Adapting to the future

Management of community equipment and adaptations

A baseline report

Prepared for the Accounts Commission and the Auditor General for Scotland

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AUDIT SCOTLAND

Adapting to the future: Management of community equipment and adaptations – a baseline report
Prepared by Audit Scotland on behalf of the Accounts Commission and the Auditor General for Scotland.

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Becki Lancaster managed the study, under the general direction of Angela Canning. The team also included Shelagh Stewart and Angela Cullen.

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

Community equipment and adaptations are an important part of an integrated community care service.

Background

1.1 Community equipment and adaptations are an important part of an integrated community care service. They support people with a wide range of needs to live in their own homes and can enhance the quality of people's lives. They can reduce demands on other health and social care services by preventing unnecessary admissions to hospital; speeding up discharge arrangements from hospital; and reducing or eliminating the need for other community care services.

1.2 No national figures are available for overall expenditure by councils or the NHS on equipment and adaptations. We estimate that council social work services spent approximately £30 million on community equipment and minor adaptations in 2001/02.[1] It has not been possible to estimate total national expenditure because of gaps in councils' housing services information and NHS information. Nevertheless, it is clear that expenditure on these services is significant.

1.3 Nationally, the demand for equipment and adaptations is likely to grow:

- About a third of households in Scotland contain at least one person with a long-term illness, health problem or disability. One in three adults with such difficulties have equipment or adaptations to their home.[2]
- The need for community equipment and adaptations rises with age and, from 2002 to 2027, the number of people aged over 65 in Scotland is due to rise by 46%, from 812,000 to almost 1.2 million.[3]

1.4 Responsibility for providing community equipment and adaptations is split between councils (both social work and housing functions) and the NHS (both the acute and primary care sectors). Councils provide adaptations to housing, and community equipment that meets a social care need.[4] The NHS is responsible for providing community equipment to meet a nursing need within the home setting. But, in practice, these divisions are not clear and this affects service delivery. Voluntary organisations and registered social landlords (RSLs) also provide equipment and adaptations, but are not within the remit of this study.

1.5 The fragmented structure and high volume of players contribute to the view that: *"equipment supply is the single most confused area of community care service provision, with adaptations being particularly complicated."*[5]

The policy environment

1.6 Community equipment and adaptation services operate within a complex and changing policy environment (Exhibit 1 overleaf).[6]

1.7 We carried out our fieldwork during a period of change when organisations were putting in place systems for improving joint working between councils and NHS bodies. This means that community equipment and adaptation services may have progressed and developed since the time of our audit. However, our recommendations are wide-ranging and still relevant.

1.8 The Scottish Executive established a Strategy Forum for community equipment and adaptations in response to the report of the Joint Future Group.[7] The Forum has issued a report offering a strategic vision about how these services should be provided and outlines a number of recommendations.[8]

Study scope

1.9 For the purposes of this study we defined 'community equipment' as equipment that provides help towards daily living or meets a home nursing need. The definition includes home nursing equipment because of people with increasingly complex care needs living at home.[9] Some examples of simple and inexpensive items of community equipment are raised toilet seats, kitchen trolleys, commodes, and urine bottles. Examples of more complex and costly items falling within our definition are hoists, profile beds and pressure relieving mattresses, and powered bathing equipment.

1 It was not possible to estimate the amount spent on major adaptations.
2 *Scotland's People: Results from the 2003 Scottish Household Survey*, Annual Report, Scottish Executive, 2004.
3 GRO Scotland 2001 census.
4 Chronically Sick and Disabled Persons (Scotland) Act 1972; Housing (Scotland) Act 1987, Part 8; National Health Service (Scotland) Act 1978.
5 *Last on the list*, Beardshaw V, 1988.
6 NHS (Scotland) Act 1978 s.13; NHS Memorandum 1976 (GEN) 90 and Joint Circular: SDD 40/1985 – NHS 1985 (GEN) 33 – SWSG 17/1985.
7 *Community Care: A Joint Future. A report by the Joint Future Group*, Scottish Executive, 2000.
8 *Equipped for inclusion*. Report of the Strategy Forum: equipment and adaptations, Scottish Executive, 2003.
9 For previous definitions that excluded home nursing equipment see *How to get equipment for disability*, Mandelstam M, 1990.

Exhibit 1

Examples of the changing policy environment affecting community equipment and adaptations

National Health Service Reform (Scotland) Act 2004

Dissolved NHS trusts and integrated the management of acute and primary care services into NHS boards. It also required NHS boards to establish Community Health Partnerships (CHPs), aiming to decentralise decision-making and resources. It is expected that CHPs will work as a key partner with councils and others in developing and delivering joint approaches to local health and social care services. These services may include community equipment and adaptations.

Community Care and Health (Scotland) Act 2002, Section 7

Places a duty on councils to offer direct payments to adults with disabilities. Councils have a duty to offer direct payments to older people with disabilities and this duty will be rolled out to all other community care client groups.

Scottish Executive's Joint Future Agenda

Places an emphasis on the concept of seamless care and joined up working.[10] It promotes improvements in service planning, organisation and delivery, through the establishment of jointly resourced (through aligned or pooled budgets, enabled through the Community Care and Health (Scotland) Act 2002), and jointly managed services, and also through Single Shared Assessment. Community equipment and adaptations were identified as areas that would improve through the implementation of joint management and resourcing policies.

Housing stock transfer

There has been a growth in housing provided through registered social landlords (RSLs) and a number of councils have undergone large-scale voluntary stock transfers. While RSLs can fund adaptations for people with disabilities through their own budgets, or apply to Communities Scotland for a grant, they do not have an absolute duty to install adaptations – this is a discretionary function.

Housing (Scotland) Act 2001, Part 6

Amended the operation of the Housing Improvement Grant (HIG) scheme that funds adaptations in private properties. The new system introduces means testing to better target resources. The maximum grant has been extended from 75% of the cost of the adaptation to 100%, with a minimum grant of 50%. The Act has raised the maximum expenditure limit from £12,600 to £20,000.

The Building Standards (Scotland) Amendment Regulations 2001

Requires new buildings to accommodate the needs of disabled people.

10 Reflected, for example, in *Modernising Community Care*, 1998, *Our National Health: A Plan for Action, A Plan for Change*, 2000, and *Community Care: A Joint Future. A report by the Joint Future Group*, 2000.

1.10 Adaptations can be categorised into two main groups:

- Minor adaptations, which are non-structural and temporary – that is, they can easily be removed from the property, such as external grab-rails and removable ramps.

- Major adaptations, which involve permanent changes to the structure of a person's home, such as widening doors for wheelchair access, installation of a through-floor lift or having an extension added to the property.

1.11 Our study does not cover wheelchair services; sensory impairment services; orthotics; prosthetics; continence advice; hospital ward-based equipment; or equipment and adaptations relating to education and employment. However, many of the recommendations emerging from the study are transferable to these other services, particularly those on joint working.

Study approach

1.12 We collected management, activity and financial data from NHS bodies and councils' social work and housing services. Most of the findings in this report are based on 29 housing[11] and 28 social work council services, and 20 NHS trusts (13 primary care[12] and 7 acute) that participated in the study.

1.13 We asked councils and NHS trusts about the community equipment and adaptation partnerships they are formally involved with. A total of 72 partnerships were reported – some organisations are involved with a number of partnerships.[13]

1.14 We also conducted interviews with service providers to identify areas of good practice.[14] Given the importance of these services to people's lives, we carried out:

- a Scotland-wide survey of just under 1,000 members of the general public, of whom a quarter were experiencing, or cared for someone with, difficulties in carrying out daily activities. Fifteen per cent also had been in contact with either council or NHS services about community equipment and adaptations

- five in-depth focus groups with users and carers.

More information about the methodology for our user research is given in Appendix 1.

1.15 Our study was undertaken before the recent reorganisation of the health service when NHS trusts were still in existence. We therefore refer to trusts throughout this report. However, our recommendations for the health service are aimed at the new NHS boards.

1.16 A study advisory group, made up of people working in the equipment and adaptations field, provided expert advice during the course of the study. Membership of the group is given in Appendix 7.

Main findings

1.17 Our main findings are outlined below and are developed further in the main body of this report:

- Community equipment and adaptation services make a positive difference to people's lives. They can enhance a person's quality of life and prevent more costly interventions. Users also speak highly of the staff with whom they have contact. (See Part 2 and Part 5)

- The services are fragmented and the split in responsibilities is unhelpful and confusing for users and providers alike. There is an opportunity to clarify national guidance and bring it into line with changes in the way in which services are jointly developed. (See Part 3)

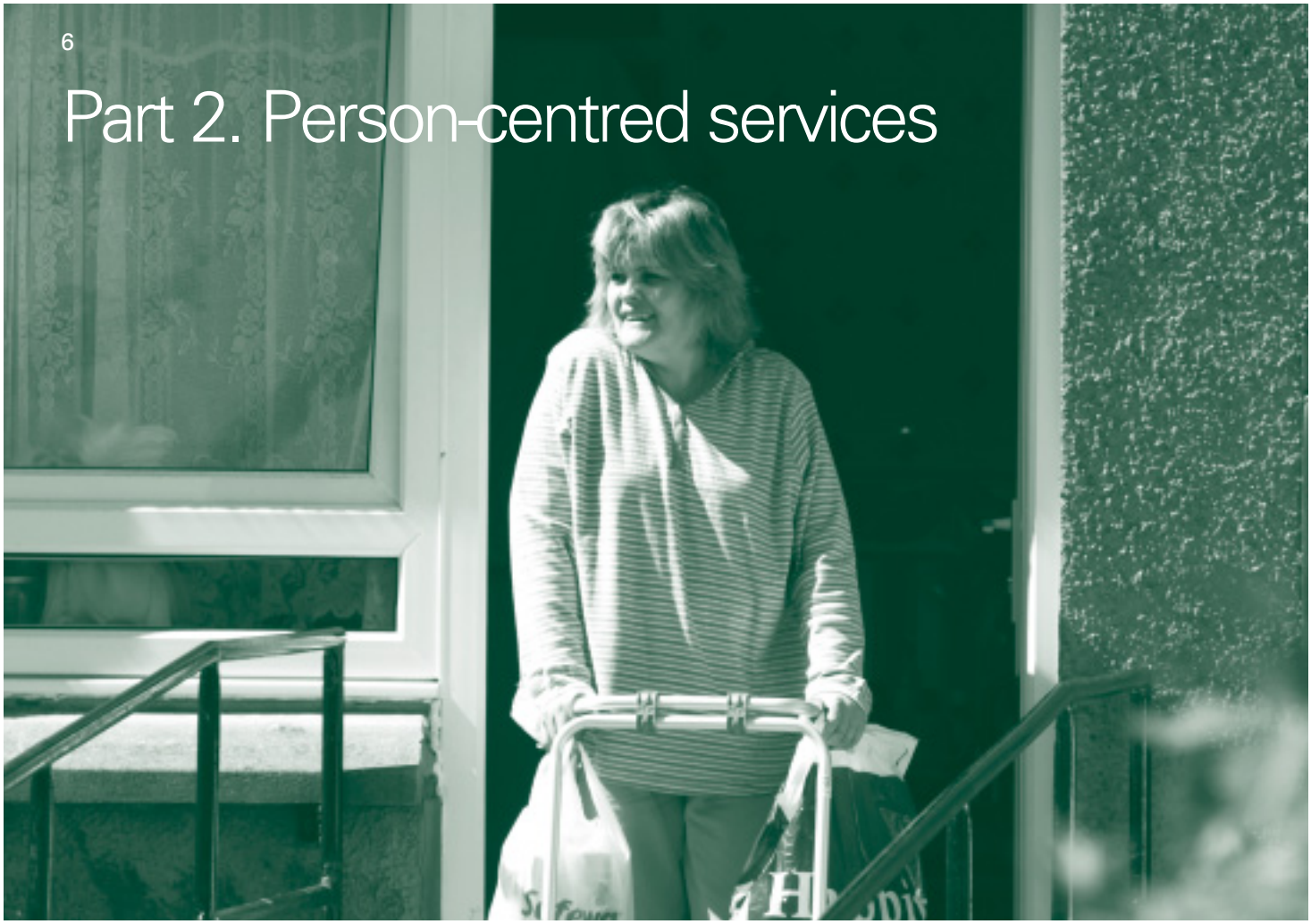
- Information about services is not easy to access and some people are waiting a long time for community equipment and adaptations. (See Part 2 and Part 4)

- There is poor information in general on the cost, management and quality of services. This limits their development and evaluation. During the audit, we had particular difficulties in getting comparable activity and financial information. (See Part 4)

- A lack of formal policies and procedures in many places is exposing users and providers to risks. (See Part 5)

11 The study examined housing services involvement with both council and private property adaptations. Where deemed important, and information was available for the two types of service, findings are presented separately. However, sometimes the findings are presented at the housing service level, hence covering both tenures.
12 What we describe as 13 primary care trusts, incorporates one integrated trust and an island board. These have been included within this group to protect their anonymity.
13 The 72 community equipment and adaptation partnerships are made up of the 33 social work, 15 housing, 16 primary care trust and 8 acute trust reported partnerships.
14 We use the term 'provider' to cover all aspects of the community equipment and adaptations process, including first contact with the user, assessment, delivery and follow-up visits.

Part 2. Person-centred services



Main findings

- It is not always easy for people to find out key information about things such as what is available; who to approach for help; whether they meet the eligibility criteria and, if they do, whether they will need to pay; and how long they might have to wait.
- What equipment and adaptations people get, and whether they have to pay, depends on where they live.
- Users do not always know what choices of equipment or adaptations are available. This could be helped by publishing catalogues, supporting self-assessment and self-selection in appropriate cases, and promoting the use of direct payments.
- Flexible services include ensuring delivery and installation dates are arranged at a time convenient for the user. But most appointments are restricted to weekdays only, between 9am and 5pm.

2.1 Person-centred community care aims to provide accessible, responsive, flexible, and seamless services which deliver better outcomes for the people who use them. But the complexity of community equipment and adaptations services makes it difficult for people to know how to access them and negotiate their way through the care system. People therefore need clear information about:

- how to get these services
- who to contact
- what services are available, and for whom
- whether they pay for these services or not
- when services will be delivered.

Better information is needed about who provides services and how to access them

2.2 Everybody in Scotland is a potential user of community equipment and adaptation services – if not for themselves, then perhaps as a carer of a family member or friend. So people should know how to access them when the need arises.

2.3 Our survey of almost 1,000 members of the general public found that:

- the majority of people have some idea of who they might contact in the first instance, with only 11% not knowing who to contact at all
- more than half (564) of respondents would contact their council if they required any community equipment and adaptations, with 80% of these identifying the social work department specifically
- almost half (437) of respondents said they would contact the NHS if they required community equipment and adaptation services and, of those, 79% would contact

their GP. While GPs do not provide community equipment and adaptation services, this highlights their important role in referring individuals to the appropriate services.

2.4 But our survey and focus groups suggest that, in general, people are unaware of the different organisational responsibilities and so do not know who to contact for *particular types of equipment* or for *meeting a particular need*. This can result in people being passed from one organisation, department or person to another, adding to how long they wait for services to be provided.

"They've all the different departments in a council, some for the parks, that's your gardens, and house things, different, like […] they've all got different departments. So it's getting the right one."

(Group 4)

2.5 People often find out about these services through informal information passed from others who have had contact with the services.

"Unless they are talking to other folk that have actually had experience, they don't have a clue where to go (or) what to do."

"You just hear people talking. I mean, I didn't know about the toilet seat and that until I was talking to some of the girls down here [at the day centre]."

(Group 2)

2.6 Users called for clearer information to be made available in public places, such as in GP surgeries and libraries, and for advertising on public transport. Whilst all but four councils publish information about services,[15] less than half publish information jointly with their local health partners.[16]

"[You need] more information I'd say about how to get in contact. How do you do that? People don't know who to contact."

(Group 3)

2.7 Levels of recall among our focus group participants were low, with few having seen advertisements for statutory community equipment and adaptation services, although some were aware of advertisements by private companies (for example, for stairlifts and walk-in showers).

"The only adverts that I've ever seen are where you've got to go out and buy the stuff yourself."

(Group 3)

2.8 Even among people who already have equipment or adaptations, there is confusion about who provides what. This has implications for what happens when equipment breaks or is no longer needed. (See Part 5)

"[The items] just appeared. I don't know where they came from. A man came with a cushion and another one came with a trolley."

(Group 1)

"I mean a lot of the time you're sort of expected to know whose remit is what. I mean at the moment I have two occupational therapists, one is because of [my son's] operation, the other one is [his regular] OT. So now I have to think, is that Jenny in X or is that Shelagh in Y. Some of the equipment is surplus to requirements now and I have to think, 'Now, where did I get that?' and […] 'I can't give it to one because it was the other one I got it from.'"

(Group 5)

2.9 Users also emphasised the important role played by frontline health and social care staff in raising awareness. Developing better information is likely to result in increased demand, so councils and the NHS need to ensure that resources are in place to deal with this (for example, that the grant allocation is sufficient to cope with a rise in applications for HIGs).

People are not always aware of what types of equipment and adaptations are available

2.10 Different types of equipment and adaptations are available to meet a social care need, but what people get depends on where they live. Some councils provide small and inexpensive items (such as feeding equipment, dressing aids and grab-rails). Others only issue items over a certain monetary value which means that people living in those council areas have to purchase any small items they need from the private sector. But, private provision can be particularly limited in rural areas.

"Previously we were [living] in [one council] and now we are in [another council] so it's a whole different ball game, and a whole different set of people, and it is difficult."

(Group 5)

2.11 There is, however, some doubt as to the legality of providers having a policy that they 'never' provide certain items of equipment or adaptations. This 'fettering of discretion' should be avoided[17] and equipment and adaptations provided on the basis of need.

2.12 Our survey of the general public found that 15% of all respondents had, at some point, bought a piece of equipment from the private sector. This rose to 34% of respondents with a frailty, illness, health problem or disability. While people have the

15 As required by the Chronically Sick and Disabled Persons Act 1970, s.I.
16 Any percentages reported are based on those participating organisations and not the total number of organisations in Scotland.
17 *Using the law to develop and improve equipment and adaptation provision*, Mandelstam M, 2003.

choice to buy privately, our focus groups suggested that higher levels of awareness of private sector advertising might mean some people buy equipment and adaptations because they are unaware of what is available from their council or the NHS. Having clear information about statutory services enables people to make informed choices about whether or not they wish to access them.

2.13 Reasons given by our focus group participants for buying directly from the private sector include not only higher levels of awareness of what they can buy privately, but also perceived long waiting times within the statutory sector.

"It's the waiting time. It irritates people because you're wanting these things to happen but they never happen. You know, maybe six months down the line you're getting the things you should have had… And the thing is you've got to keep contacting people. You get a bit irritated at doing that as well."

(Group 3)

"I find that every time you approach them, you get told you are on a waiting list for it, or no you can't have it."

(Group 5)

2.14 While people are free to make such a choice, private purchasing raises some concerns about whether equipment is suitable for someone's needs and whether it will be properly demonstrated. (See Part 5).

"[My son] got me this [chair], that's comfy, that's cosy. 'That'll do Mum' [he said]. Did it heck. Every time I sat down I was depressed because I couldn't get up again."

(Group 3)

"I had a seat […] that my grandaughter [bought], and I don't know who it was who came in [but] she says 'That's not safe, that's not safe'. So she's got me a white seat that's fine."

(Group 3)

Choosing equipment and adaptations

2.15 Our discussions with users found mixed views as to the level of choice they had, or wanted, in selecting equipment and adaptations. Some people were content with the equipment they received, either because they felt it met their needs or because they were simply unaware of what else was available.

"The toilet seat's a great thing, isn't it?"

(Group 2)

Others felt that they should be given more choice in the type of equipment or adaptations they received.

"They don't let you choose, they don't let you decide what you want for yourself. They give you what they think is best and you become dependent, you think that they must know best."

(Group 5)

Disabled Living Centres (DLCs): Supporting people to make choices

DLCs are led by a national organisation called the Disabled Living Centres Council (DLCC). DLCs provide information and impartial advice, free of charge, about equipment and adaptations. Occupational therapists or other professional staff are employed at DLCs to demonstrate equipment and advise people while trying out the various products. This allows people greater choice in deciding which equipment best meets their needs and provides them with the information to make an informed decision.

There are currently five DLCs in Scotland, located in Dundee, Edinburgh, Elgin, Grangemouth and Paisley. Four are funded by social work; one by the NHS. In England, some are funded independently and work as a charity.

2.16 While councils and the NHS need to make best use of resources, they should consider both quality and cost. But some users felt that the cheapest option was given (which providers have the right to do if they can show it meets identified needs) and this could be uncomfortable, inflexible or simply unsightly within the home. And parents of children with disabilities felt that a short-term approach was sometimes taken – issuing cheaper individual items at various points in time according to changing needs rather than providing more expensive items that are adaptable as a child grows.

"They will show you the basic model […]. There could be enhanced models that would be more appropriate, but they always offer you the cheapest option."

(Group 5)

"The way the system works is that you can only get what you need if you need it now. They're not allowed to anticipate […] they can't look ahead and plan."

(Group 5)

2.17 Catalogues of what equipment is available can be useful for both staff and users. Almost two-thirds of councils (18) and PCTs (8) have equipment catalogues, yet only one acute trust does so. Catalogues can also be used by staff to identify which items of equipment staff from a

Good practice example 1

Choosing and ordering equipment from the home

At the time of our audit, health and social work partners in both Fife and Scottish Borders Councils were developing the use of portable IT equipment. Scottish Borders was piloting the use of laptops and Fife the use of hand-held palm computers. Both technologies enable staff to take computers into users' homes, and laptops allow staff to show people an online catalogue and equipment relevant to their needs.

Both systems also allow staff to order equipment immediately after an assessment is made without the need to return to their base. This is particularly useful for community-based staff in rural areas, who spend a great deal of their time on home visits, and in responding speedily to terminally ill patients. The system notifies staff of the delivery of items to users' homes, allowing them to visit them if they are in the area.

Source: Fife Council and Scottish Borders Council

different organisation can access, although using them in this way is, at present, relatively rare. And while placing catalogues online can improve accessibility, this is not common practice in Scotland.

Direct payments are rarely used for equipment and adaptations

2.18 Choice can be enhanced by the use of direct payments. These are cash payments made directly to the user to purchase community care services. Since 1 June 2003, councils have had a duty, rather than discretion, to offer direct payments to disabled people, and other groups specified by guidance.[18] During 2004, this duty will be extended to include frail older people and will eventually be rolled out to all community care client groups.

2.19 A recent Social Work Services Inspectorate report stated that 30 councils have established a direct payments scheme, with the remaining two schemes under development.[19] Our study found only one council had offered any direct payments for community equipment or adaptations between 1999/2000 and 2001/02.

2.20 Our focus groups with users indicated that they would welcome direct payments as these would enable equipment to be 'upgraded' by allowing the user to make a financial contribution required over and above the cost of the basic model provided by councils.

2.21 Councils have a general duty of 'best value' and must have regard to quality and cost in services they purchase or provide. The requirements of 'cost effectiveness' may inhibit the development of direct payments for equipment and adaptations in Scotland, for example, where bulk purchasing may be cheaper than buying individual items through direct payments.

2.22 Direct payments do not cover council housing functions or the NHS. This is likely to confuse users (especially those receiving a complex care package from multiple providers) and it complicates joint working. However, while the NHS cannot provide direct payments directly to patients, where a package of support has jointly commissioned resources, including health services, councils can provide a joint direct payments package, covering health and community care.

Few councils have self-assessment and selection procedures in place

2.23 Self-assessment for easy-to-use, low risk, low cost, and high demand equipment (such as grab-rails and feeding equipment) is practised in just under half of councils in Scotland.[20] While the benefits, risks and costs associated with a self-assessment and self-selection policy should be considered carefully before implementing such a policy locally, it may improve efficiency by reducing waiting times and also allowing staff to focus on the assessment of people with more complex needs.

18 Community Care and Health (Scotland) Act 2002. *Direct Payments, Social Work (Scotland) Act 1968, Sections 12B and C, Policy and Private Guidance,* Scottish Executive, June 2003.
19 *Progress with Complexity: The 2003 National Overview Report. The Chief Social Work Inspector's 3rd Annual Report*, Scottish Executive, 2004.
20 Self-assessment is only relevant to council provision.

Good practice example 2

Self-assessment in West Lothian

West Lothian Council and West Lothian Healthcare NHS Trust, with their joint community equipment store, publish a leaflet on self-assessment for equipment and adaptations. The *Making Life Simpler* leaflet is also available in Braille, large-print and community languages and is publicised by posters.

The leaflet provides details of equipment and adaptations that can be requested without a formal assessment. It contains two forms to be completed by the applicant – one for equipment and one for adaptations – both of which ask for basic personal information (such as name, address, and tenure). The equipment form asks what activities cause difficulty (such as dressing, eating and bathing) and what items they would like to request. The adaptations form lists various adaptations for the person to choose from (such as an external grab-rail at the back or front door, an external handrail and a banister). The forms also ask the applicant to contact the service if they are still having difficulties after they receive their equipment and/or adaptation. Users of the self-assessment scheme are advised that a full assessment is available if requested.

The leaflet presents pictures of items of equipment and adaptations available through self-assessment, with an explanation of what they are for, what precautions should be taken and whether the item is non-returnable. Some examples of items available are sock aids, dressing sticks, drinking cups, easy-grip cutlery, bedpans and urinals.

The introduction of self-assessment is reported to have contributed to reducing average waiting times from 18 months to 6 weeks.

Source: West Lothian Joint Equipment Store

Users are confused about payment for services

"I actually think people are frightened because they think they maybe have to pay for all this. This is the problem. I mean, elderly people like Margaret and I, they have to think, 'Oh, will I have to pay for this, will I get it free or will I have to pay something towards it?'"

(Group 1)

2.24 Whether or not someone pays depends on:

- who provides the service (that is, whether it is a council or NHS body)
- where they live
- their tenancy status.

2.25 Community equipment is free when the NHS provides it but councils have a discretionary power to charge for these services.

"I don't understand how you're paying that money [for a stairlift from the council]. [My husband] got a stairlift [from the hospital] but he doesn't pay for it."

(Group 1)

2.26 COSLA[21] issued guidance in 2002 which recommended that councils do not charge for community equipment and minor adaptations,[22] but six councils continue to do so. Scottish Executive guidance states that councils should not charge frail older people leaving hospital if equipment and adaptations are supplied and fitted within four weeks of leaving hospital.[23]

2.27 Because councils' power to charge for community equipment and adaptations is discretionary, as is the awarding of HIGs, charging practices are not uniform across Scotland (Exhibit 2).

2.28 Charging for major adaptations depends on the type of tenancy. Councils do not charge for major adaptations to council properties. However, people living in privately owned properties might have to make a financial contribution. Under the discretionary HIG scheme,[24] councils can award a 100% grant up to the value of £20,000. However, a minimum grant level is set at 50% meaning that grant recipients may be required to pay up to £10,000, plus any costs beyond £20,000, towards a major adaptation to meet a need based on disability. In addition, people receiving adaptations in this way are likely to be liable for repair and maintenance costs – whereas councils meet these costs for their tenants.

"I don't think there is [a difference between council and private properties]. If you need it, I think you'll be given it….It shouldn't make a difference, I mean they're supposed to be caring for people that are ill, people with disabilities."

(Group 3)

21 Convention of Scottish Local Authorities.
22 *Guidance on charging for non-residential services that enable older people to remain in their own home.* Final draft, COSLA, 2002.
23 Scottish Executive Circular CCD/2001: Free home care for older people leaving hospital.
24 This scheme was changed through Part 6 of the Housing (Scotland) Act 2001. The HIG data supplied by councils for this study relates to the previous system, where housing services could pay up to 75% of the maximum grant of £12,600 (ie, £9,450). The additional 25% could be paid by other services (such as social work) or the applicant, for example.

Exhibit 2

Variations in charging policies among councils for community equipment and minor adaptations

Four councils provided information on their charging policy for community equipment and minor adaptations, highlighting differences in practices.

- **Council 1** – A charge is made depending on whether the equipment is for short or long-term use. Equipment for short-term use is charged at cost if the value is less than £25, thereafter it incurs a flat rate of £25. Charges for long-term use are calculated on a means-tested basis. The same charges apply to reissued equipment.
- **Council 2** – Items over £10 are charged annually. This charge increases in line with the value of equipment, to a maximum cost of £66 for items over £501. Reduced charges apply to reissued equipment.
- **Council 3** – Users pay the full cost of items under £25. Charges for items over £25 are calculated on a means-tested basis. For items costing up to £500, people will be charged a flat rate of £25, unless exempt from charges. For items costing over £500, an ongoing charge will be made, again unless exempt from charges.
- **Council 4** – Charges are made for adaptations but not equipment. Charges are based on the cost of the adaptation, with a minimum charge of £25 for those costing less than £50, and a one-off charge of 50% of the cost of the adaptation (up to a maximum adaptation cost of £500).

Some client groups are commonly exempt from charges, such as children and people with a terminal illness. However, there are variations in who is exempt among councils. Some councils also apply exemptions to certain types of equipment (such as equipment for toileting).

Source: Audit Scotland

2.29 Whilst organisations have the right to implement different practices – and in some cases this flexibility is essential to meet local needs – the differences in practice based on where you live, who provides the service and tenancy status are difficult for people to understand and raise concerns about equity.

"If you are desperate and need it, you have to pay for it, don't you? I couldnae dae without that bath thing, I couldnae have a bath."

(Group 1)

2.30 Differences in policies and practices can also be difficult for staff to understand and to work with on a practical, day-to-day level. For example, a district nurse may issue a patient with an NHS walking frame, for which no charge is made. Yet, at the same time the nurse may issue the same patient with a bath board on behalf of a council partner, and whether or not a charge is made depends on which council the patient lives in. This complicates joint working arrangements, particularly in areas where boundaries between NHS boards and councils are not coterminous. It can also be confusing for users regarding entitlement to services and raises concerns about the 'postcode issue'.

"Some people they seem to […] just say 'Oh, I need this' and [they say] 'There you are'. And, others, they say 'Oh look I need this, I need this to help me' and you've got to fight like cat and dog to get it."

(Group 3)

2.31 There can be further complications when practices are not consistent across the whole of a service. Practices, such as information recording protocols and recycling of equipment, can vary significantly between teams working in the same council or trust. Apart from complicating the delivery of services, such inconsistencies in practice make it difficult to establish performance across the organisation.

People should be kept informed

2.32 Users should be informed about:

- the outcome of their assessment
- what equipment will be delivered or what work might be done in their home, and why
- what impact the equipment/adaptation may have on the home
- when the equipment/adaptation will be delivered/installed.

2.33 It is important that users get written details of someone they can contact following assessment for services. Whilst all but three trusts provide this, just over half of housing services and less than two-thirds of social work services do. Also, only seven social work services and three trusts (one PCT and two acute) provide a written record of the assessment to users and/or their carer.

"I don't know who to 'phone. I've forgotten who the lady was that I phoned."

(Group 3)

2.34 The need for informing users is most clearly highlighted in relation to major adaptations which often involve significant disruption to home life. Yet most housing services (21) do not provide users with a written explanation of what will be involved in the major adaptations process or show a plan of what impact the adaptation might have on their home (17). While most (21) housing services provide council tenants with a date of when the adaptation will be installed, only about a third (10) do so for people requiring adaptations to private properties (Exhibit 3), as the user is responsible for arranging and managing private adaptations.

2.35 Community equipment and adaptation services should be as flexible as practicable and delivery and installation dates should be agreed between, and be convenient for, both the service provider and the user. However, delivery and installation in most councils and NHS trusts is restricted to weekdays only, between 9am and 5pm (Exhibit 4 page 14).

2.36 Flexible delivery arrangements are particularly important in terms of providing seamless care when people go home from hospital. If equipment cannot be delivered at weekends then people may have to stay in hospital unnecessarily until Monday. This is not helpful for the patient or their carer, and has implications for service providers in terms of costs, bed management and delayed discharge from hospitals.

2.37 Most councils and NHS trusts do not deliver equipment or install adaptations at weekends. Only two councils and one PCT deliver equipment or install adaptations on both Saturdays and Sundays, with a further three councils and one PCT delivering and installing on Saturdays only. There is some evidence that additional funding received in the winter is sometimes used for making weekend deliveries at this time of year to meet increased demand.

Good practice example 3

Fife's extended liaison policy

Fife Acute Trust and Fife Council have developed an extended liaison policy where the OT who sees the patient in hospital also continues to see them after discharge (usually this is the responsibility of social work or primary care staff). This means health staff have taken on the duty of care from social work. The extended liaison OT only needs to refer the patient to social work if there is a need for a major adaptation.

There were initial concerns about the impact this would have on health staff workloads. However, Fife Council pays for two social work assistants to work on the extended liaison policy.

The following improvements are reported:

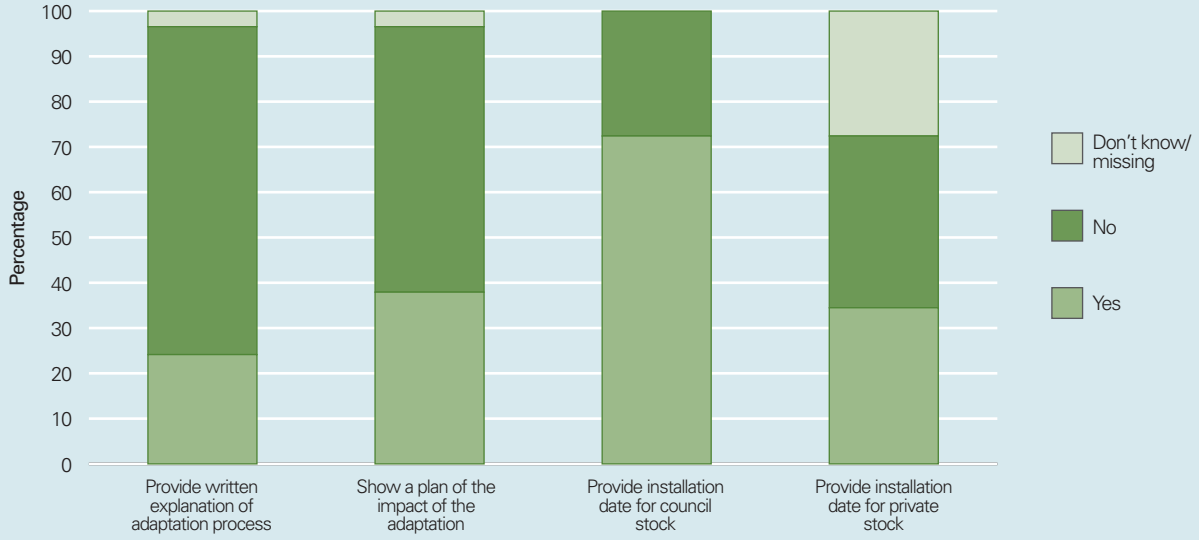
- the patient sees the same OT once they are back living in their homes, allowing for greater continuity of care
- administration is reduced since the patient is no longer referred to the Council.

Source: Fife Council

Exhibit 3

What do housing services tell users about the major adaptation process?

Most councils do not provide users with an explanation of the adaptation process or show a plan of the impact it will have on their home. Most provide council tenants with an installation date in advance of the work, but only a minority do so for private clients.



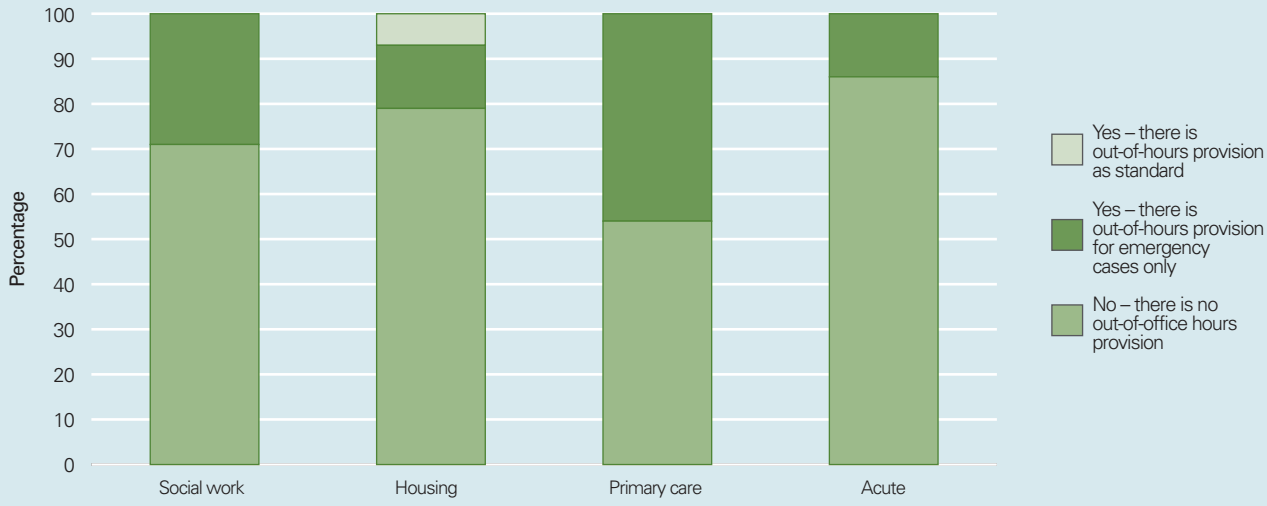
Base: 29 Housing services.

Source: Audit Scotland

Exhibit 4

Weekday out-of-hours service provision, by type of service provider

None of the social work or NHS providers operate a service outwith 9am and 5pm during the week, other than for emergency cases.



Base: Social Work, 27;[25] Housing, 29; PCTs, 13; Acute, 7.

Source: Audit Scotland

Recommendations

Councils and NHS bodies should:

- Jointly publish comprehensive information on community equipment and adaptations, covering:
  - what help is available
  - who to contact
  - eligibility criteria
  - who needs to pay and how much
  - what service people can expect, using information such as local targets for response times.

This should be published in different formats and in other languages as needed by local communities.

- Review the level of demand for out-of-hours services.

Councils should:

- Ensure that users have information on direct payments and their availability for community equipment and adaptations.
- Assess whether self-assessment and self-selection could improve the efficiency of providing low cost, low risk items.

25 One social work service did not respond to this question.

Part 3. How are services organised?

Main findings

- There is a lack of clarity and consistency around definitions of equipment, and what constitutes a minor or major adaptation. This results in confusion for users and providers about who is responsible for what.
- The national guidance about roles and responsibilities for equipment and adaptations is confusing for providers and is out of date. It can get in the way of better joint working between councils and NHS bodies by reinforcing artificial distinctions between social care and nursing needs, and housing and social work provision.
- Progress is being made in developing joint approaches, but more work is needed to agree formal policies which are understood and implemented by all staff. We found that NHS and council staff are not always fully aware of the way their partnership arrangements work and what their respective responsibilities are.
- Information systems within councils, and between councils and the NHS, are rarely compatible. This limits the ability to provide a joined-up service, and leads to inefficiencies in service delivery.

"Throughout Scotland there are many examples of good practice, however, access to equipment and adaptations remains fragmented, unpredictable and variable in quality."[26]

3.1 Organisational structures, how community equipment and adaptation services are managed and who is responsible for them, should not get in the way of providing flexible support services that meet people's needs. Services should be centred around the person who needs them and the carers who help to look after them at home.

3.2 Our study highlights the need for greater clarity, for both users and staff, about who is responsible for what. More work is also needed by local health and council partnerships to provide seamless community equipment and adaptation services.

26 *Equipped for inclusion. Report of the Strategy Forum: equipment and adaptation*, Scottish Executive, 2003.

Responsibility for services is fragmented and confusing

3.3 Responsibility for managing and providing community equipment and adaptation services is primarily split between councils' social work and housing services and the NHS. Who provides what depends on whether the equipment is to meet a health or social care need (ie, to support independent living at home) (Appendix 2), and the type of equipment or adaptation that is needed (Exhibit 5).[27]

3.4 In general:

- Social work is responsible for providing equipment to support daily living and also for providing minor adaptations to properties. In most councils (18), the day-to-day running of community equipment and minor adaptations is delegated to OT services. In other councils (10), these are the responsibility of other services such as 'Domiciliary Care' or 'Physical and Sensory Impairment'.

- Housing is usually responsible for major, structural adaptations. There are also differences according to tenure:

    - Responsibility for major adaptations to council properties lies within the housing service in most councils, although in some it has been transferred to social work or community services. Other parts of a council can also be involved in the building works, such as Direct Labour Organisations (DLOs), and architectural and construction services.

    - Responsibility for HIGs for major adaptations to private properties (both owner-occupied and privately rented) is most commonly divided between housing, social work, grants sections and commercial services within councils.

- The NHS is responsible for providing equipment to meet a home nursing need. This mainly involves PCTs (for example, through district nurses and community OTs and physiotherapists) and, to a lesser extent, acute trusts (for example, if patients need to leave hospital with a piece of equipment to help them at home). Apart from referring patients to their local council, NHS trusts are not involved in adaptations.

The voluntary and private sectors also play an important role in providing community equipment and adaptations, but they are outside the scope of this study.

Guidance does not help the move towards joint working

3.5 Managing community equipment and adaptations is not helped by Scottish Executive guidance, some of which was issued as long ago as the mid-1970s and is now out of date (Exhibit 5). Most of the guidance was issued prior to local government reorganisation and does not take account of technological advances in equipment. For example, the guidance issued under *Memorandum No. 1976 (GEN) 90* states that:

- the NHS has responsibility for the provision of equipment when it is directly related *"to the management of an illness, especially to facilitate the patient's domiciliary nursing care or to the rehabilitation of a patient from hospital"* or the *"skills of a particular discipline within the health service are more appropriate to the prescription and use of aids required on medical or nursing grounds eg, the provision of walking aids by physiotherapists."*[28]

- councils are responsible for the provision of equipment where it is *"required to help the disabled person achieve a greater independence within his own home and are predominantly of a domestic character eg, aids to daily living."*[29]

3.6 Increasingly, people with complex care needs are supported to stay at home rather than being in a long-stay hospital bed or moving into a care home.[30] People's needs also change over time – some only need a simple piece of equipment for a short time to help them rehabilitate at home whilst others need different kinds of support at home for the rest of their lives. This means the distinction between what is a health and what is a social care need, and therefore who is responsible for providing the service, is now more difficult to define. The national guidance is therefore confusing and gets in the way of better joint working between councils and NHS bodies by reinforcing distinctions between health and social care needs.

3.7 Interpretation of the national guidance can also result in duplication of services. For example, a person may get an item of equipment on short-term loan from the NHS which is then replaced with an identical item from their council when the loan period ends. Also, when funding is limited, unhelpful debates may arise

27 Councils (through their social work and housing services) are responsible for providing adaptations, regardless of whether they are to meet a health or social care need.
28 Para 2(i) of *NHS Memorandum 1976 (Gen) 90.*
29 Para 2(ii) of *NHS Memorandum 1976 (Gen) 90.*
30 *Commissioning community care services for older people*, Audit Scotland, 2004.

Exhibit 5

National guidance on who is responsible for provision based on health or social care needs

Aids and equipment which may be provided by health boards in terms of paragraph 2(i) of the Memorandum No. 1976 (Gen) 90.

	Financial responsibilities
Aids or equipment available to all sectors	
Aids/equipment directly related to the management of an illness and aids required on medical grounds, such as bedpans, walking frames and wheelchairs.	NHS
Aids/equipment of a domestic character to allow greater independence within the home eg, removable bath and toilet aids, telephone aids and special furniture.	Social Work
Environmental control equipment to give independence and make care at home easier for relatives.	NHS or Social Work depending on type of equipment supplied
Adaptations to public sector housing stock	
Adaptations designed to make dwellings suitable for particular disabled persons, which are essentially permanent in nature, such as installations of lift floors, immovable track hoists, entry phones, widening doors, permanent external handrails, etc.	Public sector landlord (ie, local housing authority, Scottish Homes)[31]
Equipment installed in public sector housing to meet the needs of the disabled person, which might be removed when no longer required (ie, internal grab-rails, temporary ramps, removable stair lifts). Community alarm arrangements tend to vary and it is up to social work and housing providers to determine responsibility.	Social Work
Installation of home dialysis equipment.	NHS
Adaptations to housing association, private rented, and owner-occupied housing stock	
Adaptations of a permanent nature and which are designed to meet the needs of a disabled person who has applied for a home improvement grant (eg, widening doors, permanent ramps etc, and other adaptations to the building fabric)*.	Private landlord or owner-occupier, with possible improvement grant assistance paid for by local housing authorities
Adaptations as at * above and for which the Social Work department may contribute at its discretion towards the occupier's/dependant's share of the costs.	Social Work
Equipment installed to meet the needs of the disabled person, which is removable and redeployable (ie, internal grab-rails, temporary ramps, removable stairlifts).	Social Work
The installation of home dialysis equipment.	NHS

Source: Memorandum No. 1976 (Gen) 90

31 Scottish Homes is now Communities Scotland.

about who is responsible for provision and maintenance.

3.8 The fragmented nature of community equipment and adaptation services is complex and confusing, both for those managing these services and for those who use them. Exhibit 6 highlights the complexity and fragmented nature of the system for the user at all stages in the care journey, including:

- accessing services
- assessing need
- deciding what services people need
- deciding whether the piece of equipment or adaptation is to meet a social care or nursing need
- knowing whether the person has to pay for the service
- who is responsible for maintenance, repair, return or recycling.

Current guidance means there are 'grey areas' of responsibility

3.9 Given the complexity of the system, it is therefore not surprising that 'grey areas' about roles and responsibilities for these services continue to exist. This can contribute to delays in decision-making and getting services in place as people negotiate their way through the system, affecting a person's rehabilitation and quality of life.

3.10 Uncertainty about responsibility includes items such as hoists, lifting equipment, bathing equipment and stairlifts (Exhibit 7 page 20).

Joint working is progressing but more needs to be done

3.11 Joint working between councils and the NHS aims to cut across the traditional organisational and statutory boundaries, helping agencies to work in partnership to provide better services to the people who need them. The Joint Future Agenda extends councils' and the NHS' legislative duty to co-operate with each other,[32] promoting joint management and joint resourcing of community care services. Importantly, it introduced new powers for councils and NHS trusts to set up pooled budgets to facilitate the delivery of joint services.[33]

3.12 Due to the large number of organisations involved in community equipment and adaptation services, formal partnerships can contribute to the development of seamless care by providing users with a more integrated, responsive and better co-ordinated service. Our survey of councils and NHS trusts, undertaken between October and November 2002, asked about formal partnerships arrangements for community equipment and adaptation services. A wide range of organisations can be involved, including councils, NHS bodies, Care and Repair,[34] voluntary sector organisations and RSLs, as well as different functions within a single organisation (eg, social work and housing). The findings in this part of the report relate to partnerships involving only council services and NHS bodies.

What do we mean by a community equipment and adaptation partnership?

In this study, a partnership was defined as when two or more service providers have a formal written agreement in relation to community equipment and adaptation services. All the partners have signed up to the agreement, which details, for example, their relative roles and responsibilities and mechanisms for joint working.

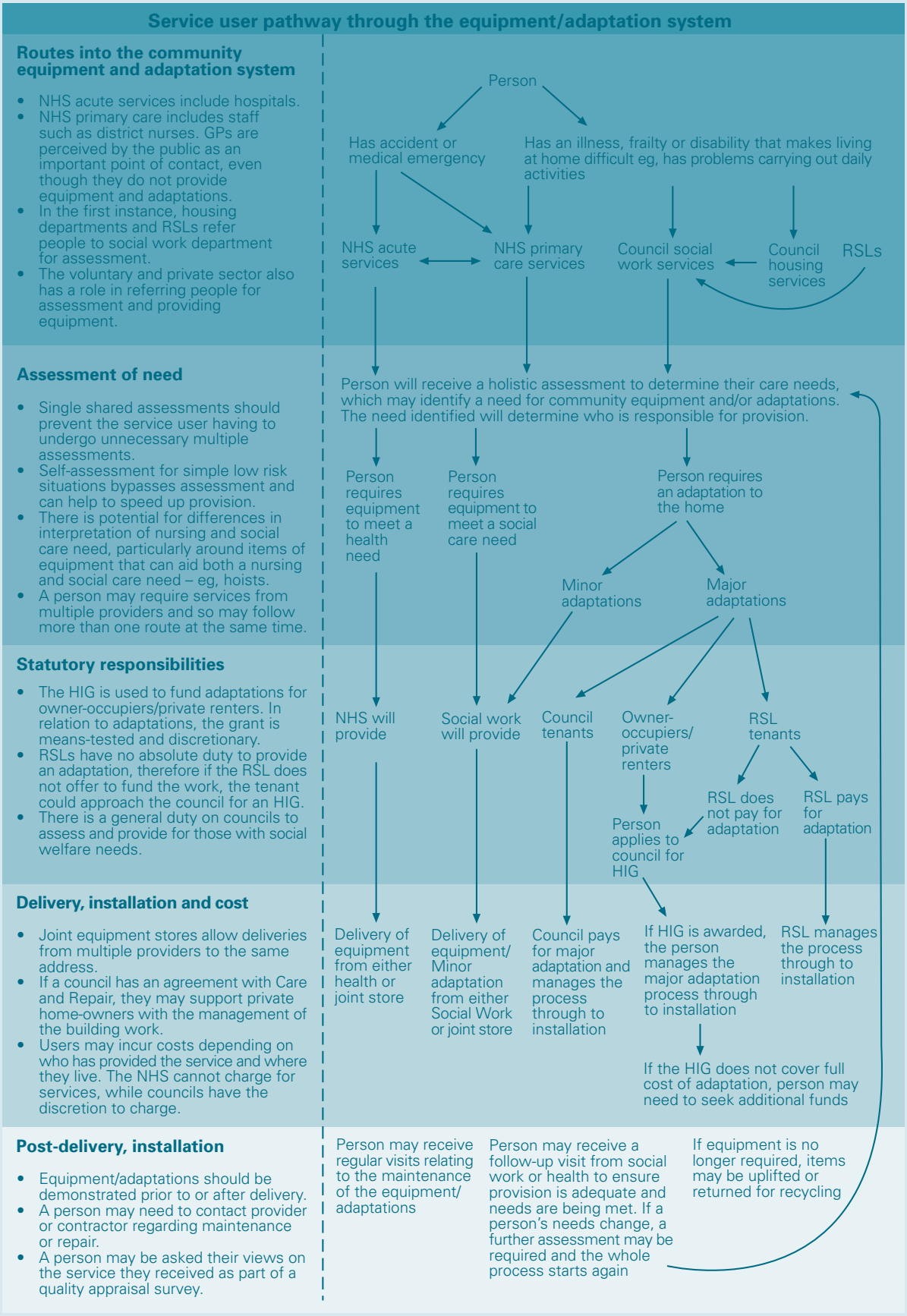
3.13 The majority of council social work and housing services and NHS trusts are involved in at least one formal partnership in relation to community equipment and adaptation services. A total of 72 partnerships were reported.[35] A higher proportion of social work services (82%) and PCTs (85%) reported being involved in partnerships compared with housing services (62%) and acute trusts (57%).[36] But we found high levels of confusion among partners about the status of their relationship. For example, two councils reported a partnership with their local acute trust, yet the acute trust did not report a reciprocal partnership.

3.14 Many councils and NHS trusts do not share the same geographical boundaries (Exhibit 8 page 21). This complicates joint working arrangements. It means, for example, staff working in a health board may have to understand what equipment is available in two or more neighbouring councils, how their services are organised, and what the arrangements are with each for sharing access to each other's stores.

32 NHS (Scotland) Act 1987 s.13 and Circular SWSG 7/94 5458 *Community care – the housing dimension.*
33 Community Care and Health (Scotland) Act 2002.
34 Care and Repair is an organisation that helps older people and young people with disabilities living in owner-occupied, private rented or crofting properties to live independently in their own homes (see Part 4).
35 The total of 72 partnerships includes duplicate partnerships. For example, where a council and a trust reported the same partnership but provided inconsistent information about it, thus making it difficult to match up.
36 Most bodies reported one partnership although some were involved in more.

Exhibit 6

Negotiating the user pathway



Note: This was the system at the time of the study ie, prior to the 2004 reorganisation of the NHS.

Source: Audit Scotland

Exhibit 7

Stairlifts – an example of the grey areas around responsibilities for community equipment and adaptations

Usually a stairlift is issued to meet a mobility need (eg, to be able to go upstairs to bed more easily). As this is defined as a social care need, it is provided by the council. The person may or may not have to contribute financially to this, depending on the particular council from which it is issued.

But…

Although not usual practice, sometimes a stairlift is issued to meet a medical need (eg, because of a heart condition) and may be provided and funded by the NHS. The item is then free of charge.

In some councils, the responsibility for provision, and for funding, depends on the type of stairlift. A straight stairlift is often deemed 'reusable' and so categorised as either equipment or a minor adaptation. Therefore, it is the responsibility of social work services. Curved stairlifts, in some councils, are considered 'non-reusable' and so are classified as a permanent, major adaptation, to be provided by housing services. Current national guidance pre-dates curved track stairlifts.

But, if classified as a major adaptation, the tenancy status of the person requiring the stairlift may also affect provision. A council tenant may get a stairlift provided on loan, free of charge, with maintenance carried out and paid for by the council. However, a private tenant or owner-occupier may have to apply for an HIG to buy the stairlift, which they then become responsible for maintaining.

Source: Audit Scotland

Formal procedures can help joint working

3.15 Formalising joint working arrangements can help clarify partners' roles and responsibilities and avoid disagreements in 'grey areas' that can cause delays in service provision. Council and health partners (plus any others involved in the partnership, such as voluntary sector organisations) need joint procedures to ensure that people get services within a reasonable timeframe. If these are not clear then decisions may be made on the basis of who visited the person first, who has the most direct contact with the person, or budgetary constraints. But many aspects of joint working in community equipment and adaptation services still rely on informal practices, procedures and relationships.

3.16 Two specific aspects of community equipment and adaptation services that benefit from having formal, joint agreed written arrangements in place are:

- eligibility criteria
- arrangements for emergency cases.

Eligibility criteria

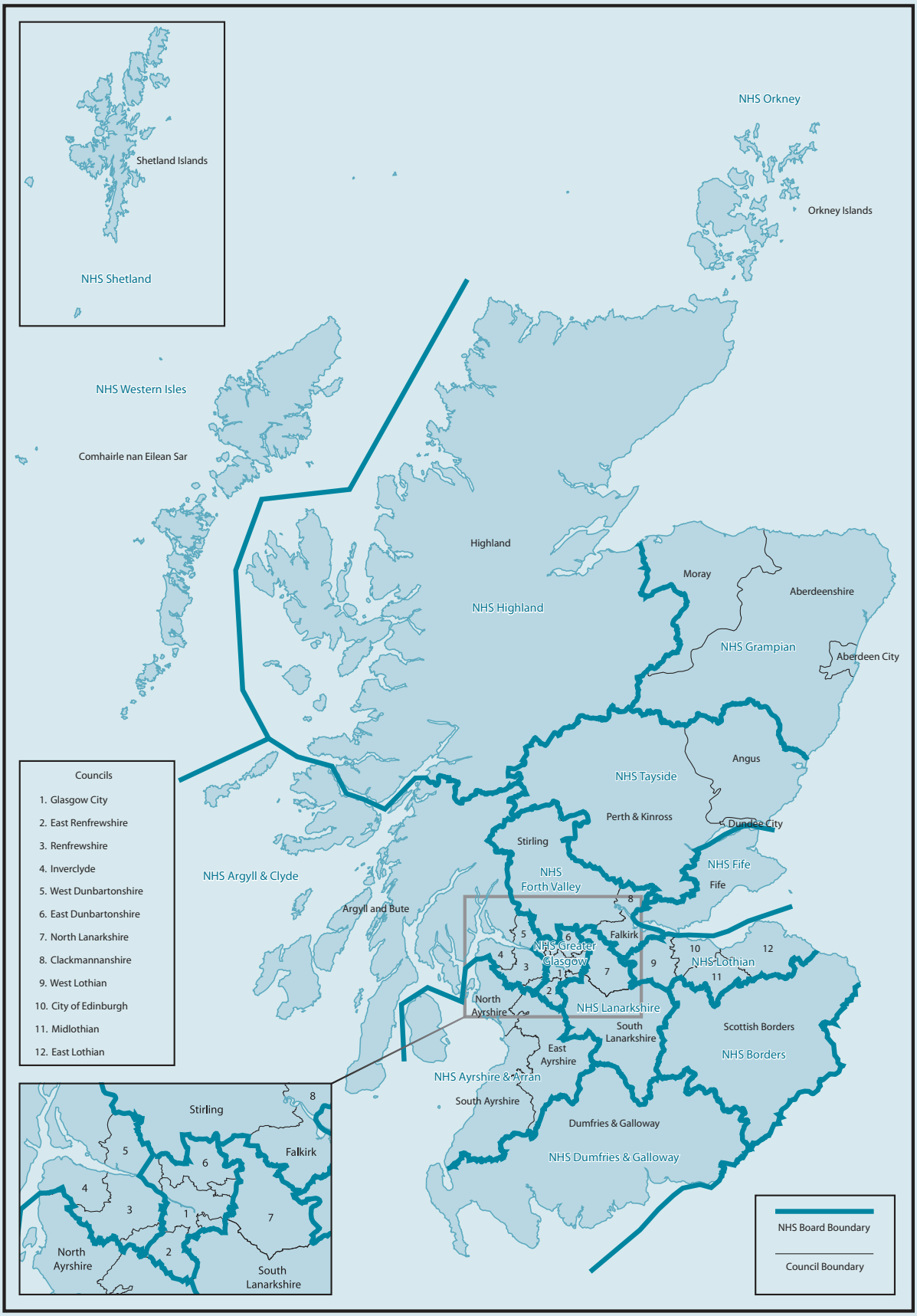
3.17 Eligibility criteria are used to regulate and control service provision in councils to ensure the equitable distribution of resources, and should be based on need rather than the types of equipment and adaptations available.[37] Jointly agreed criteria between councils and their health partners about who is eligible for particular services and who provides them can contribute to efficient and effective community equipment and adaptation services, by:

- clarifying roles and responsibilities
- contributing towards strategic planning
- avoiding 'stand-offs' between the different organisations (which can leave the user waiting for services)
- ensuring consistency in approach between individuals within the same organisation and between partner organisations
- providing a useful source of reference when addressing queries from users, other professionals, senior managers and elected members.

3.18 Of the 72 partnerships for community equipment and adaptations reported across Scotland, just over half have joint written eligibility criteria in place (Exhibit 9 page 23).

37 *Using the law to develop and improve equipment and adaptation provision*, Mandelstam M, 2003.

Exhibit 8
Council and NHS boundaries in Scotland



Good practice example 4

Using joint protocols in Glasgow

Glasgow City Council's social work services and housing service, in conjunction with NHS Greater Glasgow, have developed a joint protocol on the provision of equipment. 'The Protocol' is aimed at managers, clinicians and frontline staff, and outlines the partners' agreed timescales for assessment and handling, delivery and management of equipment. It also presents agreed processes and procedures around assessments and the provision of equipment.

A further document covering adaptations is planned.

Source: *Joint Protocol on the Provision of Equipment and Adaptations*, Glasgow City Council and Greater Glasgow Health Board, 2000

Dealing with emergency cases

3.19 It is particularly important that the NHS and councils have jointly agreed procedures for dealing with emergency cases, where the need for joined-up services is most evident. Examples of emergency cases include where:

- the lack of provision puts the person at risk
- a person is terminally ill and the provision of equipment has a significant impact on their life
- repairs are required to equipment that someone cannot manage without
- a patient's discharge from hospital is delayed because equipment is not provided to use at home.

3.20 Less than half (35) of the 72 community equipment and adaptation partnerships have agreed emergency procedures in place (Exhibit 10).

Information sharing between service providers is limited

3.21 Sharing information is key to providing streamlined and joined-up services, and includes sharing information:

- between statutory bodies
- within the same statutory body.

3.22 Traditionally, community equipment and adaptations staff working in councils and the NHS have shared limited information (both internally and externally) via the transfer of papers and telephone contact, leading to inefficiencies in processing cases. The Scottish Executive has led a move to tackle these inefficiencies through the development of the eCare agenda[38] and Single Shared Assessments (SSAs). Both highlight the importance of sharing information electronically in managing community care services.

3.23 We found that electronic information systems (both within individual organisations and between different service providers) rarely 'speak' to each other. While sharing of client information must be dealt with carefully and according to Data Protection principles, this should not prevent the development of compatible information systems.

3.24 Sharing information among partner organisations helps prevent duplication and increase efficiencies, yet most council and trust partnerships do not have a joint IT strategy that covers community equipment and adaptations. Similarly, only about one in ten partnerships have client information systems that are compatible (Exhibit 11 page 24).

3.25 A wide range of 'off the shelf' software packages and in-house developed programmes are used to manage community equipment and adaptation services in Scotland, each with varying capabilities. However, the feasibility of linking different

38 eCare is about forming partnerships aimed at providing better and more joined-up care, advice and assistance through the use of computers and communication technology.

Exhibit 9

Jointly agreed eligibility criteria, by type of organisation reporting partnership (%)

Over half of partnerships have joint eligibility criteria.

Base: All partnerships, 72; Social Work, 33; Housing, 15; PCT, 16; Acute, 8.

Source: Audit Scotland

Exhibit 10

Jointly agreed procedures for dealing with emergency cases, by type of organisation reporting partnership (%)

Less than half of all partnerships reported having jointly agreed procedures for dealing with emergency cases in relation to community equipment and adaptations.

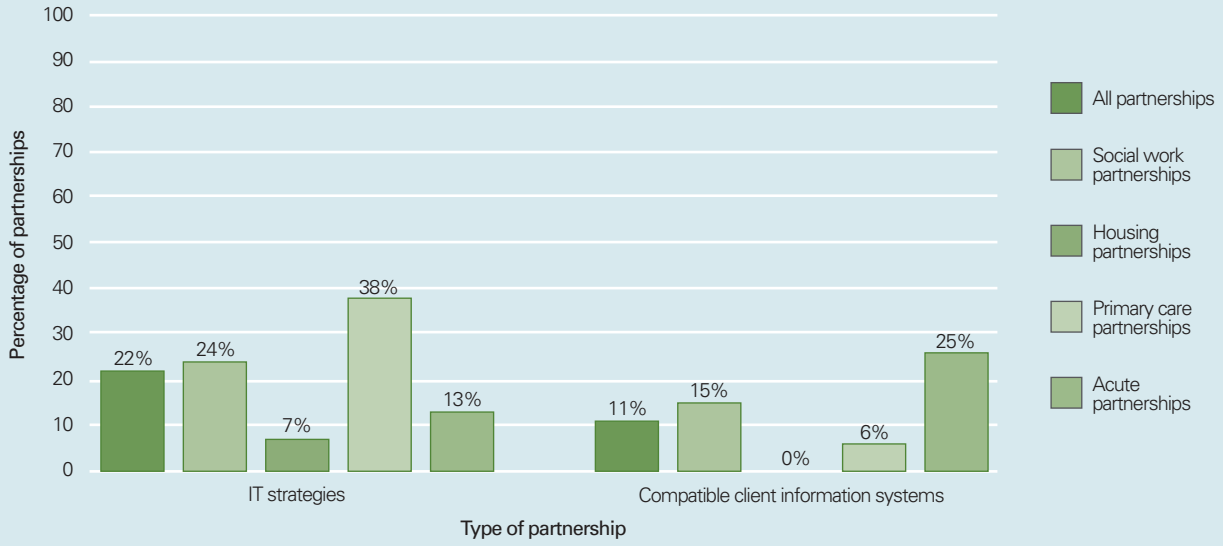
Base: All partnerships, 72; Social Work, 33; Housing, 15; PCT, 16; Acute, 8.

Source: Audit Scotland

Exhibit 11

Community equipment and adaptation partnerships with (a) a joint IT strategy and (b) compatible client information system for these services, by provider type (%)

Most community equipment and adaptations partnerships do not have joint IT strategies or compatible IT systems.



Base: All partnerships, 72; Social Work, 33; Housing, 15; PCT, 16; Acute, 8.

Source: Audit Scotland

Good practice example 5

Sharing information in Borders

Scottish Borders Council and Borders Primary Care NHS Trust devised an information system to support the joint Scottish Borders Ability Living Service which provides community equipment and adaptation services. It combines an equipment ordering facility with a stock control system, which both health and social work staff can use. This IT system was custom-made to fit the information needs of health and social work staff. The Modernising Government Fund was used to develop the system.

Once an assessment is completed an equipment order can be submitted electronically. The ordering facility works through a web-based application and so can be submitted through any computer with internet access. This speeds up the administration as orders no longer need to be put in writing, passed to the equipment store and then processed.

Stock control is made easier and more effective because orders for users can be monitored against items of equipment currently in the store. Staff members can update the stock system to show equipment has been provided. This allows more detailed monitoring of the progress of individual cases. Improvements in the processing of information are reported to have led to reduced waiting times for the user.

Source: Scottish Borders Council

Good practice example 6

Joint post to assess people for nursing and social care needs in Ayrshire & Arran

Ayrshire & Arran PCT and North Ayrshire Council pooled their resources to turn a part-time NHS occupational therapist (OT) post on the island of Arran into a full-time joint OT post. The post-holder took on responsibility for both health OT and social work OT needs assessments, including the provision of equipment. The post is funded equally by the PCT and the Council. North Ayrshire Council trained the OT to undertake social care assessments. The remit of the joint post covers physical health and some paediatrics, but both organisations still send specialist staff to the island for complex cases.

In creating the post, a number of key questions had to be answered:

- Which standards of practice should they adhere to?
- How would the use of two separate IT systems work?
- Would NHS or local authority terms and conditions apply to the post?

Despite the difficulties involved in the initial establishment of the post, it is reported to be a success. A number of service improvements are reported to have arisen because of the joint post:

- improved access to social care (because islanders previously had to wait until a council OT visited the island)
- a reduction in waiting times
- the delivery of a more economical service to the island
- an increased awareness of community equipment and adaptations, because of the raised profile of the service, and increased activity levels.

Source: Ayrshire & Arran PCT

systems is limited. Even within an individual council or NHS trust, information systems are often split according to tasks and cannot be used together. For example, a client information system within a social work service may hold information about a person's assessment, yet this cannot be linked electronically to the equipment store system providing information on delivery and installation. Similarly, a case involving a major adaptation to a person's home may involve information held on the social work service's community care system, the housing service's property register and the architect services team's job system. This disjointed approach increases delays in delivering the service to people and makes it difficult to monitor performance.

3.26 In 2002, the Scottish Executive stated that agencies should have *"a protocol for sharing information and for securing the assessed person's consent"* and details of this should be included in plans for the implementation of SSA.[39 40] While assessment of need is only one part of the care journey, it highlights the importance of sharing information between the multiple agencies that may be involved in a single case. Sharing information in this way helps not only staff (by eliminating the need to conduct duplicate assessments), but also users (by not having to provide the same information to different people on several occasions).

Joint staffing arrangements are not well developed

3.27 While the creation of joined-up services helps reduce duplication of assessments and overlap of services, the need for staff from different statutory bodies to take on each other's tasks has competency, quality and training implications, and could lead to increased demands on staff. There are also differences between councils and the NHS, for example, in terms of their cultures, procedures, legal responsibilities and employment conditions (including pay scales) which mean it is difficult, or sometimes even undesirable, for staff to change their employer. Council and NHS partnerships are looking at ways to overcome these issues.[41]

3.28 Co-location of staff is a way in which staff working in community equipment and adaptation services can work together within the same location but remain employed by their own organisation, but we found very few examples of this taking place:

- six councils have NHS-employed staff based within social work (ranging from between 0.5 and 7.4 whole time equivalent staff)
- three PCTs have council-employed staff based with them (with between 0.5 and 2 whole time equivalent staff). None of the acute NHS trusts do.

39 *Implementing the Joint Future Agenda: the bottom line*, Scottish Executive, issued 2 January 2002.
40 The SSA process aims to provide a single point of entry to community care services, where information is only sought once; a lead professional co-ordinates and shares information; and a single summary of assessment of need is produced. (www.scotland.gov.uk/health/jointfutureunit).
41 *Report of the Integrated Human Resources Working Group on the human resource implications of the Joint Future Agenda*, Scottish Executive, 2002.

Good practice example 7

Housing OT at Falkirk Council

Falkirk Council has a qualified OT based in housing. The OT is involved in assessing users' housing needs, evaluating housing options and co-ordinating all stages of the adaptations process (covering both council and external contractor responsibilities). The post-holder can also order most standard items of equipment without waiting for authorisation from social work.

This arrangement is reported to have:

- provided users with a single point of contact, from assessment through to provision
- reduced waiting times for both assessments and provision
- improved joint working between housing and social work, by having an individual link person who can 'translate' the different languages of housing and community care professionals
- enabled good practice in adaptation provision to be shared throughout local housing teams
- improved the efficiency of the recycling process, as void properties are inspected by the housing OT to see if items are suitable for recycling, or properties can be matched to other users
- increased awareness among housing and social work staff of the need for a streamlined adaptations process
- enabled a preventative approach to difficulties with adaptation provision because of the overarching nature of the post.

Source: Falkirk Council

3.29 We found:

- social work and PCT partnerships have made more progress than housing and acute trust partnerships in establishing Joint Staff Partnership Forums[42]
- joint training and development plans that specifically cover community equipment and adaptation services are rare, particularly among housing and acute trust partnerships
- while half of PCT partnerships and a third of social work partnerships reported having a Joint Statement of Intent[43] covering community equipment and adaptations, less than one in ten housing services and no acute trust partnerships had one (Exhibit 12 overleaf).

3.30 Housing services appear to be excluded from the joint working loop, even though they play a major role in major adaptation services. This suggests that, even when a council does have joint working arrangements in place, housing staff are less aware of this than social work staff. Acute trusts also seem to be less involved in partnerships and less aware of joint working developments. While they play a smaller role than PCTs in the direct provision of community equipment, they are a key link in care journeys and should be involved in all joint working developments.

Shared access arrangements to community equipment stores could be improved

3.31 Traditionally, councils and the NHS provide their own equipment from their own storage premises, reflecting the divisions in statutory responsibilities. This is not necessarily the best use of resources as, for example, it commonly means two separate deliveries are made to the same address, or staff visit more than one store to access equipment. While geography sometimes requires a large number of dispersed stores, the more stores there are the more difficult it is to keep track of what equipment is issued and returned, and the higher the running costs.

3.32 A total of 132 of these separate stores (54 social work and 78 NHS) were reported by the 19 councils and 11 trusts able to provide this information. Some councils and trusts also reported having additional 'buffer stores', the number of which was sometimes unknown. In some areas, arrangements are in place to allow some items of health or social care equipment to be kept at another organisation's store and/or be accessed by staff from another organisation. Seventeen joint stores were also reported (Appendix 3).

3.33 People often need packages of equipment and adaptations that fall under the responsibility of more than one provider, and in some areas separate arrangements need to be made with each. While some items of equipment are quite complex to use and require specialist knowledge and training of the staff issuing it (eg, electrical bathing equipment), other items are relatively straightforward and can be issued by appropriately trained council or NHS staff (eg, feeding equipment).

3.34 A pragmatic approach is taken in most areas, where NHS staff are able to access council community equipment and, although to a much lesser extent, vice versa. However, these arrangements are usually restricted to very basic pieces of equipment and are often based on goodwill rather than formal arrangements. There is considerable scope for increasing the types of equipment that can be issued by council and NHS staff, both from their own organisation and on behalf of a partner organisation, and for formalising procedures so that they are clear to all staff.

There is confusion about how joint equipment stores operate

3.35 The Joint Future Group recommended councils and NHS trusts consider the benefits of combined storage facilities.[44] While essentially a mechanism for jointly managing, organising and delivering equipment, joint stores can potentially facilitate the creation of more effective, efficient and economic services through economies of scale (for example, through joint procurement of equipment, storage and streamlined delivery procedures). They can also contribute to wider health and social care issues by incorporating other services, such as continence advice and palliative care.

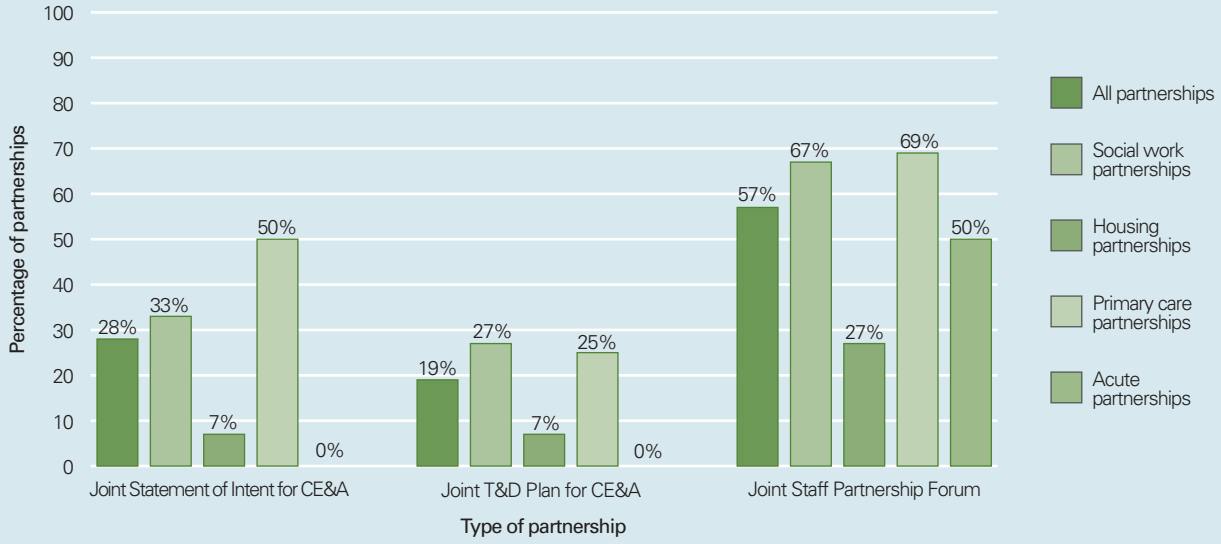
3.36 The first 'joint community equipment store' in Scotland opened in 1991 and the numbers have increased significantly since 2000. At the time of our study there were 17 stores in Scotland (see Appendix 3) that described themselves as 'joint', with councils being the lead partner in most (10). In only one store is overall responsibility split equally between the partners.[45] Most PCTs and almost two-thirds of councils are partners in at least one 'joint'

42 As recommended in *Report of the Integrated Human Resources Working Group on the Human Resource Implications of the Joint Future Agenda*, Scottish Executive, 2002.
43 The Scottish Executive Circular CCD7/2001 on *Joint Resourcing and Joint Management of Community Care Services* states that "agencies should … offer their staff a clear statement of intent that signifies their wish to support staff as fully as possible, and to develop good joint human resources policies such as secondment, joint training etc." p10.
44 *Community care: A Joint Future. Report by the Joint Future Group*, Scottish Executive, 2000.
45 In five joint stores, the NHS has lead responsibility and it was not possible to establish the management arrangements in one joint store.

Exhibit 12

Proportion of partnerships with joint working documentation in place, by provider type (%)

Most community equipment and adaptation partnerships have a Joint Staff Partnership Forum but do not have Joint Statements of Intent or Training and Development plans that specifically cover community equipment and adaptation services.



Base: All partnerships, 72; Social Work, 33; Housing, 15; PCT, 16; Acute, 8.

Source: Audit Scotland

community equipment store. It is less common for acute trusts to be partners in joint stores (3).

3.37 Partner organisations identified the main benefits of joint stores as:

- saving costs through bulk purchasing
- having flexible budgets and delivery systems due to the alignment of operational and equipment budgets
- encouraging joint agreement of working documents and practices
- providing users with a single point of contact if they are getting equipment to meet both social and nursing care needs
- allowing staff to step outside their 'statutory boxes'
- contributing to continuity of care
- enabling more efficient and effective allocation of staff tasks and time.

3.38 However, there is no common definition of what a joint store is. Stores that are collectively described as 'joint' are often very different to each other. We evaluated Scotland's joint stores against 14 characteristics that you might expect to find in a joint equipment store (Exhibit 13). None of the stores reported having all of these characteristics.

3.39 Of those we asked about, the most common characteristics of Scotland's joint stores are that they:

- allow NHS staff to access some social work equipment, and vice versa
- run joint training sessions for NHS and council staff
- operate with a single manager
- operate joint distribution procedures.

3.40 But key characteristics expected of a joint store, such as joint procurement, information sharing procedures and compatible information systems, and aligned operational and equipment budgets, are rarely in place (Exhibit 13).

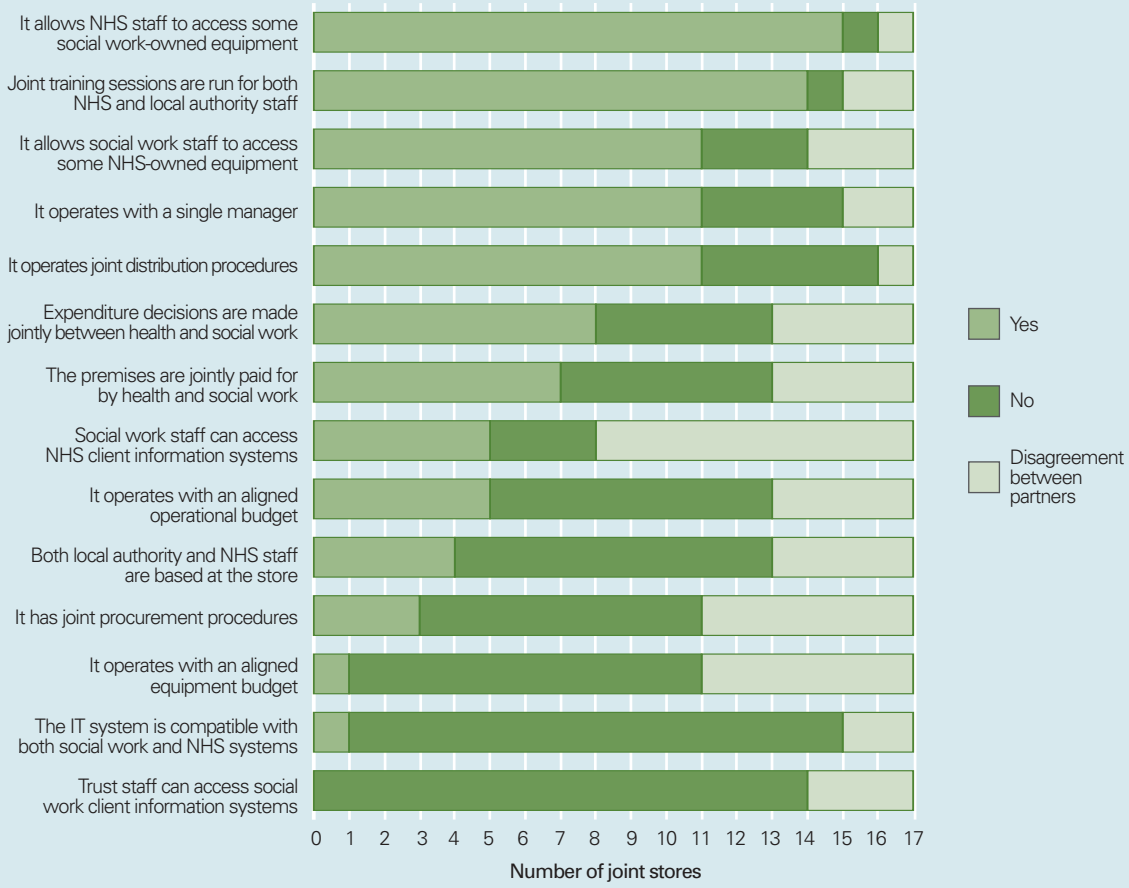
3.41 Partners disagreed about the characteristics of their joint store, particularly about whether social work staff can access NHS patient information systems; whether there are joint procurement procedures in place; and whether the store operates with an aligned equipment budget (Exhibit 13). In four of the 17 joint stores reported, partner organisations disagreed on more than 10 of the 14 characteristics asked about, including significant issues such as:

- whether spending decisions are made jointly by partners
- whether the store operates with aligned or separate operational and equipment budgets
- who pays for the premises
- whether staff can access each other's equipment and client/patient information.

Exhibit 13

Number of 'joint community equipment' stores with each of the joint working characteristics (n)

Many partners disagree about the characteristics of their joint store.



Source: Audit Scotland

3.42 All partners in a joint store should be clear about how it operates, how decisions are made and money is spent, and respective roles and responsibilities. The lack of awareness about how joint stores operate may stem from poor communication between the host organisations and the store itself. Clear lines of communication and accountability should be established.

3.43 In most cases, joint equipment stores contribute to the joint working agenda in only a limited way and do not provide a joint service. Many so-called 'joint stores' appear to perpetuate traditional barriers between health and council service providers. We found many examples of staff based outwith the store not knowing about key policies and procedures (for example, if there was a system to recall faulty equipment and if delivery drivers ever demonstrated equipment), simply stating that these were the responsibility of the store. Their duty of care to people using services and partners' financial contribution to the store means that staff should be aware of policies and procedures within the store and how their money is being spent.

Users think joint working would improve services

3.44 Most of the users we spoke to did not express views on the extent of joint working between councils and the NHS, primarily because of the confusion around who provides what services. However, some carers have relatively high levels of awareness of how the system works and the problems caused by the statutory divisions in responsibility. Despite often using these services for many years, even they find the system confusing and feel the divisions between organisations are unnecessarily rigid and unhelpful. They recognise the constraints within which staff work but find the unwillingness of some staff to make even the most tentative steps outwith their professional territory frustrating.

"I was dealing with the council for my equipment the last few years, and she said to me […] 'Oh, that won't be anything to do with me, that'll be the OT at the school'. And I've found over the years that you can ask an OT at school for something and they say 'Oh well, that's nothing to do with me, you'll have to go to the council'. All these people should be working together".

(Group 5)

"The rules are crazy."

(Group 5)

3.45 This leads to people having to find their own way around the community equipment and adaptation maze (Exhibit 6, Page 19). A single, primary contact – such as a key worker – was identified as a possible way of overcoming these problems. Joint working was identified as the key to solving many problems, such as lack of continuity of care, waiting times, and confusion over who to contact.

"It's the different rules. Health board rules and social services rules don't come together. We've been fighting for the past 12 years for them to come together."

(Group 5)

3.46 Some people felt that the level of joint working is dependent on personalities involved. When staff do work well together it has a positive impact on users.

"I mean I'm very lucky, my support team speak to each other."

(Group 5)

Recommendations

Councils and NHS bodies should:

- Work towards joint information systems that provide good management information on the community equipment and adaptation services within their partnership area.
- Clarify partnership arrangements for the assessment and provision of community equipment and adaptations ensuring that all relevant partners are involved; and formalise these arrangements in agreed policies and procedures.
- Ensure all relevant staff across the respective partner organisations are aware of the agreed policies and procedures.
- Ensure that community equipment and adaptation services are developed as part of their overall community care strategy.
- Develop protocols which maximise the ability of staff from different partnership organisations to access equipment and adaptations and reduce the waiting time for users.
- Develop joint training plans for all staff involved in assessing the need for, and demonstrating, equipment and adaptations.

The Scottish Executive should:

- Update national guidance on roles and responsibilities in relation to community equipment and adaptations to reflect new ways of working promoted by the Joint Future Agenda; local government reorganisation; and developments in technology.

Part 4. Planning and performance monitoring

Main findings

- Demand for community equipment and adaptations is high but some councils and NHS trusts do not have robust management information systems in place to allow them to assess whether local demand is being met, or to monitor performance.
- Councils and NHS trusts found it difficult to produce basic activity and financial information about community equipment and adaptations.
- The lack of common definitions around types of activity, differences in recording practices and the extent to which information systems can generate useful management information make it difficult for councils and NHS bodies to benchmark their performance with others.
- There is an over reliance on extra money being received throughout the financial year, particularly in the NHS. The use of additional funding makes it difficult to get an accurate picture of activity levels. In both the NHS and councils, expenditure is considerably higher than budgets.
- Many community equipment and adaptation service providers do not systematically monitor their service at the local level. Performance monitoring information is not reported to senior managers on a regular basis.
- Councils and NHS bodies could consult with users more effectively.

4.1 In order to demonstrate best value, effectively plan services that meet people's needs and achieve continuous improvement in performance, providers need good information about:

- current and future demand for services
- activity and cost
- performance and quality of services.

Local joint performance management frameworks should be used to support decisions about how services are organised and planned (Appendix 6).

Planning for current and future demand is essential

4.2 Equipment and adaptations are changing with the development of assistive technologies and better product designs. This means that the service requires active planning to ensure that users get the product which best meets their needs. There are also demographic and policy changes which will affect the future provision of community equipment and adaptations. Good planning is essential as there will be changes in how many people require these services and changes in who provides them. For example:

- the need for equipment and adaptations rises with age and Scotland's population is getting older (Exhibit 14 overleaf).
- Scotland's housing profile is changing, with a fall in council housing stock and tenancies and a rise in owner-occupation and Registered Social Landlord (RSL) properties[46] (Exhibit 15 overleaf).

An ageing population will increase demand

4.3 The need for equipment and adaptations rises with age. Our survey of the general public found that nearly half of the respondents in the 65+ group who had a disability had approached a council or the NHS for equipment or adaptation for themselves, and a third had made approaches on behalf of someone for whom they cared (Exhibit 14 overleaf).[47]

Changes in housing tenure require strategic planning

4.4 Changes in housing stock ownership emphasise the need for strategic service planning. The council has responsibility for adaptations to council properties, but RSLs fund adaptations themselves or apply to Communities Scotland for a discretionary grant. However, there is no absolute duty on RSLs to provide adaptations for their tenants. If the RSL decides not to fund an adaptation, tenants can apply to their local council for an HIG. This means, therefore, that a council may ultimately fund adaptations, through the grant system, to the stock it transferred. Currently Scottish Executive advice to councils and RSLs involved in housing transfers is that they should not include the cost of adaptations in their transfer valuations.[48] But this is a potentially significant issue for the funding, planning and delivery of major adaptations in future years. Councils and RSLs should work together to assess need for major adaptations in the future.

Effective management needs good information

4.5 As well as promoting independent and supported living in the home, effective and efficient community equipment and adaptation services can make substantial savings for councils and the NHS through, for example, preventing admission or readmission to hospital or a care home.[49]

4.6 Effective management relies on good information about the volume, cost and quality of the service, but activity and financial information about community equipment and adaptations in Scotland is limited.[50] We found it difficult to establish overall activity levels and costs for community equipment and adaptation services in Scotland and the extent of joint working because of:

- the split across a wide range of different service providers, each with their own activity and finance arrangements
- differences in what services are included under 'community equipment and adaptations'
- the use of different definitions for recording activity and cost information
- limited information collected, collated and used to plan, monitor and improve services
- poor information systems resulting in a lack of accurate and extractable activity, cost and quality information.

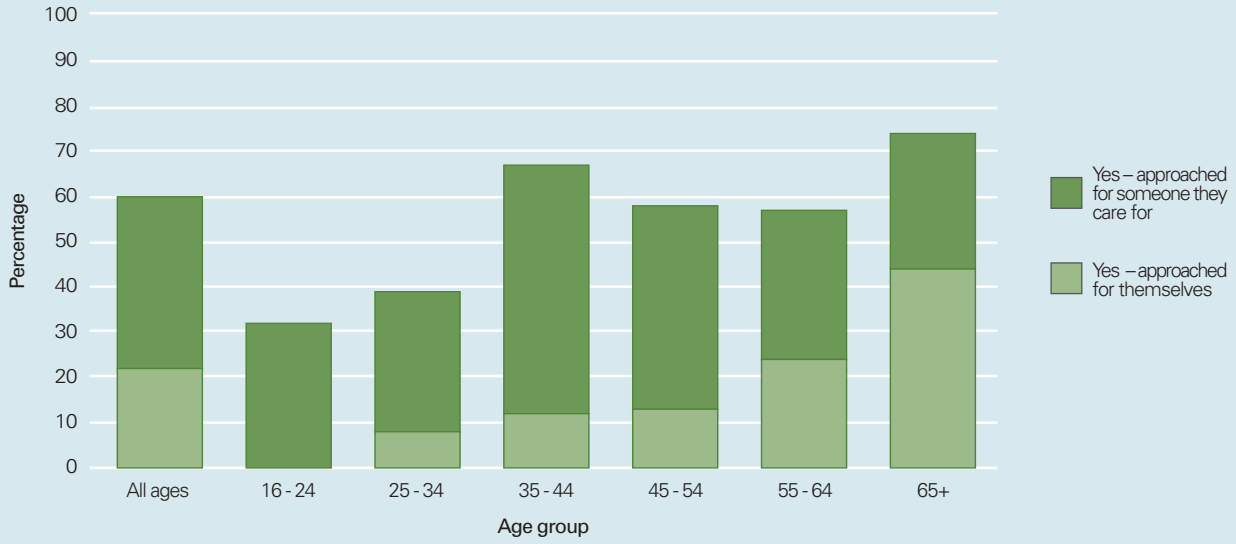
4.7 From those councils and NHS trusts able to provide the information we requested, we found varied activity, budget and expenditure patterns. While these might reflect, for example, differences in eligibility criteria, data collection practices and the quality of data, the type of equipment and adaptations available through the service, charging practices and reliance on additional funding, there are unexplained variations.[51]

46 *Statistical Bulletin. Housing Series*, Scottish Executive, February 2004.
47 Respondents could have approached community equipment and adaptation services for both themselves and on behalf of someone for whom they care.
48 For further discussion see *Using the law to develop and improve equipment and adaptation provision*, Mandelstam M, 2003.
49 *Home alone: the role of housing in community care*, Audit Commission, 2000.
50 Some of the data limitations are a result of inconsistent use of definitions applied by services. To overcome these difficulties, we asked all audited bodies to use our own definitions for the purpose of this study, however this was not always possible. See Appendix 4. Our survey of councils and NHS trusts sought activity and cost information over three financial years 1999/2000 to 2001/02.
51 Echoing findings in England and Wales, see Department of Health Circular HSC2001/008:LAC(2001) 13.

Exhibit 14

Proportion of respondents with a frailty, illness, health problem or disability having approached a council or the NHS to get community equipment and adaptations, by age group (%)

The likelihood of contacting a council or the NHS for community equipment and adaptations for oneself rises with age.



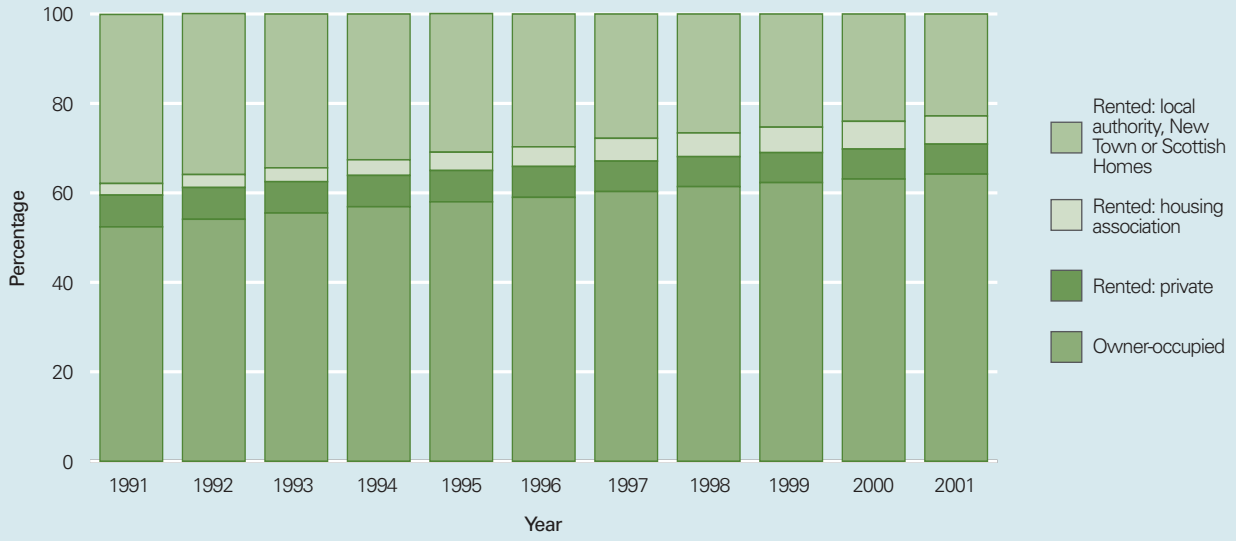
Base: All ages, 244.

Source: Audit Scotland

Exhibit 15

Estimated stock of dwellings by tenure, 1991 to 2001 (%)

Council and private renting is decreasing, whilst owner-occupation and renting from housing associations is rising.



Note: Estimates are based on the 1991 Census.

Source: Statistical Bulletin. Housing Series, Scottish Executive, February 2004

Social Care Data Standards Project

The Social Care Data Standards is a national project set up to produce data definitions and standards. It aims to improve the consistency and quality of social care information, both locally and nationally. The main output will be a Social Care Data Standards Manual containing definitions for key terminology, standard classifications and code lists for priority social care areas.

At present there are no standard data definitions for community equipment and adaptations.

Activity information in the NHS is limited, especially in acute services

4.8 Most NHS trusts could not provide information about the volume of equipment issued or the number of patients receiving equipment for use in the home. Activity information in the NHS tends to be recorded in paper-based patient case files, only extractable through a manual trawl of patient files. Most acute trusts also could not say how much was available for, or spent on, equipment for use in the home.

4.9 For the financial year 2001/02:

- no acute trusts and only seven PCTs could state how many items they issued
- only four PCTs and no acute trusts could state how many patients received community equipment directly from the trust
- despite the reliance on joint working, no trusts could state how many cases were referred to council services.

4.10 Money allocated for purchasing NHS equipment for use in the community is sometimes combined with wider equipment or 'general sundries' budgets (covering office furniture and IT equipment, for example). This approach clearly does not allow for systematic planning or assessment of whether the budget meets local need. While nearly all PCTs could provide budget and expenditure figures for equipment they issue to people living at home, no acute trusts could do so.

The NHS relies on receiving additional money through the year to fund equipment

4.11 Among those PCTs able to provide financial information, we found that budgets often do not meet demand, with trusts relying heavily on the receipt of additional funding throughout the year (Exhibit 16 overleaf). For 2001/02, the total amount of money available for community equipment over the course of the year was on average 52% higher than budgets allocated at the start of the financial year. Expenditure levels were on average 70% higher than the budgets allocated at the start of the financial year.

4.12 There is also evidence that budgets are simply carried forward from year to year with little account being taken at the budget planning stage of actual expenditure. This approach does not support the sustainable development of services. On the basis of the ten NHS trusts able to provide information for both 1999/2000 and 2001/02, while there was a 54% rise in expenditure during this period, there was only a 17% rise in budgets. The average increase in budgets per trust was 24%, compared with an average increase in expenditure of 60%.

Social work activity information is better than in the NHS but is still limited

4.13 Councils can provide more detailed activity and cost information than their health partners, but this is still limited.[52] Although most social work services could provide at least some activity information, a quarter could not provide any information about the number of referrals, assessments, completions or the number of individual items of equipment issued or adaptations installed, for any of the three years asked about.[53] Some councils cannot extract information about community equipment and adaptations from their wider community care data.

4.14 Among the social work services in our study for the financial year 2001/02:

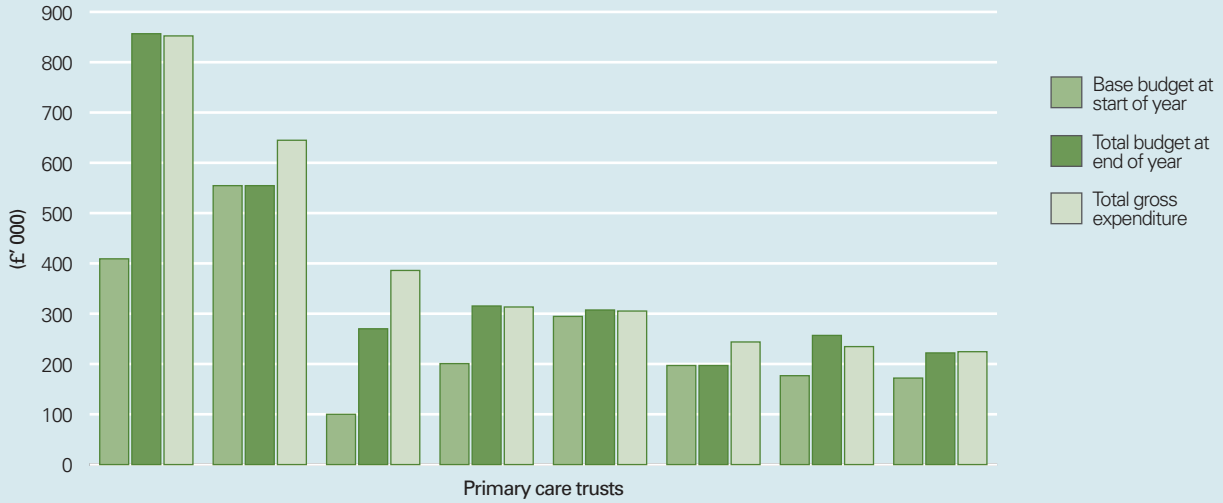
- only ten could report how many individual items of equipment were delivered and installed[54]
- just over half could state how many referrals were received for community equipment and adaptations
- less than half could provide information on who made these referrals to social work, despite the importance of joint working
- less than half could state how many assessments identified a need for community equipment and adaptations.

52 See Appendix 5 for a summary of what activity information each council could provide for the financial year 2001/02.
53 See Appendix 4 for definitions used in the study.
54 *The Local and National Information Requirements for Social Work in Scotland: Joint Statement,* A report by the Social Work Information Review Group, August 2000 concluded that the number of items delivered and installed is essential information that should be collected by council services.

Exhibit 16

PCTs' budget and expenditure for community equipment, 2001/02 (£)

In one PCT the budget at the end of the year (the 'total budget') was twice as much as the budget at the start of the year (the 'base budget'), and in another it was almost three times as much.[55]



Base: PCTs that could provide base and total budget and gross expenditure information for 2001/02 (n=8)

Source: Audit Scotland

Social work activity levels are rising but there is significant variation

4.15 Among those councils that could provide community equipment and minor adaptation information for 1999/2000 to 2001/02, social work activity has risen overall.[56] Community equipment and minor adaptation referrals rose by an average of over a quarter and assessments by 15% per council during this period. The number of items issued rose by an average of two-thirds. But, the overall increases mask significant, unexplained differences at a local level. For example, the percentage increase in assessments where a need for community equipment and minor adaptations was identified ranged from 1% to 72%.

4.16 Activity levels vary significantly at a local level. For example, in 2001/02 the number of referrals for community equipment and adaptations ranged from 11 to 36 per thousand population. Assessments identifying a need for community equipment and adaptations ranged from 16 to 32 per thousand population (Exhibit 17).

4.17 Whether an assessment identifies a need for equipment and adaptations may depend on the type of equipment and adaptations available within an individual council. Therefore variations in activity levels may suggest inequity of provision. For example, one council may have low activity levels per thousand population because it mostly issues low demand, high cost pieces of equipment and adaptations. Another council may have very high activity levels, and possibly low expenditure, because it mostly issues high demand, simple and low cost pieces of equipment and adaptations. The large variation in activity levels that we found would benefit from further investigation.

4.18 Community equipment and adaptations rely on councils, the NHS and others working together. The NHS makes up a large percentage of referrals to councils for these services (Exhibit 18 page 38).

Variation in budget and expenditure cannot be explained by differences in social work activity

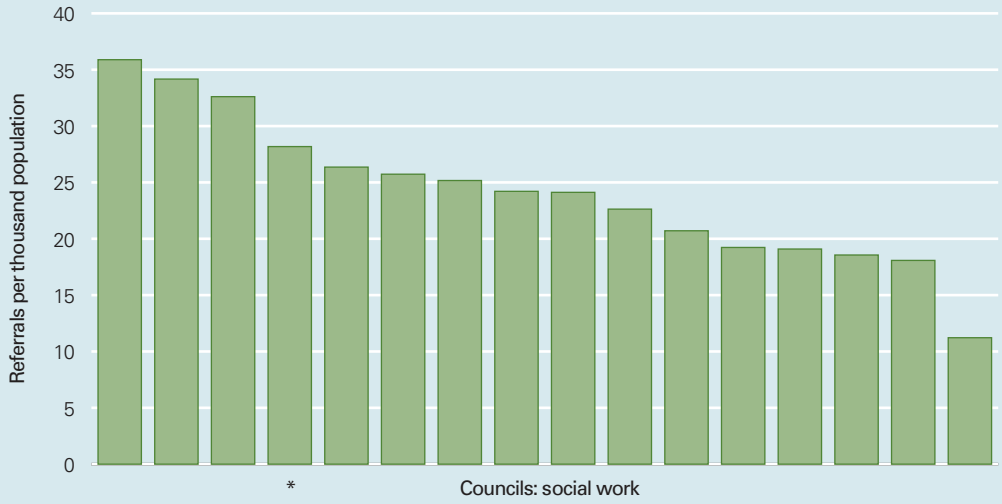
4.19 In terms of cost, we estimate that approximately £24.4 million was budgeted for, and £29.8 million was spent on, social work community equipment and minor adaptations in 2001/02. Of the 21 councils that could provide both budget and expenditure information for 2001/02, budgets varied from around £150,000 to almost £2 million, and expenditure from around £162,000 to over £3 million (Exhibit 19 page 39). Differences in budget and expenditure cannot be explained by different activity levels as some councils with low levels of activity had high levels of expenditure and vice versa.

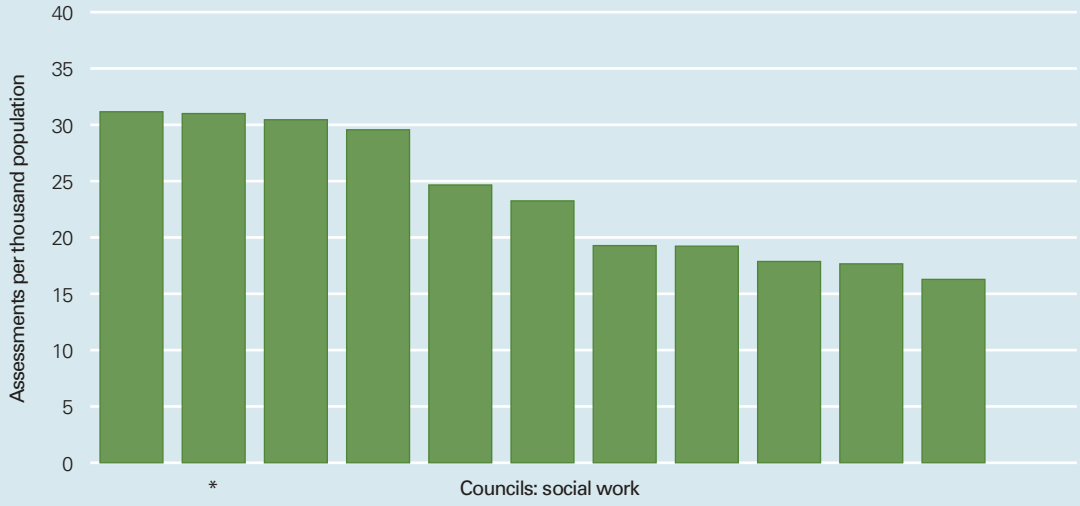
55 Base budgets are those allocated at the start of the year and total budgets are base budgets plus any additional money received throughout the financial year.

56 It is not possible to comment on the comparative rise in referrals, assessment, completions and individual items because the number of councils in each category differs. No councils could provide information in all four categories and hence the percentage changes relate to each individual category separately.

Exhibit 17

Number of social work referrals and assessments for community equipment and minor adaptations per thousand population, by council for 2001/02





Base: Councils that could provide the number of social work services referrals (n= 16) and assessments (n=11) for community equipment and adaptations.

Note: See footnote[57] for *

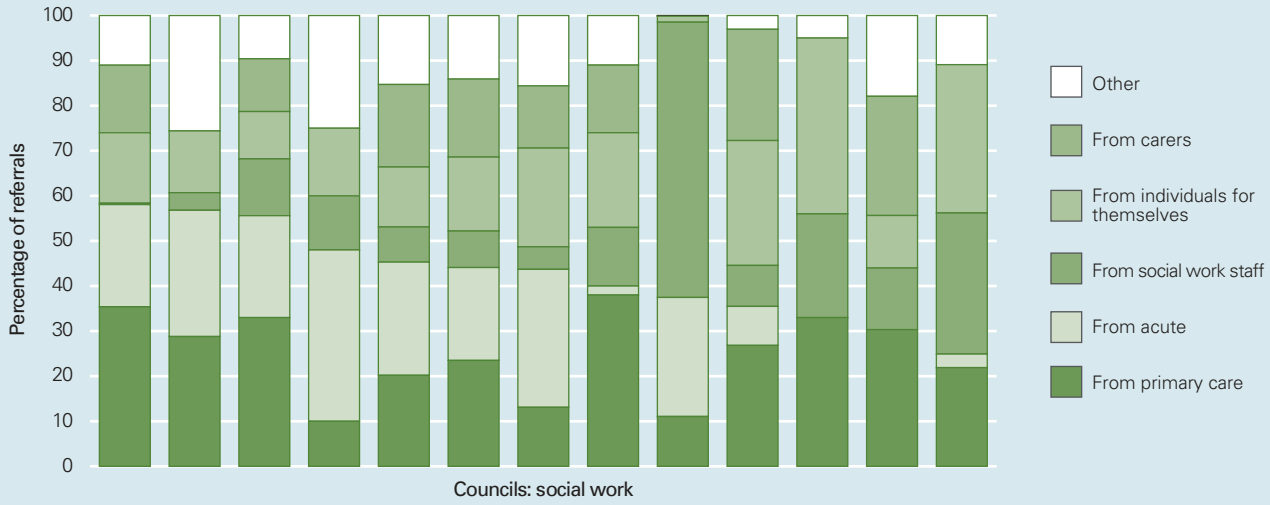
Source: Audit Scotland

57 One council has transferred all housing adaptation work to its social work service and, as a result, it proved impossible to separate out activity information on the basis of minor and major adaptations. That council's major adaptations activity is presented with the minor adaptations activity data.

Exhibit 18

Referrals to social work services for community equipment and adaptations, by source of referral (%)

Most referrals to social work for community equipment and adaptations come from the NHS. On average, over a quarter of referrals come from carers and individuals for themselves.



Base: Councils that could provide information on source of community equipment and adaptations referrals received by social work services (n=13).

Note: Referrals may include those for major adaptations.

Source: Audit Scotland

Social work budgets do not appear to meet demand

4.20 The practice of supplementing base budgets through additional funding over the year does not appear to be as prevalent among social work services as NHS trusts. Of the 19 councils that could provide full information about base and total budgets and expenditure for 2001/02, only four reported their total budget being higher than the base budget (although in one council the total budget was 52% higher than the base budget). But, social work expenditure on community equipment and minor adaptations during 2001/02 exceeded the allocated budgets by an average of 27%. As in the NHS, this suggests that funding does not meet demand and is not systematically planned, despite its importance (Exhibit 20).

Different housing tenures complicate the collection of information about major adaptations

4.21 For the financial year 2000/01, most councils could provide basic activity information on the number of recommendations for major adaptations to council properties (18) and HIG[58] applications (which cover major adaptations) for private sector properties (21). Unlike social work and NHS bodies, the majority of housing services could also provide activity information on a longer-term basis (ie, over the three years from 1999/2000 to 2001/02).

4.22 However, financial information about major adaptations was limited and inconsistent. As there is no apparent consistency in the funding streams for major adaptations across councils and there are differences in how information is recorded, it is difficult to establish how much is spent by councils on major adaptations. While most have capital budgets for major adaptations, revenue budgets are less common. Furthermore, revenue budgets for private property adaptations are significantly less common than for council major adaptations (Exhibit 21 page 41).

4.23 Only one council provided information on both capital and revenue budgets for both private and council adaptations, along with corresponding expenditure information. Some councils could provide budget information but not the corresponding expenditure figures and vice versa. Without such basic budget and expenditure information, it is not possible to effectively plan and manage services.

Overall the number of major adaptations is increasing although across Scotland the picture is inconsistent

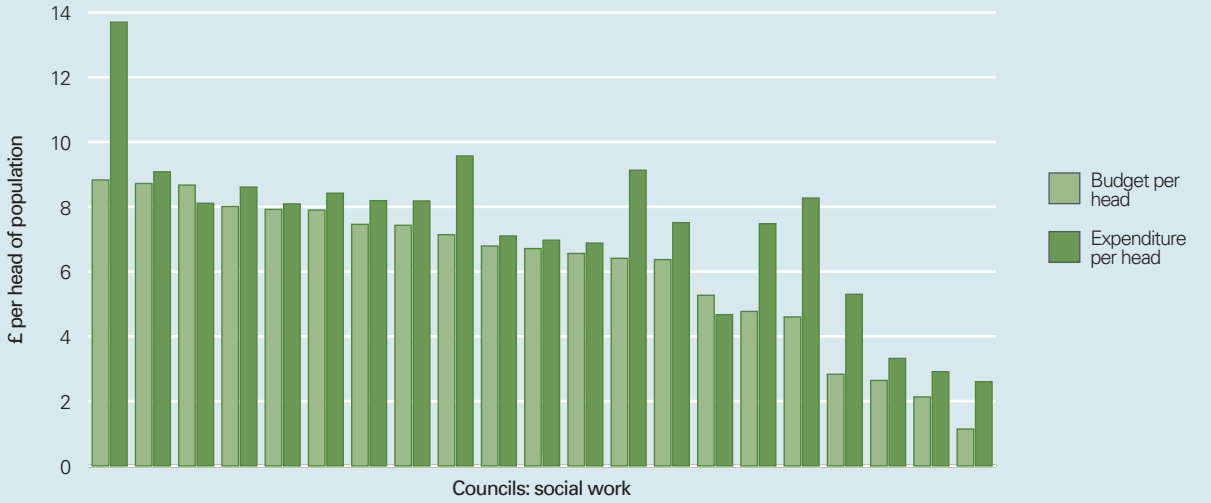
4.24 For those councils that could provide information for 1999/2000 and 2001/02 for both tenures, there was an average increase in the number of recommendations for council property adaptations of

58 HIGs are used to fund more than adaptations for people with a disability, for example, standard amenities. For the time period covered by our study, these were known as Home Improvement Grants.

Exhibit 19

Social work budget and expenditure for community equipment and minor adaptations per head of population, 2001/02

The budget allocated varies from £1 to almost £9 per head of population, and expenditure from less than £3 to almost £14.



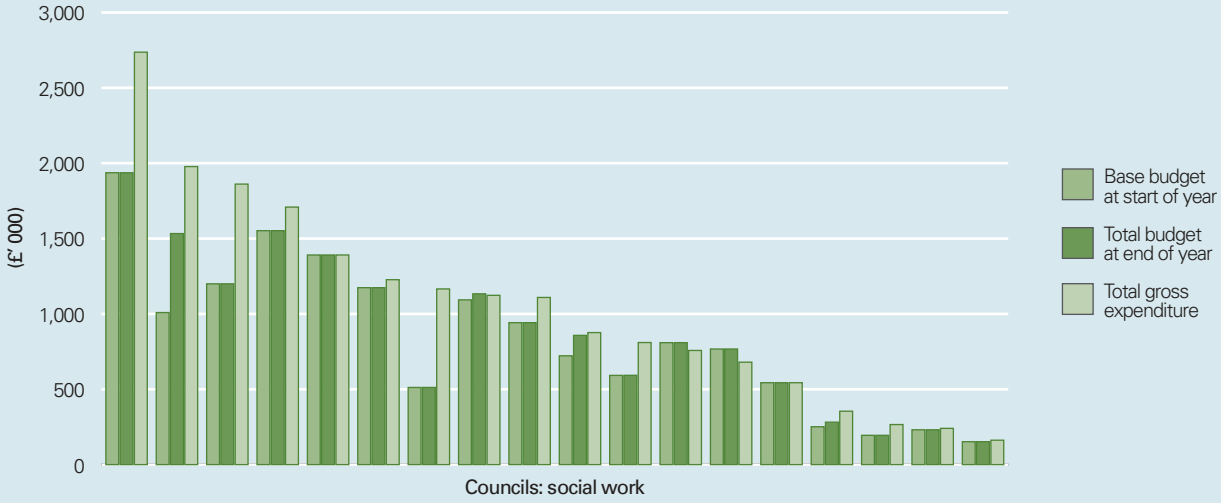
Base: Councils that could provide both budget and gross expenditure information for social work services for 2001/02 (n=21).

Source: Audit Scotland

Exhibit 20

Budget and expenditure for social work community equipment and minor adaptations, 2001/02

Expenditure on community equipment and minor adaptations exceeds allocated budgets in most councils that could provide full budget and expenditure information.



Base: Councils that could provide information on social work services base and total budgets and gross expenditure for 2001/02 (n = 18).

Source: Audit Scotland

32%, but in comparison only a 5% average increase in applications for HIGs. But these overall figures again mask significant, unexplained local variations, with some councils showing significant decreases and others increases.

4.25 In those councils providing information for both council and private property adaptations for 2001/02, the number of recommendations for major adaptations to council properties is, on average, four times higher than for HIG applications for privately owned or rented properties. Yet half of people with a long-standing illness, health problem or disability live in owner-occupied properties and around a third live in council properties,[59] suggesting there may be unmet needs.

4.26 As with social work equipment and adaptations, housing services' activity levels vary considerably at the local level. The number of recommendations received for major adaptations to council properties ranged from 0.5 to 10 per thousand population. Similarly, HIG applications ranged from 0.2 to 1.8 per thousand population (Exhibit 22).

Budgets for council property major adaptations are significantly higher than for HIGs

4.27 Of the 16 councils that could provide base budget information for both council property adaptations and HIGs, council property adaptations budgets were on average three times higher than for HIGs. Yet across these councils 31% of households live in social rented accommodation and 61% in privately owned properties. We also found significant variation among councils, with base budgets ranging from 70p to £7 per head for council adaptations, and from 60p to £5 per head for HIGs covering private sector adaptations (Exhibit 23 page 43).

4.28 Prior to changes introduced in the Housing (Scotland) Act 2001, most housing services awarded HIGs at the maximum level (75%) and only a small number awarded grants at lower levels (with two councils awarding more grants at lower levels than at the maximum). Less than half of councils' social work services 'topped up' HIGs in 2001/02, often to meet 100% of the cost of the major adaptation. In those councils where HIGs were not topped up by social work, users would have to fund the outstanding cost themselves or seek funding from another source (such as a charity). Only one council reported rejecting any applications for HIGs.

4.29 Care and Repair is a publicly funded organisation that helps people live independently in their own homes. It helps older people, young people with disabilities living in owner-occupied or private rented accommodation, and crofting tenants of any age or physical ability, to manage the process of getting repairs or adaptations done to their houses. This includes applying for HIG or other funding and minor adaptations.[60]

4.30 In 2002/03, 34 Care and Repair schemes in Scotland received over 10,500 enquiries.[61] Just over 6,000 works completions were handled in this year, with 42% of these involving clients with a disability. The total capital expenditure for all Care and Repair projects was £12.8 million, with 63% of this being funded by public capital expenditure.[62] Despite the large volume of cases and high expenditure, most relevant councils could not provide accurate information about the total number and cost of Care and Repair cases they fund. Some are unclear about the status of their relationship with Care and Repair. The limited and poor quality information provided suggests that councils need to monitor more closely activity and expenditure levels associated with Care and Repair to ensure that they are getting best value. From 2005/06, Communities Scotland's responsibility for funding Care and Repair services will transfer to councils.

Management information does not support performance monitoring

"The improvement of data collection and use of data to manage the demand and supply of equipment and adaptations could play a major role in improving provision. Until this is achieved, the measurement of the effectiveness of provision and outcomes for people using services cannot be contemplated."[63]

4.31 Measuring the performance of community equipment and adaptations services in Scotland is hampered by the lack of good management information and common definitions, robust recording methods and appropriate IT systems (for example, some service providers only measure performance on an *ad hoc* basis, sometimes after a resource intensive manual trawl for data). This mirrors findings in England and Wales.[64] It also makes it difficult for partnerships

59 *Scotland's People: Results from the 2003 Scottish Household Survey*, Annual Report, Scottish Executive, 2004. The remainder live in private (4%) or RSL (10%) rented properties or 'Other' accommodation (2%).
60 See: www.careandrepairforum.com for more information.
61 There are now 38 Care and Repair schemes operating in Scotland, covering 30 councils.
62 *Care and Repair in Scotland: national indicators 2002-2003*, Communities Scotland, 2003. Care and Repair schemes tend to be funded by council housing services and Communities Scotland, plus, to a lesser extent, NHS Boards and council social services.
63 *Equipment and Adaptation Services in Scotland: A Survey of Waiting Times for Social Work Provision*, Scottish Executive Central Research Unit, 2001.
64 *Fully equipped: the provision of equipment to older or disabled people by the NHS and social services in England and Wales*, Audit Commission, 2000.

Exhibit 21

Proportion of councils providing financial information on major adaptations, by type of expenditure and type of adaptations (%)

The sources of funding of major adaptations vary among councils

Provided information on…	Revenue		Capital	
	Council adaptations	Private adaptations	Council adaptations	Private adaptations
Base budget	45%	21%	69%	55%
Expenditure	34%	17%	57%	45%

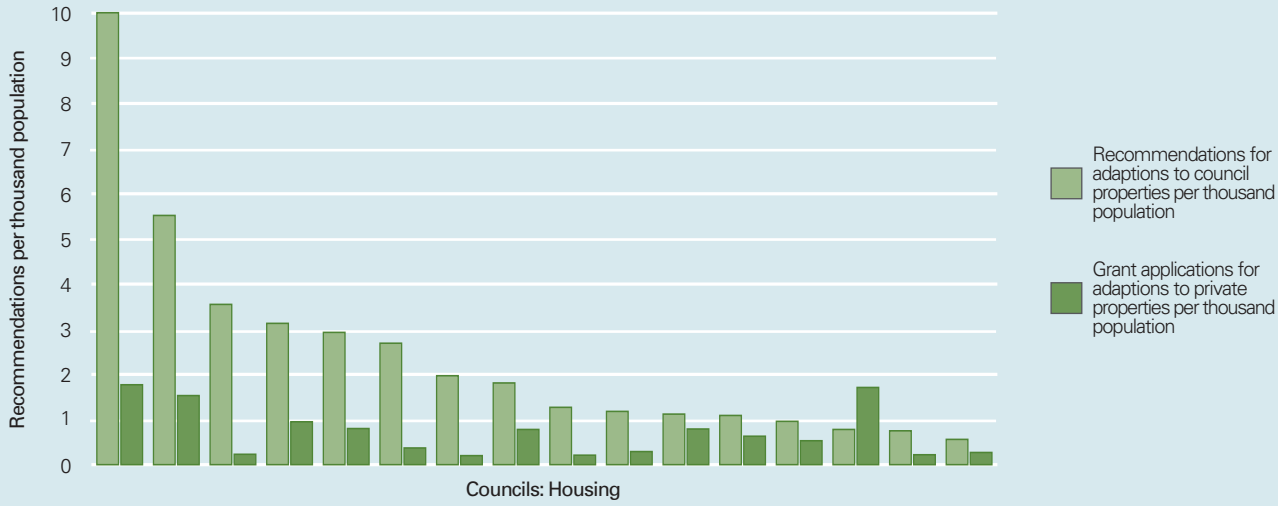
Base: 29 Housing services.

Source: Audit Scotland

Exhibit 22

Number of recommendations and grant applications for major adaptations, per thousand population, 2001/02

The number of recommendations per thousand population for major adaptations to council properties far exceeds the number of HIG applications received.



Base: Councils that could provide both the number of recommendations for adaptations to council properties and grant applications (n = 16).

Source: Audit Scotland

to benchmark their performance with others and slows progress towards integrated services that provide seamless care for users.

4.32 None of the NHS trusts and only six councils publish any service standards in relation to community equipment and adaptations. Only four councils publish information about how they perform against standards.

4.33 Failing to monitor performance can have a detrimental effect on people using these services. For example, waiting times and waiting lists are widely acknowledged as key problems with community equipment and, particularly, adaptation services.[65] Although no time limits are specified in legislation, waiting can have a significant impact on service users' quality of life. There is also a legal expectation that a duty will be performed within a reasonable time period, without undue delay.[66] Waiting times need to be carefully monitored, managed and challenged, not just accepted as a defining characteristic of the service.[67]

"The thing is when your child has a degenerative, life-limiting condition, you can't wait. […] If you need a piece of equipment you need it now. After six months or a year you don't need it anymore."

(Group 5)

"Your illness is getting worse, so you're sort of getting depressed in a sense that you can't get the things that are going to help you. You're in a bad enough situation because you're ill."

(Group 3)

Key stages of the care journey are not systematically recorded

4.34 Some of the key stages of the community equipment and adaptations care journey are:

- referral to a service
- the allocation of cases to staff
- assessment of needs, including a decision of what is to be done
- the allocation of funding
- delivery and installation.

4.35 By recording these key stages, service managers can ensure that:

- key elements of the service are undertaken
- key stages are completed within a reasonable timescale
- problem areas in both individual cases and the service as a whole are easily identifiable (for example, if waiting times are increasing or if there is a maintenance backlog)
- performance is measured across the community equipment and adaptations service
- risk exposure for both service providers and users is reduced.

4.36 To be an effective management tool, information systems need to be capable of collating information to provide performance reports, in addition to the individual case reports required by frontline staff. We found an over reliance on recording information manually in individual case files (Exhibit 24). This allows for the management of individual cases, but it does not allow managers to see the overall picture of what is happening across the service. Information needs to be recorded in electronic format, and collated and reported to service managers on a regular basis to ensure appropriate action is taken where necessary.

4.37 Although some councils and NHS trusts do record information electronically, the limitations of their systems mean it is not always possible to collate this in a useable format. And while many service providers record key dates in the user journey, this is rarely used to monitor performance formally.

Limited use is made of targets for performance improvement

Targets in the NHS

4.38 Few NHS trusts routinely measure any key aspects of community equipment services:

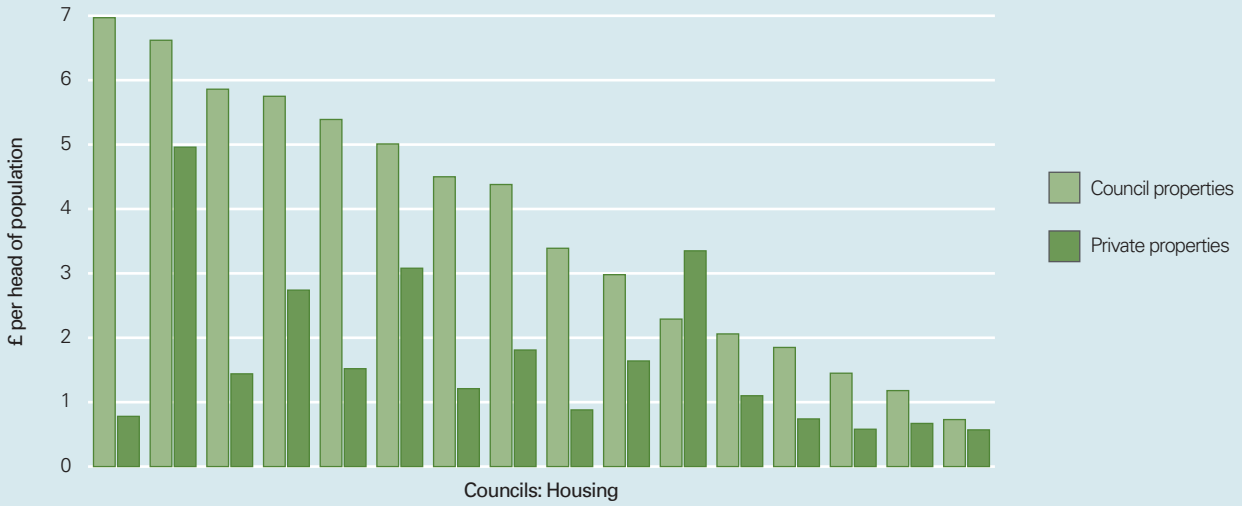
- Nearly a third of PCTs reported having a target timescale for delivery of equipment, but in most cases this did not cover the whole patient journey from assessment to delivery. None of the acute trusts have an assessment to delivery target.
- Only around a third of trusts (five PCTs and one acute) have targets in place for delivering community equipment in emergency cases, all with delivery within 24 hours (including one PCT where delivery is within four hours).
- Only five NHS trusts (four PCTs and one acute trust) and their council partners have a target for the time between an assessment by trust staff and delivery/installation by the council. In most cases, this is linked to the prioritisation systems in place within the relevant council.

65 *Ibid.*
66 *Using the law to develop and improve equipment and adaptation provision*, Mandelstam M, 2003.
67 MacGregor v South Lanarkshire Council, Court of Session, 15 December 2000.

Exhibit 23

Base budget for major adaptations in council and private properties, per head of population, 2001/02

Budgets for major adaptations to council properties exceed those for private properties by an average of three times. Within both types of budget there is significant variation at a local level.



Base: Councils able to provide base budget information for both council and private properties (n=16)

Source: Audit Scotland

Exhibit 24

Information recording practices, council services and NHS trusts (%)

Key stages in a user's journey are not being recorded electronically, especially in the NHS.

	Social work		Housing		PCT		Acute	
	% record		% record		% record		% record	
Stage of process	**At all**	**Electron-ically**	**At all**	**Electron-ically**	**At all**	**Electron-ically**	**At all**	**Electron-ically**
Receipt of referral/ recommendation	96	89	79	52	100	54	86	0
Allocation of referral/ recommendation	89	86	66	45	N/a	N/a	N/a	N/a
Assessment of client	82	71	55	34	69	23	100	0
Notification of outcome of assessment to client	54	18	55	17	38	0	57	0
Allocation of funding	82	43	76	48	31	15	0	0
Delivery of equipment/ installation of adaptation	89	61	72	45	92	54	71	0

Base: Social Work, 28; Housing, 29; PCT, 13; and Acute, 7.

Source: Audit Scotland

Targets in councils

4.39 While performance monitoring within councils is more developed than in the NHS, use of formal targets for measuring the key stages of a person's care 'journey' is limited and unsystematic – some councils with targets do not collect the relevant information to measure performance against these targets.

4.40 Most councils have targets for the time between receipt of a referral for community equipment and adaptations and carrying out an assessment (15), and for providing equipment and minor (but not major) adaptations in emergencies (19). Only a minority of councils have targets for other key aspects of the journey, for example, from assessment to delivery or installation (Exhibit 25).

4.41 Some councils have specific targets from when the store receives a request to delivery of equipment. But from the perspective of the user, what is important is the time taken from when they are first involved with the service until they get the equipment or adaptation they need. Therefore, although the service manager requires targets to be broken down for each key stage of the care journey, to help identify bottlenecks in the system (such as at the funding stage) and ensure continuous improvement, there should also be a 'whole process' target.

4.42 Among the councils with local performance targets in place there is little evidence of consistency, with the exception of the provision of equipment and minor adaptations in emergency cases, where the target is 24 hours in most councils, rising to a maximum of five days (Exhibit 26).

4.43 In about a third of social work services, local performance targets are linked to prioritisation systems for managing workloads, but there is variation in the target times set (Exhibit 27 page 46). Because of the volume of cases low-priority cases can often have significant delays.

Waiting for services

4.44 Although most councils monitor waiting times for community equipment and minor adaptations, few have information systems capable of producing specific, accurate waiting list and time information (such as long-term trend information). For 2001/02:

- only five councils could provide combined average waiting times from referral to assessment for community equipment and minor adaptations
- only two could provide this for assessment to delivery/installation
- only five could provide information for receipt of recommendation to installation for major adaptations in both council and private properties.

4.45 Of the councils able to provide information on equipment and minor adaptations, we found the average waiting time between referral and assessment was 88 calendar days, or over three months. From assessment to a delivery or installation, the two councils reported average waiting times of 23 calendar days and 56 calendar days.

"I'm supposed to be getting a new chair […] and a new stool […] for in the kitchen, so that I can do things in the kitchen. When all this is supposed to be going off I have no idea. I'm fed up waiting."

(Group 3)

4.46 Of the five councils able to provide information for major adaptations to council and private properties, the average waiting time from receipt of recommendation to installation was 93 calendar days for council properties and 226 calendar days for private properties. The average waiting time for major adaptations to private properties was at least twice as long as for council properties in four out of the five councils.

"I'm still waiting for my wet floor shower and I've been waiting for ages and ages […] and I've not had a bath since I moved, or a shower since I moved into that place [9 months ago]."

(Group 4)

4.47 Although community equipment and adaptations can play a vital role in preventing delayed discharge from hospital, none of the acute NHS trusts could provide the information we asked for on waiting lists and times for patients requiring equipment to help them return to their own homes. Similarly, none of the PCTs could provide any waiting time information in relation to this. However, we found a general perception among users that service provision was relatively quick when leaving hospital.

"They […] wouldn't let him home until things were in place. It was very quick because it was desperately needed."

(Group 1)

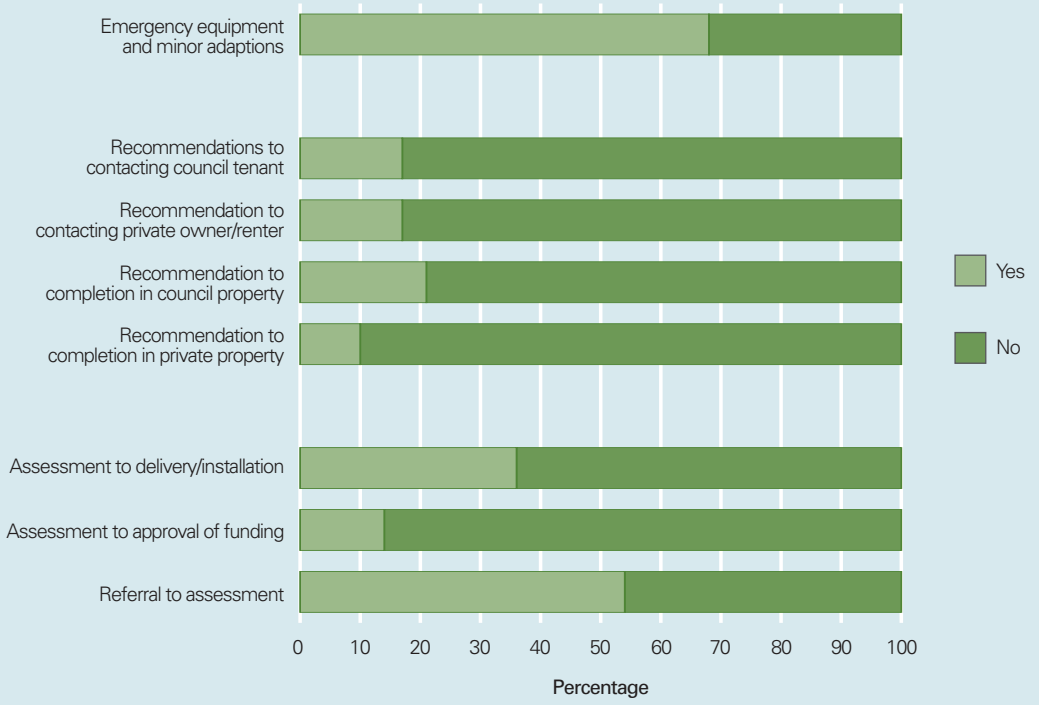
Measuring customer satisfaction

4.48 Customer satisfaction surveys are a useful way of gauging whether service providers are doing the right things and doing them well, and for identifying areas for improvement. Yet only around two-fifths of councils and a third of NHS trusts undertake customer satisfaction surveys relating to any aspect of their community equipment and/or adaptations service. Furthermore, only half of trusts and a third of social work services conducting these surveys publish the results (Exhibit 28 page 47).

Exhibit 25

Councils with targets for key stages of the care journey (%)

Although previous research has shown that delays are "particularly concentrated around the funding stage",[68] only four social work services have a target for the time in which approval for funding should be gained after assessment.



Base: Social Work, 28, Housing, 29.

Source: Audit Scotland

Exhibit 26

Summary of range of local performance targets in councils

A wide range of targets is in use.

Target	Minimum (in days)	Maximum (in days)
Receipt of referral by the social work service to assessment	1	60
Assessment to allocation of funding for equipment or minor adaptations	1	60
Assessment to delivery/installation for equipment and minor adaptations	0.5	20
Receipt of recommendation by housing to contacting tenant/owner	5	30
Receipt of recommendation by housing to installation in council property	30	120
Receipt of recommendation by housing to installation in private property	40	240

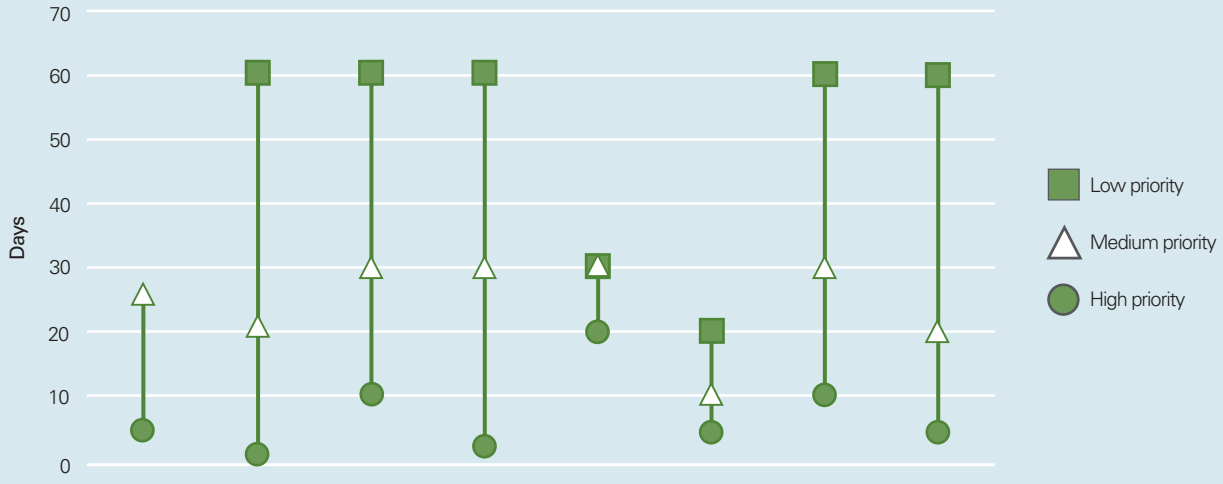
Source: Audit Scotland

68 *Equipment and Adaptations Services in Scotland: A Survey of Waiting Times for Social Work Provision*, Scottish Executive Central Research Unit, 2001.

Exhibit 27

Range in targets for time between receipt of referral and assessment by social work services according to different priority categories

The target for high-priority cases ranges from one day to as much as 20 days. There is wide variation across authorities in the targets set, especially in relation to high and low-priority clients.



Base: Social Work, 8.

Source: Audit Scotland

Good practice example 8

Fast-track procedures in Fife

Fife Council initially introduced its fast-track procedures as a means of tackling long waiting lists. First, a review of outstanding referrals was undertaken to determine which referrals were for OTs or OT assistants and for what types of equipment. This review concluded that OT assistants could provide a fast-track system for simple medical or social needs, such as bathing referrals. Second, a competency based training package was developed and, after training, a team of seven fast-track staff rotated around the area offices.

The following improvements have been reported:

- development of prioritisation of referrals
- 70% reduction in waiting list for simple assessments
- development of a flexible service that can be targeted at waiting lists.

The key to the success of this initiative is collecting the right information at the point of referral so that people are ordered according to priority.

Source: Fife Council

Exhibit 28

Customer satisfaction surveys, by service provider (%)

Most service providers do not conduct customer satisfaction surveys. Even among those that do survey users' views, some do not analyse, report or publish the information.

	Conduct surveys	Analyse results	Report results	Publish results
Social work	39%	32%	25%	14%
Housing	38%	28%	28%	17%
PCT	38%	38%	38%	23%
Acute	14%	14%	14%	0%

Base: Social Work, 28; Housing; 29; PCT, 13; and Acute, 7.

Source: Audit Scotland

4.49 Our user survey and focus groups highlight that despite concerns about choice and waiting times for example, overall levels of satisfaction are high. Almost three-quarters of respondents with, or caring for someone with, a frailty, illness, health problem or disability, were either very or fairly satisfied with the overall service they received. High levels of satisfaction are likely to reflect the huge impact that community equipment and adaptations have on a person's quality of life.

"You're happy when you get it."
(Group 2)

4.50 Most respondents who had received community equipment and adaptations from either the council or NHS, felt that their needs were met – 49% felt their needs were fully met and only 7% felt their needs had not been met at all.

"Life wouldn't be very nice [without these services], would it?"
(Group 3)

4.51 Users in our focus groups were particularly positive about the individual members of staff with whom they had been involved. Criticisms revolved around the system rather than the staff involved.

Joint development of performance indicators to measure continuous improvement

4.52 To help ensure best value in community equipment and adaptation services, it would be useful for councils and their health partners to agree on a suite of performance indicators for their local joint performance management frameworks. Agreeing these more widely with other partnerships would enable benchmarking to take place. However, before this can be achieved, there needs to be an agreed and consistent approach to:

- definitions of the key stages in community equipment and adaptation service (such as what is a case, referral, assessment)
- information recording practices, including what and how information is recorded
- management information requirements, such as what reports electronic information systems should be able to easily generate.

Useful performance indicators for these services are outlined in Appendix 6.

The complexities of community equipment and adaptations means that performance indicators will need to be interpreted alongside contextual information.

Good practice example 9

Assessing professional users' views in West Lothian

In addition to a telephone survey of users, West Lothian's joint community equipment store also surveys the views of professional users of their service (such as OTs, social workers and district nurses). The self-completion survey asks professional users from both the health and social care sectors about:

- store staff performance
- awareness of facilities at the joint store (such as the demonstration room people can use for their clients to try out equipment)
- awareness of the emergency stock facility
- the adequacy of procedures for accessing stock.

The information gathered through this survey allows the store to assess whether they are meeting the professional users' needs, whether they are using the store to its full potential and, if necessary, to make improvements to the service offered by the store.

Source: West Lothian Equipment Service

Recommendations

Councils and NHS bodies should:

- Jointly review budgets for community equipment and adaptations and HIGs to ensure that they are set at a realistic level to meet need.
- Monitor the performance on equipment and adaptation services by collecting and using robust management information on:
  - cost
  - activity, including waiting times
  - quality of services, including users' views.
- Record and monitor activity and expenditure associated with third parties, such as Care and Repair, RSLs and voluntary organisations, as changes in these areas are likely to impact significantly on future service delivery and resourcing.
- Develop joint performance indicators so that the service can be evaluated across a partnership area.
- Once trend information is available, benchmark with other partnerships using like-for-like performance measures to drive forward continuous improvement.

Councils and RSLs should:

- Work together to assess need for major adaptations in the future.

Part 5. Managing risks

Main findings

- Most councils and NHS bodies demonstrate how to use equipment and adaptations. But less than half provide written instructions on use to supplement these demonstrations.
- There is a general lack of formal policies and procedures covering the recall of faulty equipment; maintenance and repair arrangements; and recycling, including infection control procedures.
- Users have identified a lack of clarity about who is responsible for the repair and maintenance of equipment.
- Recycling is often not monitored and targets are rarely set.
- While nearly all social work providers of community equipment and adaptations carry out follow-up visits to ensure that what has been issued meets users' needs, such visits are less common by NHS staff.

Managing risks is important to safeguard providers and users

5.1 There are risks associated with using equipment and adaptations incorrectly or failing to maintain and repair faulty equipment. Formal policies and procedures are essential, therefore, to ensure that there is compliance with health and safety legislation and that:

- people know how to use equipment and adaptations
- equipment and adaptations are properly maintained and repaired
- equipment can be recalled quickly if faulty
- the recycling of equipment is managed safely and efficiently.

5.2 Many councils and NHS trusts have informal, unwritten policies and procedures. Reliance on word of mouth and individual good practice poses risks for staff and users alike and is unlikely to work where a number of agencies need to work together to provide the service.

Users are not always given written information about how to use their equipment or adaptation

5.3 Users should be provided with written information on the use of equipment and adaptations and should always be shown how they work. Our discussions with users highlighted the importance of such demonstrations – even for relatively simple items.

"[I] got a toilet seat [...] and the first time I sat on it I fell off and the seat fell off as well. So I 'phoned them and told them they could take it away."

Moderator: Had anybody come to show you how to use it?

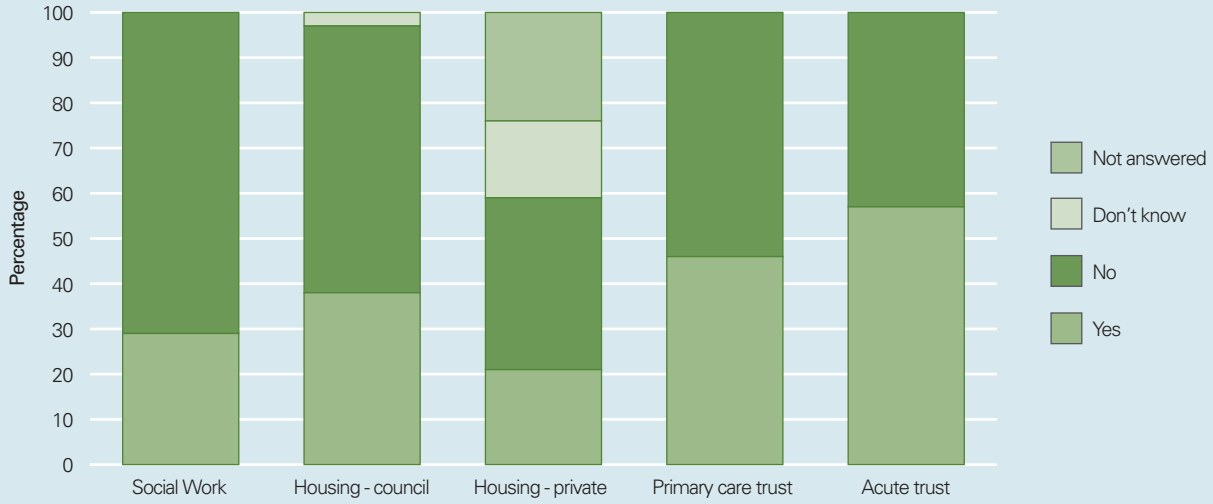
"No. My nephew went and bought me a new one and put it on."

(Group 4)

Exhibit 29

Whether councils and NHS trusts provide written instructions on how to use community equipment and adaptations

Less than half of all providers routinely provide written information to supplement verbal instructions.



Base: Social Work, 28; Housing, 29, PCTs, 13, and Acute, 7

Source: Audit Scotland

Written information is not always given

5.4 Overall less than half of providers routinely provide written instructions on how to use equipment or adaptations (Exhibit 29). Users least likely to receive any information are those who receive adaptations through the HIGs. This is because some councils consider private sector adaptations funded through the HIG scheme to no longer be the responsibility of the council once the grant has been awarded, even though the duty of care for the disabled person rests with the council.

Most providers demonstrate how to use equipment and adaptations

5.5 Demonstrating equipment is an essential part of ensuring that equipment is appropriate to meet a person's needs and that it is used safely. Most providers demonstrate how to use equipment and adaptations although people in receipt of an HIG are least likely to be given a demonstration (Exhibit 30).

5.6 We created a 'delivery and demonstration score', based on ten selected 'good practice' activities providing:

1. Verbal instructions on how to use equipment/adaptations.
2. Written instructions on how to use equipment/adaptations.
3. Verbal instructions on how to maintain equipment/adaptations.
4. Written instructions on how to maintain equipment/adaptations.
5. A written explanation of responsibilities regarding maintenance of equipment.
6. A demonstration of the equipment/adaptation.
7. A demonstration of the equipment/adaptation by qualified OT staff.
8. Contact details.
9. Details of how to return equipment.
10. An emergency telephone contact number in case the equipment/adaptation fails.

5.7 Social work services and acute NHS trusts have the highest average delivery and demonstration score, at 7, compared with an average score of 6 for PCTs, 5.5 for housing services dealing with council tenants and only 4 for private sector tenants and owner-occupiers. But among all providers there is significant variation (Exhibit 31 page 52).

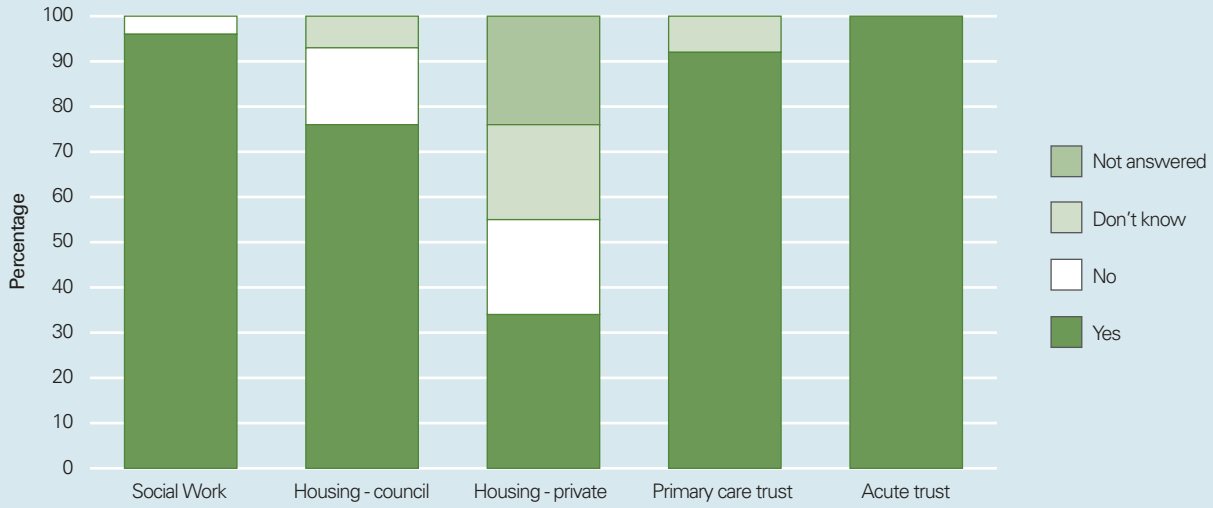
Information and support for users about the major adaptations process is particularly limited

5.8 The need for an adaptation is based on an assessment of need due to a disability, yet the different funding streams mean that people with the same need may receive a different service depending on their tenancy status. Council tenants receive a more comprehensive service than people living in private sector homes. As major adaptations to owner-occupied and private rented properties are carried out under the discretionary HIG scheme, some councils end their involvement in the process once the grant has been awarded, although some people may receive support from their council or

Exhibit 30

Whether councils and NHS trusts always demonstrate the equipment and adaptations they provide

Most providers demonstrate how to use equipment and adaptations provided.



Base: Social Work, 28; Housing, 29, PCTs, 13, and Acute, 7.

Source: Audit Scotland

Good practice example 10

Demonstrating equipment and adaptations in North Ayrshire

North Ayrshire Council operates the Eglinton Disability Centre in the grounds of Ayrshire Central Hospital, Irvine. The Centre has rooms designed to show equipment in the home setting, such as an adapted kitchen and bathroom, and stairlifts attached to staircases. There is also an information and resource facility in the Centre that helps members of the public obtain information about relevant services. People can make an appointment to view and try out equipment, and both social work and health OTs can assess people at the Centre while they are using the equipment.

The main benefits of the Centre are that it:

- enables staff to conduct comprehensive assessments while people are carrying out daily activities (eg, getting into the bath) and using different types of equipment
- gives people the opportunity to view and try out equipment
- reduces risk by ensuring people know how to use the equipment properly before it is provided. This is particularly important for equipment that has a potential risk factor if not used correctly – such as stairlifts
- provides a space for social work and health staff to come together when undertaking assessments and accessing small items of equipment held in stock
- encourages links between health and social work staff. NHS staff can access social work equipment.

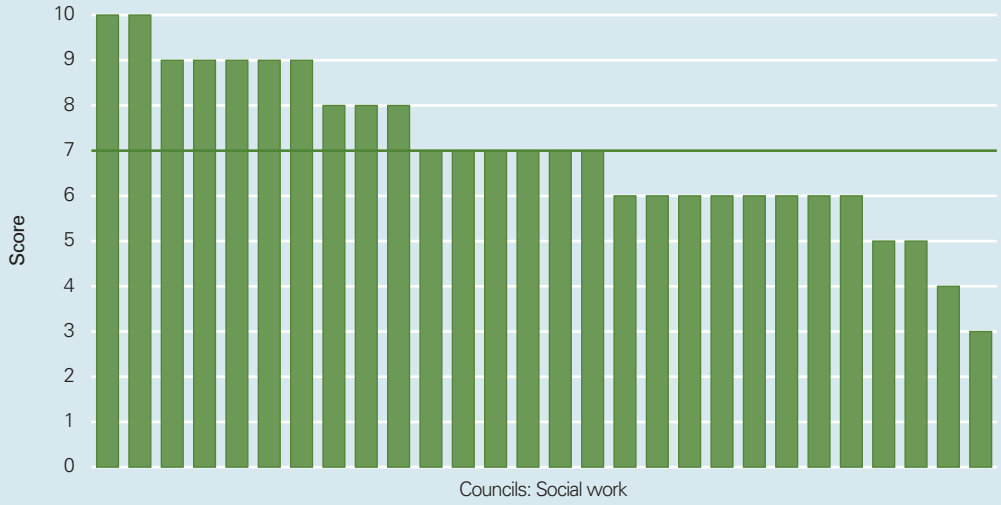
The Council feels the one disadvantage of the Centre is its static nature, and there is a need for a more mobile service to reach outlying areas and people who cannot travel to the Centre.

Source: North Ayrshire Council

Exhibit 31

Delivery and demonstration scores, by type of provider (n)

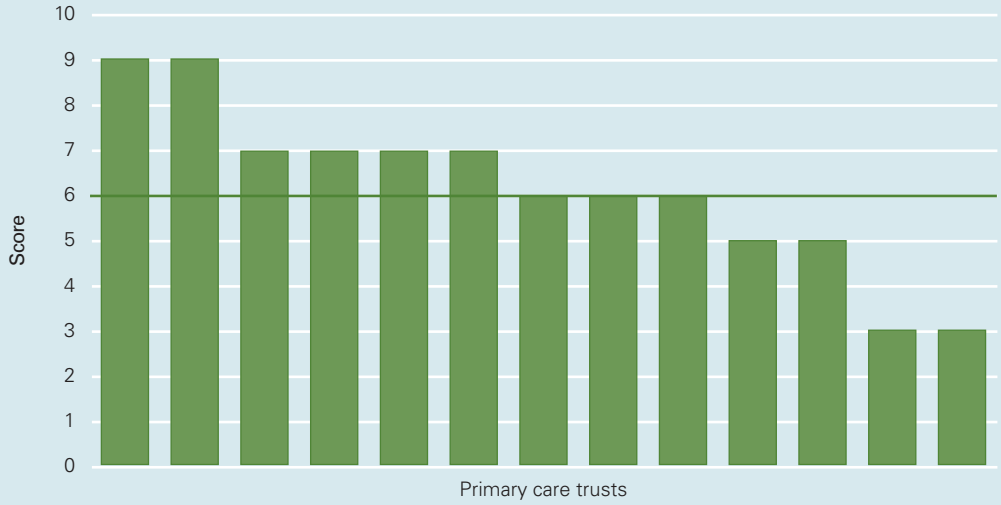
Most providers demonstrate how to use equipment and adaptations provided.

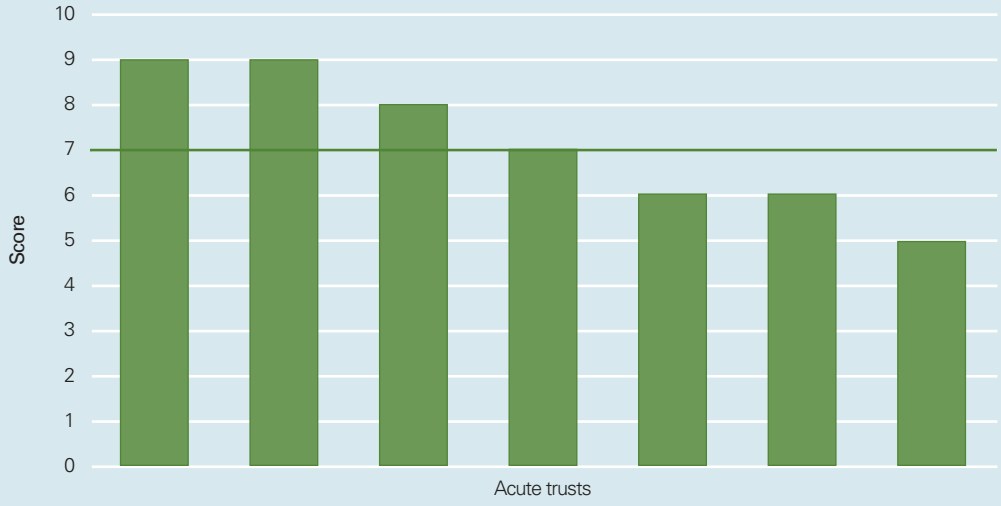


Councils: Social work

Councils: Housing, for council housing clients

Councils: Housing, for private tenants and owner-occupiers





Source: Audit Scotland

Care and Repair. However, this means that some people with disabilities, many of whom may be vulnerable, could be left to find their own way through the adaptations maze (Exhibit 6 page 19) – employing their own architects and builders, for example – whereas people in council properties have everything done for them.

5.9 Some councils inspect adaptations installed under the HIG scheme to ensure the work is of an agreed quality and only then is the money released.

"We had an awful lot of trouble… he came in and dug up the foundations and left it for a fortnight. So they were running about a mucky place for a fortnight. He kept coming for a wee bit… I mean you never knew when he was going to come. For the bedroom, I think it took him about a year to build. It took so long, and quite honestly, I don't think he's built it right."
(Group 1)

5.10 The small number of private, major adaptations' clients we spoke to felt it was difficult to manage a building project without support or advice. They felt there was a lack of information to help guide them through the process, for example, how to find a reliable tradesperson to carry out the work. They also expressed concerns about the lack of control over the quality of the end product. In one case the contractors walked out before completing the task, leaving the partially built extension structurally unsound.

"When I applied for my extension, the [council] said to me that they can't recommend an engineer and they can't recommend an architect or a builder. I look at it as if they had recommended an architect to me, or a builder, I wouldn't be thousands of pounds in debt… but these are the rules and they can't break them."
(Group 5)

Risks may arise where equipment and adaptations are not properly and regularly maintained

5.11 Community equipment and adaptations are subject to health and safety legislation;[67] for example, staff need training in using equipment such as hoists. Some equipment manufacturers recommend specific maintenance intervals for items such as hoists and slings. Information systems can prompt staff to carry out tasks at the required time – for example, alerting staff to when a maintenance check is due. This not only protects the user, but also acts as a risk management tool for the service provider.

5.12 Unless equipment and adaptations are properly and regularly maintained, they can pose serious risks to users and carers. Repairs and maintenance, particularly of stairlifts, was one of the most significant concerns raised by the users participating in our study. The experiences of some of the people we spoke to showed that the impact of poor repair and maintenance procedures can be serious; for example, being unable to go upstairs or have a bath, or the risk of injury to carers.

5.13 Many users were confused about whether they or the provider (which was often unknown to them) was responsible for maintenance. This was not surprising given that relatively few providers provide written information on maintenance arrangements (Exhibit 32). Many users were also concerned about the hidden costs of maintenance, the apparent lack of fairness with some people having to pay for maintenance whilst others do not, and the waiting times for repairs and maintenance.

5.14 Despite guidance recommending that regular maintenance checks are made for some items of equipment, our discussions with users suggest that this does not always happen.

Electronic systems can help track and locate stock but these are not always in place

5.15 Effective repair and maintenance procedures require good procedures for tracking and locating stock. A significant number of providers do not have computerised stock control systems which can track and locate items they issue (Exhibit 33). Manual stock systems that do not allow for all equipment to be quickly and easily located expose both the user and service provider to risks in cases where faulty equipment needs to be recalled or maintenance programmes need to be planned. Electronic systems can also contribute to costs savings through facilitating 'just in time' ordering, and effective recall and recycling procedures.

5.16 Bar-coding of equipment is an effective risk management mechanism and facilitates stock control, recycling and repair and maintenance procedures. Yet only four social work services and four PCTs bar-code their community equipment. None of the acute trusts do so.

Staff do not always know how to recall faulty equipment

5.17 At the time of our audit a number of separate notices were issued about faulty equipment – Medical Device Alerts, NHS Hazard Notices and NHS Safety Action Notices. The Medicines and Healthcare products Regulatory Agency (MHRA)[68] issues

67 For example: Health and Safety at Work Act 1974; Lifting Operations and Lifting Equipment Regulations 1999 (LOLER); and Provision and Use of Work Equipment Regulations 1998 (PUWER).
68 Previously known as the Medical Devices Agency (MDA).

Exhibit 32

Number and percentage of councils and NHS trusts giving verbal and written instructions about maintenance

Not all service providers give verbal instructions about how to maintain equipment/adaptations.

	Council services						NHS trusts			
	Social Work		Housing council		Housing private		Primary Care		Acute	
Give verbal instructions on …	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
…how to maintain equipment/adaptation	25	89	20	69	11	38	9	69	5	71
Give written instructions on….										
…how to maintain equipment/adaptation	11	39	4	14	4	14	4	31	4	57
…who is responsible for maintenance	12	43	5	17	6	21	2	15	3	43

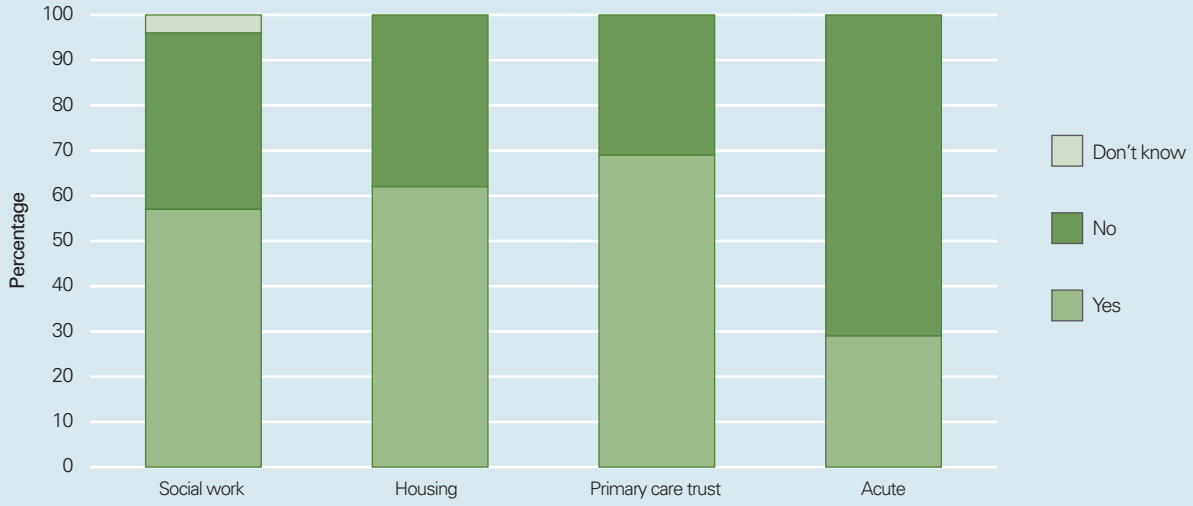
Base: Social Work, 28; Housing, 29; PCT, 13; and Acute 7.

Source: Audit Scotland

Exhibit 33

Percentage of providers with computer systems in place to locate and check all stock (%)

Many providers are relying on manual systems for stock control.



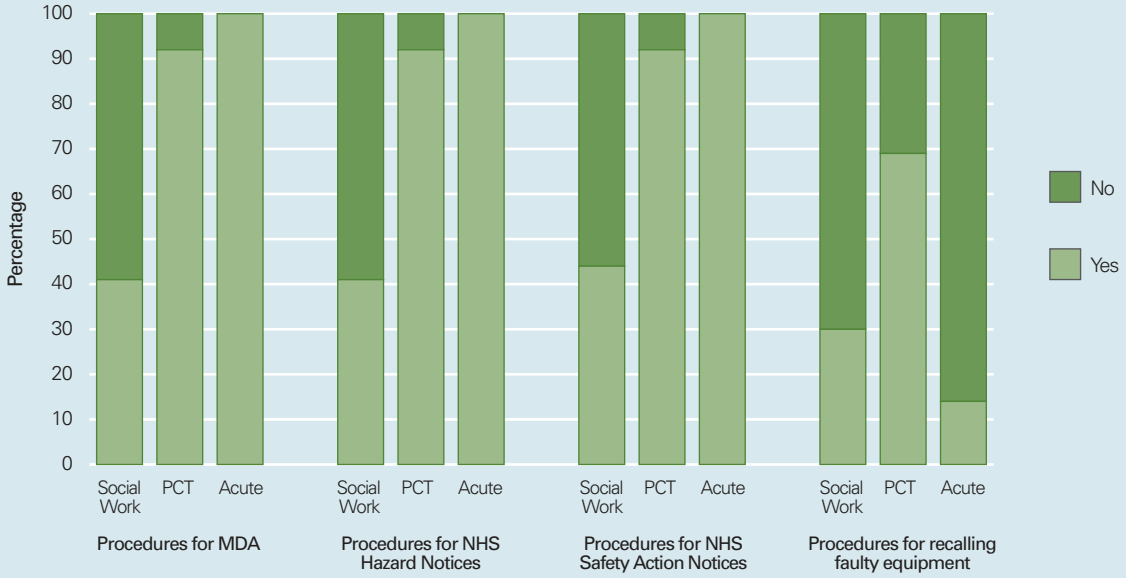
Base: Social Work, 28; Housing, 29; PCT, 13; and Acute, 7.

Source: Audit Scotland

Exhibit 34

Percentage of organisations with procedures in place for dealing with equipment faults

Most NHS trusts have procedures in place for dealing with MDA and NHS notices about equipment faults, but only a minority of social work services do so.



Base: Social Work, 27;[69] PCTs, 13, and Acute, 7.

Source: Audit Scotland

Medical Device Alerts under contract to the NHS, and NHS guidance states that these notices should be *"brought promptly to the attention of appropriate managers, staff and users of equipment."*[70] In Scotland these are distributed to the NHS but not to councils, despite the fact that many alerts are of relevance to social care providers – this should be addressed by the Scottish Executive.

5.18 For such alerts to be effective, councils and NHS bodies should have mechanisms in place for dealing with these notices and for recalling equipment. If not, the safety of users, carers and staff could be at risk and the provider may be subject to negligence claims.

5.19 All but one NHS trust has clear procedures for dealing with these notices, but only half (9 PCTs and one acute trust) have written procedures in place to recall equipment that has already been issued. Less than half of social work services have clear procedures in place to deal with MDA Device Alerts, NHS Hazard Notices and NHS Safety Action Notices; and even fewer (8) have written procedures in place to recall faulty equipment (Exhibit 34). This means that staff are not always aware of how to recall faulty equipment.

5.20 All equipment providers, except two social work services and one PCT, provide users with contact information, detailing how to make an enquiry or complaint and explaining how to return equipment.

Recycling of equipment and adaptations varies widely and could be better

5.21 Recycling appropriate items can contribute to cost savings and reduce waiting times, although not all items are suitable for recycling because of hygiene concerns or low cost equipment being cheaper to replace rather than recycle. While most councils and health bodies do recycle some equipment and adaptation components, most do not have a written recycling policy detailing, for example, what items should and should not be recycled; how they should be recycled; or what proportion of equipment should be recycled (Exhibit 35). In some areas, the decision about what to recycle is made on an *ad hoc* basis by equipment store staff.

5.22 Of those providers that do record and monitor recycling, there is significant variation in the proportion of equipment recycled. For example, the recycling rates for the seven social work services providing information ranged from 16% to 100% for shower chairs, and from 17% to 75% for stairlifts. The overall recycling rates for equipment issued for use in the community among the seven NHS PCTs ranged from 34% to 86%. This variation suggests that there is scope to increase overall recycling rates across Scotland.

69 One social work service did not respond to this question.
70 Circular NHS MEL [1995] 74. *Reporting of Adverse Incidents and Defective Equipment*, The Scottish Office.

Exhibit 35

Whether service providers have written recycling policies (n and %)

Most service providers do not have a formal, written recycling policy.

Service Provider	Has written policy		No written policy	
Council	**(n)**	**%**	**(n)**	**%**
Social work	4	14	24	8
Housing – items	4	14	25	86
Housing – properties	9	31	20	69
NHS				
Acute	0	0	7	100
Primary care	6	46	7	54

Source: Audit Scotland, 2003

Good practice example 11

Maintenance and recall/return of equipment in Highland

East Highland Equipment Loan Service – which is a partner organisation of Highland Council and Highland Primary Care NHS Trust – issues a letter to the user with each item of equipment it delivers. The letter states that:

- users should contact the service if a fault appears, and the appropriate contact details are also provided
- the service will recall electrical equipment within six to twelve months of delivery for a service check. It states that the user does not need to do anything about this as the service will contact them at the appropriate time and provide replacement equipment
- users should notify the equipment service if they move house or move away from the area and would like to take their equipment with them
- users need to return the equipment at the end of its loan period. This is done by contacting the service who then arrange for it to be uplifted. Services users are encouraged to wipe down the equipment prior to collection.

Service and maintenance contracts are being reviewed in light of Lifting Operations and Lifting Equipment (LOLER) Regulations 1998 to determine an appropriate fixed interval for maintenance. It is likely this interval will be fixed at six months.

Source: Highland Council

5.23 Only two social work services could provide the cost of recycling in 2001/02 – £204,771 and £19,148, representing 7% and less than 1% respectively of their total expenditure on community equipment and adaptation services.

5.24 It is difficult to benchmark overall recycling rates as these are dependent on the types of equipment issued, demand levels for certain types of equipment and the types of equipment deemed non-recyclable. Whilst it would be possible to ensure consistency in the latter through the issue of national guidance, the other factors are likely to ensure that recycling rates vary to some extent. Nevertheless, it is possible to set target recycling rates for individual types of equipment, especially high cost items such as stairlifts. None of the acute trusts, and only four social work services and three PCTs in Scotland have a recycling target for equipment. These range from 30% to 40%.

Recycling major adaptations

5.25 Recycling of 'major, permanent' adaptations can take two forms:

- recycling individual items, for example, through removing a through-floor lift and reusing it in another property
- 'recycling' properties, by trying to match people with disabilities to already adapted properties.

5.26 Some councils argue that the permanent nature of these adaptations means recycling of individual items is not possible, but four councils do have a written policy in relation to this form of recycling. However, this practice may not be cost-effective. Almost all councils (24) recycle adapted properties but only nine have a written policy relating to this. Only one council has a target time for this process – six weeks from the date of becoming void to the date of re-letting the property.

5.27 Most councils (19) have a register that records details of adapted properties. A minority (10) of councils include details of both private and council adaptations in their registers. While eight record only council property adaptations, one council records only private property adaptations. Most registers record the date of installation (15) and the type and cost of adaptation installed (16 and 15 respectively). The Housing (Scotland) Act 2001 states that all local housing strategies (required by all councils) must assess the need for and availability of accommodation designed or adapted for people with special needs. We found only three councils could tell us what proportion of their housing stock was adapted.

Ways to increase recycling

5.28 Good stock control systems are needed to support efficient recycling, but as we have already noted these are not in place in many councils and NHS bodies.

5.29 When equipment or an adaptation is no longer required, or the loan period has expired, it should be returned to the provider. This often does not happen because the user is not aware of this or they simply forget to do it, or the service provider does not or cannot 'chase' it. In these circumstances the equipment is simply 'lost'.

"People throw out what they've been given […] instead of returning it […]. It's not fair on other people that are waiting on that, that's the way I look at it, that are waiting on things happening."

(Group 4)

5.30 Nearly all councils and NHS trusts provide details of how to return equipment and offer a pick-up service. However, there are also other procedures that could encourage recycling, such as:

- a freephone telephone number
- an estimated recall or return date.

But these are relatively uncommon: no councils and only one NHS trust has a freephone number and only half of NHS trusts and a third of social work services provide people with an estimated return or recall date. Some service providers run *ad hoc* equipment amnesties to encourage people to return equipment no longer required.

5.31 Our discussions with users found that most people have some idea of who they might contact should they wish to return equipment. However, bearing in mind the confusion around who provides the equipment in the first place, there is no guarantee that they will return it to the correct provider. Users reported mixed experiences of returning equipment and adaptations – some requests for uplifts were dealt with quickly, whereas for others it required repeated telephone calls and a lengthy wait.

"I left [my bath seat] at the front for somebody to pick up. It was there for weeks and weeks."

"These things are lying there and I've asked ever so many people where they should go, and they don't know. I'll gladly get rid of them."

(Group 4)

Users also felt that they should have a say about when equipment should be collected.

Good infection control procedures can assist recycling

5.32 If equipment and adaptation components are to be recycled then there needs to be good infection

Good practice example 12

Written guidelines for infection control of community equipment in Comhairle nan Eilean Siar

Comhairle nan Eilean Siar has written guidelines for staff which detail:

- what cleaning products (detergent, disinfectant, bacterial agent and alcohol hand agent) to use
- how to avoid contamination (such as which areas to use for cleaning, the covering of cuts with waterproof dressings, the wearing of goggles and protective clothing, the removal of all labels from equipment)
- what to do when collecting equipment from a user's home (including instructions on the storage of equipment in designated areas of the vehicle, what cleaning should be carried in the vehicle (eg, disposable gloves, waterproof dressings, 70% alcohol hand gel, plastic bags of various sizes, clear sealing tape and a bin lined with a clinical waste bag)
- an explanation of the need to return to the depot and unload the equipment as soon as possible
- how to store clean equipment and where to place 'dirty' stock
- how to clean the cleaning facility
- infection control training to be undertaken by all cleaning staff
- the requirement for annual audits of the cleaning protocols.

This initial work has now been revised and has been central to the design of a new Community Equipment Store. It will also guide the operation of a new, integrated Community Equipment Service throughout the islands.

Source: Guidelines for disinfection of OT equipment used in the community, Comhairle nan Eilean Siar, October 2002

control systems. These help prevent cross-contamination of equipment, and maintain the safety and longevity of equipment and adaptations.

5.33 All NHS trusts and all but one council transport used and soiled community equipment in the same vehicles as new and unused equipment. But most take measures to prevent cross-contamination between the two types of equipment, such as using segregated areas and placing all used equipment in sealed bags. However, four NHS trusts and three councils do not take any such measures.

"I got this commode from the government – you've never seen anything like it. I wouldn't have had it in my house for five minutes...[it was] minging."

(Group 3)

5.34 Some service providers have special uplift services for equipment that may be severely contaminated, for example, with HIV or hepatitis. There is evidence of equipment being collected by staff in their own cars during their community delivery rounds and while this may be a cheap way of delivering and uplifting equipment, it does raise health and safety concerns. Delivery vehicles should be capable of being cleaned and disinfected – the walls and floors should be impermeable and cleaned and disinfected weekly or when visibly soiled.[71] It is unlikely that this level of infection control is implemented in staff members' own vehicles.

5.35 While most service providers have designated separate storage areas for 'dirty' and 'clean' equipment in each of their storage locations, six councils and three NHS trusts do not.

Almost every council assesses the suitability of what has been provided, but this is less common in the NHS

5.36 While the NHS sometimes issues equipment on a short-term loan basis, equipment and adaptations provided by both councils and the NHS can be issued to a user for many years or permanently. Even within a short space of time however, a person's needs can change significantly or the equipment provided may simply prove unsuitable; for example, it might be uncomfortable or too difficult to use.

"I can't get my legs over the bath anymore [to get on my bath seat], and I've got no handrails, so I can't get into it to sit on the side of the bath […] I'm just having to make do, you know, wash myself down the best way I can."

(Group 3)

5.37 All but one council conduct follow-up visits to assess the suitability of equipment and minor adaptations provided. Most of these visits are carried out within two weeks of delivery or installation. This practice is less common among NHS service providers (Exhibit 36).

"I have an awful job getting into my bed, but they gave me a lift thing. I couldn't work it, so they took it away."

(Group 3)

5.38 Some items of equipment are more likely than others to result in a follow-up visit, and practices vary among service providers. For example, of service providers involved in issuing bath seats, 93% of social work services, 64% of PCTs and 50% of acute trusts reported conducting follow-up visits. Similarly, of those issuing walking equipment, 69% of PCTs conduct follow-up visits, compared with only 17% of acute trusts and 27% of social work services.

5.39 In nearly all councils (23), social work rather than housing staff conduct the follow-up visits to check the suitability of major adaptations. Housing staff undertake follow-up visits in only six councils, and in four of these the visits are joint with social work staff.

Good information is needed to manage risks well

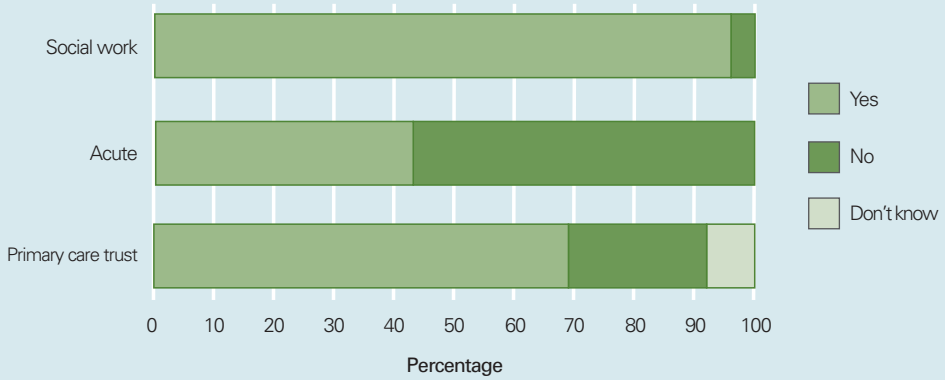
5.40 Managing risks well requires good information about key stages in the process, including areas such as demonstrations; maintenance programmes; reviews; collection and infection control procedures; and recycling. Exhibit 37 outlines the extent to which councils and the NHS in Scotland record these types of risk management information. The lack of electronically recorded information limits the extent to which managers can use it to manage risks.

71 MHRA DB2003(06) Device Bulletin, *Community Equipment Loan Stores – Guidance on Decontamination*, Department of Health, September 2003.

Exhibit 36

Conduct of follow-up visits, by type of service provider (%)

Most social work and PCT staff conduct follow-up reviews, but less than half of acute trusts do so.



Base: Social Work, 27 (as one did not respond); PCTs, 13, and Acute, 7.

Source: Audit Scotland

Exhibit 37

Information recording practices, local authority services and NHS trusts (%)

In general, social work services are better at recording information on the different stages involved in providing equipment and adaptations. But there is room for improvement in all agencies, especially in their use of electronic information systems.

	Housing		Social work		PCT		Acute	
	% record		% record		% record		% record	
Stage of process	**At all**	**Electron-ically**	**At all**	**Electron-ically**	**At all**	**Electron-ically**	**At all**	**Electron-ically**
Demonstration	32	21	75	36	38	0	57	14
Maintenance checks due	46	24	86	54	85	62	0	0
Maintenance checks completed	42	28	86	50	77	54	14	0
Review date due	28	14	64	46	69	31	14	0
Review date completed	28	14	68	46	62	15	14	0
Request for uplift lodged by client	28	21	89	57	85	62	43	0
Collection/uplift completed	25	21	89	54	92	62	43	0
Return of equipment to store	N/a	N/a	75	43	85	62	43	0
Completion of infection control/cleaning process	N/a	N/a	39	14	46	23	29	0

Base: Social Work, 28; Housing, 29; PCT, 13; and Acute, 7.

Source: Audit Scotland

Recommendations

Councils and NHS bodies should:

- Ensure stock control systems are in place to track and locate equipment.
- Ensure that written instructions on using equipment and adaptations are always provided for users and carers, and trained staff always demonstrate their use.
- Consider how best to provide advice and support to people in the private housing market who install major adaptations.
- Agree and implement formal policies and procedures that include:
  - recall of faulty equipment
  - maintenance and repair arrangements
  - recycling, including infection control procedures
  - emergency arrangements.
- Ensure management information systems contribute to the effective management of risk.
- Review user needs once equipment and adaptations have been supplied.

The Scottish Executive should:

- Produce and disseminate national guidelines on decontamination and infection control of community equipment and adaptations.
- Ensure that Medical Device Alerts are issued to Scottish councils as well as to the NHS in Scotland.

Part 6. Summary of recommendations

Part 2. Person-centred services

Councils and NHS bodies should:
Jointly publish comprehensive information on community equipment and adaptations covering:

- what help is available
- who to contact
- eligibility criteria
- who needs to pay and how much
- what service people can expect using information such as local targets for response times.

This should be published in different formats and in other languages as required by local communities.

Review the level of demand for out-of-hours services.

Councils should:
Ensure that users have information on direct payments and the availability of these for community equipment and adaptations.

Evaluate whether self-assessment and self-selection could improve the efficiency of providing low cost, low risk items.

Part 3. How are services organised?

Councils and NHS bodies should:
Work towards joint information systems that provide good management information on the community equipment and adaptation services within their partnership area.

Clarify partnership arrangements for the assessment and provision of community equipment and adaptations ensuring that all relevant partners are involved; and formalise these arrangements in agreed policies and procedures.

Ensure all relevant staff across the respective partner organisations are aware of the agreed policies and procedures.

Ensure that community equipment and adaptation services are developed as part of their overall community care strategy.

Develop protocols which maximise the ability of staff from different partnership organisations to access equipment and adaptations and reduce the waiting time for users.

Develop joint training plans for all staff involved in assessing the need for, and demonstrating, equipment and adaptations.

The Scottish Executive should:
Update national guidance on roles and responsibilities in relation to community equipment and adaptations to reflect new ways of working promoted by the Joint Future Agenda; local government reorganisation; and developments in technology.

Part 4. Planning and performance monitoring

Councils and NHS bodies should:
Jointly review budgets for community equipment and adaptations and HIGs to ensure that they are set at a realistic level to meet need.

Monitor the performance of equipment and adaptation services by collecting and using robust management information on:

- cost
- activity, including waiting times
- quality of services, including users' views.

Record and monitor activity and expenditure associated with third parties, such as Care and Repair, RSLs and voluntary organisations, as changes in these areas are likely to impact significantly on future service delivery and resourcing.

Develop joint performance indicators so that the service can be evaluated across a partnership area.

Once trend information is available, benchmark with other partnerships using like-for-like performance measures to drive forward continuous improvement.

Councils and RSLs should:
Work together to assess need for major adaptations in the future.

Part 5. Managing risks

Councils and NHS bodies should:
Ensure stock control systems are in place to track and locate equipment.

Ensure that written instructions on using equipment and adaptations are always provided for users and carers, and trained staff always demonstrate their use.

Consider how best to provide advice and support to people in the private housing market who install major adaptations.

Agree and implement formal policies and procedures that include:

- recall of faulty equipment
- maintenance and repair arrangements
- recycling, including infection control procedures
- emergency arrangements.

Ensure management information systems contribute to the effective management of risk.

Review user needs once equipment and adaptations have been supplied.

The Scottish Executive should:
Produce and disseminate national guidelines on decontamination and infection control of community equipment and adaptations.

Ensure that Medical Device Alerts are issued to Scottish councils as well as to the NHS in Scotland.

Appendix 1. Methodology for user research

Our research with the general public and users'[72] involved two elements:

- a national survey of the Scottish public, covering both users and potential users
- focus groups with users.

Survey of the Scottish public

We commissioned NFO WorldGroup to carry out research as part of its monthly omnibus survey – the Scottish Opinion Survey. The national survey included questions to:

- assess the general public's awareness of, and contact and satisfaction with, statutory community equipment and adaptation services
- establish levels of private purchasing.

A sample of 944 adults (aged 16 and over) was interviewed at home in 50 sampling points throughout Scotland between 4 and 13 September 2003. To ensure the sample was representative of the adult population in terms of age, sex and class, it was weighted to match population estimates from the National Readership Survey of January – December 2002 (Exhibit 38 overleaf).

Computer Assisted Personal Interviewing (CAPI) was used to collect the data.

Focus groups

The focus groups were structured to include a sample of users based on sex, location, age and type of user. Participants were recruited from council day centres and voluntary sector groups. Each group had between five and nine participants.

Exhibit 39 (overleaf) categorises each group by the main characteristics of participants. However, several people taking part in the focus groups could be described by more than one of these characteristics; for example, some of the older people also had, and/or cared for someone with, a disability.

The discussions from the focus groups were tape-recorded, with participants' permission, and fully transcribed. All transcripts were read and coded thematically and analysed using a matrix method.

All quotations used in this report are anonymised to protect the identity of those participating in the research. In the use of direct quotations, an ellipsis in square brackets, […], is used to signify that a section of the transcript has been omitted for the sake of brevity or clarity.

72 We have used the term 'users' to cover both people who were using services themselves and people who were accessing services on behalf of someone for whom they cared.

Exhibit 38
Sample profile

		Unweighted (%)	Weighted (%)
Gender:	Male	46	48
	Female	54	52
Age:	16-24	12	15
	25-34	17	17
	35-44	22	18
	45-54	17	18
	55-64	13	14
	65+	19	19
Socio-economic Group:	AB	18	20
	C1	27	28
	C2	24	21
	DE	30	31

Base: 944.

Note: Percentages may total more than 100% due to the effect of rounding.

Exhibit 39
Make-up of focus groups

Group	Location	Urban/rural	Sex	Type of user
1	South West	Rural	Mixed	Older people
2	South West	Rural	Mixed	Older people
3	East Central	Urban	Mixed	People with disabilities
4	East Central	Urban	Mixed	Older people
5	Central	Mixed	Female	Parents of children with disabilities

Appendix 2. Allocation of responsibilities

Aids and equipment required on medical and nursing grounds	**Aids to daily living*** *Can be supplied or advice given on by the social work department in terms of para 2(ii) of the memorandum.
Air ring cushions and covers and anti-pressure aids	Toilet aids, including • raised toilet seats and toilet support rails
Back rests, bed cradles, bed tables, bed blocks, bed rails	Bath aids eg, • bath seats and bath boards
Beds and patient support surfaces including air beds, water beds, ripple beds, nursing beds and mattresses	Bed aids, including • bed over-tables
Pillows	Sitting aids eg, • special chairs and foot stools
Bed linen	Dressing aids eg, • stocking aids and long handled shoe horn
Plastic sheets	Feeding aids eg, • special cutlery and tableware
Bed-pans	General personal aids eg, • helping hands
Urinals	Walking aids eg, • ferrules for crutches and walking sticks
Commodes	Household aids eg, • tables, stools and trolleys
Sanichairs	Kitchen aids • tin openers, left-handed utensils
Sputum mugs	Aids to leisure • reading aids, page turners
Feeding cups	Adaptations to the home eg,
Tubes	• grab rail at bath
Straws	• grab rail at toilet
Bibs	• floor fixed support rails
Protective clothing	• low or special bath and shower units
Fracture boards	• sliding doors and windows
Mobile hoists	• widen doors
Crutches, walking frames, walking sticks	• raise or lower plugs
Voice amplifiers	• fixed track and electric hoists
Replacement of ferrules for crutches and walking sticks	• raise or low work units, kitchen sinks etc • ramps – wooden or concrete

Source: Circular SWSG 7/94 5458

Appendix 3. Joint community equipment stores

The following lists the 'joint' equipment stores reported by councils and NHS trusts participating in this study. The partners are recorded as given by the audited bodies as at the time of our study (ie, prior to the reorganisation of the NHS in Scotland).

Store name	Location	Partners
Borders Ability Living Service Store	Tweedbank	• Scottish Borders Council • NHS Borders
Greater Glasgow Independent Living Equipment Service (GGILES)	Glasgow	• Glasgow Council • NHS Greater Glasgow • East Dunbartonshire
Joint Equipment Store	Nithbank, Dumfries	• Dumfries and Galloway Council • Dumfries and Galloway PCT
Annan Store	Annan	• Dumfries and Galloway Council • Dumfries and Galloway PCT
Dumfries and Galloway Royal Infirmary Store	Dumfries	• Dumfries and Galloway Council • Dumfries and Galloway Acute Trust
Joint Domiciliary Equipment Store	Edinburgh	• City of Edinburgh Council • Midlothian Council • East Lothian Council • Lothian PCT
Joint Loan Equipment Store	Grangemouth	• Falkirk Council • Stirling Council • Forth Valley Health Board • Forth Valley PCT • Forth Valley Acute NHS Trust
Fife Community Equipment Store	Glenrothes	• Fife Council • Fife PCT
East Highland Joint Equipment Store	Invergordon	• Highland Council • Highland PCT
Joint equipment store	Portree	• Highland Council • Highland PCT • Skye and Lochalsh Housing Association
Inverclyde Joint community equipment store	Gibshill	• Inverclyde Council • Renfrewshire and Inverclyde PCT • Inverclyde LHCC

Store name	Location	Partners
North Lanarkshire Joint Equipment Service	Motherwell	• North Lanarkshire Council • Lanarkshire PCT
Joint Store	Kirkwall	• Orkney Council • NHS Orkney
West Lothian Community Equipment Store	Livingston	• West Lothian Council • West Lothian NHS Healthcare Trust
Joint Equipment Store	Oban	• Argyll and Bute Council • Lomond and Argyll PCT • Argyll and Clyde Acute NHS Trust
Inverurie Store	Inverurie	• Grampian PCT • Aberdeenshire Council
Renfrewshire joint store	Linwood	• Renfrewshire Council • Renfrewshire and Inverclyde PCT

Appendix 4. Activity definitions

We used the following definitions in our surveys of councils and NHS trusts.

Assessment

A series of actions that includes identifying the needs of the person, informing the person and/or carer of the conclusion, and, where appropriate, devising a care plan. This study asked about assessments where a need for equipment and adaptations was identified, including reassessments.

Referral

A referral is a single individual at a single point in time. For example, if the same person is referred in January and then again in April, this counts as two referrals. If a single person is referred at a single point in time for one or more adaptations or pieces of equipment, this counts as a single referral.

Recommendation

A recommendation refers to when a person has been assessed for an adaptation by, for example, a social work department occupational therapist, and they formally recommend that a permanent, major adaptation is required to meet the client's need. A recommendation refers to a single individual at a single point in time. A recommendation may require the installation of more than one item.

A completion

A completion refers to when a person has been issued with the equipment/adaptation. A single completion refers to the delivery/installation of equipment/adaptations resulting from a single referral or assessment. For example, if an assessment identified a need for two items of equipment, the delivery of these items would count as one completion. If the items were not delivered on the same day, it would become a single completion when the final item was delivered.

Patient

A patient is a single individual at a single point in time. For example, if the same person is referred in January and then again in April, this counts as two patients. If a single person is identified as needing multiple pieces of community equipment, this will count as a single patient.

Appendix 5. Information collected by councils

Council	Social Work				Housing			
	Referrals for equipment and adaptations	Assessments where a need for equipment/ adaptations was identified	Completions	Pieces of equipment and adaptations issued/installed	Recommendations for council property adaptations	HIG applications	Council adaptation completions	Private adaptation completions
A	✗	✓	✓	✗	✗	✓	✗	✓
B	✓	✗	✓	✗	✗	✓	✓	✗
C	✗	✗	✗	✗	✗	✗	✗	✗
D	✗	✗	✗	✗	✓	✓	✓	✓
E	✓	✗	✓	✗	✓	✓	✓	✓
F	✓	✓	✓	✗	✓	✓	✓	✓
G	✓	✗	✗	✓	✓	✓	✓	✓
H	✗	✗	✗	✗	✓	✓	✓	✓
I	✓	✗	✓	✓	✓	✓	✓	✓
J	✓	✓	✓	✗	✗	✗	✓	✗
K	✗	✓	✗	✗	✓	✓	✓	✓
L	✓	✗	✓	✓	✓	✓	✓	✓
M	✓	✓	✗	✓	✓	✓	✗	✗
N	✓	✗	✓	✓	✓	✓	✓	✓
O	✓	✓	✓	✓	✓	✓	✗	✗
P	✓	✓	✓	✗	✓	✓	✓	✓
Q	✗	✗	✗	✗	✗	✗	✗	✗
R	✓	✓	✗	✓	✓	✗	✓	✗
S	✓	✗	✗	✗	✓	✓	✓	✓
T	✗	✓	✓	✓	✗	✓	✗	✓
U	✓	✓	✓	✗	✓	✓	✗	✗
V	✗	✗	✗	✗	✗	✓	✗	✓
W	✗	✗	✗	✗	✗	✗	✓	✓
X	✗	✓	✗	✗	✗	✓	✗	✗
Y	✗	✗	✗	✗	✗	✗	✗	✓
Z	✓	✓	✗	✓	✗	✗	✗	✗
AA	✓	✗	✗	✓	✓	✓	✓	✓
AB	✗	✓	✓	✗	✓	✓	✓	✓
AC	Did not participate in audit validation				✓	✗	✓	✓

Appendix 6. Local performance monitoring

The following performance indicators for community equipment and adaptations may be useful for partnerships to consider as part of their local joint performance management frameworks.

Activity

Number of people receiving community equipment and adaptations.

Number and percentage of assessments resulting in a referral for, and receipt of, equipment and adaptations.

Number and percentage of all community care clients receiving equipment and adaptations (by financial year, age group, client group, source of referral and provider organisation).

Average time for each of the following key stages:

- between first contact and referral
- between referral and allocation
- between allocation and completion of assessment
- between assessment and funding authorisation
- between assessment and delivery/installation
- between ordering and delivery/installation for standard stock
- between ordering and delivery/installation for special orders.

For emergency cases:

- average time between assessment and delivery/installation
- percentage of cases where delivery/installation is completed within local target time.

Percentage of cases where local target times are met.

Percentage of equipment and adaptations returned, by type and reason for return.

Percentage of equipment and adaptations recycled, by type.

Percentage of equipment/adaptations delivered/installed outside normal office hours.

Percentage of users opting to use direct payments for equipment and adaptations.

Percentage of users opting to self-select.

Cost

Variance between budget and expenditure for equipment and adaptations.

Expenditure on equipment, by type.

Expenditure on adaptations, by type and by tenure.

Expenditure on HIGs.

Expenditure on recycling.

Quality

Percentage of equipment and adaptations returned due to unsuitability.

Percentage of equipment and adaptations returned due to faults.

Percentage of equipment and adaptations where delivery/installation date met.

Percentage of equipment and adaptations getting maintained by local target date.

Percentage of users receiving follow-up visit by local target date.

Feedback from users and carers.

Appendix 7. Study advisory group

Members sat on the group in a personal capacity.

Linda Bertram	Professional Advisor Occupational Therapist, City of Edinburgh Council
Douglas Boynton	Head of Service for Community Care, Aberdeenshire Council
Peter Brawley	Project Manager, Scottish Personal Assistant Employers Network Chairperson, Glasgow Centre for Independent Living
Susan Buckle	Occupational Therapy Inspector, Social Work Services Inspectorate
Jim Cosgrove	Manager, West Lothian Community Equipment Store
Alex Davidson	Convenor, ADSW Physical Disability & Sensory Impairment Group Head of Adult Services, Social Work Resources, South Lanarkshire Council
Susan Dewar	Senior 1 Occupational Therapist, Iris Team, North Glasgow University Hospital Division, NHS Greater Glasgow
Kirsty Forsyth	Co-opted member of the Scottish Board of the College of Occupational Therapists
Bob Gomersall	Operations and Facilities Manager, Primary & Community Division, NHS Lothian
Issie Graham	AHP & Project Manager, Moray Local Health Care Co-operative, NHS Grampian
Colin McLean	Technical Services Manager, Margaret Blackwood Housing Association
Professor Alison Petch	Nuffield Chair of Community Care Studies, University of Glasgow
Jill Pritchard	Service Manager Support Officer, Social Work Department, Fife Council
Catherine Rae	District Nursing Sister, NHS Grampian
Andy Sim	Policy Officer for Health & Community Care, Age Concern
Karen Stewart	District Nurse, Cambuslang Clinic, NHS Greater Glasgow
Kate Strachan	Occupational Therapist, Housing & Social Work Department, Falkirk Council
Sarah Sutton	Senior Occupational Therapist, Disabled Living Centre, Astley Ainslie Hospital, NHS Lothian
Robert Thomson	National Co-ordinator, Care and Repair Forum Scotland

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A baseline report

Audit Scotland
110 George Street
Edinburgh EH2 4LH

Telephone
0131 477 1234
Fax
0131 477 4567

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