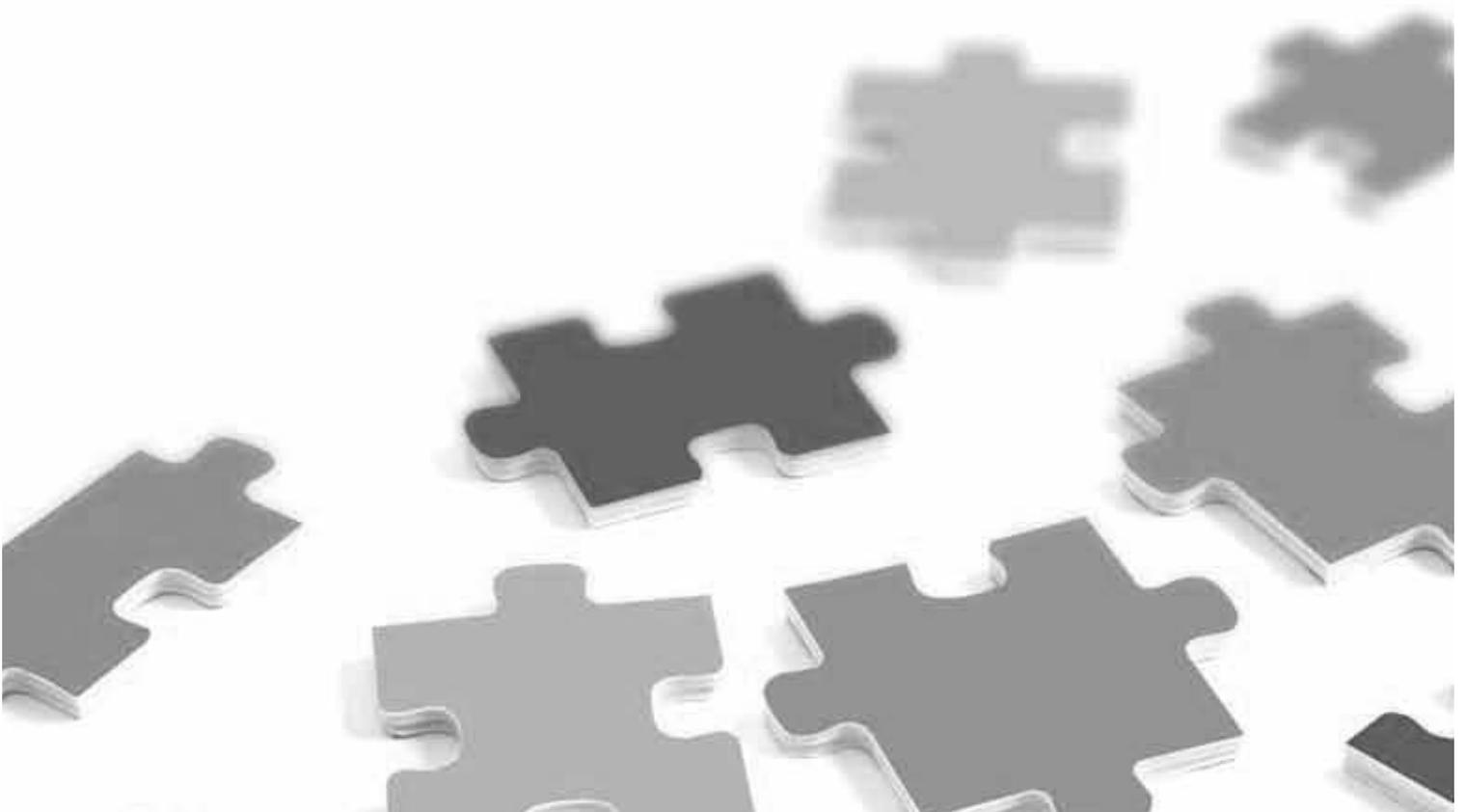


# Commissioning social care



Prepared for the Auditor General for Scotland and the Accounts Commission  
March 2012



# Auditor General for Scotland

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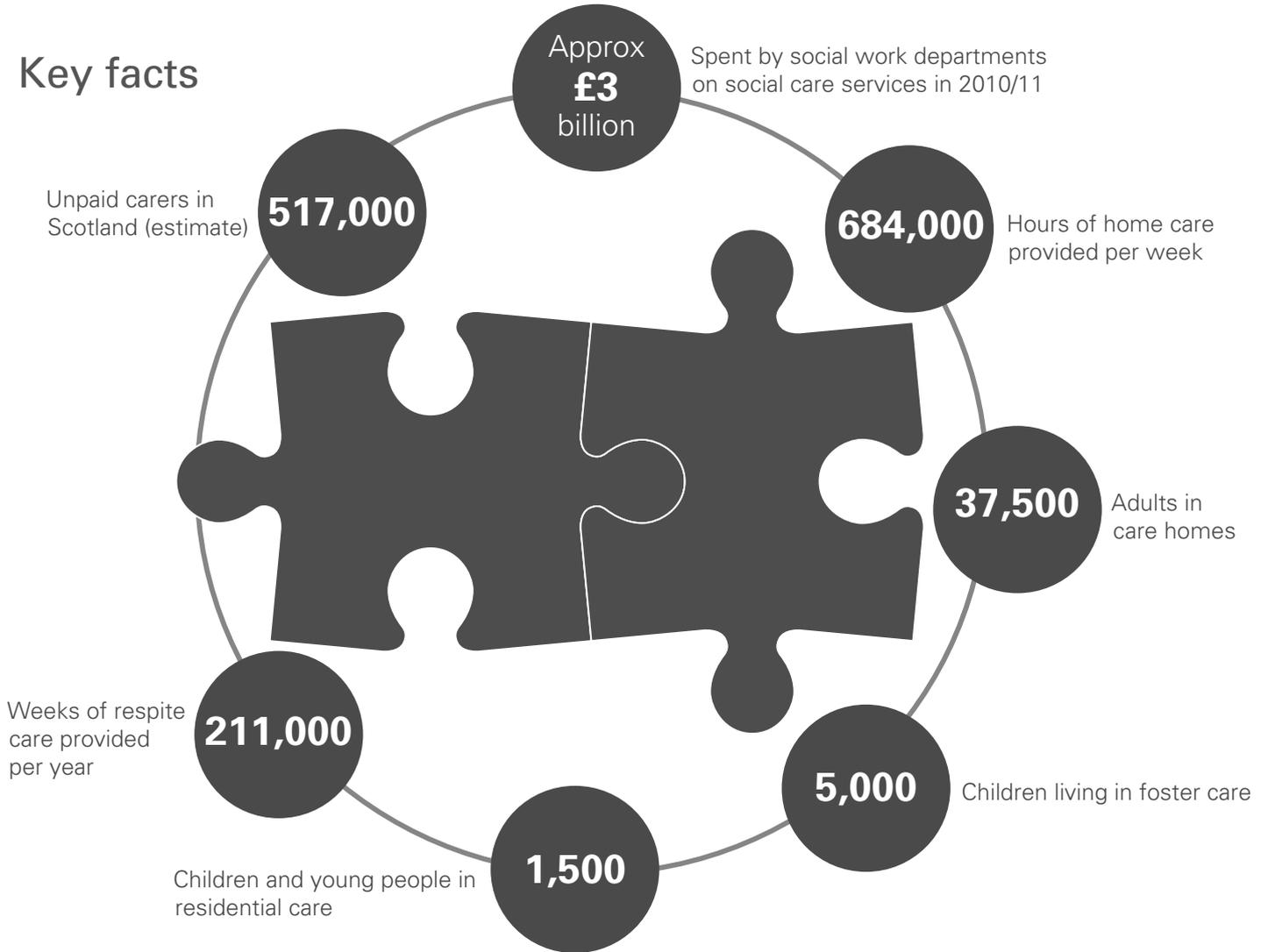
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# Summary

## Key facts



Social care services are organised by councils and delivered by a range of providers.



## Background

**1.** Social care services aim to help people lead as independent a life as possible. They range from supporting people to take part in social activities, help with basic personal care like washing and dressing, through to assistance with every aspect of their daily lives. Many people depend on social care services, including: older people living in care homes or receiving help at home; children at risk and their families; children and adults with physical, sensory or learning disabilities; and people with mental health problems, addictions or HIV/AIDS.<sup>1</sup> Staff working in social care provide a vital service for many people and are highly valued by users and carers.

**2.** Councils have a duty to provide social care for those who need it, whether they provide these services themselves, contract with voluntary or private organisations to provide them or give people a budget to arrange their own care. But helping people to live more independently and improve their quality of life is not just the role of councils' social work teams. It requires a joined-up approach with other council services, including housing, education and leisure, as well as with NHS boards and other public services such as police and prison services.

**3.** Many people needing social care services also require ongoing health care for specific long-term conditions. Some people, particularly older people, need social care when they are discharged from hospital or to help prevent them being admitted to hospital. Therefore, social care decisions taken by a council can have a direct impact not only on the

service user but on other council services, the NHS and other public services. Similarly, decisions taken by NHS boards can affect council services, for example a reduction in hospital admissions or length of stay may depend on additional social care services. This report focuses on social care services, which are a statutory responsibility of councils, but also recognises the importance of joint planning and resourcing because of the interdependent relationship between health and social care services. For this reason we make recommendations to both councils and NHS boards.

**4.** Commissioning social care is much more than councils organising and buying services. It is also how councils and NHS boards work together to plan services that will meet future demands and make effective use of their combined resources. This joint strategic approach to commissioning can help provide joined-up services to people and prevent, delay or shorten a stay in hospital. Ultimately, jointly-planned investment in social care can save expenditure on unnecessary, and relatively expensive, hospital or residential care. The Scottish Government is developing legislation to strengthen the integration of adult health and social care services through single Health and Social Care Partnerships.<sup>2</sup> In children's social care services, jointly planned and effective social care can save longer-term expenditure on health, education, police, criminal justice and prison services.<sup>3</sup>

**5.** The Scottish Government and public bodies recognise that many current models of social care are unsustainable due to

increasing demand, the changing profile of Scotland's population, reducing budgets and the move to provide services more tailored to individuals' needs.<sup>4</sup> Good strategic commissioning is therefore needed to ensure effective and efficient services are provided and continue to be developed, in partnership with users, carers and providers, so that sustainable services are in place in future.

**6.** Audit Scotland has published previous reports which have highlighted a number of the issues covered in this report, including the need for better partnership working between councils and NHS boards, the risks of not investing in preventative services, and the importance of good commissioning strategies based on effective engagement with users and carers and robust information about needs, costs and quality.<sup>5</sup> It is important that councils and NHS boards work together to address these issues, particularly given the new legislation on self-directed support to give people more control over the care services they receive (Part 4).<sup>6</sup>

## About the audit

**7.** The overall aim of our audit was to review how effectively the public sector commissions social care services. We examined how well councils and their partners plan, and how councils either procure or deliver, effective social care services. We also assessed the extent to which councils and their partners involve users and carers in developing services to meet their needs, and how they work with providers in the voluntary and private sectors to provide high-quality, sustainable

1 We refer to older people throughout the report to mean people aged 65 or over.

2 *Integration of health and social care*, News release, Scottish Government, 12 December 2011.

3 *Getting it right for children in residential care*, Audit Scotland, 2010.

4 *Projected Population of Scotland (2010-based)*, National Records of Scotland, 2011; *Health of Scotland's Population: Life expectancy*, ISD Scotland, 2011; *Scottish spending review 2011 and draft budget 2012-13*, Scottish Government, 2011.

5 *Review of Community Health Partnerships*, Audit Scotland, 2011; *Transport for health and social care*, Audit Scotland, 2011; *Getting it right for children in residential care*, Audit Scotland, 2010; *A review of free personal and nursing care*, Audit Scotland, 2008; *Commissioning community care services for older people*, Audit Scotland, 2004; *Homing in on care: a review of home care services for older people*, Audit Scotland, 2001.

6 The draft Bill is in the current legislative programme and the Government intends to introduce the Bill early in 2012.

services.<sup>7,8</sup> Procurement is one part of the commissioning process and we considered procurement issues as part of the audit. Where possible, we have identified case studies which may help organisations to improve how they commission social care services. These may refer to specific services or groups of people but the issues are relevant to commissioning for all social care services, including those for children and adults.

**8.** Evidence for this audit is based on an analysis of national and local guidance, reports and data; information from inspection bodies; interviews with key stakeholders; and focus groups or surveys with users, carers and providers. We have published supplementary reports of our focus groups and surveys with users, carers and providers on our website.<sup>9</sup> Further details of our methodology are provided at Appendix 1.

**9.** Appendix 2 lists members of our Project Advisory Group, who gave advice and feedback at key stages of the audit. Appendix 3 sets out the key policy developments for commissioning social care services. We have developed a separate self-assessment checklist on our website, highlighting specific issues to help councils and their NHS partners improve how they commission social care services.

**10.** This report is structured into four main parts:

- Social care in Scotland (Part 1)
- Strategic commissioning (Part 2)
- Delivering social care services (Part 3)
- Impact on users and carers (Part 4).

### Key messages

- Strategic commissioning of social care is complex and challenging due to reducing budgets, changing demographics, growing demands and expectations, and moves towards care more tailored to the individual's needs. Despite this, councils and NHS boards need to do much more to improve how social care services are planned, procured and delivered through better engagement with users and providers and better analysis and use of information on needs, costs, quality of services and their impact on people's quality of life.
- There are indications that councils are continuing to focus resources on people who need more intensive support, tightening eligibility criteria and increasing charges. There is a risk that people who need a small amount of support are not being offered the preventative services that might help delay or avoid their needing more costly intensive support, such as being admitted to hospital or into residential care. This trend is not new and we have reported the risks in previous audits.
- Voluntary and private sector providers deliver a significant proportion of social care services in Scotland in addition to services provided in-house by councils. While processes are in place to monitor quality, more needs to be done across

Scotland to manage the risks to users when a provider goes out of business or closes for other reasons, including having contingency plans in place and monitoring effectively the financial health of voluntary and private providers. This can be complex and will involve further development and coordination of capacity and expertise at local and national levels.

- Users and carers need to be more involved in decisions about social care services and better evidence is needed of what difference the services make to people's quality of life. Self-directed support aims to give people more choice and control over the services they receive and is likely to have major implications for the way that councils, along with NHS boards and other partners, plan and commission social care services. However, the combination of relatively low use of direct payments, a need to develop commissioning skills and capacity, and a need to improve partnership working with providers and consultation with users and carers, suggests that councils may need a significant amount of support to implement self-directed support effectively.

<sup>7</sup> We use the term carers throughout our report to mean unpaid carers such as family, friends or neighbours.

<sup>8</sup> Our report focuses on councils and on NHS boards (as councils' main commissioning partners) but for some services and some groups of people other public bodies should be involved in commissioning, such as the police.

<sup>9</sup> [www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk)

## Key recommendations

Councils, along with NHS boards and other relevant commissioning partners, should:

- develop commissioning strategies for social care services which set out:
  - an analysis of needs and potential gaps in services
  - how users, carers and providers will be involved throughout the commissioning process
  - consideration of quality and what impact services will make to the quality of people's lives, and how these will be measured
  - consideration of who might be able to provide the services needed (capacity)
  - an analysis of costs and budgets for services (both in-house and externally provided)
  - a summary of any planned improvements or different ways of working
  - timescales for implementing and reviewing the strategy
- manage the risks of contracting services from voluntary and private providers by:
  - undertaking due diligence checks before awarding contracts
  - making sure that appropriate checks on financial health and ability to deliver services are carried out regularly during contracts

- having contingency plans in place for dealing with a provider going out of business or closing for other reasons
- understanding the financial and business impact of their commissioning decisions on providers
- in implementing self-directed support:
  - provide information, advice and support to all users and carers
  - put in place processes for monitoring the outcomes for users of services purchased with individual budgets, including direct payments.

Councils and NHS boards should:

- work together to invest in preventative services that can help to delay or avoid people needing more intensive support, and monitor the impact of these services.

The Care Inspectorate and councils should:

- work together to monitor the impact that services have on people's lives as well as the quality of care provided.

The Scottish Government and the Care Inspectorate should:

- work together to ensure that councils, NHS boards and other commissioning partners are scrutinised and supported to improve their strategic commissioning.

The Scottish Government, the Care Inspectorate and COSLA should:

- consider whether there is a need for periodic expert assessment of the social care markets to support commissioning bodies in managing these markets and in monitoring the financial viability of large operators.

# Part 1. Social care in Scotland



Commissioning social care is complex and challenging.



## Key messages

- In 2010/11, councils spent approximately £3 billion on social care services. Councils and NHS boards need to work together to develop integrated social care commissioning strategies. In developing these strategies they should actively engage with users and carers, and providers in the voluntary and private sectors.
- There have been a number of significant policy developments in recent years aimed at providing care for people at home rather than in institutions. There has been a slight decrease in residential services and a significant increase in home-based services over the last ten years.
- National statistics show that councils' activity and expenditure on social care services differ markedly. Although some of the variation will reflect differences in local populations and needs, there is scope for councils and their NHS partners to benefit from comparing performance with other areas.
- Commissioning strategies should be based on an analysis of needs, costs and the capacity of in-house and external providers to meet those needs. Councils and NHS boards need this information to support their joint decisions about how to use their resources effectively.
- Strategic commissioning of social care is complex and challenging due to reducing budgets, changing demographics, growing

demands and expectations, and moves towards care more tailored to the individual's needs.

### **Social care services are organised by councils and delivered by public, voluntary and private sector organisations**

**11.** Councils have a statutory duty to provide social care for people who need it. They are responsible for assessing people's social care needs and, if they assess someone as being eligible, then they must provide or pay for appropriate services to meet that person's needs.<sup>10</sup> Common care services include day care, home care, supported housing, residential care, respite, equipment and adaptations and telecare.<sup>11</sup> A number of organisations are involved in delivering these services (Exhibit 1, overleaf).

### **Councils spent approximately £3 billion on social care services in 2010/11**

**12.** In 2010/11, council social work departments spent approximately £3 billion on social care services.<sup>12</sup> Councils' social care spending increased by 46 per cent (in real terms) over the eight years from 2002/03 to 2010/11, although there was a slight decrease in 2010/11. The overall increase was greatest for adults with learning disabilities (68 per cent) and least for adults with physical or sensory disabilities (21 per cent) (Exhibit 2, page 9).

### **Councils need to work closely with the NHS to meet local needs**

**13.** Councils and NHS boards need to work together to plan and deliver services. Many people needing social care services also require ongoing healthcare for specific long-

term conditions; and some people, particularly older people, need social care when they leave hospital or to help prevent them being admitted to hospital. Decisions that councils make about services can improve the quality of people's lives as well as affecting the efficiency and effectiveness of other public services, particularly the NHS, for example through reducing admissions to hospital and coordinating services for people leaving hospital. Decisions made by NHS boards about the delivery of healthcare will also affect social care services. This report focuses on social care services, which are councils' responsibility, but also recognises the importance of joint planning and resourcing because of the interdependent relationship between health and social care services.

**14.** There are national policies and initiatives in place aimed at further integrating health and social care services (Appendix 3), including:

- Community Planning Partnerships (CPPs), introduced in 2003 to help communities influence services and to coordinate partnerships in a local area. Each CPP has a Single Outcome Agreement (SOA) which sets out its priorities and targets for the local community.<sup>13</sup>
- Community Health Partnerships (CHPs), established in 2004 as subcommittees of NHS boards to support better joint working between primary and secondary health care, and between health and social care. Of the 36 CHPs in Scotland, 29 are structured only around health services and seven are integrated partnerships that were set up to plan and provide joined-up health and social care services.<sup>14</sup>

10 Social Work (Scotland) Act 1968, NHS and Community Care Act 1990, The Children (Scotland) Act 1995.

11 Telecare covers a range of devices and services that use technology to enable people to live with greater independence and safety in their own homes. For example, electronic sensors in the home which are used to monitor things like movement, falls or bath water levels and which can trigger an alert to a call centre or local carer who can contact the person or arrange help for them.

12 *Scottish Local Government Financial Statistics 2010-11*, Scottish Government, 2012.

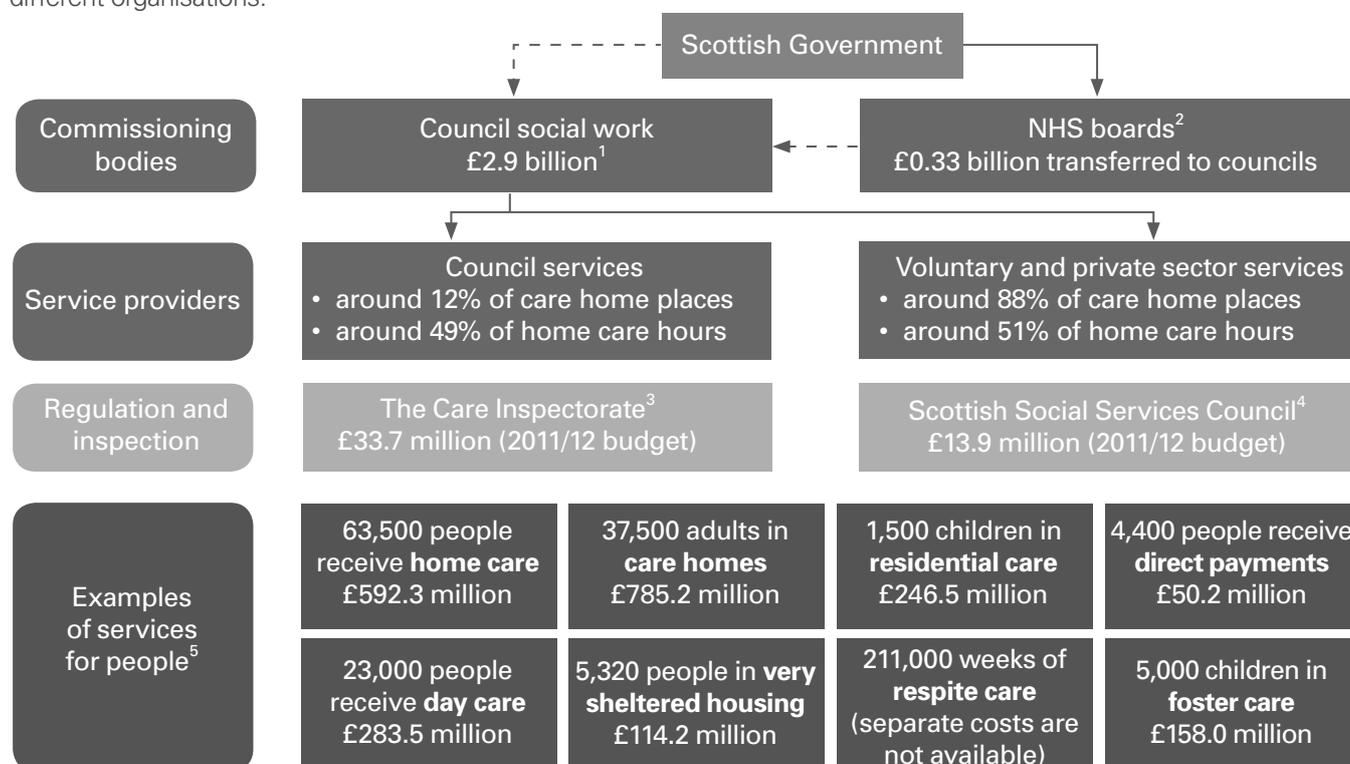
13 *The role of community planning partnerships in economic development*, Audit Scotland, 2011.

14 *Review of Community Health Partnerships*, Audit Scotland, 2011.

## Exhibit 1

### Social care services in Scotland

Councils must provide or pay for social care services to meet people's needs and this can involve a number of different organisations.



#### Notes:

1. The total cost of social care in Scotland is more than £2.9 billion as many people contribute to their own care by paying providers directly, eg many of the 37,500 adults in care homes. Also, the £2.9 billion excludes expenditure from other council departments such as housing, which spent £0.23 billion on housing support in 2010/11, and education, which often fund residential school places for children. The £2.9 billion does not include the £0.33 billion transferred to councils from NHS boards to help support patients discharged from long-stay hospitals.

2. NHS boards provide continuing healthcare services for people who need ongoing and regular specialist clinical supervision when they are discharged from hospital. This may be in a hospice or care home. While we do not specifically review continuing healthcare services in our report, some people living in care homes will be receiving these services.

3. The Care Inspectorate is responsible for registration, inspection, complaints and enforcement for social care services, and for scrutiny of councils' social work and child protection services.

4. The Scottish Social Services Council (SSSC) is responsible for registering everyone who works in social care services and for regulating their training and qualifications. A timetable is in place for having all social care staff registered with the SSSC.

5. These are examples of the main types of services provided and reported nationally. They show the number of people receiving services at a single point in time. Individuals often receive more than one type of service. Expenditure is approximate. Other examples, such as social activities or individual, tailored care are not covered by the national statistics.

Source of council expenditure data: *Local Financial Returns 2010-11*, Scottish Government, 2012

- Change Funds of £500 million, to be spent over the three years from 2012/13 on preventative services for older people, early years and reducing reoffending. These funds are intended to reduce people's need for crisis services, such as long-term hospital care or prison, and help drive the further integration of services and sharing of resources between partners<sup>15</sup>
- Integration of health and social care – the Scottish Government is currently developing legislation to strengthen the integration of adult health and social care services through single Health and Social Care Partnerships with integrated budgets.<sup>16</sup>
- **15.** As well as working well together, councils and NHS boards also need to work closely with the voluntary and private sectors to plan, develop and deliver effective and sustainable services. The role of the voluntary and private sectors in social care has increased over the last ten years. For example, they now provide:

<sup>15</sup> *Scottish spending review 2011 and draft budget 2012-13*, Scottish Government, 2011.

<sup>16</sup> *Integration of health and social care*, News release, Scottish Government, 12 December 2011.

- 88 per cent of care home places (31,700 places in the private sector and 6,000 places in the voluntary sector)<sup>17</sup>
- around 51 per cent of home care hours (around 350,000 hours per week)<sup>18</sup>
- housing support services to around 40 per cent of housing support clients (approximately 85,000 clients)<sup>19</sup>
- around 60 per cent of residential child care placements.<sup>20</sup>

### More people are being cared for at home or in the community

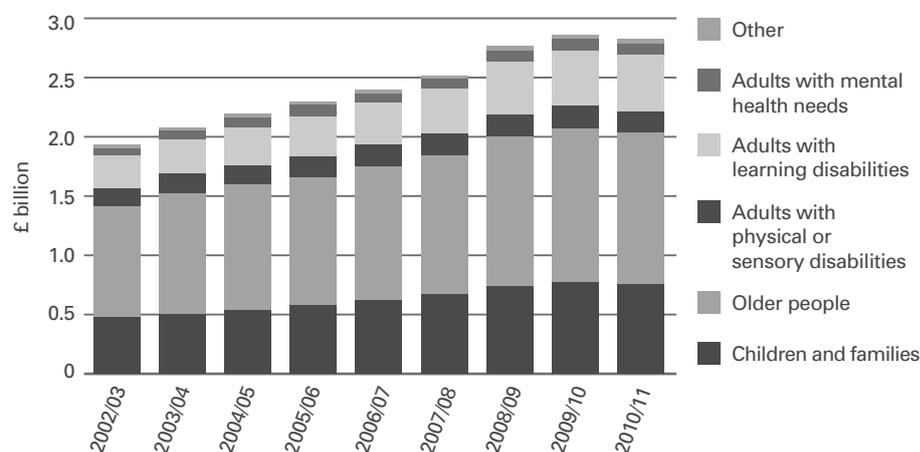
**16.** Approaches to strategic commissioning must be reviewed and refreshed regularly to ensure that they reflect local and national policy, follow current guidance and good practice and comply with relevant regulations. Policy developments have focused on three main priorities:

- caring for people in their own homes or communities rather than in institutions such as care homes or residential schools for young people (Exhibit 3, overleaf)
- providing services that have a positive impact on people's independence and quality of life, including preventative services to help delay or avoid the need for more intensive support (see Part 2)
- delivering services tailored to people's needs and preferences and to allow people to have more control over the services they receive (see Part 4).

## Exhibit 2

### Councils' expenditure on social care services, 2002/03 to 2010/11

Councils' spending on social care services increased every year (in real terms) between 2002/03 and 2009/10 but decreased in 2010/11.



#### Notes:

1. Figures show net revenue expenditure for 2002/03 to 2010/11 restated to 2010/11 prices using HM Treasury deflators. They exclude non-direct expenditure such as service strategy and children's panels.

2. Other includes adults with addictions/substance misuse and HIV/AIDS.

Source: *Scottish Local Government Financial Statistics 2002/03 to 2010/11*, Scottish Government, 2004 to 2012

**17.** National statistics show that the activity and expenditure on social care services differ markedly between council areas. For example, the number of people receiving home care per 1,000 population varies from just under nine in Aberdeen City and Aberdeenshire to over 20 in Eilean Siar, Shetland and South Ayrshire. The average number of hours provided weekly per person varies from 3.8 hours in Angus to 21.1 hours in Fife.

**18.** Some of the variation will reflect differences in local populations and needs. It could also be due to other factors such as the eligibility criteria used to decide who receives services, how successfully councils and NHS boards are arranging

care at home instead of care in residential settings, or how successful services are in helping people to return to independence without further support. There is scope to better understand how services are delivered across the country and for councils and their NHS partners to benefit from comparing performance with other areas.

**19.** Total spending on social work per head of population ranges from £534 in West Lothian to £907 in Glasgow and more in the three islands councils.<sup>21</sup> This will be influenced by, among other things, levels of deprivation and health and the urban/rural distribution and age profile of the local population.

<sup>17</sup> *Care Home Census 2011 – Interim Analysis*, ISD Scotland, 2011.

<sup>18</sup> *Home care services Scotland 2011*, Scottish Government, 2011.

<sup>19</sup> *Supporting people client statistics 2007-08*, Scottish Government, 2008.

<sup>20</sup> *Getting it right for children in residential care*, Audit Scotland, 2010.

<sup>21</sup> *Scottish Local Government Financial Statistics 2009-10*, Scottish Government, 2011; *Projected Population of Scotland (2010-based)*, National Records of Scotland, 2011.

### Exhibit 3

#### Trend in the balance between residential care and support at home or in the community, 2000–11

There has been a gradual shift towards caring for people at home or in community-based environments.

#### Residential care

- The number of care home places for older people decreased from 49 per 1,000 people aged 65+ in the population in 2000, to 44 per 1,000 in 2011, with a two per cent decrease in the number of older people staying in care homes.
- The number of adults with learning disabilities in care homes decreased by 36 per cent from 3,300 in March 2000 to 2,100 in March 2011.
- The number of looked after children in residential units or schools decreased from 1,600 in 2000 to less than 1,500 in 2010 over a time when the total number of looked after children increased.

#### Support at home or in the community

- The number of hours of home care provided has increased by 74 per cent between 2000 and 2011 to 684,000 hours a week.
- The proportion of looked after children in foster care has increased from 28 in every 100 looked after children in 2000 to 31 in every 100 in 2010.
- In 2011, 17.7 older people per 1,000 population were receiving intensive home care (10+ hours a week) compared with 10.7 in 2000.
- The number of very sheltered housing units for older people and those with disabilities almost trebled from 1,820 in 2001 to 5,320 in 2010.

#### Commissioning strategies should give a clear direction for the provision of social care

**20.** Strategic commissioning takes a long-term approach to planning and delivering services, based on an analysis of local users' needs and a good understanding of the costs and capacity of providers in the local area to deliver these services (Exhibit 4). It should be a continuous and transparent process, involving users and their carers in the planning and provision of their services and in monitoring performance. We examine the impact of commissioning on users and carers in Part 4.

**21.** Strategic commissioning is complex and needs to take account of a number of factors including:

- Scotland's changing population profile
- reducing budgets across the public sector
- increasing demand and expectations
- national policies.

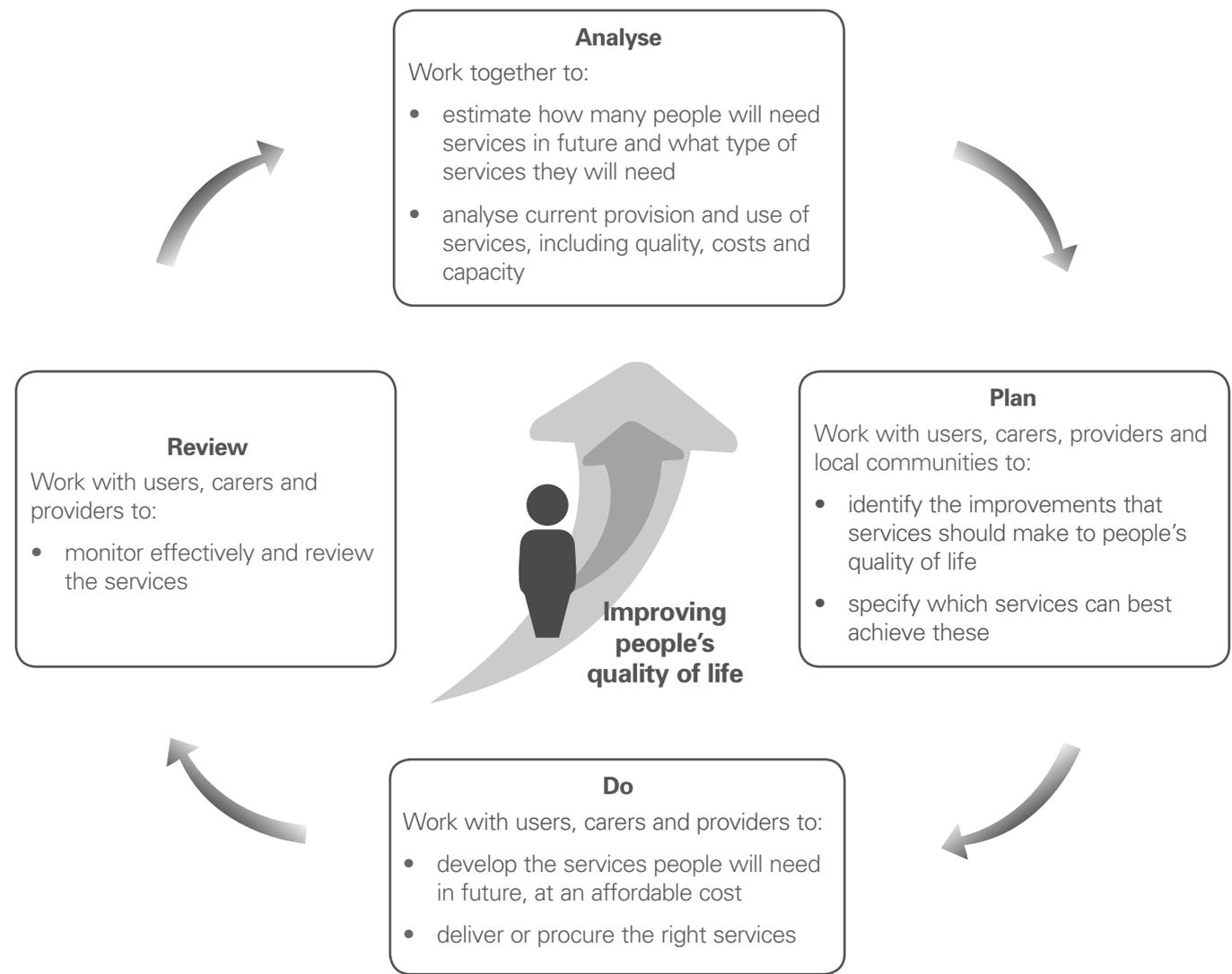
**22.** In this challenging context, it is important for councils and NHS boards to have commissioning strategies that give a clear direction for local social care services over the short, medium and long term. The strategies should be based on the results of the analysing and planning stages of commissioning, and support the development of sustainable services. This will help councils and NHS boards, working with users and providers, to plan and develop the right services for their area and target their resources effectively. In partnership with the Care Inspectorate, we have developed a set of key characteristics that underpin good commissioning, based on a review of guidance and scrutiny reports (Exhibit 5, page 12).

Source: Audit Scotland, from *Care Home Census 2011 – Interim Analysis*, ISD Scotland, 2011; *Project Population of Scotland (2010-based)*, National Records of Scotland, 2011; *Children Looked After Statistics 2009-10*, Scottish Government, 2011; *Home Care Services, Scotland 2011*, Scottish Government, 2011; *Housing Statistics for Scotland – Housing for older people and those with disabilities*, Scottish Government, 2011.

**Exhibit 4**

**Commissioning processes**

Effective commissioning involves councils and NHS boards working with users, carers and providers.



Source: Audit Scotland, based on work by the Institute of Public Care (Oxford Brookes University), 2007

**Exhibit 5****Characteristics of good strategic commissioning**

Characteristics that are key to good strategic commissioning include certain behaviours and culture, a strategic approach and a focus on performance and improvement.

Key characteristics	When things are going well	When things are not going well
<b>Behaviours and culture</b>		
<p>Commitment from political and organisational leaders to a joint long-term strategy for commissioning social care</p> <p>Transparent and inclusive approach to commissioning social care</p>	<p>Leaders agree, own, promote and communicate the strategy for commissioning social care</p> <p>Leaders are committed to working with their partners, and with users and carers, providers and local communities, to provide the best possible care and support for local people with the resources available</p> <p>Leaders are committed to working jointly to improve social care services and are clear about the impact that these services should have on people's lives</p> <p>There is a culture of listening to, and acting on, users' and carers' views and ensuring that they are involved throughout the commissioning process</p> <p>The information and expertise that external providers offer is valued and their contribution is sought throughout the commissioning process</p>	<p>There is a lack of joint strategic planning and leadership in commissioning social care services</p> <p>Leaders do not share a clear vision about future social care services or about the impact that services should make to people's lives</p> <p>Commissioning is seen as being separate from day-to-day decisions about services, or is viewed only as the process of procuring services from external providers</p> <p>Commissioning may be seen as a council responsibility only</p> <p>Users and carers are not seen as central to helping to develop and sustain social care services</p> <p>Providers are seen as separate and outwith the broader commissioning process, there to provide services but not contribute to developing the overall strategic approach</p> <p>Leaders do not recognise the need to work with local communities</p>
<b>Strategy and engagement</b>		
<p>A single, overarching commissioning strategy for social care services</p> <p>Risks associated with strategic commissioning of social care are identified and actively managed</p>	<p>There is an agreed, joint strategy for commissioning social care for at least the next 5+ years</p> <p>The strategy focuses on the outcomes for users and carers based on an assessment of need</p> <p>The strategy demonstrates a clear understanding of needs and sets out how current provision has to change to meet future needs</p> <p>The strategy reflects national policies and developments including self-directed support</p> <p>Managing risks is part of regular management, including identifying risks, taking action to mitigate each risk and having in place contingency plans for key risks</p>	<p>There is no overarching strategy for commissioning social care</p> <p>If a strategy is in place, it does not set out a clear vision for the future and is not based on evidence of what works, local needs, information about costs and quality or the views of users, carers and communities</p> <p>There is a lack of detailed analysis of local needs and a limited understanding of current provision and how that has to change to meet future needs</p> <p>Separate strategies are produced in isolation for individual user groups</p> <p>Little consideration has been given to how self-directed support affects service provision</p> <p>Risks to users, carers, providers, partners and other stakeholders are not identified, appropriate action is not taken to mitigate risks, and contingency plans are not in place for key risks</p>

Key characteristics	When things are going well	When things are not going well
<b>Strategy and engagement (continued)</b>		
<p>Right staff in place with the necessary skills to commission social care services</p> <p>Working in partnership with local communities, users, carers, providers, the NHS and other relevant partners</p>	<p>There is sufficient capacity to commission social care services and staff with the necessary skills and expertise are trained and in place</p> <p>Users and carers influence strategic planning through proportionate consultation, information and involvement, and are central to assessing the quality of services</p> <p>Providers are consulted and kept informed of plans and are involved in improvements and developments</p>	<p>There are insufficient staff numbers to commission social care services and the staff in place do not have the necessary skills or experience</p> <p>Users and carers are either not consulted or involved in strategic planning or engagement is ineffective or without focus</p> <p>Providers are not engaged throughout the commissioning process and not involved in, or may be unaware of, future plans so services are not developed in line with plans</p>
<b>Performance and improvement</b>		
<p>Evidence-based approach to commissioning social care</p> <p>Transparent performance management arrangements and measures</p> <p>Focus on improvement</p>	<p>Decisions about services are made on the basis of good evidence about costs, quality, outcomes and risks for users, including both in-house and externally provided services</p> <p>There are detailed plans for each care group</p> <p>Clear performance management arrangements and measures are in place; these involve users and carers; they focus on the impact that services have on people's quality of life; and performance is publicly reported</p> <p>Partners are signed up to performance management arrangements and jointly review performance regularly</p> <p>Partners routinely consider how to improve services, not just for new users but for people who already receive a service</p> <p>There is regular sharing of benchmarking information among partners and this is used to improve services</p>	<p>There is no clear approach to determining what works or whether the services provided meet needs</p> <p>There is no attempt to identify gaps in services</p> <p>Information on performance is not routinely gathered, analysed or reported publicly or does not involve users and carers</p> <p>It is not clear who is responsible for doing what</p> <p>Partners are unable to demonstrate progress or what difference they are making to people's lives and do not have a shared approach to managing performance</p> <p>Efforts to improve services or change the way they are delivered are only directed at new users and carers, not those already receiving services</p> <p>Services and processes are not subject to benchmarking or review</p>

Source: Audit Scotland and the Care Inspectorate

### Current approaches to delivering services are not sustainable

**23.** There are particular demographic and financial challenges for councils and NHS boards which mean that current models of care are unlikely to be sustainable in the longer term. These challenges include:

- The number of older people in Scotland is projected to rise by 22 per cent over ten years (from 879,000 in 2010 to 1,075,000 in 2020), and by 63 per cent over 25 years (to 1,431,000 in 2035). The number of people aged 85 and over is projected to increase by 39 per cent over ten years and by 147 per cent over 25 years. These population trends will increase demand for health and social care services in future. The Scottish Government has reported that the amount spent on health and social care services would need to increase by £3.5 billion by 2031 if the systems remain as they are now.<sup>22</sup>
- The ratio of pensioners to people of working age is expected to increase from the 2010 level of 32 pensioners per 100 people of working age to 38 pensioners per 100 people of working age by 2035. This means relatively fewer people available to deliver public services and to contribute taxes that pay for health and social care.<sup>23</sup>
- More people with complex and severe impairments are surviving as a result of medical advances, and people with long-term conditions are living longer.<sup>24</sup>

- More children are being looked after by their council and have increasingly complex needs.<sup>25</sup>
- The amount spent by councils providing personal care to people in their own homes has grown from £133 million in 2003/04 to £318 million in 2009/10, a rise of 105 per cent in real terms.<sup>26</sup>
- Public sector budgets are expected to be reduced by 12.3 per cent in real terms between 2010/11 and 2014/15.<sup>27</sup>

**24.** Faced with these significant and complex challenges, there is a risk that councils and NHS boards take short-term decisions based on the cost of services rather than focus on the longer term. Such short-term decisions could include reducing funding for preventative services and focusing on providing care for those with the most intensive needs. This may add to future pressures for other parts of the public sector. We comment on these issues in Parts 2 and 3.

<sup>22</sup> *Projected Population of Scotland (2010-based)*, National Records of Scotland, 2011; *Health of Scotland's Population: Life expectancy*, ISD Scotland, 2011; *Reshaping care for older people: A programme for change 2011–2021*, Scottish Government, 2011.

<sup>23</sup> *Projected Population of Scotland (2010-based)*, National Records of Scotland, 2011.

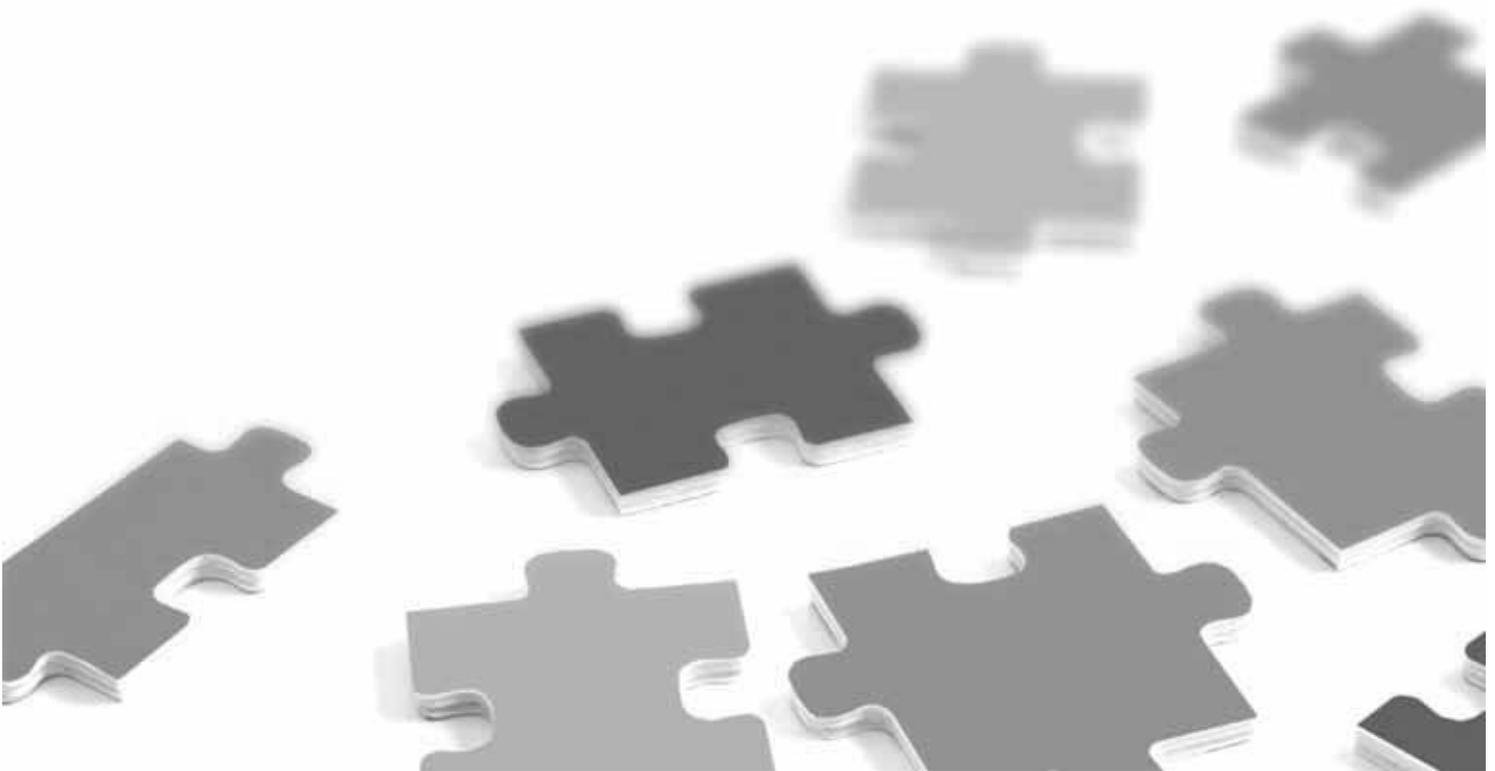
<sup>24</sup> Long-term Conditions Alliance Scotland, 2011.

<sup>25</sup> *Children looked after statistics 2009-10*, Scottish Government, 2011; *Higher aspirations, brighter futures: National Residential Child Care Initiative*, Scottish Institute for Residential Child Care, 2009.

<sup>26</sup> *Free personal and nursing care, Scotland 2009-10*, Scottish Government, 2011.

<sup>27</sup> *Scottish spending review 2011 and draft budget 2012-13*, Scottish Government, 2011.

# Part 2. Strategic commissioning



Councils and NHS boards have been slow to develop strategic commissioning.



## Key messages

- Councils and NHS boards have been slow to develop strategic commissioning. Only 11 of the 32 council areas had commissioning strategies covering all social care services. Most of the strategies we reviewed did not include an analysis of local needs or the costs and capacity of in-house and external providers to meet those needs. Councils and NHS boards need this information to make informed decisions about which services to invest and disinvest in.
- Joint commissioning by councils and NHS boards is challenging but is essential to delivering effective social care services with limited resources. We found limited evidence of joint strategic commissioning between councils and NHS boards. Of the commissioning strategies that do exist, most relate to the council rather than reflecting the important interdependence of health and social care services. There are, however, examples of collaborative working between councils on specialist services that are expected to make savings and improve services.
- Despite a range of initiatives aimed at improving commissioning, councils and NHS boards need more help to improve. Guidance has been produced on commissioning and procurement but the lack of commissioning strategies in place highlights that many councils and NHS boards have not yet fully implemented the guidance.

- Skills and capacity in commissioning and procurement need to develop further. When procuring social care from external providers, councils have found it difficult to implement formal procurement processes while also ensuring that the services best meet users' needs. Staff need to be trained so they understand procurement regulations, legal requirements and the sensitivities of procuring personal care for local people.
- There are indications that councils are continuing to focus resources on people who need more intensive support, tightening eligibility criteria and increasing charges. There is a risk that people who need a small amount of support are not being offered the preventative services that might help delay or avoid them needing more costly intensive support, such as being admitted to hospital or into residential care.

### Progress with developing strategic commissioning has been slow

**25.** Between 2003 and 2007, the Social Work Inspection Agency (SWIA) carried out performance inspections of all 32 councils and reported that strategic commissioning was generally underdeveloped for social work services.<sup>28</sup> Key weaknesses included a lack of plans and strategies, insufficient engagement with some users, planning only for the short term (one or two years) and limited use of planning information. Twenty-seven of the 32 councils received recommendations for improving commissioning. Follow-up inspections during 2008 to 2010 found that substantial progress was evident in only seven of the 27 councils.<sup>29, 30</sup>

**26.** We found little evidence in our audit of significant improvements and limited progress on joint commissioning by councils and NHS boards. Of the commissioning strategies that do exist, most relate to the council rather than reflecting the important interdependence of health and social care services.

**27.** Across the 32 councils, only 11 had commissioning strategies covering all social care services. A further seven had strategies for some services (eg, for children or older people only). The remaining 14 councils were developing their strategies. We reviewed a sample of eight commissioning strategies in detail and found:

- one strategy was long term (10–15 years), six covered a three to five-year period and one covered a year
- five were not based on a detailed analysis of local needs or capacity to meet these needs
- four only referred to basic population trends to project people's needs in future years. They did not analyse patterns of current service use or refer to local or national research about the factors affecting demand
- three of the strategies did not set out specifically what differences services should make to the quality of people's lives
- four had clearly involved users and carers in preparing the strategy
- none included information about the quality and costs of both in-house and external provision.<sup>31</sup>

<sup>28</sup> SWIA is now part of the Care Inspectorate, which was established on 1 April 2011.

<sup>29</sup> *Report on the follow-up of performance inspections of council social work services*, Social Work Inspection Agency, 2011.

<sup>30</sup> Clackmannanshire, East Lothian, Falkirk, Midlothian, Scottish Borders, Glasgow City, Moray.

<sup>31</sup> The sample of eight strategies were from the following councils: Argyll & Bute (draft), East Ayrshire, East Dunbartonshire, City of Edinburgh, Fife (older people only, joint with NHS Fife), Glasgow City, North Lanarkshire, South Lanarkshire.

### Joint commissioning and collaborative working can lead to more effective and efficient services but few joint strategies are in place

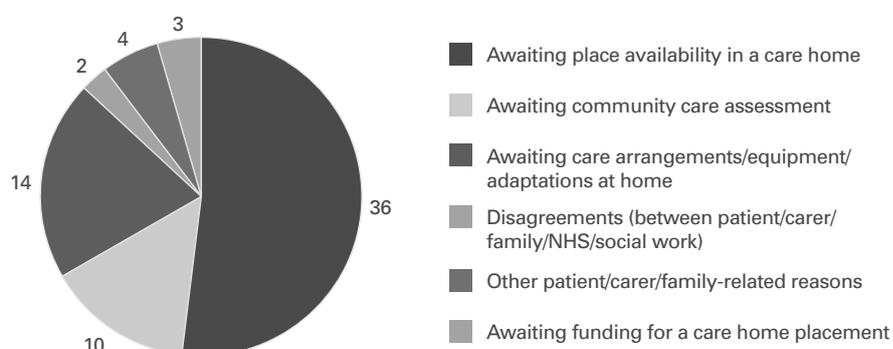
**28.** Commissioning social care services requires a joined-up approach with other council services, including housing, education and leisure, as well as with NHS boards and other public services such as police and prison services. Councils and NHS boards, along with other relevant commissioning partners, should plan services together to help provide joined-up care and make the most efficient use of their collective resources. For example, many people need healthcare and social care services at the same time so it is important that they receive a joined-up service. Users may be confused about which services they can access or there may be interruptions or delays to their services if they are not planned jointly and it is not clear who is responsible.

**29.** One important area where councils and NHS boards need to plan and work together is in reducing the number of people who are unnecessarily delayed in hospital.<sup>32</sup> This is a key indicator of how well partners are working together and is showing signs of pressure. Although the number of people delayed has fallen significantly over the last decade, it has been increasing slightly since 2008 (from 434 in April 2008 to 665 in April 2011).<sup>33</sup> The most recent analysis of reasons for people being delayed in hospital for longer than six weeks shows that over half were waiting for care home places (Exhibit 6).

#### Exhibit 6

##### Principal reason for delayed discharges of more than six weeks

At October 2011, 69 people had been waiting longer than six weeks to be discharged from hospital. Over half were waiting for a care home place.



Source: *Delayed discharges October 2011*, ISD Scotland, 2011

**30.** Partnership working, including commissioning, for health and social care is challenging and requires strong, shared leadership by both NHS boards and councils. Differences in organisational cultures, planning and performance, and financial management are barriers that need to be overcome.<sup>34</sup> There are few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available.

**31.** Joint strategies are being developed, mainly for older people's services as part of the Reshaping Care for Older People programme.<sup>35</sup> This is likely to result in joint strategies for older people's services either being in place, or at least being in development, by February 2012, when applications for the next round of the Change Fund are due to be submitted (Exhibit 7, overleaf).<sup>36</sup>

### Councils and NHS boards need better information about the costs of social care services

**32.** Councils and NHS boards do not have sufficient information to make informed decisions about how they allocate their combined resources. In particular they do not have a full understanding of how much social care services cost and their value for money. The Scottish Government is developing an Integrated Resource Framework (IRF) to provide better information on how health and social care money is spent. If successful, the project should help councils and NHS boards to prioritise and align their resources to support changes in how care is provided. However, information on resources within NHS boards and councils is not well developed and councils in particular have made variable progress in mapping cost and activity information.<sup>37</sup>

<sup>32</sup> Inpatients are categorised as a 'delayed discharge' when they are clinically ready for discharge but are unable to leave the hospital because other necessary care, support or accommodation for them is not readily accessible and/or funding is not available to purchase, for example, a care home place.

<sup>33</sup> *Delayed discharges, October 2011*, ISD Scotland, 2011.

<sup>34</sup> *Review of Community Health Partnerships*, Audit Scotland, 2011.

<sup>35</sup> *Reshaping Care for Older People: A programme for change 2011–2021*, Scottish Government, 2011.

<sup>36</sup> The Change Fund was introduced in 2011/12 and aims to support councils and the NHS to change how they provide older people's services. Councils and their NHS partners have to submit joint applications, also signed off by the third and independent sectors, to access this funding.

<sup>37</sup> *Review of Community Health Partnerships*, Audit Scotland, 2011.

**Exhibit 7****Commissioning guidance and support**

There have been several initiatives to try to improve commissioning.

Support to improve commissioning	
<b>Guidance</b>	
<i>Guide to strategic commissioning: taking a closer look at strategic commissioning in social work services, SWIA</i>	Self-assessment guide, published in 2009 after SWIA made recommendations to 27 of the 32 councils to improve strategic commissioning.
<i>Guidance on the Procurement of care and support services, Scottish Government and COSLA</i>	Published in 2010 to help public bodies make decisions that fit with procurement rules while maintaining the principles of social care.
Reports and guidance from the rest of the UK	Including the work of the Institute for Public Care, Department of Health, Local Government Improvement and Development.
<b>Organisations/groups</b>	
The Joint Improvement Team (JIT)	Provides practical support and additional capacity to health and social care partnerships to help improve effectiveness and joint working. Sponsored by the Scottish Government, COSLA and the NHS. Has produced guidance and run seminars to help partners prepare joint commissioning strategies for older people's services.
Scotland Excel	Centre of expertise to coordinate and lead improvement, and to help make savings for local government as part of the Scottish Executive's 2006 Public Procurement Reform Programme. <sup>1</sup> Carries out the Procurement Capability Assessment programme to help councils improve how they plan and manage procurement across all services, including social care. <sup>2</sup>
<b>Programmes for specific groups</b>	
The Same as You? National Implementation Group	Works with providers, users, carers and councils to help develop services to better meet the needs of the increasing number of people with learning disabilities living in the community.
The Looked After Children Strategic Implementation Group	Set up in 2010 to implement a programme to improve outcomes for looked after children and young people, including work on improving strategic commissioning.
Reshaping Care for Older People	Programme of workstreams, events and other initiatives led by the Scottish Government to support all organisations involved in caring for older people to address the challenges of supporting and caring for Scotland's growing older population. This includes an initial £70 million Change Fund in 2011/12 for NHS boards and partners to support changes to the way services are provided and a further £80 million in 2012/13, £80 million in 2013/14 and £70 million in 2014/15.

**Notes:**

1. Public Procurement Reform Programme, set up by the Scottish Executive in 2006 following publication of the report *Review of Public Procurement in Scotland, Report and Recommendations*, John F McClelland, Scottish Executive, 2006.

2. *Procurement Capability Assessment 2010*, Scottish Government, 2010.

Source: Audit Scotland

**33.** In Highland, the NHS board and council are in the process of implementing plans where one partner will delegate responsibility to the other for certain services. The delegating partner will also transfer agreed resources such as budgets, staff and assets to the lead agency which it will pool with its own resources to manage the integrated service. NHS Highland will be the lead agency for adult community care services and Highland Council will be the lead agency for children's services. Detailed planning is under way and these new arrangements are expected to be implemented in April 2012.

#### **Collaborative working on specialist services can improve services and reduce costs**

**34.** Working collaboratively on small-scale, specialist services can create opportunities to benchmark costs, share experiences of delivering services and seek specialist advice at relatively small cost to each partner. For example, three councils in the Clyde Valley area have been working with NHS Greater Glasgow and Clyde to review foster care services (Case study 1).<sup>38</sup>

**35.** There are also benefits in procuring small-scale, specialist services on a national basis. For example, secure care for young people has recently been procured through a single national contract in place of councils purchasing single places when they need them (Case study 2, overleaf).

**36.** A national approach to contracting services can also save duplication of effort and unnecessary variation among councils. For example, a national care home contract and pricing structure was introduced in 2007 and was negotiated between councils and providers through their representative organisations.<sup>39</sup> The

#### **Case study 1**

##### **Collaborative working in Clyde Valley for specialist foster care services**

East Dunbartonshire, Renfrewshire and West Dunbartonshire Councils are working with NHS Greater Glasgow and Clyde to develop a multi-dimensional treatment foster care service (MTFC) for the Clyde Valley area. The service will support eight young people aged 11–16 with severe emotional and behavioural problems to live with specially trained foster carers within the local community for a period of six to nine months. A range of professionals, including health specialists, provide intensive support to the foster carers. Research in North America and England has found treatment foster care to be a more effective alternative to regular foster care or residential care.<sup>1</sup>

Currently the only Scottish MTFC service is in Glasgow. However, none of the three councils involved in this Clyde Valley initiative has as many as eight young people who need these specialist places at one time. It would therefore not have been feasible for one of the councils to develop this service on its own.

This new, shared MTFC service for the Clyde Valley area is expected to be in place by summer 2012 at an estimated cost of around £600,000 a year. This equates to £1,500 per place per week. At present, these young people are typically placed in residential care, at an average cost of £3,000 per place per week, or they are in mainstream foster care which does not fully meet their needs. Some young people eligible for MTFC will be at risk of being placed in secure care at a cost of around £5,000 per week.

Note: 1. *Multi-dimensional treatment foster care in England – Annual Project Report 2010*, MTFC Implementation Team, 2010.  
Source: Audit Scotland

national contract for care homes was introduced to help raise the quality of care and standardise the price of places. It is currently being reviewed by national partners, providers and user representative organisations with the intention of producing a national framework for commissioning care home services.

#### **More support is needed despite previous initiatives to improve commissioning**

**37.** Over the last few years a range of initiatives and guidance has been produced to help councils and NHS boards to improve how they commission social care services, including procurement (Exhibit 7).

The two main guides about commissioning were produced by SWIA and the Scottish Government.<sup>40</sup> These were prepared in response to SWIA's evidence that councils and their NHS partners needed to improve their strategies and practices (paragraph 25), as well as widespread concerns about how to implement EU Procurement Directives and Scottish procurement regulations in a way that supports high-quality care services.

**38.** Three-quarters of council social work departments told us that they found SWIA's guidance very useful, particularly the clear definitions and self-assessment checklists, and over half found the Scottish Government's guidance very useful. However, our

<sup>38</sup> The review of foster care services is one strand of work of a regional initiative, funded by the Scottish Government and hosted by Renfrewshire Council. The initiative involves the eight councils and two NHS boards within the Clyde Valley area with the purpose of developing strategic collaborative approaches to the commissioning of children's services. It is one of the developments being overseen by the Looked After Children Strategic Implementation Group.

<sup>39</sup> Convention of Scottish Local Authorities (COSLA), Scottish Care and the Coalition of Care and Support Providers in Scotland (CCPS).

<sup>40</sup> *Guide to strategic commissioning: taking a closer look at strategic commissioning in social work services*, Social Work Inspection Agency, 2009; *Guidance on the procurement of care and support services*, Scottish Government, 2010.

## Case study 2

### National contract for secure care

Secure care is a specialist type of care which provides a safe and secure residential environment for young people who require care for their own safety and for those who present a risk to others. In July 2011, following a detailed review of need and provision across Scotland, a national contract to provide secure care was awarded to four providers. The contract is valued at £40 million over two years for 78 places, each costing around £5,000 per week. Previously, councils arranged individual places in a variety of ways, ranging from a covering letter to a service level agreement.

The national secure care contract has reportedly brought about the following benefits:

- The national contract sets out the rights and responsibilities of all parties, drawing also on the National Care Standards for Care Homes for Children and School Care Accommodation, and aims to improve outcomes for the children and young people.<sup>1</sup>
- It uses a standard service specification detailing 13 elements that must be provided as part of the weekly rate. These include 24-hour care and accommodation, clothing, schooling, toiletries and a specified rate of pocket money dependent on age. Before this was in place, these elements tended to be negotiated on an individual basis and could vary by provider and by which council was paying for the care.
- Working collaboratively on one national contract is beneficial in terms of resources for providers, councils and the Scottish Government.
- Managing the contract centrally will free up council resources and pool expertise. The commercial aspects of the contract are being managed by Scotland Excel while the service and outcomes aspects are the responsibility of a national children's commissioning manager appointed by COSLA and the Scottish Government.<sup>2</sup> This allows a coordinated response to any issues which might arise with a provider.
- Savings have been forecast for councils and the Scottish Government at around £400,000 per year.

#### Notes:

1. *National Care Standards*, Scottish Government, 2002–05.

2. Scotland Excel is a centre of expertise for coordinating and leading improvement in the procurement of public services.

Source: Audit Scotland, based on report on Secure Care Tender to Scotland Excel executive subcommittee, 17 June 2011

audit and the lack of commissioning strategies in place in Scotland highlight that many councils and NHS boards have not yet fully implemented the guidance.

**39.** SWIA reported that progress on improving strategic commissioning was slow because some councils and their NHS partners found it too complex (Case study 3).

**40.** There is limited evidence that councils and their NHS partners are sharing their learning to help improve commissioning processes. Despite the support and guidance already available (Exhibit 7), social work directors and managers in councils told us they would welcome practical tools to accompany existing guidance. These include information and templates to help analyse current service provision, case studies of how

to commission services that make a positive difference to people's lives, and data and tools to help project local needs in future years based on demographic trends.

**41.** A number of councils are involved in regional benchmarking groups, for example in Tayside and Forth Valley. However, although they compare some social care cost and performance information, they report difficulties in benchmarking because data are often collected differently and cannot be compared. For example, data on service costs do not always include the same elements of expenditure. There is a need for more consistent data and much greater transparency about the costs of in-house and externally provided care services.

### Skills and capacity to commission social care need to develop further

**42.** Staff involved in commissioning social care come from a variety of backgrounds, including social work. No qualification is currently available that covers all the skills required. To help address the skills gap, Scotland Excel is working with the Association of Directors of Social Work (ADSW) to develop a Professional Development Award in commissioning, supported by the Scottish Qualifications Authority. It will tie in with National Occupational Standards in commissioning, procurement and contracting already specified by the Scottish Social Services Council (SSSC).

**43.** In addition to a need for better commissioning skills, there is a lack of capacity to commission effectively. SWIA reported that some of the difficulties faced by social work services and partnerships in improving commissioning were insufficient management capacity, underdeveloped information systems and pressure on staff resources.<sup>41</sup>

**44.** When procuring care services from voluntary and private providers, councils have found it difficult to

implement formal procurement processes while also ensuring that the services best meet users' needs. Procurement is generally a corporate function in councils so there is a risk that neither procurement professionals nor social work staff have all the professional skills to commission social care services effectively. A combination of both is needed. Argyll & Bute Council has attempted to address this problem by merging its social care commissioning and corporate procurement teams (Case study 4).

**45.** Scotland Excel carries out a Procurement Capability Assessment (PCA) in every council each year.<sup>42</sup> This model is used in other sectors too, including the NHS. It aims to help drive improvements in procurement policies and practices across all service areas, including social care, by assessing public bodies' performance against a set of standards. Councils currently perform worse than other sectors in their Procurement Capability Assessments. However, in many cases, it is social care procurement that is one of the main weaknesses rather than other procurement activity. This is often because social care has not been following corporate policies and procedures or the policies do not take sufficient account of users' personal dependence on the services.

#### **Investing in preventative services can help delay or avoid the higher costs of more intensive support**

**46.** Preventative services are designed to help people live as independently as possible and to maximise their quality of life. They include practical assistance with everyday tasks such as shopping, cleaning and small jobs around the house; advice on managing finances or accessing benefits; access to social activities; equipment and adaptations to make people's homes safer and prevent accidents; telecare; and occasional respite to

### **Case study 3**

#### **Fife Council and NHS Fife joint commissioning strategy for older people's services**

Fife Council and NHS Fife began developing a joint commissioning strategy for older people in 2006. The strategy took several years to develop and was finally published in June 2011 as the *Joint health and social care strategy for older people's services in Fife, 2011–2026*. SWIA had reported in 2010 that the delay in finalising this strategy presented an ongoing weakness in commissioning, especially in view of the significant strategic service and financial planning that had taken place in Fife.<sup>1</sup>

Fife Council cited two principal barriers to producing the commissioning strategy. First, the significant change in the economic climate since work on the strategy began meant that the council and NHS board had to build into their strategy how they would deal with the impact of decreasing budgets. Second, the policy landscape had changed and the council needed to take this into account.

The Joint Improvement Team funded a temporary post to help Fife Council and NHS Fife develop their commissioning strategy. A draft version was produced in April 2010 but the council delayed publication of the strategy to take account of the Scottish Government's Reshaping Care for Older People policy, which was published in March 2011.

Note: 1. *Fife Council Scrutiny Report*, Social Work Inspection Agency, December 2010.  
Source: Audit Scotland

### **Case study 4**

#### **Argyll & Bute Council's joint social care commissioning and procurement team**

In May 2010, Argyll & Bute Council's social care commissioning team merged with its procurement team to form a single team of 21 staff. The heads of each team had recognised linkages and overlaps between their work, eg testing the market, specifying services and outcomes, and developing contract management frameworks. They also saw potential benefits in sharing their respective expertise.

Senior managers in the team believe the advantages of this arrangement have been that all the qualifications, skills and experience needed to commission and procure social care services are now combined in a single team, with a single work plan. Sharing good practice and knowledge within the new team has brought commissioning skills to procurement officers and procurement skills to commissioning officers. The annual Procurement Capability Assessment will help the council to assess longer-term effectiveness.

Source: Audit Scotland

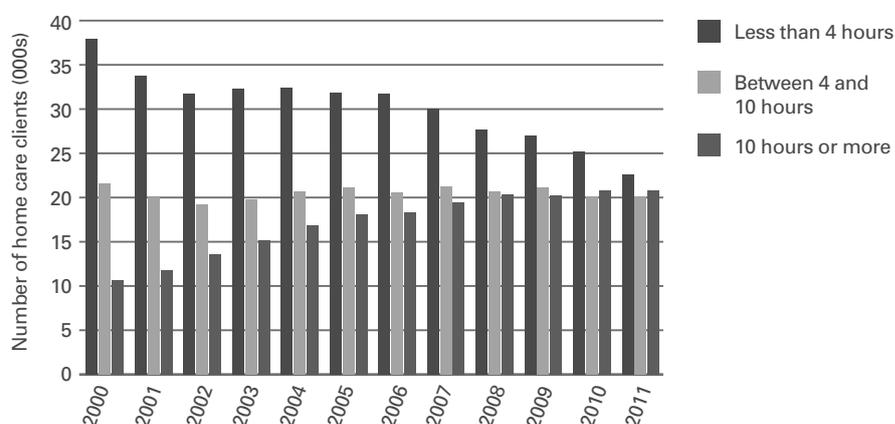
help carers or families. They may be provided by voluntary or community organisations, possibly with some financial investment from the council. The benefits of these services for people are potentially significant but are difficult to measure. For example, opportunities for social interaction can make a huge difference to the quality of someone's life or services arranged by a council to keep a frail, older person safe in their own home might prevent an accident that results in an emergency admission to hospital, at a significantly higher cost than the preventative home care service. The Scottish Parliament Finance Committee's recent inquiry on preventative spending referred to strong evidence of the long-term financial benefits of preventative services, particularly in health and social care, and the Scottish Government is supporting developments in preventative spending through Change Funds.<sup>43, 44</sup> Audit Scotland has also commented in previous reports on the value of preventative services.<sup>45</sup>

**47.** The Scottish Government introduced the Reshaping Care for Older People programme and the Change Fund over the last couple of years. They aim to help commissioning partners work together to develop alternative, more effective and more efficient services for older people, including preventative services. Many councils have worked with NHS boards to develop specialist services aimed at providing intensive home care on a short-term basis to people leaving hospital or people at risk of being admitted or re-admitted. The service usually lasts for up to six weeks and aims to give people the confidence and skills to continue to live at home with minimal support.

### Exhibit 8

#### Home care hours, 2000–11

Councils are targeting their resources at people who need more intensive home care.



Source: *Home care services, Scotland 2011*, Scottish Government, 2011

**48.** A study of these services in England found that up to 68 per cent of people no longer needed a home care package after this kind of short-term support, and up to 48 per cent continued to manage without any home care two years later.<sup>46</sup> In Scotland, Dumfries & Galloway Council found that, of 70 people who received this type of service in 2009/10, 30 (43 per cent) needed no further care immediately afterwards and 16 (23 per cent) had a reduced care package.<sup>47</sup> In Edinburgh, the council provided this service to 90 people. After the six weeks, the total hours of care required were reduced by 41 per cent, 60 per cent of users needed fewer hours, and nearly two-thirds of these required no further service at the end of the period. It was more expensive to provide this specialist six-week service but the longer-term costs were reduced through fewer hours being required.<sup>48</sup> The Scottish Government is developing national guidance on this type of service (Intermediate Care Framework).

**49.** There is evidence that councils may be targeting their resources at people who need more intensive support. At a national level, more hours of home care support were provided in 2011 compared with 2000 but the number of people receiving home care has decreased by nearly ten per cent to 63,500 over the same period (Exhibit 8). The number of people receiving home care of less than four hours a week has decreased by 41 per cent, and a survey of housing support providers reported that the number of older people receiving housing support of less than four hours a week fell from 84 per cent in 2008/09 to 47 per cent in 2009/10.<sup>49</sup> This suggests that people who need less intensive support are not being offered some services that might help delay or avoid their needing more intensive services. However, people often receive more than one service, eg a combination of equipment and adaptations, telecare, home care, and support from local voluntary organisations, so it is hard to draw definitive conclusions from

43 *Report on preventative spending*, Finance Committee, Scottish Parliament Paper 555, FI/S3/11/R1, 2011.

44 *Renewing Scotland's public services: Priorities for reform in response to the Christie Commission*, Scottish Government, 2011.

45 *A review of free personal and nursing care*, Audit Scotland, 2008; *Adapting to the future: management of community equipment and adaptations*, Audit Scotland, 2004; *Commissioning community care services for older people*, Audit Scotland, 2004; *Homing in on care: a review of home care services for older people*, Audit Scotland, 2001.

46 *Home care Re-ablement Retrospective Longitudinal Study*, Personal Social Services Research Unit, University of York, 2007.

47 *Short-term Augmented Response Services (STARS)*, Dumfries & Galloway Council, Social Work Services Committee paper, 29 June 2010.

48 *Evaluation of City of Edinburgh Council home care re-ablement service*, RP&M Associates, Scottish Government, 2009.

49 *Research into housing support funding levels and service volume in Scotland 2009/10*, Housing Support Enabling Unit, 2010.

the national data available. In 2008, we recommended that councils should work with local health partners to evaluate the longer-term consequences of reducing domestic home care services such as cleaning, shopping and laundry services. The trend in reducing these lower-level, preventative services has continued.<sup>50</sup>

**50.** There has been a slight increase in the amount of respite care provided between 2007/08 and 2010/11, when 211,250 weeks of respite care were provided.<sup>51</sup> Statistics on day care centres show that provision was relatively static between 2001 and 2007.<sup>52</sup>

**51.** Social work directors and managers told us that budget pressures have led 13 councils to implement new, tighter eligibility criteria. Seven councils now charge for services previously provided without charge or have increased charges already in place, typically for services such as community alarms.

**52.** Enhancing preventative services requires councils and NHS boards to work together and use their combined resources to invest in these services. This may mean freeing up resources by stopping some services or delivering some services differently, which the Reshaping Care for Older People programme and the Change Fund are aiming to support. This will be challenging and needs strong leadership at national and local levels. However, the lack of joint commissioning strategies, insufficient information about service costs and a recent rise in the number of people unnecessarily delayed in hospital all point to more progress being needed.

## Recommendations

Councils, along with NHS boards and other relevant commissioning partners, should:

- develop commissioning strategies for social care services which set out:
  - an analysis of needs and potential gaps in services
  - how users, carers and providers will be involved throughout the commissioning process
  - consideration of quality and what impact services will make to the quality of people's lives, and how these will be measured
  - consideration of who might be able to provide the services needed (capacity)
  - an analysis of costs and budgets for services (both in-house and externally provided)
  - a summary of any planned improvements or different ways of working
  - timescales for implementing and reviewing the strategy
- seek opportunities to work collaboratively with other councils and NHS boards to share information and expertise and benefit from economies of scale, including:
  - share planning resources for forecasting needs and planning services
  - participate in benchmarking with other councils and

NHS boards to compare performance and share tools and learning

- undertake joint procurement exercises with other councils and NHS boards for small-scale, specialist services
- ensure that they have in place, and make the best joint use of, professional skills in both procurement and social care commissioning
- train their commissioning staff in the appropriate skills, making use of the national commissioning skills programme where appropriate.

Councils and NHS boards should:

- work together to invest in preventative services that can help to delay or avoid people needing more intensive support and monitor the impact of these services.

The Scottish Government should:

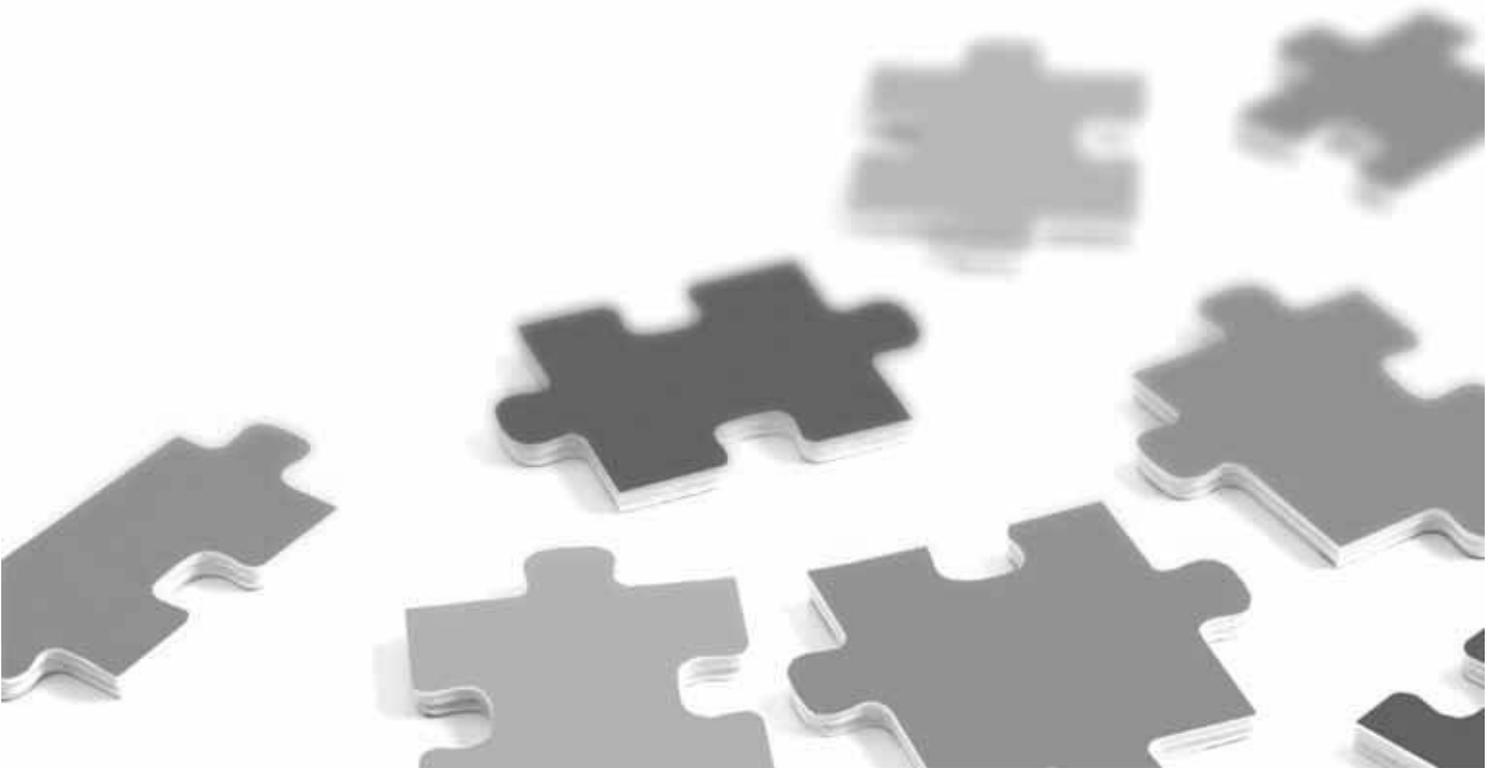
- provide clear leadership for joint commissioning of health and social care services between councils and NHS boards by:
  - setting out clear expectations and priorities
  - supporting development of practical tools to help councils and NHS boards improve their strategic commissioning
  - working with the Care Inspectorate to ensure scrutiny and help for councils, NHS boards and other commissioning partners to improve their strategic commissioning.

<sup>50</sup> *A review of free personal and nursing care*, Audit Scotland, 2008.

<sup>51</sup> *Respite Care, Scotland 2011*, Scottish Government, 2011.

<sup>52</sup> In March 2007, there were 633 registered day care services, ten fewer than in 2001. In 2007, there were 17,600 places providing a service to 23,000 people, compared to 18,800 places providing a service to 22,200 people in 2001. (*Day care services, Scotland 2007*, Scottish Government, 2007). More recent data were published in 2011 but use different definitions and therefore are not comparable with previous years.

# Part 3. Delivering social care services



There is scope to improve provider involvement and the management of risks associated with providers closing.



## Key messages

- Voluntary and private sector providers deliver a significant proportion of social care services in Scotland. Councils and NHS boards do not always involve voluntary and private providers in planning which services are needed in the local area, how best to provide them and in developing new, more flexible services. Councils do not fully analyse the costs, capacity, accessibility, quality and impact of in-house and voluntary and private sector provision in their commissioning decisions. None of the eight commissioning strategies we analysed explained decisions about in-house and externally provided services based on information about quality and costs.
- Although information is available from the Care Inspectorate about the quality of services, councils also need to know what difference the services make to people's independence and quality of life so they procure on the basis of evidence of what works. With reducing budgets across the public sector, there is a risk that councils focus too much on reducing costs when procuring services and give insufficient regard to the range and quality of services and their impact on individuals.
- While processes are in place to monitor quality, more needs to be done across Scotland to manage the risks to councils and users when a provider goes out of business or closes for other reasons. This includes having contingency plans in place and monitoring effectively the financial health of voluntary and private providers. This can be

complex and will involve further development and coordination of capacity and expertise at local and national levels.

### Providers should be more involved in strategic commissioning

**53.** Voluntary and private sector providers deliver a significant proportion of social care services in Scotland in addition to services provided in-house by councils. Councils and their NHS partners need to make sure there is a range of high-quality services and providers to meet people's needs and give them choices about their care. To do this, they need to work effectively with voluntary and private providers when they are analysing local needs and planning services to meet those needs, as well as when making contractual arrangements to deliver services. Providers' information and expertise can help to identify people's needs, map out current provision and capacity, and develop new and more effective services.

**54.** None of the sample of eight commissioning strategies we analysed contained a full analysis of current service provision for each of the main care groups. An analysis should set out as a minimum the current type, quality, cost, capacity and accessibility of all services in the area, including councils' in-house services, and identify how they need to change to meet future needs. Providers may need time, and smaller providers may need support, to change.<sup>53</sup>

"Commissioners don't always seem sure of what services are available. There is a lack of information about what has been commissioned and a reliance on word of mouth for connections."

Voluntary sector organisation,  
provider focus groups

**55.** As well as mapping current supply, councils and NHS boards also need to have an understanding of the financial and business challenges facing providers.<sup>54</sup> Without this, it is difficult to make informed decisions about whether to procure services or provide them in-house. Providers have expressed concerns that councils maintain funding for in-house services while freezing or reducing funding to providers whose services are cheaper but of equally good quality. Our report on residential child care for looked after children found that few councils understood the full costs of services, particularly their in-house services, so were not able to make informed judgements about the value for money of all the options.<sup>55</sup>

**56.** The Scottish Government's guidance sets out advice for commissioning bodies on how to work successfully in partnership with providers (Exhibit 9, overleaf). One of the difficulties councils find in involving providers in strategic discussions is that it is not easy for one or two voluntary and private sector organisations to represent the views of all organisations. They can be very different from each other in the services they provide, their size and the way their organisations operate. Councils can be faced with large, resource-intensive meetings and consultations to engage with providers. Providers also find this challenging as they often do not have the resources to take part in various consultation exercises.

**57.** Provider forums exist in many council areas and allow public bodies and providers to discuss issues relating to the delivery of services and to share information. Such forums work most effectively if arranged around service development areas or care groups. For example, Association for Real Change (ARC) Scotland (funded by the Scottish Government and the Big Lottery Fund) facilitates

53 *Changing Lives: A personalised commissioning approach to support and care services*, Scottish Government, 2009.

54 *Developing market intelligence, National Market Development Forum Discussion Paper 2*, Institute for Public Care at Oxford Brookes University, 2010.

55 *Getting it right for children in residential care*, Audit Scotland, 2010.

## Exhibit 9

### Partnership working between commissioning bodies and service providers

Successful partnership working must be built upon openness and transparency, mutual respect and a joint understanding of the roles and responsibilities of each partner and the challenges that they face. To achieve this, public bodies should:

- recognise service providers' contribution to achieving positive outcomes for service users
- involve service providers in the development of local commissioning strategies and local policies and procedures for the procurement of care and support services
- be proactive in involving service providers in service design and the development of service specifications
- engage with service providers in remodelling services to make them more personalised and outcome focused
- develop a 'can do' culture which promotes innovation
- publish statements of their purchasing intentions, to assist business planning
- establish good lines of communication with service providers, with designated staff who are approachable and able to deal with issues
- engage with service provider forums in discussion of policy and practice and the development of good practice
- be open to suggestions from providers about how the public body's systems could be improved and costs reduced.

Source: *Guidance on procurement for social care and support*, Scottish Government, 2010

the regional provider forums for learning disability service providers in Dundee, Fife, Scottish Borders, Aberdeenshire and Dumfries & Galloway Council areas. The councils, and on occasion NHS boards, attend the meetings for part of the time to share information and discuss issues of mutual interest.

**58.** Councils vary in the extent to which they involve voluntary and private providers. Although all councils reported that they had relatively good relationships with some providers and involved them in strategic planning, providers said they were not involved

in strategic discussions and, when they were consulted, they felt their views were often ignored.

**59.** Providers can find it very difficult to challenge councils if they see problems with the commissioning process as they feel their relationship with the council may be affected. However, they did report positive experiences of being involved with councils, which they felt helped them to better understand the context for the council's decisions (Exhibit 10).

**60.** In 2009, a mixture of contract types was in use in social care.<sup>56</sup>

Councils were more positive about using call-off contracts, where they have agreed prices and terms with providers and pay for only the services they use. Councils had the most negative experiences from spot contracts, where services are purchased on an individual basis as and when they are required; and block contracts, where the council buys a fixed amount of service and pays for it whether or not it uses the service. Both these contract types are commonly used.

**61.** Councils should use a range of different types of contract to have a balance between economies of scale and flexibility. Providers told us it was very hard for them to plan ahead and offer stability to their staff when contracts are renewed annually, or when there are delays in councils making decisions. With the move towards more self-directed support, councils are likely to use fewer contracts that commit them to a fixed amount of service, thereby losing the benefit of economies of scale. This will mean they are more likely to use framework agreements, call-off contracts or spot purchase, so that they only pay for what they use. This lets them respond to users' needs and preferences. We comment on self-directed support in Part 4.

### Councils need to consider cost, quality and the difference that services make to people's lives

**62.** The Care Inspectorate is responsible for, among other things, regulating and inspecting all care services against national care standards.<sup>57, 58</sup> It prepares inspection reports which assess the quality of services on a scale from 'excellent' to 'unsatisfactory'. All types of care service have improved according to inspection reviews. Recent trends

<sup>56</sup> *Social care procurement national survey report*, Joint Improvement Team and Scottish Procurement Directorate, Scottish Government, 2009.

<sup>57</sup> The Care Inspectorate was established on 1 April 2011. It is responsible for registration, inspection, complaints and enforcement for social care services, and for scrutiny of councils' social work and child protection services. It was formed by a merger of SWIA, the Care Commission and the joint child protection team that was previously led by HM Inspectorate of Education (HMIE).

<sup>58</sup> The national care standards were developed in 2002–05 by the Scottish Government, along with national bodies, providers, users and carers, for all the main care services. They set out the standards of care that users can expect to receive.

**Exhibit 10****Challenges and what works well for providers**

Provider focus groups identified some challenges around councils' procurement practices and what works well.

**Challenges for providers include:**

- consistency of decision-making: with many providers feeling there is a lack of a commissioning strategy or plan for their area
- procurement administration: with systems often seen as complex, inaccurate or unclear about services required or inaccuracies in tendering requests
- capacity of providers: responding to purchasing processes puts pressures on staff time, particularly for small organisations
- communication, awareness and joint working within and between commissioning bodies: with different levels of awareness and some challenges to joint working
- balancing quality and price: with providers experiencing pressure to reduce charges while at the same time maintaining or improving quality
- equalities: with many service providers commenting that consideration of equalities groups in procurement processes is basic
- no assessment of the long-term implications of procurement decisions.

**Providers feel processes work well when:**

- there is clarity and fairness around purchasing processes
- providers are supported to develop appropriate skills, including being given feedback on unsuccessful bids
- purchasing decisions take more account of providers' performance to date, including evidence such as service reviews and inspections
- commissioners procure services to achieve good outcomes for service users
- there are reasonable timescales: with time for providers to respond and decisions made quickly.

Source: Audit Scotland

in quality assessments indicate that more services are achieving the highest scores (excellent or very good), with an increase from 17 per cent to 26 per cent of services receiving the highest scores from March 2009 to March 2010.<sup>59</sup> A smaller percentage of care homes scored this highly when compared with other types of care service, although it rose from seven per cent in 2009 to 16 per cent in 2010. Councils are required to take account of the Care Inspectorate's reports when procuring social care services.<sup>60</sup>

**63.** As well as information about the quality of services, councils also need to know whether services are making a difference to people's independence and quality of life so that services are planned and procured on the basis of evidence of what works. However, it is hard to specify and measure outcomes for individuals because they are personal and subjective, for example feeling safe, feeling valued, and having fulfilling social relationships (see Part 4).

**64.** With reducing budgets across the public sector, there is a risk that councils focus too much on reducing

costs when procuring services and give insufficient regard to the range and quality of services and their impact on individuals. The voluntary sector has raised concerns about the financial pressures it faces as a result of public bodies seeking to implement budget cuts by reducing payments to voluntary organisations.<sup>61</sup>

**65.** In 2009, South Lanarkshire Council undertook an e-auction, an online bidding auction, for home care services. This was examined as part of a Scottish Parliament Committee inquiry into home care services

59 *Improving the quality of care in Scotland: An overview of Care Commission findings 2002 to 2010*, Scottish Commission for the Regulation of Care (Care Commission), 2011.

60 Public Services Reform (Scotland) Act 2010.

61 *Scotland's public finances: addressing the challenges*, Audit Scotland, 2011.

for the elderly.<sup>62</sup> The Committee concluded that the method was legal but inappropriate for care services because it encouraged providers to offer their services at such a low cost they would have to cut corners in their services to survive in business. The practice has not been used again, but it was a factor in leading to the development of the Scottish Government's procurement guidance (see paragraph 37).

"It seems to be a race to the bottom in terms and conditions for staff – to get the most for least. This has serious impacts on the quality of staff."

Voluntary sector organisation,  
provider focus groups

**66.** Voluntary organisations report that they have implemented pay freezes, reduced staff numbers and changed the terms and conditions of their staff to remain competitive and secure council contracts.<sup>63</sup> This poses a risk that experienced staff may leave and be difficult to replace, disrupting the relationships they have with users and carers and affecting the quality and continuity of care. However, this is a risk not only to the voluntary sector but to all organisations having to implement budget cuts.

"Why would people put up with increasingly challenging and dangerous behaviours from clients, reduced wages, and lack of understanding from commissioners, when they could earn as much sitting on a till."

Voluntary sector organisation,  
provider focus groups

**67.** The quality of the staff providing social care is essential to the overall quality of the service being provided. The SSSC is in the process of registering everyone who works

### Case study 5 Financial collapse of Southern Cross

As the largest care home provider in Britain, Southern Cross ran 95 care homes in Scotland, providing around 5,600 places, mostly for older people.<sup>1</sup> In spring 2011, Southern Cross announced that it was in severe financial difficulties and was unable to pay rent for the properties it uses. In October 2011, following months of negotiations with councils and other providers, Southern Cross transferred all its homes to other providers and ceased operating.

The Scottish Government and COSLA responded through the National Contingency Planning Group for Adult Care. The group issued national guidance on managing care home closures and now actively monitors progress to ensure that appropriate contingency plans are in place in every council area. The group's membership includes the Scottish Government, COSLA, the Care Inspectorate, Scotland Excel and the Association of Directors of Social Work.

Southern Cross's difficulties were widely reported in the months before it ceased operating. At least one council, Stirling Council, had been monitoring the company's financial viability for two years and had contingency plans in place, having previously had to deal with a small private care home going into administration.

Note: 1. Figures at April 2011, Care Inspectorate, 2011.  
Source: Audit Scotland

in social services (unless they are registered with another relevant professional body). It regulates the training and required qualifications of all registered workers. Users and carers place a lot of importance on the continuity of staff because of the relationships they have built up. Any changes to who is providing care services can have a significant impact on the individual and on the provider organisation. It is therefore important that providers in all sectors invest in training and development and staff retention and that contractual arrangements take this into account.

#### **There is scope to improve the management of risks associated with providers' financial health**

**68.** Business failure is a normal part of a market but, as the Southern Cross example shows (Case study 5), failures in the social care market can

have significant consequences as it involves very vulnerable people, causes distress and anxiety to users and their families, and the council has to quickly put in place alternative care provision. As well as having financial difficulties, voluntary or private care providers can close for other reasons, eg if the Care Inspectorate requires them to close because of unsatisfactory quality of care. In 2010/11, 23 care services received enforcement actions (excluding child minders). These are urgent improvement notices issued by inspectors, with the threat of closure if they are not implemented. Nineteen of the 23 (83 per cent) were care homes, although only 19 per cent of all registered services (excluding child minders) are care homes.<sup>64</sup>

62 Scottish Parliament Local Government and Communities Committee Official Reports 3 June 2009 and 10 June 2009.

63 *Employment conditions in the Scottish social care voluntary sector: impact of public funding constraints in the context of economic recession*, Dr Ian Cunningham, University of Strathclyde, for Coalition of Care and Support Providers in Scotland, 2011.

64 Care Inspectorate, 2011.

### Councils should carry out due diligence when they contract services from third party providers

**69.** Councils need to be vigilant about all the providers they use to deliver services, not just those delivering care home places, and to ensure that the risks are managed. Information about the quality of services is available from the Care Inspectorate and from councils' own processes for checking and monitoring quality. To manage the risks associated with the financial health of providers, councils should carry out due diligence checks before awarding a contract, monitor the financial health of providers throughout the life of the contract, have effective contingency plans in place, and understand the financial and business impact on providers of their commissioning decisions.

**70.** Due diligence means undertaking checks to be satisfied that the provider is currently financially viable and capable of delivering the services (Case study 6). Many of the checks are usually carried out before inviting providers to tender for the contract. For regional or national contracts, Scottish procurement regulations set out the information that public bodies should take into account at the selection stage of a tender exercise. For example, when providers expressed an interest in tendering for the national secure care contract, they were required to submit:

- audited annual financial accounts and annual reports for the previous three years and details of any significant changes since the most recent report
- a completed financial statement about annual turnover and reserves.

### Case study 6

#### Midlothian Council's due diligence checks

Midlothian Council awarded a contract in 2009 to FPCS, a company that provides care services, which went into administration within a few months. The subsequent internal audit found a series of failings in the procurement process, including a number relating to financial health checks.

The procurement process required each tenderer to submit an audited set of accounts for the last three years or a company credit check report. These were to be reviewed by the council before deciding whether that tender would proceed to the final stage of the process. The internal audit review found that:

- FPCS had not provided accounts for the year ending 31 December 2008 despite the tender being submitted in August 2009
- the latest accounts which FPCS provided, for the year ending 31 December 2007, showed the company had made a loss of £126,000, which should have raised concerns
- the council did not undertake a financial health check, such as a company credit check, which may have highlighted a risk in the financial position of FPCS which could then have been investigated more fully. Midlothian Council has now added a financial check of this kind to its procurement procedures.

Source: Audit Scotland, based on *Internal audit report: procurement of the community care at home contract*, report to Midlothian Council Audit Committee, Item No 9(b), 14 December 2010

### Councils should have contingency plans in place to minimise disruption to users, carers and other services should a provider business fail

**71.** Due diligence checks alone cannot prevent providers going out of business and councils should therefore have contingency plans in place to minimise disruption to users, carers and other services. In September 2011, all 32 councils provided COSLA and the Care Inspectorate with a contingency plan for care home residents following the collapse of Southern Cross. The Care Inspectorate monitors individual councils' risk management arrangements as part of its ongoing inspection processes.

**72.** In June 2011, the Care Inspectorate issued guidance under its legislative powers that requires all

care providers (except child minders) to maintain up-to-date contingency plans to be implemented in the event of closure of the service.<sup>65</sup>

### Regulators have an important role in assessing the financial health of providers

**73.** Arrangements are in place to regulate the financial operation of voluntary and private providers when they first register as care providers in Scotland. When a care service first registers with the Care Inspectorate, inspectors assess its arrangements for delivering services that will meet the National Care Standards.<sup>66</sup> They also undertake basic checks to assess its financial viability. At subsequent inspections, once the service is running, inspectors assess the quality of services and award a set of quality scores, but do not

<sup>65</sup> Public Services Reform (Scotland) Act 2011; *Financial viability guidance OPS-111-097*, Care Inspectorate, 2011.

<sup>66</sup> *National Care Standards*, Scottish Government, 2002-05.

consider financial arrangements.<sup>67</sup> The Scottish Parliament Health and Sport Committee recently recommended that the Care Inspectorate gather financial information from providers annually, which could provide an early indication for commissioning bodies of the need to engage with the provider.<sup>68</sup> From 2012/13 onwards, the Care Inspectorate will require all providers to notify it of specific financial events that may indicate financial difficulties.<sup>69</sup> The Care Inspectorate's complaints and inspection processes may also identify declining service quality which can be a symptom of financial difficulties.

#### There is potential for developing a national approach to monitoring and reviewing the social care markets

**74.** As the Southern Cross example demonstrates (Case study 5), it can be more difficult to review the financial viability of very large providers which may deliver services across council boundaries or across the UK. Their financial and organisational arrangements are more complex and it is unlikely that an individual council will have the necessary expertise to examine complex financial models in the private sector. It is also inefficient for every council working with a regional or national provider to undertake this analysis, and for the provider to respond to information requests from each one.

**75.** There is, therefore, a strong case for developing a national approach to monitoring and reviewing the social care markets to support councils in monitoring effectively the financial viability of providers in a way that is proportionate to risk, and to review on their behalf the financial standing of large complex companies like Southern Cross whose failure can have a huge impact on a large number of particularly vulnerable users.

Where appropriate, this expert review function would liaise with relevant UK or other national organisations and with regulatory bodies such as the Care Inspectorate and the Office of the Scottish Charity Regulator (OSCR) to gather intelligence and avoid duplication of effort. The Scottish Government, the Care Inspectorate and COSLA are considering whether further action should be taken to minimise the likelihood of sudden care home closures and the consequent disruption for residents. However, none of these actions removes the need for appropriate, risk-based contingency plans for all care services.

#### Recommendations

Councils, along with NHS boards and other relevant commissioning partners where appropriate, should:

- develop a clear approach to establishing and maintaining good working relationships with providers throughout the strategic commissioning process
- map out current service provision and develop an understanding of quality, effectiveness, the cost of services and the financial and business challenges facing providers
- base their decisions about whether to provide services in-house or procure them from voluntary or private sector providers on a full understanding, for in-house as well as externally provided services, of:
  - the costs
  - the quality of care offered by providers, including using Care Inspectorate inspection report

- the impact of services on people's quality of life
- develop transparent procurement processes and share procurement plans with all the providers who may be able to deliver the services
- manage the risks of contracting services from voluntary and private providers by:
  - undertaking due diligence checks before awarding contracts
  - making sure that appropriate checks on financial health and ability to deliver services are carried out regularly during contracts
  - having contingency plans in place for dealing with a provider going out of business or closing for other reasons
  - understanding the financial and business impact of their commissioning decisions on providers.

The Care Inspectorate and councils should:

- work together to monitor the impact that services have on people's lives as well as the quality of care provided.

The Scottish Government, the Care Inspectorate and COSLA should:

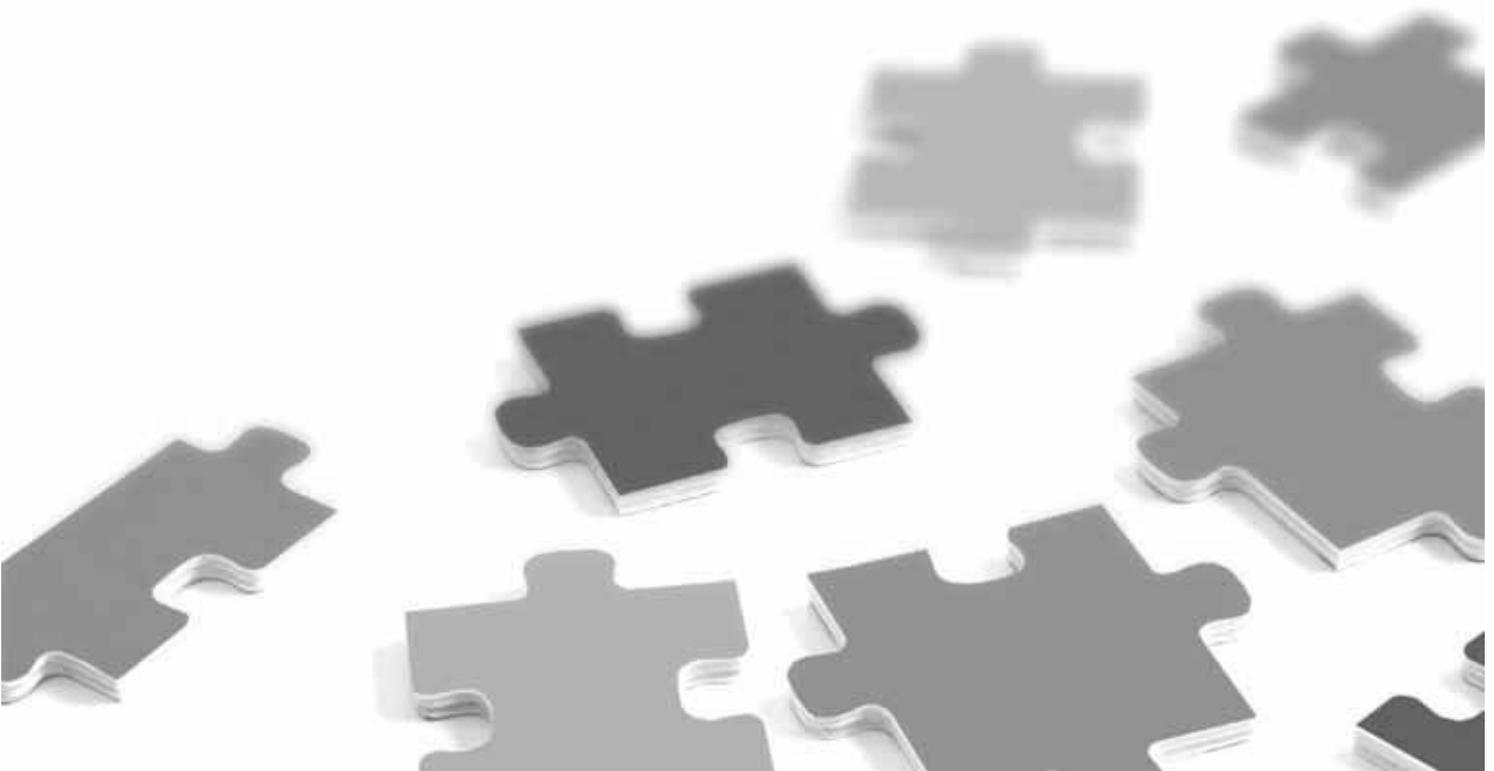
- consider whether there is a need for periodic expert assessment of the social care markets to support commissioning bodies in managing these markets and in monitoring the financial viability of large operators.

67 Quality scores range from 1 (unsatisfactory) to 6 (excellent) against each of four quality themes: quality of care and support, quality of environment, quality of staffing, quality of management and leadership.

68 *Report on Inquiry into the Regulation of Care for Older People*, Health and Sport Committee, Scottish Parliament Paper 40, HS/S4/11/R3, 2011.

69 *Financial viability guidance OPS-111-097*, Care Inspectorate, 2011.

# Part 4. Impact on users and carers



Users and carers should have a say in what services have the best impact on their lives.



## Key messages

- Users and carers need to be more involved in commissioning services. They have been consulted and involved in some aspects of commissioning, but this is not happening in all areas or for all user groups. The impact of not properly involving users and carers can be significant for those receiving services. One very important issue for them is the continuity of services, and in particular the staff who deliver them. Better evidence is needed of what difference social care services make to people's quality of life.
- Self-directed support aims to give people more choice and control over the services they receive. This is likely to have major implications for the way that councils and NHS boards commission services as well as making a significant difference to users and carers. However, the combination of relatively low use of direct payments, a need to develop commissioning skills and capacity, and a need to improve partnership working with providers and consultation with users and carers, suggests that councils may need a significant amount of support to implement self-directed support effectively. The implications for councils and NHS boards of stopping some existing provision and developing alternative services need to be properly planned in consultation with both users and providers.
- There are significant risks to users if councils and NHS boards do not commission services well. Councils have a responsibility to ensure that users and carers have choice and control under self-directed

support and that they receive the advice and support they need to make the best use of resources allocated to them.

### **Most users and carers are satisfied with their care but councils and NHS boards could improve how they involve them**

**76.** A large majority of the adult service users we consulted felt that they definitely or mostly receive all the services they need. Ninety-six per cent of users and 82 per cent of carers were broadly happy with the services, although 20 per cent of users and 27 per cent of carers felt they had not been involved in deciding which services they (or the person they care for) need.<sup>70</sup> In particular, they raised some issues about the level of home care services they receive:

- some carers felt under pressure in terms of their time and responsibility in supplementing the home care service provided to their family member or friend
- ten-minute visits from home care staff make the time allocated to tasks very tight
- the time of day when support is provided is often not based on the person's needs
- many users and carers feel they have to "push and fight" to get the level of service they need
- inflexible support, where staff are not allowed to do certain tasks.

"You are just told you will have ten minutes each day."

Adult with physical disabilities,  
home care

"[With home care] you get what you are given."

Carer of older person,  
home care and day care

"Timing is the main problem. Some times aren't suitable. It isn't very flexible."

Adult with physical disabilities,  
home care

**77.** For example, one carer felt that the person they cared for lost weight because of the times that her meals were arriving.

"She wasn't eating enough. But they brought lunch at 2pm then dinner at 4pm. They wondered why she only wanted a biscuit at teatime."

Carer of older person, home care

**78.** For users and carers, poor-quality commissioning of social care services can have a significant impact. These services can be very personal, and people may take time to build trusting relationships and settle into a routine. This means any changes in the timing, quality or people involved can cause considerable concern to users and their carers if they are not consulted or involved in decisions. For people in care homes or children in residential care, having to move to a different provider can have a life-changing impact, especially if they are not informed, involved and supported throughout the process.

"[These services] can be the difference between getting through life and it falling apart. I can tell you right now that if my son wasn't able to access the same respite centre because [the provider] lost a tender, his world would most definitely fall apart."

Parent of disabled child, respite care

<sup>70</sup> Interviews and surveys with users and carers, ODS Consulting for Audit Scotland, 2011. The sample was not necessarily representative of all users and carers as the work was done to identify the issues rather than quantify the strength of views.

**79.** Users and their carers should be involved at all stages of commissioning to make sure the commissioning process results in services that meet their needs and preferences and make a difference to their independence and quality of life. In particular, they should have an influence when councils and their NHS partners are:

- identifying needs and what the services should achieve
- identifying what services need to be in place
- considering how to ensure that the right range of services are available
- working with providers to develop the services people will need in future
- developing procurement strategies and plans
- undertaking procurement exercises
- monitoring and reviewing the services.<sup>71</sup>

**80.** Not all councils and their NHS partners have a plan for how they will involve users and carers at each stage of the commissioning process. Only half of the strategies we reviewed had clearly involved users in their preparation although social work directors and managers told us that they do generally consult with the main client groups when they are planning or considering major changes to services. Seventy per cent of users and 63 per cent of carers told us they had at least some choice about the services they receive. But some felt the level of service they received was under threat, or had already been reduced.

“The council is a bit strapped. We’ve had to cut my support and the amount of hours of care I receive. It has made things harder. And it is disappointing.”

Adult with physical disabilities,  
home care

**81.** Social work directors and managers felt that they do more to engage with people with learning disabilities than other users. This is due to long-standing advocacy and focus groups that were set up when long-stay hospitals were closed in the late 1990s and early 2000s. Councils and NHS boards were also required to have a joint ‘Partnership in Practice’ agreement to make sure they took joint responsibility for the health and non-health-related needs of people with learning disabilities, their families and carers.<sup>72</sup>

**82.** Carers have a crucial role in looking after family members and friends and should be consulted and involved as equal partners in decisions about provision. The number of carers in Scotland has been estimated as 517,387 and the value of the care they provide as £10.4 billion.<sup>73</sup> Carers may need help to manage and sustain their caring role, often in the form of respite or short breaks, when the person they care for is looked after for a short time to give the carer a break. Councils have a duty to assess carers’ needs and provide support where their care responsibilities are significant or they are having difficulties with caring.<sup>74</sup> However, many of the carers we consulted had not been offered support by their council or were not sure what support might be available. They tended to rely on voluntary organisations for information and support.

**83.** Some councils have been trying to improve how they consult with users and carers and involve them in decisions about services (Case studies 7 and 8, overleaf). For example, City of Edinburgh Council has developed a strategy and has begun to consult widely after not engaging well with users in a previous procurement exercise (Case study 7).

### Information on the impact of services is limited

**84.** The Scottish Government and councils developed the Community Care Outcomes Framework in 2008. It was established as a voluntary set of common indicators on the impact that care services were having. While all councils report on the measures within the framework that are already collected for other national datasets, there are other measures within the framework that are not universally applied and the information is not readily available to the public.<sup>75</sup> This means that important measures about users’ and carers’ views and experiences of services are not being used to support improvements. Some CPPs have included outcome measures in their SOAs, with the two most common targets being to improve educational attainment of looked after children and to enable older people to live independently as long as possible. National measures are useful but commissioning partners also need a mechanism for measuring the difference that specific services have made to the individuals.

**85.** There are examples of systems and tools being used to assess the impact that services are making, such as those in *Getting it right for every child*.<sup>76</sup> There are also examples of trying to capture users’ views, such as ‘Talking Points’.<sup>77</sup> However,

71 *Caring together: the carers strategy for Scotland 2010-2015*, Scottish Government and COSLA, 2010.

72 *The same as you? A review of services for people with learning disabilities*, Scottish Government, 2000.

73 *Valuing Carers 2011: calculating the value of carers’ support*, Carers UK and the Centre for International Research on Care, Labour and Equalities, University of Leeds, 2011.

74 *Caring together: the carers strategy for Scotland 2010-2015*, Scottish Government and COSLA, 2010.

75 Community Care Outcomes Framework, Scottish Government, 2008.

76 *Getting it right for every child*, Scottish Government, 2008.

77 Talking Points is a tool developed by the Joint Improvement Team to help structure discussions with people about what difference they want services to make to their lives, and to help monitor progress against their identified aims.

### Case study 7

#### City of Edinburgh Council's consultations with users

In 2009, the City of Edinburgh Council invited tenders for a range of care and support services for nearly 800 adults with learning disabilities, mental health issues, physical disabilities and hearing impairment. It proposed to award contracts mostly to new providers, meaning a change in service provider for over 600 individuals. User groups protested to the council about a lack of consultation and argued that the importance of stability for people receiving social care services had been overlooked. In February 2010, the council decided not to award the proposed contracts as originally planned because of shortcomings in key elements of the tendering and evaluation process, the potential adverse impact on users and the substantial increase in direct payment applications, which might have affected the viability of the contracts.

In June 2010, a 'lessons learned' review of the process concluded that:

- a commissioning strategy should have been in place before the tendering process began
- reporting to elected members could have been better
- there was insufficient clarity over roles and responsibilities in the project team

- the council had not engaged or consulted adequately with service users.

The council has since been working to an action plan to address the various issues identified in the review. In relation to engagement and consultation, it has developed an engagement and communication strategy for care and support services (October 2010) and has consulted extensively on its care and support commissioning strategy and supporting plans during 2011. Methods used to promote the consultation and encourage participation included features in council, NHS and partner publications, local press, a targeted e-newsletter issued to over 300 groups and individuals, 60 consultation meetings and briefing sessions and a flyer to 20 per cent of the hardest-to-reach adult social care users.

The consultation exercise was overseen by a group of users, carers, voluntary and private sector providers, and council and NHS staff to ensure good engagement with all the relevant people. Over 2,000 people took part in the consultation and the council published the results, identified actions it will take and continues to report progress to the group.

Source: Audit Scotland, based on *Care and Support Services: 'Lessons Learned' and overview report*, Paper from the Chief Executive to the Policy and Strategy Committee, City of Edinburgh Council, 8 June 2010

### Case study 8

#### North Lanarkshire Council's consultation with users

Over the last few years, North Lanarkshire Council has embarked on a number of activities aimed at improving how it involves users of social care services. For example:

- consultation on North Lanarkshire Council's Living Well strategy for older people. In 2009, SWIA described this as 'an impressive example of community engagement and strategic development'. The consultation involved over 400 people at numerous locations across North Lanarkshire
- involving users and carers in the tendering process, through participation in selection panels when procuring services from external providers
- holding a major stakeholder event in April 2009 as part of the council's best value review of home care. Users, carers, home support workers and managers, providers and trades unions were brought together at one event

and facilitated to identify, then prioritise, the criteria for a high-quality home care service

- supporting the development of a new organisation called Partnership 4 Change (P4C) in 2010. P4C brings users and carers from voluntary sector organisations together with NHS Lanarkshire and North Lanarkshire Council. Through P4C, users and carers are recognised as equal partners and are represented at all levels of the structures that plan, organise and deliver community care in North Lanarkshire. P4C meetings take place every six weeks.

Service improvements have been implemented as a direct result of user and carer consultation. For example, the 2009 engagement exercise helped to identify gaps in night-time services which have now been addressed. Also, a carers' subgroup of P4C identified a need to offer better support to carers from minority ethnic communities, which resulted in a targeted engagement exercise.

Source: Audit Scotland

regardless of the systems or tools, it is important that councils and NHS boards understand which services have the best impact on people's lives and commission these services to ensure that they achieve this impact. North Lanarkshire Council has been developing its approach to commissioning personalised services and monitoring the impact that services make (Case study 9).

### Self-directed support has major implications for the way that councils and NHS boards commission services

**86.** The Scottish Government's Self-directed Support Strategy and planned legislation aim to give users a bigger say in the services they receive.<sup>78, 79</sup> Research has shown that users and carers are positive about having more choice and control over the services they receive. People currently receiving direct payments are very positive about their ability to choose and change providers and the relationship they have with staff when they feel more like an employer.<sup>80</sup>

"I do the telling – in my house, I'm the boss. I'm paying for it, so they can leave the attitude at the door."

Older person, home care

"We get the final say and that makes me happy."

Adult with learning disabilities, home care

**87.** The Scottish Government defines personalisation in social care as 'enabling the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the

### Case study 9

#### North Lanarkshire Council's outcomes-focused commissioning strategy

North Lanarkshire Council published its commissioning strategy for community care, children and families and justice services in November 2008. The strategy, jointly prepared with NHS Lanarkshire, focuses on how the council will deliver personalised services to meet local people's needs and improve their quality of life. A crucial element of preparing the strategy was engaging with users, carers and providers.

The strategy sets out a number of indicators to measure what difference social care services are making to people's lives. The indicators include people being cared for at home, faster access to services and better-quality services. The council also set out that it would support people to achieve their full potential so that they can be included and feel safe and healthy. Staff have been trained to specify what impact they expect services to achieve for people and review progress regularly.

North Lanarkshire Council has also moved from a focus on how the council and its partners buy services from external providers to an emphasis on calculating individual budgets and supporting people to have more choice and control over the support they need, what the budget is spent on and who delivers the support.

Over a number of years, the council has closed ten out of 14 residential care homes for older people and closed almost all residential care and day centres for people with learning disabilities. It has instead invested in community-based personalised support. For example, two residential care homes for older people have been converted from permanent housing to intermediate care facilities, providing assessment, rehabilitation and respite, with a focus on helping more older people to remain at home.

Source: Audit Scotland

services they receive'.<sup>81</sup> Delivering personalised services affects how social care is paid for and how budgets are managed by either public bodies or service users, depending on the type of self-directed support the user chooses (Exhibit 11, overleaf).

**88.** It is too early to be clear about the impact of self-directed support but it is likely to have major implications for the way that councils and NHS boards commission services. Instead of arranging service-based provision, they will have to develop services

which are tailored to individual needs and choices. This move from a service focus to a greater focus on the individual creates a challenge for councils. For example, money which is needed to deliver personalised services may currently be committed to traditional services which involve fixed building and staff costs, such as day care centres. The implications of stopping some existing provision and developing alternative services need to be properly planned in consultation with both users and providers.

78 *Self-directed Support: A National Strategy for Scotland*, Scottish Government, 2010.

79 *Self-directed Support: A draft bill for consultation*, Scottish Government, 2010.

80 *Views of people using social care services and their carers*, ODS Consulting for Audit Scotland, 2011.

81 *Changing Lives: Personalisation: A Shared Understanding; Commissioning for Personalisation; A Personalised Commissioning Approach to Support and Care Services*, Scottish Government, 2009.

### Use of direct payments has been low

**89.** Direct payments have been available to various groups of users for a number of years but only 4,400 people were receiving direct payments in 2011.<sup>82</sup> It has been a legal power since 1997 for councils to make direct payments available to disabled adults. In 2003, the power to make payments became a duty and councils were required to make direct payments to service users who requested them. This duty was extended to include disabled children (or their parents/carers) and older people, and in 2005 and 2007 to include almost all other people using social care services.<sup>83</sup>

**90.** With self-directed support, including direct payments, councils and NHS boards must also ensure that there are processes in place for monitoring the outcomes for users of services purchased with individual budgets. Three councils piloted self-directed support between 2009 and 2011 (Case study 10).

**91.** The evaluation of the three pilots (Case study 10), the relatively low use of direct payments (see paragraph 89), the need to develop commissioning skills and capacity (see paragraphs 42 to 45) and the need to improve partnership working with providers and consultation with users and carers, all suggest that councils may need a significant amount of support to implement self-directed support effectively.

**92.** There is a risk that councils may focus on the potential to reduce costs when they introduce self-directed support (Case study 11). In England, studies have shown that self-directed support has the potential to be more cost-effective but is unlikely to result in significant cost savings.<sup>84</sup>

## Exhibit 11

### Self-directed support

A budget is allocated to a person after their needs have been assessed. The person then chooses how the budget is managed and by whom, and may choose a combination of approaches.

Paid to user or carer as a direct payment	Managed by a third party on behalf of user	Managed by council on behalf of user
Direct payments allow people to choose, arrange and pay for their own services rather than having them organised by their council.	Council-commissioned or independent brokerage services may manage people's budget and arrange their services for them.	The council may manage the budget and arrange the services in consultation with the user. Services may be provided in-house or by voluntary or private sector providers, which the council would pay for from the budget.

Source: Audit Scotland

## Case study 10

### Piloting self-directed support in three councils

Dumfries & Galloway, Glasgow City and Highland Councils piloted activities to increase the uptake of self-directed support between 2009 and 2011, receiving financial support of £3.5 million from the Scottish Government. They looked at three particular areas: leadership and training; cutting red tape; and bridging finance (temporary additional funding to cover development of new services while still running existing services).

By 2011, fewer than 150 new self-directed support arrangements were set up. While the pilots improved access to self-directed support for people with learning disabilities, it did little to promote it to other groups, such as those with mental health problems or older people.

An evaluation of the pilots reported that all three councils had set up dedicated self-directed support teams which had invested a lot of time in designing new systems. This was effective in supporting the small number of users involved and in giving them more choice, flexibility and control. However, it limited the extent of system change across the council as a whole. It also created the impression that self-directed support was separate from, and operated differently to, direct payments. As a result, the three councils had tended to add to, not reduce, paperwork.

The evaluation concluded that maintaining this support for greater numbers of individuals and streamlining paperwork will be key challenges for councils. It also highlighted the need for councils to involve user and carer organisations more and invest in advice and support services. It recommended specific funding to support starting up new arrangements.

Source: Audit Scotland, based on *Evaluation of Self-Directed Support Test Sites in Scotland*, Scottish Government Social Research, 2011

<sup>82</sup> *Self-directed Support (Direct Payments), Scotland, 2011*, Scottish Government, 2011.

<sup>83</sup> Community Care (Direct Payments) Act 1996, and Amendment Regulations 2003, 2005 and 2007.

<sup>84</sup> *Research Briefing 20: The implementation of individual budget schemes in adult social care*, S Carr & D Robbins, Social Care Institute for Excellence, published 2007, updated 2009.

### Case study 11

#### Glasgow City Council making savings through its approach to self-directed support

An explicit aim of Glasgow City Council's approach to self-directed support was to find savings for the council. This was in addition to the aims of ensuring a more equitable allocation of available resources and maximising users' choice and control. The council wanted to save 20 per cent of its expenditure and re-invest some of that in developing services to meet future needs. Rather than continue to pay for traditional services for fewer clients, it wanted to find a way to distribute the available resources more fairly among its existing and new clients.

In October 2010, the council set out to calculate individual budgets for 1,800 adults with learning disabilities over a period of six months, and a total of 7,650 adults and children with learning or physical disabilities or mental health illness over 18 months. This meant allocating them an individual budget based on a process involving users and carers evaluating their needs, assisted by the service provider. The council has experienced some delays in this roll-out but still expects to make £3 million savings in 2011/12 and £10 million savings in 2012/13. The move to self-directed support is expected to make a significant contribution to this target.

In April 2011, the Care Inspectorate reported that carers, staff and providers were concerned about the process, the speed of change and the reductions in many care packages. Many of those involved perceived the council's motive as primarily, or solely, that of saving money rather than improving services. In April and December 2011, the council held sessions with carers, providers and other local authorities to discuss how personalisation is being implemented in Glasgow.

Source: Audit Scotland, based on *Glasgow City Council Scrutiny Report*, Care Inspectorate, 2011

**93.** Social work directors and managers told us their councils were at very different stages in implementing self-directed support. Some are beginning to implement it with selected user groups, while others are waiting to see what the expected legislation specifies and how other councils and NHS boards have gone about implementing it. Successful implementation of self-directed support will depend on good strategic planning; information for, and consultation with, users and carers; and effective joint working with providers and organisations offering advice and support.

#### Users and carers need access to information, advice and support

**94.** Experience of self-directed support in England shows that users and carers will need information, advice and assistance.<sup>85</sup> Some users and carers may also need support, for example from an advocate who can advise and speak on their behalf. Users in our consultation exercise who had experience of using an advocate felt it had helped them to speak out and ask the right questions.

"She sorts problems for me. She puts things in a different way so that I can figure it out. She helps me with my confidence, because I could be shy."

Adult with learning difficulties,  
home care

### Recommendations

Councils, along with NHS boards and other relevant commissioning partners where appropriate, should:

- have a clear plan for engaging a full range of service users and carers at every stage of the commissioning process, including:
  - consulting with and involving users and carers when they do their strategic planning, including consideration of retendering or stopping services
  - fully involving users, with their carers, in decisions about their own care
- use consistent and comparable measures of what differences services make to people's lives and make the results readily available to the public
- use these measures for both in-house provision and in contractual agreements with providers
- in implementing self-directed support:
  - be transparent about how they calculate individual budgets or determine the amount of resource available for an individual's care services
  - provide information, advice and support to all users and carers
  - put in place processes for monitoring the outcomes for users of services purchased with individual budgets, including direct payments.

# Appendix 1.

## Audit methodology

Our audit had six main components:

- Desk research – we reviewed existing information to inform our audit, including:
  - national statistics on use of social care services and population estimates
  - local government financial statistics
  - a sample of social care commissioning strategies
  - the work of local auditors, including external and internal audit reports
  - reports and information from the Social Work Inspection Agency and the Care Commission (now both part of the Care Inspectorate)
  - publications by other UK audit agencies and other Scottish and UK reports, strategies, legislation and consultation documents.
- Interviews with national bodies – we interviewed people in a range of national bodies, including the Scottish Government, COSLA, the Care Inspectorate, Scotland Excel, Association of Directors of Social Work, Coalition of Care and Support Providers in Scotland, Scottish Care, and organisations that represent, or work with, users and carers.
- Interviews with directors of social work or managers they nominated in their place – we appointed a consultant to conduct telephone interviews with all 32 councils (Comhairle nan Eilean Siar could not participate within our timescale due to staff changes). The interviews aimed to find out broadly how councils go about strategic commissioning, how they involve users and carers and how they work with providers.
- Interviews and surveys with users and carers – we appointed ODS Consulting to gather the views of users and carers across six council areas. The consultants asked them how they felt about the services they receive and what involvement they had in choosing and influencing services. A separate report on this work is available on our website ([www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk)).
- Focus groups with service providers – we appointed ODS Consulting to run focus groups with voluntary and private sector providers in six council areas. The consultants discussed with them how they worked with councils and NHS boards throughout the commissioning processes. A separate report on this work is available on our website ([www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk)).
- Case studies – we developed the case studies included in our report through a combination of discussions and reviews of internal and published reports.

# Appendix 2.

## Project advisory group members

Audit Scotland would like to thank the members of the project advisory group for their input and advice throughout the audit.

Member	Organisation
Ron Culley	Team Leader, Health and Social Care, Convention of Scottish Local Authorities
Susan Duncan	Head of Procurement Policy, Scottish Procurement, Scottish Government
Annie Gunner Logan	Director, Coalition of Care and Support Providers in Scotland
Nick Kempe	Social Care Commissioning Manager, Scotland Excel
Kenny Leinster	Convenor of the Community Care Standing Committee, Association of Directors of Social Work, and Head of Community Care and Housing, South Ayrshire Council
Peter Macleod from September 2011	Vice President, Association of Directors of Social Work, and Director of Social Work, Renfrewshire Council
Ranald Mair	Chief Executive, Scottish Care
Jacquie Roberts until January 2012	Interim Chief Executive, Care Inspectorate
Brian Slater	Integration and Service Development, Primary and Community Care Directorate, Scottish Government
Simon Steer	Community Care Integration Manager, NHS Highland and Highland Council
Margaret Whoriskey	Director, Joint Improvement Team

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

# Appendix 3.

## Summary of social care policies

Date	Policy/legislation	Summary
July 1968	Social Work (Scotland) Act 1968	Gave councils a duty to promote social welfare by making available advice, guidance and assistance on such a scale as may be appropriate for their area, and to arrange, provide or secure suitable and adequate provision.
June 1990	NHS and Community Care Act 1990	Provides the legislative framework for the policy on shifting the balance of care from hospitals and institutions to community-based settings. It placed a duty on public bodies to assess the need for community care services for elderly and disabled people and those with mental/physical health problems.
July 1995	Children (Scotland) Act	Placed a responsibility on local authorities to protect and promote children's welfare and to respond to the requirements of children 'in need' and 'looked after' by them.
July 1996	Community Care (Direct Payments) Act 1996	Gave councils the power (but not a duty) to make direct payments to individuals who could then purchase services and facilities themselves.
1998	<i>Modernising Community Care: an Action Plan</i> , Scottish Office	Published in response to concerns about the way community care services were being managed and delivered, the action plan aimed to improve the successful delivery of community care through more effective and efficient joint working based on partnerships between councils and NHS boards.
November 2000	<i>Community Care: A Joint Future</i> , Scottish Executive, Convention of Scottish Local Authorities and NHS Scotland.	Contained recommendations to secure better outcomes for people through improved joint working between health and social care, including developing arrangements for managing and financing joint services.
July 2001	Regulation of Care (Scotland) Act 2001	Provides the legal basis for the application of national care standards for services and codes of practice for social service workers and employers. It sets out requirements concerning registration, inspection, complaints and enforcement.
March 2002	Community Care and Health (Scotland) Act 2002	Introduced free personal and nursing care for older people and regulation of home care services. It enabled schemes to promote choice in care provision, included measures to enable greater joint working between NHS and councils and contained measures to increase the rights of carers. The Act also gave councils and NHS boards the ability to delegate functions and make payments to each other for these services.

Date	Policy/legislation	Summary
February 2003	<i>Partnership for Care</i> , Scottish Executive	A white paper including proposals to increase patient-centred care. It called for the establishment of Community Health Partnerships to bridge the gap between primary and secondary healthcare; and between health and social care.
February 2003	Local Government in Scotland Act 2003	<p>Gives councils a duty to secure best value in the performance of their functions. Councils must continuously improve directly provided services and those which they purchase from external providers, while maintaining an appropriate balance between quality and cost.</p> <p>The Act also placed a duty on councils to take a lead role in community planning and on NHS boards and a number of other public bodies to participate in Community Planning Partnerships.</p>
May 2003 and March 2005	<p>The Community Care (Direct Payments) (Scotland) Regulations 2003</p> <p>The Community Care (Direct Payments) (Scotland) Amendment Regulations 2005</p>	Extended the Community Care (Direct Payments) Act 1996 to place a duty on councils to make direct payments available to almost all people using social care services (with the exception of people subject to compulsory measures of care under mental health and criminal justice legislation).
February 2006	<i>Changing Lives: Report of the 21st Century Social Work Review</i> , Scottish Executive	Recommended professional development of the social care workforce and delivery of more personalised services to achieve better outcomes and quality of life for people using social care services.
2007	Adult Support and Protection (Scotland) Act	Introduced additional measures to protect vulnerable adults.
December 2007	<i>Better Health, Better Care</i> , Scottish Government	Sets out the Scottish Government's vision and five-year action plan for the NHS. It gives CHPs lead responsibility for working with their partners to move more care out of hospitals and into the community.
February 2010	<i>Self-directed Support: A National Strategy for Scotland</i> , Scottish Government	Sets out the ten-year strategy for self-directed support in Scotland to help take forward personalisation of health and social care services. The strategy aims to give individuals and their carers choice and control over the services they receive.
March 2011	<i>Reshaping Care for Older People: A Programme for Change 2011 – 2021</i> , Scottish Government	Programme of workstreams, events and other initiatives led by the Scottish Government to support all organisations involved in caring for older people to address the challenges of supporting and caring for Scotland's growing older population. This includes an initial £70 million Change Fund in 2011/12 for NHS boards and partners to support changes to the way services are provided, and a further £80 million in 2012/13, £80 million in 2013/14 and £70 million in 2014/15.

# Commissioning social care

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