This briefing provides some contextual background to the issue of community care. The briefing considers the legislation governing the area, the organisation of services and available funding data. It then considers some of the topics that may be key issues facing community care over session four of the Scottish Parliament.
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BACKGROUND INFORMATION

The aim of community care is to enable people to live for as long and as independently as possible in their own homes, or in the community. The result of this policy since the 1990s (if not before) has been a shift away from hospital and institutionalised care, to services being provided in the community, particularly people’s own homes. Legislation has enabled the transfer of resources from the NHS and the Department of Work and Pensions (previously the Department of Social Security), to local authorities, while social work has been given a key role in the planning, assessment and commissioning of services. The public, private and third sectors are also involved in the delivery of these services.

Adult community care services are aimed at several key groups of people often referred to as client or service user groups. They include: older people; people with physical disabilities; people with learning disabilities and autistic spectrum disorders; people with mental health problems; and, carers.

KEY LEGISLATION

The primary statutory provisions for adult community care are contained within a number of statutes. The key piece of legislation is the Social Work (Scotland) Act 1968 (the 1968 Act) (as amended). It places a duty on local authorities to assess community care services for those who are in need, and placed the organisation and provision of welfare services with social work departments. It also introduced a duty on local authorities to promote social welfare. The 1968 Act continues to form the basis of community care regulations, together with the amendments of the Community Care and Health (Scotland) Act 2002 (the 2002 Act).

The 2002 Act introduced changes to the delivery of residential and non-residential care services in Scotland. It provided for the introduction of free personal care for the elderly and the regulation of charging for home care services. It also contains a power for Scottish Ministers to regulate charging for home care services (though policy since the legislation came into force has been to achieve a greater level of consistency by self-regulation through the Convention of Scottish Local Authorities (COSLA) (2009) guidance on charging). The Act also enabled a number of schemes to promote choice in care provision; including measures to enable greater joint working between NHS and local authorities; and, contains a duty for local authorities to identify as well as inform carers of their right to a needs assessment independent of the person being cared for.

The other notable pieces of primary legislation are detailed in Appendix 1.

THE ORGANISATION OF COMMUNITY CARE SERVICES

A basic diagram of how adult community care services are organised is shown in Figure 1 below.

The Scottish Government is responsible for policy direction and funding mechanisms. As noted above, local authorities have a duty for first undertaking community care assessments for those in need, and is then responsible for developing packages of care to meet identified need, planning services and commissioning services. In doing so they will utilise their own services, those of the private sector and those of the third sector. Services should be needs led and as a result they are varied, from the more comprehensive care home services on the hand, to the more support-based home helps, meals on wheels, equipment and adaptations and respite services on the other. Beyond these arranged services, individuals can tailor-make flexible support packages to meet some or all of their needs through self-directed support, such as
through direct payments, where they can purchase support from providers and/or to employ personal assistance.

**Figure 1: Organisation of formal community care services in Scotland**

As noted in Appendix 1, the current regulatory framework affecting many community care services is now provided for through the Public Service Reform (Scotland) Act 2010 (2010 Act). In effect, this combined the previous functions of the Care Commission (with the exception of those concerning private health care) with the functions of the Social Work Inspection Agency and the child protection responsibilities of Her Majesty’s Inspectorate of Education (HMIE), under a new body called Social Care and Social Work Improvement Scotland (SCSWIS). It came into being on 1 April 2011. SCSWIS has been set up as an independent body, and is funded through a combination of Scottish Government funding, registration fees and continuation fees. SCSWIS (2011a) notes that its budget for 2011/12 is £35.1m, which comprises of a £22.9m (65%) grant from the Scottish Government and the remainder is income from fees charged to service providers.

SCSWIS is primarily responsible for the regulation, inspection, complaints and enforcement. It inspects care services according to the National Care Standards and any other agreed benchmarks set by the Scottish Government. All care services must be registered with SCSWIS and will face inspections, which as a default will be unannounced, unless there are specific reasons for having an announced inspection. However, unlike the regime under the Care Commission, the new model of inspection means that there is no longer a statutory minimum frequency of inspection for care services. Instead SCSWIS will plan inspections based on an assessment of risk meaning that poorly performing services will be inspected more often than services which are performing well.
The assessment of risk is based on the service's previous performance, an annual self-assessment (focused on outcomes for service users) and taking into account other information SCSWIS has about the service such as complaints and notifications of things like injuries and accidents. In addition, SCSWIS will randomly sample and inspect a selection of services which would not otherwise have been due for inspection. SCSWIS now publishes an annual non-statutory plan (SCSWIS, 2011b) for inspection frequency which is approved by Scottish Ministers. This sets out the frequency of inspection based on quality grading and assessed risk. It does not preclude SCSWIS from inspecting a service more frequently should circumstances change (such as following a complaint), or should a service be randomly sampled. In terms of adult care homes, the frequency of inspections outlined in the latest plan are as follows:

**Table 2: SCSWIS Frequency of inspections for adult care homes 2011-12**

<table>
<thead>
<tr>
<th>Type of service</th>
<th>If quality grades are good (4+) and assessed risk is low</th>
<th>If quality grades are &lt;4 and/or assessed risk is not low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care homes for older people</td>
<td>1 unannounced inspection in each 24 months</td>
<td>2 unannounced/short notice inspections in each 12 months</td>
</tr>
<tr>
<td>All other adult care homes (inc nursing homes)</td>
<td>1 unannounced inspection in each 24 months</td>
<td>1 unannounced inspection in each 12 months</td>
</tr>
</tbody>
</table>

Source: SCSWIS (2011b)

The justification given for this new model is that it is risk based and so allows SCSWIS to focus its resources on the services that need it most. Following inspections each service will be graded according to the principles in the relevant care standards. Where necessary SCSWIS will make recommendations or requirements for improvement. In areas where there are serious causes for concern SCSWIS has the power to place improvement notices with the provider, with time limits. Ultimately, SCSWIS has the power to cancel the registration of that service if the improvement notices are not adhered to. Cancellation of the registration means that the provider can no longer provide that service and is effectively prevented from operating.

The 2010 Act also provides SCSWIS the role of coordinating joint planning of scrutiny and improvement activity, together with multi-disciplinary inspections, with other scrutiny bodies.

It should also be noted that local authorities and health boards, as they procure many care services, can also take action against providers should there be concerns about quality and performance. Not only can they withdraw funding but they can also remove service users from facilities. The recent Elsie Inglis case is an example where both SCSWIS and the local authority took action. The regulation and inspection regime as regards care homes is one of the key issues discussed, below.

**DATA SOURCES**

There is a range of statistics on community care services, primarily available through the Scottish Government’s statistics web pages and ISD Scotland. These are detailed and hyperlinked below, for easy access. Some of these and others are used and discussed in the discussion of key issues, below.

- Community Care Outcomes Framework
  
  Whilst this has been revised over recent years, it was developed to enable local authorities and their NHS partners to gain a better understanding of their performance in delivering community care services and thus help them in planning and delivering services in the future.
• **Care homes**  ISD Scotland web page providing data from the annual care home census. Data goes back to 2003. Each annual report shows the number of homes and residents by sector and client group.

• **Home care**  Provides data on the number of clients receiving home care by local authority and also data on the number of hours of home care being purchased and provided by sector.

• **Direct Payments**  The Scottish Government web page for this is under construction, but the latest data was published in a statistical bulletin in September 2010. It contains data by local authority and client group, as well as the value of packages.

• **Free Personal and Nursing Care Services**  The Scottish Government web page for this is under construction, but the latest data is available through this link, which contains links to high level and local authority data up to 2009-10.

• **Carers**  Presents the latest data available on respite care provision by local authorities and data collected on unpaid carers in Scotland.

• **People with learning disabilities**  This provides a high level summary of community care services being used by those with learning disabilities. More detailed information is available through the eSay statistics published on the Scottish Consortium for Learning Disability website. These are published annually, with the latest being for 2009 and published in 2010.

• **Mental Health Services**  Many mental health statistics are health-related. However, this high level summary provides data on those receiving community care services.

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**FUNDING**

The total resource allocation for community care in Scotland is difficult to ascertain given its cross sector nature. The vast majority of local authority and NHS Board funding comes from block funding from the Scottish Government. It is up to these organisations to allocate that funding according to their own individual priorities based on the needs of their populations, as long as they meet various performance targets agreed with or set by the Scottish Government. However, there is data on expenditure by local authorities and the resource transfer to local authorities from NHS Boards.

Local authority community care is funded primarily through Grant Aided Expenditure. It is possible to obtain data on net expenditure across all local authorities spent on social work community care by client grouping (Table 2) and by type of service (Table 3).

**Table 2: Local Authority Net Expenditure, Community Care by client group, 2007-08 to 2010-11, Scotland (£000s)**

<table>
<thead>
<tr>
<th>Client Group</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11&lt;sup&gt;p&lt;/sup&gt;</th>
<th>Change 2007/08 to 2010-11&lt;sup&gt;p&lt;/sup&gt;</th>
<th>% Change 2007/08 to 2010/11&lt;sup&gt;p&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older persons</td>
<td>1,089,452</td>
<td>1,209,507</td>
<td>1,266,027</td>
<td>1,264,955</td>
<td>175,503</td>
<td>16.1</td>
</tr>
<tr>
<td>Adults with physical or sensory disabilities</td>
<td>167,671</td>
<td>180,108</td>
<td>183,866</td>
<td>192,136</td>
<td>24,465</td>
<td>14.6</td>
</tr>
<tr>
<td>Adults with learning disabilities</td>
<td>352,031</td>
<td>425,960</td>
<td>455,710</td>
<td>452,209</td>
<td>100,178</td>
<td>28.5</td>
</tr>
<tr>
<td>Adults with mental health needs</td>
<td>79,580</td>
<td>88,986</td>
<td>90,377</td>
<td>99,773</td>
<td>20,193</td>
<td>25.4</td>
</tr>
<tr>
<td>Adults with addictions/substance misuse</td>
<td>27,875</td>
<td>36,224</td>
<td>36,380</td>
<td>36,824</td>
<td>8,949</td>
<td>32.1</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1,535</td>
<td>1,326</td>
<td>1,473</td>
<td>2,308</td>
<td>773</td>
<td>50.4</td>
</tr>
<tr>
<td><strong>Total Community Care</strong></td>
<td><strong>1,718,144</strong></td>
<td><strong>1,942,111</strong></td>
<td><strong>2,033,833</strong></td>
<td><strong>2,048,205</strong></td>
<td><strong>330,061</strong></td>
<td><strong>19.2</strong></td>
</tr>
</tbody>
</table>

<sup>p</sup> Provisional  
Source: Scottish Government (2011b)
Table 2, above, shows that, over the period 2007-08 to 2010-11 there has been an increase in net expenditure on community care by over £330m, representing a 19.2% increase. In 2010-11, local authorities spent over £2bn on community care.

Over the period, services for older people make up the majority of the expenditure, though this share has fallen slightly from 63.4% of all community care funding in 2007-08 to 61.8% in 2010-11. Between 2009-10 and 2010-11 the amount spent on older people fell slightly. The care of older people is a significant issue and is discussed in the ‘key issues’ section below. Proportionately, the smaller client groupings have seen greater increases over the period, particularly for those with HIV/AIDS and adults with addictions / substance misuse, which may reflect increasing numbers of people in those categories requiring community care services.

Table 3 shows how the same expenditure has been spent by service type. The data for 2010-11 is not complete enough in order to show a breakdown by service, and so only the years 2007-08 to 2009-10 are shown.

Table 3: Local Authority Net Expenditure, Community Care by service type, 2007-08 to 2009-10, Scotland (£000s)

<table>
<thead>
<tr>
<th>Service expenditure analysis</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>Change 2007-08 to 2009-10</th>
<th>% Change 2007-08 to 2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment, Casework etc ¹</td>
<td>195,604</td>
<td>219,294</td>
<td>229,384</td>
<td>33,780</td>
<td>17.27</td>
</tr>
<tr>
<td>Accommodation-based services</td>
<td>745,799</td>
<td>835,641</td>
<td>872,585</td>
<td>126,786</td>
<td>17.00</td>
</tr>
<tr>
<td>Homecare</td>
<td>448,739</td>
<td>538,386</td>
<td>571,109</td>
<td>122,370</td>
<td>27.27</td>
</tr>
<tr>
<td>Day Care</td>
<td>204,024</td>
<td>215,377</td>
<td>225,299</td>
<td>21,275</td>
<td>10.43</td>
</tr>
<tr>
<td>Equipment and adaptations</td>
<td>29,258</td>
<td>32,227</td>
<td>30,973</td>
<td>1,715</td>
<td>5.86</td>
</tr>
<tr>
<td>Fostering/family placement</td>
<td>82</td>
<td>25</td>
<td>15</td>
<td>-67</td>
<td>-81.71</td>
</tr>
<tr>
<td><strong>NET Revenue Expenditure with specific grants added back</strong></td>
<td><strong>1,718,144</strong></td>
<td><strong>1,942,111</strong></td>
<td><strong>2,033,833</strong></td>
<td><strong>315,689</strong></td>
<td><strong>18.37</strong></td>
</tr>
<tr>
<td>Of which Respite Care / Support for carers</td>
<td>77,359</td>
<td>86,597</td>
<td>91,707</td>
<td>14,348</td>
<td>18.55</td>
</tr>
</tbody>
</table>

¹ Assessment, Casework, Care Management, Occupational Therapy and Criminal Justice Field Work

Source: Scottish Government (2011b)

As Table 3 shows, between 2007-08 and 2009-10 accommodation-based services (e.g. care homes) have accounted for the largest share of expenditure, accounting for around 43% in each year. Homecare services, although rising by 27% across the time period, has only accounted for 26% of the total in 2007-08 rising to 28% in 2009-10. Indeed, in cash terms accommodation based service expenditure has risen at a faster rate than homecare services. This is interesting given the focus in policy terms over the past decades to be encouraging far greater numbers of people to remain at home with support for as long as possible. Associated services such as day care and equipment and adaptations have also risen, but at even slower rates. Assessment costs have risen significantly by 17% over the time period, which may relate to increasing numbers of people seeking an assessment of their needs, and the expenditure on respite care has also risen, which may reflect Government targets on increasing the number of hours of respite care available (see the ‘key issues’ section below).

Local authorities also receive money from the NHS via Resource Transfers. Local negotiations take place between Health Board and council officials to determine both the amount and the timing of the cash transfers. Scottish Government guidance provides for the transfer of resources from boards to local authorities in order to facilitate the transfer of people from long stay hospitals to the community. Whilst the vast majority of resource transfer will have gone to local authorities, some may have also gone directly to voluntary organisations. The Scottish Government has advised that the totals for the past three years of available data were as follows:
Table 4: Community Care related resource transfer from NHS Boards to local authorities, Scotland

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>£m</td>
<td>£308.409</td>
<td>£323.074</td>
<td>323,850</td>
</tr>
</tbody>
</table>

Source: Scottish Government. (2011b)

KEY COMMUNITY CARE ISSUES

This part of the briefing provides more information on some of the topics that may be key issues over the next few years: services for older people, regulation of care services, delayed discharge, integration of health and social care, carers and self directed services. The following sections provide background information on each, together with key data where possible.

SERVICES FOR OLDER PEOPLE

This is an area of growing interest and concern. The Scottish population is aging, increasing numbers of people are being assessed as requiring services, and public finances are being squeezed.

The current strategy (Reshaping care) for developing service for older people, (Scottish Government et al) (2011, p 8), devotes its introductory chapters to considering current and future demand. It notes projections showing that the number of people in Scotland aged over 65 will be 21% greater in 2016 than in 2006 and 63% greater by 2031; for those 75+, the increase is 21% and 83% respectively. Meanwhile, as demonstrated in Figure 2, below, whilst 90% of those aged 65+ do not receive formal care, either through the NHS or social care, as a person’s age increases it becomes more likely that they will.

Perhaps unsurprisingly, given the numbers of those over 65 who do not receive any formalised care, the strategy also demonstrates that many older people are carers. Indeed, it found that older people provide more care than they receive: “It is estimated that just over 3,000 people over 65 years receive more than 20 hours of paid care per week while over 40,000 people over 65 years provide more than 20 hours unpaid care per week” (Scottish Government et al, 2011, p 6).

Figure 2: Current service provision by service type

Source: Scottish Government et al) (2011, p 5)
Emergency care is another important consideration in the strategy (Scottish Government et al, 2011, p 6 & 9). It shows that the probability that someone will be admitted to hospital increases with age and the time spent in hospital after admission is also longer, on average, with increasing age. Robson (2011) shows how the number of emergency admissions in the over 65s has been increasing over the last decade, from just over 180,000 in 2000-01 to nearly 213,000 in 2009-10. Reshaping Care considers the projected rise in older people and then the growth in emergency admission and the effect this may have on emergency bed numbers. It shows that in 2007 there were nearly 8,000 emergency beds for those aged 65+ in Scotland. If current rates remain the same then it predicts that by 2021 emergency admissions may rise to around 11,000 and by 2031 to around 14,000.

Given the squeeze on public funding, Reshaping Care then considers the funding of services for older people. As noted in the ‘Funding’ section above, over 60% of local authority expenditure on social work community care goes towards older people. Figure 3 provides an analysis of the costs across health and social care.

**Figure 3: Health and Adult Social care Expenditure 2007-08 for those aged 65+**

Using analysis of 2007-08 expenditure data Reshaping Care estimates that £4.5bn is spent on health and social care for those aged 65+. Figure 3 shows that 51% is spent on acute hospital care, and a further 12% spent on care home provision. However, the strategy finds that only 7% is spent on home care “in spite of our vision that older people should be helped to remain at home or in a homely setting for as long as possible”. (Scottish Government et al, 2011, p 7).

**Reshaping Care – The strategy**

Reshaping Care (Scottish Government et al, 2011) was the result of a decision of the Ministerial Strategic Group for Health and Wellbeing (the MSG) to develop a strategy that considered ways of improving the quality of services, at a time of demographic change and decreasing public expenditure. Throughout the document a number of barriers to service delivery are identified, but also the actions proposed to help deal with them. These are outlined in Figure 4, below:

The strategy is seen as the first volume of work on the issue, setting out the principles on which the new model will be based. The final chapter considers the next steps, most notably:

- costing the model of care, with the primary objective being to improve outcomes at less cost to the public purse
- assessing the levers that are directly within the control of the Scottish Parliament and come to a view about which of these can be used
- the levers that are within the control of the Scottish Local Government, including charges for community care services
- considering the procurement of care will be considered, including an assessment of whether current procurement routes deliver best value

**Figure 4: Reshaping Care barriers to delivery and actions for change**

<table>
<thead>
<tr>
<th>Barriers to delivering services</th>
<th>Actions to bring about change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work agencies, operating in an environment of reducing budgets, required to apply higher eligibility thresholds to meet their statutory duties that have the unintended consequence of squeezing out low level preventative and anticipatory care.</td>
<td>Utilise a new Change Fund of £70m to drive service re-design and enable shifts in core budgets.</td>
</tr>
<tr>
<td>Care based on an assumption that it will always be required rather than being designed to rehabilitate or re-able.</td>
<td>Focus on outcomes and enablement.</td>
</tr>
<tr>
<td>Risk-averse interventions that deny choice and opportunity and limit participation.</td>
<td>Support a shift in focus to 'support', and away from 'services'.</td>
</tr>
<tr>
<td>Long-term admissions to care homes, which could be avoided.</td>
<td>Support carers and communities to advance supported self care.</td>
</tr>
<tr>
<td>Fragmented and disjointed care that fails to focus on and produce the outcomes that the older person seeks and needs.</td>
<td>Develop and extend low level preventative services, including equipment and adaptations, handyperson services and housing support.</td>
</tr>
<tr>
<td>Assessment and care planning excessively based around incapacity and dependence rather than capability and independence.</td>
<td>Put in place a community capacity building programme in collaboration with third sector partners.</td>
</tr>
<tr>
<td>Insufficient support for unpaid carers.</td>
<td>Develop information, advice and assistance to help older people make key decisions and navigate the care system.</td>
</tr>
<tr>
<td>Lack of leadership or incentives to promote changes to the design and delivery of services and a reluctance to embrace change.</td>
<td>Create clear pathways into and through services, particularly for older people with complex needs.</td>
</tr>
<tr>
<td>Lack of incentives to promote change and an infrastructure designed to perpetuate what exists.</td>
<td>Continue to roll out the Integrated Resource Framework.</td>
</tr>
</tbody>
</table>

**Source:** Scottish Government et al (2011)

The strategy also notes that there are levers that are reserved to the UK Parliament, in particular the tax and benefits systems, which would be required in order to achieve any significant changes to the balance of funding between the state and the individual. On this front, the UK Government has set up the [Commission on Funding of Care and Support](https://www.dilnotcommission.org.uk/) (Dilnot Commission). It has been asked to make recommendations on how to achieve an affordable and sustainable funding system or systems for care and support, for all adults in England, both in the home and other settings. It is due to report to UK Ministers in July 2011, and the strategy notes that the outcome of these and the UK Government’s response will need to be taken into account in any future plans.
The second volume of Reshaping Care is to take account of such issues and is due to be published towards the end of 2011.

The Change Fund

One action noted in Figure 4 was the introduction of a Change Fund to support local partnerships (ie local authorities, NHS Boards and third sector organisations) in redesigning services and shifts in core local authority and NHS Board budgets. This was announced in November 2010 as part of the Draft Budget 2011-12, and amounted to £70m. It is the Scottish Government’s intention to seek to maintain the Fund at this level for the following three years as part of the next Spending Review.

In December 2010, the Scottish Government and COSLA (2010) published the Change Fund guidance, which was provided in order to support local partnerships in the preparation of Change Plans. The plans were to detail how each partnership was going to use their share of the Change Fund, and the outcome measures that would be used in order to measure performance. The guidance also detailed how the Change Fund would be allocated to partnerships. The guidance is shown in Appendix 1.

Each Partnership’s plan was to be submitted by 28 February and all were examined by the MSG. Each of the plans can be found on the Joint Improvement Team ‘Change Fund Plans’ web page. The MSG subsequently published an overview report (Scotland Government, 2011c) in March 2011. Whilst acknowledging that the Plans had to be prepared in a short period of time and that they represented a “strong start” to progressing the programme, there were a number of areas of concerns noted, including:

- anxiety over political support for disinvesting in institutional provision, and the need for reassurance as soon as possible regarding continuation of the Fund over the next three years
- many Plans confused outcomes, outputs and inputs, particularly in describing activities and developments
- some placed the emphasis on projects and initiatives, suggesting poor strategic planning
- involvement was variable with the Third Sector, and particularly so with Independent Sector interests. Many plans merely consulted such partners, instead of engaging with them
- many Plans are not convincing with regard to describing how core budgets will be influenced and in particular how funding will shift from institutional settings to community setting

The MSG has subsequently written to each Partnership with specific comments about their plans. The funding allocation by partnership is detailed in Appendix 2.

FREE PERSONAL CARE

Free personal care (FPC) for those aged 65 and over was introduced in July 2002, following enactment of the Community Care and Health (Scotland) Act 2002. Prior to this policy personal care was a chargeable service and only those who were assessed as needing public funding were not charged. This meant there were many people having to fund their personal care in full from their capital and income (known as self-funders). FPC sought to ensure that free personal care was free for all those regardless of means. Free nursing care (FNC) was already free prior
to FPC for those that were assessed as needing it and is available to those under the age of 65 as well as those over 65.

**Numbers receiving FPC**

The latest annual FPC statistical report (Scottish Government, 2009a) is for 2008-9. This shows that, in total there were, 53,770 receiving personal care services free of charge. As regards care homes, there were 31,280 long-stay residents aged 65+ in 2008-09, compared to 31,899 in 2003-04. In 2008-09 there were 9,570 self-funders receiving FPC compared to 8,350 in 2003-04. Thus, the proportion of all long stay residents who were self funders and receiving FPC was 26% in 2003-04 and rising to 31% in 2008-09. These people currently receive £159 each week for personal care and around two-thirds receive a further £72 each week for nursing care.

As regards home care services (HCS), after the introduction of FPC total numbers of those aged 65+ receiving these services increased to a high of 57,880 in 2004-05, falling steadily to 54,760 in 2008-09. However, the number of those receiving FPC for free at home has increased from 36,300 in 2004-05 to 44,200 in 2008-09. Therefore, the proportion of those receiving FPC of the total number receiving HCS has increased from 63% in 2004-05 to 76% in 2009-10.

The next report for 2009-10 should be available in July or August 2011 (Scottish Government, 2011b).

**Expenditure**

It is difficult to assess the funding of community care services, and, in terms of FPC, it is not possible to ascertain how much the Scottish Government allocates for free personal care in its block grant to local authorities. However, the amount spent by local authorities on FPC is collected centrally. The most recent figures were published by the Scottish Government (2009a) in June 2009. The data is presented by local authority, but the headline figures are:

- **between 2007-08 and 2008-09, Local Authority total expenditure on free personal and nursing care for self-funding residents in care homes showed little change from £102.6 million to £102.8 million, an increase of 0.2%**

- **total expenditure on free personal and nursing care for self-funding residents in care homes was £83.3 million in 2003-04 rising to £102.8 million in 2008-09, an increase of 23.4%. This is new expenditure arising as a result of the FPC policy**

- **between 2007-08 and 2008-09, Local Authority expenditure on personal care for home care clients increased from £263.8 million to £273.7 million, an increase of 3.7%**

- **expenditure on personal care for home care clients was £128.8 million in 2003-04 rising to £273.7 million in 2008-09, an increase of 112.6%**

- **expenditure on home care clients is not all new expenditure attributable to the free personal care policy. It is estimated that local authorities were spending at least £64.5 million on personal care services in 2001-02**

The Scottish Government (2009a) states that the reasons for the large increase in expenditure on personal care at home include: a shift in the balance of care towards larger packages of care at home; a shift towards more personal care provided by home care staff; the introduction of equal pay provision in local authorities leading to higher wage costs; and the reimbursement of
charges for meal preparation (see Appendix 3). Figures for 2009-10 should be available in July or August 2011 (Scottish Government, 2011b).

The Sutherland Review

In the summer of 2007 the Scottish Government asked Lord Sutherland to chair a review to investigate:

- the funding available for the policy
- the distribution of resources between local authorities
- the impact of the withdrawal by the UK Government of Attendance Allowance from people receiving free personal and nursing care
- how to ensure the funding for the long-term care of older people is sustainable

Lord Sutherland published his report, in April 2008. The final report contained 12 recommendations split into short, medium and longer term goals. In May 2008, the Scottish Government (2008) announced that it would accept all the recommendations as part of a wider package of measures being developed with local government, including: additional funding of £40 million per year to local authorities from 2009-10 and increased personal and nursing care payments in line with inflation annually; legislation to clarify charging for food preparation; and, a more open and transparent system that explains how access to free personal and nursing care is managed. Appendix 3 outlines each of the short term recommendations and the progress noted by the Scottish Government.

Sustainability

Despite much political support for the policy, bodies such as COSLA (The Scotsman, 2010) and the Association of Directors of Social Work (The Herald, 2011) have questioned the ability of local authorities to continue funding FPC in the current spending climate. Other commentators and think tanks, such as the Centre for Public Policy for Regions (Scottish Parliament Finance Committee, 2009, p 7), pointed out that the current financial situation means there are choices to be made concerning whether such general entitlements are still affordable, whether other programmes need to be foregone in order that they continue, or whether they should be more targeted.

In his report for the Scottish Government, Lord Sutherland (2008) considered a range of evidence concerning the funding of FPC, including the Audit Scotland (2008) review of the policy. His report identified a number of problems in estimating the cost of FPC, such as the availability of financial data and changes in population projections since the inception of the policy. He considered (2008, p 30) that the policy had been fully funded up to 2005-06, but that a shortfall had developed since then, amounting to around £40m annually. He recommended that the Scottish Government provide additional funding to stabilise the policy over the following five years. As noted above this was accepted, with an additional £40m being provided to local authorities from 2009-10.

The most recent assessment of the policy was that undertaken by the Independent Budget Review (IRB) Panel (2010). In its report, the IRB accepted that the provision of free personal and nursing care to all those aged over 65 meant that “a significant number of older people are being supported who would otherwise have sufficient resources or disposable assets to fund their own care” (2010, p 105). However, reflecting on evidence it received concerning future cost pressures and expected demographic changes, it questioned the universality of the policy.
It considered a number of options for creating savings in providing free personal and nursing care in residential care and for those in home care.

As regards residential care, the IRB considered reducing the FPC payment to £100 per week, removing free personal care in care homes and removing free nursing care in care homes. The report (2010, p 7) found that these options had the potential to generate estimated cash savings of between £81m and £279m over three years compared with 2010-11 baseline costs, depending on the option pursued. In terms of home care, the IRB (2010, p 108) noted it was difficult to estimate the potential savings that could be generated from a range of options. This was because of factors such as: the different charging policies across the 32 local authorities for chargeable services other than FPC; and, the difficulty of predicting the future disposable income of older people. However, it considered several options: a flat weekly fee of £77 and £50 for all personal care clients, and providing only the first 5, 10 and 15 hours of care free. It found that depending on the option, these could save, in cash terms, between £99m and £588m over three years compared with 2010-11 baseline costs.

However, the report also noted that any change would depend on the early and successful passage of primary legislation, and also would need to be phased in order to protect the sustainability of the current services. The IBR recommended that the Scottish Government review eligibility for the FPC as part of the ongoing work undertaken through Reshaping Care.

REGULATION AND INSPECTION OF CARE HOMES

The system for regulating care service is discussed above. However, the regulation and inspection of care services has come into sharp focus recently as a result of the case of the Elsie Inglis care home in Edinburgh. Following the death of a resident in hospital, the remaining residents were removed from the home to alternative accommodation by the local authority and the care home registration revoked, which effectively shut the service down. A number of matters have been highlighted as a result.

Funding of SCWIS

As noted above, SCSWIS is funded through a combination of Scottish Government funding, registration fees and continuation fees. Its budget for 2011/12 is £35.1m, which comprises of a £22.9m (65%) grant from the Scottish Government and the remainder is income from fees charged to service providers.

The issue of funding arose during a Scottish Parliament (2011a, col 464 and 472) debate on 9 June 2011. Jackie Baillie MSP said that SCSWIS had faced a 25% budget cut. The Cabinet Secretary for Health, Wellbeing and Cities Strategy, replied saying SCSWIS did not begin with a 25% budget cut, rather this will take place over a number of years to reflect that SCWIS is three organisations merged into one.

Inspection regime

During the Parliamentary debate on 9 June concerns were raised about the new regime. The Minister for Public Health stated that he would be happy to consider such matters and see if there were any further ways in which the current system can be enhanced (Scottish Parliament, 2011a, col 509).

During the same debate, Mary Scanlon raised concerns that under the previous Care Commission, such recommendations were often not followed up. She sought assurances from
the Government that SCWIS would. The Minister for Public Health said he was happy to do
that.

**DELAYED DISCHARGE**

“Delayed discharge” refers to hospital in-patients who are ready to move to another care setting
but who have to wait for a significant period. The current discharge planning period is 6 weeks,
therefore any timescale greater than that is defined as being delayed. Recently, there have
been concerns raised that, whilst over the course of the last Parliament there was significant
success in reducing the numbers of delayed discharges, recent statistics indicated that they
were beginning to increase over time again.

ISD Scotland’s report from February 2011, which contained the January 2011 delayed
dischARGE figures (ISD Scotland, 2011a, p 6), shows the long term trend from the last quarter of
2000. Between September 2000 and January 2003, each quarterly report showed there were
between 1,500 and 2,000 in-patients described as delayed discharges, peaking at 2162 in
October 2002. In March 2002 a delayed discharge action plan was published by the then
Scottish Executive. This, together with other developments, began to have an impact on the
statistics, and, as Figure 5 shows, the most dramatic falls occurred between January 2008 and
April 2008, when the there were no delayed discharges.

**Figure 5: Delayed Discharges, Scotland, January 2007 to April 2011**

![Delayed Discharges Graph](source)

Source: ISD Scotland (2011a and 2011b)
Over the past couple of years the trend has been for there to be fewer delayed discharges in the spring and summer quarterly census’. This may be related to winter pressures, when admissions, particularly amongst older people tend to increase. Despite the overall downward trend, recent quarters have shown a steady increase from 62 in July 2010 to 168 in January 2011. The key reasons for the numbers in January 2011 were either waiting for a place in a care home or for the funding to be arranged so that an individual could move into a care home. This may demonstrate the onset of the funding pressures being experienced by local authorities. However, as Figure 1 shows in April there were 12 delayed discharges. Therefore, it is difficult to come to any conclusions on the overall trend.

On 10 February 2011 the Cabinet Secretary for Health & Wellbeing made a statement to Parliament (Scottish Parliament, 2011b, col 33275 to 33287) on delayed discharges. This took place against a background of media coverage concerning particular issues in NHS Fife and the general concern about recent increases in delayed discharges. As well as dealing with the particular issues raised in NHS Fife, the Cabinet Secretary also stated (col 33277) that, if re-elected, the Scottish Government would look to decrease the six week target.

INTEGRATED HEALTH AND SOCIAL CARE

A key part of the health and community care debate during the election campaign was how to better deliver health and social care services. Each of the main parties had their own views on this:

- SNP - favoured integrating health and social care according to the Integrated Resource Framework model (see below)
- Scottish Labour - wanted to create a new commissioning body, the National Care Service, which would bring together health and social services
- Scottish Conservatives - proposed the merger of health and social care budgets, placing social care under the control of the NHS.
- Scottish Liberal Democrats – wanted to find solutions to bridging the gap between health and social services, but were against centralising services
- Scottish Greens – could see the benefits of integrating health and social care but wished to have a consultation on a range of options

However, how best to support health and social services to work more closely is not a particularly new debate. Woods (2001) notes that as far back the 1970s UK policy makers devised joint finance - a dedicated sum of money to be invested jointly by health and social services – as a way of facilitating better joint working. In the Scottish context Woods (2001) also describes how a number of labels have cropped-up to describe the policy of integration, for example: “joined up services”, “clinical or care pathways” and ‘care networks’. He explained: “Their common denominator is the purposeful working together of independent elements in the belief that the resulting whole is greater than the sum of the individual parts”. Some of the key developments in the run up to devolution and since are shown in Appendix 3.

However, despite such initiatives, there have been persistent concerns that joint working between partners has not been as effective as it could be, or that it has at least been patchy across the country.

Integrated Resource Framework

The Integrated Resource Framework (IRF) is a programme of work that has been developed since 2008 against the broad policy objective of the Scottish Government’s Shifting the Balance of Care (SBC) initiative.
The IRF is being developed jointly by the Scottish Government, NHS Scotland and COSLA (Scottish Government, 2011d). By enabling local partnerships to understand more clearly their patterns of spend and activity across health and social care, the IRF seeks to help local managers, clinicians and other care professionals to examine current service delivery and plan for improvements in quality, effectiveness and efficiency. The Scottish Government (2011b) believes that the IRF responds to the observation made by many who work in health and social care that they could deliver better outcomes if resources could follow patients and service users round the system to maximum effect rather than being constrained to use within structures and “silos”. By enhancing local understanding of costs, activity and variation across service planning and provision for different population groups, it is hoped that partnerships will be better equipped to realign their resources to support shifts in clinical/care activity within and across health and social care systems. Thus, the IRF is not intended to be merely a financial or reorganising tool, as it will involve analysing the decisions made by health professionals, and how these lead to resource commitments and outcomes for patients.

The IRF development process has two main phases. The first is to map patient and locality level cost and activity information for health and adult social care and to provide a detailed understanding of existing resource profiles for partnership populations. The Scottish Government (2011d) states that all NHS Boards, some with their local authority partners, have been applying this approach. In addition data is now available for most partnerships, which it was envisaged would be used in developing Change Fund plans (see above).

The second phase is to develop mechanisms or protocols that describe agreed methods to allow resources to flow between partners, following the patient to the care setting that delivers best outcomes. Mechanisms under consideration include the “lead agency” model under development in Highland, total budgets for CHP populations, budgets for care programmes (e.g. mental illness) and pooling arrangements for health and social care.

All of these mechanisms are currently provided for in legislation and guidance, such as those in Part 2 of the Community Care and Health (Scotland) Act 2002 (see Appendix 3).

Phase 2 has been taken forward through four test sites, each of which is implementing the IRF by focusing on selected populations of interest (defined either geographically or by care group). The Scottish Government is keen to stress that the IRF will be a tool that will able to be used flexibly in order to respond to local need. The objective for the test sites is to implement new governance and financial arrangements that enable resources to flow between health and social care. The test sites are:

- **Highland test site**: NHS Highland with Argyll & Bute Council and Highland Council
- **Tayside test site**: NHS Tayside with Angus Council, Dundee City Council and Perth and Kinross Council
- **Ayrshire test site**: NHS Ayrshire and Arran with East Ayrshire Council, North Ayrshire Council and South Ayrshire Council
- **Lothian test site**: NHS Lothian with City of Edinburgh Council, East Lothian Council, Midlothian Council and West Lothian Council

The test sites began their work in August 2009, and an evaluation team is currently monitoring progress. The evaluation is due to report in November 2011.
Lead Agency Model

This is the model being pursued in the Highland Test site, and is the one that has received the most public discussion and debate. The lead agency model is that used in a number of partnerships in England, where it is known as lead commissioning. The Scottish Government (2011b) believes that “lead agency” is the most appropriate term in Scotland, but in all practical senses the model is the same as “lead commissioning” in England. In a briefing on the lead commissioning arrangements used in England Scottish Government (2011g) describes it as:

“…an arrangement via which statutory bodies as currently configured contract for the commissioning of services for a defined population. Contracting in this way allows Partnerships to pool their respective resources for the population of interest, into a single integrated budget for the commissioning of services. In many cases staff also transfer from one body to another to allow integrated service provision for the target population, which may be based on age (such as older people), or care groups.” (2011d, p 1)

In Scotland, powers contained the Community Care (Scotland) Act 2002 allows for the same type of arrangement to be implemented by NHS Boards and Local Authorities. The Scottish Government (2011b) has stated that the key feature of a lead agency arrangement is managers’ and clinician’s focus on how best to support the particular service involved and the outcomes that it hopes to achieve. Thus different solutions may be best for different types of service.

The lead agency model being adopted in Highland was backed by the then Minister for Public Health, Shona Robison MSP, on 2 February 2011 and was backed by Lord Sutherland (Scottish Government, 2011e). However, COSLA (2011), has concerns that any plans of wholesale movement of social services to another body, such as the NHS, that the cost of such a move would be £300m, and raised a number of concerns about what this would mean to services and staff.

In terms of the Highland test site, its plans revolve round local authorities delegating adult social care to NHS Highland, and NHS Highland delegating children’s community services to the local authority. A joint paper prepared by the council and NHS Board outlines the case for change, details the engagement undertaken in developing the proposal, a proposed list of functions that would sit in each body, accountability and governance arrangements and the implications of the model. The new arrangements are to be in place by April 2012. However, there are a variety of steps that will be required to be taken of the course of the year until then. The next report on progress is due to be presented to a joint meeting of the Council and NHS Board on 23 June. (Highland Council and NHS Highland, 2011).

UNPAID CARERS

A recent study by Carers Scotland and the University of Leeds (Carers Scotland, 2011) calculated that the care provided by friends and family members to ill, frail or disabled relatives was worth £10.3 billion every year, a rise on the 2007 estimate which was £7.6bn. Given that overall policy is aimed at enabling as many people in need of community care services to be able to live as independently as possible at home, it is perhaps unsurprising that, given such figures, the contribution of unpaid care has been a key community care issue for successive Governments.

Prevalence

There are a number of data sources that can indicate the prevalence of unpaid caring in Scotland. The Scottish Government’s strategy for adult carers, ‘Caring Together’ (Scottish Government, 2010b, p 32), pulls together data from a range of sources, including:
• there are an estimated 657,300 carers in Scotland (Scottish Household Survey (SHS) 2007-08)

• there is a person requiring care in around 14% of households. However, 33% of households report that there is a person in the household with a long-term illness or disability (SHS 2007-08)

• around 10% of the population provides care to another person. (Census 2001)

• 79% of households with carers in them have one carer, 17% have two carers and 4% have three or more carers providing care in the household (SHS 2007-08)

Other data in the strategy shows that the majority of carers provide care to a parent, almost half of carers provide continuous care and that there are more women carers than men.

The strategy for young carers notes that some studies have estimated there to be over 100,000 young carers in Scotland, which is 1 in 10 of the school age population. However, adds that there are a number of reasons for variations in estimates, including: there are different definitions of a “young carer”, universal services do not keep information on the numbers of young carers they are working with, and children and young people who provide care do not always see themselves as “young carers”. (Scottish Government, 2010c, p 29).

In 2001, the Census included a question to help identify the numbers of unpaid carers in Scotland, their ages and the impact their caring contribution made on their own health. This identified 16,701 young people in Scotland who were recorded as providing some unpaid care. In addition it indicated that 13,511 young people were providing less than 20 hours care each week, 3,190 were providing more than 20 hours care each week, and 1,364 providing over 50 hours. (Scottish Government, 2010c, p 30).

Respite for carers

Under the concordat (Scottish Government, 2007) between the Scottish Government and local authorities, it was agreed that local authorities would make progress towards delivering 10,000 extra respite weeks by 2011. Note was also made of working towards providing more respite and support for 1,000 young carers. The Scottish Government (2011b) has advised that it included an extra £4 million over 2 years, in addition to the resources within the local government settlement, to support the delivery of these additional weeks. The aim was to ensure a wide range of carers and people with care needs would benefit from such short breaks. Table 6, shows overall figures for weekly respite in Scotland, for all ages:

<table>
<thead>
<tr>
<th>Number of respite weeks provided</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight Respite Weeks</td>
<td>63,590</td>
<td>62,750</td>
<td>62,800</td>
<td>62,730</td>
<td>64,110</td>
</tr>
<tr>
<td>Daytime Respite Weeks</td>
<td>100,050</td>
<td>109,980</td>
<td>111,230</td>
<td>132,980</td>
<td>139,250</td>
</tr>
<tr>
<td>Total</td>
<td>163,640</td>
<td>172,730</td>
<td>174,030</td>
<td>195,710</td>
<td>203,360</td>
</tr>
</tbody>
</table>

Source: Scottish Government (2010d)

1 All figures rounded to the nearest ten.
2 Same methodology used as in 2007/08 making the figure comparable to 2007/08
3 New methodology used making the figure incomparable to 2007/08 but comparable with 2009/10
Table 6 shows that the total number of respite weeks provided in Scotland increased by 5.6% between 2006-07 and 2007-08 and by 0.8% in 2008-09. Between 2008-09 to 2009-10 the total number of respite weeks provided in Scotland increased by 3.9% (7,650 weeks) over the time period. Statistics also show that respite provision has increased from 172,730 weeks in 2007-08 to 203,360 weeks in 2009-10. This represents a 15% increase over the period, of which 8,950 weeks is due to an increase in respite provision, and 21,680 weeks is due to improved data recording and/or methodology changes. (Scottish Government, 2010c, p 3).

**Strategies for carers**

Last year the Scottish Government, in partnership with COSLA and the voluntary sector published two strategies – one for adult carers and one for young carers.

The strategy for adult carers (Scottish Government, 2010b) was published in July 2010, with the aim of improving outcomes for carers through better recognition and support, including that they are:

- recognised and valued as equal partners in care
- supported and empowered to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of caring
- full participants in the planning and development of their own personalised, high-quality, flexible support and not shoe-horned into unsuitable support. The same principle applies to carers’ involvement in the services provided to the people they care for

The strategy contains ten headline actions in order to progress these, including:

- develop a Carers Rights Charter, consolidating existing legal rights and setting out key principles for carer support both now and in the future
- put in place measures to help professionals in the health and social care workforce identify carers
- invest £281,000 in carer (and workforce) training this year through a grant to the national carer organisations and to work with NHS Boards to ensure a ‘training offer’ is made to carers in greatest need, contingent on the outcome of the next Spending Review
- work with a range of partners to promote the further development of flexible, personalised short breaks and to provide investment to provide more innovative short breaks provision in Scotland to be delivered by the voluntary sector. The Scottish Government (2011b) notes that it has invested £1m in 2010-11 and 2011-12 to facilitate this. It has also
- provided an additional £2 million for disabled children and their families for short breaks in 2011-12
- promote better strategic planning and collaborative working between health and social care services to ensure the delivery of co-ordinated services and supports.

The young carers strategy (Scottish Government, 2010c) was also published in July 2010. Whilst recognising that many young people can benefit from providing care to a relative or friend this strategy aims to relieve young carers of inappropriate caring roles and support them in being able to live their lives as young people. It also contains 10 headline actions, including:

- continue to engage with young carers and will fund (£170,000) a fourth Scottish Young Carers Festival, in 2011
• put in place measures to help professionals in education, health and social care to identify young carers

• work with the Scottish Young Carers Services Alliance to produce a practice guide on young carers for teachers and schools

• work with a range of partners to promote the further development of flexible, personalised short breaks

• work with Skills Development Scotland to design and develop suitable materials and training opportunities to support young carers’ services’ contact with young adult carers

An important element of both strategies is to improve the information available to carers. One of the main vehicles for this is through the development of NHS Carers Information Strategies. These are required of each NHS Board through the Community Care and Health (Scotland) Act 2002. There are minimum requirements for what they should contain (see hyperlink above). The Scottish Government (2011b) states that it provided NHS Boards £9 million in the years 2008-09, 2009-10 and 2010-11 to develop these strategies, and has allocated a further £4.9m in 2011-12. The Scottish Government hope to continue this level of funding as part of the Spending Review, but also that that completion of it and some of the other actions in the strategy will depend on the outcome of the review.

Both strategies also contain the same commitments for monitoring and review. Both state that the Scottish Government and COSLA will keep the strategies under review. Specifically, the Implementation and Monitoring Group will report annually on progress, with the first report being undertaken by August 2011. A formal review will be concluded by August 2013.

Finally, in order to meet manifesto commitments on improving care for the elderly, the Scottish Government plans to provide an additional £300 million for this purpose, at least 20% of which will go towards helping carers (2011b).

FORTHCOMING LEGISLATION

At the time of writing there is an expectation that there will be two community care related Bills – one covering self-directed support and another following a limited review of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Social Care (Self-directed Support) (Scotland) Bill

Self-directed support (SDS) is a term that describes the ways in which individuals and families can have informed choice about the way that support is provided to them. As such it is seen as a key way of redesigning services and giving people greater empowerment, as discussed in Reshaping Care.

Direct payments are the most recognised form of SDS. It enables individuals to direct the care or support they need to live more independently at home, instead of, or in addition to, services that might be arranged by their local authority. To receive direct payments, an individual must have been assessed by their local authority as needing community care services. The local authority then makes a payment to the individual who can create their own care package. Councils have a duty to offer direct payments if a person is eligible, but the person concerned does not have to take it if they do not want to. The Scottish Government notes that they have been available to disabled people aged 18-64 since April 1997, and to disabled people aged 65 and over since July 2000. Since 21 December 2001 they have also been available to disabled 16 and 17 year olds and disabled parents for children’s services. From 1 June 2003 it became
a duty for local authorities to offer direct payments in place of providing services to all eligible disabled people aged 16 and over and to parents (or those with parental responsibility) for disabled children aged 15 and under. (2010e).

As regards the current numbers of people who are using direct payments, the key findings from the bulletin included:

- The number of people in receipt of Self-directed Support (Direct Payments) has increased each year from 207 in 2001 to 3,678 in the year to 31st March 2010.
- The value of direct payments has increased each year from £2.1 million in 2001 to £40.2 million in 2010.
- 45 per cent of people receiving Self-directed Support (Direct Payments) had a physical disability and 23 per cent had a learning disability. A further 3 per cent had both a physical and a learning disability.

Whilst the Scottish Government acknowledges that there has been an increase in the numbers of those taking up direct payments, it believes the numbers are still low, and that a number of barriers are preventing take-up, not least that it can be a bureaucratic process, and that it promotes an all or nothing approach – an individual either takes the direct payment and takes full responsibility for it or they don’t.

In November 2010, the Scottish Government (2010f) published ‘Self-directed support: A National Strategy for Scotland’. Its aim is to give more flexibility, choice and control to individuals and families. It wishes to see better outcomes through better assessment and review, improved information and advice to those considering SDS, and a clear and transparent approach to support planning. In addition, three SDS test sites, in Glasgow, Dumfries and Galloway and Highland have each been given £1.2 million funding from the Scottish Government over three years. These charged with increasing the uptake of self-directed support by focusing on three themes: bridging finance; cutting red tape and leadership and training. Underpinning the new strategy is to be a new Bill on self-directed support. In December 2010, the Scottish Government (2010f) published a draft Bill for consultation. It contained a number of proposals, including:

- Introducing the term self-directed support into statute and providing for general principles on user choice and control.
- Placing a duty on local authorities to provide people with a range of options so that the citizen can decide how much choice and control they want e.g. the individual receives the payment and chooses what type of service they wish, but employment and other issues continue to be dealt with by the local authority.
- Powers for local authorities to provide support to carers along with a duty on the local authority to empower the carer to direct their support.
- Encouraging and underpinning self-directed support in relation to packages involving joint social and health care funding.
- Consolidating and modernising current statute on direct payments.

The consultation ended in March 2011, and an analysis report and Scottish Government response is due in the near future. The Scottish Government (2011d) has advised that it is looking to introduce the Bill at the earliest opportunity.
Mental Health Bill

In January 2008, the then Minister for Public Health, Shona Robison MSP, announced the establishment of a group, headed by Professor Jim McManus, to undertake a limited review of the Mental Health (Care and Treatment) (Scotland) Act 2003. It was given the following remit:

- to review the processes in respect of the civil provisions of the Act and to advise on changes that should be made to improve the efficiency of the operation of the Act and experience of patients
- to advise on minor amendments to the Act
- to engage with those who operate the Act and report back to the Minister for Public Health with recommended changes

The review presented its report (Scottish Government, 2009b) to Ministers in March 2009, and it included a number of recommendations on advance statements, independent advocacy, named persons, medical matters and tribunals. Some of these would require primary legislation. This led to the Scottish Government (2009c) publishing a consultation in August 2009. This closed in November 2009, and was followed by an analysis (Scottish Government, 2010g) of the responses received in March 2010.

The Scottish Government. (2010h) published its response to the consultation in October 2010. It agreed that some topics would require primary legislation to amend the 2003 Act. The Scottish Government (2011b) has advised that it is currently aiming to introduce the Bill towards the end of the 2011/2012 parliamentary session. However, this is subject to Parliamentary timings, Cabinet clearance and the Government’s priorities following the Scottish Parliament elections. Otherwise, it will look to the 2012/2013 session for introduction.
SOURCES


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## APPENDIX 1: CURRENT PRIMARY STATUTORY PROVISIONS FOR ADULT COMMUNITY CARE IN SCOTLAND

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Main Provisions</th>
</tr>
</thead>
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<tr>
<td><strong>PRE DEVOLUTION</strong></td>
<td></td>
</tr>
<tr>
<td>Social Work (Scotland) Act 1968 (c. 49)</td>
<td>Placed the organisation and provision of welfare services for 'persons in need' with Social Work Departments, and introduced local authority duty to promote social welfare. Provided the basic structure for contemporary social work in Scotland. This Act (as amended) largely forms the basis of community care regulations, together with the amendments of the NHS &amp; Community Care Act 1990 (see below).</td>
</tr>
<tr>
<td>Chronically Sick and Disabled Persons (Scotland) Act 1972 (c. 51)</td>
<td>Extended sections 1 and 2(1) of the Chronically Sick and Disabled Persons Act 1970 to Scotland, providing local authorities with a duty to obtain information on those with chronic illnesses and disabilities who live in their areas. It also provided a duty on local authorities to, after assessment, support anyone covered by the legislation with practical assistance, including adaptations and equipment at home.</td>
</tr>
<tr>
<td>Housing (Scotland) Act 1987 (c.26)</td>
<td>Compelled the local housing authorities to consider the needs of chronically sick and disabled people when allocating accommodation.</td>
</tr>
<tr>
<td>National Health Service and Community Care Act 1990 (c.19)</td>
<td>The first piece of legislation to introduce a specific statutory framework for community care. It forms the cornerstone of community care law. It aimed to oversee the policy aim of shifting the balance of care from hospitals and institutions to community based settings. It was also an attempt to bridge the gaps in community care law. It placed a duty on local authorities to assess the need for “community care services” and enhanced their duty to secure the provision of welfare services. It applied to the elderly, disabled and those suffering from mental/physical health problems and so extended provision to those omitted in the Chronically Sick &amp; Disabled Act 1970.</td>
</tr>
<tr>
<td>Carers (Recognition and Services) Act 1995 (c.12)</td>
<td>Allowed carers to request an assessment of their needs when the person being cared for is being assessed or re-assessed. This was developed further under the Community care and Health (Scotland) Act 2002 (see below).</td>
</tr>
<tr>
<td>Community Care (Direct Payments) Act 1996 (c.30)</td>
<td>Gave local authorities the power (but not the duty) to make direct payments to individuals who could then purchase services and facilities themselves.</td>
</tr>
<tr>
<td><strong>POST-DEVOLUTION</strong></td>
<td></td>
</tr>
<tr>
<td>Adults with Incapacity (Scotland) Act 2000 (asp 4)</td>
<td>Provided for decisions to be made on behalf of adults who lack legal capacity to do so themselves because of mental disorder or inability to communicate. The decisions concerned may be about the adult's property or financial affairs, or about their personal welfare, including medical treatment.</td>
</tr>
<tr>
<td>Regulation of Care (Scotland) Act 2001 (asp 8)</td>
<td>Overhauled the registration and inspection of social and independent health care services together with the social services workforce. It established the Scottish Commission for the Regulation of Care (the Care Commission) and the Scottish Social Services Council (SSSC). The former was charged with the registration and inspection of a wide range of care services defined in the Act, including care homes, in accordance with regulations and taking account of the twenty one 'National Care Standards’. The SSSC was made responsible for the registration, practice and training of the social services workforce.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Main Provisions</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Community Care and Health (Scotland) Act 2002 (asp 5)</td>
<td>Introduced changes to the delivery of residential and non-residential care services in Scotland. It provided for the introduction of free personal care for the elderly and the regulation of charging for home care services. It contains a power for Scottish Ministers to regulate charging for home care services. However, policy since the legislation came into force has been to achieve a greater level of consistency by self-regulation through the Convention of Scottish Local Authorities (COSLA) guidance on charging, the most recent guidance being published in 2009. The Act also enabled a number of schemes to promote choice in care provision; including measures to enable greater joint working between NHS and local authorities; and, contains a duty for local authorities to identify as well as inform carers of their right to a needs assessment independent of the person being cared for.</td>
</tr>
<tr>
<td>Mental Health (Care and Treatment) Act 2003 (asp 13)</td>
<td>This Act came into force in October 2005 and was the result of a fundamental review of mental health law in Scotland. It renewed the previous 1984 Act, but, importantly, also provided for new provisions including the establishment of Mental Health Tribunals and a new system of appeal against compulsory treatment/right to independent advocacy. Further information is contained in the Scottish Government web page &quot;Mental Health Law: Information and Topic Guides.&quot;</td>
</tr>
<tr>
<td>Adult Support and Protection (Scotland) Act 2007 (asp 10)</td>
<td>Part 1 of the Act introduced new provisions for the protection of adults at risk of abuse, including inspection and investigation powers for local authorities and a range of interventions. Part 2 of the Act amended the Adults with Incapacity (Scotland) Act 2000 (asp 4), with the aim of simplifying and streamlining the protections for adults with incapacity and improving access to them. Part 3 of the Act made a number of amendments and repeals to the Social Work (Scotland) Act 1968 (c. 49), in the areas of ordinary residence, care home fees and direct payments.</td>
</tr>
<tr>
<td>Public Services Reform (Scotland) Act (asp 8)</td>
<td>This made provision for the purpose of simplifying public bodies, including the transfer and delegation of certain functions. The Act dissolved the Care Commission and the Social Work Inspection Agency. Part 5 created a new body called Social Care and Social Work Improvement Scotland (SCSWIS), which took over the vast bulk of the functions of the two previous bodies, including the registration of care services and their inspection.</td>
</tr>
</tbody>
</table>
### APPENDIX 2: CHANGE FUND ALLOCATIONS BY PARTNERSHIP AND NHS BOARD

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Partnership</th>
<th>Partnership allocation (£m)</th>
<th>Total Board allocation (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>East Ayrshire</td>
<td>1.65</td>
<td>5.50</td>
</tr>
<tr>
<td></td>
<td>North Ayrshire</td>
<td>1.96</td>
<td></td>
</tr>
<tr>
<td></td>
<td>South Ayrshire</td>
<td>1.89</td>
<td></td>
</tr>
<tr>
<td>Borders</td>
<td>Scottish Borders</td>
<td>1.73</td>
<td>1.73</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>Dumfries and Galloway</td>
<td>2.56</td>
<td>2.56</td>
</tr>
<tr>
<td>Fife</td>
<td>Fife</td>
<td>4.90</td>
<td>4.90</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>Clackmannanshire</td>
<td>0.59</td>
<td>3.63</td>
</tr>
<tr>
<td></td>
<td>Falkirk</td>
<td>1.89</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stirling</td>
<td>1.16</td>
<td></td>
</tr>
<tr>
<td>Grampian</td>
<td>Aberdeen City</td>
<td>2.74</td>
<td>6.76</td>
</tr>
<tr>
<td></td>
<td>Aberdeenshire</td>
<td>2.84</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moray</td>
<td>1.19</td>
<td></td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>West Dunbartonshire</td>
<td>1.21</td>
<td>14.80</td>
</tr>
<tr>
<td></td>
<td>East Dunbartonshire</td>
<td>1.22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East Renfrewshire</td>
<td>1.12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glasgow City</td>
<td>7.92</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inverclyde</td>
<td>1.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renfrewshire</td>
<td>2.11</td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td>Argyll and Bute</td>
<td>1.71</td>
<td>5.14</td>
</tr>
<tr>
<td></td>
<td>Highland</td>
<td>3.43</td>
<td></td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>North Lanarkshire</td>
<td>3.84</td>
<td>7.86</td>
</tr>
<tr>
<td></td>
<td>South Lanarkshire</td>
<td>4.02</td>
<td></td>
</tr>
<tr>
<td>Lothian</td>
<td>East Lothian</td>
<td>1.26</td>
<td>9.75</td>
</tr>
<tr>
<td></td>
<td>Edinburgh, City of</td>
<td>6.01</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midlothian</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West Lothian</td>
<td>1.50</td>
<td></td>
</tr>
<tr>
<td>Orkney</td>
<td>Orkney Islands</td>
<td>0.32</td>
<td>0.32</td>
</tr>
<tr>
<td>Shetland</td>
<td>Shetland Islands</td>
<td>0.33</td>
<td>0.33</td>
</tr>
<tr>
<td>Tayside</td>
<td>Angus</td>
<td>1.69</td>
<td>6.20</td>
</tr>
<tr>
<td></td>
<td>Dundee City</td>
<td>2.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Perth and Kinross</td>
<td>2.27</td>
<td></td>
</tr>
<tr>
<td>Western Isles</td>
<td>Eilean Siar</td>
<td>0.53</td>
<td>0.53</td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
<td>70</td>
<td>70</td>
</tr>
</tbody>
</table>

Source: Scottish Government and COSLA (2010)
APPENDIX 3: LORD SUTHERLAND’S INDEPENDENT REVIEW OF FREE PERSONAL AND NURSING CARE IN SCOTLAND 2008 – SUMMARY OF RECOMMENDATIONS

SHORT TERM – stabilise and address difficulties in funding and variability of provision

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Address Funding Gap:</strong> The Scottish Government should provide additional funding to stabilise the policy in the short-term i.e. for the next 5 years. It is estimated that the shortfall in funding is around £40m.</td>
<td>Action: SG provided £40m per annum in additional funding to local authorities from 2009-10 to stabilise the policy.</td>
</tr>
<tr>
<td><strong>2. Up-rate Fixed rate allowance:</strong> The Residential and Nursing Care Fixed Rate Allowances should in future be up-rated annually in line with inflation.</td>
<td>Action: Payments for Personal and Nursing Care have increased in line with inflation annually from April 2008.</td>
</tr>
<tr>
<td><strong>3. Standardise assessment and delivery:</strong> There should be a clear ‘entitlement’ for all those assessed as needing personal and nursing care, analogous with the NHS, and in line with that, local authorities and their partners should consolidate standardisation of assessment for and delivery of services, to common processes and clearly stated target waiting times.</td>
<td>Action: SG and COSLA jointly issued guidance on a common eligibility framework and consistent approach to waiting times to local authorities on 28 September 2009.</td>
</tr>
<tr>
<td><strong>4. Establish clear national priorities and outcomes for older people:</strong> There should be a specific reference to securing wellbeing of older people included within the Scottish Government’s 15 National Outcomes set out in its National Performance Framework.</td>
<td>Action: Since moving to adopt an outcomes-based model of governance in 2007, the Scottish Government has used a wide range of measures to assess progress against the Purpose and National Outcomes set out in its National Performance Framework (NPF) and reported through Scotland Performs. These measures reflect broad social and environmental aims, as well as the economic measures more traditionally used by governments. The NPF is a 10 year plan, which will be refreshed to take account of achievements to-date, experience of outcomes-focused government and wider economic and other developments. At the same time, the opportunity will be taken to consider how the line of sight between the high level Purpose Targets and National Outcomes and more service specific or local outcomes frameworks, such as that for Community Care Outcomes Framework, might be improved. The Community Care Outcomes Framework sets out 16 key measures which could appropriately underpin an overarching outcome for older people. That framework is now being widely used by health and community care partnerships across Scotland as part of their own performance arrangements. Work on Re-shaping Care for Older People will include consideration of key measures of success, linked to proposals for a specific reference to securing the wellbeing of older people, for consideration in any revised National Performance Framework.</td>
</tr>
<tr>
<td>5. <strong>Ensure costs are accurately monitored and reported:</strong> The current failings in information systems identified should be addressed and more accurate systems to collect comprehensive and accurate cost information set in place.</td>
<td></td>
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<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Action:</strong> Figures on FPNC expenditure are published as National Statistics for Scotland. This means they are produced entirely independently of Ministers and go through rigorous quality assurance and validation before they are published.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SG, in partnership with COSLA also issued guidance on 22 March 2010 to local authorities on Monitoring of National Standard Eligibility Criteria and Waiting Times for FPNC of older people.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. <strong>Improve local accountability:</strong> A performance framework for long-term care services for older people should be built into the Single Outcome Agreement model.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action:</strong> Community Planning Partnerships incorporate improvement measurement into their SOAs on the basis of the Menu of Local Indicators, which was drawn up by a national working group supported by SOLACE, the Improvement Service and Scottish Government.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. <strong>Address imbalance in funding streams:</strong> The UK Government should not have withdrawn the Attendance Allowance funding in respect of self-funding clients in care homes, currently amounting to £30 million a year. That funding should be reinstated in the short-term while longer-term work to re-assess funding streams takes place.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action:</strong> The issue of reclaiming these monies from the UK Government is long standing and remains a matter of Ministerial, Parliamentary and public concern in Scotland. The issue has been raised with Whitehall on various occasions at various levels to no avail. Ministers plan to continue to pursue an equitable resolution.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. <strong>Clarify expectations:</strong> Renew efforts to improve public information and understanding of the policy. A clear understanding of shared responsibility needs to be fostered.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action:</strong> SG published a new public information leaflet on the free personal and nursing care policy in March 2010.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. <strong>Address cross-border/boundary issues:</strong> Conclude work to ensure greater consistency in interpretation and application of Ordinary Residence legislation and guidance without further delay.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action:</strong> Following extensive consultation and amendments to the legislation, new regulations were published in April 2010.</td>
</tr>
</tbody>
</table>

Source: Scottish Government (2011b)
Local Health Care Cooperatives (LHCCs) – created through ‘Designed to Care’ (Scottish Office, 1997), and coming into being in 1999, these were part of Primary Care Trusts (PCTs) and organised round groups of GP practices in distinct geographical areas. They were not provided for through legislation. They were intended to bring health and social care providers together to deliver services.

‘Modernising Community Care: Action Plan’ – published by the Scottish Office in 1999 it aimed to secure better and faster results for people by focusing on them and their needs. It also sought more effective and efficient joint working based on partnerships between health, local authorities and other stakeholders.

The Joint Futures Group - established following a post-devolution summit of senior NHS and local authority personnel, which found that the vision of joint-working espoused in ‘Modernising Community Care’ had not been fully realised. It published ‘Community Care: A Joint Future’ (2000), which recommended securing better outcomes for older people through improved joint working, including developing arrangements for managing and financing joint services, and the introduction of a ‘single shared assessment’.

Community Care and Health (Scotland) Act 2002 – Part 2 provides Scottish Ministers the power to introduce regulations that enabled further flexibility for joint working between NHS Boards and local authorities, by permitting them to make payments to one another, delegate functions and pool budgets. Such arrangements came into effect in January 2003. The Act also provides Ministers with intervention powers to direct NHS Boards and local authorities to enter into joint working arrangements where poor joint working prevails.

National Health Service Reform (Scotland) Act 2004 – As well as abolishing PCTs and acute trusts, bringing all the responsibilities under one unified NHS Board, it also required Boards to establish one or more Community Health Partnerships (CHPs) as subcommittees of the Board. CHPs were called for in the White Paper ‘Partnership for Care’ (Scottish Executive, 2003). They replaced LHCCs and were to bridge the gap between primary and secondary healthcare, and between health and social care.
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RELATED BRIEFINGS

**SB 07-29 Community Care in Scotland**
This briefing provides background information on the statutory framework underpinning community care, general community care policy developments, specific policy developments for particular client groups and the organisation and funding of community care services.

**SB 09-51 Frequently Asked Questions: Care for Older People (260KB pdf)**
This briefing is intended to assist MSPs and their staff in dealing with issues around care for older people that frequently arise in the context of their constituency caseload.

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