



SCOTTISH EXECUTIVE

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Your ref:
Our ref:

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Dear Colleague

GUIDANCE ON CARE MANAGEMENT IN COMMUNITY CARE

Introduction

1. This circular provides local authorities and NHS Boards with updated guidance on improving care management. In particular, it refocuses care management on people with complex needs, or frequently or rapidly changing needs, and on extending the range of professionals undertaking care management. It should be read in conjunction with the original guidance on care management (1991)^{1, 2}, the guidance on integrating professional assessment and care management for older people (1998)³ and the Guidance on Single Shared Assessment (2001)⁴. Partnerships are expected to implement this guidance by April 2005.

Background

2. The original guidance on care management issued in 1991 provided the policy direction and set out the values and principles underpinning the then novel concept of care management. The Joint Future Group's Report and a major study commissioned by the Executive both recognised the need to re-focus care management. In short, practice had drifted from the original concept; systems to support it effectively were not in place comprehensively; and policy, (especially in areas such as empowerment of individuals and joint working) had moved on significantly.

¹ Social Services Inspectorate and Social Work Services Group, 1991, *Care Management and Assessment: Managers' Guide*, HMSO.

² Social Services Inspectorate and Social Work Services Group, 1991, *Care Management and Assessment: Practitioners' Guide*, HMSO.

³ Scottish Office, 1998 *Community Care Needs of Frail Older People – Integrating Professional Assessment and Care Management*, Circular SWSG10/98.

⁴ Scottish Executive, November 2001, *Guidance on Single Shared Assessment of Community Care Needs*, Circular No: CCD 8.2001.

The Joint Future Unit leads policy development and implementation on joint working between health, housing and social work (which its membership reflects) and is located in Community Care Division 2 of the Health Department.

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New guidance

3. The annex provides both policy and practice guidance. It supplements, but does not supersede, the existing guidance in 1991 and that for older people in 1998. It brings care management up to date in both its context and application.

4. The new guidance sets care management in the context of Joint Future and, particularly, the development of single shared assessment. It also puts care management alongside the policy developments in community care over the last few years. Its main aim is to invite partnerships, together, to re-focus care management on people with complex or changing needs (as originally envisaged) and on extending the range of care managers to include more professionals from the NHS, the voluntary sector, etc.

5. This guidance should therefore:

- contribute to people getting better and faster access to services (as part of Ministers' outcome focus for Joint Future); and
- by targeting care management more effectively, make better use of professional and other resources.

6. Since the research was published and the Joint Future Group reported, we believe that Partnerships have made changes to care management. This guidance aims to make more consistent the arrangements for care management, to raise standards, and to provide the results that were originally intended. That means local partnerships being more systematic in the way care management is organised and provided. This guidance invites them to decide together certain key factors:

- the eligibility criteria for care management;
- the range of staff in different settings who can be care managers;
- the arrangements for care managers to access comprehensively services/resources across agency boundaries;
- the arrangements for delegating decisions/resources to front-line staff; and
- the training/retraining of staff.

There is considerable consistency between these elements and developments on Joint Future and in the NHS more generally, in areas such as delegating decision making and resources.

Responses to consultation

7. The thrust of the draft guidance was generally welcomed and supported. It was clear that there was little wrong with the basic concept of care management, but that it had lost its way. We have responded positively to suggestions in the consultation for:

- clarification on issues such as the distinction between “care management” and “care co-ordination”;
- the relationship to the Care Programme Approach in mental health;
- recognising the importance of reviewing and monitoring care and of workload management.

We were specifically invited to extend the guidance to include key parts of the original guidance, so as to refresh existing practitioners and to provide a context and a field of interest for potential new care managers, particularly in the NHS and voluntary sector. We were also invited to add examples of good practice in care management. The appendices address these and other aspects.

Implementation

8. Reinvigorating and re-focusing of care management is an integral part of the wider Joint Future agenda of improving outcomes through better joint working. It is also inextricably linked to the implementation of Single Shared Assessment. They should, therefore, come together in implementation terms. Partnerships are already in the course of implementing fully Single Shared Assessment across the whole of community care from April 2004. We recognise that over the course of 2004-05 partnerships will be embedding and refining these arrangements. We believe, and so do partnerships, that the reinvigorating and refocusing of care management should be part of these wider developments. Care management is already well established in every partnership as a concept, but they should, by April 2005, have brought it up to speed in terms of implementing this guidance.

9. To support that, the Executive will put in place a number of implementation events and extend the learning support networks to include care management. We are also discussing with training interests the prospect of developing a national training framework with accreditation for practitioners, in care management.

Resources

10. This guidance aims to make better use of the significant resources, especially among professional staff, in care management. It aims to systematise and re-focus these arrangements. It should therefore, over time, make for more cost effective care management. To get there, some training/retraining of staff will be necessary if these results are to be achieved. This may mean partnerships refocusing some of their existing training/development programmes locally. Nationally, the Executive will provide both implementation seminars and more sustained learning opportunities, as part of Joint Future generally.

Action

11. Local partnerships are invited to review their current arrangements for care management and to implement the more systematic and focused arrangements set out in this guidance, with effect from April 2005.

12. To help local partnerships with implementation, and to provide advice on progress on implementation for the Executive we have drawn up a self assessment framework (to be found at the end of the annex). Partnerships are invited to forward completed returns to Jean.Milne@scotland.gsi.gov.uk by 31 October 2004.

Enquiries

13. Enquiries on this circular should be addressed in the first instance to Jean Milne, Joint Future Unit, Community Care Division, 3rd Floor East (Rear), St Andrew's House, Regent Road, Edinburgh EH1 3DG (telephone: 0131 244 5481). Professional issues should be referred to Margaret-Anne Dale at the same address (telephone number 0131 244 5331, email: MargaretAnne.Dale@scotland.gsi.gov.uk).

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GUIDANCE on CARE MANAGEMENT IN COMMUNITY CAREIntroduction

1. This circular provides local authorities and NHS Boards with updated guidance on improving care management. In particular, it refocuses care management on people with complex needs, or frequently or rapidly changing needs, and on extending the range of professionals undertaking care management. It should be read in conjunction with the original guidance on care management (1991)^{1, 2}, the guidance on Integrating Professional Assessment and Care Management for older people (1998)³ and the Guidance on Single Shared Assessment (2001)⁴. Partnerships are expected to implement this guidance by April 2005.

2. Ministers emphasise consistently that, under Joint Future, improving outcomes for people through faster access to services and better results from services is imperative. Care management is a key part of their agenda to deliver better outcomes through better joint services. It should:

- empower people who use services by giving them greater choice in how their support and care are tailored to meet their needs;
- ensure greater continuity and speedier delivery of care;
- enable care managers to reach key decisions and determine service outcomes quickly and effectively; and
- shape the development of more integrated and more responsive services, with better results for people who use them.

¹ Social Services Inspectorate and Social Work Services Group, 1991, *Care Management and Assessment: Managers' Guide*, HMSO.

² Social Services Inspectorate and Social Work Services Group, 1991, *Care Management and Assessment: Practitioners' Guide*, HMSO.

³ Scottish Office, 1998 *Community Care Needs of Frail Older People – Integrating Professional Assessment and Care Management*, Circular SWSG10/98.

⁴ Scottish Executive, November 2001, *Guidance on Single Shared Assessment of Community Care Needs*, Circular No: CCD 8.2001.

3. The White Paper, “Caring for People” (1989)⁵ described assessment and care management as ‘... the cornerstone of high quality care’ and advocated care management as ‘... an effective method of targeting resources and planning services to meet specific needs of individual clients.’ Subsequent guidance^{1,2} described the policy and practice of assessment and care management and set the framework for care management for the next decade.

4. The original guidance issued in 1991 remains the baseline. It sets out the legal framework, the duties on key agencies and professionals, and the principles and process of care management. This updated guidance sets care management in the context of the Joint Future Agenda and wider policy developments in community care. More particularly, it re-focuses care management on those who really need it, on enabling a wider range of professionals in health and social care to be care managers, and on developing systems that support effective care management. We have responded positively to comments in the consultation that this guidance should refresh practitioners on some of the core elements of care management set out in the 1991 guidance, and also provide a reference point for possible new care managers in, for example, the NHS. Appendices 1-3 do that, and also refer to examples of good practice.

Context

5. This guidance responds to the recommendations of the Joint Future Group (JFG)⁶ which were accepted by the Scottish Executive in 2001, that:

- care management should be redefined as “intensive care management”, to focus on people with complex needs, or frequently or rapidly changing needs;
- the role of care manager could be fulfilled by social workers, community nurses, occupational therapists or other similar professionals, supported by appropriate training; and

⁵ Department of Health and Social Security, and the Welsh Office, 1989, *Caring for People: Community Care in the Next Decade and Beyond*, HMSO.

⁶ Joint Future Group, 2000, *Community Care: A Joint Future*, Scottish Executive, Edinburgh
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- local authorities and the health service should provide jointly the organisational framework to ensure the effectiveness of care management.

6. The term ‘intensive care management’ was used in the report of the Joint Future Group to emphasise the need to redefine and reinvigorate care management. It was not intended to suggest that there should be different levels of care management, i.e. intensive and non-intensive, but some have interpreted the report in this way. To clarify any misconception, the term **care management** will be used to describe this intensive and targeted approach to more complex cases in community care.

7. The JFG identified the need to redefine and refocus care management to overcome a lack of clarity of purpose and inconsistency in practice in many existing arrangements across Scotland. This may be due in part to a lack of common understanding and language in defining and describing care management. The study commissioned by the Scottish Executive in 2001 and undertaken by the Social Work Research Centre at Stirling University ⁷ identified the ways in which local authorities are currently using care management to support people at home. Although the original guidance made clear the expectations for care management, the JFG report and the study showed that in many areas they were not being met.

8. Partnerships have been making progress since both the study and the JFG reported and this will be reflected in the Extended Local Partnership Agreements of April 2004. But partnerships are still at different stages of implementation of the Joint Future Agenda, and this guidance should help identify obstacles and suggest ways to overcome them. Both Ministers and practitioners/managers recognise the need for an updated circular to support local developments and to move towards more consistent practice across Scotland.

9. The Stirling University study highlighted inconsistencies across Scotland: a diverse range of policies and practice; insufficient differentiation between complex and more straightforward cases; varied arrangements for decision-making about

⁷ Stalker K, Campbell I, 2002, *Review of Care Management in Scotland*, Scottish Executive Central Research Unit.
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resources; a lack of devolved budgets; caseload issues and the need for more training; and confusion between the practices of ‘care management’ and ‘care co-ordination’. In other words, care management is not serving well all of those who need it.

10. In particular, we need to distinguish **care management** - for people with complex needs, or rapidly or frequently changing needs - from **care co-ordination** - for people with more straightforward and/or stable needs who do not require complex care arrangements. We need to recognise, too, that needs and care arrangements change and flexibility between these processes is necessary. Some people with complex needs will have stable care arrangements and, while these last, care co-ordination may be appropriate. Other people may have less complex needs but still require the focused approach of care management, for example, to find innovative solutions or overcome problems in delivering appropriate care, to ensure that their ongoing needs are met. Whether care management or care co-ordination is more appropriate in individual cases should be a matter for professional judgement.

Legislative and Policy Framework

11. Under Section 12A of the Social Work (Scotland) Act 1968, (inserted by Section 55 of the NHS and Community Care Act 1990), local authorities have a duty to assess the needs of any person for whom they may have a duty or power to provide community care services. Therefore, local authorities have the lead responsibility for co-ordinating the assessment of all community care needs, on an inter-agency basis.

12. The Community Care and Health (Scotland) Act 2002 promotes integration in other ways by enabling the delegation of functions, the transfer of resources and the pooling of budgets between local authorities and NHS Scotland.

13. Since care management was introduced over a decade ago, community care policy has advanced significantly. Individuals are more empowered; Direct Payments have been introduced and are being extended to all care groups; carers have new rights to an assessment; joint working has progressed through work in multi-disciplinary teams and, especially of

late, has been mainstreamed under Joint Future. More generally, the Executive is committed to modernising services to achieve better results. Care management needs to embrace these improvements.

Joint Future and Care Management

14. Joint Future aims to improve outcomes by:

- enabling better and quicker access to services through Single Shared Assessment;
- more integrated approaches to managing, financing and running services;
- supporting professionals and managers to improve decision-making; and
- agencies reporting performance jointly.

15. The development of care management must take place within the context of that agenda. Joint resourcing and joint management will ensure a co-ordinated approach and more integrated services. Within a framework of delegated decision-making and devolved budgets, care management will provide a single point of access to and co-ordination of the services that people with complex needs require. In due course, the Single Shared Assessment Indicator of Relative Need (SSA-IoRN) will help inform the planning of services for older people at locality level and provide a national overview, complemented by the Care Assessment Data Summary.

16. Single Shared Assessment (SSA) is at the centre of Joint Future. SSA is part of care management and the arrangements for both clearly overlap:

- the underpinning values will be the same, emphasising a person-centred focus (guidance on Single Shared Assessment, 2001, 4.3);
- assessment as part of care management will be Single Shared Assessment at the comprehensive and specialist levels;
- both will be supported by the same systems for information sharing; and
- care managers will be found among the groups of professional staff who will be the lead assessors for comprehensive assessments.

Agencies should now extend the joint working arrangements for Single Shared Assessment, in place for all community care groups, to include care management.

What is Care Management?

17. Care management is:

- a process that includes assessing individual needs and tailoring services to meet those needs;
- focused on people with complex, or frequently or rapidly changing needs; and
- undertaken by a range of professionally qualified staff in social work and health, with appropriate training, skills and experience.

18. The key principles in care management are:

- people who use services and their carers should be actively involved and enabled to participate;
- the needs and aspirations of people and their carers should be central;
- care arrangements should be tailored to individual need;
- care management should promote choice for people;
- care management should facilitate access to all community care services, across agencies and sectors; and
- care management is an integrated process leading to co-ordinated care.

The Scope of Care Management

19. Care management should be a targeted activity, available as long as necessary to support people who are the most vulnerable or dependent in terms of their community care needs, and who may require a range of co-ordinated services. It should be available to all community care groups, including carers who have new rights to a carer's assessment and support under the Community Care and Health (Scotland) Act 2002 (s.8-11). Care managers should recognise also the potential of

Direct Payments to empower people who have complex or frequently changing care needs.

20. The Care Programme Approach (CPA)⁸, widely used in mental health services, is a form of care management for people with severe and enduring mental illness who also have complex health and social care needs. Partner agencies should harmonise their arrangements for CPA with those for care management. Assessment in both should be Single Shared Assessment. People with mild to moderate mental health problems may not be eligible for CPA but they should be considered for care management where their community care needs are complex or frequently or rapidly changing.

21. Better targeting of care management is essential. In order to ensure that people receive an appropriate response to their needs and agencies make the best use of their skilled staff, it is essential that eligibility criteria are established. **Partnerships should agree clear eligibility criteria for care management across agencies.** People who should be considered for care management, in all community care groups, will include those who:

- may require or are at risk of permanent admission to care homes or other long-stay care settings;
- are being discharged from hospital or other care settings after a period of long-term care;
- are being discharged following major intervention or serious illness requiring acute hospital care;
- are experiencing severe mental or physical incapacity and loss of independence;
- are terminally ill and may require palliative care;
- are at high physical risk;
- are in need of care and protection;

⁸ Scottish Office, 1996, *Community Care: Care Programme Approach for People with Severe and Enduring Mental Illness including Dementia*, Circular SWSG 16/96: DD 38/39.
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- have complex needs or challenging behaviour where high level support is necessary or whose care arrangements are at risk of breaking down;
- have rapidly or frequently changing needs;
- are highly dependent on the input of a carer; and
- are carers of people with complex needs whose own care needs mean they are unable to maintain their caring role and require services in their own right.

22. **Care management** should be distinguished from **care co-ordination**⁷. This term applies to the process of planning and co-ordinating care arrangements for people with more straightforward and stable needs, and who do not require complex care arrangements. Care co-ordination will often be part of Single Shared Assessment as the responsibility of the lead assessor. It is important none the less that care co-ordination includes clear arrangements for monitoring and review, so that changing needs or problems with services are identified and dealt with, averting any crisis or breakdown in care. When needs and care arrangements become more complex, care management should be considered. While being clear about their respective roles, there is, nevertheless, a need to have some flexibility between care co-ordination and care management, to support service users who move between these arrangements.

The Organisation of Care Management

23. Organisational arrangements for care management follow two recognised models: the 'Role Model' and the 'Task Model'. The task model is more common, (used in 21 authorities), with a mix of both models in the others.⁷ Table 1 describes them and lists some of their advantages and disadvantages. With both models there are wide variations in policy and practice, with problems particularly of lack of clarity over who care management is for and barriers to implementing care plans. These fundamental issues have a much greater impact on the effectiveness of care management than the choice of model. It is likely that both models will continue to exist side by side to suit local circumstances. They will extend in scope as a wider range of staff are employed as care managers or take on the task.

Table 1. **Models of Care Management**

ROLE MODEL	ADVANTAGES	DISADVANTAGES
Professional staff are specifically employed as care managers with responsibility for all the elements within care management.	<ul style="list-style-type: none"> • clarity about who is receiving care management • staff time is dedicated to care management • care managers build up expertise • tasks of assessment & care planning are separate from service provision 	<ul style="list-style-type: none"> • may be additional cost in providing a specialist service
TASK MODEL	ADVANTAGES	DISADVANTAGES
Care management is a task itself, carried out by professional staff in addition to other duties	<ul style="list-style-type: none"> • a wider range of staff may be available • more staff develop skills in care management • more appropriate in the context of integrated services with various professionals undertaking care management. 	<ul style="list-style-type: none"> • assessment and care planning are not independent of service provision • other demands compete for time with care management • implementing care plans can make high demands on staff time

Care Managers

24. Care management is a complex activity that should be carried out by professionally qualified staff, suitably trained, who have appropriate skills, competencies and experience. Within that broad framework there are, in mental health, specific duties and responsibilities placed on dedicated Mental Health Officers. The role and practice of Mental Health Officers as care managers will need careful consideration locally to avoid arrangements that might create a conflict of interest for these staff in dealing with particular cases.

25 At present the majority of staff employed as care managers or who undertake care management are professionally qualified social workers in local authorities. This is likely to remain the case, though our explicit aim is to extend care management to

other areas. About 9% each are professionally qualified nurses and occupational therapists⁷, demonstrating the potential for other key community health and social care professionals to extend their role. In appropriate circumstances this may include professionals in the voluntary sector, for instance the agencies commissioned by local authorities to provide services to people who have sensory impairments. The case studies in the research report⁷ provide examples of different professionals acting as care managers across agencies and in joint, multi-disciplinary teams.

26. Within Joint Future generally, joint resourcing and joint or single management of services will extend opportunities for joint working and widening of staff roles. The further development and extension of care management must take place on a jointly planned and agreed basis between health and social work.

27. Joint arrangements for care management should make the best use of staff skills and experience. Extending the remit for care management to a wider range of staff is appropriate, has implications for social work and health, but needs to be put into perspective. Not all community nurses or all occupational therapists, for instance, will become care managers, nor will they necessarily be the care manager in all of the cases known to them where this level of intervention is required.

28. Staff need to be clear on what basis they are being identified as possible care managers, and any implications for terms and conditions of employment should be managed. Partnerships should recognise that NHS staff will need support to embrace care management as a style of working. The cultural and organisational obstacles will be overcome through partnership working and supported through training.

29. Arrangements for care management need to make efficient and effective use of resources. Agencies should determine jointly the likely demand for care management, bearing in mind that this will increase with the rising number of people with complex needs who will receive their care at home. The deployment of staff as care managers should reflect local needs, but the configuration by profession will depend on current and emerging patterns of staffing across agencies, the attraction of being a care manager, and the availability of training opportunities. Arrangements for joint or single managers under Joint Future will clarify lines of accountability within

and across agencies. **Partner agencies should agree the range of staff in different settings who may be care managers, and the core competencies required.**

30. Local agreements for care management will need to specify:

- how many care managers will be needed to meet overall demand;
- which professional staff may be care managers and in what circumstances;
- the most appropriate mix of professional staff; and
- how care managers are to be deployed to meet local demand.

Workloads in care management

31. The workload in care management for individual professionals will depend on whether care management is their job or a task within their substantive job. Care management of complex cases and where needs are often changing can be time consuming, but it will not be effective if care managers cannot devote the time needed. Workload management will be crucial to ensuring the appropriateness of cases and their ongoing need for care management, as well as controlling the number of cases. Joint and team working will give better opportunities for managing demand and workloads.

32. Suggestions for case load size have ranged from 15⁷ to 40-45⁶ complex cases. Much will depend on the organisational arrangements for care management, whether it is being undertaken by staff on a 'role' or 'task' basis, the other responsibilities that staff might have and local variables like geography. What is feasible and reasonable will depend on people's other workload commitments and the local arrangements for care management.

Arrangements for monitoring and reviewing

33. Monitoring and reviewing are essential parts of care management if services are to respond to changing needs and resources are to be used to best effect, including the resource of care management itself. Care managers should be able to devote time

to situations that require active and ongoing care management. They should be able to respond also to changing circumstances which mean renewed effort in care management. But it is not good use of their time to maintain active involvement in situations that are stable and satisfactory. They must discriminate effectively where care management should and should not be used.

34. Care managers should be responsible for:

- ensuring that appropriate arrangements are in place for monitoring and reviewing in each individual case;
- acting on the findings of monitoring and reviews to ensure that individuals' changing needs continue to be met through acceptable and appropriate services; and
- assessing the ongoing need for care management, as part of the review process.

35. This does not mean that care managers must undertake themselves all the activities in monitoring and reviewing. The joint agency arrangements for care management should agree the means by which monitoring and reviewing may be carried out, taking account of the different circumstances in which care managers are working. The roles and responsibilities of staff should be made clear.

Access to resources

36. People with complex and/or frequently changing care needs may require a wide range of community care services over time. Some people will be making life-changing decisions and should be able to do so having considered all the options for their care and support. These options should increase as new joint services are developed. The challenge for partner agencies is to offer flexible but reliable and sustainable solutions to people's care needs.

37. If care management is to be a speedier route to an expanded range of community care resources or services in social care, health and housing, greater

flexibility is needed locally. **Partner agencies should jointly map and agree the process for accessing the full range of community care services, ensuring simplicity and minimum bureaucracy.** Some of this work will have been done in agreeing access to services across agencies through Single Shared Assessment.

Decision-making in care management

38. Care managers are responsible for ensuring that people's changing needs are met by responsive services. But they need the authority to make this possible. Their approach should be person-centred and needs-led. This means that the working partnership between people who use services and their carers and the care manager should decide how to meet assessed needs within available resources. Care managers should then be able to commit resources accordingly, by commissioning suitable services in social care, health and housing or by purchasing such services.

39. To help people make informed choices about how their care needs might be met, and to make decisions themselves about services, care managers will need reliable information on:

- available community care services across sectors;
- the quality of services;
- the unit costs of services; and
- contractual arrangements with service providers.

40. In many areas delegating decision-making will mean giving much greater autonomy to staff. Local authorities should review their current policies and practice, some of which are unnecessarily bureaucratic and agree joint arrangements with health partners who themselves will be pursuing greater delegation to and by Community Health Partnerships. The aim should be to give care managers direct access to services. But with responsibility goes accountability. Agencies should agree and make clear to staff the roles and responsibilities of care managers and line managers, the lines and systems of accountability and the parameters of decision-making.

41. In the Stirling survey⁷, 75% of care managers faced some restrictions on accessing services or resources, such as limits on the use of external providers and/or referring decision-making to more senior levels. But if individuals are to be best served by care management, care managers need to commission or purchase services across sectors. This can also help policy goals of increasing choice in provision, stimulating service developments and shifting the balance of care. **Care managers should be given the authority to commit resources to meet needs, within jointly agreed parameters and the limitations of available resources.**

Devolved budgets

42. Devolving budgets goes a step beyond delegated decision-making by giving care managers direct access to a wider range of resources, allowing them to offer more flexible and innovative care arrangements. Despite the promotion of devolved budgets in the 1991 guidance on care management, in *Modernising Community Care* (1998)⁹ and in the report of the Joint Future Group, only one local authority currently devolves budgets to individual care managers. Around two-thirds have devolved limited budgets or resources to team managers.⁷ **Partner agencies should agree a timetable for devolving budgets to care managers for the purchase of appropriate services.**

43. Partnerships have to make progress on devolving budgets, at least to team level, for the provision of appropriate services in social care, health and housing for people with complex needs. For instance, allowing care managers to purchase care across sectors to certain costs limits, such as the cost of a care home place, will increase choice of provision. They must be able to use budgets flexibly if the balance of care is to be shifted to care at home.

44. Agencies will need to decide and agree:

- the resources to be devolved;
- the level of devolution;

⁹ Scottish Office, October 1998, *Modernising community care: an action plan*.
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- how budgets will be constructed to give flexibility;
- the parameters for spending budgets; and
- the systems to monitor and control devolved budgets.

45. Some agencies, managers and care managers may have concerns about devolved budgets and financial responsibility. The centralised and hierarchical arrangements that exist at present may seem to offer a greater degree of security and control over the use of scarce resources but these are sometimes a substitute for inadequate financial systems. Effective financial management and control come from good management information, sound financial systems, and knowledgeable and skilled staff at all levels of budget and financial responsibility. The balance needs to shift from more centralised control and decision making to localised decisions in a context of sound arrangements for financial control.

Support for Delegated Decision-making with Devolved Budgets

46. Joint resourcing and joint management provide the lead for joint agreement on the devolution of budgets. Local Partnership Agreements provide the joint resourcing framework that will determine the scope of resources available to care managers, together with the governance arrangements for schemes of delegation and the parameters for budgetary control and decision-making.

47. Having agreed a framework, partner agencies need to ensure a sound financial infrastructure to support delegated financial decision-making. **They should establish systems to report and monitor expenditure and to provide necessary management and financial information.** Devolving budgets on a pilot basis would be a positive way forward.

48. Audit Scotland has identified the requirements for staff to operate devolved budgets successfully ^{10 p.92}.

- knowledge of the budget and any commitments or restrictions;

¹⁰ Accounts Commission, October 2000, *Commissioning community care services for older people*, Audit Scotland, Edinburgh.
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- an understanding of what is required of them individually and collectively in managing the budget;
- a system for recording and reporting committed expenditure in a timely manner that is easily maintained and processed regularly;
- clear, up-to-date reports on actual spend, committed and projected expenditure and activity data;
- budget profiling to highlight any likely variations in anticipated expenditure;
- analysis of variances, highlighting necessary corrective action.

49. In addition to the above, agencies will need to provide staff with clear guidelines for making purchasing decisions, to include ^{10 p.92}.

- priorities for service provision;
- eligibility criteria for services and levels of service;
- indicative targets for average spend per client or cost limits on individual care packages;
- criteria and procedures for accessing care beyond cost limits;
- rules for use of contingency funds, if any;
- use of compensatory savings (under-spends offsetting over-spends);
- the range of services and providers;
- the range of prices that may be paid.

Training for Care Management

50. Training for care managers generally has varied in scope and for many care managers took place sometime ago⁷. The re-focusing of care management is an opportunity to address training needs through a joint approach. Training should build on staff's existing knowledge and skills, and on lessons learned from experience. Training will be within the local context, reflecting the different organisational and cultural factors across Scotland. An important aspect of joint training will be to ensure a shared understanding of the principles and processes of care management and a common language. The process of care management is described in Appendix 1

51. Staff who undertake care management will have received training in Single Shared Assessment. They should be familiar, therefore, with the use of the local assessment tool in comprehensive assessments, with the process of SSA and its links to care management. They should also understand and be able to incorporate into their practice the principles of needs-led assessment and partnership working with people who use services and their carers. The knowledge and skills for care management are set out in Appendix 2.

52. The content of training for care management can be categorised under five key themes and within these themes key topics are suggested in Table 2. The key themes are:

- the care management process - specific knowledge and skills for care management;
- partnership working;
- securing services;
- systems and procedures to support care management; and
- the legislative, policy and organisational context.

Table 2 **Training for Care Management**

	PARTNERSHIP WORKING Empowering users/carers Choice and decision- making Advocacy Networks and Communities Working in teams	
SECURING SERVICES Identifying services/resources Innovation in care planning Service specification Commissioning and purchasing Evaluating outcomes Developing resources	CARE MANAGEMENT PROCESS Assessment Care planning Implementing care Monitoring Reviewing Risk assessment & risk management	SYSTEMS & PROCEDURES Understanding contracts Budgets and finance Financial management Measuring performance IT Training
	CONTEXT Changing cultures Roles and responsibilities Rights and Risk Legislative & policy framework	

53. The Scottish Executive will support training with a series of implementation seminars, but the primary focus will be on local training and development. Different levels will be needed for experienced and new care managers respectively (and for basic awareness rising to more in-depth training on assessment and care management) but training should always build on people's existing knowledge and skills and any lessons learned from good practice in care management.

54. In extending the joint working arrangements from SSA to care management, partnerships will want to consider the skills, knowledge, training, accountability arrangements and responsibilities of agencies and staff. They may wish to

consolidate learning and experience with older people's services, where that has been their starting point, before progressing to other care groups.

Progress towards Implementation

55. All local authorities provide care management for people with complex needs and although current policies and practice vary considerably, all have experience on which to build. A few will have in place many of the elements of an effective, efficient and targeted service. Many partnerships will, however, need to make significant changes to provide the organisational framework to support effective care management.

56. The same is true for extending care management to suitable professionals in other agencies. This is not just an issue for the health service and, in particular, primary care but also for parts of voluntary sector. Some areas will be able to build on their experience of a range of staff undertaking care management in joint, multi-disciplinary teams.

57. More generally, the clarification and development of care management has to be seen in the wider context of Joint Future's initiatives to improve results for people who use community care services. In particular, this guidance should link with the implementation of single shared assessment and joint resourcing and joint management (all of which should be in place for all community care groups from April 2004).

58. Local authorities and their partner agencies should now develop care management as the targeted and devolved activity described in this circular.

59. A self-assessment form is included at Appendix 4 to assist agencies in improving care management. It sets out key steps and should record how these have been achieved or are being approached, and how those not yet underway will be addressed, with timescales. The Joint Future Unit will use the framework to monitor progress.

Enquiries

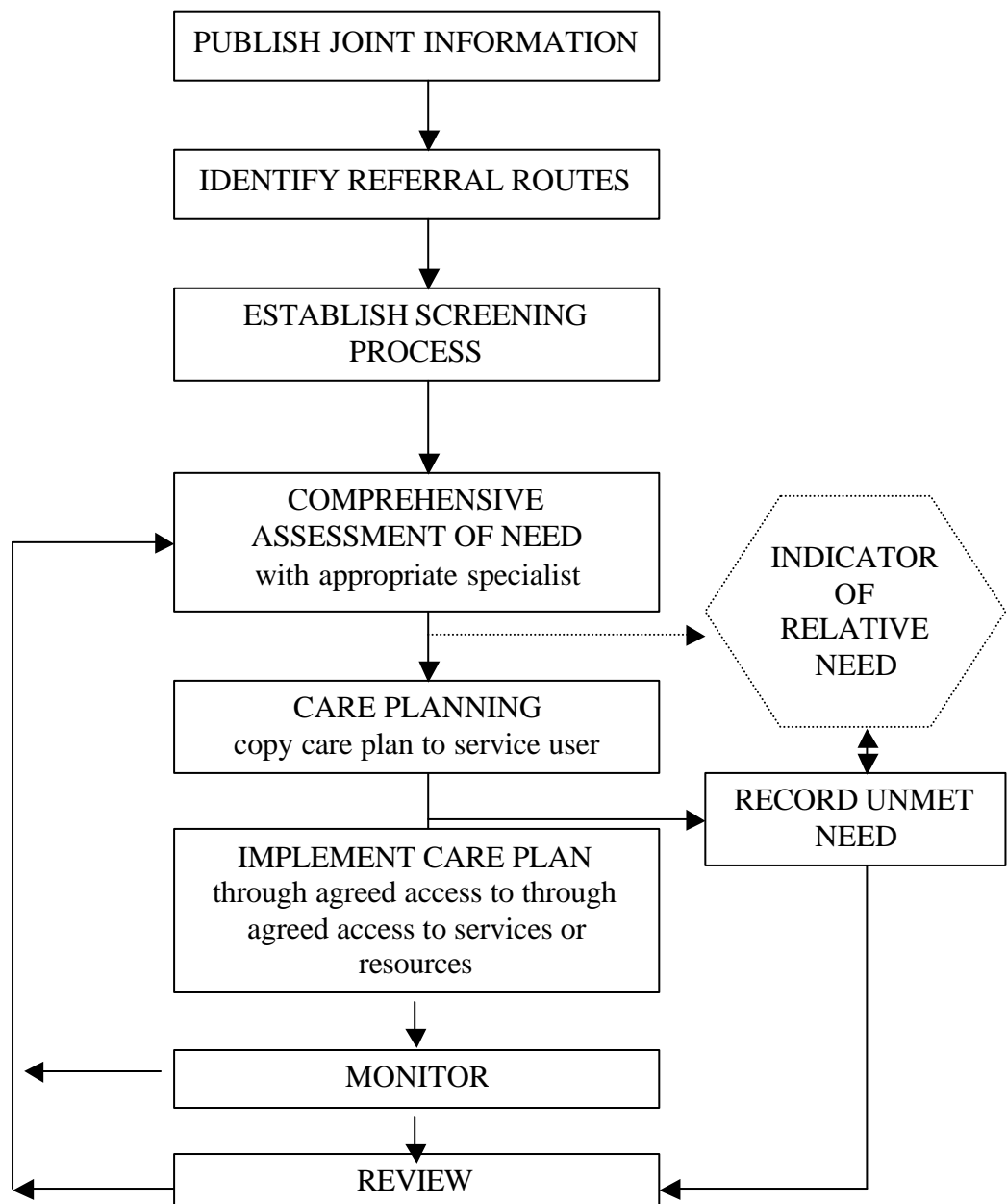
60. Enquiries relating to this circular should be addressed in the first instance to Brenda Kerr, Joint Future Unit, Scottish Executive, Health Department, Community Care Division, 3rd Floor East Rear, St Andrew's House, Regent Road, Edinburgh EH1 3DG (telephone: 0131 244 3744). Professional issues should be referred to Margaret-Anne Dale at MargaretAnne.Dale@scotland.gsi.gov.uk (telephone: 0131 224 5331).

GUIDANCE on CARE MANAGEMENT IN COMMUNITY CARE

THE PROCESS OF CARE MANAGEMENT

1. The elements that make up the process of care management – as set out in Figure 1 - will be familiar to many professionals and managers.

Figure 1 Care Management Process Map



Publishing information

2. Publishing information about care management is an essential step to ensuring that people receive a quick and appropriate response to their needs, and to help them understand the arrangements and what care management can offer. Published information should explain in suitable format for service users and carers and staff:

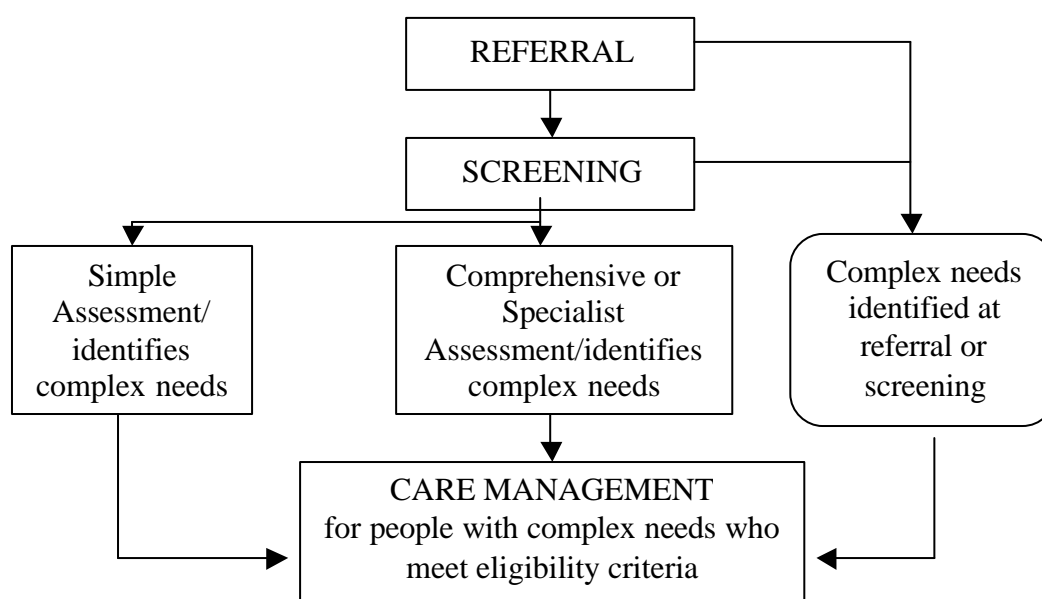
- what care management means;
- who is eligible for care management as a targeted service;
- how to access care management; and
- what can be expected from care management.

3. Clear and accessible information should assist professionals and managers to decide if care management is appropriate to the individual's needs. Need should be the basis of eligibility.

Identifying referral routes

4. Clarity about referral routes will help to prevent unnecessary barriers and delays to people receiving appropriate help. Many potential beneficiaries of care management will have been assessed through Single Shared Assessment and will be receiving services already. Lead assessors should be familiar with the criteria that trigger care management. Some will become the care manager for people whose needs they have assessed already. There will be people, too, who will become known to services in a crisis or when needs are already complex and the possibility should be there for directing them to care management without delay. Figure 2 shows the likely referral routes to care management.

Figure 2 Routes to Care Management



Screening

5. Screening will determine if care management is an appropriate response to the level of need identified. With clear eligibility criteria, care managers are in a good position to make screening decisions, allowing direct referral and a fast-track route to care management. Where there is an intermediary who decides on the most appropriate action, the screening and allocation process should not delay the response.

Assessing need

6. **Assessment is part of the care management process** and the foundation of good care. Single Shared Assessment should ensure that people will receive an appropriate level of assessment and that existing information on the individual will be available to the care manager, avoiding duplication. Whether or not there is existing assessment information, the task of the care manager is to ensure that all appropriate assessments are completed to give a holistic view of the person's needs. This should include assessment of people's financial circumstances.

7. Care managers will undertake needs-led, comprehensive assessments and will request and co-ordinate specialist assessments in accordance with the principles and local arrangements for single shared assessment. Some people being assessed will have a clear idea of their needs and preferences, while others will require more time to explore their needs and consider the interventions that might help. The outcome of the assessment should be agreement about the individual's needs, and priorities and preferences for meeting them. Individuals should receive a copy of the assessment record unless there is good reason to the contrary.

8. Care managers should take account of the views and contribution of carers when assessing the person in need. Carers should be treated and supported as partners in providing care. Where the views of the person in need are at odds with a carer's views the care manager's skills will be needed to reconcile different interests. Where appropriate, independent advocacy should be sought.

9. Carers should be informed of their right to an assessment to determine their ability to care and the resources needed to help them, independent of any assessment of the person they care for. Care managers should undertake or arrange carers' assessments, bearing in mind the potential for conflict of interest between the needs of the carer and the person cared for.

Care planning

10. Care planning is an opportunity to consider all the options available for meeting assessed needs. People may be making crucial life-style choices and should have full information about the range of resources available to best meet their needs. Care planning should be more than matching needs to off the shelf services. Service solutions should be seen in the wider context of the individual's family, social and community supports. Informal care and support may be at least as important to maintaining a chosen lifestyle as formal services. Care planning should recognise how the various elements in the person's support network interrelate.

11. Care managers should support the person to make informed choices and should agree the expected outcomes with the individual, carers and other relevant professionals or agencies. The result should be an **individual care plan** to meet agreed needs. Matching needs and resources will highlight areas of need which are likely to remain unmet once the care arrangements are put in place. They should be recorded. The care plan should be in a format suitable to the person's circumstances and able to be shared as appropriate. It should state the arrangements and timescale for reviewing care. The person should receive a copy of the care plan.

Implementing the care plan

12. Implementing the care plan will involve the care manager in a range of activities requiring a number of skills and a good knowledge of community care resources and how to access them. The care manager will need to:

- identify and secure the necessary resources or funding for services;
- specify the services required and the expected outcomes for the service user;
- negotiate with service providers and agree the terms of service provision;
- ensure that any contractual requirements will be met;
- make decisions to commit resources or budgets; and
- co-ordinate the range of services to meet the care plan.

13. The person receiving the services should be made aware of the outcome of these activities. A **care timetable** will be a useful supplement to the care plan. Where agreed needs cannot be met as planned, substitute arrangements should be made, and any unmet needs recorded.

14. Implementing the care plan may be time consuming. Where complex care arrangements are being made their success will be determined by the attention to detail. Workload management issues should be addressed.

Monitoring

15. Monitoring the implementation of the care plan will be an ongoing task as people's needs and circumstances change. Where needs are rapidly or frequently changing adjustments may have to be made to the care. Arrangements for monitoring should be part of the specifications for services and the care manager will be responsible for ensuring that they are followed. The focus should be on whether the quality and appropriateness of the provision meet the agreed outcomes for the individual. The person receiving the services, carers and service providers all have a part to play in formal and informal monitoring.

Review

16. Reviewing needs and services should take place at the times or intervals specified in the care plan or at any other time it seems necessary. Reviewing is a formal arrangement, but it should be conducted to suit the circumstances of the individual and need not involve large, formal meetings. Whatever the arrangements, the review should:

- ensure that changing needs are being recognised and re-assessment of needs undertaken if necessary;
- ensure that the care plan is revised to suit changing needs or circumstances;
- ensure that services are meeting needs appropriately and to the quality standards expected; and
- consider whether care management is still required and make alternative arrangements where appropriate.

17. Reviewing is an integral part of care management. The care manager is responsible for ensuring that appropriate arrangements are in place through the care plan and that decisions from reviews are actioned. It may be desirable for care managers to conduct reviews, but this will not always be feasible as the numbers of reviews increase and make demands on care managers' time. Alternative arrangements for conducting reviews should suit the individual circumstances of people with complex or rapidly or frequently changing needs, and should definitely not become a 'routine' or 'administrative' task.

GUIDANCE on CARE MANAGEMENT IN COMMUNITY CARE**KNOWLEDGE AND SKILLS IN CARE MANAGEMENT**

1. Care management is a complex activity, dealing with people who have the most complex needs. It should be undertaken by staff with appropriate skills and knowledge. This extends the principle from Single Shared Assessment of levels of need being matched to appropriate levels of skill in assessors.

2. Staff with professional qualifications in social work, occupational therapy and nursing will understand human needs and the problems faced by people who use community care services. They will have skills in communicating and working with people and skills in assessment, care planning and providing care and support to meet needs, within their own area of professional expertise. This is the basis for developing skills in care management.

3. In deciding which staff will undertake care management, partnerships will want to consider how best to make use of their experienced staff to achieve the right skill mix overall. A wide range of skills, underpinned by knowledge and experience, are needed for care management. The key skills are the ability to:

- undertake comprehensive, needs-led assessment, including risk assessment;
- prioritise the needs of people who use services and match needs with resources;
- plan, specify and negotiate complex care arrangements;
- show creativity in making best use of resources;
- challenge effectively and act as an advocate;
- evaluate quality, value for money and outcomes of services;
- plan and manage the use of resources and budgets; and
- understand and report financial information.

4. In addition to these skills, professionals will need to be able to deal with relationships and complex family dynamics. They will need to work in partnership with people who use services, their carers and their care networks, and with other professionals. Good communication skills will be essential.

GUIDANCE on CARE MANAGEMENT IN COMMUNITY CARE PRACTICE EXAMPLES

1. MODELS OF CARE MANAGEMENT

Clackmannanshire Council has organised care management as a task, carried out by community care workers as part of their wider caseload. Features of this model are;

- Community care workers are professionally qualified social workers and occupational therapists;
- They work with most community care groups;
- They undertake all levels of assessment;
- They have no more than 12 care managed cases at any time;
- People move in and out of care management as their needs vary; and
- The rest of their workload is made up of less complex cases.

Clackmannanshire believes that this arrangement allows them to make the best use of workers' skills, knowledge and experience in meeting people's needs.¹¹

2. ARRANGEMENTS FOR MONITORING AND REVIEWING

Dundee City Council has review arrangements to suit different situations.

- Older people's teams each have a care manager designated as a Review Officer for people living in care homes. The review officer is responsible for carrying out the review and ensuring any agreed changes to the care plan are implemented. If a re-assessment of the person's needs or major changes to the care arrangements are indicated the original care manager takes on the case.
- For people who are living in their own home, their care manager is responsible for carrying out reviews and taking any action as a result.

The benefits of this approach are said to be the development of skills in reviewing for people in care homes and more time for care managers to focus on assessments, monitoring care and reviewing the needs of people living at home.

¹¹ Clackmannanshire Council, 2001, *Fair Care - Best Value Review – Assessment and Care Management*, Alloa.
CM Final2

3. JOINT ARRANGEMENT FOR EXTENDING CARE MANAGEMENT

Care Management in Scottish Borders

Scottish Borders has a partnership approach to care management, built on their experience of good joint and multi-disciplinary working. Staff are working together and have good local links without re-organising into multi-disciplinary teams. However, more recently, local multi-disciplinary rapid response services have been developed who also use this approach.

Key features of this partnership approach are

- care management is a task, carried out as part of a wider role;
- it is undertaken by social workers, community nurses (District Nurses, CPNs in the elderly mental health team) and occupational therapists;
- complex cases are dealt with by professionally qualified staff;
- staff have been trained in care management;
- a single shared assessment tool is in use;
- screening determines priority and level of response;
- all care managers have the same access to social care services; and
- staff are based in social work, in primary care settings and in hospitals.

Training in assessment and care management is joint and where possible involves service users and carers. It has focused on values and principles, assessment, and practicalities of care management and putting together packages of care. Unqualified staff, community care assistants, have been included in training to develop their skills in simple assessment and co-ordinating basic packages of care. As well as preparing staff to undertake care management, training has helped increase different disciplines' understanding of each other's roles and responsibilities and job shadowing is an aspect staff have valued particularly.

Though staff undertaking care management are predominantly social workers, others take on this function when they are the most appropriate person, often when they already know the individual or are likely to have most contact. This avoids duplication of work and ensures a quicker response to setting up and making changes to care arrangements. This has been of particular value in the palliative care service, which has its own funding, allowing specialist nurses have immediate access to care providers and put arrangements in place in a few hours. Other areas of success are CPNs as care managers for people with dementia and District Nurses and OTs with younger people with physical disability. Though nurses have concerns about extra 'paperwork' the overall benefits to patients outweigh this.

The benefits of this partnership approach are seen as

- quicker and easier response to meeting people's needs;
- greater ease and speed of access to social care services by health staff; and
- better understanding of professional and agency roles.

4. SUPPORT FOR DELEGATED DECISION MAKING WITH DEVOLVED BUDGETS

Aberdeenshire Council has built up experience over 10 years of budgets devolved to care managers. This includes staff whose job is care management, who may be professionally qualified in social work, community nursing or occupational therapy, and staff in multi-disciplinary specialist teams, who may be social work or health staff, who take on the task of care management. Key features of devolved budget arrangements are:

- Eligibility criteria for care management;
- Care managers have authority to spend up to £300 per person per week to provide care at home.
- Within this limit they have complete freedom to purchase services across sectors.
- They purchase in-house home care services.
- Higher cost care arrangements are approved by the Social Work Manager.
- Care management teams make decisions about purchasing care home places sharing or pooling budgets.
- Care managers are clear about their roles and responsibilities for budgets; and
- Devolved budgets are supported by sound financial management and information systems, including IT systems.

The main benefits of devolved budgets are perceived to be:

- Empowerment of care managers and, in turn, of people who use services;
- Care arrangements made more quickly;
- A wider choice of provision for individuals;
- Greater flexibility and opportunity for innovation; and
- Greater quality control over services.

ANNEX

CARE MANAGEMENT - PROGRESS ON IMPLEMENTATION - SELF ASSESSMENT

KEY STEPS For Joint implementation	ACHIEVED	UNDERWAY	TO BEGIN	ACTION	TIMETABLE	
Agree which professional staff will be care managers						
Agree roles and responsibilities						
Agree arrangements for accountability						
Agree eligibility criteria for care management						
Agree access to services/resources						
Agree plan for devolving budgets						
Agree plan for implementing training						
Agree plan for implementing care management system						

APPENDIX 4

GUIDANCE ON CARE MANAGEMENT IN COMMUNITY CARE

References

1. Social Services Inspectorate and Social Work Services Group, 1991, *Care Management and Assessment: Managers' Guide*, HMSO.
2. Social Services Inspectorate and Social Work Services Group, 1991, *Care Management and Assessment: Practitioners' Guide*, HMSO.
3. Scottish Office, 1998 *Community Care Needs of Frail Older People – Integrating Professional Assessment and Care Management*, Circular SWSG10/98.
4. Scottish Executive, November 2001, *Guidance on Single Shared Assessment of Community Care Needs*, Circular No: CCD 8.2001.
5. Department of Health and Social Security, and the Welsh Office, 1989, *Caring for People: Community Care in the Next Decade and Beyond*, HMSO.
6. Joint Future Group, 2000, *Community Care: A Joint Future*, Scottish Executive, Edinburgh
7. Stalker K, Campbell I, 2002, *Review of Care Management in Scotland*, Scottish Executive Central Research Unit.
8. Scottish Office, 1996, *Community Care: Care Programme Approach for People with Severe and Enduring Mental Illness including Dementia*, Circular SWSG 16/96: DD 38/39.
9. Scottish Office, October 1998, *Modernising community care: an action plan*.
10. Accounts Commission, October 2000, *Commissioning community care services for older people*, Audit Scotland, Edinburgh.
11. Clackmannanshire Council, 2001, *Fair Care - Best Value Review – Assessment and Care Management*, Alloa.

1. Consultation – Summary of Responses to Draft
Guidance on Care Management in Community Care, January 2004

Introduction

1.1 Overall, there was general support for the guidance on care management in community care from the 43 respondents. They confirmed that it provided an accurate overview of the current arrangements, re-emphasised appropriately existing policy and practice, and updated the current guidance in light of the Joint Future Agenda, all with a “person-centred” focus. The Scottish Executive will therefore proceed to full implementation of the care management arrangements, from 1 April 2005.

1.2 There were a number of comments on the structure and content of the guidance itself. A few suggested that the guidance should be re-written, as the 1991 guidance is now out of date. On the other hand, 10 respondents wanted the guidance extended to include more detail and background information.

1.3 To put all this in context, it should be acknowledged that partnership areas are at different stages of implementing care management. Some will associate more readily than others with the key elements of the guidance. But the updated guidance should assist partnerships across the board to develop a more consistent approach, that will contribute to better outcomes.

2. Terminology

2.1 A few respondents agreed that the term ‘intensive care management’ used in the Joint Future Group report had created confusion. Therefore, the refocusing was needed and welcomed. This was part of a more general need for a “joint understanding” and “common language” to move forward the integration agenda between LA’s and the NHS.

2.2 Thirty-three respondents commented on the definitions of ‘care management’ and ‘care co-ordination’. They seek greater clarity and agreed common definitions.

In response, the guidance has been expanded to distinguish more clearly between care management and care co-ordination, and to provide more flexibility between the two, where required. More generally, the guidance has been strengthened to reinforce the general recommendations made by the Joint Future Group on care management and care co-ordination, providing a more targeted and focused approach (in line with the concept as set out in the original guidance).

3. Joint Future and Care Management

3.1 Respondents generally accepted Joint Future's aim to improve outcomes for service users and the crucial role of the Single Shared Assessment in that. Five respondents sought greater clarity on the potential use in planning of the Indicator of Relative Need (IoRN).

3.2 A few respondents highlighted the importance of assessment as an integral element of care management, and sought greater acknowledgement of the varied implementation patterns of SSA across Scotland at present. However, the main aim of this guidance is to raise standards and achieve greater consistency across the board, not perpetuate current imbalances.

4. The Scope of Care Management

4.1 Respondents generally agreed the suggested scope of care management. A few respondents suggested reference to the separate carers' assessment tool. Since the draft guidance has been issued there has been progress in this area through the developing carers' strategies.

4.2 Eleven respondents welcomed the links to the Care Programme Approach. A few also suggested recognising more fully the duties and legislative requirements on MHO's and their relationship to care management generally. This has been addressed in the revised guidance.

4.3 In terms of "targeting" care management, a few respondents suggested greater recognition of the shared responsibility for care management across agencies, and that

the assessment process should be the means to ensure access to services and resources. The guidance already asks partnerships to map and agree the process for accessing the full range of community care services, in line with developments under Joint Future generally.

Respondents supported local partnerships having agreed ‘eligibility’ criteria for care management. A few also suggested expanding the eligibility criteria. In the light of that the criteria in the guidance will now also include:

- Major intervention or serious illness requiring acute care.
- Carers requiring services in their own right.
- People vulnerable to exploitation or abuse who are in need of care and protection.
- People with high care needs and support from carers.

4.4 Four respondents reinforced the importance of monitoring and reviewing the arrangements for care management and care co-ordination, and that flexibility was required as service users frequently move between them. The guidance has been strengthened on this account

5. The Organisation of Care Management

5.1 Despite one suggestion that the Executive should set out a preferred model, respondents generally recognised that the “role” and “task” models of care management co-exist, and that it was important to have flexibility across them. One respondent suggested that the task model was more appropriate in the context of integrated services. The consensus supported the approach in the guidance that both models should exist, and that local partnerships should decide for themselves the appropriate model to suit local circumstances.

5.2 A few respondents sought more detail on technical aspects of the different models, which the revised version addresses.

6. Care Managers

6.1 The consultation strongly supported that care managers require to be qualified and suitably trained, that NHS staff will need support to embrace care management as a style of working, that joint training will be needed to overcome the organisational and cultural obstacles, and core competencies need to be agreed by partner agencies.

6.2 More information was requested on key skills and knowledge, and has been included in the revised guidance.

7. Caseloads

7.1 Seventeen respondents highlighted issues around workload demands and caseload size. A number recognised the potential impact on clinical time for nursing staff. The guidance did not suggest an optimum caseload but this was requested by 8 respondents. Two respondents requested a workload management tool. Illustrations of caseload sizes have now been included for reference purposes. However, local partnerships need to develop their own approaches in the light of their choice of model etc.

8. Access to Resources

8.1 This is a central aspect, on which there were 21 responses. A major success factor in SSA for all professionals is the ability to improve access to resources. A few respondents highlighted the wider relationship to Joint Management and Joint Resourcing, and the need for further guidance in these areas.

8.2 The main thrust was that respondents agreed the need for comprehensive local protocols and for arrangements to achieve speedier access to services and improved outcomes for service users, as part of Joint Future generally. Ensuring delivery is

essential and monitoring will be through the Extended Local Partnership Agreements in the first instance.

8.3 A few commentators recognised that improved access to resources and better joint working may result in increased demand, which could lead to longer waiting lists and generate resource issues. These aspects are not new. They are addressable as part of the implementation arrangements for care management and Joint Future generally.

9. Delegated Decision-making

9.1 The comments recognised that delegated decision-making was in place in certain areas, but should be more consistently applied – as the guidance seeks to do – and that the guidance re-enforced the need for decisions at all levels to be within the resources available. They supported the drive for continued progress on delegated decision-making at partnership level.

10. Devolved budgets

10.1 Again the centrality of this aspect is recognised through its generating 19 comments. A few suggested that devolving budgets to care managers was purely ideologically based, and expressed concern that devolving budgets to care managers would be problematic for smaller partnership areas.

10.2 More generally, while the responses acknowledged the desired direction of travel, they identified a range of practical implementation issues: clear parameters needed locally (one respondent), scheme of delegation required (one respondent), financial systems required (2 respondents), an agreed ceiling (one respondent), budget issues generally (3 respondents), pooled budgets (one respondent), pilot devolved budgets (one respondent), and charging issues (one respondent). The guidance therefore maintains the drive towards devolving budgets, while recognising the practical aspects needed.

11. Support for delegated decision-making with devolved budgets

11.1 The support systems for delegated decision-making and devolved budgets are also relevant to wider developments in joint access to services. Commentators recognised that greater delegation and developing systems of control needed to proceed concurrently, as the guidance makes clear.

12. Training

12.1 This section generated the greatest number of responses, with 33 comments. They covered mainly requests for national training, to ensure suitably qualified and suitably trained staff with agreed competencies and skills. A combination of implementation seminars and “hands on training” will be needed to address these.

12.2 As partnerships extend joint working from SSA to care management they require to consider fully the needs of the workforce in terms of the skills, knowledge, accountability arrangements and responsibilities to undertake the tasks. They may benefit from consolidating first the learning and experience with older people, before extending to other care groups.

12.3 The Executive will provide implementation seminars, but local partnerships will have lead responsibility for training/re-training their staff. More generally, National Education for Scotland and the Scottish Social Services Council have been commissioned to map out the training needs for Joint Future and are due to report in Summer, 2004.

13. Progress towards Implementation

13.1 The aim of progress towards consistent national arrangements for assessment and care management is supported. But respondents want the implementation timetable to be clear and manageable. They suggest, that the “local pace” on implementation should be taken into account in the timing and planning of implementation. We think it is important that implementation of care management

proceeds alongside the current implementation of SSA. We believe it is realistic to see full implementation of both by April 2005.

13.2 Two respondents suggested that the Extended Local Partnership Agreements could provide an update on current progress (to prevent duplication with the self assessment form). However, other respondents welcomed the use of the self-assessment form. The timing is an issue: we are looking for partnerships to complete the self assessment forms within 3 months of the issuing of the circular. The ELPA's of will not be due until April 2005.

14. Conclusions

14.1 The draft care management guidance was generally accepted in principle, but respondents were looking for greater clarity on points of detail within the guidance including:

- Definitions of care management.
- Clarity between care 'co-ordination' and 'care management', with an acknowledgement of flexibility across the processes.
- Full list of reference material to be included.
- Guidance on workload size.
- Risk management to be included.
- Links between CPA and care management, and with the statutory duties of MHO's.
- Recognition of the separate carers' assessment.
- Acknowledge developments in direct payments.
- Greater clarity around eligibility criteria linked to the level of assessment, and suggested additional eligibility criteria for care management.
- Further detail of the "role" and "task" models respectively.
- Clarity on the use of the IoRN in planning.

The revised guidance has been amended to take account of them.

14.2 We will develop a framework at a national level to support implementation, based around seminars, and we will consider in the light of the current JPIAF assessments, the need for action across assessment/care management, joint management and joint resourcing, especially in their approach to access the resources.

14.3 We will also work with the training agencies to develop a suitable framework for training in care management.

15. Next Steps

15.1 The following steps will be taken in response to the consultation:

- The draft guidance has been revised to take account of the comments received. We plan to issue the guidance circular by the end of July 2004.
- We are reviewing currently the ELPAs for 2003-04. We will consider what further action/guidance on cross-over issues is needed in the light of the evaluations.
- The Joint Future Unit will assess the self assessment forms to be returned within 3 months from the issuing of the circular.
- The national training framework should be progressed.
- The JFU arrange seminars to support implementation.

MARGARET-ANNE DALE
Joint Future Unit
June 2004