's services in Scotland has heightened over recent years. The Scottish Parliament has established a cross party group on Older People, Age and Aging; in 2003 there was the election to Scottish Parliament of the

14 Non-institutional care includes home care, day centres and other care at home.

15 Institutional care refers to care homes.

16 *Scottish Community Care Statistics 2002*, Scottish Executive (2003). These figures refer to all clients, not just older people.

17 Accounts Commission Statutory Performance Indicators 2003.

18 Accounts Commission Statutory Performance Indicators 2003.

19 *Scottish Community Care Statistics 2002*, Scottish Executive (2003). These figures refer to all clients, not just older people.

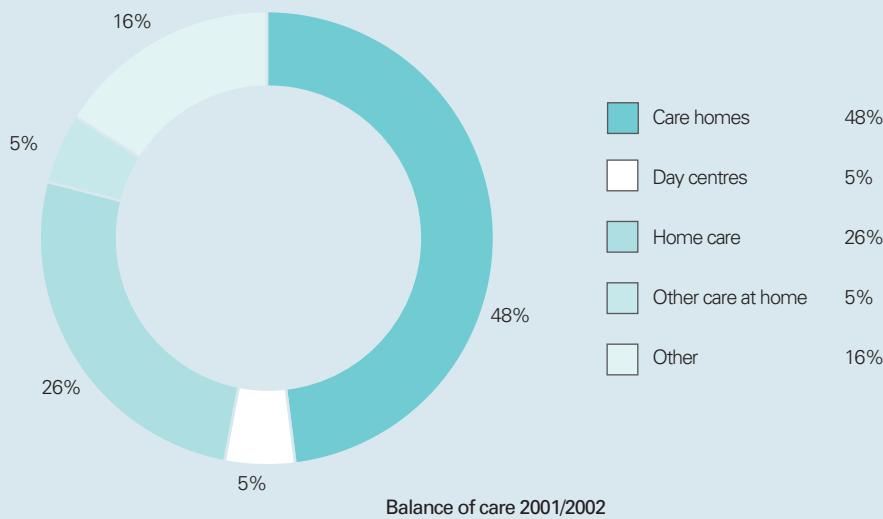
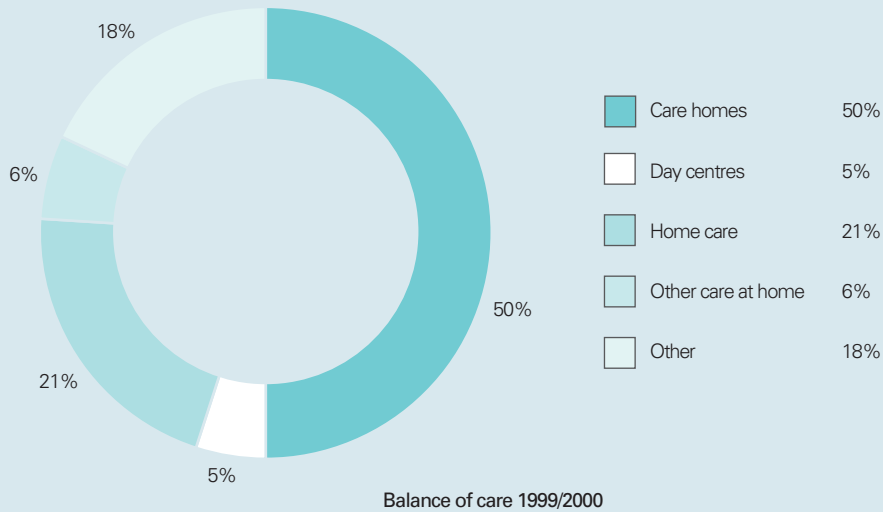
20 *Scottish Health Resources Utilisation Groups/Scottish Care Resource Utilisation Groups – Statistical Report*, ISD 2003.

21 *Low dependency residents in private nursing homes in Glasgow*, Scottish Executive Health Bulletin 59(1), January 2001.

### Exhibit 3

#### Balance of care, Scotland (net expenditure) 1999/2000 and 2001/02

There has been a move in the balance of care towards non-institutional forms of care.



**Note:** 'Other' includes expenditure on older people's services and may include expenditure on care at home or care homes (eg, 'senior management and purchasing').

**Source:** *Scottish Community Care Statistics 2002*, Scottish Executive, 2003

## Exhibit 4

### Balance of care, councils 1999/2000 - 2001/02

The balance of care has shifted in favour of non-institutional forms of care in 21 councils, while in eight the shift has been in favour of institutional care.

	1999/2000		2000/01		2001/02	
	Non-institutional %	Institutional %	Non-institutional %	Institutional %	Non-institutional %	Institutional %
Aberdeen City	41	59	38	62	34	66
Aberdeenshire	35	65	34	66	39	61
Angus	30	70	36	64	37	63
Argyll & Bute	32	68	31	69	38	62
Clackmannanshire	25	75	64	36	59	41
Dumfries & Galloway	50	50	55	45	55	45
Dundee City	39	61	41	59	40	60
East Ayrshire	38	62	40	60	44	56
East Dunbartonshire	80	20	80	20	48	52
East Lothian	43	57	45	55	46	54
East Renfrewshire	30	70	36	64	45	55
Edinburgh, City of	55	45	55	45	49	51
Eilean Siar	42	58	37	63	41	59
Falkirk	48	52	47	53	50	50
Fife	47	53	48	52	48	52
Glasgow City	21	79	40	60	39	61
Highland	25	75	29	71	33	67
Inverclyde	41	59	43	57	50	50
Midlothian	44	56	45	55	44	56
Moray	45	55	38	62	46	54
North Ayrshire	34	66	32	68	34	66
North Lanarkshire	34	66	35	65	46	54
Orkney Islands	42	58	41	59	45	55
Perth & Kinross	31	69	43	57	36	64
Renfrewshire	56	44	53	47	52	48
Scottish Borders	41	59	45	55	46	54
Shetland Islands	55	45	57	43	52	48
South Ayrshire	44	56	42	58	48	52
South Lanarkshire	40	60	40	60	37	63
Stirling	49	51	52	48	63	37
West Dunbartonshire	35	65	39	61	33	67
West Lothian	49	51	54	46	49	51

Note: The figures relate to spend on older people's services reported by each council in LFR3 returns made to the Scottish Executive. Institutional care represents spend on nursing and residential care (now called care homes) and non-institutional care represents spend on home care, day care, meals on wheels, aids & adaptations and community alarms.

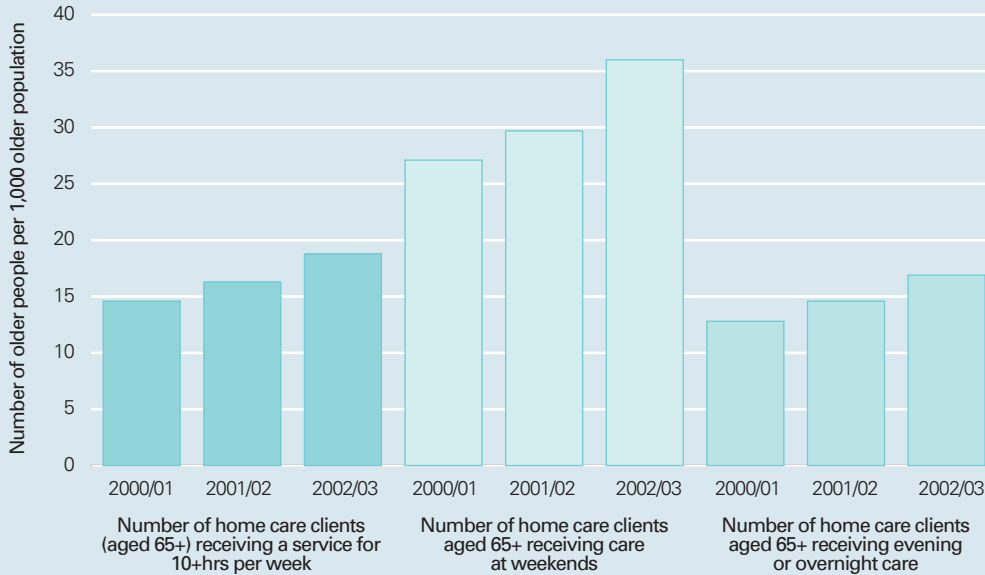
Source: Scottish Executive



### Exhibit 5

Flexibility in providing home care, councils, 2000/01 - 2002/03

Councils are increasing the levels of care they provide to older people living at home and providing it in a more flexible way.

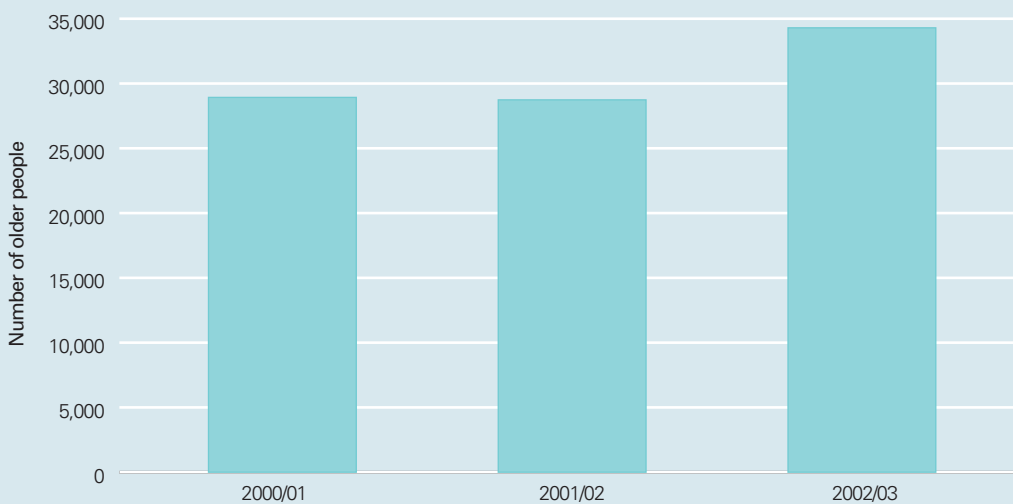


Source: Accounts Commission Statutory Performance Indicators 2003

### Exhibit 6

Number of older people recorded as receiving personal care at home organised by councils, 2000/01 - 2002/03

Across Scotland the number of older people receiving personal care at home has increased by 19%, from 29,000 in 2000/01 to 34,000 in 2002/03.



Source: Accounts Commission Statutory Performance Indicators 2003

first MSP to represent the Scottish Senior Citizens Unity Party; and a Joint Services Framework for Older People is being developed.

**28.** Policies developed at a national level have significant implications for local planning and commissioning. We looked at three areas of community care policy affecting older people, aiming to give an early indication of how progress is being made on their implementation across the country:

- free personal and nursing care
- direct payments
- rapid response services.

#### Free personal and nursing care

**29.** Free personal care was introduced in Scotland under the Community Care and Health (Scotland) Act 2002. This Act also introduced free nursing care for people in care homes, aimed at ending the inequity where some older people at home and in hospital received free health care, whilst older people in nursing homes had to pay for their nursing care. Its implementation means there are no more charges for personal care for older people who live at home, and there is help towards the cost of personal care for those in care homes.

**30.** Personal care<sup>22</sup> is defined as including:

- personal hygiene
- continence management
- problems of immobility
- food and diet (eg, assistance with eating)

- simple treatments (eg, assistance with medication, simple dressings)
- personal assistance (eg, assistance with dressing and getting into or out of bed).

**31.** As a result of the Act people over the age of 65 are now entitled to a contribution of up to £145 a week towards the cost of personal care and, where the person resides in a care home, they are entitled to up to a further £65 a week if they also require nursing care.

#### Implementation of free personal and nursing care

**32.** Free personal and nursing care for older people was introduced within a matter of months of the passing of the Act in February 2002. Implementation was originally intended for April 2002, but was delayed until July 2002 to give councils sufficient time to prepare. Preparation included the development of IT systems, staff training, assessment of the eligibility of older people and estimating take-up in order to bid for funding from the Scottish Executive. Even with this extension councils reported that the timescale for implementation was tight. Over 40% of councils told us that the main difficulty they experienced involved updating their IT systems to administer the policy; 40% also stated that they had seen increased pressure on staff and budgets. A number of councils commented on the difficulty they had in explaining what free personal care actually is to the public and to people using services. Public perceptions are reported to have been that all aspects of care are 'free' when in fact it is only the 'personal' element of their care that is free.

**33.** The Scottish Executive collects data from councils on the take-up of free personal care and free nursing care payments by older people in care home and at home. However, data are incomplete: some councils are still not able to provide data and some only started to provide data recently.

**34.** Exhibit 6 (opposite) shows the number of people receiving personal care at home organised by councils. Since the implementation of free personal care this figure has increased across Scotland. This is expected: the profile of free personal care has reportedly led to more people coming forward for assessment for this service; and people previously paying for their personal care privately can now claim towards the cost of it.

**35.** Looking at the implementation of free personal care formed only a small part of our review. A more detailed review is needed which should involve looking at the numbers receiving this service, how it has affected their quality of life and the cost of this policy. It is difficult without information like this to assess the impact of this policy and forecast future expenditure.

<sup>22</sup> Implementation of free personal and nursing care guidance, Scottish Executive, Circular No. CCD 4/2002.

## Exhibit 7

### Take-up of direct payments by older people, 2002 and 2003

More older people are using direct payments to organise their own care.

	At 31 March 2002	At 31 March 2003
Number of direct payments made to older people	52	141
Number of direct payments made to older people as a percentage of total direct payments	18%	26%

Source: *Direct payments, National Statistics Publication, Scottish Executive, 2003*

### Recommendations

6. Councils should collect comprehensive data about the take-up of free personal and nursing care. This will assist planning and performance monitoring at both local and national levels.
7. The Scottish Executive should collect comprehensive information from all partnership areas on the implementation of national policies. This is essential to enable the Scottish Executive to evaluate the impact on service users and the associated costs.

### Direct payments

**36.** A direct payment is a payment of cash from the council to an individual so that they can arrange for their own care independently of the council.<sup>23</sup> The aim is to enable people to make their own choices about

their care: they can decide who delivers their care and where and when it is delivered.

**37.** Since 1 June 2003 councils have had a duty to offer direct payments to disabled older people. During 2004, this duty will be extended to include frail older people. Currently, a council may choose to offer a direct payment to any older person who has received a community care assessment stating they require care.

**38.** There are potential consequences for councils if older people opt to take a direct payment. If significant numbers decide to organise their care themselves and choose not to purchase existing services, this could make these services uneconomic to run. It could also provide information about services which are not meeting expressed need. Councils need to plan for the full implementation of direct payments. This planning will also need to take account of the support which people who opt for

direct payments may need in purchasing their own care – for example, help with managing employment contracts.

### Current take-up of direct payments

**39.** Twenty-five councils offered direct payments to their older population at the time of our audit. Current take-up is at a low level across Scotland, but is increasing (*Exhibit 7 above*). At 31 March 2003, the value of direct payments to older people totalled £783,000 representing an average of £5,600 per person<sup>24</sup> (and representing 14% of the value of all direct payments made).

### Forecasting future take-up of direct payments

**40.** While significant take-up of direct payments may have an impact on future patterns of service delivery, only 11 councils have estimated the numbers of older people likely to take up direct payments over the next five years. Of those councils, nine have estimated the likely

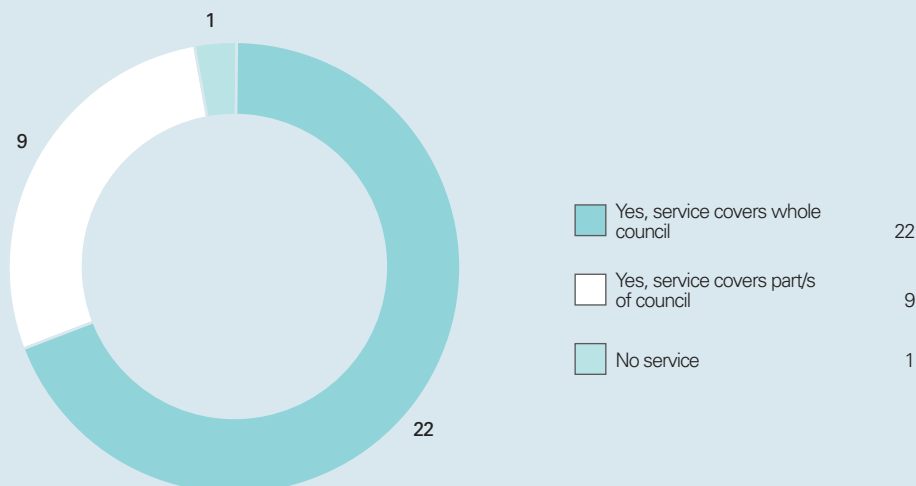
<sup>23</sup> Direct payments were introduced under section 12B of the Scotland Work (Scotland) Act 1968. This was amended by the Community Care and Health (Scotland) Act 2002 in order to make direct payments more widely available.

<sup>24</sup> *Direct Payments, National Statistics Publication, Scottish Executive, 2003.*

## Exhibit 8

### Rapid response service across councils, December 2003

Only 22 councils comply with the Scottish Executive's target to implement comprehensive rapid responsive services across their full council area.



Source: Scottish Executive, data at December 2003

expenditure. Two of the councils estimating both numbers and expenditure are yet to introduce a direct payment scheme for older people.

**41.** The estimated costs and take-up of direct payments vary among the nine councils that have gone through this exercise. For example, one council estimates an increase of 100 payments over the next five years at a cost of £750 per payment; another council estimates an increase of eight payments at a cost of almost £21,000 per payment over the same timeframe.

**42.** The variation in estimating take-up of direct payments may be explained in part by: the availability of alternative providers; older population predictions for the next five years; and current interest and take-up in direct payments. It may also reflect a lack of information given to people about direct payments. Consulting with the older population living in the council

area would help councils get an indication of awareness and interest in direct payments to help their planning.

#### Recommendation

**8.** Councils should plan now for the extension of direct payments due to the potential cost and the implications for service provision. They also need to ensure that users who opt for direct payments are supported to achieve their successful implementation.

#### Rapid response services

**43.** Older people can be susceptible to falls and illness which often lead to stays in hospital. Responsive and flexible care services can help prevent hospital admissions or support early discharge from hospital. This was a key recommendation of the Joint Future Group which stated that every local authority area should

have in place a comprehensive joint hospital discharge/rapid response team by mid 2001-02.<sup>25</sup> Additional funds were also allocated to council and health partnerships to develop these services.<sup>26</sup>

**44.** We looked at rapid response services across Scotland focusing on:

- whether councils have a service
- what the service has achieved
- what methods councils are using to monitor them.<sup>27</sup>

#### Implementation of rapid response services

**45.** The Scottish Executive provided us with data about the extent of rapid response services across each council area. However, while the Executive gave a target date for implementation of mid 2001-02, at the time of our audit in 2003 one council did not have a service in place and nine councils did not have

<sup>25</sup> *Report of the Joint Future Group*, Scottish Executive, Edinburgh, 2000.

<sup>26</sup> This includes £3 million which was allocated by the Scottish Executive to support the recommendations of the Joint Future Group. (Scottish Executive News Release SE2645/2000, October 5, 2000.

<sup>27</sup> The information noted reflects the information given at the time of the audit (March – May 2003).

a comprehensive service which covered the whole council area (Exhibit 8 page 15).<sup>28</sup> It is not possible to tell from the information currently available what proportion of the population live in an area not covered by a rapid response service.

### Monitoring the performance of rapid response services

**46.** Monitoring the performance of rapid response services allows councils and their partners to evaluate the services, assess their success, and make improvements where necessary.

**47.** Over a third of the 31 councils that have a rapid response service use the data returns they submit to the Scottish Executive to help monitor these services. These returns record:

- the availability of rapid response services
- numbers of referrals from hospital and the community
- origin of the service (eg, whether the service started in hospital or the community)
- estimated number of hospital admissions avoided
- estimated number of early discharges from hospital achieved.

**48.** Because the data reported at a national level are incomplete, we have limited findings on the effectiveness of rapid response services. It appears, however, that these services can help reduce unnecessary admissions to hospital (Exhibit 9 opposite) and help achieve earlier discharges from hospital (Exhibit 10 opposite).<sup>29</sup> But these results are based on data from seven councils only. The Scottish Executive should require complete data from all areas so that a full evaluation can take place.

### Recommendations

- 9.** In line with the Joint Future Group's recommendation, all councils should have a comprehensive rapid response service for older people serving their whole council area.
- 10.** Councils and NHS partners should collect data about their rapid response services to help measure whether they are value for money and having a positive impact on the local care system. This information will support future service development.

<sup>28</sup> The Scottish Executive has asked that this data, which is unpublished, remains anonymised.

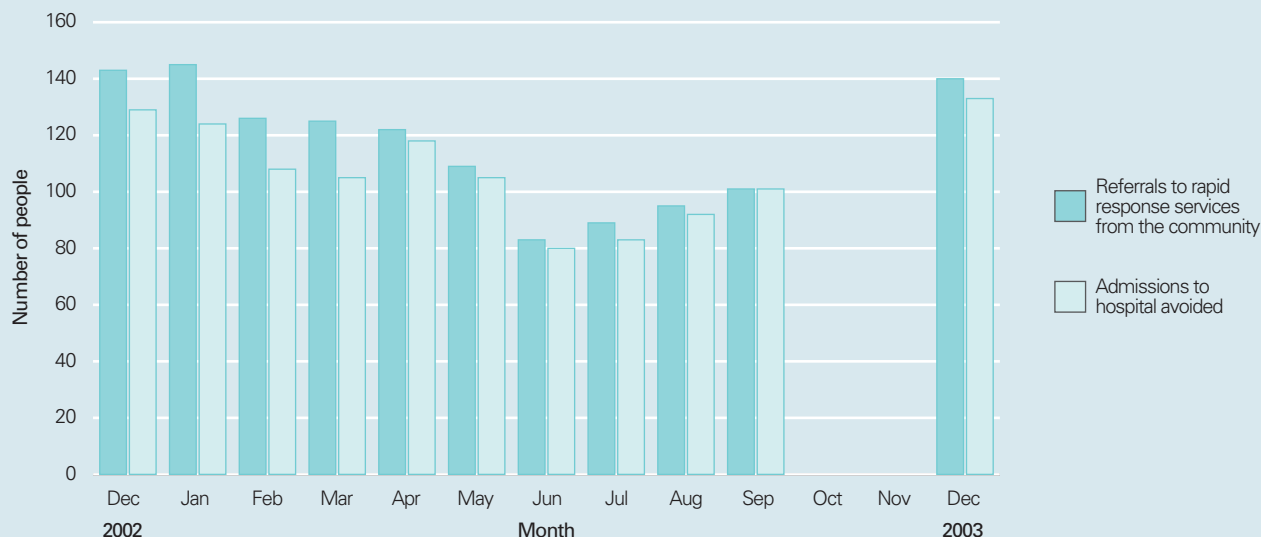
<sup>29</sup> These data are collated from the Scottish Executive. They are incomplete data and are used here to give an indication only of emerging patterns.



## Exhibit 9

### Estimated impact of rapid response services on hospital admissions

Rapid response services have a positive impact on the number of hospital admissions; most referrals to rapid response services from the community result in older people not being admitted to hospital.



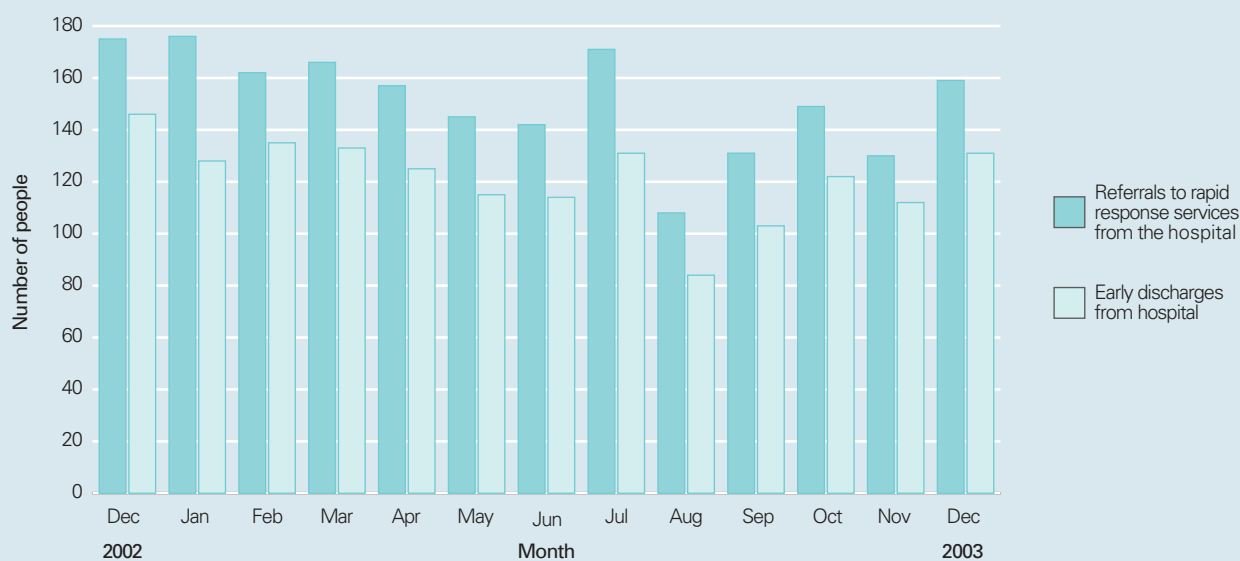
**Note:** The information is based on seven councils supplying data consistently over the timeframe. Data for October and November 2003 are unreliable, and have not been included.

**Source:** Scottish Executive

## Exhibit 10

### Estimated impact of rapid response services on early hospital discharges

Rapid response services have a positive impact on the number of early discharges from hospital; most referrals to rapid response services from hospital result in older people being discharged earlier than would otherwise have been the case.



**Note:** The information is based on seven councils supplying data consistently over the timeframe.

**Source:** Scottish Executive

## Part 3. Planning for commissioning



### Key messages

Councils and their partners need to use the information they have on older people's needs when planning services.

### Assessing need

**49.** All councils have either a joint commissioning strategy with their health partners, or a plan for older people's services, which directs the overall development of services in the area. In order for these plans to be effective, councils must base them on good knowledge of their older population and its needs. Assessing needs is therefore fundamental to providing relevant services to older people and enables councils to build up a picture of what services are required, where, in what quantities and for how long.

**50.** We asked councils about the information they collect on their older population and how they use this for planning. We picked out the areas in [Exhibit 11 \(overleaf\)](#) because councils

have to plan carefully for these in light of population increases and the emphasis on older people living at home or as independently as possible.

**51.** While the majority of councils collect information about their older population, there is often no link between the information collected and its use in service planning. [Exhibit 12 \(overleaf\)](#) summarises these findings; a fuller summary for each council is found in [Appendix 1 \(page 36\)](#).

**52.** In addition, a number of councils collect information on the health needs of their older population. Some councils collect this information themselves, while others use information already collected by the health service. Around half of all councils use the information they have on the health needs for service planning purposes.

**53.** Councils need to know what needs are not being met by current services so that planning for improvements can include this information. Two-thirds of councils

collect information about unmet needs. But several councils highlighted that their information systems are unable to collate information recorded in care plans about individual service users, including their unmet needs. Some councils find it useful to compare prevalence data with information collated from the care planning system to help establish unmet need for older people living in the community but who are not known to social care services.

### Recommendations

**11.** Councils and NHS partners should use information on their older population to plan and develop services that can both respond to a predicted growth in demand and ensure that older people can live as independent a life as possible.

**12.** To comply with the Race Relations (Amendment) Act 2000, councils and their health partners should collect and use information on their older

population from a minority ethnic background. In doing so they should be aware of the differences between minority ethnic groups and ensure that services are developed to meet the needs of the diverse backgrounds of older people.

- 13.** Councils should consider comparing prevalence data to information collated from assessments to help establish unmet need about older people who live in the community but are not known to social care services.

### Consulting older people and their carers

**54.** Councils need to understand what service users, potential service users and their carers think of current services. This can help to improve services in line with users' experiences.

**55.** Most councils have systems in place to consult with older service users and their carers in the development and planning of current and future services:

- Thirty councils reported they regularly consult with older service users and their carers in the community. The main methods used are public meetings, face-to-face interviews and focus groups.
- Over two-thirds of councils also reported using other methods of consultation to canvass the views of service users. These include the media (local press and television), internet sites, conferences and feedback gleaned through community care forums; 24 councils reported making use of advocacy services.

**56.** Consultation with older people and their carers takes place at different intervals depending on the method used; for example, carers forums might be monthly, but a roadshow might be an annual event.

**57.** Improvements could be made in how councils collect information about this older people who are not currently using services and their carers. Councils tended to cite the same methods for consulting with non-service users and their carers as they do for service users. This 'one size fits all approach' is not effective. Councils need to know about groups who might be entitled to services, but who are not currently making use of them. Many carers don't regard themselves as carers or don't know that support is available. Councils need to get better at getting information to these people.

### Recommendation

- 14.** Councils should develop methods of consultation which are specific and appropriate to the different groups of older people and carers in their area, including those not currently using services.

## Exhibit 11

### The needs of older people

Councils must plan carefully for groups of older people with specific needs to ensure good provision of services that allow older people to maintain their independence.

In light of a predicted growth in the number of older people, and an emphasis on care at home, it is important that councils have a good knowledge of their older population in the following areas:

<b>Dementia</b>	<ul style="list-style-type: none"> <li>• Older people with dementia have many complex needs.</li> <li>• This illness is progressive, so people require more support over time.</li> <li>• This illness becomes more prevalent with age (it is estimated that an average of 7% of people over 65 have dementia; within the over 85 age group this figure rises to over 20%).<sup>30</sup></li> </ul>
<b>Physical disability</b>	<ul style="list-style-type: none"> <li>• Older people with a physical disability may need specific help to live independently in their own homes.</li> <li>• Many older people require aids to help them with daily tasks or permanent adaptations to their homes.</li> <li>• Prevalence of physical disability increases with age (over a fifth of over 75s are estimated to have a physical disability).<sup>31</sup></li> </ul>
<b>Minority ethnic background</b>	<ul style="list-style-type: none"> <li>• Older people from minority ethnic backgrounds have specific needs that may differ from those of other older people.</li> <li>• Older people from a minority ethnic background should not lose out on services due to lack of knowledge about what is available or assumptions made about their culture.</li> <li>• The Race Relations (Amendment) Act 2000 requires councils to consider race equalities issues.</li> </ul>
<b>Socio-economic status</b>	<ul style="list-style-type: none"> <li>• It is generally accepted that the lower the socio-economic status of a population the greater their health needs.</li> <li>• If an older person has health needs then they are more likely to require care services at home.</li> </ul>
<b>Housing support needs</b>	<ul style="list-style-type: none"> <li>• If older people are to remain at home then their homes need to be suitable for them.</li> <li>• Older people with for example, a physical disability may need accessible homes with certain adaptations.</li> </ul>
<b>Carers</b>	<ul style="list-style-type: none"> <li>• It is estimated that one in ten people in Scotland provide care to a relative or friend living at home.</li> <li>• The number of available carers is estimated to fall as the older population increases.</li> <li>• Carers often need some kind of support for themselves to help them continue to care.</li> </ul>

30 Prevalence rates detected by EURODEM and reported in *Planning signposts for dementia care services*, Alzheimer Scotland – Action on Dementia, 2000.

31 *Survey of disability in Great Britain*, Office of Population Censuses and Surveys, 1998.

<b>Health</b>	<ul style="list-style-type: none"> <li>• Councils and the NHS have a duty to work together.</li> <li>• Health deteriorates as people get older.</li> <li>• Older people may go to hospital more, suffer from strokes or falls at home.</li> <li>• The greater number of people with health problems then the more they rely on community care services.</li> </ul>
<b>Unmet need</b>	<ul style="list-style-type: none"> <li>• Councils need to know what needs are not met currently in order to prioritise service development in the future.</li> </ul>

## Exhibit 12

Information about older people and its use in the planning process

While the majority of councils collect information about their older population, there is often no link between the information collected and its use in the planning process.

	<b>Number of councils collecting this information</b>	<b>Number of councils which can demonstrate a link between the information collected and its use in planning</b>
Older people with dementia	32	28
Older people with a physical disability	28	22
Older people from minority ethnic groups	27	15
Older people's socio-economic status	24	19
Older people's housing support needs	26	23
Carers	24	25



## Good practice example 2

City of Edinburgh Council, NHS Lothian and partners

A detailed 'Capacity Planning' exercise, initiated by the Director of Social Work and NHS Lothian's Acting Director of Social Inclusion and Community Care, has been undertaken by the City's Strategic Development Group (Older People).

This group is part of the City's joint planning structure and includes representatives from the City of Edinburgh Council, NHS Lothian, Edinburgh Leisure, voluntary sector, users, carers and minority ethnic communities. By analysing current demands and estimating future needs (5-10 years), the main aim was to ensure that the City has an adequate supply of accommodation with support and care, and can meet its policy aims set out in *A City for All Ages* (Edinburgh City's plan for older people's services).

The capacity planning exercise has included all forms of accommodation including NHS long-term care, care homes, sheltered housing, mainstream and adapted housing with extra care and support. The Group also considered respite care provision, the needs of people with dementia and the needs of minority ethnic older people.

The main findings of the exercise included identification of:

- expected demand (including consideration of population projections, delayed discharge and waiting lists and the requirement for respite places)
- projected supply (including the impact of projected closures and the introduction of the single room standard)
- implications for City of Edinburgh Council and its partners in health, the voluntary sector and the private sector, including plans to commission an additional 240 care home places and to support an additional 600 older people in the community through joint care packages.

Source: City of Edinburgh Council and NHS Lothian

## Part 4. Commissioning



### Key message

The balance of contracts needs to support strategic planning to ensure value for money and the sustainability of services.

**58.** Increasingly councils contract with the private and voluntary sectors to provide community care services for older people. Purchasing services from a variety of providers allows councils to offer a wider range of services (including specialist services) than they can offer themselves.

**59.** It is important that councils commission external provision in a carefully thought-out and joined-up way. In order to make external provision cost effective and sustainable councils need to consider what services they need and how they want them delivered in the long-term. Even if councils decide to provide services themselves, they

should plan the direction of service developments before beginning to arrange them.

**60.** This section considers how councils purchase community care services so that they can make best use of their resources. Specifically, it looks at the type of contracts councils use.

### Contracting services

**61.** In the past most social care services were delivered directly by councils. However, over the last 15 years councils have made increasing use of independent providers. Overall Scottish councils spend just over half of their budgets for older people's services on directly provided services.<sup>32</sup> The remainder is spent on services provided by the independent sector through specific contractual arrangements for the delivery of each service or package of care. [Exhibit 13 \(overleaf\)](#) shows the different contracts that are used

across Scotland. A significant proportion of contract expenditure is on spot contracts (29%).

**62.** Different contracts are suited to different situations and there are advantages and disadvantages with each one. [Exhibit 14 \(overleaf\)](#) gives an explanation of each contract type and suggests the type of situation it could be used in to help councils decide what mix best suits their requirements.

**63.** The use of different contract types across councils varies significantly ([Exhibit 15 page 27](#)) and there are some interesting trends:

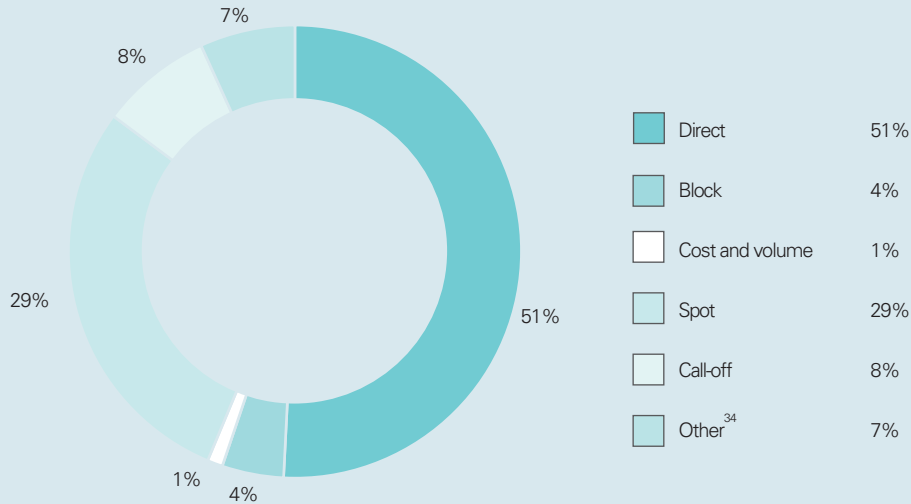
- twenty councils have a 50% or higher reliance on direct services
- four councils have a 50% or higher reliance on spot contracts
- one council has over a 50% reliance on call-off contracts.

<sup>32</sup> Based on 51% of expenditure spent on directly provided services.

## Exhibit 13

### Expenditure on older people's community care services by contract type, Scotland<sup>33</sup>

Councils spend just over half of total expenditure on direct services with the rest bought using a variety of contract types.



Source: Audit Scotland 2003

**64.** To get the best out of services for older people, councils have to make judgements about how best to meet people's needs while paying due attention to the overall cost and sustainability of services. It is important that councils do not rely on one type of contract too heavily and instead have a range of options open to them. This will help get the right balance of contracts to ensure value for money.

### Recommendations

- 15.** Councils and NHS partners should regularly review their commissioning strategy (eg, on an annual basis) to ensure it is sustainable and delivers value for money.
- 16.** Councils should carry out a risk assessment of their spread of contracts types; for example the consequences of too heavy a reliance on spot or block contracts.

<sup>33</sup> Data provided by 30 councils: City of Edinburgh and Shetland could not extract expenditure or contracts for older peoples services from all community care services.

<sup>34</sup> For example, service level agreements.

## Exhibit 14

### Pros and cons of different contract types

Councils have to decide what mix of contracts best suits their needs.

Contract type	Description	Advantages	Disadvantages	This contract could be used if...
Block	These contracts are for the provision of a given service eg, a council may contract out their meals-on-wheels service for three years	<p>Simplifies administration: there will be an agreed price for an agreed service</p> <p>Provides value for money due to the volume they are purchased in</p> <p>Stable types of contract that run for an agreed time – this allows the provider to invest in their service</p>	<p>Inflexible: the contract is for a fixed time and service level</p> <p>May not be realistic for the future with the increase forecast in the take-up of direct payments</p>	... you have a service with a steady demand that has a long-term future
Cost and volume	With these contracts the cost of provision decreases with the number of places bought for example, the first ten places will cost £390 per week; the next ten might be £370 per week.	<p>Can help to manage unpredictability in service demand</p> <p>Costs are guaranteed and known in advance</p> <p>Can be flexible</p>	<p>Cost per placement may be higher than with block contracts</p> <p>Pre-contract negotiations can be long and complex (like those with block contracts)</p> <p>Accounting costs will increase due to the variable pricing structure</p> <p>Can create a perverse incentive to fill places in order to secure cheaper rates</p>	... you know you need a service, but are not sure of the demand over time, which may fall or grow
Call-off	A variant of the cost and volume contract. A provider agrees to provide a service for a fixed fee regardless of volume and agrees provision on a stand-by basis	<p>As for cost and volume, in addition:</p> <p>accounting is less complex</p> <p>No incentive to place in order to keep costs down</p>	<p>As for cost and volume, in addition:</p> <p>unpredictability of placing numbers may discourage providers from investing in services</p>	<p>... you know that a service will be needed in the future</p> <p>... you know that demand for that service could vary</p> <p>... you need a service to be provided as and when you need it</p>

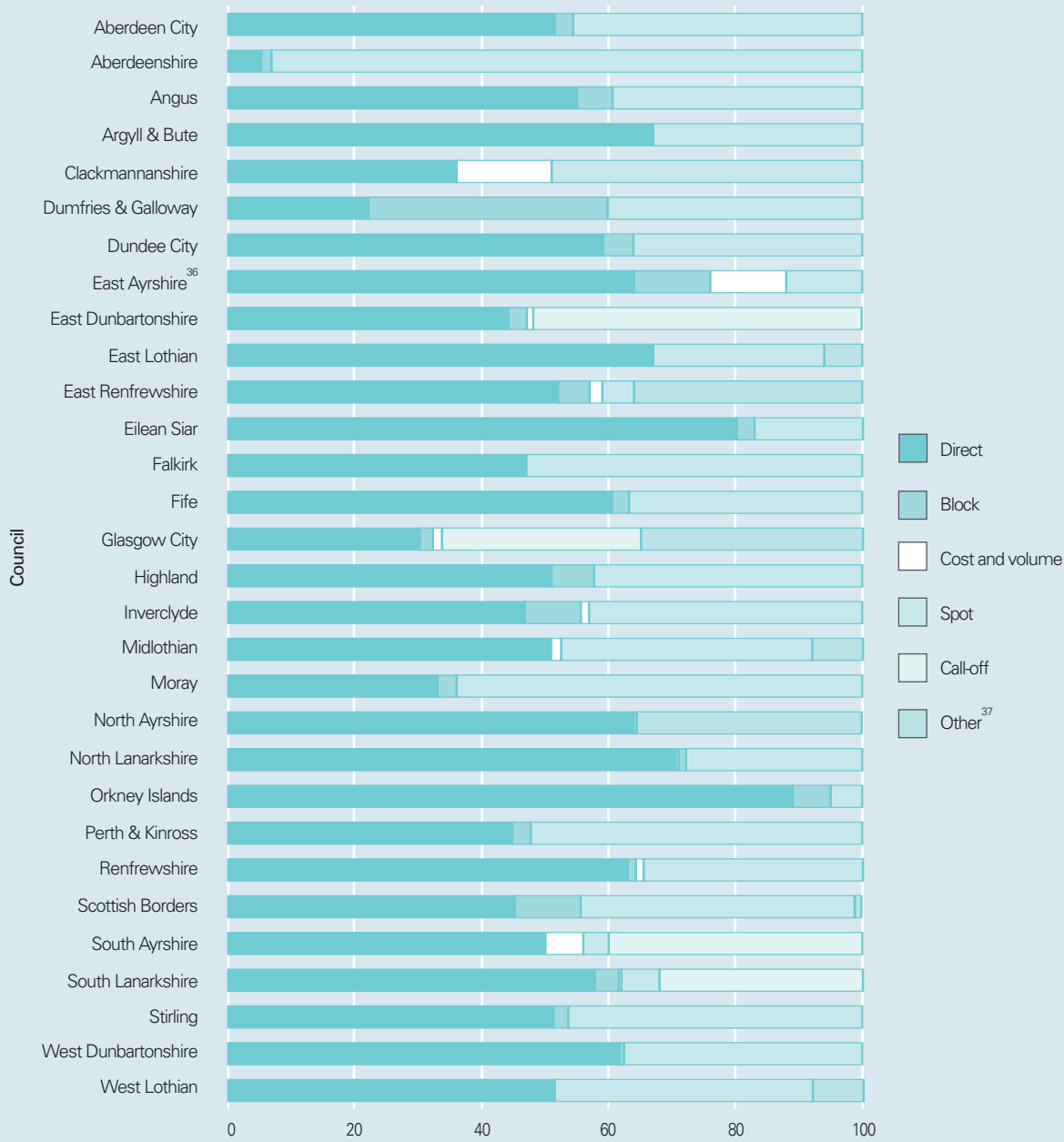
Contract type	Description	Advantages	Disadvantages	This contract could be used if...
Directly provided	Services are directly provided and delivered by the council	<p>Increased level of control over supply</p> <p>Easier financial controls/no financial transaction costs</p> <p>Secure supply</p>	<p>Limited choice</p> <p>Limited flexibility</p> <p>Reduced incentive to continuously improve – no competition</p> <p>Potentially higher costs due to situations where all places are not filled</p>	<p>... you have a service that you will not get value for money from if it is contracted out</p> <p>... there is no credible/available local provider</p>
Spot	Services are purchased on an individual basis	<p>Tailored to individual needs and choice avoiding one-size-fits-all approach</p> <p>Can be put in place quickly as they avoid lengthy contract negotiations</p> <p>Encourage improved services due to competition of providers</p> <p>No waste – services are purchased as and when they are needed</p> <p>Enable easy identification and transfer of money for direct payments</p>	<p>Lack of security for providers which discourages investment in services and could ultimately lead to a shortage of places</p> <p>High financial costs</p> <p>Limits ability of council to take a lead in developing community care services</p> <p>Requires good financial control and care managers require good purchasing skills</p> <p>Monitoring is difficult due to the number of individual contracts</p>	<p>... an individual has specific needs that are unlikely to be the same as other older people's needs and they require a tailored service</p>

Source: Adapted from *Community care services for older people: applying a best value framework*, Accounts Commission, 2000 and from *Commissioning and Purchasing*, Bamford, T, Routledge, London 2001

### Exhibit 15

#### Community care spending by contract type on older people’s services

The use of contracts varies widely from council to council.<sup>35</sup>



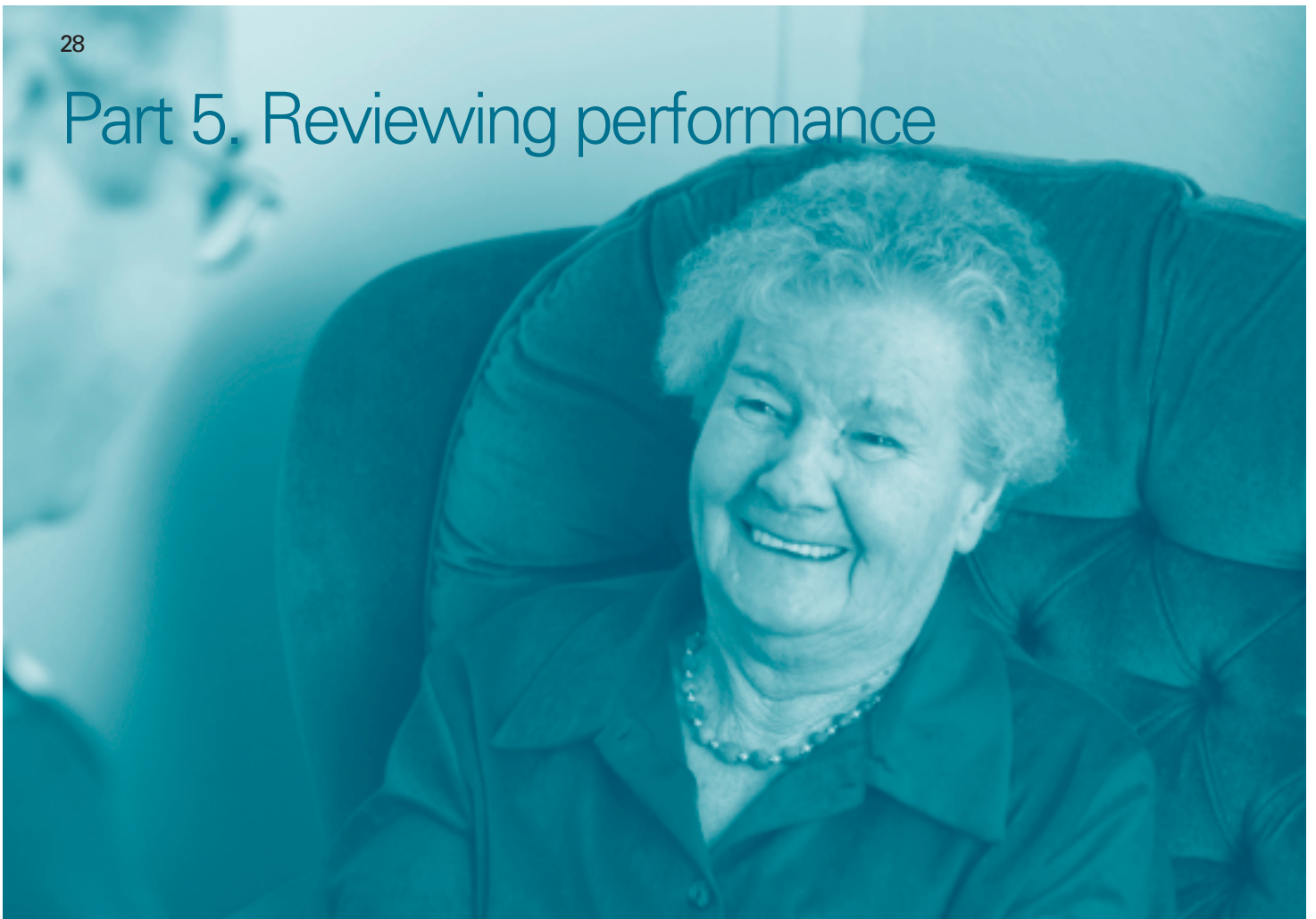
Source: Audit Scotland 2003

35 The City of Edinburgh Council and the Shetland Isles Council were unable to supply this data for older people specifically. They were not able to separate out information about contracts for older people’s services from information about community care contracts in general.

36 East Ayrshire were unable to break down expenditure for block, cost & volume and spot contracts. Total expenditure on these contracts represents 36% of contract expenditure.

37 For example service level agreements.

## Part 5. Reviewing performance



### Key messages

Almost every council has a waiting list for care home places and two-thirds have one for home care. But monitoring how long older people wait for services to be provided is patchy and inconsistent.

There is wide variation in the progress of joint working in delivering community care services.

**65.** Reviewing performance is essential to developing relevant and responsive services; councils and their partners need to know what services are making a positive impact on older people's quality of life and why, and which services are failing to do so.

**66.** This section looks at the ways in which councils monitor and review the services they commission. We focused on three mechanisms for reviewing performance:

- monitoring services through reviewing waiting times and waiting lists
- best value reviews of services
- evaluating joint working between councils and the health service through the Joint Performance Information and Assessment Framework (JPIAF).<sup>38</sup>

### Monitoring waiting times and lists

**67.** Having to wait for the provision of services can detrimentally affect an older person's health and well-being. Monitoring waiting times is therefore an important indicator when reviewing performance and is a key indicator for ensuring older people get the support they need within a reasonable timescale.

**68.** Most councils collect information about how long older people wait for a place in a care home, but only half collect information on waiting times for a place in special needs housing ([Exhibit 16 opposite](#)). In addition, this information is not collected on a consistent basis which means councils are unable to benchmark their performance with each other.

**69.** A new national performance indicator (PI) is being developed as part of the JPIAF. This will measure the time interval between an individual's first contact with a council or health body and the delivery of the first community care service by the provider. While the national PI will not break this down into the type of service (for example, home care or care home place), having information broken down in this way would be useful local management information.



## Exhibit 16

### Monitoring waiting times for community care services

Most councils monitor the time older people wait for a care home place; only half monitor waiting times for special needs housing.

Length of time waited for a ...	Number of councils monitoring waiting times for this service
Place in a care home	30
Community equipment and adaptations	26
First home visit for home care	23
Place at a day centre	18
Place in special needs housing	16

Source: Audit Scotland 2003

### Census of waiting lists

**70.** We carried out a census to find out on a particular day (31 March 2003) how many older people in the community (ie, not in hospital) were waiting for a place in a care home or for home care. This provides a snapshot of the numbers waiting for these services at a particular point in time; we did not ask how long individuals had been waiting. The results were:

- 1,188 people were waiting for a placement in a care home, an average of 37 people per council<sup>39</sup>
- 636 people were waiting for home care, an average of 20 people per council.<sup>40</sup>

**71.** Exhibit 17 (overleaf) shows the results of our census in each council. The figures have been converted into figures per 1,000 older population in order to allow for fair comparison. The exhibit shows that in the majority of councils (23) more older people

were waiting for a care home place than are waiting for home care. In 14 councils there was no waiting list for home care and in one council no-one was waiting for a place in a care home at the census date. Overall, there is a large degree of individual variation among councils. However, there are no common definitions to calculate how long people wait for services to enable comparison of waiting times across councils.

### Recommendations

- 17.** Councils should collect waiting times for different community care services. If collected on a consistent basis, councils could use it to benchmark and to promote continuous improvement in services.
- 18.** Councils should monitor waiting lists for services and include this as part of their local performance management frameworks.

### Best value reviews

**72.** On 1 April 2003 a new duty of best value was introduced for councils.<sup>41</sup> This requires councils to ensure that local services:

- actively aim for continuous improvement
- achieve a balance between quality and cost
- ensure accountability by being responsive to stakeholders
- pay attention to sustainable development
- ensure that equalities issues are addressed.

**73.** Although the principle of best value was used across councils previously, it now has a statutory basis. The aim is to modernise local government management and business practice so that local authorities deliver better, more responsive public services.

<sup>39</sup> One council estimated this figure (Perth & Kinross).

<sup>40</sup> Six councils estimated this figure (Argyll & Bute, Dumfries & Galloway, East Lothian, Renfrewshire, Scottish Borders and Shetland Islands).

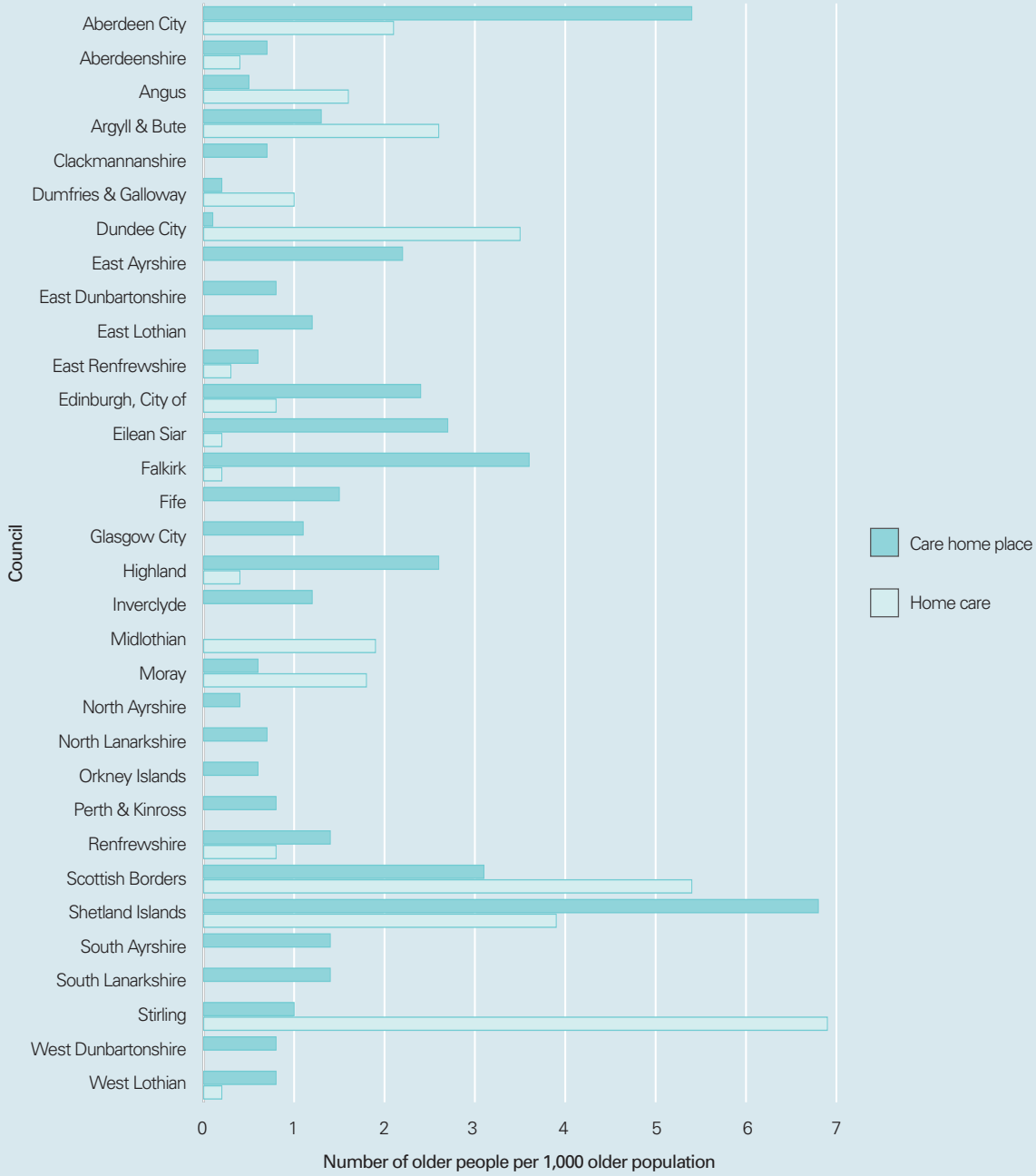
Perth & Kinross could not provide this information.

<sup>41</sup> Local Government in Scotland Act 2003.

## Exhibit 17

Care home and home care waiting lists census, at 31 March 2003

Almost every council (31) has a waiting list for a care home place; nearly two-thirds (18) have one for home care.



Source: Audit Scotland 2003

### Content of best value reviews

**74.** Councils were asked about best value reviews they have carried out that focused on, or included older people's residential care services. We selected older people's residential services as it is an area of high spend and one that councils and their partners should have already considered when addressing balance of care issues.

**75.** Twenty-three councils reported carrying out best value reviews which covered older people's services. Most of the reviews were carried out between 1999 and 2000 although some were as early as 1997. All of the councils that carried out a best value review included an initial assessment of the situation covering residential care services. Eighteen councils of the 23 included a cost analysis in this assessment. Other elements covered by reviews are displayed in [Exhibit 18 overleaf](#).

**76.** We also looked at the options councils included when appraising older people's residential services ([Exhibit 19 overleaf](#)). Most councils looked at improving in-house services, reconfiguring service management and delivery, and decommissioning services.<sup>42</sup> Only five councils market tested their in-house services although a number considered externalising services.

**77.** Elected members should have a strategic involvement in the delivery of best value services. We asked about the involvement of elected members in best value reviews of older people's residential services. This ranged from elected members commissioning the review in the first place to having no involvement at all. The most common method of involvement was elected members agreeing the terms of reference for the best value review.

### Recommendations

**19.** Best value reviews should be rigorous. They should always include an assessment of the cost and efficiency of the service as well as the quality.

**20.** Best value reviews of community care services for older people should include an equalities impact analysis.

**21.** Elected members should be provided with comprehensive information from best value reviews in order to make strategic decisions about community care services for older people.

### Reviewing joint working

**78.** The Joint Future Agenda is concerned with delivering better services to all community care groups. It aims to promote this through encouraging joint working practices mainly between councils and the health service. The idea underpinning the Joint Future Agenda is that through joint working it is possible to prevent duplication among service providers, provide seamless care to clients and break down barriers between agencies to ensure efficient service delivery. This means in practice that services are delivered through a single body, usually a partnership between the NHS and council, which has control of the relevant resources from social care and health. Discussion are ongoing as to how these local partnerships will link with the new Community Health Partnerships.<sup>43</sup>

**79.** Every council in Scotland now has a Local Partnership Agreement, mainly with their health partners, which covers three key areas:

- joint management of community care services (for example, a high level joint committee or board, joint managers for services, joint governance and accountability arrangements)
- joint resourcing of community care services (for example, agreed financial management arrangements, protocols and financial plans)
- Single Shared Assessment (where assessments of individuals are more person-centred, led by a single professional, and the results acceptable to all professional in social work, health and housing).

**80.** All three initiatives were to be in place for older people's services by 1 April 2003 and all other community care groups by 1 April 2004. Information is also collected in Local Partnership Agreements about joint human resource (HR) arrangements and local performance management frameworks.

**81.** The Scottish Executive has developed a joint performance and information assessment framework (JPIAF) to assess the performance of local partnerships against these initiatives. Currently, JPIAF consists of nine indicators with four grades of assessment (see [Appendix 3 page 39](#)). The results of the first JPIAF undertaken in April 2003 are illustrated in [Exhibit 20 \(overleaf\)](#). It is planned that in the future JPIAF will move from process PIs to measuring performance through improvements in outcomes for service users.

<sup>42</sup> An explanation of the various options appears in Appendix 2, page 38.

<sup>43</sup> NHS Reform (Scotland) Act 2004.

## Exhibit 18

### Content of best value review

Of the 23 councils that carried out a best value review, more than half included all the elements highlighted below. Only one council undertook an equalities impact analysis.

Does the best value review ...	Number of councils with this response
Identify how the views of the stakeholders were sought and taken into account in developing options and recommendations?	20
Provide a systematic option appraisal to explore other policy choices and delivery options?	16
Use benchmarking for quality standards and costs?	16
Provide an analysis of past and current performance?	15
Indicate future levels of service?	13
Provide an equalities impact analysis (as part of option appraisal)?	1

Source: Audit Scotland 2003

## Exhibit 19

### Best value option appraisals

Councils consider a number of different options for older peoples care as part of their best value review.

Options considered in best value review as part of its option appraisal	Number of councils including these options
Improved in-house service	19
Reconfiguring service management and delivery	18
Cessation (or decommissioning)	16
Externalisation	13
Joint working	12
Partnership	10
Hybrids	6
Market testing the in-house service	5

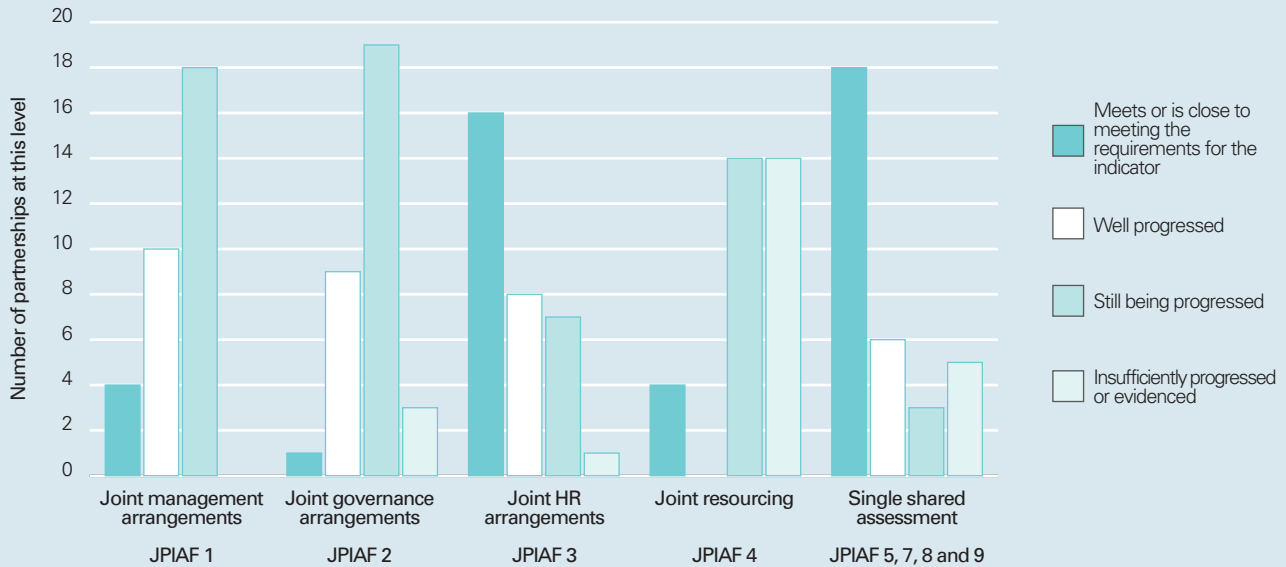
Note: An explanation of the various options appears in Appendix 2, page 38.

Source: Audit Scotland 2003

## Exhibit 20

### Summary of JPIAF evaluations, 2002 - 2003

There is a wide variation of progress across partnerships. The implementation of joint HR arrangement and single shared assessment are the best progressed.



Source: JPIAF annual statements 2003 ([www.scotland.gov.uk/health/jointfutureunit](http://www.scotland.gov.uk/health/jointfutureunit))

**82.** Exhibit 20 above shows that there are a variety of performance levels across partnerships and across the different indicators. Overall the best progressed are joint HR arrangements (with 16 partnerships 'meeting' or 'close to meeting' the requirements for the indicator) and Single Shared Assessment (with the performance of 18 partnerships assessed as meeting or close to meeting the requirements for the indicator).

**83.** The progress of the partnerships towards joint resourcing showed the weakest performance. Only four partnerships met or were close to meeting the requirements for the indicator, with the other 28 partnerships split between 'still being progressed' and 'insufficiently progressed'. Each partnership has agreed an action plan with the Joint Future Unit to take forward the areas requiring further work.

**84.** Overall councils are responding to the Joint Future Agenda but there are a significant number of partnerships and areas where progress could be improved.

**85.** National work is in progress as part of JPIAF on enabling local partnerships to measure whether joint working is making a difference for older people. This will be an important development as process indicators in themselves do not provide a complete picture of local service delivery.

## Good practice example 3

Angus Council and NHS Tayside

Forfar and Kirriemuir Community Resource Centre (CRC) is a joint project by Angus Council and NHS Tayside. It aims to provide integrated community health and social work services to the people of Forfar, Kirriemuir and the surrounding area. It involves the building of a new integrated facility on the site of an existing hospital which will replace both that facility and Forfar Infirmary and the refurbishment and re-configuration of Beech Hill House. It will provide residential and day care facilities for older people and people with dementia.

The Forfar and Kirriemuir CRC will bring together health and social care services including:

- community mental health teams
- day services for people with physical disabilities
- residential care for older people and people with dementia
- day care for older people and people with dementia
- respite care for older people
- GP in-patient ward
- physiotherapy, chiropody and speech and language therapy
- continuing care for frail older people
- continuing care for people with dementia
- palliative care.

Source: Angus Council and NHS Tayside

# Summary of recommendations

- 1.** Councils and NHS partners should collect information about carers in their area for example, number of carers, hours and type of care provided, support received by carers from the council. They should use this information to inform service developments for carers and to prepare for any future decline in carer numbers.
- 2.** Strategic planning for and investment in future community care services for older people should be developed in line with the policy on achieving a balance of care in favour of maintaining people in their own homes where possible.
- 3.** Councils should ensure that older people are appropriately placed and that older people do not move into care homes unless their needs require it.
- 4.** Councils and NHS partners should assess local services, including capacity, and monitor progress in shifting the balance of care towards care at home.
- 5.** Partners should involve their local independent providers in discussions about the future development of services eg, capacity of care services and models of service delivery.
- 6.** Councils should collect comprehensive data about the take-up of free personal and nursing care. This will assist planning and performance monitoring at both local and national levels.
- 7.** The Scottish Executive should collect comprehensive information from all partnership areas on the implementation of national policies. This is essential to enable the Scottish Executive to evaluate the impact on service users and the associated costs.
- 8.** Councils should plan now for the extension of direct payments due to the potential cost and the implications for service provision. They also need to ensure that users who opt for direct payments are supported to achieve their successful implementation.
- 9.** In line with the Joint Future Group's recommendation, all councils should have a comprehensive rapid response service for older people serving their whole council area.
- 10.** Councils and NHS partners should collect data about their rapid response services to help measure whether they are value for money and having a positive impact on the local care system. This information will support future service development.
- 11.** Councils and NHS partners should use information on their older population to plan and develop services that can both respond to a predicted growth in demand and ensure that older people can live as independent a life as possible.
- 12.** To comply with the Race Relations (Amendment) Act 2000, councils and their health partners should collect and use information on their older population from a minority ethnic background. In doing so they should be aware of the differences between minority ethnic groups and ensure that services are developed to meet the needs of the diverse backgrounds of older people.
- 13.** Councils should consider comparing prevalence data to information collated from assessments to help establish unmet need about older people who live in the community but are not known to social care services.
- 14.** Councils should develop methods of consultation which are specific and appropriate to the different groups of older people and carers in their area, including those not currently using services.
- 15.** Councils and NHS partners should regularly review their commissioning strategies (for example, on an annual basis) to ensure they are sustainable and deliver value for money.
- 16.** Councils should carry out a risk assessment of their spread of contracts types; for example the consequences of too heavy a reliance on spot or block contracts.
- 17.** Councils should collect waiting times for different community care services. If collected on a consistent basis, councils could use this to benchmark and to promote continuing improvement in services.
- 18.** Councils should monitor waiting lists for services and include this as part of their local performance management frameworks.
- 19.** Best value reviews should be rigorous. They should always include an assessment of the cost and efficiency of the service as well as the quality.
- 20.** Best value reviews of community care services for older people should include an equalities impact analysis.
- 21.** Elected members should be provided with comprehensive information from best value reviews in order to make strategic decisions about community care services for older people.



# Appendix 1: Summary of information collected and used by councils

	Older people with dementia		Older people with a disability		Older people from minority ethnic groups	
	Information collected?	Linked to planning?	Information collected?	Linked to planning?	Information collected?	Linked to planning?
Aberdeen City	Yes	Yes	No	N/A	No	N/A
Aberdeenshire	Yes	Yes	Yes	Yes	Yes	Yes
Angus	Yes	Yes	Yes	No	Yes	No
Argyll & Bute	Yes	Yes	Yes	Yes	Yes	No
Clackmannanshire	Yes	Yes	Yes	No	Yes	No
Dumfries & Galloway	Yes	Yes	No	N/A	No	N/A
Dundee City	Yes	Yes	Yes	Yes	Yes	Yes
East Ayrshire	Yes	Yes	Yes	No	Yes	No
East Dunbartonshire	Yes	Yes	Yes	Yes	Yes	No
East Lothian	Yes	Yes	Yes	Yes	Yes	No
East Renfrewshire	Yes	Yes	Yes	Yes	Yes	Yes
Edinburgh, City of	Yes	Yes	Yes	Yes	Yes	Yes
Eilean Siar	Yes	Yes	Yes	No	No	N/A
Falkirk	Yes	Yes	Yes	Yes	No	N/A
Fife	Yes	Yes	Yes	Yes	Yes	Yes
Glasgow City	Yes	Yes	Yes	Yes	Yes	Yes
Highland	Yes	Yes	Yes	No	Yes	No
Inverclyde	Yes	Yes	Yes	Yes	Yes	Yes
Midlothian	Yes	Yes	Yes	Yes	Yes	No
Moray	Yes	No	No	N/A	No	N/A
North Ayrshire	Yes	Yes	Yes	Yes	Yes	Yes
North Lanarkshire	Yes	Yes	Yes	Yes	Yes	Yes
Orkney Islands	Yes	Yes	Yes	Yes	Yes	Yes
Perth & Kinross	Yes	No	No	N/A	Yes	No
Renfrewshire	Yes	Yes	Yes	Yes	Yes	Yes
Scottish Borders	Yes	No	Yes	Yes	Yes	Yes
Shetland Islands	Yes	Yes	Yes	Yes	Yes	Yes
South Ayrshire	Yes	No	Yes	Yes	Yes	No
South Lanarkshire	Yes	Yes	Yes	Yes	Yes	No
Stirling	Yes	Yes	Yes	No	Yes	No
West Dunbartonshire	Yes	Yes	Yes	Yes	Yes	Yes
West Lothian	Yes	Yes	Yes	Yes	Yes	Yes
<b>Total</b>	<b>32</b>	<b>28</b>	<b>28</b>	<b>22</b>	<b>27</b>	<b>15</b>

	Older people's socio-economic status		Older people's housing support needs		Carers looking after older people	
	Information collected?	Linked to planning?	Information collected?	Linked to planning?	Information collected?	Linked to planning?
Aberdeen City	Yes	No	Yes	Yes	Yes	Yes
Aberdeenshire	Yes	Yes	Yes	Yes	Yes	Yes
Angus	Yes	No	Yes	Yes	Yes	Yes
Argyll & Bute	Yes	Yes	Yes	Yes	Yes	Yes
Clackmannanshire	No	N/A	Yes	No	No	N/A
Dumfries & Galloway	No	N/A	Yes	No	Yes	Yes
Dundee City	Yes	Yes	Yes	Yes	Yes	Yes
East Ayrshire	No	Yes*	Yes	Yes	Yes	Yes
East Dunbartonshire	Yes	Yes	Yes	Yes	Yes	Yes
East Lothian	Yes	No	Yes	Yes	Yes	Yes
East Renfrewshire	Yes	Yes	Yes	Yes	Yes	Yes
Edinburgh, City of	Yes	Yes	Yes	Yes	Yes	Yes
Eilean Siar	Yes	Yes	No	N/A	No	N/A
Falkirk	No	N/A	Yes	Yes	Yes	Yes
Fife	Yes	No	No	N/A	Yes	Yes
Glasgow City	Yes	Yes	Yes	Yes	Yes	Yes
Highland	Yes	No	No	No	No	No
Inverclyde	Yes	No	Yes	Yes	No	N/A
Midlothian	No	Yes*	Yes	Yes	No	Yes*
Moray	No	N/A	No	N/A	Yes	Yes
North Ayrshire	Yes	Yes	Yes	Yes	Yes	Yes
North Lanarkshire	Yes	Yes	Yes	Yes	Yes	Yes
Orkney Islands	No	N/A	No	N/A	Yes	Yes
Perth & Kinross	No	N/A	Yes	No	No	N/A
Renfrewshire	Yes	Yes	Yes	Yes	Yes	Yes
Scottish Borders	Yes	Yes	Yes	Yes	Yes	Yes
Shetland Islands	Yes	Yes	Yes	Yes	Yes	Yes
South Ayrshire	Yes	No	Yes	Yes	No	N/A
South Lanarkshire	Yes	Yes	No	No	No	No
Stirling	Yes	Yes	Yes	Yes	Yes	Yes
West Dunbartonshire	Yes	Yes	Yes	Yes	Yes	Yes
West Lothian	Yes	Yes	Yes	Yes	Yes	Yes
<b>Total</b>	<b>24</b>	<b>19</b>	<b>26</b>	<b>23</b>	<b>24</b>	<b>25</b>

\* Council uses information collected by a different organisation.

# Appendix 2: Definitions of best value terms

Best Value reviews rigorously assess what the activity is aiming to achieve, whether it is still required, and whether it will continue to meet future needs.

The review establishes which options are available and which will ensure that customers receive the highest quality of service possible within the resources available. Options may include:

- **improved in-house service** – the strongest argument against maintaining (or developing) an in-house provision is that there is another option that can deliver services and meet the authority's objectives more economically, efficiently and effectively
- **reconfiguring service management and delivery** – this may be part of the in-house solution or the first stage towards any one (or combination) of the other procurement options
- **joint working** – this may be working with other councils to design and run services, working together to commission services or activities from third parties, or a hybrid including a mixture of provision and commissioning
- **market testing the in-house service** – a 'half-way' between improving the in-house provision and externalisation, where there is an in-house bid in the tender process
- **partnership** – for example, where an executive partnership procures the goods, works and services needed for the partners' purposes; where there is an advisory partnership to co-ordinate partners' resources in the pursuit of commonly agreed objectives; where there are working arrangements based on communications and/or custom and practice; or where there are partnering contracts with the basis of partnership being that of a client-contractor relationship (where the contractor signs a partnering agreement committing it to work with the council rather than as an adversary)
- **externalisation** – the service management and delivery becomes the responsibility of an external organisation (usually chosen through a process of competition). This is different from market testing as there is no in-house bid
- **ceasing provision (or decommissioning)** – the council decides to stop a service or activity (or part of a service or activity), for example: where there is little or no demand for the service from local people; costs of provision outweigh any benefits; or where there are alternative providers of the services (and individuals using those providers are not disadvantaged)
- some variation or combination of these (**hybrid**) – where the service management and delivery is designed to suit the particular circumstances of each local authority service, for example: the in-house professional practice supported by bought-in expertise for peaks of work or particular specialist skills; or the social work department working with a charity to provide specialist services for older people.

Decisions on how to use the market, with or without an in-house bid, will be transparent and justified on Best Value grounds.

The selection of an option takes into account service quality, cost and sustainability, as well as strategic objectives. Political and managerial judgement may also be involved.

# Appendix 3: Explanation of JPIAF indicators

<b>JPIAF 1</b>	<p>Joint management arrangements</p> <ul style="list-style-type: none"> <li>• Joint high-level management arrangements in place</li> <li>• Joint operational management arrangements including joint managers</li> </ul>
<b>JPIAF 2</b>	Joint governance and accountability arrangements
<b>JPIAF 3</b>	<p>Joint human resources arrangements</p> <p>Human resource arrangements in place by 1 April 2003, to cover:</p> <ul style="list-style-type: none"> <li>• joint LA/NHS staff forum</li> <li>• joint statement of intent for staff</li> <li>• joint training/OD plan agreed by April 1 2003.</li> </ul>
<b>JPIAF 4</b>	Joint resourcing arrangement
<b>JPIAF 5</b>	Implementation of single shared assessment framework
<b>JPIAF 7</b>	Joint training for SSA
<b>JPIAF 8</b>	Joint protocol for accessing resources
<b>JPIAF 9</b>	Information protocol





# Commissioning community care services for older people



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