Health and Social Care Alliance Scotland
Briefing: Public Bodies (Joint Working) (Scotland)
Stage Three – briefing paper

1. Introduction

This paper briefly outlines the ALLIANCE’s support for several Stage Three amendments to the Bill. These follow the amendments proposed by the ALLIANCE in late 2013, with support from over 30 third sector organisations, and developed through substantial engagement with people who use health and social care services and their representative organisations. The issues of greatest concern were:

- Supporting a human rights based approach
- Co-production – ensuring service users and unpaid carers are central to planning and shaping integrated services
- Ensuring the third sector has a strong role in joint strategic commissioning, integration and locality planning
- Ensuring a focus on personal outcomes and on quality of provision

2. Key Issues

A Human Rights Based Approach to Health and Social Care

“(Human rights) should be enshrined within the legislation to promote a rights-based culture as part of the new joint working, which would require a more person-centred approach. This Bill is very technical, and the focus on the patient or service user should not be lost.”

Scottish Association for Mental Health, written evidence, Stage One, Public Bodies (Joint Working) (Scotland) Bill

During Stage 2 of the Bill’s progress, a series of amendments were made that more clearly framed human rights principles at the heart of the integration planning and delivery principles. The ALLIANCE strongly pursued and supported these amendments. These included:

- Stronger reflection of a human rights based approach and coherence with self-directed support through inclusion of a statement requiring that respect is given to both the person’s dignity and their participation in the community.
- Replacing the term ‘recipients’ with ‘service users’
- Amending the principles to give effect that services should be planned and led locally in a way that engages in particular with people who use services, unpaid carers and those involved in health and social care from across
sectors. The amendment also makes a very welcome change in emphasis away from the idea of health and social care being ‘professionally-led’ (something that jars significantly for many disabled people and people with long term conditions) and more strongly reflects a co-production approach⁴.

- An emphasis on **improving the quality of health and social care services**.

The Scottish Government has proposed Stage 3 amendments 10 and 48 which seek to make stronger reference to rights based and assets based language on the face of the legislation. We welcome these amendments and urge MSPs to support them:

**Amendment 10**

*In section 4, page 4, line 9,* at end insert *( ) takes account of the particular characteristics and circumstances of different service-users,* *( ) respects the rights of service-users,*

*(lodged by Alex Neil MSP)*

**Amendment 48**

*In section 25, page 16, line 11,* at end insert *( ) takes account of the particular characteristics and circumstances of different service-users,* *( ) respects the rights of service-users,*

*(lodged by Alex Neil MSP)*

However, further amendments could be made to the principles that more strongly and clearly reflect human rights and, particularly, a more person centred approach. This would include making explicit reference to people’s ‘aspirations and abilities’ as well as ‘needs’, and reference to ‘choice and control’.

**Amendment 101**

*In section 4, page 4, line 7,* after <needs> insert <, aspirations, abilities, characteristics and circumstances>

*(lodged by Nanette Milne MSP)*

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¹ This principle must be supported by the requirement in statutory guidance/secondary legislation for each Health and Social Care Partnership to develop a **Community Capacity Building Strategy**, to be jointly signed off by the third sector.
Amendment 104

In section 4, page 4, line 10, at end insert <( ) enables service-users to exercise choice and control and participate in decisions regarding their need for services and the provision of those services to them,>
(lodged by Malcolm Chisholm MSP)

Amendment 109

In section 25, page 16, line 9, after <needs> insert <, aspirations, abilities, characteristics and circumstances>
(lodged by Nanette Milne MSP)

Amendment 112

In section 25, page 16, line 12, at end insert <( ) enables service-users to exercise choice and control and participate in decisions regarding their need for services and the provision of those services to them,>
(lodged by Malcolm Chisholm MSP)

“All legislation passed by the Scottish Parliament requires, under the Scotland Act 1998, to be fully compliant with the European Convention on Human Rights. Nevertheless, the Committee invites the Scottish Government to consider whether there might be an appropriate way of amending the Bill to ensure that human rights principles are more explicitly stated in the text of the Bill.”


The regulations and guidance supporting this legislation must ensure that human rights based principles are put into practice, particularly in relation to health and wellbeing outcomes, strategic commissioning, service delivery and improvement. This would:

- Align strongly with the Scottish Government’s commitment to taking forward the recommendations of the Christie report on the future delivery of public services
- Embed a strong principle of participation and support the drive for co-production
- Help ensure a focus on the outcomes that matter to people who use support and services and their families, rather than structural change as an end in itself

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2 [http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/her-13-11w.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/her-13-11w.pdf)
• Provide a clearer link (particularly if the Bill made reference to ‘independent living’ as well as ‘wellbeing’) between integration of health and social care and moves towards **personalisation and self-directed support**

• Provide a **robust framework for strategic commissioning** so that: processes support co-design with people who use services; considerations of outcomes and financial resource can be balanced fairly and people’s right to human dignity is not undermined, even in times of austerity; and issues of equality (including health inequalities) are inherently addressed.

• Be an effective tool to **drive culture change** that produces person-centred services/practice and better experiences and outcomes for people using services, unpaid carers and staff.

• Build on the human rights based approach adopted in relation to Scotland’s **Dementia Strategy**, **Self-Directed Support and learning disability strategy** (Same as You and more recent Keys to Life). All of these policies have paved the way for a human rights based approaches to be taken to development and delivery of local strategies and service delivery. For an example of such a human rights based approach to health and social care see [Appendix 1: Care About Rights](http://www.scotland.gov.uk/Resource/0042/00423472.pdf).

• Provide a key part of the foundation for implementing of **Scotland’s first National Action Plan for Human Rights (SNAP)**, published on 10 December 2013.

**Third Sector as Strategic Partner**

The **third sector is a key strategic partner** alongside health boards and local authorities. The sector forms the major part of the wider health and social care landscape, particularly in relation to preventative support, as well as delivering over a third of registered social care.

**Third Sector in Scotland**

• Employs 5% of Scotland’s workforce and includes around 1.2m adult volunteers.
• Provides over a third of all registered social care services.
• Over 1,000 organisations working in healthcare and over 8,000 in social care and development.
• Has an annual income of £4.36bn and expenditure of £4.24bn.
• Pre-dates the NHS with many organisations established over 100 years ago.
• Significant investor in health and social care services (including research, specialist nurses and service innovation), and strategic partner in service redesigning and improvement.

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5 [http://www.scotland.gov.uk/Publications/2013/06/1123](http://www.scotland.gov.uk/Publications/2013/06/1123)
The role of the sector must be clearly articulated in statutory guidance/secondary legislation and the ALLIANCE – along with many others – continues its call for third sector sign off of strategic plans prepared by Heath and Social Care Partnerships. Joint sign-off under the Reshaping Care for Older People Change Fund has enabled many areas to overcome barriers to partnership and has been a key driver for the cultural change that is widely acknowledged as the essential foundation for integration. For more information see Appendix 2: Learning from the Experience of Implementing Reshaping Care for Older People (RCOP) To Date.

“Without a more formalised role for the third sector there is a risk that the Bill will not fully achieve the policy objectives. The Red Cross would support a stronger requirement in the legislation to establish the third sector as a partner with a crucial role in the planning, development and delivery of care.

Without formalising the role of the third sector in the integration process we remain concerned that integration will be hindered by structural and budgetary issues around the two statutory bodies, rather than focussed on improving outcomes for people.”

British Red Cross, written evidence, Stage One, Public Bodies (Joint Working) (Scotland) Bill

Third Sector Interfaces (TSIs) report that the Reshaping Care for Older People Change Fund has been an important catalyst for building strategic relationships between the third and statutory sector locally. While the process has not always been easy – and there remains a long way to go – the compulsion to jointly agree the Change Fund Plans has enabled many areas to tackle the challenges of partnership and move beyond some of the barriers. For an example of strategic involvement of the third sector see Appendix 3 – Case study: Perth and Kinross Older People’s Partnership.

We need to build on the gains that have been made through the Change Fund and ensure a clear role, and sufficient capacity, for the TSIs to provide the strategic interface into the third sector locally. There are arguments that the Change Fund was a small level of discretionary resource and that the sector lacks the accountability of its statutory partners to allow it to have the same level of influence in relation to the mainstream health and social care resource. There is no doubt however that a robust arrangement could be reached to enable the third sector to carry the strategic influence that will be vital to ensuring we do not continue to plan and invest only in existing services and models, despite our broad consensus that this is not effective or sustainable. If, as articulated by Christie, we are to rethink the relationship and power balance between state and society we need to improve our
recognition of the various assets brought to the table by each partner.

The ALLIANCE and partners support the following amendment on behalf of Nanette Milne which proposes that third sector organisations are invited to express views on draft strategic plans and that these would have to be taken into account. Whilst not as strong as the joint sign-off arrangements under Reshaping Care for Older People, it would help to embed the role of the third sector as a key strategic partner clearly on the face of the legislation.

**Amendment 117**

In section 27, page 18, line 23, at end insert <() groups appearing to the integration authority to be representative of non-commercial organisations contributing to the health and wellbeing of service-users in the area covered by the strategic plan.> (lodged by Nanette Milne MSP)

**Co-production**

“…SHC (Scottish Health Council) argued that the Bill did “not appear to go as far as suggested in the Scottish Government’s response to the 2012 consultation exercise, which had said: “It is therefore our intention … to legislate for a duty on Health and Social Care Partnerships to ‘engage with and involve’, rather than merely to ‘consult’ … representatives of patients, people who use services, and carers…”


The Bill as introduced referred to “consultation” throughout, despite the language of co-production being included throughout the Policy Memorandum. Whilst we welcome the change in title of the “consultation group” to the “strategic planning group” at Stage 2, the Bill must be strengthened so that people affected by the plans have a direct role in shaping them. There is a growing bank of evidence that co-production:

- Produces better outcomes
- Maximises the assets and contribution of individuals, communities and the third sector alongside statutory services
- Helps drive preventative approaches

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6 [http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/her-13-11w.pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/Reports/her-13-11w.pdf)

7 Examples include: Evidence cited in ‘Co-production of Health and Wellbeing in Scotland’ (Joint Improvement Team/Governance International 2013) and RCOP case studies, The Business Case for People Powered Health, NESTA (April 2013) which suggests savings of around 7% of the commissioning budget through co-production in health, Evaluation of Year 1 of Reducing Reoffending Change Fund which found co-production was one of the most valuable elements of the Public Social Partnerships (Scottish Government, 2013), Carnegie UK Trust’s Enabling State evidence review expected in 2013(led by Sir John Elvidge)
• Enables solutions to be found that are sustainable in the face of economic constraints (by making best use of financial and statutory and non-financial and non-statutory resources and preventing waste associated with poor commissioning processes)

Co-production is also fundamental to a human rights based approach, a key aspect of which is people’s right to participate in decisions that affect their lives.

“When the first proposals on integration came out, we held quite a lot of consultation with carers. They felt that, for integration to be successful, it was absolutely essential to have not just carer engagement but meaningful carer engagement, and a move beyond involvement towards co-production.”

Claire Cairns, Coalition of Carers in Scotland, Scottish Parliament, Health and Sport Committee evidence session, 24 September 2014

“Many disabled people’s organisations are operating at below a critical mass. We are saying that we really need to be engaged, and disabled people are innovative because they have to be. When I get out of bed in the morning, I need to think of solutions to a lot of problems. Health boards, local authorities and others in our society could draw on that. However, that needs to be resourced and supported, and many disabled people’s organisations are struggling with that.”

Pam Duncan, Independent Living in Scotland project, Scottish Parliament, Health and Sport Committee evidence session, 24 September 2014

The principle of co-production should be embedded throughout the legislation, reflecting Scottish Government Minister’s frequent assertion that public services must move beyond consultation.

Amendment 116

In section 26, page 16, line 40, at end insert <( ) at least one person who the integration authority considers to be representative of service-users in the area to which the strategic plan relates, ( ) at least one person who the integration authority considers to be representative of carers in the area to which the strategic plan relates,>

(lodged by Rhoda Grant MSP)

Co-production with people who use health and social care support and services and unpaid carers remains an issue of significant concern and must be viewed as distinct from involvement of the third sector. The ALLIANCE will be seeking clear

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requirements in statutory guidance/secondary legislation for Health and Social Care Partnerships to engage directly with service users and unpaid carers.

For an example of co-production in practice see Appendix 4: Barbara’s story.

Advocacy

Independent advocacy helps people to express their own needs and make informed decisions. Independent advocates support people to gain access to information and explore and understand their options. They speak on behalf of people who are unable to speak for themselves, or choose not to do so. They safeguard people who are vulnerable or discriminated against or whom services find it difficult to support. They also safeguard the rights of people who lack capacity.

Ensuring that independent advocacy is included – for those who choose to access it – would support the aims and the principles of the Bill and help ensure the voice of individuals and communities are at the heart of planning, design, delivery and review.

The ALLIANCE supports proposed amendments to the principles that will ensure consideration is given to support through access to independent advocacy.

Amendment 102

In section 4, page 4, line 7, at end insert <, including the need for access to independent advocacy services> (lodged by Nanette Milne MSP)

Amendment 110

In section 25, page 16, line 9, at end insert <, including the need for access to independent advocacy services> (lodged by Nanette Milne MSP)

Complaints

Complaints represent one of the ways in which people engage at an individual level with services, have their voice heard and access their rights. Everyone who makes a complaint about health and social care support and services in Scotland has the right to be listened to and have their concerns resolved as quickly and efficiently as possible. Complaints handling and encouragement of patient feedback in healthcare
were key to the Patient Rights (Scotland) Act 2011\(^\text{10}\) and social work departments are subject to legislative guidance and directions on the complaints procedures\(^\text{11}\).

Most health boards and local authorities have developed accessible and clear complaints processes over a number of years to value the input of people who use support and services and ensure quality service provision that meets their needs. Listening and learning from complaints can highlight where support or services need to be changed.

If integration is to produce seamless services from the perspective of people using them, Health and Social Care Partnerships must be required to provide a clear, single route into complaints processes. Accessible and clear complaints processes are one facet of ensuring the needs and experience of people who use services can be listened to, learned from and help to drive improvement. Complaints processes are also a key accountability mechanism to enable people to access their rights in relation to health and social care.

Complaints handling arrangements have the potential to be further complicated through integration, however, the Bill makes no reference to the complaints process. During Stage 2, the Cabinet Secretary for Health and Wellbeing, Alex Neil MSP, said that a new social work complaints system is under development that will be “more accessible, allow complaints to be completed far faster and produce a co-ordinated response for the complainant.” We still believe, however, that the Bill would be strengthened through amendment at Stage 3 to include reference to **ensuring effective access to complaints** and support the following amendment.

### Amendment 95

**In section 1, page 1, line 26, at end insert** *( ) arrangements for a single point of entry to complaints system for all services provided in pursuance of functions delegated under paragraph (b) or (c).*

*(lodged by Nanette Milne MSP)*


Additional Issues

- The Scottish Government has indicated that the terms ‘independent living’ and ‘co-production’ are not subject to the necessary degree of common definition or interpretation for legal use, and therefore cannot be used on the face of the Bill. The ALLIANCE still questions this, particularly in relation to ‘independent living’ which is defined within the United Nations Convention on the Rights of Persons with Disabilities. It will be essential that both concepts will feature strongly and explicitly throughout statutory guidance (and secondary legislation where appropriate).

- **Definition of social care**
  In any work to define social care functions in relation to the bill care will need to be taken to agree a definition that is not at odds with the drive for health and social care to encompass a far broader landscape of support, including preventative and non-statutory activity.

For further information

- Health and Social Care: Integration or Transformation?
- Being Human: A Human Rights Based Approach to Health and Social Care in Scotland

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Appendix 1 – Case study: Care About Rights – a human rights based approach to health and social care

Care about Rights is a training and awareness raising resource relating to the care and support of older people developed by the Scottish Human Rights Commission. Care about Rights explains the benefits of applying human rights principles to everyday situations.

The training is designed to increase awareness and knowledge of human rights issues, and give practical advice about how to apply human rights principles in the delivery of care. The approach assists social care workers to involve service users, their families or their advocates in decision-making and deliver more personalised services, thus helping to shift the balance of power relationships between providers and users.

The Care about Rights resources look at:

- What human rights are and how they are applicable in care settings;
- The relationship between human rights and other legislation and standards;
- How human rights can help to balance risks and rights in decision making;
- How human rights can support the delivery of person centred care;
- How human rights can help resolve conflict and improve communication with people using services, their families and others.

Around 1,000 care staff and managers have taken part in training for Care about Rights since September 2010, as well as around 80 older people and older people’s advocates across Scotland.

More than half of care staff respondents to the follow up survey on Care about Rights felt that it was helping them to deliver better person centred care, whilst also helping older people and their representatives to articulate concerns and provide a framework for change. Care plans had been enhanced, even if the agreed approach did not change significantly, and the satisfaction of both care users and the workforce increased. The evaluation included a recommendation that using person centred, human rights based approaches becomes a core competence for the care workforce.

http://www.scottishhumanrights.com/careaboutrights
Appendix 2: Learning from the Experience of Implementing Reshaping Care for Older People (RCOP) To Date

The ALLIANCE lead the Change Fund: Enhancing the Role of the Third Sector Programme, commissioned by the Scottish Government to enhance the third sector's ability to contribute to RCOP. An important element of the programme is gathering and disseminating information about how RCOP implementation is progressing across Scotland and the overarching and underlying factors that are influencing the manner and quality of the sector's engagement in this. The programme has just completed its second detailed scoping exercise, conducted September 2013 to January 2014. This appendix captures the main findings and insights that have relevance to the current debate:

**Involvement in Strategic Thinking and Decision Making**

**The Outcomes of Fuller Involvement**

- There is general consensus that RCOP has been a catalyst for meaningful change in the way public sector services are designed and delivered, and has facilitated greater third sector involvement in this.

**The Challenges of Not Having a Prescribed 'Seat at the Table'**

**The Third Sector**

- The involvement of the third sector is understood by all to be a 'work in progress'. The relationships developed to date have taken commitment from all partners and have required a significant investment of time and resources.

- In some areas the relationships were only initiated because there was a requirement for the third sector to sign off the local Change Plan. In a couple of these areas this also took more than a year to initiate, despite the requirement in the Change Plan guidance.

- Although progress is now being made across Scotland, there is a significant difference in the quality of the relationships. Several remain fragile and the majority have still not reached the level of maturity required to enable the full and open exploration of difficult issues.

- The partnerships who evidence more mature relationships also evidence different patterns of investment that are more aligned with longer term outcomes and the prevention agenda.
The vast majority of TSIs report that their statutory sector partners are evidencing a much stronger understanding of the sector and its capabilities as a result of the way RCOP implementation has progressed.

**Older People and Carers**

- Although improving outcomes for older people and their carers sits at the core of the RCOP agenda, many RCOP Strategic Partnerships do not have robust mechanisms for ensuring that older people and their carers are directly involved in setting the strategic direction or shaping implementation.

- The Partnerships who have decided to embed representation in their processes, and/or have evolved more holistic engagement processes, evidence more sophisticated relationships and decision-making processes. They also evidence different patterns of investment that are more aligned with longer term outcomes and the prevention agenda.

This evidences that the full involvement of the third sector, people who use services and their carers is essential but that it will not happen universally unless it is prescribed. Furthermore, in some areas, changing the current arrangements could reverse or erode the progress made to date.

**Joint Strategic Commissioning and Investment Decisions**

- Although RCOP has a focus on improved outcomes of older people and their carers, the indicators for evaluating progress are more aligned with traditional service provision, and operate in an environment dominated by a focus on HEAT targets. As a result much Change Fund investment has been targeted at activities that are seen to have a direct impact on reducing the number of bed days used by people over the age of 75 years.

- The third sector interfaces (TSIs) represent the sector on RCOP Partnerships. TSIs are generalists, rather than health and social care specialists, and their feedback indicates that this enables them to offer a different perspective to Partnerships. As well as advocating for the interests of the sector they are able to offer a different, and often new, perspective on issues and many act as a ‘critical friend’ for their statutory sector partners. Their role and focus also enables them to make links and connections between RCOP activity and the local implementation of wider national policies whilst simultaneously keeping the thinking grounded in what matters for the individuals and communities that the RCOP Partnerships serve.

- Although all would agree that it remains a ‘work in progress’, many TSIs argue that their generalist perspective has played a critical role in beginning to
shifting the thinking in Partnerships beyond HEAT targets and traditional service delivery models. The link between the maturity of the relationships and the different levels of progress made in this regard would support this argument.

- The sector is viewed as having significant expertise in community capacity building and as a result leads this strand of work in many areas. Although the investment in this type of activity has been small (in financial terms) it has generated a number of projects and initiatives that all partners agree make a significant contribution to the RCOP agenda.

- In the vast majority of Partnership areas these projects and initiatives are seen as short term investments to demonstrate the potential contribution of this type of activity rather than an exploration of whether they form an integral part of any new service landscape. This means that this type of upstream prevention activity remains peripheral to Joint Strategic Commissioning (JSC) process.

- The third sector interfaces (TSIs) actively work with projects and initiatives to generate external income streams to resource their continued contribution. Several also see the strategic levering of additional external income streams as one of their primary functions in relation to JSC, and one that will develop more fully as partnerships continue to mature.

- Change Fund investment has also been targeted at improving the information available to inform decision making. Although much of this has been targeted at improving statutory sector data, there has also been investment in the sector mapping its activity in local areas. In the main this has provided significantly more than basic hard data about the current context and as a result has provided Partnerships with information about how things may evolve, informing their market facilitation strategies.

- The vast majority of the 'demonstrator' projects and initiatives proposed by third sector organisations were either developed from information provided by older people, carers and the wider community or were co-designed with them. There are many examples of this process generating significant volumes of rich qualitative data that could be used to inform JSC more widely. Particularly given that several organisations were able to gather this information from and / or engage with individuals and groups that statutory services find it difficult to reach.
A shift in investment patterns towards anticipatory care and upstream prevention activity are key requirements of the RCOP programme. However, Audit Scotland\textsuperscript{12} report that to date Change Fund investment has not generated this. Our evidence would suggest that although this is the case, some of the key elements of the environment that enables this are beginning to embed and have the potential to bear fruit in time. Furthermore, the evidence also suggests that the involvement of the third sector at the core of the JSC process may have a significant contribution to make in relation to addressing health inequalities because of the sector's ability to reach out and engage marginalised groups.

\textsuperscript{12} Audit Scotland (2014) Reshaping Care for Older People. \url{http://www.audit-scotland.gov.uk/docs/central/2014/nr_140206_reshaping_care.pdf}
Perth and Kinross Older People’s Partnership has played a key role in enhancing partnership working at all levels across sectors. Three Community Engagement posts have been created through the Change Fund and are jointly managed by the local authority and the local Third Sector Interface (TSI). Through a process of engagement and capacity-building, the posts aim to foster co-production and promote the independence and wellbeing of older people within communities. Joint planning days with peers in health and local authority are leading to closer partnership working on the ground in relation to shared agendas and community engagement opportunities.

The co-location of teams from Health, Local Authority and Third Sector within localities has placed a greater emphasis on the importance of achieving the culture change. The Change Fund and Joint Commissioning Strategy have set the foundations for the Third Sector to play a role in commissioning decisions. The local TSI is working with partners to consider valuable data held within the Third Sector relating to investment, service consumption and community assets to help enhance the ‘place and prevention’.
Appendix 4: Barbara’s story – Personal outcomes approach used to enable an older person to live independently at home

Barbara’s story is told by the Levern Valley Older People’s Team

“Barbara collapsed on the stairs at Strathclyde University as a result of a brain haemorrhage. Due to the fall, she sustained a shattered skull and further bleeds to her brain. She was treated at the Southern General Hospital, then transferred to the Royal Alexandra Hospital. There was only basic information about Barbara at that time. In fact Barbara was a volunteer tour guide with Strathclyde University prior to her accident. She had a good network of friends and attended her local church on a weekly basis. She does not recall much about her personal circumstances as a result of her head injury.

Barbara ‘failed’ every aspect of her risk assessment except for moving and handling. This led to a referral to East Renfrewshire CHCP for assessment for long-term care. However by assessing her using a personal outcomes approach the team discovered what Barbara wanted. This was: being as independent as possible to live her life, to live in her own home, to feel safe in her home and in her community, to see her friends, to be well and to be fully occupied with her interests and hobbies. The team discovered this by listening to what she said and helping her express herself. That meant that she was responded to for the person she was and her confidence and skills improved.

Barbara was transferred to a care home for intermediate care and rehabilitation. She was then introduced back into her home and community in a phased approach with a process of continuous review.

Finally, Barbara achieved her personal outcomes. She went back to living in her own home - without services. She had control of her day to day and week to week finances while there was Guardianship for financial matters. Barbara worked with her computer and entertained her friends. She participated in the life of her church, did voluntary work with Accord Hospice and took up her interests and hobbies.

This was achieved by multi-disciplinary working; outcomes focused assessment, Mental Health Legislation used with the least restrictive option, Independent Advocacy, Care Planning, implementation and review. It was a team effort from: Barbara, the Social Work Assistant, the Occupational Therapist, the Physiotherapist, the Older People’s Team Assistant, the Speech and Language Therapist, the Community Psychiatric Nurse, the Consultant Psychiatrist, the Mental Health Officer, the Independent Advocate, The First Care Home and the Team Manager.”