



Chapter 3: The Scottish Policy Context for Partnership

**HEALTH, SOCIAL CARE AND HOUSING
PARTNERSHIP WORKING**

**BRIEFING NOTES FOR PRACTITIONERS AND
MANAGERS**

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This series of brief guidance notes is aimed at helping managers and practitioners understand and apply the evidence of best practice in partnership to their own practice. Based on extensive review of the literature, it provides short and practical guides, with review questions on:

- 1. Why work in Partnership?**
- 2. What is Partnership?**
- 3. The Scottish Policy Context for Partnership**
- 4. Barriers to Partnership**
- 5. The Characteristics of Successful Partnerships**
- 6. Partnership Assessment and Development Toolkits**
- 7. Bibliography.**

Full references to works cited are given at Chapter 7

INTRODUCTION

The Scottish Government's current emphasis in sustaining and developing joint working between local partnerships in social care, health and housing and other partners, particularly the third sector is aimed towards improving outcomes for individuals through community care.

Over the last 2 decades policy relating to partnership working as a vehicle for improving community care has revolved around 5 themes:

- Caring for people in their own homes/shifting the balance of care.
- Enabling people who use community care services to be better informed/empowered/socially included.
- Improving people's wellbeing and their outcomes.
- Improving the quality of services/care and using innovation positively.
- Supporting carers.

The language and the emphasis may shift from time to time; but broadly speaking that has been and is still the agenda.

Underpinning all of the work to "join-up" services is the drive for partnership, whether that is across primary, secondary and tertiary health care, between health and social care or across a wider range of players including housing, justice, voluntary sector and regeneration. The assumption is that there is more in common between the different players than sets them apart, and that for all of them the focus will be shared objectives concerning better outcomes for service users.

POLICY DEVELOPMENT

The 1989 White Paper '**Caring for People' (DoH 1989)** announced a radical shift in the way community care was to be delivered. "Caring for People" set out amongst other things the goal of re-balancing care from institutional care to people's own homes. It triggered a renewed emphasis on community care in the early 1990s, embodied in the NHS and Community Care Act (1990).

"Modernising Community Care: an action plan" (Scottish Office 1998) set the ball rolling in terms of policy development on joint working by focusing on:

- Quicker and better decision-making, to delegate decision-making and financial responsibilities;
- More flexible and better quality home care services, including a shift in the balance of care towards these services; and
- Agencies working in partnership in localities, through better operational and strategic planning, joint budgets, joint services and joint systems.

Within the NHS at the same time, “**Designed to Care**” (Scottish Office 1997), took the first steps in trying to join-up the health system and move towards a more patient focused service, with service design based around the patient rather than the professions.

These policies set the direction of travel in joint working. But their journey was rather slow and often winding. Joint working was still something of an afterthought, rather than the mainstream; and tended to happen in pilots, projects or localities.

A JOINT FUTURE

Ministers’ frustration at the lack of mainstreaming of joint working and progress on shifting the balance of care led to **Joint Future**. It took forward a number of the key strands in Modernising Community Care in an agenda to improve results through:

- **Re-balancing care**, through more intensive care at home, rapid response teams, early intervention services and more short breaks.
- **Improving joint working** through development of Single Shared Assessment and intensive care management, information sharing, and joint resourcing and joint management.

The Joint Future Group’s report – “**Community Care: A Joint Future**” (December 2000) set the clear direction for health boards and local authorities to improve results through more effective joint working. It focused on structures and processes such as Single Shared Assessment, Joint Management, Joint Resourcing, Joint Performance Information and Monitoring and the development of Joint Services. These in turn led to other positive developments that helped to shape the community care future. These include eCare, the ability to share information electronically and the Indicator of Relative Need (IoRN) which uses the information in the Single Shared Assessment to place people into 9 categories of dependency, in order to inform planning decisions at a strategic level.

At this time, new legislation and other departmental policy development supported the Joint Future agenda: “**Our national health**”, 2000 and “**Rebuilding Our National Health Service**” published in 2001 further encouraged partnership working in the NHS and the development of service design that crosses organisational boundaries between the different parts of health and health and social care.

Almost all the joint working agenda in Scotland has an administrative backdrop. There are few provisions specifically on joint working. The **Community Care and Health (Scotland) Act 2002** introduced key new provisions on joint working, to remove any uncertainties that may have existed. The Act, and a subsequent Circular (CCD7/2001) required each Local Authority and Health Board to reach agreement on six key action steps, including joint management, joint resourcing, governance and accountability, priorities and targets, and set this out in a Local Partnership Agreement (LPA). The new range of provisions enabled partnerships to make payments to one another, to delegate functions to one another and, on the back of that, to pool their budgets. Other important provisions in the same Act were making

carers' assessments a legal requirement, introducing free personal care, extending the range of direct payments and introducing Ministerial powers of intervention where joint working was failing.

The provisions on pooling of budgets in Scotland were different to those elsewhere in the UK in that a pre-requisite was the requirement to delegate functions from one party to another. In practice, formalised pooled budgets of this sort did not take off. Most partnerships continued to "align" their budgets. A few had pooling arrangements of a more informal nature. Possibly the best example is the resources provided for delayed discharge which, though provided to the NHS initially, were applied across the system to achieve the goals intended.

The new agenda took some time to bed in and there were a number of other policy initiatives that were intended to support it:

- A further Circular set out the need for **Extended Local Partnership Agreements (ELPAs) for 2003-04** that extended the scope of Joint Future from older people to all community care groups from April 2004. ELPAs were required to demonstrate progress made against the indicators of the **Joint Performance Information and Assessment Framework (JPIAF)**, a national assessment process that comprised a number of joint performance indicators.
- The **Local Government in Scotland Act 2003** made Community Planning a statutory requirement for all local authorities in future, and placed a duty on NHS Boards, the Police and the Enterprise Networks to participate in the process, and on Scottish Ministers to promote and encourage it. Community Planning was intended to rationalise and streamline the wide variety of other partnerships.
- **The National Health Service Reform (Scotland) Act of 2004**, which built on the white paper "Partnerships for Care" 2003, brought in further structural changes to support the development of more effective partnership working, including the establishment of Community Health Partnerships.

However, progress between 2003 and 2004 was not as quick as had been hoped for. Perhaps the agenda had turned out to be bigger than anticipated, or there was just too much to do, or partnerships were not yet ready for such a substantial transformational agenda. There was also concern within partnerships that performance was being measured on inputs rather than the results that these inputs produced. Thus began the journey to outcomes in community care.

OUTCOMES

Whilst joint working was improving, it was not as fast as Ministers and others would like. Single Shared Assessment was speeding up the time taken for assessment and reducing duplication. And in many areas access to services was improved through assessors being able to access resources across agency boundaries. But speed of service delivery remained an issue generally. The key change was that joint working generally was as less of an add-on and became much more part of the day job.

There were of course competing agendas. The two major new policy directions for health and social care respectively - **Delivering for Health** and **Changing Lives; the Report of the 21st Century Social Work Review** - used different language to achieve broadly the same results. The intended outcomes of the 2 strategies were similar, and the content was similar: for example a key focus on re-balancing care, integrated approaches and a user focus, but they were often dealt with, both locally and centrally, as separate issues.

Dissatisfaction with the previous performance arrangements based on inputs referred to earlier was led by the then Deputy Minister. He pushed for a transformation in thinking towards outcomes, and for performance assessment to be similarly based. Many of the previous process indicators in the JPIAF were replaced by a package based more on outcomes. The indicators focused on waiting time from referral to first service delivery, the whole systems approach to delivering community care, and the effectiveness of Local Improvement Targets (LITs) to drive progress. So began the real journey to Outcomes in community care.

Reinforcing this focus on Outcomes, the publication '**Better Outcomes for Older People**', 2004, aimed to encourage the development and mainstreaming of joint and integrated services.

A National Community Care Outcomes Programme Board was established in 2006, which by 2007 had produced an outcomes framework for Community Care comprising 4 high level outcomes and 16 measures. Pilot partnerships known as 'Early Implementers' trialled elements of this approach and there was linkage to the developing outcomes-based approach to assessment, support planning and review, [Talking Points](#) (formerly known as UDSET). When individuals are asked about the outcomes that are important for their own quality of life, they do not tend to answer in terms specific to the services provided by any one public agency. The focus on individual outcomes has brought a renewed emphasis on the importance of partnership working between agencies, focussed on improving outcomes for individuals as the key measure of success.

At the end of 2007, the future direction for the NHS in Scotland was set out in the [Better Health, Better Care Action Plan](#) whose key themes of a mutual NHS, and ensuring better, local and faster access to health care fitted well with the outcomes approach to community care and its emphasis on partnership working. Under the theme of shifting the balance of care, the Action Plan proposed that Community Health Partnerships would adopt the [Integrated Resource Framework](#), which offers

health and council partnerships a means to identify how their joint resources are being used, and then to work together to shift resources to ensure that outcomes for individuals using services or support are improved. Ultimately, this would support strategic joint commissioning and collaborative contracts to deliver local shifts in the balance of care.

Shifting the balance of care has developed 8 [Improvement Areas](#), one of which is to integrate health and social care and support for people in need and at risk. The Long Term Conditions Collaborative has also agreed 7 [High Impact Changes](#), including the provision of better, local and faster access to services for long term conditions – specifically highlighting the need for the NHS to collaborate better with local authority services.

The Better Health Better Care Action Plan also committed the government to sustaining and developing joint working between local authorities and NHSScotland, to secure further improvements in key areas including user satisfaction, faster access, better support for carers, the quality of assessment and care planning, identifying those at risk of admission to hospital, and moving services closer to users/patients. These are the 6 key themes of the [Community Care Outcomes Framework](#). It is anticipated that this growing focus on improving people's experience of using NHS and partner services will be developed further through the new [NHS Scotland Quality Strategy](#) .

Through the 2007 [Concordat](#), local government and the Scottish Government moved towards a new relationship and a focus on improving outcomes. A central element of the new relationship was the ending of ring fencing of local government funding and the creation of a Single Outcome Agreement (SOA) between each council, initially, and the Scottish Government, based on the 15 [National Outcomes](#).

From April 2009, these agreements are between each Community Planning Partnership (CPP) and the Scottish Government. A SOA is the means by which CPPs agree their strategic priorities for their local area and express those priorities as outcomes to be delivered by the partners, either individually or jointly, while showing how those outcomes contribute to the Scottish Government's relevant National Outcomes.

A Menu of Local Indicators has been developed by local government to support the delivery of outcome agreements and Community Planning Partnerships are able to develop their own Local Indicators to sit alongside these if desired. In the field of health, housing and social care, the Community Care Outcomes Framework, with 16 measures, is available to support the local indicators.

NHS Scotland continues to use the [NHS HEAT](#) performance management system, which supports the delivery of key outcomes in the National Performance Framework through focussing primarily on actions wholly within the control of the NHS. However, a number of HEAT targets explicitly require NHS Boards to agree actions with their local partners, and these measures and targets often feature in SOAs as part of the local Community Planning Partnership's joint commitment.

The landscape of public scrutiny in Scotland is changing as the [Public Service Reform Bill](#) goes through parliament in 2009/10. A single new scrutiny body for social care is envisaged (Social Work and Social Care Improvement Scotland, (SWSCIS)), with a separate body for health care Health Improvement Scotland (HIS). These bodies will be required to co-operate with each other to promote improvement through national standards and outcome measures. This focus on improving outcomes through joint working is already very evident in the approaches being taken by NHS Quality Improvement Scotland, the Social Work Inspection Agency and the Care Commission, not least through joint inspections of services for older people and (separately) people with learning disabilities.

CONCLUSION

Community care policy and within that the joint working strategy have no predetermined end line. They are founded on continuous improvement. Much has been achieved on both fronts but most commentators recognise that there is still some way to go. The key is that joint working is now mainstreamed. The challenge is how to take it to new levels. The outcomes approach should do that. But to make it work the culture has to shift too. It needs to be embedded comprehensively: from the joint strategic objectives of partnerships to the personal objectives of managers, professionals and front line staff, with local and national performance systems to drive continuous improvement.