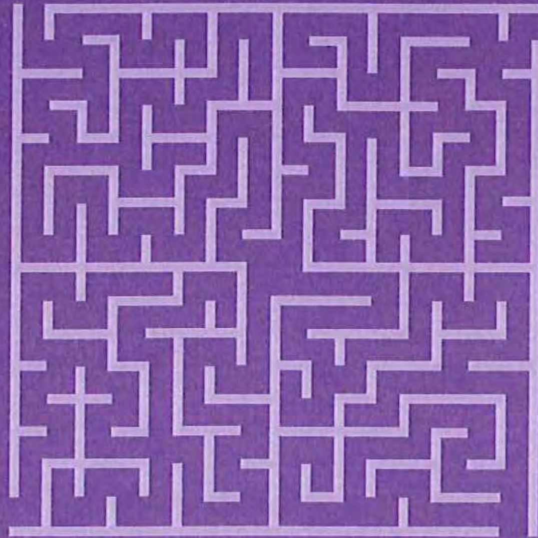
Accounts Commission for Scotland



The commissioning maze

Commissioning community care services

NOVEMBER 1997

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The Accounts Commission is a statutory, independent body which through the audit process assists local authorities and the health service in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the statutory external audit
- following up issues of concern identified through the audit to ensure a satisfactory resolution
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in the NHS and local authorities
- issuing an annual direction to local authorities setting out the range of performance information which they have to publish.

The Commission assists the NHS in achieving value for money by highlighting good practice, providing comparative information, and supporting auditors in reviewing performance locally. Its Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies. Part of the 1997 programme included a review of how councils commission community care services.

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Responsibility for the contents and conclusions rests solely with the Accounts Commission.

Note on terminology

The language of community care is still evolving, and some words carry a range of meanings. The following definitions have been used in this report:

- **commissioning:** the processes involved in developing and securing services, through in-house provision by the council itself, or through contracting with external providers in the private or voluntary sector, or other statutory bodies.
- **care manager:** a generic term for those staff who responsibility is to identify the needs of individuals, and develop and manage packages of care to meet those needs.

1. Introduction

Community care is about enabling people to live as normally and independently as possible, by helping them to live in their own homes or in homely settings rather than in institutional care. There are two dimensions to the policy: the assessment of individuals' needs for services; and a significant shift in the type of care available, away from institutional care towards a range of flexible, community-based services. Councils have the main responsibility for achieving this change, which requires a major shift in culture.

The scale of the challenge should not be underestimated. Councils have faced a major change in their role, from direct providers of services to commissioners responsible for planning and developing services from a range of different providers. They have taken over responsibility for funding residential and nursing home care from the Department of Social Security, together with a transfer of money to meet that responsibility. Finally, they have had to develop new relationships with the other agencies involved in community care, including those responsible for housing, education, health and social care, drawn from the public, private and voluntary sectors.

All this has taken place against a background of local government reorganisation, increasing the number of councils responsible for community care from 12 to 32. Although this offers the potential to improve community care, by bringing together responsibility for social work, education and housing within unitary authorities, it has undoubtedly disrupted service development and delivery. As well as problems caused by the process of reorganisation itself, councils have been faced with:

- a shortage of expertise in specialist areas such as planning, contracting and finance
- altered geographical boundaries in some areas, together with more complex relationships with health boards
- disruption to information and other systems.

The Accounts Commission first reviewed community care in its 1994 report *Squaring the circle* [1]. This report represents, in part, a follow up to the earlier study, examining progress three years later. It focuses on how councils are fulfilling their responsibilities as commissioners of community care services, and examines progress in the following areas:

- planning for community care, in collaboration with other agencies
- developing a 'mixed economy' of services and service providers, offering the full range of community care services
- providing information to those responsible for assessing the needs of individuals for care and arranging for services to be provided
- monitoring progress in developing and delivering community care.

Most councils have not yet made the shift to a commissioning culture, linking together these elements into a coherent role with effective systems to support them. This is particularly apparent in a serious lack of information. Good information is crucial to planning and monitoring community care services which are tailored to the needs of service users. However, few councils have comprehensive, timely and accurate information routinely available to them, and many experience great difficulty in producing it in response to specific requests.

Community care will only achieve its aims if these problems are addressed. This report highlights a number of specific areas where there is scope for improvement, together with examples of good practice and recommendations for change. These changes, however, must take place as part of a wider cultural shift if they are to be effective.

Community care is a major area of public policy, and one in which the Accounts Commission is uniquely placed to make a contribution. This report is a first step in examining how the new councils are tackling their responsibilities, and it sets out a comprehensive picture of the community care landscape in Scotland. However, there are several areas where further work is needed to investigate particular issues in more depth. The Commission will take into account the views of stakeholders in setting the programme for this follow-up work; comments from readers of this report are particularly welcome.

2. Background

Community care is a major service area for local authorities. It has a direct impact on the lives of the most vulnerable people in their local communities, and it accounts for significant amounts of money. Councils budgeted to spend more than £750 million on community care services in 1996/97; this represents just over two thirds of total social work spending. Within this overall figure, there are wide variations between councils. Average spending per head of adult population was £199 while individual councils' expenditure ranged from £104 to £382 (exhibit 1). The variation does not appear to be related to need, as measured by the size of the elderly population or deprivation.

Exhibit 1: Community care spending per head of adult population

Source: Accounts Commission

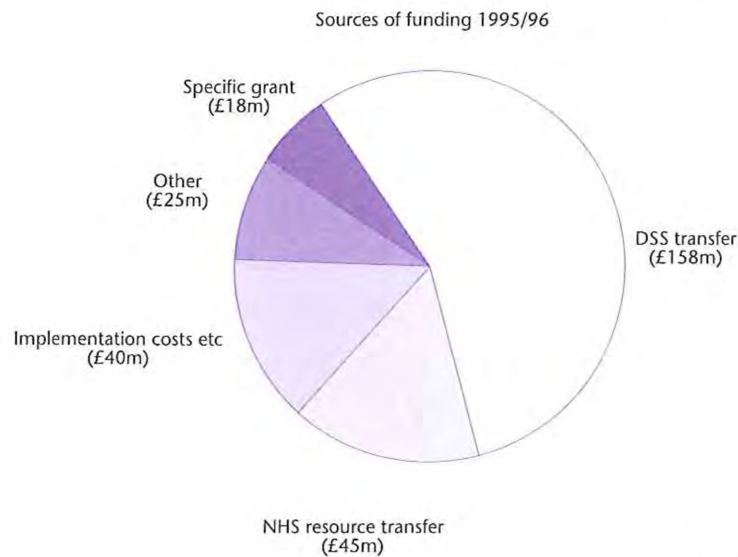
Around 85% of councils' spending on community care is supported by general government grant, which offers councils some flexibility in how they allocate it between services. There are also some comparatively small specific grants, notably the Mental Illness Specific Grant, which must be applied by councils to a particular service. Government grants are supplemented by the council tax and by income from charges.

Councils have also received transferred resources to match their new responsibilities for community care. At national level, resources have been transferred from the Department of Social Security. These were previously used by the DSS to fund residential or nursing home places in the voluntary or private sector for eligible people. These funds rose from £40 million in 1993/94 to £198 million in 1996/97. The funds are not linked to particular individuals, but form a block of resources which can be used to purchase residential or nursing home care, or, in line with the Government's policy, to develop alternative services in the community and so prevent unnecessary admissions to institutional care.

At local level, there have also been transfers of resources from health boards to local authorities, reflecting shifts in responsibility for groups of patients. These funds have been less uniform and predictable than the DSS transfer, as they are based on local negotiation between councils and health boards. The Commission has recently examined this transfer process in its report *Shifting the balance* [2], which identified a number of problems with the resource transfer mechanism.

Exhibit 2: Funding of post-1990 responsibilities

Funds totalling £286m were made available to local authorities to supplement the substantial resources already within social work budgets and housing departments' capital allocations.



Source: The Scottish Office

The primary objective of community care has been that people should be able to live in their own homes, or at least in homely settings, wherever possible. This requires the development of a full range of services, including home care or domiciliary services provided in people's own homes; respite care; day care; and residential and nursing homes. One of the key issues facing councils is determining the appropriate balance between these different types of services.

The community care policy is also based on the promotion of a mixed economy of care, with councils responsible for commissioning the most appropriate services, regardless of who provides them. However, there is no requirement in Scotland to spend a fixed percentage in the independent sector as there is in England and Wales. There are several advantages in having a range of different providers for each type of care, including flexibility in service planning, choice for service users, and potential cost advantages.

A strategic view of community care, including clear longer term plans, is essential if the community care policy is to be successfully implemented. This is not straightforward. The numbers of people needing services, and the type of care they are likely to require, have to be estimated; the type, volume and quality of existing services must be identified; and plans made to develop new services to fill the gaps identified. All this must be achieved within a climate of tight resources and rising demand.

3. Service planning

The complexity of community care means that good planning is essential if it is to be successfully implemented. A range of different stakeholders have an interest in these plans, from the other statutory agencies involved, such as health, housing and education, through the various service providers in the voluntary and private sectors, to the people who use community care services and those who care for them. This chapter reviews how councils are fulfilling their central responsibility for planning, starting with the involvement of users and carers.

User involvement in planning

Service users and the people who care for them need to be involved in planning community care at two levels: they have a central role in planning their own care packages, but also in developing the overall strategy for community care. Involvement in individual care planning is discussed later in the report; this section covers overall planning.

Most councils feel that they have involved users in planning, and described a range of mechanisms which have been used to involve both service users and their carers. Consultation on the community care plan was most common. Most councils rely on traditional methods, such as circulation of plans for comment and public meetings. More innovative methods include presentations to small group with a particular interest in community care, and the production of summaries and posters describing the plan. Two councils have gone further and invited service users onto planning or advisory bodies, and another has a user member on its planning committee.

These methods can be applied to issues other than the community care plan. One council which wished to develop its learning disability services carried out a separate consultation exercise, which resulted in two valuable outputs - a report, and a network of user contacts.

In addition to consultation on the community care plan, councils have developed other mechanisms for involving users. These include support for advocacy; commissioning research into specific user needs; and establishing focus groups. One third of councils have provided funding for voluntary bodies which councils felt had access to, or represented, the views of service users. A number of more experimental mechanisms are shown in box 1.

Box 1: Mechanisms for involving users

- Area forums to permit decentralised consultation
- Service user or involvement strategies
- Voluntary organisation used to establish user panels for old people
- Specialist user involvement officer
- 'Customer comment cards' to record the views of users of respite and residential care
- User and carer development and support unit
- A Care Committee, with co-opted user and voluntary sector representatives
- A joint housing/social work group, including user representation, to advise the council on its service policy.

It is clear that councils have developed a wide range of mechanisms for involving users in the planning of community care. However, very few of these mechanisms have had their effectiveness evaluated systematically. There were some exceptions to this pattern. Two councils had commissioned a voluntary sector organisation to provide information or research, and a third had recently begun an in-house evaluation. In general, it is unclear whether the consultation methods used by councils truly allow users' views to be taken into account, or whether there are better ways of discovering these views and using them in community care planning.

Recommendations

Councils should ensure that they have arrangements to involve users in strategic and local planning (as well as in planning their own care packages). They should also evaluate the effectiveness of these arrangements against pre-set objectives.

The planning process

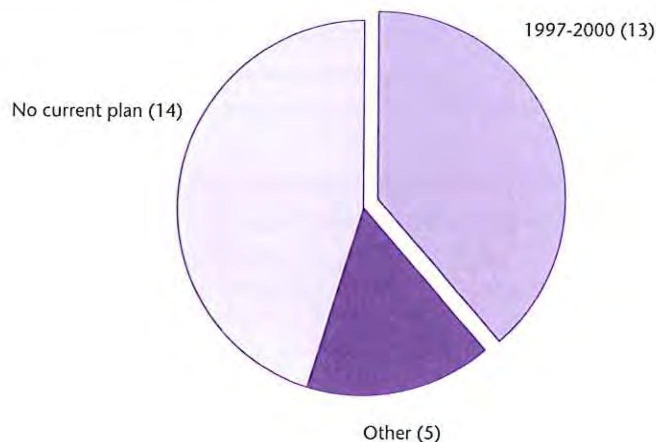
The aim of planning should be to identify the council's service provision proposals by setting out an analysis of:

- the need for community care services in a council's area
- the services available to meet those needs (either through direct service provision by the council or by purchase from external providers)
- the financial and other resources available to secure services
- the actual services which the council intends to secure in the period covered by the plan.

This information should be set out in the council's community care plan, which is one of its main tools in developing and delivering community care. The NHS and Community Care Act 1990 requires each council to prepare a community care plan, covering a three year period, which sets out the council's assessment of the need for community care services in its area, the services which are available, and the services it intends to commission. These may be either provided in-house by the council or secured from an external provider.

Scottish Office guidance advised the new councils to publish the first community care plans for their areas, to cover the period 1997-2000, by June 1997. By August 1997 only 13 were available, not all in final form (exhibit 3).

Exhibit 3: Availability of community care plans



Source: Accounts Commission

More than half the new unitary authorities had been unable to produce a community care plan by the summer of 1997 and were instead working to older plans, including some regional council plans. Two councils submitted one year plans, covering 1997/98, and three councils, unaffected by local government reorganisation, had plans which covered different three year periods.

Community care plans should contain details of the value, volumes and providers of services the council plans to commission. This is a requirement of directions issued by the Secretary of State in 1994, and is essential if plans are to fully achieve their objectives. The information is needed by councils to commission services, and to signal the council's intentions to other stakeholders; it is also necessary in monitoring how successful the council has been in implementing its objectives.

In practice, few of the plans which are available are comprehensively quantified. The following elements were reviewed by the Commission:

- information on services planned and currently commissioned
- whether services are planned in terms of the number of people to benefit
- whether current and future spending is reported
- how gaps in provision are discussed and quantified within plans
- the extent to which the plans are informed by data on needs.

Services

Even for the first year covered, only a few of the current three year plans contain information about the type and volume of services the council currently purchases, or plans to purchase in future. Seven plans list the services available; no plan contained a complete list, and overall the information is more descriptive than quantitative. Councils are more likely to include volume data for services which are easier to define or measure, such as institutional care and the provision of meals.

Most plans contain information on the amount of service purchased from each sector, but this is reported as the total value by sector, with no breakdown by volume or type of service.

For information on services to be meaningful, it should relate to both the services provided and the care groups of people who receive them. The Accounts Commission defined five main services and seven main care groups (box 2).

Box 2: Services and care groups

Services

- nursing home care
- residential home care
- respite care
- day care
- home care

Care groups

- elderly people
- people with dementia
- people with mental illness
- people with learning disabilities
- people with physical disabilities
- people with HIV/AIDS
- people who misuse drugs or alcohol

Ten community care plans contain information about these main services, and nine do so by the main care groups, but other councils report on different care groups. For example, a significant number of councils do not separate people with dementia from elderly people, while seven councils do not treat people with HIV/AIDS as a separate care group. These differences result from both gaps in the data available to councils, and different approaches to planning. They mean, however, that it is hard to draw comparisons between councils in their level of provision for different care groups and services.

Scottish Office guidance gives councils discretion over the care groups used in community care plans, and in some council areas certain user groups are regarded as too small to warrant separate identification in plans. There is also a professional debate about whether it is appropriate to 'label' people.

However where a council plans, assesses and arranges services for different user groups, it must be able to quantify budgeted and actual spending, the volume of service involved and the number of people benefiting. In most councils, community care services for people with dementia, for example, are sufficiently important in spending terms to require this basic information.

Number of people

Only five councils reported in their community care plans how many people they expect to benefit from their planned services. This is surprising given the comparative completeness of data on service users. Only one council reported the number of users intended to benefit for all the services listed in its plan. Another council reported the number of 'places' available as a proxy for the number of users of residential, respite, day and home care services. Two further councils noted the number of people who currently receive home care, but provided no data on the number of users of any other services.

Current and future spending

According to Scottish Office guidance, plans should demonstrate a realistic appraisal of current and future resources. Of the 18 current plans, 15 report current spending on each of the major care groups, and 13 report current spending on each main service. Only five councils report future spending, while a further two councils include future spending for specific development proposals.

Gaps in provision

Fifteen plans discussed gaps in provision, but only 8 quantified them. This quantification is rarely available for each identified service or user group, and is by no means comprehensive. For example, one council reports only the waiting list for services for people with learning and physical disabilities. A further two councils quantify only one service gap each, for housing and services for carers respectively. Three plans do not discuss gaps in provision at all.

Needs

Scottish Office community care planning guidance states that council plans should indicate a clear picture of existing need. Without exception, all the current community care plans rely heavily on broad prevalence figures to inform commissioning. The analysis uncovered little use by councils of their own data on unmet need, or of data from other local sources.

In a small number of plans some aspects of planned service provision are based on targeted reviews or investigations of specific services. For example, Clackmannanshire has used data from a detailed study of the needs of people with physical disabilities, while two other councils base their plans for older people and those with dementia on a more detailed analysis of local need. Highland Council has established a working group to establish systems for recording unmet need, as part of a wider council strategy to map need in its area.

The prospect of change is not a valid reason for failure to quantify needs. While overall care needs may change over time, this effect is unlikely to be significant in the short term, with the exception of hospital discharge programmes which relate to the needs of a known population. Moreover, even if needs do change significantly, planned provision still has to take account of the resources available. However, it is clear from the review of community care plans that most councils do not have simple and effective systems to record and analyse local information, and access national data.

Recommendations

Councils should quantify their current position, in terms of spending, volumes of service, providers, and numbers of people needing services. They should also quantify, as far as possible, their plans for future service provision. This will entail addressing gaps in information which hinder effective planning.

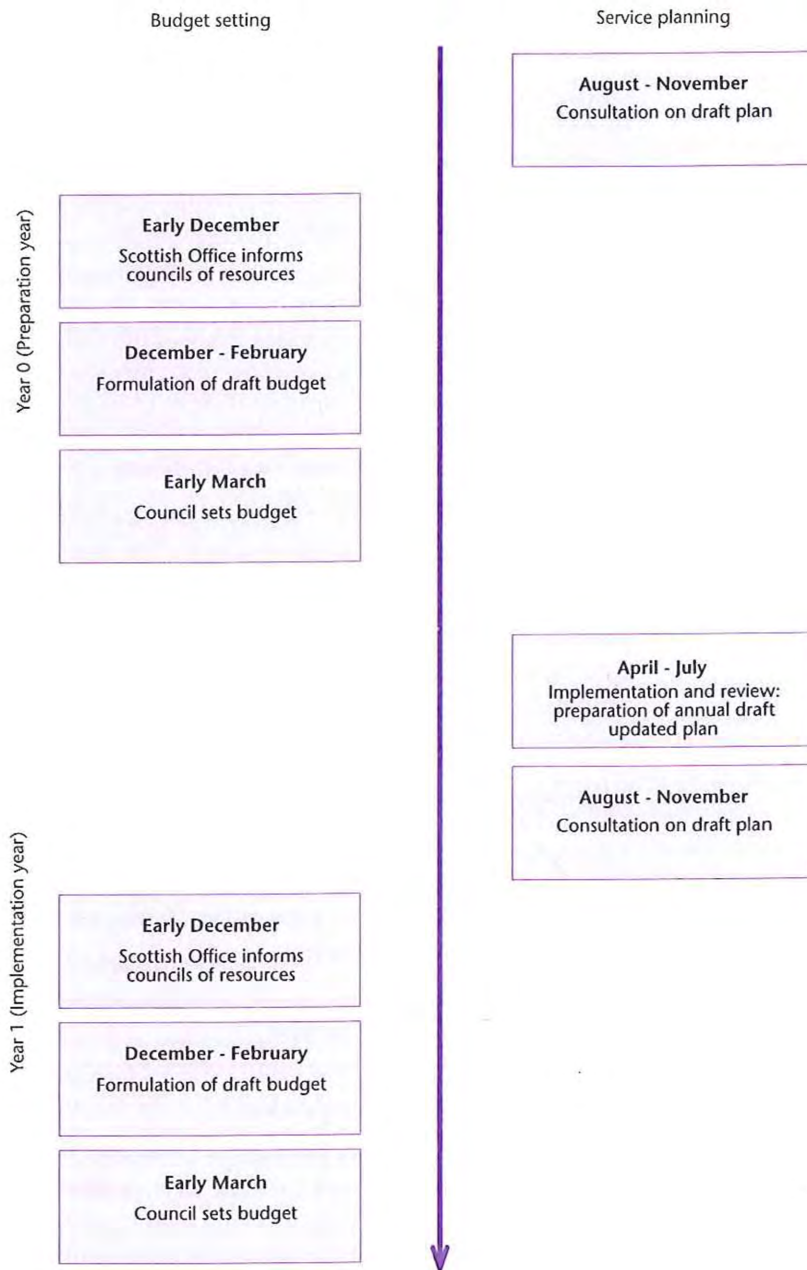
The community care plan should include this information, and explain any significant planned changes and resource shifts.

Planning and budget setting cycles

Community care planning and budget setting are closely related. Both involve allocating resources between different services and user groups, and both provide a basis for monitoring how resources are used in practice. They should therefore be closely integrated, so that the community care plan reflects the funds available to secure services, while the budget reflects the priorities identified in the plan.

However, there are some difficulties in integrating the two activities. Budget setting is an annual process, while community care plans should cover a three year period, with annual reviews to ensure that there is a 'rolling' process to update plans. More seriously, the planning and budget setting cycles can get out of phase, a problem mentioned by several councils. This can mean that, for example, where a council wishes to adjust the priorities set out in its draft plan, budgetary revisions may not be possible until the following year's budget-setting round. The duty on councils to set their budgets by March for the following financial year is statutory, while the planning cycle is advisory, so that the planning cycle must be adjusted to fit the budget cycle.

Exhibit 4: Integrating service planning and budget setting



Source: ADSW

Recommendations

Councils should ensure that their planning and budget-setting cycles are synchronised. Preparing and consulting on the community care plan should:

- *be phased so that it fits the council's budget-setting timetable*
- *enable the plan to be used in allocating financial resources*
- *ensure that changes to the plan can be identified and agreed before budgets are set.*

Since budget-setting is determined by a statutory timetable, it is the planning cycle which must be adjusted. This may mean that further guidance from the Scottish Office Social Work Services Group would be useful in integrating the two cycles.

Budgets as commissioning instruments

The council's budget should express its priorities for the funds available to it, including its plans for community care. For this reason, the budget should reflect the main services which are to be secured, whether by direct provision or by purchase from an external provider. Similarly, they should reflect the costs reported in the community care plan, so that financial and service planning are integrated. This structure should work its way down through the information used for financial management and monitoring.

In practice, this information is not readily available. The Commission requested 38 items of basic financial data from all councils: 17 items of budget information and 21 relating to actual spending. (More information on the data is contained in Appendix 1). Only three councils were able to report all 38 items. On budgeted spending, six councils could report all 17 items; nine could report all but one item of budget data, and four councils all but two. Most councils could provide the majority of the data requested on actual spending (exhibit 5), but only 3 councils reported all 21 data items.

Exhibit 5: Availability of information on actual spending

Source: Accounts Commission

Of the five main services, councils are less likely to have data about their budgeted spending on nursing home and respite care. Of the seven care groups, data about people with dementia and people with HIV/AIDS cause most problems. Only half of councils could provide data about their planned or actual spending on services for people with dementia, reflecting wider difficulties in their information on this care group. Information on services for people with HIV/AIDS is most limited, with only eleven and thirteen councils respectively able to provide data on budgeted and actual spending.

A significant number of councils were unable to identify the amount of money spent purchasing community care services from providers outwith their areas. Again, the most notable data gaps relate to nursing home and respite care services. In part, these purchases reflect user choice. However, they may also reflect the absence of those services in a council's area, and this management information is valuable in planning for future needs.

Councils were asked to grade the financial data they reported according to its availability and accuracy. Availability was lower for actual spend than for budgeted spend, which raises questions about the way in which expenditure is monitored.

Although there are clear gaps in the availability of data, accuracy present even more problems. Overall, councils assessed their finance information as more available than accurate. As with availability, the item graded as accurate by most councils was total budgeted social work spend. Accuracy decreases as the budgeted and actual expenditure figures are disaggregated. For example, 21 councils assessed their budgeted expenditure on community care as reliable data, but only 3 gave this grade to their actual expenditure on respite care.

In order to make sense of financial data, councils must also have reliable information about the volume of service to which the financial data relate. Councils were therefore asked to provide information about the volume of care provided for each of the five main services, the seven main care groups and the three sectors. The information relating to services was broken down further, by volume available to the council, planned volume, and volume actually commissioned. Definitions for each are given in box 3.

Box 3: Definitions of volume

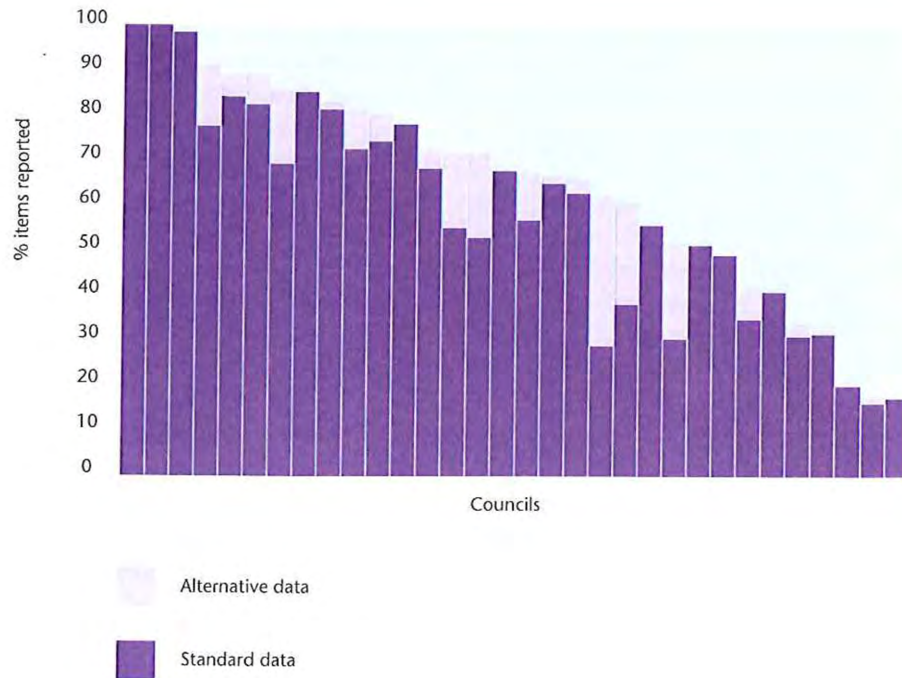
Volume available: the volume of service which was available within the council's geographical area for 1996/97, excluding provision which may be available to be commissioned from elsewhere.

Volume planned: the total quantity of services which the council planned to be delivered during 1996/97.

Volume commissioned: the total volume of service actually commissioned and delivered in the six months to 31 December 1996, including services which were not purchased for specified individuals.

Overall, councils generally know how many people are receiving services, but they are less able to produce information on how much of each service they commission and from which providers. Data on the volumes of councils' in-house provision are no more likely to be reported than data relating to the voluntary or private sectors. On average, councils were only able to report 60% of the service volume data requested about their own service provision, although there was wide variation between councils (exhibit 6). These are major data gaps, which have serious implications for the planning and implementation of community care.

Exhibit 6: Availability of volume data



Source: Accounts Commission

The problem of incomplete information on community care is well known. It has been highlighted in *Squaring the circle* and in other publications [3]; this study confirms the problem, and reveals how widespread it is and how serious its impact. Several councils frankly described their information systems as inefficient, outdated or unsuitable. Gaps in this information undermine effective service planning and monitoring. Linked to the gaps in financial data, councils are unlikely to be able to demonstrate that they are managing their resources effectively.

Recommendations

Each council should:

- *assess the data gaps which hinder effective planning and management, and*
- *arrange to fill them, giving priority to the information most important for service planning and monitoring.*

4. Commissioning

This chapter reviews how councils go about securing the services which are needed by their local communities, identified through the planning process and set out in the community care plan. This operates at two levels: the overall strategy for developing and securing services; and the operational commissioning process by which services are planned and provided for individual service users according to their needs.

Commissioning models

Once councils have planned the community care services they wish to provide for their communities, they must develop ways to ensure that those services are in place, either by in-house provision, or by entering into contracts with organisations in the voluntary and private sectors which can provide them. In some cases, the range of services available already matches those planned by the council, with a choice of alternatives available from each sector. In particular, there is often a wider choice of providers for residential homes, with significant provision by local authorities themselves as well as the private and voluntary sectors.

In other cases, councils have to encourage the development of services which they wish to commission but which are not available in sufficient quantities. This means specifying the services in more detail; identifying possible providers, whether new or existing ones; and working with them to develop services of the appropriate quality and cost. This is part of the process of commissioning.

For services which already exist, councils face the challenge of commissioning these in a way which balances flexibility and choice for service users with the best value for money for the council. In practice, this means that there is no single 'best' model for commissioning; the council's strategy should make use of the various different models available to balance these objectives, which can conflict. The various models identified are set out in box 4.

The five models were familiar to all councils interviewed, but the definitions differed between councils. In a small number of councils, differences in understanding within the council emerged during interviews, where staff differed on the meaning of each commissioning model and how they were used in their own department.

Problems of definition are most common in relation to spot purchasing, pre-placement agreements and service level agreements. For example, in some councils service level agreements act as contracts in themselves, whereas in others this form of agreement is always linked to another contract model, such as block or spot purchase. Moreover, some councils purchase via block or spot purchase contracts within the terms of a pre-placement agreements, while for others pre-placement agreements stand alone.

Three councils reported that they use commissioning models other than those set out above. One council uses a cost and volume contract with a local housing association, which provides the council with access to a maximum of 16 housing places at an agreed unit cost. Another described block commissioning with certain providers as a way of providing deficit funding; the third council facilitates an arrangement whereby the individual service user acts as the service provider's employer.

Box 4: Commissioning models and definitions

Block purchasing: the payment of an annual fee for access to a defined range of services. This type of commissioning is not initially related to individual users, and the service volumes will be estimates. The model has the advantage of guaranteeing service availability and guaranteeing funding for the provider, although it may 'lock up' resources in the short/medium term

Spot purchasing: the purchase of a specific type and volume of care for a named individual. It secures an immediately available, more tailored service, but may also have a higher unit cost than block purchasing.

Pre-placement agreements: establish an option to purchase a pre-defined service at a set price. The option is usually established as part of strategic commissioning, but is exercised at the operational level. A number of councils use the term 'call-on/call-off agreement'. The model helps co-ordinate strategic and operational requirements.

Service level agreements: specify in detail (e.g. volume, value, quality, access) the minimum acceptable service to be provided. Mainly used for in-house or voluntary sector provision. The model helps emphasise service quantity or quality, rather than availability.

Grant aid: voluntary sector services are increasingly funded by means of contracts or service level agreements, although the agreements may span a number of years. Many councils now use grant aid only for lower cost services. Councils find it useful in supporting the continuing functioning of voluntary organisations.

All councils have their own approach to commissioning community care services, but there are a number of areas of similarity. In particular, most councils commit the largest proportion of their commissioning resources by means of block contracts or spot purchasing. In-house services are generally treated as block contracts, although in practice they are neither commissioned nor contracted for in the same way as voluntary or private sector services.

Spot purchasing and pre-placement agreements are mainly used for nursing and residential home places and home care services from the voluntary and private sectors. These models of commissioning are also favoured by councils when purchasing services from other councils. Grant aid is used for services provided by the voluntary sector. Core funding via grant aid for voluntary sector providers is decreasing, and is often tied to a tighter specification of the services to be provided in the form of contracts or service level agreements.

Practice is most varied in relation to service level agreements (SLAs). All councils use this model, but in very different ways and for a variety of reasons, including:

- providing grant aid to a service provider
- when dealing with the voluntary sector
- all contracts above a given value.

SLAs were used within councils in relation to central departments (eg IT), but no examples were found for in-house care provision. This model would provide a mechanism for starting to treat in-house provision on a more contractual basis, setting out what volume and quality of service is to be provided in return for guaranteed funding.

Regardless of the model used to secure any service, the council must set service specifications and standards which apply to all providers including the council itself. These standards and specifications would also provide a basis for monitoring contract compliance and quality.

None of the 18 current community care plans report the mix of commissioning models used; only one of the 18 includes a statement on the overall approach to commissioning. For most councils, the pattern of commissioning reflects that inherited from their predecessor authorities, but it is unlikely that the use of inherited policies is appropriate if they have not been reviewed against the new council's circumstances. A small number already acknowledge the need to review the mix. Falkirk Council is approaching this by undertaking a review of the commissioning models used to purchase services for one care group. The knowledge gained from this targeted review will be used to inform other service areas.

Recommendations

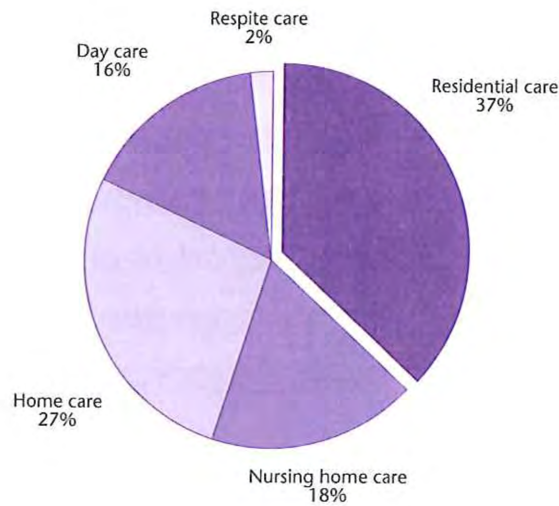
Councils should review the commissioning models available to them, relating the advantages and disadvantages of each to its overall plan of the services required. There may be benefits in doing this on a service by service basis. These reviews should lead to a strategy for commissioning, with a clear rationale behind the mix of commissioning models used.

Councils should also develop standards and specifications for each service they commission, whatever the model or whoever the provider. These should apply to all providers, including in-house services.

Range of services

For effective community care, councils need to have access to an appropriate balance of the five main services. Exhibit 7 sets out the budgeted spending across Scotland for 1996/97, broken down by service. The exhibit excludes those councils which were unable to report information on their expenditure plans by service.

Exhibit 7: Budgeted spending by service



Source: Accounts Commission

Across Scotland, residential care accounts for nearly 40% of all community care spending, while nursing and residential home care together account for 55%. In contrast, services provided to people in their own homes accounted for around a quarter of total expenditure. Within these national figures, there is considerable variation between councils (exhibit 8).

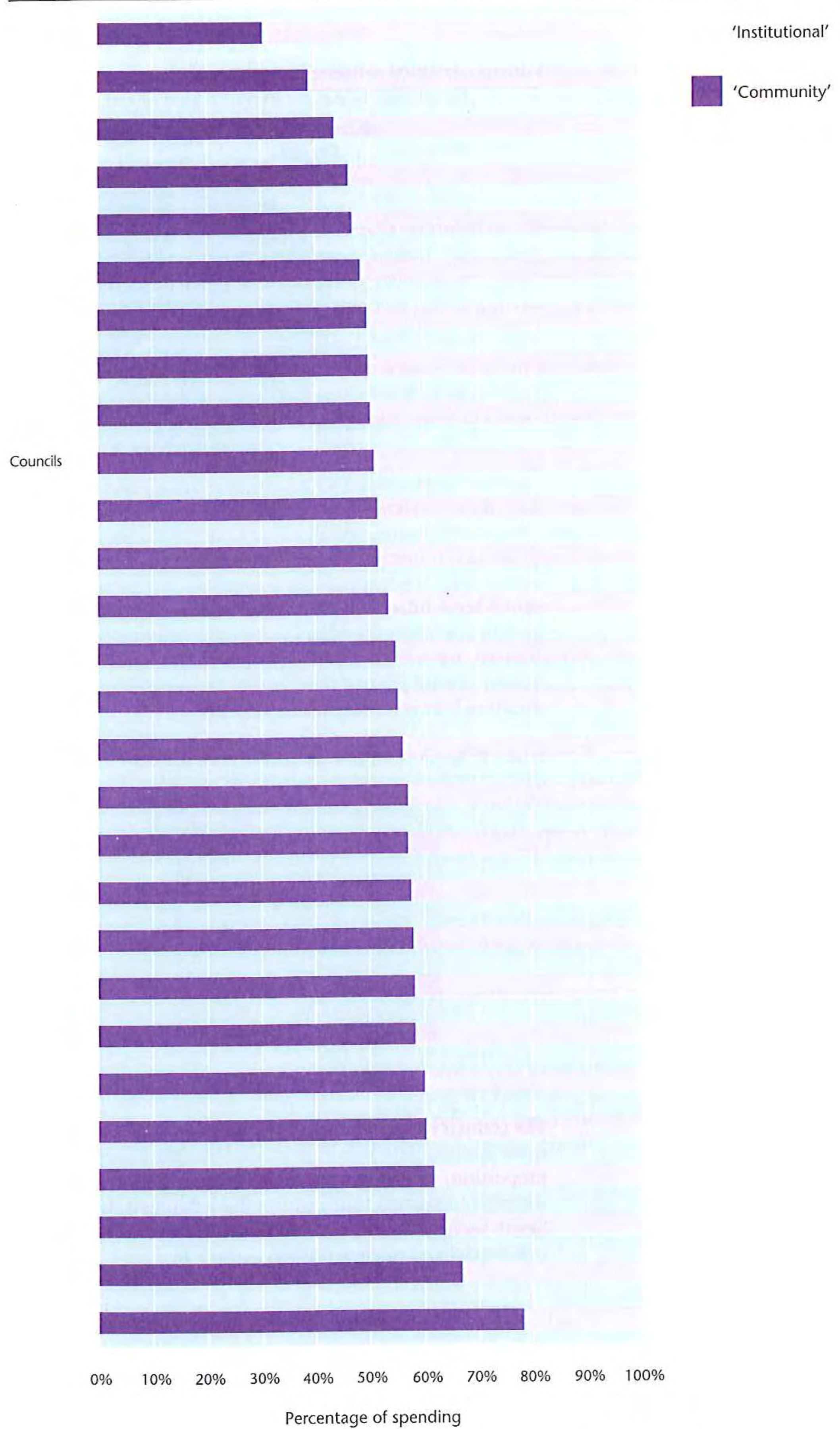
Exhibit 8: Range of expenditure on five main services

Service	Minimum % of budgeted expenditure	Maximum % of budgeted expenditure
Residential care	10%	60%
Nursing home care	13%	32%
Home care	6%	47%
Day care	3%	27%
Respite care	0%	5%

Source: Accounts Commission

The council which allocated the highest proportion of its budget to residential care spent approximately six times more than the council which allocated the lowest proportion, while for home care the variation was more than eight times. Perhaps the most important factor within these figures is the balance between 'community-based' services (home, day and respite care) and 'institution-based' services (residential and nursing homes) exhibit 9.

Exhibit 9: Budgeted spending on community-based and institution-based care



Source: Accounts Commission

Once again there are wide variations between councils. In 1996/97 the proportion of funds spent on community-based provision ranged from 30% to 78%; the council which invested most heavily in community-based services planned to spend more than two and a half times as much of its budget as the council investing least.

It is clear that institution-based care still accounts for the majority of expenditure on community care services. Residential and nursing home care accounts for 55% of the budget but only 16% of service users (exhibit 10). Community-based services by contrast, account for around 45% of the total community care budget, but 84% of service users.

Exhibit 10: Expenditure and volume of home-based care

Service	% of total users	% of total budget
Residential care	9%	38%
Nursing home care	7%	18%
Home care	61%	26%
Day care	17%	16%
Respite care	6%	2%

Source: Accounts Commission

This data raises two main questions. The first is whether all those who are placed in residential and nursing homes actually require that type of care. There is conflicting evidence available [4,5], but it is possible that some of those who enter institutional types of care could remain at home if more flexible services were available. This seems to be particularly true of those older people who enter continuing care on leaving hospital, perhaps after fracturing a hip in a fall. Although they may initially require more intensive support, they may later recover to the point where they can live safely at home. This may not be possible, however, if they have already entered permanent institutional care.

The second question raised by the data is the extent to which more intensive packages of home care are available and appropriate. There has been a tendency for home care services to be spread more thinly as demand increases, but this may mean that people with higher levels of need can no longer cope at home. Intensive packages of home care may cost as much or more than care in a nursing or residential home, and it is unclear how councils balance cost against choice in this situation.

There are financial incentives in favour of institutional care as far as councils are concerned. If someone is placed in a nursing or residential home, their capital assets must, by law, be taken into account in assessing how much they have to pay towards their care. These capital assets are not taken into account in assessing charges for home care.

There is no 'right' balance between the two broad categories of care, but it is clear that some councils are much more successful than others in developing a range of options for service users in their communities. Most councils interviewed indicated that they do not expect major change in the balance of services commissioned.

Recommendations

Councils should develop comprehensive information on the range and quantity of services they commission from all sectors, detailing the volume commissioned and the commissioning model used.

They should also develop a clear strategy setting out the range of services they wish to commission in future, and how they plan to encourage the development of these services.

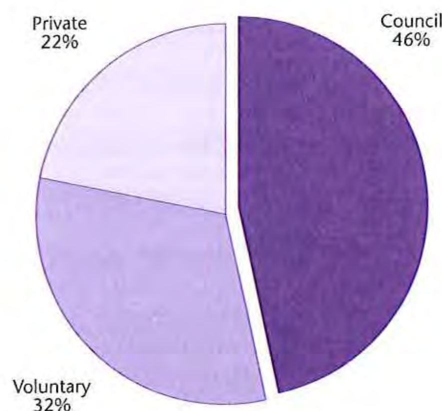
Developing a mixed economy

Most councils express support for a mixed economy of providers drawn from the public, voluntary and private sectors. In practice, however, few have an overall policy for developing such a mix, and no council has measurable targets in this area. A mixed economy is being developed through incremental changes in commissioning practice. Most councils consider that the overall mix of local authority, voluntary and private provision will emerge from a series of individual operational decisions.

The 18 community care plans were reviewed for policy statements on the mixed economy. Fifteen statements were found, but only three recorded that the encouragement of a mixed economy of care was a community care policy objective. At four councils, officers expressed the view that their councillors were reluctant to encourage a mixed economy, for two main reasons: fear of redundancy or job losses among council staff; and limitations in the monitoring framework for private sector home care. One council has an explicit policy not to purchase private home care.

The extent to which a mixed economy is developing can be expressed in terms of the volume of service commissioned, as well as its cost. This is important because of the different costs of each service. Institution-based care currently demonstrates the most developed economy (exhibit 11). More than half of residential care home places are commissioned from the private and voluntary sectors. Councils provide no nursing home care, which is all commissioned from the independent sector.

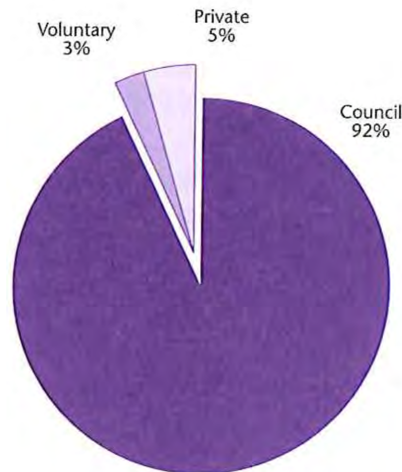
Exhibit 11: Mixed economy for residential care by volume



Source: Accounts Commission

The equivalent breakdown for home care is shown in exhibit 12.

Exhibit 12: Mixed economy for home care by volume



Source: Accounts Commission

The overwhelming majority of home care (92%) is provided by councils themselves. In part this reflects concerns about the difficulties of ensuring adequate standards of quality and safety in home care services, since there is no equivalent to the registration of care homes. However, it also suggests that councils have not been pro-active in encouraging the development of new service providers, offering greater choice. Independent providers of home care may be more innovative in the type of care provided and, particularly, in its flexibility, for example extending the availability of out-of-hours care, which can be crucial in enabling a person to remain in their own home rather than moving into residential care.

There is a further dimension to this pattern of provision. Private and voluntary homes enjoy a cost advantage, due to the residential allowance which is available to people entering these homes. This has the effect of reducing the cost of these places to the council. In addition, evidence from a number of sources suggests that residential care provided by the private and voluntary sectors can be less costly than councils' own provision [6,7,8].

Not all of this apparent cost difference can be easily realised, because of the high costs of disinvesting from services, and there may be differences in service quality and the level of care available which cannot be assessed under the current monitoring systems. However, by developing a strategy for reducing reliance on the in-house provision of residential care and shifting to independent sector provision, councils would release funds that could be used to develop new forms of care closer to the ideal of community care. It may also avoid the need for capital investment to upgrade homes which fall below current standards.

A number of councils interviewed envisage that their in-house provision will reduce in relation to the voluntary and private sectors. This shift is often driven by cost pressures. It may also reflect policy considerations such as the wish to ensure that council provision meets the same standard required of the voluntary and private sectors. At the same time, some councils plan to retain in-house provision to avoid an independent sector monopoly. Few envisage large scale change. They do not anticipate that they will take an active role in managing the market by encouraging the development of new services.

Recommendations

Councils should have a comprehensive picture of the extent to which they currently use a mixed economy of care. They should also develop a specific policy on the future mix of provision, made public through the community care plan and supported by clear criteria against which progress can be measured.

Implementing policy and plans

The report so far has focused on the challenge of developing a strategy for community care, supported by plans for the services that will be provided. In practice, these plans are implemented by operational staff such as care managers, who are responsible for assessing the needs of individuals, arranging for services to be provided to meet those needs, and monitoring both the provision of services and the financial resources used to provide them.

In order for care managers to be able to do this effectively, councils need to have in place structures and processes which support them. In the main, the new councils are working with what they have inherited from their predecessors. So far, they have made little progress in developing formal guidance on roles and procedures for operational staff.

Care managers need information about the services available, their cost and quality. However, the information which is available to care managers is very variable. In the 16 councils interviewed it includes:

- some unit costs (for in-house services) and price information (for external providers), mentioned by eight councils
- inspection reports, mentioned by six councils
- access to contracts and service specifications, mentioned by five councils
- a register or list of approved providers, mentioned by three councils.

This information needs to be not only available, but easily accessible by care managers. This is not always the case. Some councils do supply information directly to care managers, others supply it to the care managers' managers, and a small number of councils only make the information available 'on request'.

In spite of some innovations, both the information itself and the mechanisms for dissemination suffer from serious limitations. These are caused by both the basic gaps in data outlined in chapter 3, and difficulty in keeping information on availability, quality and cost up to date. Overall, the information used by care managers lacks accuracy, comprehensiveness and objectivity. Care managers appear to make decisions about services mainly on the basis of client choice and ease of access to services, within a list of providers pre-selected on the basis of cost or price. In the case of independent providers, this is followed by selection on reputation, care philosophy and quality of provision.

It is hard to escape the overall impression that in most councils, care managers rely on their own local knowledge of services. Four councils specifically noted that care managers use their local knowledge when comparing providers, and two acknowledged that care managers have no centrally provided information on the strengths and weaknesses of providers. This local knowledge may be valuable, but used in isolation it runs the risk of missing important issues and may result in inequity for service users.

Recommendations

Councils should review the range of information available to care managers as they put together care packages, to ensure that it includes full unit costs (for in-house services) and price (for independent sector services); service quality information; and service availability.

Care managers should also be seen as a key source of information. Councils should consider whether systems are in place to bring this information together so that central commissioning and planning staff can review the overall effectiveness of commissioning.

Budget holding

Care managers also need to know how much money is available to pay for the care packages they plan. This can be achieved by devolving budgets to teams or to individual care managers. Information on the extent to which councils have devolved budgets for community care was available for 22 councils. Of these, 17 have devolved commissioning budgets to some extent; most have devolved these budgets to teams, and only two have devolved budgets to individual care managers. One council has suspended devolved budgeting, as it believes its control mechanisms are not sufficiently developed to offer adequate control of spending.

Overall, devolved budgets are small in relation to total budgeted spending for most councils, and in practice the budgets are used chiefly for the purchase of services from the independent sector. In-house services are not charged to devolved budgets. This may distort the financial limits beyond which many councils require special authorisation of higher-cost care packages. It may also distort the pattern of services commissioned. This has two potential effects; service users may not be offered a real choice in the services available to them, and the total cost of the care package may be higher than it would be if care managers took true costs into account.

Staff involved in operational and strategic commissioning need to be equipped to carry out their responsibilities effectively and efficiently. Care managers, who are not normally from a financial background, may need training in financial management and commissioning. Reorganisation has meant that strategic commissioning expertise is more thinly spread.

Recommendations

Councils should develop a policy on the devolution of budgets for community care, which clearly balances the need for flexibility and control.

Councils should ensure that staff involved in commissioning have the expertise they need, by conducting a skills audit and acting to develop staff as necessary. The results of this audit should be reported to councillors to ensure that any request for resources is underpinned by a comprehensive understanding of the strengths and weaknesses of the department, and the effect on efficiency and effectiveness.

Eligibility criteria

Eligibility criteria are an essential part of community care policies and practice. They provide a mechanism for allocating services on a consistent and open basis, by prioritising need against available resources in recognition of the fact that all demands cannot be met.

In *Squaring the circle*, the Commission reported that many authorities acknowledged the need to develop their eligibility criteria further. In the intervening period, the demand for community care services has continued to increase as people live longer, physical and mental incapacities rise in number and complexity, and the expectations of user groups and carers are heightened.

Fourteen authorities selected for the survey of charging policies participated in this part of the study. The councils responded to a questionnaire which sought to:

- establish the extent to which eligibility criteria were applied (services and user groups)
- establish the purpose and objectives of eligibility criteria in use
- explore the involvement of service users in this process
- assess the success of the criteria as a means of allocating limited resources.

No authority is yet in a position where comprehensive eligibility criteria for all services are routinely being used. Eleven of the 14 councils have formal eligibility criteria for some or all of the 5 major services. The remaining three councils apply a broad definition of eligibility, which allows care managers flexibility to allocate services on the basis of professional judgement and local circumstances.

Only four councils had reviewed eligibility criteria during the financial year 1996/97. This was a lower number than expected, given the impact of recent budget restrictions and the trend of increasing demands for services.

A majority of the councils which operate eligibility criteria have adopted a system of priority levels for access to some services, which relate to the degree of risk and vulnerability of the client. Typically, councils adopt three or four priority levels, though the content of each is not uniform between authorities. For example, one council considers older people currently in hospital who require residential or nursing home care to fall within the lowest priority category, while another gives such clients the highest priority.

No council has sufficient resources to be able to meet all assessed need. In most cases, clients at the lowest level of risk are either:

- not allocated a service (typically in home care), or
- added to the waiting list for a service which is subject to regular review (such as permanent residential or nursing home care).

Those assessed as having a higher priority do not necessarily receive the full volume of care which they require. The majority of councils have set cost limits for services, expressed as a weekly upper limit on the costs of a care package. However, in-house services are not always included in these limits, and they often only apply to elderly people as a care group. The reason cited overwhelmingly for cost limits is cost control.

Responsibility for allocating services rests at one of two levels of the organisation: either with care managers who also carry responsibility for the assessment process, or, where resources are particularly scarce, with a panel of senior managers who meet regularly to allocate services.

In most cases, councils reported that the purpose of their eligibility criteria is to target resources on their most vulnerable clients. This was sometimes combined with other objectives such as controlling spending, identifying unmet need in a systematic way, and achieving clarity and openness.

Only 3 of the 15 authorities indicated that they record and use information on unmet need for planning purposes. One council reports this information on a regular basis to its social work committee. However, most authorities recognise this as an important area for development, which they hope to address within the next two years.

In 1996, the Scottish Office issued guidance on NHS responsibility for continuing health care which encouraged the development of joint strategies and eligibility criteria for health and social work services. There are clearly advantages to clients where shared or complementary criteria are applied for access to services. However only two councils reported that they have developed, or are in the process of developing, eligibility criteria with health boards for a range of services.

Six authorities indicated that they had consulted user groups in the course of developing or adjusting eligibility criteria, and that it was their practice to publicise eligibility criteria or information about priority levels. Those councils which had consulted widely reported that the response of users was less negative than they had anticipated.

In general, councils commented that more detailed guidance on eligibility criteria would be helpful, reflecting the recommendation of the Scottish Affairs Committee that eligibility and minimum entitlements to service should be specified centrally by the Scottish Office. In the absence of such guidance, there is scope for better information sharing between councils, allowing others to learn from the experiences of the small number of councils who have made progress in this area.

Recommendations

Each council should:

- *review its current arrangements for allocating services, to identify shortcomings*
- *develop explicit criteria, including priority levels, for all community care services and client groups, in consultation with users*
- *agree joint or complementary eligibility criteria with health boards in order to improve services and facilitate access by users*
- *regularly monitor the effects of eligibility criteria on unmet need.*

At national level:

- *councils should develop a common framework for eligibility, by sharing information through ADSW, building on the experience of those councils which have comprehensive criteria already in place*
- *the Scottish Office should consider whether further guidance on eligibility criteria is necessary.*

User charges

Like eligibility criteria, charging policies are important in achieving value for money. In *Squaring the circle* the Commission identified the need for authorities to develop such policies. The charges to be made for residential care are set out in statute, but councils have discretionary powers to introduce charges for non-residential services, and Scottish Office guidance issued in 1997 identified specific services for which councils could reasonably expect to make charges. These should be within the financial means of the user. The new councils inherited a wide variety of charging arrangements and eligibility criteria from their predecessors, which needed to be reviewed and updated to ensure equity and value for money.

The same 14 councils were included in this part of the study, completing a questionnaire which sought to identify:

- the purpose and objectives of the charging policy
- the nature and extent of charging arrangements in terms of services and user groups
- the success of the policy in terms of income generation
- the effect of the policy on service users
- examples of good practice or comparisons which could be drawn between authorities.

All 14 councils had charging policies for a variety of non-residential services, and the majority of authorities had increased charges since April 1996. In general, social work managers expect that charges will continue to increase, both in terms of the level of charges and in the range of services for which charges are levied, in the light of continuing budget constraints. However, one council announced in its community care plan that charges for home care had recently been withdrawn. Although this represents a departure from the general trend, no reasons for this were offered within the plan.

The primary objective of councils in setting charges was partially to recover the costs of providing the service, in order to maintain service levels as demand increased. None of the 14 councils sought to recover the full economic cost of services, since they believed this was impractical and would not generate the income levels required. Most councils aimed to incorporate equity in their charging structures, but recognised that this had not yet been fully achieved. Some significant anomalies remained which would require to be addressed in future years.

Authorities reported a general reluctance amongst elected members to levy charges for services, and strong resistance to charges for some client groups. For example, in all but one of the councils surveyed, no charge is levied for day care services for people with a learning disability, apart from a charge for lunch.

Charges are usually applied to the individual services which a client might receive, rather than applying to their care package as a whole. Some councils acknowledged that this aspect of charging policy required further review, to simplify arrangements for clients, and to take account of the impact of charges on those receiving complex packages of care.

There is some uniformity in the range of services for which charges are currently being levied (exhibit 13).

Exhibit 13: Number of councils charging for non-residential services, by user group

User group	Home care		Day care*		Respite care	
	%	(n)	%	(n)	%	(n)
Elderly people	100	(14)	40	(14)	100	(14)
People with dementia	100	(14)	9	(14)	100	(14)
People with mental health problems	100	(11)	9	(12)	100	(12)
People with learning disabilities	100	(12)	21	(14)	100	(14)
People with physical disabilities	100	(14)	30	(12)	90	(12)
People with HIV/AIDS	100	(8)	30	(10)	90	(9)
People with drug/alcohol addications	100	(11)	33	(12)	100	(12)

(n = number of councils providing the service)
*numbers exclude those only charging for meals/lunches

Councils' main objective in levying charges is to offset the costs of service provision. Information on the amounts raised from charges was requested from all councils; one was unable to provide the information. For the other 31 councils actual income from July-December 1996 ranged considerably, from 1.3% to 14.9% of budgeted social work spending in 1996/97. In 16 councils, charges represented 3.2% or less of budgeted spending.

All councils believe that their charging structures and collection arrangements represent value for money, though only three had tested this assumption as part of the process of developing or reviewing charging arrangements. A small number of authorities have an automated system for issuing invoices and collecting income, but others have to rely on labour intensive manual arrangements for collecting, logging and banking cash. Most authorities have met their own targets for income from user charges.

Monitoring arrangements revealed a tendency for take-up of services to drop when charges were introduced or significantly increased. Councils put considerable effort into verifying that those users who withdrew from the service were not at serious risk as a consequence and, where appropriate, took action quickly to waive charges where undue hardship or risk were identified. Councils reported a very small number of cases where charges had been waived, and the majority of clients returned to the service within the same financial year. All but one of the 14 authorities reported that they assess clients' entitlements to welfare benefits in an attempt to maximise their incomes before introducing charges, and in most authorities this represented a routine, ongoing arrangement.

Only four councils had actively consulted users or user representatives as part of the introduction or extension of charges. This reflected two factors:

- the short timescale available for developing and introducing charges (typically a two month period within the annual budget setting exercise)
- councils' general perceptions that user response would be overwhelmingly negative.

In fact, those councils which did carry out consultation exercises found that users accepted the reasons for charging, and were quite prepared to pay if it gave them increased control over the type of services available, who provided them and how they were delivered.

Recommendations

Councils should:

- *set clear objectives for their charging policy*
- *consult with users and other interested parties (eg users, relatives, carer groups, voluntary and private sector providers) in both the development and monitoring of charging arrangements*
- *adopt a charging structure which reflects the whole package of care received by the client*
- *develop a charging structure which is equitable, comprehensive and capable of being consistently applied without being inflexible*
- *ensure that the reasons for exemptions from charging are transparent*
- *ensure full income maximisation routinely precedes the application of a charge to a client*
- *set anticipated income levels at a realistic level which facilitates the achievement of the council's primary objectives and ensures equity and value for money are achieved, and*
- *monitor user withdrawals from service, where charges are introduced or significantly increased, and operate an efficient complaints and appeals mechanism to avoid hardship.*

COSLA should:

- *consider with developing a common framework for charging (eg charging structures, disregards, range of chargeable services and collection systems) which authorities can adapt as appropriate within their own authority to minimise the extent to which different charges are levied for the same service by different councils*
- *developing a system for charging based on the full cost of service delivery for the whole care package, with an appropriate means test to establish the actual charge.*

5. Internal monitoring and external reporting

Community care is complex to manage, as well as to plan and implement. A wide range of services may be provided in different combinations to people with widely varying needs, and each decision to provide a service is likely to commit the council to continuing expenditure over a long period. It is also an important area of public policy. For both these reasons, councils need to be clear about what information they need about their community care services, and how they are going to collect and manage it. This chapter considers both internal monitoring and external reporting in the following areas:

- financial resources
- effectiveness of care packages
- overall quality of services
- performance and management information.

Financial management

There are serious weaknesses in the financial systems used by councils to manage their spending on community care. These stem in part from local government reorganisation, which has led to some councils needing to bring together different systems, but this can conceal more fundamental problems. Difficulties identified by councils include:

- the absence of links between financial data and care activity data
- inconsistencies in the recording of base data
- lack of timeliness in the data available
- difficulties in interpreting financial data
- poor reporting of management information.

Because of the long term implications of many community care commissioning decisions, commitment accounting systems are particularly valuable in social work departments. Most departments have limited commitment accounting systems, mostly developed in-house using spreadsheets. Many are used only for long term placements in residential and nursing homes, and few can be reconciled to the financial ledger.

Such systems, however, need reliable unit cost information to be useful, and few councils have comprehensive information in this area. Unit costs are more widely available for in-house services. Three of the 16 councils interviewed reported that they gather unit cost data annually for both in-house and external providers. One council, which plans to collate such costs routinely, has compiled comprehensive unit costs and asked individual providers to confirm that they are accurate.

Unit costs are also more likely to be available for institution-based forms of care, such as residential and nursing homes, than for other services. Overall, unit costs are recognised as unreliable because of the problems associated with them (box 5).

Box 5: Problems in collating unit costs & prices

- Allocation of overheads
- Allocation of central service costs
- Allocation of capital charges
- Apportionment of the costs of different services and services to different user groups provided from a single service delivery point
- Difficulties in defining services for costing purposes. For some services the costs depends on the time of delivery (day, evening, night or weekend) and different measures (eg occupancy or capacity levels)
- Difficulties in collecting appropriate activity measures, such as occupancy rates and staff time
- Constructing costs which are comparable with external providers' prices.

These difficulties mean that, although unit costs have been used for some special developments (such as reviewing future in-house provision, or to support hospital closure programmes), they have minimal impact on strategic commissioning decisions. Some councils felt that some form of central guidance on how to tackle these problems would be useful, both to avoid the wasteful duplication of work in each council, and to improve the comparability of the information produced.

Recommendations

Each social work department should:

- *review the extent to which its systems meet the council's management information and operational needs*
- *review whether commitment accounting should be introduced, or, where it exists, whether it needs modifying to include a link to the main financial system*
- *liaise with other councils through the Association of Directors of Social Work in carrying out these reviews.*

CIPFA guidance

The problems which councils experience in developing unit costs for their services have not been resolved by the CIPFA guidance *Accounting for social services in Great Britain* [9], which should have been applied from April 1994. The purpose of the guidance is 'to promote a common and therefore consistent basis for producing statistics and published financial information'.

However, across Scotland there is great variation in the extent to which the guidance has been implemented. In particular, several councils experience difficulties in allocating overheads to services. This means that councils have deficient financial management information (including unit costs) for internal management. In addition, externally reported information is not consistent and comparable. This in turn leads to a vicious circle, in which the presentation of financial data in this way is seen as a chore, rather than as a mechanism which provides information useful for a variety of purposes.

Several councils made suggestions on how the guidance might be improved:

- reconsider the assumption of a purchaser/provider split, which does not reflect practice in some councils
- make definitions narrower and more detailed to improve the precision and consistency of reporting
- redefine the care groups to include those needed for planning and monitoring (particularly people with dementia and HIV/AIDS) and services (eg to include respite care)
- improve the guidance on the allocation of management and support costs. At present these are treated as a year-end allocation, which makes it more difficult to take account of them in day-to-day financial decisions
- improve information on some user groups or services, which in some councils is limited to payments to voluntary organisations or other bodies and does not include the cost (eg staff) of in-house service provision
- sharpen the general approach, which leaves too much to the discretion of individual councils which may in turn lead to inconsistent external reporting, and can result in information reported at too high a level of aggregation to be useful for inter-council comparisons by council staff.

Recommendations

Each council should:

- *review what is necessary to complete implementation of the guidance and*
- *consider what improvements might be made to the guidance itself*

ADSW should consider collating these comments and liaising with CIPFA in order to:

- *review the guidance in Scotland in the light of experience of community care practice over four years; in particular it should consider how consistency of reporting can be achieved*
- *take account of the views gathered on the guidance during the Commission's study.*

Monitoring the effectiveness of care packages

Councils experience significant difficulties in evaluating whether the care packages they commission actually have the desired impact on the lives of service users. The information needed for evaluation comes from two sources:

- care managers, who can form a judgement on the effectiveness of the care they have arranged for individuals against the needs and objectives which were originally assessed
- service users, whose views should be taken into account.

This evaluation should take place at regular reviews of care packages. In general, the information is unavailable to councils, either because it is not being recorded, or because it is unavailable to staff other than individual care managers. The information is key if community care is to continue to develop in ways which meet the changing needs of service users.

Recommendations

Each council should:

- *review its present arrangements for recording information on the effectiveness of care arranged for individuals and for ensuring it reaches others who need it, and*
- *if necessary, agree specific arrangements (such as guidance for operational staff and adjustments to department-wide information systems) to improve information flows.*

Monitoring service quality

As well as monitoring the impact of care packages on individuals, councils also need to monitor the overall quality of the services they commission. A wide range of mechanisms is used (box 6).

Box 6: Tools for monitoring service quality

- Statement of commissioning values in community care plan
- Pre-planning agreements
- Provider standards statements, and provider self-monitoring
- Lists of approved providers
- Tendering
- Monitoring of compliance with contracts and service level agreements
- Registration and inspection
- Complaints procedures
- User and carer feedback: individual care (needs-based assessment, reviews); strategic planning (focus groups, customer care cards)
- Involvement of users and carers in tendering
- External quality accreditation.

As with the evaluation of the effectiveness of care, information on service quality from this wide range of sources is not consolidated, so most councils have no strategic overview of the quality of services they commission. There is also great unevenness in the monitoring which does take place. For example:

- there are significantly fewer contracts or service specifications for in-house services than for externally provided services
- councils have better information and contract compliance procedures for external providers.

Overall, quality monitoring is hampered by:

- reliance on a wide range of complex information
- scattered responsibilities for collecting and acting on this information
- weak overall responsibility for service quality at strategic and operational levels.

Performance and management information

This report has already demonstrated serious gaps in the information available to councils for planning and managing community care. Seventeen councils were asked about the information they have specified to monitor performance. Of these, seven had only the performance information reported annually to the Accounts Commission under the Local Government Act 1992. One of the seven compiled this information at six month intervals rather than annually. The remaining 10 had specified some in-house performance information.

To be meaningful, these indicators and targets should be linked to objectives. One of the main objectives of the community care policy is to shift away from institution-based care to community-based services, but councils' routine monitoring mechanisms have a noticeably stronger focus on the more institutional forms of care. For example:

- registration and inspection services are required by law to cover residential care, and information is often available on nursing home inspection. However, only certain aspects of day care and no part of home care are covered by registration and inspection
- standards are better developed for care homes, particularly those monitored through registration and inspection (such as physical environment and quality of life)
- financial and non-financial information systems are oriented to care homes (eg information on costs per place, length of stay).

Some examples of monitoring in relation to community forms of care were found:

- financial and non-financial information systems which provide information on home care (eg type of home care provided, volume of service provided)
- complaints systems which cover the full spectrum of services
- user comments from reviews of existing care packages, where this information is sought and recorded.

Overall, however, monitoring mechanisms focus more strongly on care homes in their degree of sophistication and the number and range of mechanisms used. The use of different mechanisms for monitoring does not in itself amount to a strategy for monitoring service quality and value for money, which provides comprehensive and timely information to those who need to take action.

Recommendations

Councils should have available, on a routine basis, a core departmental community care database, including comprehensive and readily available information on budgeted and actual spending; service volumes available, planned and actually commissioned; and user numbers.

They should also develop a range of key performance indicators, which are reviewed regularly by senior managers and elected members.

External reporting

The problems which many councils encountered in providing information for this study reflect the difficulties they experience in reporting routine statistics. Consistency in definitions, units of measurement, and the periods to which data relate pose particular problems. National statistical liaison bodies have attempted to deal with these issues, and some progress has been made, but this study suggests that the problems have not been resolved.

These problems are aggravated by the perception of many councils that the national statistical returns have little relevance to councils themselves, and that the publications in which they are used are of limited usefulness. This presents a vicious circle - because the data are not seen as useful, they are unlikely to be accurate or timely, which further limits their usefulness. This suggests the need for national co-ordination of the collection of information, and several councils commented favourably on the attractions of a single system.

The Social Work Services Group is reviewing the national statistical returns, with the aim of ensuring that they reflect the information required for central monitoring. This is being done in consultation with COSLA.

6. The way forward

This study has demonstrated that, while councils are committed to community care, there are significant problems with its implementation:

- many community care plans lack quantification
- there is a serious lack of financial and management information
- councils do not have clear strategies which inform their use of different commissioning models
- policies on the mixed economy are vague, and the mixed economy itself is slow in developing
- care management is not well supported by information
- the effectiveness of care packages is not evaluated
- monitoring mechanisms are underdeveloped.

The study also underlines the interdependence of different parts of the community care system, such as service planning, strategic commissioning, assessment and care management, and monitoring. All of these issues have implications for the way councils achieve value for money in community care.

There are many similarities with the Commission's earlier review of community care[1]. Perhaps the most striking is the continuing lack of information for planning and management. This is in part due to the effect of local government reorganisation, but also reflects a failure to commit adequate resources to the development of systems for capturing, analysing and using information. There is no question that resources are tight, and it can be difficult to invest in support services like information systems rather than in direct service delivery. However, the Commission believes that this investment is vital if councils are to be able to match the challenges facing them.

One of the key policies of the new government is the introduction of Best Value. This is developing as a means of encouraging councils to demonstrate the effective use of their resources, and to build in continuous improvement. Community care will be an important area in which councils will need to apply the principles of best value, because of both the amount of money involved and the number of people affected. If this is to be achieved, councils will need to address the issues identified in this report which represent important obstacles.

Summary of recommendations

Councils should:

- ensure that they have arrangements to involve users in strategic and local planning (as well as in planning their own care packages). They should also evaluate the effectiveness of these arrangements against pre-set objectives.
- quantify their current position, in terms of spending, volumes of service providers, and numbers of people needing services. They should also quantify, as far as possible, their plans for future service provision. This will entail addressing gaps in information which hinder effective planning. The community care plan should include this information and explain any significant planned changes and ensure that their planning and budget-setting cycles are synchronised.
- phase preparing and consulting on the community care plan to fit the council's budget-setting cycle.

- assess the data gaps which hinder effective planning, and arrange to fill them, giving priority to the information most important for service planning and monitoring
- review the commissioning models available to them, relating the advantages and disadvantages of each to its overall plan of the services required. There may be benefits in doing this on a service by service basis. These reviews should lead to a strategy for commissioning, with a clear rationale behind the mix of commissioning models used.
- develop standards and specifications for each service they commission, whatever the model or whoever the provider. These should apply to all providers, including in-house services.
- develop a clear strategy setting out the range of services they wish to c ommission in future, and how they plan to encourage the development of these services.
- develop a specific policy on the future mix of provision by sector, made public through the community care plan and supported by clear criteria against which progress can be measured.
- develop a policy on the devolution of budgets for community care, which clearly balances the need for flexibility and control. They should also ensure that staff involved in commissioning have the expertise they need, by conducting a skills audit and acting to develop staff as necessary.
- review their current arrangements for allocating services to identify shortcomings; develop explicit criteria, including priority levels, for all community care services and client groups, in consultation with users; agree joint or complementary eligibility criteria with health boards in order to improve services and facilitate access by users; and regularly monitor the effects of eligibility criteria on unmet need.
- set clear objectives for their charging policy, based on consultation with users and other interested parties. The charging structure should reflect the whole package of care received by the client, and should be equitable, consistent and capable of being consistently applied without being inflexible. Full income maximisation should routinely precede the application of a charge to a client. User withdrawals from service should be monitored where charges are introduced or significantly increased, and an efficient complaints and appeals mechanism should be operated to avoid hardship.
- review the present arrangements for recording information on the effectiveness of care arranged for individuals and for ensuring it reaches others who need it, and, if necessary, agree specific arrangements (such as guidance for operational staff and adjustments to department-wide information systems) to improve information flows.

- have available, on a routine basis, a core departmental community care database, including comprehensive and readily available information on budgeted and actual spending; service volumes available, planned and actually commissioned; and user numbers. This should be linked to a range of key performance indicators, which are reviewed regularly by senior managers and elected members.
- review what is necessary to complete implementation of CIPFA guidance, and consider what improvements might be made to the guidance itself.

Social work departments should:

- review the extent to which its systems meet the council's management information and operational needs.
- review whether commitment accounting should be introduced or, where it exists, whether it needs modifying to include a link to the main financial system.
- liaise with other councils through ADSW in carrying out these reviews.

COSLA should consider, with ADSW:

- developing a common national framework for eligibility, by sharing information and building on the experience of those councils which have comprehensive criteria already in place.
- developing a common framework for charging which authorities can adapt as appropriate within their own authority to minimise the extent to which different charges are levied for the same service by different councils. This framework could be based on the full cost of service delivery for the whole care package, with an appropriate means test to establish the actual charge.
- collating councils' comments on the CIPFA guidance , and liaising with CIPFA to review the guidance in Scotland in the light of practice over four years; in particular the review should consider how consistency of reporting can be achieved.

The Scottish Office should consider:

- issuing further guidance on the planning cycle for community care, so that it can be integrated with the budget-setting cycle.
- whether further guidance on eligibility criteria is necessary.

Appendix: Sources of study data

Data collected for the study

There were two main sources of data used in the study:

- primary sources, developed by the Commission itself
  - quantitative data from all 32 councils, comprising information on finance, service volumes and user numbers
  - qualitative data from interviews (involving 16 councils)
  - a monitoring checklist (a short questionnaire which covered management information and other issues), completed by 17 of the 18 councils whose financial data were audited
  - the study auditor's comments.
- secondary sources: existing documents provided by councils
  - community care plans
  - other papers provided by councils (eg on charging and eligibility; reviews; monitoring; etc).

The **quantitative** data requested related to the financial year 1996/97, and was broken down by:

- the seven major community care user groups
  - elderly people
  - people with dementia
  - people with mental health problems
  - people with learning disabilities
  - people with physical handicaps
  - people with HIV/AIDS
  - people with drug/alcohol problems, and
- the five major community care services
  - residential care
  - nursing home care
  - home care
  - day care
  - respite care.

This quantitative data comprised both financial and non-financial information, as follows:

- 38 items of financial information, comprising
  - 17 items of information on the council's full-year budgeted expenditure,
  - 21 items of part-year actual spend information on community care (covering the 6 months to 31 December 1996, a period chosen to test ability to report part-year data for a period which did not include the start or end of the financial year).

- 196 items of non-financial information, comprising
  - 23 items of information on the volume of services available for commissioning in each council's area (broken down by the five major services and the sectors from which provision was available)
  - 23 items on the volume of service which the council planned to commission (broken down as for 'service volume available')
  - 136 items on the volume of service actually commissioned (in six months to 31 December 1996, broken down as for 'service volume available' and also by the seven user groups)
  - 14 items on the number of users benefiting from service provision in this period (broken down as for 'service volume available').

'Reported' includes

- data reported in the unit of measurement requested
- data reported in an alternative unit of measurement
- service not available or not purchased.

Self-assessment by councils of data availability and accuracy

Councils were asked to assess *availability* of their own financial and non-financial data using a four-part scale:

- routine data (ie data which are immediately available as requested from routine information systems
- data not readily available but which were obtained within five working days
- data which could be /were obtained only after extensive search/re-working of records
- data wholly unavailable by any method.

Similarly, councils were asked to assess the *accuracy* of their own data using a three-part scale:

- reliable data: data consistent with the Commission's definition guidance for the study and produced by a suitable manual or electronic information system
- an estimate/apportioned data: an estimate (eg based on incomplete data) or data based on apportionment (where the basis of apportionment is acceptable
- unreliable data: data which are incompatible with the Commission's guidance for the study; the lack of suitable systems, and/or reliable data, and/ or decision rules has resulted in the authority producing information which is unreliable.

Audit of financial data

One feature of the study was that some of the quantitative information collected was audited to test the consistency of reporting in relation to the Commission's guidance. The scope of the audit was confined to the 38 items of financial information. The audit was carried out in 18 councils.

One outcome of the audit process was that, for each of these 18 councils, at least one alteration had to be made to the data they had already reported. In the case of most councils, the alterations to previously reported data were more substantial. For this reason, the Commission wrote to the remaining unaudited 14 councils, enclosing a copy of the audit spreadsheet (a tool developed by the study auditor to facilitate and standardise reporting of information), noting that data from the audited councils had had to be re-reported, and inviting the unaudited councils to consider whether there was any need for them to re-report any financial information. Three councils did so.

Qualitative interview data

In addition, the study gathered detailed 'qualitative' data from interviews with 16 of Scotland's 32 councils. These interviews were intended to provide information about the policy and practice context in which councils make commissioning decisions, by exploring two areas - information on each council's current and future policies; and an assessment of the extent to which each council felt its own policy and practice was successful.

The interview schedule was wide-ranging, covering the following issues:

- the council's overall commissioning policies
- the range of service it commissions
- its policy on the volume and financial value of these services
- its policy on the mix of providers
- its policy on 'community-based' forms of care
- user involvement
- its routine information on service quality
- availability and use of comparative data on cost and quality
- models of commissioning and purchasing
- current and future commissioning policy
- departmental budgets
- the quality of the council's cost and price information
- cost limits for individual care.

Qualitative data were also gathered on councils' eligibility and charging policy and practice was collected from 14 councils.

Involvement of councils in the study

All councils provided quantitative data. However, the involvement of councils which provided qualitative information varied. The councils which were involved in the interviews (16 councils) were not necessarily the same as those whose financial data were audited (18 councils). Similarly, the 14 councils from which eligibility and charging policy information was collected again differed.

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