Guidance on the Provision of equipment and adaptations

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Scottish Government
Riaghaltas na h-Alba

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Introduction

Health and Social Care Integration

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Joint Working Act) establishes the legal framework for integrating health and social care in Scotland. The Act requires each Health Board and Local Authority to delegate some of their statutory functions, and associated budgets, to their Integration Authority.

Regulations that underpin the Act set out which health and social care functions must be delegated. The provision of equipment and adaptations are functions which **must be delegated** to the Integration Authority.

Power of Ministers to Issue Direction and Guidance

Under the Joint Working Act Ministers have the power to issue Directions and Guidance to Health Boards, local authorities and Integration Authorities in relation to carrying out their functions.

This guidance is issued as statutory guidance under the terms of Section 53 of the Joint Working Act, and as such Health Boards, local authorities and Integration Authorities must have regard to the advice provided.

Purpose of the Guidance

This guidance covers the responsibilities of NHS Scotland and Local Authorities, Integration Authorities, and their Housing and Education partners for the provision of equipment and adaptations, and replaces all previous guidance on this issue. This updated guidance is issued with immediate effect.

The guidance outlines the responsibilities of all relevant agencies, with the aim of supporting partnerships, across Scotland, to deliver a more equitable and accessible approach to the provision of equipment and adaptations.

The overall aims of the guidance are to:

- Remove barriers in the systems promoting seamless pathways which are consistent and equitable across the country;
- Ensure services evidence that the service user, and unpaid carer (and family members providing support and care, but who may not identify as a carer), are at the centre of provision.
- Enable choice and control for service users and unpaid carers as partners in the process of assessment and support planning.
- Focus service provision on supporting the achievement of successful outcomes for the individual, and where relevant, their unpaid carer.

- Endorse a consistent approach to the assessment for, and provision of, equipment and adaptations, which promotes prevention and early intervention, and supports self-management.
- Ensure that service users and unpaid carers have access to up to date and relevant information on equipment and adaptations.
- Promote good practice and effective partnership working in relation to equipment and adaptation provision.

Background

Equipment and adaptations are an essential component of an integrated health & social care service. Timely provision of these often simple solutions, enable people affected by disabilities and health conditions to achieve their individual outcomes, living in their own home, or a homely setting, for as long as possible. This enables them to participate fully in daily life and achieve the quality of life they wish, as well as being a cost effective model of intervention.

Scotland's population is ageing. The number of people aged 75 and over is set to increase by 85% by 2039. It means that, by then, over 800,000 people will be over the age of 75. This has implications for the services we deliver. More people are also living longer with complex conditions, from childhood into adulthood. However, there are also people living with incurable conditions for whom urgent and proactive actions are required. Our services need to support these varying needs in a seamless way.

Supporting as many people as possible to continue to live well in their own home, also crucially depends on effective strategic & operational joint working with housing partners, to help with the better planning, and delivery of barrier free housing solutions.

The provision of equipment and adaptations, including the opportunities provided by innovative technology, should be an integral part of mainstream housing, health & social care assessment and service provision.

Where this is not already in place, it can result in a breakdown of care, especially during periods of transitions across a wide range of our service settings e.g. from child to adult services, community to prison settings and vice versa, and between hospital and community settings, and with the changes and progression of health conditions.

It is therefore critical that effective policy, systems, processes, resources and infrastructure, are in place to ensure the seamless provision of equipment and adaptation solutions.

Since the publication of the previous guidance in 2009, service models have evolved, particularly in relation to the integration of health & social care, and also with improved alignment with housing. It is however acknowledged that there is still

considerable work to do in terms of streamlining the pathways for provision of equipment & adaptations, and ensuring the best fit possible with new models of health & social care, and the effective interface with other relevant partners including, housing, education, and prisons.

This guidance recognises the need for more extensive service improvement, which is consistent with the intent and aspirations of the recent review of adult social care, The Independent Review of Adult Social Care, and subsequent proposals for a wider inter-agency, national care service.

- The sections in this guidance therefore highlight the need to support more fundamental change, and particularly address issues with equity of access, and the need to remove barriers which prevent responsive service provision, and the ability to help people to self-manage and make their own choices.
- The guidance also references the need to address inconsistencies in funding arrangements which create barriers in the service pathways, and ensure that community equipment and adaptation services are fully resourced, to be as effective as possible.
- The consistent themes throughout this document, focus on ensuring that prevention and early intervention are the objectives which dictate the way our services are developed and delivered, and help minimise, where ever possible, the need for reactive, and crisis intervention.

Key Actions are identified for each section in the guidance, with the expectation that all partnerships will review these by using the new self-assessment Equipment & Adaptations Baseline Assessment Tool which has been developed to help partnerships evaluate their performance in relation to the updated national guidance, and identify the actions required to address issues and improve their services.

Improvement work will also be supported by the revised '*Good practice guides'* for both community equipment, and adaptations which are relaunched as accompanying documents. These document can be found on the Scottish Government's blog page.

The aim is to provide a standardised approach for the effective provision of equipment & adaptations across Scotland, to help improve the consistency, quality, and equity of service.

A summary of the **Key Actions** can be found at the end of this document.

Defining equipment and adaptations

The timely provision of equipment and adaptations, supports the health, housing, social care and educational needs of a broad range of children and adults, and can help reduce risk, and support independence and control. They support those with short, and longer term needs, and assist those with physical, or learning disabilities, mental health needs including dementia, and individuals who require support with communication, including Alternative and Augmented Communication (AAC) users. Many older people do not see themselves as disabled, but may be frail, or have difficulty with everyday tasks, and also benefit from these services.

Equipment

Equipment can be defined as any item or product system, whether acquired commercially off the shelf, modified or customised that is used to increase the functional capabilities of individuals. Community equipment can include, but is not limited to:

- Equipment to support people with more significant health needs to be nursed or cared for, such as profiling electric community beds, pressure relief mattresses, and a range of moving and handling equipment.
- Equipment to support daily living tasks, or make caring for the individual safer and easier such as shower chairs and stools, bath lifts, raised toilet seats & frames, grab rails, and mobility aids.
- Technology enabled care products such as flood detectors, falls monitors, smoke detectors and movement sensors. These are often linked to a call centre, triggering a response when activated, and provided as part of a service.
- Children's equipment to support every day functions, including their education.
- Ancillary equipment for people with sensory impairments, such as flashing doorbells, low-vision optical aids, text-phones and assistive listening devices.
- Wheelchairs for short-term loans.
- Environmental control equipment.
- Communication aids (including AAC) – to assist children and adults who have difficulty with speech. Equipment includes aids to writing and reading as well as speech.

NOTE: It does not include any medical devices or anything that is invasive to the body (e.g. PEG feeding equipment).

Adaptations

The purpose of an adaptation is to modify an environment in order to restore or enable independent living, privacy, confidence and dignity for individuals and their families. As defined by The Public Bodies (Joint Working) (Scotland) Act 2014, the form of the adaptation can be wide ranging and is not restricted to defined types. Rather, the emphasis is on the intended goal, to maximise independence and ensure people of all ages are supported to live safely in their own home.

Adaptations can improve confidence, skills and mobility and reduce symptoms. They can form part of a range of options available to people experiencing a disabling environment. This could include, but is not limited to:

- Adaptations to a bathroom, e.g. replacing a bath with a walk in shower;
- Improvements to support access into, and around the home e.g. widening of a door frame to allow wheelchair access and external access improvements;
- Adaptations and equipment which provide safety features for people with autism, signage & tonal contrast for people living with dementia etc.;
- Fitting lower work surfaces in the kitchen;

Section One: Policy Overview

Core Values and Principles

People must be able to access support at the point they feel they need it, including for advice and signposting. Fair and consistent access to suitable assessments should be available on a non-discriminating, tenure neutral and human rights basis.

Assessment should be focused on individual outcomes and enablement, have service users and unpaid carers listened to, have a say, be respected and responded to, and be reliable. As stated in the Equality Act, there should be no discrimination on the grounds of:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex

Health boards and local authorities have responsibilities under equality legislation for ensuring that discrimination does not occur, and for promoting equity of opportunity. Equity recognises that each person has different circumstances and allocates the exact resource and opportunities needed to reach an equal outcome. The focus should be on proactively seeking to improve access and experience for all, but especially those at greatest risk of disadvantage and inequality.

People needing equipment and adaptations, and their unpaid carers and family, need to understand clearly their right to an assessment and the assessment process; what needs can be met by health and social care services, and other agencies such as Housing, Education, and Prisons, as well as any costs involved. They should receive advice and information to enable them to participate in informed decisions about the outcomes they wish to achieve. Any decisions made, and the reasons behind them, should be transparent from the outset for service users, unpaid carers, family, and staff.

The Carers (Scotland) Act 2016 puts in place a system of carers' rights designed to listen to carers; improve consistency of support; and prevent problems – helping sustain caring relationships and protect carers' health and wellbeing – set out in our Carers' Charter. This includes each carer's right to an Adult Carer Support Plan or Young Carer Statement (sections 2 and 3 of the Carers' charter) to identify what is important to them and their needs for support. Carers also have rights to have their views taken into account in assessing the needs of the person they care for (section 5c of the Carers' charter). Every area must also have a local carer strategy and carer information and advice service.

Although the term 'unpaid carer' is used throughout this document, as highlighted in Missing out: the identification challenge a report from Carers UK It is important to recognise that not everyone will identify as an unpaid carer.

Some may prefer to identify as family members or friends and may choose to reject the label of unpaid carer. As one carer shared, ‘I am his wife, I cannot stand being called his carer’.

When assessing for equipment and adaptations, there should be clear evidence that outcomes for the service user, and also the unpaid carer have been addressed in the care plan, and an updated adult carer support plan (or young carer statement). This also applies to the transition from children services to adult services.

There should be no discrimination in the provision of equipment and adaptations based on where a person lives, this is of particular importance for people living in care homes.

Statutory Responsibilities & Policy Context

NHS and local authority

The National Health Service (Scotland) Act 1978 places a duty on Health Boards to:

- Promote a comprehensive and integrated health service designed to secure improvement in the physical and mental health of the people of Scotland, and the prevention, diagnosis and treatment of illness
- To provide medical, nursing and other services, whether accommodation or premises, in the home of the patient or elsewhere (e.g. a care home)
- To meet all reasonable requirements, for the purposes of the prevention of illness, the care of persons suffering from illness or the after-care of such persons.

Section 12 of the Social Work (Scotland) Act 1968 places a duty on local authorities to promote social welfare by making available appropriate advice, guidance and assistance, and such facilities as they may consider suitable and adequate to anyone over 18 who need assistance.

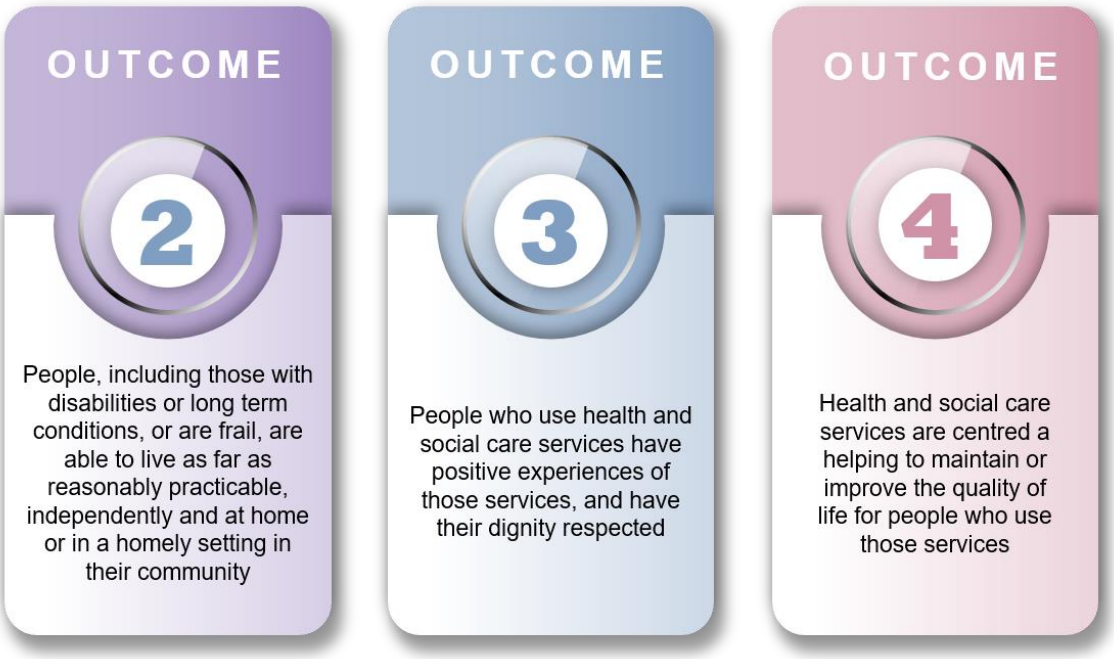
Section 12a of the 1968 Act places a duty on local authorities to carry out an assessment of need for anyone they are under a duty to provide care or assistance to, and decide whether those needs call for the provision of any service.

Section 2(1) of the Chronically Sick and Disabled Persons Act 1970, as enacted by the Chronically Sick And Disabled Persons (Scotland) Act 1972 places a duty on local authorities to provide assistance in arranging adaptations or the provision of any additional facilities designed to secure greater safety, comfort or convenience.

Health & Social Care Integration

The Public Bodies (Joint Working) (Scotland) Act 2014 established the legal framework for the integration of health and social care in Scotland. It requires each health board and local authority to delegate some of their statutory functions, and associated budgets, to their Integration Authority (IA). The IA is responsible for the planning and delivery of the related services using the entire delegated budget.

The Act also introduced the National Health and Wellbeing Outcomes that apply equally across health and social care services in Scotland. These outcomes aim to enable service users and unpaid carers to have a clear understanding of what they can expect in terms of improvements in their health and wellbeing.



Successful integration of health and social care services should provide for more people to be cared for and supported at home or in a homely setting. This outcome aims to ensure delivery of community based services, with a focus on **prevention and anticipatory care,** to mitigate against inappropriate admissions to hospital or long term care settings. It recognises that independent living is key to improving health and mental wellbeing.

Delegated Functions

The 2014 Act provides the statutory framework for driving forward these changes and is supported by regulations and statutory guidance, including an Adaptations, aids and equipment advice note that prescribes the housing-related functions that must and may be delegated by a Local Authority.

The guidance defines equipment (aid) and adaptations as:

> Any alteration or addition to the structure, access, layout or fixtures of accommodation, and any equipment or fittings installed or provided for use in accommodation, for the purpose of allowing a person to occupy, or continue to occupy, the accommodation as their sole or main residence.

The guidance also states that:

> Where equipment and adaptations are provided, these services, along with the resources which fund this support must be included in the integration arrangements.

The Rehabilitation Framework

The impact of Covid-19 has sharply brought into focus the importance of the availability of comprehensive, multi-agency, and multi-disciplinary rehabilitation pathways, and the negative effect on our population, when this is not available. The Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic, which was launched in August 2020, has been developed to mobilise our services and provide a strategic framework for the provision of rehabilitation in response to the impact of the virus.

> By the end of 2025 all adults who require rehabilitation will have timely access to the right information and services in the right place to support them to participate as actively as possible and enjoy the life they choose
>
> **The Rehabilitation Framework**

The Framework recognises that people in our communities have been adversely affected, both by more limited access to existing rehabilitation services as a result of the lockdown, as well as experiencing significant physical and psychological effects following direct exposure to the virus.

The timely provision of appropriate equipment and adaptations, easily accessible by all relevant services, will be crucial in supporting effective interventions. The Framework also highlights the importance of early intervention, prevention, and self-management and the need to help people to support themselves.

National Care Service

The Independent Review of Adult Social Care was initiated by Scottish Government in Sept 2020 and reported with a wide range of recommendations, in February 2021. The report highlights the requirement for new thinking in the provision of social care with emphasis on preventative and anticipatory approaches, and "a vehicle for supporting independent living".

> If our aim, as so often stated in Scotland, is to emphasise supporting people to stay in their own homes and communities for as long as possible, we must do more to improve and adapt those homes to support a better quality of life.
>
> **The Independent Review of Adult Social Care**

The report of the Independent Review of Adult Social Care raises expectations in terms of improving the provision of equipment, adaptations, and technology, in a range of community and institutional settings, with greater clarity called for on the responsibilities for the funding and delivery of these solutions.

Following these recommendations and a National Care Service consultation, the National Care Service (Scotland) Bill was introduced to Parliament on 20 June 2022.

The Scottish Government has committed to establishing a functioning National Care Service by the end of this parliamentary term in 2026. The National Care Service will have equality, dignity and human rights at its heart. It will empower people to make the choices that are right for them. You can read about the vision for a National Care Service in the National Care Service: Statement of Benefits

Health and Social Care Standards

The Health and Social Care Standards: My support, my life set out what people should expect when using health and social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights are upheld.

There are five headline outcomes:

1. I experience high quality care and support that is right for me.
2. I am fully involved in all decisions about my care and support.
3. I have confidence in the people who support and care for me.
4. I have confidence in the organisation providing my care and support.
5. I experience a high quality environment if the organisation provides the premises.

Within these headline outcomes the following standards are relevant in terms of individuals human rights:

1.1 I am accepted and valued whatever my needs, ability, gender, age, faith, mental health status, race, background or sexual orientation.

1.2 My human rights are protected and promoted and I experience no discrimination.

1.37 My meals and snacks meet my cultural and dietary needs, beliefs and preferences.

2.3 I am supported to understand and uphold my rights.

4.1 My human rights are central to the organisations that support and care for me.

4.4 I receive an apology if things go wrong with my care and support or my human rights are not respected, and the organisation takes responsibility for its actions.

National Carers Strategy

The National Carers Strategy was published in December 2022. The Strategy recognises the diverse experiences of carers and sets out a range of actions to ensure they are supported fully in a joined up and cohesive way. It brings together existing initiatives and new approaches, and proposes new and better ways to

support carers. It seeks to reflect both the diversity of careers' experiences and their lives beyond caring to avoid pigeonholing people as carers and nothing else.

The key themes of the strategy intend to put the individual carer at the centre and focus on five different aspects of unpaid carer support:

- Living with COVID-19
- Recognising, valuing and involving carers
- Health and social care support
- Social and financial inclusion
- Young carers

Children and Education

Section 2 of the Chronically Sick and Disabled Persons Act 1970 is effective in Scotland through the Chronically Sick and Disabled Persons (Scotland) Act 1972. It applies to any disabled child to whom section 2 of the Children (Scotland) Act 1995 applies.

Sections 22 and 29 of the Children (Scotland) Act 1995 also place a duty on local authorities to provide services that promote and safeguard the welfare of children.

The Education (Additional Support for Learning) (Scotland) Act 2004 introduced a single structure for meeting the needs of children who require additional support to ensure they can make the most of their education. This ensures that education authorities identify, provide for and review the short or long term additional support needs of their pupils, as a result of the learning environment, family circumstances, health, wellbeing needs or a disability.

This was amended by The Education (Additional Support for Learning) (Scotland) Act 2009 and the subsequent Additional Support for Learning: Statutory Guidance 2017.

Education authorities have duties under the Equality Act 2010 to actively address inequality, prevent disability related discrimination and make reasonable adjustments for disabled pupils.

Under the Education (Disability Strategies and Pupils' Educational Records) (Scotland) Act 2002 education authorities also have duties to develop and publish accessibility strategies to increase pupils access to the curriculum, access to the physical environment of schools and improving communication with pupils with disabilities.

Getting it right for every child (GIRFEC) is the national approach in Scotland to improving outcomes and supporting the wellbeing of our children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them. The first version of the policy was published in 2008 detailing the practice model. The principles of the approach were then brought into law in the Children and Young People (Scotland) Act 2014. The aim of the Act is to put children and young people

at the heart of planning and delivery of services, and ensuring their rights are respected across the public sector.

The **United Nations Convention on the Rights of the Child** (UNCRC) includes 54 articles that cover all aspects of a child life, from birth to 18 years, and sets out the rights they are entitled to.

Article 23 states that:

> A child with a disability has the right to live a full and decent life with dignity and, as far as possible, independence and to play an active part in the community. Governments must do all they can to support disabled children and their families.

In addition, Article 12, states that:

> Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously.

The Children and Young People (Scotland) Act 2014, the principles of GIRFEC, and the UNCRC, all underpin the development of 'Ready to Act' which is the first Children and Young People's (CYP's) services plan in Scotland to focus on the support provided specifically by Allies Health Professionals (AHPs).

The main aim is to work collaboratively and in partnership with children and young people, parents, carers, families, stakeholders and communities to understand what is needed to improve well-being outcomes.

Adaptations & Home owners

Local authorities currently have powers and duties under the Housing (Scotland) Act 2006 to assist home owners in certain circumstances, including assistance to adapt the home for a disabled person.

This updates previous arrangements under the Housing (Scotland) Act 1987, and includes a system of financial assistance with a wider range of structural adaptations attracting a mandatory grant of at least 80% of the cost of the work, and 100% for those applicants in receipt of certain income replacement benefits. The Scottish Government provided guidance on this in the Implementing the Housing (Scotland) Act 2006, Parts 1 and 2: Statutory Guidance for Local Authorities: Volume 6 Work to Meet the Needs of Disabled People.

Contribution of Equipment & Adaptations

For people in our communities

Equipment and adaptations, need to meet the needs of people of all ages and disabilities, and respond appropriately when these needs change. Adults and children, affected by illness and frailty, can significantly benefit from equipment and adaptations, enabling them to lead independent lives and achieve their desired outcomes. For many people, particularly those affected by progressively disabling conditions, equipment and adaptations are vital to allowing people to remain at home, and to live life with dignity and care.

The provision of equipment and adaptations can reduce risk and injury, help with people's confidence and their mental well-being, and may prevent unnecessary admission to hospital or care settings. In terms of those within prison settings, over recent years there has been an increase in the complexity of needs, and it is recognised that these solutions are vital to support people to maintain or maximise their functional ability.

Children and students affected by disability, may need a variety of equipment and adaptations at home, school, college and university such as special seating, SleepSystems, mobility equipment, augmented communication equipment, and/or adaptations to the environment etc. Delays in the assessment of need, and the delivery of services may impede access to education, learning and the child's development; and may even cause greater dependency.

For people living with progressive terminal conditions, future needs should be planned for, by working closely with the individual, and specialist nurses and occupational therapists, to ensure that equipment and adaptations are provided in time. In these instances the prompt uplift of any equipment no longer required is also essential, to reduce stress on bereaved families.

Appropriate equipment provision is also vital to those who provide care, whether family members or care staff, enabling them to work safely and effectively. Equipment and adaptations are essential to avoiding dangerous practices in terms of moving and handling. The range of equipment provided should be tailored to help the individual achieve their desired outcomes, and support them in a way that fits in with their chosen lifestyle.

Furthermore, the ability to communicate effectively is a fundamental human right. It is therefore vital that individuals with communication needs are provided with, and trained in the use of, appropriate communication equipment (e.g. Alternative and Augmented Communication equipment (AAC)).

The examples below are taken from a Service user Outcomes survey conducted by one of the community equipment partnership services in Scotland, and these comments evidence the impact simple equipment can make for people's overall mental well-being, and not just their physical health:

> The shower chair improved her life so much she is going out more it's crazy to think that a small chair can make so much difference we live close to a supermarket and she'll go to the shops now.
>
> She probably didn't feel dressed or clean before. She was like a prisoner in her own home. She's so much more confident

> Just out of hospital having taken a stroke. I use the walking aid to get out the Zimmer was a godsend for the house and I now use the trolley to carry the injections, medicines and for my makeup in case Mr. Right comes to the door!

> I'm 81 years of age. The equipment for the shower and the rail at the back door is fantastic. When I came out of hospital my leg was weak and I was walking badly. The equipment has helped me so I'm happy as Larry to get back into the greenhouse and look after my tomatoes.

Equipment Service User Feedback

For our services

The timely provision of Community equipment and adaptations, is a cost-effective solution which can contribute significantly to the streamlining of service responses and pathways, and support wider agendas including, hospital discharge and avoidance of admission, prevention and early intervention, frailty pathways, Anticipatory Care Planning, Mental Health & Dementia, child development, and the management of long-term conditions, including end of life care.

These interventions can allow people to do more for themselves and avoid the need for additional, more expensive, input from other services, and compliments rehabilitation intervention, for people of all ages.

A recent report from the Foundations Independent Living Trust on The Social Value of Aids and Adaptations Provided by Home Improvement Agencies, utilises blended, anonymised case studies, to illustrate significant cost benefits from early interventions and the provision of often very simple adaptations.

The Outcomes of adaptations sections of the Evidence review of home adaptations in the UK and other OECD countries, from the University of Stirling in partnership with the UK Collaborative Centre for Housing Evidence (CaCHE), details the economic benefits of adaptation provision, reviewing sources from across the world, to confirm evidence of reduction in home falls, reduction in the need for care provision (predominately informal), and reduced Care Home admissions.

One large store service in Scotland estimated that approximately 80% of equipment provided by community based occupational therapists is under the value of £50, equating to approximately 20% of overall equipment expenditure. This is because

low cost equipment (procured effectively at competitive rates and/or recycled at very low cost) is often the main solution for people whose needs require to be addressed urgently within the community.

Equipment is prioritised in terms of the need it meets, rather than its cost value, therefore the low value of equipment is not reflective of the type of need it is being provided to address. Often this type of equipment supports the ability to quickly deal with crisis and at key stages in vulnerable people's life's e.g. prevention of falls, avoiding admission to Care Homes and hospital, supporting hospital discharge, maintaining people of all ages to live in the community.

These lower cost equipment solutions mainly support emergency needs such as toileting, safe transfers to prevent falls, and are provided to address critical and substantial needs.

Good Practice Example

One community equipment service has been able to evidence in 2020/21, that it provided 918 deliveries of equipment to people in their communities, which directly helped avoid an admission to hospital.

- When Integration Authorities, and other relevant partners e.g. Housing and Education, are reviewing their service provision, they need to recognise the value effective and efficient community equipment and adaptations provision makes to the delivery of key service goals. Any proposed policy changes need to have scoped, and fully considered the implications of stopping or inhibiting the provision of equipment, and its wider impact on meeting wider strategic service objectives.
- Equipment and adaptation services need to be fully resourced in a way that is effectively integrated, and does not create barriers and blockages by having different funding arrangements e.g. for different types of equipment by profession or agency.

In general terms, the main cost pressures on community equipment and adaptations budgets come from more complex needs, however the benefits of this provision are also substantial. Hospital and community-based services rely on the timely provision of beds, and moving & handling equipment, and also adaptations including bannisters, showers, and stairlifts, to support people who have increased frailty, often to support hospital discharge, but also to maintain people safely in the community.

Over recent years there has been a steady increase in the number of frail adults and those with long term conditions, being cared for in the home environment, and bariatric needs have also increased. Children with complex needs are also being successfully supported to live longer at home.

- Addressing these more complex needs with equipment and adaptation solutions, remains the most cost-effective way for health and social care services to support people in our communities. For example, standard specialist seating and postural care solutions can greatly assist both adults and children with complex needs to be more independent, address their health needs, and engage in social activities, education and work, avoiding dependency and the need for additional care. Many community equipment store services have standardised the provision of these categories of more expensive equipment and, as a result, recognised the benefits of **procurement** savings, significant **recycling** efficiencies, as well as ensuring that they are delivering effective person-centred outcomes for service users in line with strategic service objectives.

Good Practice Example

The EquipU community equipment Partnership has employed a paediatric occupational therapy technician to help support the more specialised recycling and refurbishment of all children's equipment provided for home use, and school. The cost benefits of this post are evidenced by increased volumes and values of both Core and non-stock recycled equipment, averaging savings of £300,000 per year (20/21). Equally important, the pathways have been improved, allowing quicker provision to the child, access to more recycled equipment, and improving the quality of the available products, with all options available for selection via the online ordering system.

Key Actions

- Integration Authorities (IAs) should work with relevant partners to capture data which evidences the value, effective and efficient community equipment and adaptation provision makes to the delivery of key service goals.
- IAs require to ensure they are resourcing their community equipment and adaptations services to be as effective as possible in providing responsive, outcome focused services, with fully integrated funding streams.
- Any proposed policy changes related to the provision of equipment and adaptations need to be scoped and reviewed to identify any potential implications of stopping or inhibiting the provision of equipment, and its impact on meeting wider strategic service objectives across health & social care, and other relevant partners e.g Housing.
- IAs require to ensure they have reviewed their pathways and access to equipment and adaptations, as part of delivering the aims of the Rehabilitation strategic framework.
- In terms of children's needs, Health and Social Care, Housing, and Education services, require to ensure that they are compliant with the relevant legislation, and the principles and values of wellbeing, early intervention, and child-centred practice are evidenced in all aspects of equipment and adaptations service provision.

Section Two: Equipment & Adaptations Service Delivery

Assessment & provision

Assessment pathways

To enable the delivery of person centred, outcomes focused, and streamlined service provision for all ages, it is essential that the governance, and delivery of equipment, and adaptations (for children and adults), are effectively incorporated into the integrated arrangements for IAs, and their relevant partners, including Housing, Education, and Prisons.

In the context of the National Health & Wellbeing Outcomes, services should be able to evidence that the operational arrangements reflect a focus on prevention and anticipatory care**,** avoiding inappropriate admissions to hospital or long term care settings, and promoting independent living and self-management, as key to improving health and wellbeing.

It is important that clear links are established between health & social care, education (both school and post school), and housing partners, to develop and embed these principles within their service pathways. Links also need to be established with external providers of care services, such as housing and support providers, the residential childcare sector, care home sector, the care at home and housing support sectors, and the third and independent sectors.

Assessment Principles

Good assessment practice is fundamental to the provision of effective equipment and adaptations services. This should be in the context of promoting independence, and should balance risk with the need to maximise functional potential and avoid over-prescription.

Equipment and adaptations can support a range of needs and complement interventions including rehabilitation and the management of conditions, and should be viewed as integral to the delivery of wider service objectives.

- Service users and their carers require to be fully involved in all aspects of the assessment process and it is essential that there is a person-centred, personal outcomes focus.
- Early intervention and prevention must be the key focus to avoid the need for crisis response at a later date. This is particularly important for those with long-term and progressive conditions.
- Engagement should be on the basis of ‘good conversations’, with the assessor utilising the skills needed for anticipatory care planning discussions, with clear goals identified, agreed, and recorded, and the provision of the equipment and adaptation solutions, understood as a ‘means to an end’, rather than being ‘an end in itself’.
- The principal of ‘minimum intervention, in order to help people achieve, where ever possible, maximum independence’, should underpin the assessment, and alternative methods of managing, been fully explored.

- Positive risk-taking must be embraced and engaged with to allow assessors to support individuals to achieve their full potential. The RCOT publication Embracing Risk, Enabling Choice supports this approach.

In terms of housing and adaptations, it is critical that all our agencies, and a wide range of staff, recognise their responsibilities in supporting people at the earliest possible stage to consider their longer term needs, with early consideration of alternatives to adaptations, which may provide a better long-term solution e.g. a move to more suitable housing. This type of 'Housing solutions' approach, should evidence that our services are working in partnership with the person, empowering them with information and options to enable them to think and plan ahead at a time when they are able to do so.

It is also necessary to remove any barriers in the assessment pathways, ensuring that **direct access** opportunities are maximised, for standardised equipment and adaptation solutions where needs are straightforward and non-complex.

The assessment process should also take into account the principles of the Health and Social Care Standards. The following Standards are relevant to the assessment process:

- I am accepted and valued whatever my needs, ability, gender, age, faith, mental health status, race, background or sexual orientation.
- My human rights are protected and promoted and I experience no discrimination.
- I am supported to understand and uphold my rights.
- My human rights are central to the organisations that support and care for me.

The next section in this document focuses on the types of models and service responses that can support prevention and early intervention strategies, and some of the approaches services have implemented to offer self-assessment and direct access pathways.

Individuals will have widely different attitudes and experience of illness, impairment or disability. This can be influenced by a number of factors including the person's own life experiences, the attitudes of those around them, and the availability of accessible information, services, and opportunities. For many, it is the environment they live or work in that is disabling.

It is therefore essential that our services apply the principles of the social model of disability, ensuring an approach which addresses the barriers created by society and our systems, rather than the focus on the impairment of an individual.

The ability to read and write is seen as a basic human right. For individuals with a sensory impairment or communication needs, access to equipment to enable them to achieve or maintain this function should be given a high priority.

It should also be recognised that many solutions for people with a visual impairment or Dementia may not require a piece of equipment or major structural changes to a person's home, and instead, improvements such as lighting, colour schemes, and layout should be considered. It is therefore essential that staff have a good understanding of the way different conditions can impact on a person's needs, and the wide range of solutions that are potentially available to support these. A good Practice Guide in Design for Dementia and Sight Loss is available from the Dementia Services Development Centre.

Additionally, Scottish Government have provided funding to develop accessible training resources in the form of 3 e-learning modules on deaf awareness, sight loss awareness and dual sensory impairment, recognised by NHS Education Scotland (NES). These training modules are available to anyone on the NHS Education for Scotland website. Whilst aimed at professionals in the health and social care sector, these modules can be accessed by anyone by registering and creating a username and password.

A guide on activities and care for people living with dementia and sight loss has also been developed. The guide is based on learning from a Sight Scotland Rights Made Real project funded by the Life Changes Trust, and their Dementia and Sight loss guide.

Person-centred, outcomes focused approach to assessment will identify the desired outcomes for the individual and support individualised interventions, including, where appropriate, equipment and adaptations. This should also be reflected in the services provided for children and young people where equipment and adaptations can play an important role in maximising development and potential.

Self-directed support in Scotland is part of the mainstream of social care delivery, targeted at empowering people to make their own choices about their support. Self-directed support encompasses what has historically been called *direct payments*, but can include personal budgets, and other forms of control and direction on how support is provided. It allows an individual more flexibility, choice and control over the support they receive, and promotes confidence and wellbeing for those with an assessed need.

A new Framework of Standards for Self-directed Support (SDS) was jointly agreed with COSLA and published in March 2021. The aim of developing the Standards was to help support the consistent, implementation of the Social Care (Self-directed Support) (Scotland) Act 2013.

To clarify if an SDS approach is the best outcome, it is important that, when services are supporting an individual to secure equipment and adaptation solutions, as part of wider interventions, that the person is provided with information and advice which explores all considerations..

Issues associated with the need to replace/renew equipment in response to changing needs, and systematically maintain equipment to meet health and safety legislation need to be considered. Often direct provision from an efficient community equipment service can meet the required needs most effectively, and ensures that equipment can be maintained, replaced, and effectively recycled when no longer required.

'Out of Area' Equipment provision

Equipment is provided through most community equipment services on a loan arrangement and should not be removed from the service. If a service user is moving out with the boundary areas of the community equipment service, it is important that arrangements are put in place to provide replacement equipment, and support a seamless transition for the service user and their family.

This should ensure that appropriate equipment can be provided in the receiving authority, and any ongoing assessment, and provision, maintenance and repair of required equipment can be met responsively by local services. The responsibility for funding this will be determined by whether the move is a permanent one, or temporary. This is in reference to the Scottish Government Guidance: The Recovery of expenditure on accommodation and services under section 86 of the Social Work (Scotland) Act 1968 published June 2015:

- When a service – user is **permanently** moving out with the existing partnership area, the care manager/practitioner lead, should liaise with the service-users new HSCP, to arrange for the receiving authority to assess and provide equipment as required, from their local community equipment service.

The service-user's needs become the responsibility of the HSCP they have moved to.

- For **temporary** moves e.g., foster placements, student placements, and circumstances where the service user remains the client of the placing authority, then the process should be as above to refer the child/adult to the local HSCP services, so that their needs can be responsively met within that locality.
- However, the funding for any replacement equipment and any ongoing costs for repair/maintenance, or new equipment needs, should be met by the placing authority. Section 86(1) of the 1968 Act provides that any expenditure incurred by a local authority in respect of a person who is ordinarily resident elsewhere, can be recovered from the local authority of ordinary residence

Highly specialised needs - In exceptional circumstances equipment can be transferred with the service- user, (e.g., where an item is bespoke (not off-shelf) and manufactured specifically for that individual, and therefore can't easily be replaced).

- For **permanent** moves, the original equipment service provider must ensure that financial reimbursement is secured from the out of area, new HSCP, for the equipment that has been transferred, and the receiving authority would take responsibility for that equipment for any ongoing maintenance.
- For **temporary** moves, the arrangements would be as above, with any ongoing costs for repair/maintenance for the highly specialised equipment, or new equipment needs, being met by the placing authority. The equipment would remain the property of the placing authority and should be returned if no longer required.

Key Actions

- Equipment, and adaptations assessment pathways, should be clearly evident in the integrated arrangements for health & social care, and relevant partners (e.g. housing organisations, education, prison service etc.), supported by robust governance arrangements.
- Operational arrangements for the assessment and provision of equipment and adaptations, should reflect a focus on **prevention**, early intervention, and anticipatory care, avoiding inappropriate admission to hospital or long term care, and promoting independent living and self-management as key to improving health and wellbeing.
- Service users (children and adults), and their unpaid carers, should be fully involved in the assessment process. There is a person-centred, personal outcomes focus to the assessment with clear goals identified, agreed, and recorded, and the provision of the equipment recognised as a 'means to an end', rather than being 'an end in itself', with the principles of the social model of disability informing practice.
- The principal of 'minimum intervention, maximum independence' should underpin all assessments, and alternative methods of managing, should be fully explored supported by Rehabilitation and reablement interventions as appropriate.
- Staff should have a good understanding of the way different conditions can impact on a person's needs, and the wide range of solutions that are potentially available to support these, with the assessment pathways recognising, and helping deliver, solutions which support mental well-being, as much as physical needs.
- Services should have clear policy and processes to support service users moving from one service boundary, to another, to ensure a seamless service.

Prevention, Early Intervention, and Self-management

Helping people to help themselves understand and manage their conditions, and make informed choices which help minimise any potential future crisis, is critical to achieving the objectives set out in the National Health and Wellbeing Outcomes.

The promotion of Self-management is a crucial basis for the future of effective health and social care provision. The aim is to support people to make their own choices and decisions at the earliest stage, and maximise their opportunities for control and ownership, minimising the need for input from services.

If we are to effectively engage with people earlier, we have to move the conversations away from service responses informed by 'criteria' and 'eligibility'.

The focus needs to be on:

- simple engagement in the form of effective conversations, which helps holistically identify the issues;
- assistance, provided with the lightest of touches, and;
- ensuring the person is taking the lead in understanding and addressing any actions required.

> I have already been trying to futureproof our home by removing carpets and laying laminate floors. I have also been thinking of our garden and have already bought 3 troughs for growing our own vegetables so again thinking towards our older age and constantly trying to plan for our future needs as my husband has cancer along with myself being thalidomide, I am desperately trying to be so organised for our future.
>
> **Service User Response**
> **Consultation on the Guidance**

Services should review their strategies, policies, and existing operational arrangements, to ensure they can help people maximise their own independence. A number of partnerships are developing new service models with this intent, and recognise that this requires a whole system approach which addresses, not just current service models, but the cultural attitudes and behaviours, within our services, as well as the general public, which sustain the current arrangements.

Work around the Rehabilitation Framework will help underpin the new approaches, and has highlighted the importance of engaging with people much sooner, and offering simple advice and signposting which will enable the person to better understand how best they can support themselves.

The Housing Solutions approach described later in this Guidance highlights the importance of having early housing conversations with people before they are in crisis, to help them identify their long term housing needs, fully explore all options, and plan accordingly.

There are also simple mechanisms which can support prevention, early-intervention and self-management: A number of partnerships have worked with charitable or commercial organisations, or developed their own in-house solutions to assist people to be able to self-manage and self-assess their needs and make informed choices.

For example, East Lothian have developed their ADL Smartcare HILDA tool as part of their front line service, and Borders HSCP and the Equipu Partnership have worked with the Disability Living Foundation (DLF) to customise their *Ask Sara* Tool, to provide this as an important development to their early intervention, and self-management service pathways.

The Equipu Ask Sara tool allows people to self-assess their needs, and provides a range of information and guidance related to equipment and adaptations, but also wider housing related needs, helping people to think about the impact their environment has, and planning for their future requirements, and options that may be available. There is a link to the DLF 'Living Made Easy' part of the wider website which provides access to more than 10,000 products and 950 national suppliers, supplemented with over 800 local retailers, which allows people to purchase items recommended by the online assessment.

Good Practice Example

In East Renfrewshire HSCP, colleagues have utilised the customised Ask Sara tool, to support new community models e.g. their Rapid Access, front door service response. They have also used it to review their waiting list, and are supporting their co-production, community based organisations and volunteers to promote the use of the tool as part of their Talking Points approach, supporting early intervention and prevention. They have planned some engagement with GP surgeries, and have been able to evidence some reduction in people being referred on, into the services.

In a similar approach, Aberdeen City, Bon Accord service, have developed their own in-house website, to help support people to make their own choices and manage their needs independently.

Good Practice Example

Following an initial retail project based within one of their local independent living centres, Aberdeen City developed the Equipment for living retail website offering a range of equipment which was not part of the eligibility criteria, which was launched in September 2020. Working closely with suppliers, the service has developed the website to provide access to a wide range of products including mobility, personal care, eating and drinking, seating, kitchen and household products.

The website allows customers to buy directly or make contact for any specific advice they may require, and delivery within Aberdeen for the items in stock is free and usually the next day. Larger mobility aids are on display in one of their local centres and customers interested in these can make an appointment with an OT and receive a professional assessment, trial the products, and purchase these there and then with a Point of Sale system in place. They also offer a servicing plan for relevant products, and are considering expanding the service to offer a rental service for short term loans.

Approaches such as these described above, can also help assist with 'healthcare literacy', which has been one of the key issues highlighted as a barrier to supporting people to better understand their condition(s), and then to help them, help themselves. Interface with primary care services will also be crucial in engaging people in self-management early in their care journey.

It is critical that our services support measures to promote better access to quality information, and effective methods of sharing of information, which help people to live as well as possible, safely and with choice, exploring and understanding their options, allowing them where ever possible, to manage their conditions, as part of early intervention strategies.

Key Actions

- Services should review and challenge their strategies, policies, and existing operational arrangements and service pathways across equipment and adaptation service provision, to ensure they are actively promoting and helping people maximise their own independence.
- Services should implement a range of approaches/solutions, at key stages in the service pathways (E.g. front door services, but also where service users and their families may require support when needs change), across all service settings (hospital and community), to assist people to self-manage and self-assess their needs, and make informed choices.
- Services should support measures to promote better access to quality information, in all relevant accessible formats, and effective methods of sharing of information which helps people explore and understand their options, and manage their conditions, as part of early intervention strategies.

Unpaid Carers

Unpaid carers are at the heart of health and social care policy and should be considered as key partners in care. We need to also acknowledge that this is not a role that can be taken on by everyone, and any assessment needs to be based on open and frank discussions to clarify all support needs.

We noted earlier in the document that, although the term, 'unpaid carer' is used throughout this document, it is important to acknowledge that the same approach must apply to family members providing the support and care, but who may not identify with this label.

We recognise the important role unpaid carers play in supporting people with disabilities to remain at home. Therefore, providing these carers and the person they care for with self-management care skills, and effective rehabilitation services is essential. A holistic approach with early engagement/assessment is essential to ensure appropriate support is in place, particularly where end of life palliative needs are to be addressed in a dignified way.

The timely provision of equipment and adaptations, and/or housing solutions, are critical to supporting the person being cared for, and the person who is caring, to live safely within their home environment, optimising well-being, and avoiding admittance to hospital, falls, and supporting effective discharge home.

To help unpaid carers, we also need to ensure effective hospital discharge policies are in place for the provision of equipment & adaptations/housing support. Leaving hospital can be a difficult experience, especially if the person leaving hospital is unable to function as they did before. It can also be a difficult time for their carers and family too.

Under the Carers Act, unpaid carers have the right to be involved in the hospital discharge process of the person they are or are going to be caring for. They also have the right to have their views taken into account in assessing the needs of the person being cared for. (See sections 5 and 6 of the Carers' charter).

Health boards must take appropriate steps to: inform carers as soon as they can about when the person they care for is to be discharged from hospital; invite their views about the discharge; and take their views into account when planning the discharge (as far as 'reasonable and practical'). This must include the carer's views about the suitability of the current home environment for the service users longer term needs, and proactively support the exploration of alternative housing options, as well as any equipment and adaptations that might be needed. A good practice guide on discharge planning has been developed to provide practical support in involving carers.

Any subsequent support, help, housing advice, equipment or adaptations will play a key part in this process. Having this support in place allows the cared for person and

the carer to remain at home for longer, reduces the pressure on the family and importantly helps avoid hospital readmission.

- Assessors must take account of the views and contribution of carers when assessing the person in need.
- Carers must be informed of their right to an adult carer support plan or young carer statement, to determine what is important to them and their own support needs, independent of any assessment of the person for whom they care.
- An adult carer support plan or young carer statement must be offered to anyone who provides care for a disabled or older person, or someone with a long-term health condition (sections 2 and 3 of the Carers' charter), and they should be encouraged to have one.
- The plan or statement must cover a number of issues, including identifying the unpaid carer's needs for support. That can include the carer's need for equipment or adaptations to enable them to support the cared-for person successfully. It must also include their need for advice and training on safe operation of equipment, and the need for ongoing training support as required.

The carer themselves may require information in an alternative format or language to that of the cared for person.

Key Actions

- Assessors must take account of the views and contribution of carers when assessing the person in need, and fully engage them in discussions about future housing needs, and any associated equipment and adaptations which may support the service user to remain safely in the community. The outcomes should be clearly recorded and reviewed as required.
- Carers must be informed of their right to an adult carer support plan or young carer statement to determine what is important to them and their own support needs, independent of any assessment of the person for whom they care.
- An adult carer support plan or young carer statement must be offered to anyone who provides care for a disabled or older person, or a disabled child.
- Carers should be fully involved in assessment and discharge planning from hospital, with agreed outcomes clearly recorded for the provision of any equipment and adaptation and housing solutions, and relevant support identified as required.

Moving & Handling

Equipment and adaptations play a critical role in supporting the effective moving & handling of people who are frail or unable to transfer independently. Where an unpaid carer is assisting the person, the correct equipment plays an equally critical role in enabling them to do so safely. The Health & Safety section in this guidance confirms the obligations in relation maintenance, inspection and testing requirements, clearly outlining the responsibilities that agencies hold, as employers of staff, to ensure that equipment is safe for their staff to use. It also highlights the employers responsibilities related to the training of staff, and good practice recommendations for unpaid carers.

It is equally important that the assessment process to determine appropriate equipment and adaptation provision, evidences clearly the views of the person who requires to be moved and handled, and a risk-enabled, person-centred approach is promoted.

- Services need to evidence a minimum intervention ethos, which aims to maximise a person's ability to utilise functional performance, and avoids practice which provides the incorrect equipment , or over prescribes equipment requirements, and 'disables' the person and impacts negatively on their potential wellbeing.
- Risk assessment should promote this ethos, and health & social care partners and care agencies should ensure they work jointly to develop person-centred approaches, as well as supporting the wellbeing of staff involved

To support anyone with a terminal or progressive illness to live at home, and to live to their end of life preferences, it is essential that services act in line with good practice/policy for those with palliative needs, and ensure the service users wishes are central to the decision making for any required equipment provision e.g. often a person in the very 'end of life' stages would prefer to be allowed home to their own bed for their last few days/often hours, with a reduction or removal of formal care provision and more discreet personal care, rather than be cared for in a hospital bed. The risk-enabled Care Plan needs to have explored these options, clearly evidencing the views and wishes of the service user and their family. Any equipment or adaptations which are required, should be provided in a timely way to ensure the service user can be effectively supported.

It is also important that equipment categorised as 'moving & handling', in line with the previous recommendations from the 2009 Guidance, should not be viewed, as only the responsibility of certain professions to provide. Often a multidisciplinary approach is vital to secure the best outcomes for the service user, and to ensure all aspects of the person's needs have been fully considered. A wide range of professionals, across health and social care services, including physiotherapists, nurses, occupational therapists, and social care staff, should be able to assess for and provide moving and handling equipment as required, as part of the service they are providing, and health and social care services should ensure that they avoid

arrangements which encourage duplication in the assessment pathways, and inappropriate onward referrals.

Increasingly services have considered the application of ‘single-handed care’ initiatives whereby they embark on a review and reduction of care packages to require fewer care workers per person, without putting that person’s health and wellbeing in harm’s way.

This approach recognises concerns about the adoption of generalised practice, which assumes double-handed care as the standard response and default position in all circumstances. The Health & Safety Executive (HSE) are clear in their guidance that blanket solutions should not be applied, and their helpful guide Getting to Grips with Hoisting provides information which highlights the importance of the individual assessment in determining the appropriate number of care workers required to safely move and handle the person.

Unnecessary use of additional care workers has implications, not just in terms of costs, and best use of valuable resources, but more importantly, can be more intrusive for the person who requires moving and handling support, and can prevent them from being encouraged or supported to maximise or regain any functional potential they may have.

Forth Valley health and social care partners have implemented a new programme encapsulating these principles, to ensure a person receives the right amount of care and support in the appropriate environment, whilst creating capacity across the whole system. This is called Prescribing Proportionate Care[PPC]. This approach has already evidenced significant whole system benefits, by changing the equipment, to a type which can be used by a single carer or family members.

> We have one patient who went home from acute setting. A really complex patient with complex needs. This person would have had 2-3 paid carers to assist moving and handling, but introducing new equipment has allowed that person to go home with family supporting and no paid care. The patient can go to toilet as and when they need to, rather than waiting on carers arriving, and no intrusion of many carers. Over and above the clear benefits for the patient, the cost saving for that one person was £22,000
>
> **AHP Manager for Rehabilitation,**
> **Clacks and Stirling Health and Social Care Partnership**

Effective and robust individual risk assessments and care plans, produced with the full involvement of the service user, their family, any unpaid carers, and all relevant professionals, are essential to ensure risks are fully understood from the service user and unpaid carers perspective, and minimised for all involved. As evidenced in the Forth Valley example above, a number of equipment solutions can effectively support -single-handed care strategy, and these should be considered as appropriate as part of the local equipment service core stock provision.

With the publication of the Scottish Manual Handling Passport in 2016, health and social care services have recognised the importance of a strategic, partnership approach to the effective provision of manual handling interventions, ensuring safety, and competence, in the workforce, whilst promoting person-centered approaches which maximise independence and choice. Further work is required to encourage more widespread uptake of the tool and partnerships should review their arrangements to encourage standardisation and consistency that this promotes.

Key Actions

- Assessments should evidence the views of the person who requires to be moved and handled and a person-centred, and risk-enabled approach should be promoted.
- Services should apply a minimum intervention ethos, which aims to maximise a person's ability to utilise functional performance and avoids practice which 'disables' the person and impacts negatively on their potential wellbeing.
- For 'end of life' ensure that services act in line with good practice/policy for those with palliative needs and ensure the service users wishes are central to the decision making, avoiding unnecessary equipment provision.
- Ensure that a wide range of professionals are able to assess for and provide moving and handling equipment as required, either to support hospital discharge and/or as part of the service they are providing.
- Services must ensure robust training and refresher training, is in place to support the effective assessment (including positive risk-taking), and use of the equipment.
- Services should ensure they avoid arrangements which encourage duplication in the assessment pathways and inappropriate onward referrals.
- Blanket solutions to moving and handling should not be applied and individual assessment is used to determine the number of care workers required to safely move and handle the person, encouraging the use of single-handed care where appropriate.
- Partnerships should review arrangements to encourage good practice recommendations from the Scottish Manual Handling Passport which aim to help standardise good practice across Scotland.

Postural Care

For people with many conditions, effectively addressing their postural care needs, is central to maximising their independence and well-being, and their potential to engage fully in everyday activities. In addition, for the person, family and carers, this supports the promotion of self-management, which is a wider driver in terms of other national strategies, both for children and adults e.g. Ready to Act, and the Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic.

The postural care strategy, Your Posture Matters outlines a range of key ambitions to improve postural management care for people of all ages across Scotland, and specifically highlights the critical role equipment plays in meeting those aims.

> Equipment has the potential to protect, preserve and improve someone's positioning; their age, the reason why they have a movement difficulty and geographical location should not be a barrier to accessing the right equipment to protect their posture.
>
> **Ambition 3**
> Your Posture Matters

Any equipment and adaptation solutions should be considered in the context of '24 hour postural management' so that this is complimenting the wider interventions.

It is also crucial that comprehensive education is provided for a wide range of professions and staff, working across all relevant services, on the importance of postural care for people of all ages. There are powerful examples evidencing the difference the timely provision of equipment to support postural care can make to both children and adults. With children it is evidenced that this can change the trajectory of their lives, vastly improving the quality of life they will experience and their well-being, as well as the positive benefits for their families. For people with long-term conditions and older people, again this can change their ability to be able to maximise their functional potential for as long as possible, significantly supporting their mental health.

It is therefore essential that Integration Authorities, and their equipment services, have an aligned strategy and policy, for the provision of equipment which helps supports those ambitions.

Good Practice Example

In NHS Greater Glasgow & Clyde, Specialist Children's Services Physiotherapists have worked collaboratively with their local Community equipment service, to stock and recycle SleepSystem products and assessment kits to help streamline and standardise access to this equipment. This has brought a range of efficiencies including, reducing demand for wider ongoing service inputs and care, reducing clinical input time, improving decontamination, streamlining procurement, and promoting self-management. This work was recognised at the national AHP awards in 2020 as an example of good practice.

Read the report from Glasgow City for more information

Historically, most community equipment services have routinely provided supportive seating for postural care needs, however, far less have systematic arrangements in place for the provision of other key products which can ensure correct alignment e.g. SleepSystems. This issue requires to be addressed, and services should work with all relevant stakeholders to develop effective arrangements for the provision of this equipment acknowledging that it can take a variety of forms e.g. a SleepSystem can constitute simple cushions or a complete bed system.

Scottish Government guidance in relation to the Provision of Equipment to Children and Young People with Disabilities (2015), specifically highlights the requirement to standardise the provision of SleepSystems as standard core equipment for children.

Key Actions

- Health & Social Care services should have an aligned strategy and policy, for the provision of equipment for people of all ages, which helps support the Postural Care Strategy.
- Health & Social Care services should work with all key stakeholders, and community equipment Store service providers, to develop effective arrangements for the provision of SleepSystems and other relevant products which support effective postural care.

Hospital discharge

To ensure seamless arrangements for the discharge from hospital settings, it is important that a range of staff within the hospital (e.g. occupational therapists, physiotherapists, liaison nurses, and staff within multi-disciplinary discharge teams) can assess and order directly, equipment and relevant adaptations, for 'safe discharge', for their patients. It is important that these staff are supported to provide all aspects of the assessment role including follow-up and conclusion of the assessment following provision, and/or work jointly with other colleagues to fulfil these responsibilities.

Pathways for safe discharge must bridge the hospital to home gap through effective holistic joint multi-disciplinary and multi-agency working, with all relevant services e.g. community based health and social care services, Housing, technology, etc, to ensure each plan is discharge ready, the home environment is suitable, arrangements are subject to review, and the service user will be safe.

Potential rehousing needs should be identified at the earliest possible stage, ideally at admission, if not prior, to ensure a multi-agency approach which can work in partnership with the service user and their family, to identify and explore potential solutions which will support long term needs.

A hospital discharge guide Planning Discharge from Hospital, A guide to Providing Community Equipment on Discharge from Hospital, is based on arrangements tested and implemented in some existing services in Scotland. It has been developed to assist local services clarify roles and responsibilities for the provision of equipment, between the hospital and community settings, and support the implementation of clear and effective pathways.

- Ongoing needs, require to be taken forward by appropriate community services so these can be properly assessed in the context of the person's home environment, and wider rehabilitation needs, as part of their recovery plan. Therefore, although hospital based staff can access a wide range of equipment, they will only provide what is appropriate to support the service user to safely return to the community.
- In addition, it is essential that clear pathways are in place to allow hospital staff, to refer to relevant community staff for the assessment and ordering of equipment for more service users with more complex, ongoing needs, for example tissue viability. Ideally, this should ensure that one assessor will take on the provision of all relevant equipment for discharge to avoid duplication and multiple deliveries.
- It is important that hospital-based referrers avoid risk-averse behaviour, and over-prescription of equipment e.g. tissue viability, moving and handling etc, for all patients, and services agree provision of standard simple solutions, to ensure a safe discharge and allow for a review of needs and more specialist provision, if required, once the person is back in their home environment.

There will also be circumstances where joint working should prevail, and the expertise of the hospital based practitioner should be utilised alongside the skills of the community professional to meet the needs most effectively e.g. service users with spinal injuries, children with complex needs, or requirement for equipment for use within planned adaptations related to discharge.

Effective planning is crucial, and initiatives to improve discharge pathways by introducing a 'Planned day of Discharge' will be important in improving the processes. This provides a change in emphasis from Estimated Date of Discharge to Planned Date of Discharge, which should be an agreed date and plan for discharge that the multi-disciplinary team, as well as the patient, family and carers, are involved in. In terms of on-going care and support needs it is important that planning starts early and that all parties actively work towards the Planned Date of Discharge and not from the Date of Discharge.

Good Practice Example

In South Lanarkshire the introduction of Home First, Planned Date of Discharge, intermediate care, and discharge to assess/ rehabilitation has led to a 70% reduction in delays. The PDD initial tests of change were undertaken in high referring wards in Hairmyres, mainly care of the elderly. The focus was still on home first and enablement, but when care at home or long term care was required, social care would be part of the daily MDT, all working towards a planned discharge.

It is hoped that this approach will support the more effective provision of equipment, and also ensure the opportunity to clarify other wider needs related to the home environment e.g. need to discuss re-housing and/or the need for adaptations. In some areas, in-reach models have been explored as a way of supporting improved discharge pathways.

Good Practice Example

The Inverclyde in-reach Occupational Therapy Service started as a pilot project in 2015 utilising a Band 6 Occupational Therapist based in the community, with the aim of improving hospital and community links and to work with hospital based occupational therapist and physiotherapist colleagues, to plan and follow up on complex discharges, with a 'home first' approach.

This involved establishing good communication links within the hospital and community settings, working closely with the In-reach community nurse colleague, and other relevant rehabilitation and social care services. This post has now been integrated into the service provided by the Rehab and Enablement Service (RES) team.

The benefits have included the streamlining of the discharge process for complex cases, a more coordinated multi-disciplinary approach to planning and support for complex discharges with better communication and knowledge sharing, patients and their families feeling reassured due to improved continuity, and timely and effective service intervention.

Key Actions

- Integration Authorities (IAs) should utilise the hospital discharge equipment provision good practice guide, to support improvements in the provision of equipment for discharge.
- IAs should ensure that a range of staff within the hospital can assess and order directly, equipment and relevant adaptations, for ‘safe discharge’.
- IAs should ensure that clear pathways are in place to allow hospital staff to refer to relevant community staff for the assessment and ordering of equipment and adaptations for more complex, ongoing needs.
- All services should avoid over-prescription for patients with standard needs, and agree simple solutions, to ensure a seamless, and safe discharge.
- Services should explore the opportunities to implement a Planned Date of Discharge approach, to improve forward planning for the provision of equipment and relevant adaptations for discharge.

Children & young people

The provision of equipment and adaptations for children and young people is an essential part of the therapeutic support for their needs, and is effective both in terms of improving quality of life and potentially reducing costs for more intensive intervention and care.

Although some children and young people with very complex needs may require highly specialist bespoke solutions, the majority of equipment provided can be categorised as 'standard children's equipment'. This includes bathing/showering and seating solutions, as well as items to provide postural support (including sleep systems), mobility, and moving and handling. In some cases, it is also relevant to provide standard adult equipment, augmented with relevant accessories.

Services need to apply the ethos of anticipatory care planning when working with children and their families to help identify, at the earliest point, the types of solutions that may be required in the home environment, as the child grows and their needs develop.

This is crucial when it comes to considering the long-term suitability of their home. The earlier we can engage with families, it provides them with time to reflect and consider options and potential support available, as in many cases traditional family built homes over two levels or more, will not be the best solution over time, requiring either considerable disruptive adaptation to try to address changing needs, or be unsuitable for any type of adaptation.

Therefore, early engagement with Housing Services, and full exploration of rehousing options with all relevant agencies supporting, is essential to identify and promote suitable housing solutions. This approach should evidence a holistic approach to the whole family's needs and wellbeing, which recognises that there are often complex needs that require a combination of solutions or range of interventions to meet these most effectively.

Whilst acknowledging that not all services for children were formally integrated under the provision of the Public Bodies (Joint Working) (Scotland) Act 2014, it is essential that the provision of equipment to children and young people is provided in an integrated way, and recognised as an integral part of community equipment service provision within the integrated arrangements. This should include Education partners who play a pivotal role in providing equipment for use in educational settings. This will be particularly important in terms of achieving the aims of GIRFEC, and ensuring an effective joint approach to manage risk and address prevention and early intervention, across a multi-disciplinary team and operational and strategic contexts.

It is also crucial to highlight the importance of ensuring effective pathways for the transition of Children into Adult services, which require good planning arrangements in place that consider all aspects of relevant equipment,

adaptation and housing solutions needs, e.g. some service have good arrangements in place which allow for equipment to be moved with the child, and funding is dealt with behind the scenes.

In March 2015, the Scottish Government issued guidance to Health Boards and local authorities on their statutory responsibilities in relation to the Provision of Equipment to Children and Young People with Disabilities.

This recommended that arrangements for the provision of children's equipment should be jointly agreed, and budgets should be set up in a way which supports direct access to equipment in line with the health & social care children's services pathways, and ensures appropriate funding by Education partners for equipment for use in school settings.

It also encourages Community Equipment services to establish 'Standard Core Stock for Children' for the range of needs most commonly met, to assist with delivering efficiencies in the service pathway including standardisation of practice and policy, procurement, and improved recycling which can deliver significant financial savings. This should include equipment commonly assessed for by occupational therapists, physiotherapists, and nurses, working in a range of relevant service settings.

Good Practice example

The guidance attached an example Joint Protocol for the provision of Children's equipment. This has now been updated to include arrangements for joint working with Education partners.

This provides a template to support IAs and their Education partners to establish effective and consistent pathways for the provision of equipment to children and young people with complex needs.

The Pathways should:

- Clarify roles and responsibilities of all agencies concerned in the provision of equipment to children and young people. Ideally in the form of a joint protocol and encourage integrated arrangements with all relevant stakeholders e.g. health and social care and education partners
- Identify sources of funding from a joint equipment budget which must also include monies to cover the cost of servicing, maintenance and replacement as a child grows or their needs change.
- Standardise and normalise equipment provision for children, establishing 'standard core stock' where possible.
- Clarify within the agencies responsibility for the provision of solutions not classified as equipment e.g. Environmental/behavioural solutions (see below).
- Encourage initiatives to maximise recycling efficiencies e.g. the employment of suitable experienced staff to support the refurbishment and reuse of children's equipment.

Children, and environmental supports

It is acknowledged that staff working with Children and their families may be sometimes asked to identify solutions which go beyond traditional equipment needs.

The Children (Scotland) Act 1995 created a broader duty to children with disabilities and it is recognised that an increasing number of children with behavioural issues are being managed at home which may require an environmental support component to the care package.

It is not appropriate for this type of solution to be provided via community equipment loan stores, and it should not be assumed that it the responsibility of occupational therapists to provide these.

Where the provision of an environmental solution is to support the wider needs of a child (e.g. emotional or psychological stress, behaviour, or sleep management) and extends beyond physical disability and functional needs, it is the responsibility of the health & social care services to determine which agency/clinician is most appropriate to lead on the identification of the needs e.g. this may be social worker/social care manager, and/or psychologist colleagues, or other relevant health professionals.

It is paramount that the views of the child are expertly sought and evidenced as part of the multi-disciplinary approach to any agreed provision, in line with the principles of the UNCRC Article 12, and that any concerns about potential restraint, are robustly addressed by the multi-disciplinary assessment process.

If it is agreed that the provision of an environmental solution is appropriate, it is the responsibility of the health & social care partners to agree the primary purpose of the provision, and identify funding for this type of environmental support from relevant Children's Services budgets, and to then monitor this provision, and evaluate the outcomes. Ideally, clear pathways should be agreed which clarify local roles and responsibilities and processes.

Key Actions

- The provision of equipment and adaptations to children and young people, for home and school settings, should be provided in an integrated way, and recognised as an integral part of community service provision, in order to streamline and standardise provision.
- Services should apply an anticipatory care planning approach to housing needs to ensure more effective early intervention work to help identify and plan for housing solutions as the child's needs change.
- Arrangements for the provision of children's equipment should be jointly agreed, and budgets should be set up in a way which supports direct access to equipment in line with the education, and health & social care children's services pathways.
- Community equipment services should establish a 'Standard Core Stock for Children' of equipment commonly assessed for by occupational therapy, physiotherapy, and nurse colleagues, for the range of needs most commonly met.

- Relevant local services should clarify responsibility for the provision of solutions not provided via local store services as equipment e.g. Environmental / behavioural solutions. Health & social care services should put in place arrangements which clarify for individual cases, the lead agency/clinician, the funding source, and monitoring arrangements.
- Services should ensure that the views of the child are sought and clearly evidenced as part of the multi-disciplinary approach to any agreed provision.
- Services should ensure effective transition arrangements for children moving into adult services to minimise disruption and ensure a seamless approach to the provision of equipment and adaptations.

Care Homes

In 2012 the Convention of Scottish Local Authorities (CoSLA) and Scottish Government jointly issued a National Protocol for the Provision of Equipment in Care Homes, in order to provide consistency of service delivery across Scotland, and provide clarity of roles and responsibility for both private care homes and statutory organisations. The Protocol was developed and agreed with CoSLA, Scottish Care, local health & social care partners, and the Scottish National Association of Equipment Providers. The Protocol became a part of the National Care Homes Contract. The document contains a section which confirms the responsibilities for provision, according to the type of equipment, and the facility e.g. residential or nursing.

The Protocol reiterated that care homes are expected to provide a wide range of equipment to fulfil their obligations to their service users, and to their workforce. More recent national policy has encouraged the further improvement and standardisation of social care provision, and it is essential that anyone who requires to be cared for within a care home setting, has the equipment they need to support their well-being and quality of life. This should be in the context of the promotion of strength, balance, and physical activity, with equipment solutions complimenting these interventions.

It is essential that health and social care managers with the responsibility of overseeing the provision of Care Home arrangements, ensure that they are also proactively reviewing the appropriate provision of equipment by the Care Home sector, and the arrangements outlined here. It is also critical that care managers and those involved in placing service users in appropriate care settings, are clear on the responsibilities of the Care Home to provide equipment, and can support families effectively in these matters.

As per the Health and Social Care Standards, care home residents should be treated equitably to those living in their own home or other community setting.

> My human rights are protected and promoted and I experience no discrimination.
>
> **Standard 1.2**
> Health & Social Care Standards

- In order to ensure equity, people who are self-funding, and have been confirmed as having an assessed need for specific equipment should not be charged for this essential equipment provision. Similarly, families should never be asked to fund equipment which has been assessed for, and identified as a requirement.

- Where partnerships have developed interim care home placement models, it is essential that appropriate arrangements for equipment are in place. Therefore, the approach is the same as for permanent care home placements, whilst acknowledging that timely provision of equipment to support more complex needs will be even more critical to the success of the transitional pathways. Commissioning contract arrangements should therefore ensure that the care home facilities have suitably resourced themselves with a stock of equipment which will support these needs e.g. including standard support seating to address essential postural management needs (see below).
- For day, and respite facilities, and for Care Homes for all care groups including younger adults, again it is expected, that the same approach and principles will apply, as for the other facilities, and that these settings are suitably resourced with appropriate equipment for the service users they are funded to support, and these requirements are built in to the contractual arrangements.
- It is acknowledged that, similar to the arrangements for long term care homes, there may be some rare circumstances where it would be appropriate for service users with more complex, specialist needs, to have their existing equipment from home brought with them, and/or community services to provide additional equipment, as a loan, for the period of the service provision e.g. equipment to meet complex bariatric needs.

To support good practice, commissioning and equipment service leads within statutory providers (Integration Authorities) should work with their local care home sector to agree the most suitable makes and models of generic equipment e.g. modular support seating, tissue viability mattresses, moving and handling equipment etc Using seating as an example, this approach will assist the care homes in the cost effective procurement of appropriate seating to meet common postural management needs within the Care Home population. It will also assist local equipment stores to stock a range of suitable bespoke attachments to customise the equipment as required, to meet the assessed needs of an individual.

Standard support seating includes a range of products, designed to meet more complex but common postural management needs. It will support a range of service user's postural needs, and offer attributes which assist with tissue viability and the prevention of skin breakdown. The need for this type of seating is commonplace, and it is critical that these needs are addressed by the care home provider as an integral part of their care for the person, ensuring the optimum quality of life and well-being.

Poor seating can directly contribute to skin breakdown and compound postural issues, which then impact on the function of the person and their ability to carry out normal activities including social engagement and eating .

This type of seating is available from many different suppliers and manufacturers, and are frequently modular, and can meet a wide range of needs and include tilt and space attributes. These chairs are cost-effective as they can be easily recycled and adapted with relevant accessories to meet the specific needs of different service

users, and are readily available as pre-manufactured products, directly from suppliers ('off the shelf'). These types of chairs are generic and not for one-off use. Care homes should therefore be encouraged to have effective procurement arrangements in place which work across the sector to bring business efficiencies, allowing them to ensure efficient access to local stock. HSCP commissioners should be responsible for supporting the care homes to meet these obligations and ideally this should be taken forward at national level to encourage consistency across the sector, and assist the Care Homes to secure procurement efficiencies for all equipment provision.

For care homes providing nursing care, standard equipment includes items such as profiling beds, pressure reducing and relieving overlays and full replacement specialist mattresses to maintain tissue viability. That is, if a service user in a care home providing nursing care is assessed as requiring preventative care for pressure ulcers, the care home should provide for that service user

Where the needs of the individual require the provision of *bespoke* equipment *or attachments* the responsibility lies with the Integration Authority.

Bespoke equipment can be defined as:

- Any item of equipment **specifically manufactured** to meet the unique needs of an individual. E.g. the Care Home would be unable to purchase the seating ready-made.
- Bespoke **attachments or accessories** for a standard piece of equipment, to meet the assessed needs on an individual (e.g. accessories for standard off the shelf seat to support complex postural management needs).
- An item of equipment that would **rarely be required** by the population within the care home, and unlikely to be used again for another service user, e.g. this mainly applies to bariatric equipment. It is important to highlight that local community equipment services should have a core stock of standard bariatric equipment e.g. beds and mattresses, that can be provided in a responsive and timely way for use in all areas of service provision.
- *note: 'bespoke' does not apply to any of the standard support seating described above, including chairs with tilt in space attributes, as this is considered equipment which meets common and frequently occurring needs within the older and frail population.

This guidance lays out the key guiding principles in terms of the responsibilities for the provision of equipment in relation to care homes in line with the Care Homes Equipment Protocol.

- When a person is being considered for a Care Home placement, assessment of their needs should include consideration of the equipment that is needed to support their care and their postural needs. Care homes should not accept people whose assessed needs they are unable to meet, however, they should not refuse placements because they do not want to provide for that persons equipment needs.

- The Care Home Protocol defines the types of equipment which care homes are responsible for providing, and those which HSCPs should provide. Local HSCP commissioners are responsible for ensuring the care homes meet their contractual obligations and local HSCP managers, and care managers, should proactively review and monitor these arrangements.
- However, where the care home is temporarily out of stock of items of equipment for which it is responsible, and the provision of equipment would facilitate a discharge from an acute hospital bed, or enable the client to stay in the care home, the equipment may be supplied on loan from the relevant local community equipment service, for a period of up to **four weeks** following an appropriate assessment. This allows the Care Home time to have restocked the equipment and the loan equipment can then be returned.
- When the requirement for equipment is 'bespoke' (as defined above), responsibility lies with the local HSCP for this provision.
- Where equipment has been loaned to a care home, as described above, and it is not the responsibility of the HSCP to provide, the Care Home must put in place arrangements to provide this equipment as quickly as possible, and before the end of the 4 week period. .
- Care homes much ensure that their staff are appropriately trained in the use, cleaning and maintenance of equipment as set out in The Health and Safety Executive and MHRA regulations.
- Where equipment has been loaned to a care home, repair and service maintenance responsibility remains with the equipment provider, however the care home must ensure they regularly clean and maintain the equipment in a good condition.
- It is the responsibility of the Care Home to ensure they understand how to use the equipment, and to ensure that this training is cascaded to all staff likely to use the equipment.

Scenario One

Mrs A is assessed as requiring assistance with seating posture. The care home she resides in has a range of adaptable chairs to address postural issues but does not have the attachments necessary to fully adapt the chair to meet Mrs A's specific needs. The local HSCP via their community equipment service, loans the care home the necessary attachments – headrest, and pressure relieving cushion and the seat is adjusted by Mrs A's Occupational Therapist to her required specifications. Once Mrs A no longer requires the seating, the attachments are returned to the local community equipment service for decontamination and recycling, and the Care Home is able to use the seat for future clients with these assessed needs.

Scenario Two

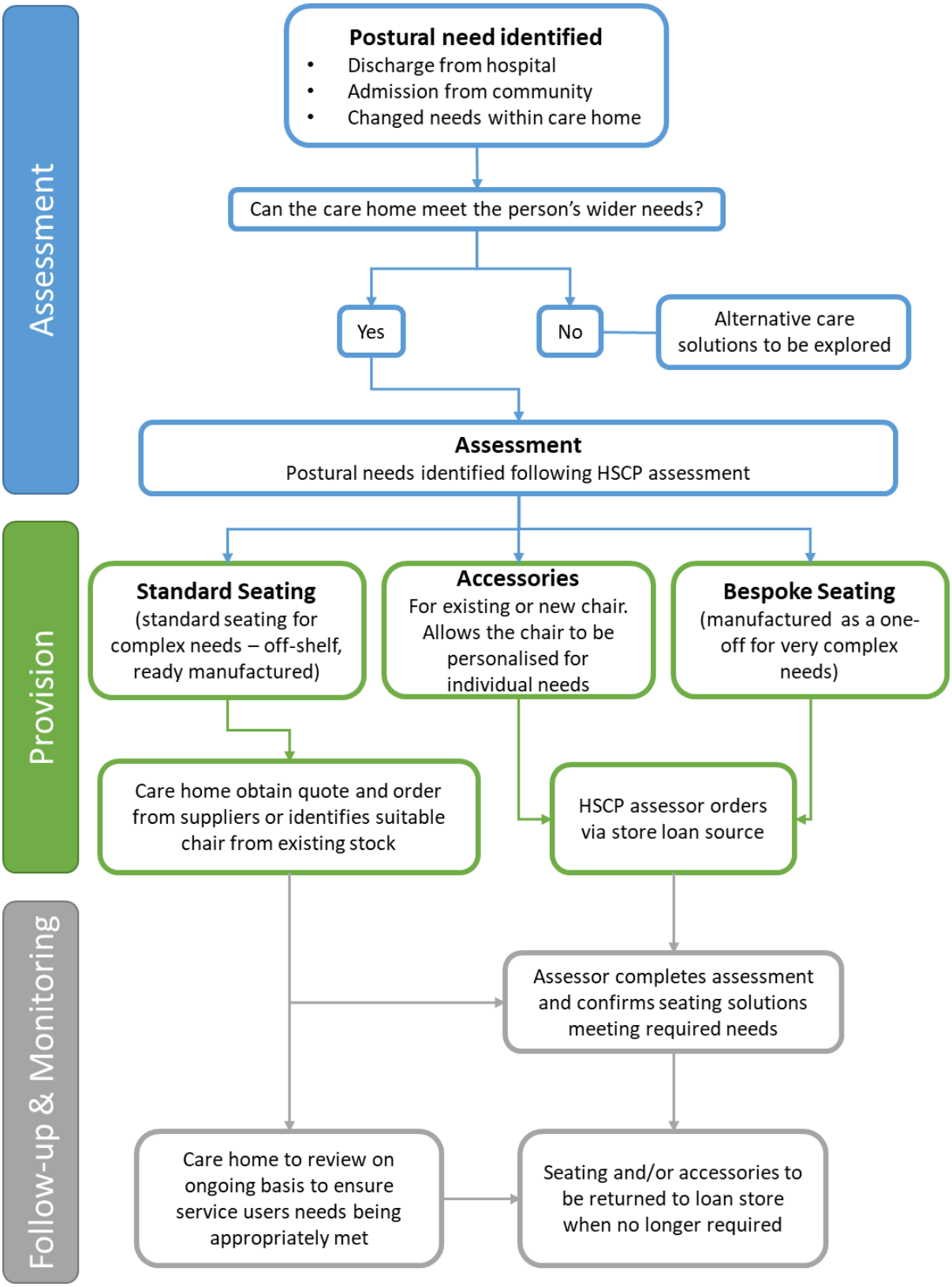
Mr B, currently resident in a specialist Dementia unit, has deteriorated physically and due to his size the hoist, bed, mattress and slings used by the home are inappropriate. To avoid an unnecessary admission to hospital the HSCP assess the needs, and via the local community equipment service, loan the required bariatric equipment to the care home. Maintenance responsibility remains with the community equipment service. Clear protocols for returning the equipment for recycling are also agreed, once the equipment is no longer required by Mr A, and it is returned to the equipment service for decontamination and recycling.

A **flow chart** for the provision of seating in care homes is provided at the end of this section to assist local partners and their care home providers further clarify these responsibilities.

Key Actions

- Care homes should provide a wide range of equipment to fulfil their obligations to their service users and to their workforce, in line with the national Protocol for the Provision of Equipment in Care Homes.
- Services users who have been confirmed as having an assessed need for specific equipment should not be charged for this essential equipment, and families should not be asked to fund this provision, this includes people who are self-funding.
- Commissioning and equipment service leads within statutory providers should work with their local care home sector to agree the most suitable makes and models of generic equipment, and ensure this equipment is in place.
- These principles should also apply to all care groups including homes for younger adults, interim care home models, and day and respite facilities.

Care Homes Seating Provision Flowchart



Prisons

It is now recognised that there is significant pressure within the prison system from a growing ageing population, coupled with almost 40% describing themselves as having a long-term condition or a disability (Scottish Prison Service 2019 Prisoner Survey).

This has implications for the support required within the prison service, but also when prisoners are eligible for release. Alongside, proactive therapeutic intervention which promotes strength and balance and physical activity, equipment and adaptations are part of the services which require to be systematically provided to support people within the prison system, and also facilitate successful transitions: at the point of admission, when transferred within the prison estate, or on release to the community.

Drawing on good practice from partnerships and their local prisons, a new Protocol for the Provision of Equipment to Prisons has been developed. The protocol aims to promote a consistent and reliable approach to the assessment, provision and uplift, of community equipment, used within the prison settings, to ensure that the needs of these prisoners are met effectively.

Key principles of the Protocol include:

- All assessments will be carried out either by appropriately trained HSCP staff for complex needs, or relevant prison based NHS healthcare starr for non-complex needs.
- SPS will provide a range of standard equipment to need long-term needs.
- The HSCP will provide equipment to meet short-term temporary needs.
- Wherever possible, equipment should be procured, maintained and paid for through local community equipment stores.
- Access to, and use of, recycled equipment should be encouraged.

It is hoped that this joint-working approach will ensure an effective and responsive service and ensure better outcomes for those within the prison population.
It is expected that local partnerships should utilise this Protocol as a tool to help them jointly review any current arrangements with their SPS colleagues, and improve these as required.

To aid transition into the community, the Scottish Prison service, Housing partners, and HSCP's should ensure clear pathways are developed with all relevant agencies, to ensure effective communication and engagement resulting in the provision of appropriate housing, and equipment and adaptations where required. This should be in line with the SHORE (Sustainable Housing On Release for Everyone) standards.

Key Actions

- Local partnerships should apply the principles of the Good Practice Guide for the Provision of Equipment to Prisons as a tool to help them jointly review any current service provision with their SPS colleagues, to streamline and improve

the pathways for all equipment provision, and establish cohesive governance arrangements.

- It is expected that the following arrangements should be in place:
  - Robust and consistent assessment pathways with NHS healthcare staff within the prison able to assess and recommend equipment for non-complex needs, and HSCP staff assessing for more complex needs;
  - SPS to fund equipment for long term needs, and HSCP's to fund equipment for short-term loan;
  - Business efficiencies maximised with access to local Store service arrangements for the provision of effectively procured and standardised equipment solution for both long-term and short-term provision.
- Local partnerships should work with SPS, and Housing colleagues to ensure the effective transition back into community, providing appropriate housing, and equipment and adaptations as part of a seamless pathway, and in line with the SHORE standards.

Wheelchairs

In March 2021 Scottish Government issued new Guidance on the provision of Wheelchairs for short-term loan. This was developed in response to national work involving the Red Cross, which highlighted inconsistency and gaps in the provision of basic wheelchairs for temporary, short-term loan.

Current criteria advises that the regional NHS Wheelchair services will, following assessment, provide standard wheelchairs for 'permanent and substantial usage'. However if the needs are short term or intermittent then the needs will not be met by the service. In terms of residents within Care Homes (residential and Nursing), it is the responsibility of the Care Homes to purchase and provide standard wheelchairs for any short term/variable needs.

Further work to clarify provision nationally has confirmed that historical arrangements for short term provision of standard wheelchairs have been inconsistent, unclear, reliant on the third sector, and staff are often left to problem solve this gap in provision leading to frustration and delays. There is evidence of a direct impact on delaying discharges from hospital settings, and lack of timely short term provision has an effect on both the physical and mental wellbeing for those patients who are at key stages in their illness/condition.

This new Guidance does not replace the obligations of regional wheelchair services but rather, addresses the gaps in provision for short-term loan needs. It provides detail on the definition of short-term loan and type of wheelchairs suitable for these temporary needs, and useful information to help services establish clear criteria and processes.

Some community equipment services have already applied this approach and can evidence the benefits in terms of the impact on wider service provision, as well as for the person who requires the wheelchair loan. A community Occupational Therapist from West Dunbartonshire said:

> I was duty OT and received a call from one of our Physiotherapists who was trying to prevent and admission to hospital. The speedy provision of the chair allowed the client to remain at home with support. The wheelchair was delivered the next day and the outcome was that the client was not admitted, instead cared for in their own home.
>
> It's great to now have this service through our community equipment store service.
>
> **Occupational Therapist**

Key Actions

- Integration Authorities must adhere to the recommendations within the Scottish Government Guidance on the provision of Wheelchairs for short-term loan, and have suitable arrangements in place to meet any eligible needs for a wheelchair on short-term loan, for up to a maximum of 6 months, to ensure no gaps in service provision.
- These arrangements must also be monitored, and reported within the Integration Authority.

Communication aids (Augmentative and Alternative Communication - AAC)

> People who have difficulty speaking and who can be assisted by communication equipment have the right to get the equipment and support they need to use it, when they need it, whoever they are and where ever they live in Scotland, enabling them to participate in their communities and be fully included in society.
>
> Vision statement from Guidance on the Provision of Communication Equipment and Support in using that Equipment.

Communication equipment may be used by people who have no speech, who are at risk of losing their speech, or whose speech is not sufficient to meet their everyday needs. The purpose of this equipment is to support a person to communicate in their daily life.

Communication equipment is either 'low-tech' or 'high-tech' and people may require to use a combination of these. The range of equipment may change over a person's lifetime.

Following the publication of the Provision of Communication Equipment and Support: Part 4 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 the Scottish Government issued guidance on the Provision of Communication Equipment and Support in using that Equipment.

In terms of the specific implications for equipment provision, or NHS Boards in Scotland, it became a legislative duty to provide or secure communication equipment and the support in using that equipment. This brings a clear spotlight on the provision of Communication equipment (AAC), and increased urgency to the need for a streamlined and standardised approach to this provision.

- In August 2018, the Augmentative and alternative communication (AAC) National Core Pathway was launched as a reference guide for health boards and all relevant partners in Education, Social care, and the third sector. This supports local partnerships in the development of their own local arrangements, allowing flexibility in the implementation. It specifically highlights the importance of clarity on the processes, and roles and responsibilities in the procurement of equipment, with the aim of streamlining service provision and delivering much improved transparency.
- In most cases, across Scotland, Community Equipment Store services have been integrated within the new HSCP (Health & Social Care partnership) Integration

models. It may be possible that further opportunities exist, working in partnership, to utilise the resources, experience, and systems that these services offer, particularly in relation to procurement and asset management, for the provision of communication (AAC) equipment, and also linking provision of other relevant equipment and technology e.g. environmental controls.

- There are also existing good practice models which have evolved in line with local service arrangements between Education and Children's services, and exemplify joint working approaches with all relevant agencies, and these offer examples of good practice to build upon.

Therefore there is not one model which is recommended. Rather, the aim is to develop local arrangements which focus on the principles of improving governance, systems, and financial and performance monitoring, which in turn help improve the service for people of all ages who need this equipment.

Approaches should be flexible and inclusive, creating the opportunity for standardisation of provision, adhering to common principles, and exploring what that might look like, recognising the wider breadth of partners and agencies involved in supporting people of all ages in our communities. In particular, Education partners have a significant role in supporting the effective use and provision of appropriate communication aids to children.

Agencies providing support for people using communication/equipment should have a robust system for equipment management (this should include the communication equipment as well as any access and/or mounting equipment used). Equipment management relates to a range of services, systems, processes, and procedures that support the provision of the relevant equipment.

It is important that local partners jointly identify the most effective model, which best suits their local arrangements, to achieve these aims:

The Model framework outlined below, was developed by colleagues engaged in the development of proposals to help deliver the requirements of the AAC Guidance.

Effective Procurement
Provide the opportunity for a broader procurement strategy that helps support standardisation of the provision of cokmmonly provided products and more specialist equipment, and offers transparancy and efficiencies around these pusiness processes.
Asset Management
Including the maintenance of an IT susten and databasem, whicb monitors activity relating to prescribing, loans, recycling and equipnebt usage to support the review of core provision and replacement/removal of products as required.
Financial monitoring and reporting
Providing regular, standard report which summarise activity, types of provision, and all costs associalted with the provision of the service e.g. not just equiopment expenditure but all relevant resource costs.

Health & Safety
Compliance with all Health & Safety legislation (e.g. PUWER / LOLER)
Decontamination and infection control
Repair, refurbishment and recycling (including resetting and depersonalisation)

The aim is to assist partnerships to have an integrated, comprehensive, and structured approach to the provision of this equipment which effectively makes best use of all partner resources, and provides robust governance and strategic direction. This provides an infrastructure which supports and compliments the AAC National Core Pathway.

The template uses the example of the good practice approach by Fife Education and Health & Social Care partners to help illustrate potential application. Whilst providing a framework around the principles of the recommended approach, it also offers flexibility in the detail of local implementation.

FAACT (Fife Augmentative & Alternative Communication Team) Structure & Principles Good Practice Example

Governance

- Joint Governance with input from all agencies.
- Written protocol defining responsibilities
- Integrated funding arrangements and robust reporting.
- **Advisory Group**: Includes managers from each of the 3 funding organisations, Speech & Language Therapy (SLT) and teacher from FAACT. Group oversees budget and work together to provide strategic direction for the service. Meets quarterly and ongoing email communication between meetings.
- **Funding:** Integrated funding pot from Education and the HSCP.
- **Monitoring and Reporting:** Advisory Group reports to the clinical lead in SLT and the Education manager, with strategic lead on additional support needs. Expenditure is monitored by the FAACT Team and reported quarterly to the Group.

Service Delivery Model

- Integrated approach with all partners supporting specialist resources and clarity of service scope.
- Strategic and operational model of service delivery with best use of wider resources supporting targeted and universal intervention.
- **Resources:** FAACT are a dedicated team with specialist teacher (0.5), Speech & Language Therapist (0.6) and technician post (0.6). Roles are interchangeable between the teacher and SLT, working across all are groups.
- **Service scope:** Delivers services to children, adults with acquired and progressive conditions, and adults with a learning disability.
- **Role:** FAACT applies the model of supporting individuals, carers and staff through the levels of universal, targeted and specialist needs. They do this by raising awareness, building capacity of carers and staff to better support AAC

needs without need for specialist intervention, and providing specialist support when required.

- **Assessment Pathways:** Individuals in the wider workforce are trained to identify communication issues and advise colleagues on support and onward referral, as required. Generic SLTs carry out early AAC assessment and interventions using toolkits, and FAACT carry out specialist assessment for a device, if required.

Equipment Provision

- Standardisation of procurement with transparency and evidence supporting business efficiencies.
- Best use of IT systems and processes for ordering and asset management of equipment.
- Best use of resources to support set-up and installation.
- Effective systems for the maintenance (H&S), repair, decontamination and recycling of equipment. Reporting of this activity and its impact on provision.
- **Procurement:** Whilst having an agreed set of providers and products, staff can order individual items to suit clients. FAACT use Enterprise Resource Planning (ERP) to procure and order equipment.
- **Ordering:** Laptops and IT equipment are ordered by FAACT via Fife Council's First Contact system. Other items are ordered, delivered and paid for by the clerical team.
- **Installation & Provision:** FAACT technician will support the programming, preparing and setting up of equipment. FAACT will ensure knowledge and skills are in place to support the use of devices supporting individuals, carers and staff.
- **Asset Management:** FAACT keep a log of equipment by retaining orders and invoices. Equipment is issued to clients and recorded via the loan agreement.
- **Health & Safety:** Compliance with PUWER and Health & Safety at Work Act 1974.
- **Repairs:** Repairs are logged and often carried out by the FAACT technician. Products bought with warranties are returned. Some equipment (e.g. laptops) will be scrapped if older or not repairable.
- **Decontamination & Recycling:** FAACT technician will decontaminate and recycle equipment which will be flattened and re-spec'd.

Key Actions

- Health and social care services, working with their adult services and education partners, should use the AAC National Core Pathway and the AAC Good Practice Model, to develop their local arrangements for the provision of AAC equipment, making best use of all local resources for the procurement and storage of equipment, and ensuring a focus on the principles of improving governance, robust systems, procurement, and financial and performance monitoring.

Technology Enabled Health & Care

Digital technology is the area of greatest change in society, and of potential transformation for health and social care.

Scotland's Digital Health and Care Strategy, April 2018

Technology Enabled Care (TEC) is defined as “where outcomes for individuals in home or community settings are improved through the application of technology as an integral part of quality, cost effective care and support”. Included under the definition of TEC, are community alarm and telecare services.

The Telecare Feasibility Study found that in Scotland, around 20% of people aged over 75 are in receipt of a community alarm/telecare service. Services can be provided by Integration Authorities, housing providers or independent providers. The majority of people in receipt of telecare (around 137,000 people) receive their service from their IA. Almost all IAs charge for their service – between £1.40 and £8.50 per week.

Telecare services support people to live safely at home with greater confidence, independence and freedom – often preventing or delaying admissions to care homes and hospitals, as well as supporting people on discharge from hospital. The service provides the person, their unpaid carers, and families, with peace of mind and assurance of a rapid response should an incident occur.

Remote Health Pathways is a term used to describe the use of digital technologies to enable citizens to gather, send, receive, record and relay relevant information about their current health and wellbeing as part of an accepted healthcare pathway.

Remote Health Pathways are a vehicle to support the movement of care delivery closer to the citizen and they are used to support asynchronous consultation with clinicians, guide both supported and independent self-management decisions by the citizen and to support health and care teams in their diagnosis, treatment and care planning activities.

A **community alarm** is a form of equipment, linked to the home telephone, for communication, especially useful as an alert should the user have an incident where they require to call for help quickly. Typically, it includes a button/pull cord/pendant. It can be used within an individual’s own home or part of a communal system.

Telecare refers to a technology enabled care package which goes over and above the basic community alarm. It usually refers to sensors or alerts which provide

continuous, automatic and remote monitoring of care needs, emergencies and lifestyle. Examples include smoke, heat, gas and flood detectors, fall detectors, door exit sensors, epilepsy and enuresis sensors and GPS locator trackers. Telecare will usually, but not always be 'linked' to the home hub or communal alarm system.

Both community alarms and telecare transfer alerts, alarms or data to a call handler in a 24/7 monitoring centre or an individual responder, such as a carer or family member. Many HSCP telecare services also offer a telecare responder service, which provides an in-person response to an alert, when required. For services that don't have this option, the call handler can contact a responder, identified by the person receiving the service. Emergency services will always be contacted when required.

An additional offering of most telecare services is Lifestyle Monitoring. Lifestyle Monitoring is a digital activity monitoring system that can help care professionals complete objective and evidence-based assessments, enabling people to receive the right level of care and support. It involves installing discreet door and movement sensors around a person's home for a limited assessment period, providing an overview of their daily activity, and helping professionals make proportionate care decisions.

A telecare self-check online tool is available on NHS inform, which enables people to find information about telecare services in their area.

Telecare services are entering a significant period of change - over the next few years they will transition from an analogue to a digital service. The transition will be a major piece of work, however, it will bring opportunities to redesign and innovate, and achieve better outcomes for people who receive the service. Ambitions for telecare include adopting a more integrated, proactive and intelligence-informed approach to care and support, which embraces smart sensor technology and consumer devices.

Scotland's Digital Health and Care Strategy outlines how technology will be used to reshape and improve services, support person-centered care, and improve outcomes.

The vision going forward is of a better, integrated approach. Technology plays an important role in supporting prevention, early intervention, and self-management, and many community services have started to explore consumer pathways, providing options for people to choose their own digital solutions as part of self-management and earlier intervention strategies.

There are also excellent examples from Housing providers which illustrate how important this type of technology can be, in preventing isolation and enabling people to better manage all aspects of their lives. There are good examples, such as Digital Housing strategies, and of joint working between the agencies

The TECHousing website provides examples of initiatives already in place by housing providers, which have been invaluable during the Covid pandemic, making a significant contribution to helping people feel less isolated and more connected and assisting them to access services far more easily. These approaches are also promoting the use of preventative analytics to allow greater opportunity for intervention at an earlier stage, potentially reducing the risk of falls and frailty. There is considerable opportunity for Housing and Health and Social Care partners to expand on their work together to further maximise the opportunities these approaches offer.

In the context of the review of Adult Social care, and the proposals for a national Care Service, the provision of technology is acknowledged as an important mechanism to support the shift to more preventative services. A feasibility study for the provision of telecare services for over 75s, published in August 2017, explored the potential for universal Telecare services, as a way of helping achieve these aims. The report identified ways in which uptake of services could be improved and charging was identified as one of the barriers. Recommendations from that report included the need to standardise approaches across the country, increase equity, and full exploration of ways to reduce costs in the system and in turn, reduce cost to the service user, as a barrier to provision. Overall strategy needs to be aligned with wider health and social care service objectives, in order to help maximise the potential of these services, to keep people safe and well in their own homes, preventing cost elsewhere in the health and social care system. This approach includes the need, as with all equipment & adaptation provision, for effective staff training across a wide range of services and agencies to support effective assessment and provision.

For more information on the Scottish Government's TEC Programme and telecare, please go to TECScotland.

Key Actions

- Health and Social Care partners, with their Housing colleagues, should work together to maximise the opportunities provided by TEC, developing local strategy and policies, which help people to choose their own digital solutions as part of self-management and earlier intervention approaches, as well as utilising technology to address issues of isolation and frailty.
- This should include reviewing charging policies to ensure that these are not acting as a barrier in the system, preventing services from supporting those most vulnerable.

Sensory Impairment

The Scottish Government is committed to supporting children and adults who have hearing loss, sight loss and dual sensory loss to access the health services and social care they need and to have the same access to employment, education and leisure as everyone else through its National See Hear Strategy.

See Hear provides a strategic framework of action for meeting the needs of people with a sensory impairment against a background of increasing demand, requirements for greater efficiency and effectiveness, and Health and Social Care Integration. It is designed to act as a lever for change, and facilitate that change across multiple agencies and services. Since publication in 2014, the Scottish Government has provided funding to establish and support a national network of *See Hear* Leads and local partnerships between statutory and third sector organisations, across every local authority area in Scotland.

This funding is used to help achieve the recommendations set out in the strategy, and these are implemented via the local partnerships. The Partnership Leads Network is facilitated and supported by the National Co-ordinator for See Hear, who regularly meet to share progress, ideas and best practice.

In addition, the Scottish Government provides funding for the Scottish Sensory Hub, based in the ALLIANCE. The hub hosts the See Hear National Coordinator, along with Deaf Scotland, and the Scottish Council on Visual Impairment (SCOVI). Its role is to facilitate collaboration between the Deaf, Deafened, Hard of Hearing, Deafblind and Sight Loss sectors and develop a rich resource base of expertise, skills and knowledge for people with sensory loss and those who work in this field and will signpost to local pathways of support and services.

The Scottish Government also continues to fund and support the contact SCOTLAND - BSL online interpreting Video Relay Service, which enables Deaf and Deafblind British Sign Language (BSL) users to telephone, via video relay interpreters, private sector numbers as well as statutory and third sector numbers, 24 hours a day, 365 days a year.

The timely provision of appropriate equipment is crucial in terms of effectively delivering the strategic objectives of the *See Hear* strategy. As with people with all other needs, equipment can make a significant difference, helping people to fulfil their potential, and actively participate in employment, education, and in their everyday activities, supporting their overall well-being.

Fire Safety Alarms

Appropriate specialist alarms can also help ensure people with sensory loss are kept safe in their home. The Housing (Scotland) Act 1987 (Tolerable Standard) (Extension of Criteria) Order 2019 brought in a requirement for all homes in Scotland to have interlinked alarms.

By February 2022 every home must have:

- one smoke alarm in the living room or the room you use most;
- one smoke alarm in every hallway or landing;
- one heat alarm in the kitchen.

All smoke and heat alarms should be mounted on the ceiling and be interlinked.
If there is a carbon-fuelled appliance – like a boiler, fire, heater or flue – in any room, there must also be a carbon monoxide detector in that room, but this does **not** need to be linked to the fire alarms.

Although the legislation does not refer to specialist alarms, it is important to highlight that existing Deaf alert systems are not compatible with the new interlinked products. Therefore, if a homeowner has an existing **specialist** alarm, they will need to contact their local Health & Social care, Sensory impairment services, to seek advice on which type of new system they will require to purchase, so that they select a system which will also provide them with the option for new compatible specialist deaf alarms, which can then be installed by the local services.

This will avoid having to have two separate systems, and any confusion that may cause, and ensure that they are protected. There are companies which manufacture compatible specialist accessories already available.

Local health and social care partnership Sensory Impairment services, and community equipment services, should review the compatibility of their specialist alarms to the new interlinked systems, so that they can advise service users as required.

In terms of overall responsibilities, IAs and their Community Equipment services should ensure that they work with relevant stakeholders, and have effective pathways in place which meet the key equipment needs of people with sensory loss, and offer streamlined access to a range of appropriate equipment as part of the core equipment service provision

Key Actions

- Health & Social care services and their Community Equipment services should ensure that they work with relevant stakeholders and have effective pathways in place which meet the equipment needs of people with sensory loss
- This should include the provision of streamlined access to a core range of appropriate equipment for both hearing and visual impairment.

Integrated service pathways for provision

Pathways

Anyone requiring equipment and adaptations, or other care services should experience a seamless journey through the pathway of care, which then ensures they receive the right intervention at the right time. To guarantee that changing care needs are managed effectively, it is essential that equipment and adaptations are seen as an integral part of the service pathways and can be provided by a wide range of staff across all service settings.

Some service users have progressive conditions that change over time. Anticipatory approaches to provision are needed to ensure that services, including equipment and adaptations, are made available to accommodate these changes.

It is therefore essential that health and social care services extend staff roles, and move away from traditional professional boundaries, and service arrangements, which act as a barrier to effective equipment service provision.

The Integration of Health & Social Care has encouraged services to review their pathways and better utilise multi-disciplinary approaches to service provision. Within this context, work to integrate Occupational therapy roles in health and social care, has supported a number of partnerships to review the role of Occupational Therapy and the contribution of the profession through a wider lens, encouraging more targeted use of the specialist contribution, and a sharing of more generic roles (e.g. including equipment and adaptations). Nurses and physiotherapists are well placed in the service pathways to assess and provide equipment in a timely and responsive way, and pathways should be reviewed to ensure all other relevant staff and third sector partners are also able to take on these roles as appropriate.

Responsibility for provision

Assessment and provision of equipment is recognised as the responsibility of all care groups and services, as a means of supporting overall service delivery. Staff should therefore not be viewed as ‘orderers of equipment’, or this only to be the responsibility of certain professions or services. Instead, our pathways should be designed to ensure that any staff who are involved in assessing the needs of a person who may require equipment to support them, are then able to directly provide equipment, to complement their interventions, and/or support wider service goals. Relevant Health & Social Care staff, should be able to access a wide range of equipment and simple adaptations, appropriate to the type of service they are providing, and not based on professional or agency boundaries.

- It is essential that financial arrangements support this, and that Integration Authorities have funding mechanisms which ensure that all equipment purchased by the Community Equipment Store services is paid for from the one joint funding mechanism (‘pot’), and then recharged to partners according to the services which have assessed for and requested the provision of the

equipment , rather than to do with certain types of equipment being funded by particular agencies.

- The same principles, of streamlining the funding arrangements should apply to the provision of Adaptations and these themes are more fully explored in the next section of this Guidance.

Consideration should also be given to the inclusion of other partners e.g. Housing, Education, and relevant third sector partners, in the service pathways, to open up and streamline access according to levels of need.

These arrangements ensure that staff can access ordering arrangements directly, without the need to refer on to a separate agency or professional group to order on their behalf.

Provision should differentiate between meeting straightforward, non-complex needs (Standard provision), and where a specialist assessment is required to meet complex and/or high risk needs (specialist provision). Through good assessment practice and by evidencing their reasoning, staff will be able to establish what the risks are around the provision, and consider their own competence to meet these needs. This approach is therefore not dependent on the type of equipment or adaptation being provided, as:

- some complex equipment (e.g. hoists) can be provided in a straightforward manner without fear of risk, if the service user and/or carers are familiar with that equipment and there are no other risk factors:
- Some very simple non mechanical equipment can pose significant risk if not provided with due consideration of the potential hazards (e.g. bath boards).

This is equally true of adaptation provision, and there are examples nationally where the assessment and provision of adaptations has been widened out to ensure staff other than Social Care occupational therapists (traditionally viewed as the assessors of adaptations), can competently meet these needs without referring on.

It is expected that the majority of provision can be met directly by staff who originally identify the needs, however if the member of staff does not feel competent due to the complexity of needs falling within another professions expertise, they should refer to that service for an assessment, and/or jointly assess as this can often be most effective in ensuring that all needs are considered. The referral should not prejudge what the outcome of that may be e.g. this should not be a ‘prescriptive referral’ for a certain type of equipment/adaptation, but identify the needs that require to be met.

Training

Staff across services who are involved in identifying equipment and housing based needs should be trained to assess and provide a wide range of relevant solutions, irrespective of their own professional background, or agency. The training should strongly emphasise good assessment practice, the need for ‘good conversations’ which focus on personal outcomes, and encourage prescribers to consider their

reasoning for provision, contraindications, recording of decision making, and ensures avoidance of over-prescription.

Core Training modules should be available as part of an annually updated training programme which is open to all relevant partners and agencies.

Where these arrangements are in place, this encourages:

- Robust and consistent approach to the assessment of need and prescription of appropriate solutions, simplifying service pathways across service and professional boundaries.

Promotion of joint working and partnership approaches in the assessment and prescription of equipment and adaptations, in the context of wider service provision for all care group services.

Protocols & policy

Inter-agency agreements (Protocols) should be in place, defining the arrangements between the Partners in terms of the roles and responsibilities of staff and their managers, and the processes for assessment, prescription, and provision of equipment and adaptations.

Partnership arrangements (including all relevant agencies e.g. housing and third sector partners) should prevent duplication in the assessment process by allowing staff to directly access equipment & adaptations, without having to refer to another practitioner, and widen access in the service pathway (allowing other staff/professions/services to order equipment & adaptations) so that service users and their carers receive equipment far quicker and more effectively.

This should result in the following outcomes:

- Streamlined access to service provision
- Improved speed, efficiency and effectiveness of service delivery
- Maximise the use of resources
- Better outcomes for people who need equipment and adaptation solutions

Increasingly a number of health and social care partners have chosen not to include some small, low cost items within their standard stock of equipment as these may not be vital to meet the desired outcomes of individual. Examples provided in the 'Prevention, Early intervention, and Self-management' section in this document, outline the initiatives developed by a number of partnerships to improve the signposting to advice, and self-assessment and self-purchase options, allowing people to independently access relevant solutions.

- Individuals with simple or non-complex needs should be able to access equipment and minor adaptations without the need for a specific professional assessment thus making services more accessible. A streamlined approach to assessment and provision, which avoids unnecessary bureaucracy will ensure that services are provided in a timely and efficient way. This can include models utilising direct access.

The refreshed Good practice guide for the provision of community equipment services, and a version for Adaptations (with an accompanying example Housing Solutions Protocol) and the self-assessment tool which accompanies this Guidance, should assist partnerships to review their arrangements in line with these aims. All these resources can be found on the Scottish Government blog page.

Key Actions

- Equipment and adaptations should be seen as an integral part of the wider service pathways and their contribution should be clearly articulated in local health and social care strategies.
- Relevant health & social care staff, should be able to access a wide range of equipment and relevant adaptations, appropriate to the type of service they are providing, and not based on professional or agency boundaries.
- Partnerships must have funding mechanisms which ensure that all equipment purchased through the Store service is paid for from the one funding 'pot', with no barriers according to type, or professional use.
- Staff across services who are involved in identifying equipment and adaptation needs should be trained to assess and provide a wide range of solutions, irrespective of their own professional background. The training should strongly emphasise good assessment practice, the need for 'good conversations' which focus on personal outcomes, and encourage prescribers to consider their reasoning for provision, contraindications, recording of decision making, and encourages avoidance of over-prescription.
- Inter-agency agreements (protocols) should be in place, defining the arrangements between the partners in terms of the roles and responsibilities of staff and their managers, and the processes for assessment, prescription, and provision of equipment and adaptations.
- Individuals with simple or non-complex needs should be able to access equipment and minor adaptations without the need for a specific professional assessment. This can include models utilising direct access and self-assessment tools.

Community equipment Store service models

Since the original guidance in 2009 many Store service arrangements have been reviewed, and Integration has also proved to be a catalyst in helping partners reflect on their local models for provision.

However more could still be done to improve service pathways and remove barriers to the provision of equipment for people in our communities, particularly in relation to issues with the separate funding stream arrangements some equipment services have in place, which can create barriers and blockages.

Store services should be resourced by partners with a funding 'pot' which allows the Stores to procure equipment into the service, according to demand, throughout the year, with all equipment funded equally from this arrangement. Costs for the use of the equipment should then be charged to partners according to use by their services, rather than by type.

The Store service arrangements should be designed and resourced to effectively meet the partner objectives, ensuring that the equipment service is strategically aligned across all relevant services, with clear statements which articulate the expected benefits of timely equipment provision within the service pathways, between hospital and home, institutional settings, and community.

It is the partners' responsibility to ensure that the Store service is appropriately resourced and is provided with clear direction on the business requirements with robust governance in place. Operational and strategic managers should be clearly accountable for expenditure, and actively support the Store service managers to achieve business efficiencies, as well as ensuring they provide a responsive and effective operational service.

The partnership should have documentation which supports effective governance including a service level agreement with the Store service which clarifies the service specification, standards, and monitoring and reporting requirements. The partners should also outline their own arrangements and relationship to the Store service as 'service provider', with an agreement which confirms their obligations and roles and responsibilities.

The funding model needs to allow the Store service to seamlessly procure a wide range of standardised **core equipment** (and nonstock equipment as required) which should include equipment most commonly assessed for by physiotherapists, nurses and occupational therapists, and for all care groups, and ages including children, with an annually agreed budget which guarantees appropriate levels of funding throughout the year.

The earlier section on the ‘Contribution of equipment and adaptations provision’ highlighted the importance of equipment and adaptations, as a cost-effective intervention, with significant benefits for people in our communities, and any decisions to adjust funding need to be properly thought through in terms of the wider impact on service pathways and outcomes.

A fit for purpose IT system should not only allow streamlined processes for the ordering, delivery, and asset management of equipment and relevant adaptations, but also ensure detailed activity information which provides performance and management reports, supporting the proactive strategic management of the service, and accountability at front line and local team level.

The refreshed **Good practice guide for the provision of community equipment services** and the **baseline assessment tool** which accompanies this Guidance, should assist partnerships to review their Store service models in line with these aims. These resources are available on the Scottish Government blog page.

Key Actions

- Store service arrangements should be designed and resourced to effectively meet the partner objectives, ensuring that the equipment service is strategically aligned across all relevant services to help deliver key aims related to supporting hospital discharge, and effectively maintaining people in the community.
- Store services should be resourced by partners with a funding ‘pot’ which allows the Service to procure equipment into the service, according to demand, throughout the year, with all equipment funded equally from this arrangement. Costs for the use of the equipment should then be charged to partners according to use by their services, rather than by type.
- Funding model should allow the store service to procure a wide range of standardised core equipment (and non-stock products as required) for people of all ages and needs (e.g. including equipment assessed for by all relevant Allied Health professionals (AHP’s), nurses, care staff, staff working in Sensory services etc.), with an annually agreed budget which guarantees appropriate levels of funding throughout the year.
- Operational and strategic managers should be clearly accountable for overall expenditure and actively support the store service managers to achieve business efficiencies, as well as providing a responsive and effective operational service.
- Partnerships should utilise the **Good practice guide for the provision of community equipment**, and the new **self-assessment tool**, to assess current services and ensure their arrangements are in line with the aims of the national guidance.

Health & safety

The Health and Safety at Work etc. Act 1974 requires employers to ensure the health safety and welfare of all their employees, so far as is reasonably practicable.

It is therefore important to clarify that the liability and responsibility for ensuring adherence with health & safety legislation sits with the employers of staff using equipment, and not with the Store service provider who procures and delivers the equipment. Store services will, as part of their wider service, provide repairs, maintenance, and health and safety testing as directed by the partners, who fund the Store service arrangements.

The Store service is therefore responsible for carrying out testing arrangements as agreed with the partners. It is therefore incumbent upon the partners to ensure they have funded and resourced, and clearly directed their Store service provider on the requirements to be met.

The general provisions in the 1974 Act are reinforced by Regulations which define in more detail what duty holders must do in particular areas.

Since 1993 the Manual Handling Operations Regulation 1992 have provided a general framework for tackling handling activities at work. The regulations require the following approach:

- To avoid the manual handling activities where it is reasonably practicable to do so; and, where it is not,
- To assess the risk and take appropriate steps to reduce it so far as is reasonably practicable.

The above regulation is not restricted to the lifting and moving of objects, but also covers ‘helping people’ tasks such as helping a disabled child out of bed or helping an elderly person go upstairs.

Risk Assessment

As an employer, the service provider or the employing agency has primary responsibility for ensuring the health and safety of their care workers and managing the risks associated with their work duties.

Mobility assistance considerations will be a significant factor in determining the overall cost of delivering any care package to the service user. Health and safety risk management must, therefore, form an integral part of the care assessment, so that the hazards are identified and dealt with before the care worker and the service user are put at risk.

This should be considered, while ensuring an enablement, rehabilitative approach to the shared care and support plan. The Moving and handling section earlier in this document highlighted the need to avoid blanket approaches to the management of risk and our services need to avoid inadvertently disabling people and impacting on their well-being, by over-prescribing equipment and adaptation provision.

Training

Training is an essential part of a proper risk management, based on sound risk assessment. When providing mobility assistance to a service user it is not always possible to avoid manual handling tasks, even when support equipment is available.

- It is essential, therefore, that all care workers (including unpaid carers) are suitably trained in safer handling techniques.
- It is the responsibility of the employing agency to provide appropriate Moving and Handling training for their staff.
- When services are assessing and providing equipment to be used by an unpaid carer they should be referring the carer, for support with accessing moving & handling training – this may be via their local Carer's project team.

Using equipment safely

Service users and care workers can be injured if equipment is used inappropriately, or is not properly maintained. Service providers, or employing agencies must ensure that the equipment is in good working order, and that all care workers are aware of and understand the appropriate application and limitations of the different pieces of equipment they are expected to use.

- Good practice advises that a visual inspection of equipment should take place by the workers, before they use the equipment, to ensure all parts are in working order. This is considered vital in the overall maintenance and safe-use of equipment.

Responsibility for maintenance of equipment

Equipment provided for use by care workers:

If the health and social care service provider supplies equipment such as a stair lift, or hoist, intended for use by care workers while attending to the service user, then the equipment may be considered 'work equipment'. In these circumstances, the Provision and Use of Work Equipment Regulations 1998 (PUWER) will apply.

Depending on the type of equipment, the Lifting Operation and Lifting Equipment Regulations 1998 (LOLER) may also apply, i.e. if the principle function of the equipment is lifting. For example, LOLER will not apply to electrical profiling beds but it will apply to hoists, as their principle function is lifting persons.

- These regulations require the employer of the staff using the equipment, to ensure that equipment and adaptations are maintained and inspected as part of a servicing programme.
- In addition to routine maintenance and servicing, LOLER requires lifting equipment to be inspected and thoroughly examined. Thorough examination by a 'competent person' is required either at six-monthly intervals or in accordance with a written scheme of examination drawn up by a 'competent person'. A competent person is someone with the relevant technical knowledge and practical experience of lifting equipment to enable them to detect defects or weaknesses and to assess their importance in relation to the safety and continued use of the specific equipment being examined.

- It is therefore the responsibility of the partners to work with their community equipment Store service and adaptation service providers to agree and ensure appropriate inspection and service maintenance arrangements are in place for all relevant products.
- In most cases, Store services sub-contract this work to ensure this is kept separate from routine maintenance and repairs. It is essential that Store service keep accurate records detailing the testing schedules, and review these to ensure adherence with the timescales recommended in the regulations.

Equipment provided for use by the family and unpaid carer:

If the equipment is not intended for use by people at work, then PUWER/LOLER regulations will not apply. However, the equipment provider has responsibility under the general provisions of the Health and Safety at Work etc. Act 1974, to ensure that it is safe for the service user and others to use. Although the PUWER/LOLER regulations may not apply, their provisions can be used as a guide to establish proper maintenance arrangements. It is important that all parties involved are clear at the outset who will carry out the necessary maintenance. Partners and their Store service provider should ensure they have clarified what arrangements they wish to have in place as standard maintenance arrangements for all relevant equipment.

Equipment provided by the service user:

Service users have no duties under health and safety legislation to maintain their own equipment. However, the position is complicated where a formal carer is employed directly, for instance where the service user funds their care through self-directed support arrangements. In these circumstances, service users may have duties under health and safety legislation. The Scottish Government fund a number of independent agencies across the country which are facilitated by Inspiring Scotland to assist people to access and manage their self-directed support.

Health and social care service providers have no powers under health and safety legislation to compel service users to have their own equipment maintained. However, as an employer, the service provider is still responsible for ensuring their care workers' safety. It is up to the service provider to assess whether any equipment provided by the service user is suitable for their care workers to use, to discuss with the service user any changes which may need to be considered, and if the equipment is to be used by people at work, to ensure that any applicable maintenance and inspection legal requirements of PUWER and LOLER are complied with.

In these circumstances the HSE would expect a competent person, trained in risk assessment, to make the initial risk assessment of the tasks associated with delivering the care, including the use of the equipment, and to record the significant findings. This is in addition to the day to day need for formal carers (who have had sufficient and appropriate training) to make an assessment of a task before undertaking it.

Assessing equipment owned by the service user:

In some cases, service users may have a service agreement with an equipment supplier, particularly for major items of equipment, such as stair lift or mobile hoists.

Where these arrangements provide evidence that the equipment is properly maintained and the service provider is satisfied that it is safe for their care worker to use, then it can be incorporated into the care plan. However, it will be necessary to confirm periodically that the service contact continues to operate and the necessary checks have been carried out regularly.

In the absence of such service agreements, the service provider will need to take other measures to ensure the safety of their care workers. This may be by taking over, with the service user's agreement, the equipment maintenance arrangements or instructing the care worker not to use the equipment.

Reporting Adverse Incidents to IRIC

The Incident Reporting & Investigation Centre (IRIC), which is part of Health Facilities Scotland (HFS), receives adverse incident reports from NHS Boards and local authorities. It is responsible for coordinating, investigations so that, as far as possible, root causes can be established, and remedial action taken to prevent or reduce any identified risks.

- Partnerships should have clear arrangements in place which identify the roles and responsibilities of all stakeholders, in the event of an incident. These arrangements should ensure a thorough investigation which confirms whether potential equipment failure, or user error has caused the incident. This should clarify the role of the person reporting the incident, the role of the member of staff who originally assessed the provision of the equipment, their line manager/service, the role of the Store service in investigating any suspected failure of the equipment, with the manufacturer, and for notifying IRIC.

Details on how to report an adverse incident is available on NHS Scotland's Incidents and Alerts site.

Member of the public can also report adverse incidents through the Yellow Card Scheme.

Medical Device Alerts

The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for the regulation of medical devices throughout the UK and for issuing Medical Device Alerts (MDAs).

A new Electronic Medical Device Alerts (eMDA) format has been used by MHRA since April 2009 and applies throughout the whole of the UK. It is a web based system with various information sections which include sections for each devolved administration so that relevant information may be selected for cascading within each organisation

As soon as a new alert is published HFS will notify all Equipment Coordinators in Scotland by email, as detailed in the Safety Of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities guidance.

In the case of an eMDA the email will contain a summary page and a link to the MHRA website. It is the responsibility of each Equipment Coordinator to determine if each alert is relevant to their organisation and to download it for onward distribution and action. In most cases, the Store service manager will circulate relevant alerts and identify appropriate action for the service and communicate this to partners e.g. this may involve the removal of a stock product.

The latest MDAs can be found on the HFS site on the NHS Health Facilities Scotland website.

Key Actions

- Partnerships should follow the Manual Handling Operations Regulation 1992 which provides a general framework for tackling handling activities at work.
- Health and safety risk management must form an integral part of the care assessment.
- All care workers (including unpaid carers) must be suitably trained in safer handling techniques. It is the responsibility of the employing agency to provide appropriate training for their staff and the assessor/care manager should refer the unpaid carer to relevant support for moving and handling training.
- Care service providers, or employing agencies must ensure that the equipment is in good working order, and that all care workers are aware of and understand the appropriate application and limitations equipment.
- Partners and their Store service provider should ensure they have clarified what arrangements they wish to have in place as standard maintenance arrangements for all relevant equipment. It is then the store services responsibility to ensure robust servicing and maintenance arrangements are in place.
- Partnerships should have clear arrangements in place which identify the roles and responsibilities of all stakeholders, in the event of an incident, including reporting to IRIC.
- Store services should have arrangements in place for the circulation of relevant MHRA alerts, and appropriate responses to the alert.

Recycling, Infection Control and Decontamination

The Health and Safety at Work etc. Act (1974) places a number of duties on employers and employees concerning the requirements of safe working practices. Furthermore, The Management of Health and Safety at Work Regulations (1999)[36] place a statutory duty of co-operation between employer and employee to provide each other with clear communication in health and safety matters, including any hazards associated with their activities, e.g. decontamination, transfer of material or equipment etc.

It is therefore expected that Store services, on behalf of the partners, will have in place arrangements which ensure the robust cleaning, and refurbishment of all equipment and relevant adaptations. Advice can be provided by local NHS infection control leads. It is recommended that there should be a separation of arrangements within the Store to comply with decontamination good practice, for 'dirty' and 'clean' equipment.

Investing in cleaning facilities and systems within the Store can deliver business efficiencies, and significant savings can be made through the effective retrieval, cleaning and servicing of equipment.

Good Practice Example

EquipU, the joint equipment store covering 6 local authorities and NHS Greater Glasgow and Clyde in the central west of Scotland, reported that during 2021 £4.2 million worth of equipment was recycled back to the partners, with a reuse cost of only £410,000. The ability to evidence these efficiencies has allowed the partnership to continue to develop, and helped protect the funding for the Store Service.

Partnerships and their Store service providers should be encouraged to record and monitor the recycling benefits they deliver, as this information can be used to evidence savings and efficiencies as part of wider budgetary discussions.

These principles should also apply to the provision of Adaptations. It is evidenced across Scotland that commonly provided standard adaptations have the ability to be recycled.

There are differences in the funding arrangements nationally, for items such as Stairlifts, with some services defining these as equipment, and providing them as part of their Community Equipment services, and other partnerships defining these as Adaptations and funding them from those budgets. Irrespective of the funding arrangements, there are significant opportunities to encourage the recycling of these type of solutions, and this can also be true of other types of adaptation provision.

‘Recycling’ efficiencies should also apply to the adapted properties themselves, and it is recognised that services need to do more to ensure the appropriate allocation of accessible and adapted properties to match needs in the community, avoiding unnecessary waste.

Key Actions

- Store services will have in place arrangements which ensure the robust decontamination, cleaning, and refurbishment of all equipment returned to the Stores service.
- IAs and their equipment and adaptation service providers should ensure they maximise the potential benefits from recycling of all equipment and relevant adaptations, and record and monitor the recycling benefits they deliver, as this information can be used to evidence savings and efficiencies as part of wider budgetary discussions.

Section Three: Adaptations and Housing Solutions

Adaptations and Housing Solutions

Improving services

The timely provision of adaptations can make a significant difference to the outcomes for an individual in relation to where they can live and the level of independence they have within their daily environment. These modifications can be critical in acting as preventative measures. They can help to reduce the number of emergency hospital admissions through falls and other accidents, and also reduce the need for home care or long-term admission to a care home. For children, adaptations can support functional, social & emotional development and can provide an improved quality of life for the whole family.

However, adaptations should be seen as one of a number of possible solutions available, and it may be that housing support, or re-housing could be a better option for long term needs.

> It is therefore essential that any person or family seeking any type of disability-related adaptations, should be properly encouraged to discuss their wider housing circumstances at the earliest possible stage. It is vital that we help families consider their long-term housing needs at an early stage, and proactively support them to identify solutions that could minimise the need for more extensive adaptations, and disruption, in the future.

It is also essential that there is an understanding of the depth and breadth of this agenda, recognising that adaptations and inclusive housing environments, are required for a broad cross section of people of all ages and with different physical, sensory, cognitive, mental health & neurodiversity needs. General accessibility issues become more pronounced where people are wheelchair users.

The 2018 report by Horizon Housing Association and the Chartered Institute of Housing (CIH), Still Minding the Step?, is a review of their original 2012 report, produced to estimate the housing needs of wheelchair users in Scotland, and to recommend a range of improvements.

The report emphasises the requirement for a strategic approach and better planning, noting that their review of the 32 local housing strategies indicated that a quarter of authorities do not plan for housing to a wheelchair standard. The authors also criticise the application of the medical model of disability, which is still in evidence across the housing sector, and the practice of categorising the needs of wheelchair users as ‘specialist’ provision, rather than acknowledging the need for accessible housing as a standard. The overall aim is one which mainstreams an ‘Inclusive design/living approach. The report lists a number of recommendations that call on action from government but also should help inform local housing, health and social care partners in their strategic planning.

The growing prevalence of Dementia has been recognised as a pressure in health & social care, with over 90,000 people estimated as living with the condition, but also has an impact on housing. The Scottish Housing and Dementia Framework was published in Oct 2019 and aims to support the housing sector to articulate its contribution to supporting people living with dementia to stay at home for as long as practically possible.

Although the framework has been primarily designed to be applied by the housing sector, with specific support in place to assist housing organisations to sign-up to this, it can also, usefully be adopted as a tool to review local strategy and arrangements between housing and health and social care partners.

Policy context

There have been a number of policy & legislative developments since the original guidance, which have shifted the tone of the discussion around adaptations, to widen the perspective in terms of the need for effective strategic approaches, embedded and aligned with the developments in health & social care. These recognise the need to move away from reactive provision, and instead encourage better planning for the needs of people, in our communities.

In addition, in the wake of The Independent Review of Adult Social Care**,** there is a renewed interest in fundamentally improving the processes and infrastructure which deliver services, to offer greater emphasis on preventative and anticipatory responses, and removing barriers in the systems.

Adaptations Working Group and Adapting for Change

This context offers an opportunity to revisit the work previously carried out by the independent Adaptations Working Group (AWG), (and the subsequent Adapting for Change programme), which reported in Dec 2012, with recommendations which are still very relevant but, have as yet, with the exception of the Housing Solutions programme, had little support in terms of large –scale roll-out, which was the original aim.

The clear messages from the AWG highlighted the need for:

- A person-centred approach to Adaptations;
- Prevention as a key focus, with early consideration of alternatives to adaptations, which may provide a better solution e.g. move to more suitable housing;
- Providing equity in the system, removing tenure as a barrier – requiring a ‘tenure neutral’ approach;
- Effective integrated strategic planning, and governance with involvement of all key partners;
- Pooled budgets, and avoiding budget driven service provision.

Adapting for Change (AfC)

The Adapting for Change programme, was initiated to identify and deliver improvements to the provision of Adaptations for people living across all tenures in our communities based on the recommendations from the 2012 report, Adapting for Change: the Adaptations Working Group's Final Report. Its remit was to explore ways to achieve the best possible outcomes for older people and disabled people from investment in housing based solutions. It made a number of recommendations in the main report and in an additional report, Planning Ahead: Living at Home which focused on promoting opportunities for self-help and forward planning to help avoid the need for crisis responses.

The Adapting for Change (AfC) report highlighted a number of opportunities to improve housing adaptations but concluded that more fundamental action was needed. In 2016 and 2017 the Scottish Government worked with health, social care and third sector organisations, to support the testing of innovative approaches to these challenging issues, with the aim that recommendations from the evaluation of the programme, and the ongoing outputs from the test sites would provide practical help to inform effective service improvement, across the country.

The AWG's recommendations were tested in five test sites across the country (Borders, Fife, Falkirk, Aberdeen and Lochaber). The full Adapting for Change evaluation report and shorter Adapting for Change learning points summary, provide detail on the outcomes and recommendations from this work.

The key principles and themes which emerged from the Adapting for Change programme include the need to:

- streamline processes;
- evidence effective Outcomes for people;
- deliver tenure neutral approaches which treated all service users equally irrespective of the type of property they happened to live in;
- provide one-stop shop/integrated approaches;
- a wider focus on all housing solutions including rehousing,
- an emphasis on prevention and early intervention strategies to help people consider their longer term housing needs, in advance of crisis situations.

Housing to 2040

> Housing to 2040 sets out a vision for housing in Scotland to 2040 and a route map to get there. It aims to deliver our ambition for everyone to have a safe, good quality and affordable home that meets their needs in the place they want to be.
>
> **Housing 2040**

Published in March 2021, Housing to 2040, and the document's vision and principles for the future of housing, outline what the Scottish Government wants housing and communities to look and feel like, for the people of Scotland, with actions on how to achieve this.

The principles underpinning the Vision provide a high-level guide, directing local partnerships as to how policy decisions might be shaped in the future, in order to deliver these requirements. This is Scotland's first long-term national housing strategy.

Around £16 billion will be invested to deliver 100,000 more affordable homes by 2032, with a minimum of 70% of these being for social rent. Plans for a new legal requirement for all homes to meet the same standards are also included in the strategy. The new, tenure neutral Housing Standard, will create a single set of quality and accessibility standards, and the proposals will also review Housing for Varying Needs.

The Vision also emphasises the importance and need for homes that effectively meet the needs of people of all ages, including children, with the requirement for responsive provision of equipment and adaptations, and technology. Government has therefore also made a commitment to review adaptations within this context. Scottish Government will publish a draft Standard in 2023 and introduce legislation in 2024-25, for phased introduction between 2025 and 2030.

Integration

Under the Public Bodies (Joint Working) (Scotland) Act 2014, responsibility for delivery of functions relating to housing adaptations and equipment (aids) now lies with Integration Authorities. Key responsibilities delegated to the Integration Authority are:

- The duty to assess for an adaptation
- Planning for and resourcing adaptations.
- The duty to provide grants of 80% or 100% for those living in the private sector, who are assessed as needing adaptations.

Financial resources previously deployed for tenants of Councils have also passed to the Integration Authority. Funds for adaptations undertaken by Housing Associations and Co-operatives (RSLs) etc. have not been passed to the Integration Authority, but the IA has responsibility for ensuring that relevant HSCP services are available to support adaptations for RSL tenants.

Despite the scope of the delegated duties above, little has changed in terms of widespread strategic planning, or improvements in the delivery of services although, encouragingly, there have been some more recent examples of tenure neutral approaches being applied, and some HSCP's working closely with Housing colleagues to progress a strategic improvement approach. These approaches are very encouraging and need to be supported

Work needs to be actioned in line with recommendations outlined below, which would properly realise the original vision and intent behind the move to shift governance under the integrated arrangements. This is articulated in a report by the University of Stirling developed as part of The Adaptations Policy and Practice Project, co-ordinated by the UK Collaborative Centre for Housing Evidence (CaCHE):

> If the ambitions of key policies such as Housing to 2040 are to be fulfilled, the current adaptations system in Scotland not only needs to be reviewed, but overhauled and reset to support investment, partnership working and integration of adaptations into wider health, social care, and housing priorities.
>
> **University of Stirling**
> Adaptations Policy and Practice Project

Delivering change

There is now an impetus to address the outstanding issues, with the need to bring all relevant housing, and health & social care stakeholders together to create service models which remove the barriers to provision, and offer a genuine person-centred, **'tenure neutral'** approach, for people living in our communities.

One of the ways of addressing inequities in the system, would be to remove the need for owner occupiers to apply for grant and instead provide 100% funding for the provision of fully assessed and recommended adaptations.

A number of services have come to this conclusion, and have been happy to implement changes for certain types of provision funded by adaptations budgets (e.g. Stairlifts), which streamline processes for owners and remove bureaucracy in the system.

However, this needs to be systematically applied more widely across partnerships, and there are good practice examples which evidence the benefits of removing the requirement for grant aid in the system, and can help other areas to review their arrangements.

Good Practice Example

Both Glasgow City and West Dunbartonshire private sector housing changed their arrangements in 2011 & 2012 to remove the requirement for a grant application for the provision of Stairlifts to owner occupiers. Instead, owners are now assessed in the same way as people living in publicly funded housing, and receive their Stairlift provision via the EquipU partnership Stairlifts contract.

This has:

- Ensured owners are treated equitably in a 'tenure-neutral' service;
- Significantly reduced timescales from assessment to installation - average 2-5 weeks;
- Delivered procurement and recycling savings with over a third of all stairlifts recycled back for use in other homes;
- Improved maintenance arrangements, as owners do not own the stairlifts, and are therefore no longer required to maintain these themselves;
- Frees up staff resources as they no longer require to process grant applications.

One of the first owners to receive a new Stairlift under the changed arrangements, Mrs F, stated that she couldn't believe how quickly she had received the stairlift, and called it her 'golden chair', advising that because it helped her now access her upstairs shower room, she "felt good about herself again, and hadn't felt that way for a long time".

The scheme of assistance is resource intensive for services, inhibits access by creating a financial barrier, is not person-centred, and considerably slows the process of provision.

Removing grant arrangements and instead encouraging partners to focus on partnership business models, which **maximise procurement and recycling** benefits, would establish a basis for effective tenure neutral integrated approaches and genuine equity in the delivery of services to people in our communities.

It is also necessary to remove barriers related to the assessment pathways, ensuring that **direct access** opportunities are maximised, for straightforward and standardised adaptation solutions e.g. shower installations in local authority and housing association properties.

- This should remove the need for occupational therapy assessment for these type of installations. As it stands there is no legal requirement for an OT assessment yet this has become a requirement as a matter of practice, by many housing providers in Scotland, as a way of managing demand and budget expenditure.
- To address these types of issues and help partners jointly manage budgets in a more strategic and planned way, partners should jointly identify the most effective mechanisms to utilise financial resources collectively, including consideration of **pooled budgets** under joint governance.
- These changes and improvements need to be supported by clarity of strategic direction, with robust **joint governance arrangements** which include a wide range of relevant stakeholders across housing (all tenures), health and social care.
- Work also requires to focus on the need for cohesive local housing plans, aligned to housing allocation policies, which promote the provision of **barrier-free housing** and **early intervention strategies**, supporting service users and their families, to review their long-term housing needs, including the needs of children with long-term conditions.

All of the above needs to be supported from government, and it is proposed that as a next stage of work, a national **Adapting for Change Action Plan** should be devised to compliment other policy work, and assist partnerships to drive forward these changes, and address the outstanding issues in our services.

Housing Solutions Programme

The 'Housing Solutions' change programme has been developed as an output from the AfC programme, applying the principles of Adapting for Change, and is essentially about supporting prevention, and early-intervention. This offers a framework for service improvement which would help drive forward the range of required changes identified in the earlier section above.

In most areas of Scotland, the provision of permanent ramps is a complex and lengthy process, and is often not the ideal solution where there are wider issues with the long term suitability of the home.

Good Practice Example

During April 2020 to March 2022, Angus Health and Social Care Partnership (AHSCP) agreed to take a tenure neutral approach to the use of removal ramps.

In total, 124 removable ramp recommendations were made within the trial period. Of the removable ramps that were inst.alled, there was variation in the timescales being realised, however this was much less that those incurred with permanent solutions. The delays incurred were related to issues with

obtaining approval, as opposed to the design and cost information being obtained from the contractor for the removable ramp.

Throughout the test period AHSCP were able to recycle a number of ramps enabling the component parts to be reused and offsetting the installation costs of other ramps.

AHSCP identified that greater efficiency and flexibility could be realised through using removable ramps as well as enabling the opportunity of recycling ramp component parts.

AHSCP have now adopted the use of Removable Ramps across all tenures.

The HSCP identified the following Benefits:

- Equity across all tenures is being realised for the installation of removable ramps;
- Greater efficiency in delivering access solutions across all tenures. (historically delays can be encountered when awaiting landlord permission);
- Greater emphasis on Housing Solution discussions, and ability to realise short, medium, as well as long term use of removable ramps, to support this approach;
- Improved recycling, which reduces the expenditure on removable ramps over time.

This approach offers a practical and effective way of encouraging wider responsibility across our housing, health, social care and Third Sector services, for the identification and discussion of housing needs and solutions with people in our communities who need advice and support.

This is in line with the recommendation from the AWG Report which recognised the need for early consideration of alternatives to adaptations, which may provide a better solution e.g. move to a more suitable home at an earlier stage in someone's condition.

An important dimension of the Housing Solutions approach also focuses on the need to apply a **tenure neutral** approach, maximising business & procurement efficiencies, simplifying the systems and processes, helping staff, as well as people in our communities, make sense and navigate the pathways.

> As an older person wanting to move, I can get help to move to a home which better meets my needs. My current home is no longer right for me but would be ideal for a family
>
> **Housing Solutions Service User**

This approach fits seamlessly with the direction from government in Housing to 2040: Vision and principles, where it highlights the importance of supporting people to reflect on the suitability of their current housing, and the benefits this can have for the wider community.

Implementing Housing Solutions

The Housing Solutions approach encourages working in partnership with the person, empowering them with information & options to enable them to think and plan ahead. In many areas partnerships have used this approach as a wider framework which supports pathways around other local service provision e.g. Housing Options services. Examples such as the HOOPs (Housing Options for Older People) service in Glasgow City, and the Disabled Person Housing Service in Aberdeen City, are both examples of intervention to support critical parts of the service pathways related to hospital admission/ discharge.

As part of the Housing Solutions programme, a simple booklet, 'Do you want to Move or Stay? has been produced, which a number of partnerships in Scotland have customised for their own local services, and has been helpful in supporting staff, who may not have previously been used to initiating housing conversations e.g. nursing colleagues, support workers, podiatrists, third sector staff etc.

This booklet was first developed for Falkirk Council Housing Services, with help from the *Make it Happen Forum* and local people, and utilised as part of the AfC test site work within that area. Two examples are available on Healthcare Improvement Scotland's iHub website.

Training, and improving the Assessment pathways

Importantly, training modules to support the Housing Solutions programme, and encourage a multi-partnership integrated approach to identifying and assessing for local solutions have also been developed.

- The aim is to ensure that needs can be assessed, and solutions provided, by a wider range of front-line staff across Housing, health and social care, and third sector settings, removing the traditional requirement for an occupational therapy assessment for every adaptation solution. The core half day module (1) is for all relevant staff across all services and third sector partners. Additional modules (2&3) are available for supporting wider groups of staff to be able to assess for adaptation provision.

The Adaptations without Delay 2019 publication, commissioned by the Royal College of Occupational Therapists (RCOT) from the Housing Learning Improvement Network (LIN), was developed to demonstrate how adaptations can be delivered with the individual at the centre. The document highlights how, and when occupational therapists add value to the process, where complexity of individual circumstances dictates this is appropriate. However, the important message in this publication is clarifying that for many types of straightforward adaptation provision, an Occupational therapist is not required to assess these needs.

- The focus is about avoiding unnecessary delays, empowering housing associations to take a pro-active approach to providing straightforward adaptation solutions for their tenants with non-complex needs, without the need for an OT assessment.
- This opens up the opportunity for services and agencies to develop self-selection where appropriate and to explore the meaningful involvement of other staff and professions in the service pathways to ensure a more streamlined, responsive, and effective approach to meeting the adaptation needs of people in our communities.

The **Housing Solutions** approach and **Adaptations without Delay** are complimentary, and can be used as a catalyst for improvement. They provide a framework for all stakeholders across Social Care, Health and Housing (and third sector where appropriate) to review current service pathways and agree a strategic operational improvement plan, regardless of the starting point.

Working in partnership

An example Partnership Joint Protocol for Housing Solutions & Adaptations has been developed as a good practice tool to help partners embark on their strategic improvement work and some partnerships in Scotland have already utilised this to help them work with a wider range of stakeholders with the aim of taking forward service improvement.

The Housing Solutions approach can assist partners to collectively agree their policy in relation to circumstances which may sit outside current legislation or guidance. For example, health & social care partners require to clarify their policy in terms of supporting people in their communities who may live in a mobile home as their permanent residence. There are a range of historical issues with adapting these properties as these types of homes do not hold a title, and therefore this prevents the provision of grants, under current housing legislation.

Given the diverse range of organisations who may be involved in supporting peoples housing needs, it is essential that partnerships develop strong links with all relevant stakeholders and partners.

- In order to deliver an efficient service, front-line assessors should have clear referral routes and contact points for progressing cases and seeking professional advice. To further avoid any unnecessary delay it is essential that contact with other services, and external organisations is made as quickly as possible.
- To help facilitate this process IAs should work closely with their local housing partners to help develop fast track referral routes and pathways for housing solutions and adaptations, and should also develop local protocols, to ensure consistent and co-ordinated working practices between all different stakeholder organisations.

Key Actions

- A national *Adapting for Change Action Plan* should be devised to compliment other policy work, and assist partnerships to drive forward the changes recommended from the original Adapting for Change report by the Adaptations Working Group.
- To assist with the practical implementation of the Adapting for Change recommendations, partnerships should implement **Housing Solutions** change programmes which assist all relevant partners to develop local Protocols, and deliver training programmes, which effectively promote:
  - Early intervention with full exploration of rehousing opportunities;
  - Better planning for the delivery of barrier-free housing and an inclusive design/living approach;
  - Robust joint governance, which provides a clear strategic direction and supports priority setting;
  - Joint finance arrangements which help streamline service improvements (e.g. pooled budgets)
  - Equity in the system, applying a **'**tenure neutral' approach;
  - To address barriers in the system, removing the requirement for grant assistance for owner occupiers and providing 100% funding for the assessed adaptations;
  - Removing the need for occupational therapists to provide an assessment for standard adaptations in housing association properties e.g. shower provision; and encouraging 'direct access' arrangements.
  - Maximising procurement and recycling benefits to help deliver efficiencies.

Summary of Key Actions

Contribution of Equipment & Adaptations

- Integration Authorities (IAs)should work with relevant partners to capture data which evidences the value, effective and efficient community equipment and adaptation provision makes to the delivery of key service goals.
- IAs require to ensure they are resourcing their community equipment and adaptations services to be as effective as possible in providing responsive, outcome focused services, with fully integrated funding streams.
- Any proposed policy changes related to the provision of equipment and adaptations need to be scoped and reviewed to identify any potential implications of stopping or inhibiting the provision of equipment, and its impact on meeting wider strategic service objectives across health & social care, and other relevant partners e.g Housing.
- IAs require to ensure they have reviewed their pathways and access to equipment and adaptations, as part of delivering the aims of the Rehabilitation strategic framework.
- In terms of children's needs, Health and Social Care, Housing, and Education services, require to ensure that they are compliant with the relevant legislation, and the principles and values of wellbeing, early intervention, and child-centred practice are evidenced in all aspects of equipment and adaptations service provision.

Assessment & Provision

- Equipment, and adaptations assessment pathways, should be clearly evident in the integrated arrangements for health & social care, and relevant partners (e.g. housing organisations, education, prison service…), supported by robust governance arrangements.
- Operational arrangements for the assessment and provision of equipment and adaptations, should reflect a focus on **prevention**, early intervention, and anticipatory care, avoiding inappropriate admission to hospital or long term care, and promoting independent living and self-management as key to improving health and wellbeing.
- Service users (children and adults), and their unpaid carers, should be fully involved in the assessment process. There is a person-centred, personal outcomes focus to the assessment with clear goals identified, agreed, and recorded, and the provision of the equipment recognised as a 'means to an end', rather than being 'an end in itself', with the principles of the social model of disability informing practice.
- The principal of 'minimum intervention, maximum independence' should underpin all assessments, and alternative methods of managing, should be fully explored supported by Rehabilitation and reablement interventions as appropriate.
- Staff should have a good understanding of the way different conditions can impact on a person's needs, and the wide range of solutions that are potentially available to support these, with the assessment pathways recognising, and

helping deliver, solutions which support mental well-being, as much as physical needs.
- Services should have clear policy and processes to support service users moving from one service boundary, to another, to ensure a seamless service.

Prevention, Early Intervention, and Self-management
- Services should review and challenge their strategies, policies, and existing operational arrangements and service pathways across equipment and adaptation service provision, to ensure they are actively promoting and helping people maximise their own independence.
- Services should implement a range of approaches/solutions, at key stages in the service pathways (E.g. front door services, but also where service users and their families may require support when needs change), across all service settings (hospital and community), to assist people to self-manage and self-assess their needs, and make informed choices.
- Services should support measures to promote better access to quality information, in all relevant accessible formats, and effective methods of sharing of information which helps people explore and understand their options, and manage their conditions, as part of early intervention strategies.

Unpaid Carers
- Assessors must take account of the views and contribution of carers when assessing the person in need, and fully engage them in discussions about future housing needs, and any associated equipment and adaptations which may support the service user to remain safely in the community. The outcomes should be clearly recorded and reviewed as required.
- Carers must be informed of their right to an adult carer support plan or young carer statement to determine what is important to them and their own support needs, independent of any assessment of the person for whom they care.
- An adult carer support plan or young carer statement must be offered to anyone who provides care for a disabled or older person, or a disabled child.
- Carers should be fully involved in assessment and discharge planning from hospital, with agreed outcomes clearly recorded for the provision of any equipment and adaptation and housing solutions, and relevant support identified as required.

Moving & Handling
- Assessments should evidence the views of the person who requires to be moved and handled and a person-centred, and risk-enabled approach should be promoted.
- Services should apply a minimum intervention ethos, which aims to maximise a person's ability to utilise functional performance and avoids practice which 'disables' the person and impacts negatively on their potential wellbeing.
- For 'end of life' ensure that services act in line with good practice/policy for those with palliative needs and ensure the service users wishes are central to the decision making, avoiding unnecessary equipment provision.

- Ensure that a wide range of professionals are able to assess for and provide moving and handling equipment as required, either to support hospital discharge and/or as part of the service they are providing.
- Services must ensure robust training and refresher training, is in place to support the effective assessment (including positive risk-taking), and use of the equipment.
- Services should ensure they avoid arrangements which encourage duplication in the assessment pathways and inappropriate onward referrals.
- Blanket solutions to moving and handling should not be applied and individual assessment is used to determine the number of care workers required to safely move and handle the person, encouraging the use of single-handed care where appropriate.
- Partnerships should review arrangements to encourage good practice recommendations from the Scottish Manual Handling Passport which aim to help standardise good practice across Scotland.

Postural Care

- Health & Social Care services should have an aligned strategy and policy, for the provision of equipment for people of all ages, which helps support the Postural Care Strategy.
- Health & Social Care services should work with all key stakeholders, and community equipment Store service providers, to develop effective arrangements for the provision of SleepSystems and other relevant products which support effective postural care

Hospital Discharge

- Integration Authorities (IAs) should utilise the hospital discharge equipment provision good practice guide, to support improvements in the provision of equipment for discharge.
- IAs should ensure that a range of staff within the hospital can assess and order directly, equipment and relevant adaptations, for 'safe discharge'.
- IAs should ensure that clear pathways are in place to allow hospital staff to refer to relevant community staff for the assessment and ordering of equipment and adaptations for more complex, ongoing needs.
- All services should avoid over-prescription for patients with standard needs, and agree simple solutions, to ensure a seamless, and safe discharge.
- Services should explore the opportunities to implement a Planned Date of Discharge approach, to improve forward planning for the provision of equipment and relevant adaptations for discharge.

Children & Young People

- The provision of equipment and adaptations to children and young people, for home and school settings, should be provided in an integrated way, and recognised as an integral part of community service provision, in order to streamline and standardise provision.

- Services should apply an anticipatory care planning approach to housing needs to ensure more effective early intervention work to help identify and plan for housing solutions as the child's needs change.
- Arrangements for the provision of children's equipment should be jointly agreed, and budgets should be set up in a way which supports direct access to equipment in line with the education, and health & social care children's services pathways.
- Community equipment services should establish a 'Standard Core Stock for Children' of equipment commonly assessed for by occupational therapy, physiotherapy, and nurse colleagues, for the range of needs most commonly met.
- Relevant local services should clarify responsibility for the provision of solutions not provided via local store services as equipment e.g. Environmental / behavioural solutions. Health & social care services should put in place arrangements which clarify for individual cases, the lead agency/clinician, the funding source, and monitoring arrangements.
- Services should ensure that the views of the child are sought and clearly evidenced as part of the multi-disciplinary approach to any agreed provision.
- Services should ensure effective transition arrangements for children moving into adult services to minimise disruption and ensure a seamless approach to the provision of equipment and adaptations.

Care Homes

- Care homes should provide a wide range of equipment to fulfil their obligations to their service users and to their workforce, in line with the national Protocol for the Provision of Equipment in Care Homes.
- Services users who have been confirmed as having an assessed need for specific equipment should not be charged for this essential equipment, and families should not be asked to fund this provision, this includes people who are self-funding.
- Commissioning and equipment service leads within statutory providers should work with their local care home sector to agree the most suitable makes and models of generic equipment, and ensure this equipment is in place.
- These principles should also apply to all care groups including homes for younger adults, interim care home models, and day and respite facilities.

Prisons

- Local partnerships should apply the principles of the Good Practice Guide for the Provision of Equipment to Prisons as a tool to help them jointly review any current service provision with their SPS colleagues, to streamline and improve the pathways for all equipment provision, and establish cohesive governance arrangements.
- It is expected that the following arrangements should be in place:
  - Robust and consistent assessment pathways with NHS healthcare staff within the prison able to assess and recommend equipment for non-complex needs, and HSCP staff assessing for more complex needs;

  - SPS to fund equipment for long term needs, and HSCP's to fund equipment for short-term loan;
  - Business efficiencies maximised with access to local Store service arrangements for the provision of effectively procured and standardised equipment solution for both long-term and short-term provision.
- Local partnerships should work with SPS, and Housing colleagues to ensure the effective transition back into community, providing appropriate housing, and equipment and adaptations as part of a seamless pathway, and in line with the SHORE standards.

Wheelchairs

- Integration Authorities must adhere to the recommendations within the Scottish Government Guidance on the provision of Wheelchairs for short-term loan, and have suitable arrangements in place to meet any eligible needs for a wheelchair on short-term loan, for up to a maximum of 6 months, to ensure no gaps in service provision.
- These arrangements must also be monitored, and reported within the Integration Authority.

Communication Aids

- Health and social care services, working with their adult services and education partners, should use the AAC National Core Pathway and the AAC Good Practice Model, to develop their local arrangements for the provision of AAC equipment, making best use of all local resources for the procurement and storage of equipment, and ensuring a focus on the principles of improving governance, robust systems, procurement, and financial and performance monitoring.

Technology Enabled Care

- Health and Social Care partners, with their Housing colleagues, should work together to maximise the opportunities provided by TEC, developing local strategy and policies, which help people to choose their own digital solutions as part of self-management and earlier intervention approaches, as well as utilising technology to address issues of isolation and frailty. This should include reviewing charging policies to ensure that these are not acting as a barrier in the system, preventing services from supporting those most vulnerable.

Sensory Impairment

- Health & Social care services and their Community Equipment services should ensure that they work with relevant stakeholders and have effective pathways in place which meet the equipment needs of people with sensory loss
- This should include the provision of streamlined access to a core range of appropriate equipment for both hearing and visual impairment.

Integrated service pathways for equipment provision

- Equipment and adaptations should be seen as an integral part of the wider service pathways and their contribution should be clearly articulated in local health and social care strategies.
- Relevant health & social care staff, should be able to access a wide range of equipment and relevant adaptations, appropriate to the type of service they are providing, and not based on professional or agency boundaries.
- Partnerships must have funding mechanisms which ensure that all equipment purchased through the Store service is paid for from the one funding 'pot', with no barriers according to type, or professional use.
- Staff across services who are involved in identifying equipment and adaptation needs should be trained to assess and provide a wide range of solutions, irrespective of their own professional background. The training should strongly emphasise good assessment practice, the need for 'good conversations' which focus on personal outcomes, and encourage prescribers to consider their reasoning for provision, contraindications, recording of decision making, and encourages avoidance of over-prescription.
- Inter-agency agreements (protocols) should be in place, defining the arrangements between the partners in terms of the roles and responsibilities of staff and their managers, and the processes for assessment, prescription, and provision of equipment and adaptations.
- Individuals with simple or non-complex needs should be able to access equipment and minor adaptations without the need for a specific professional assessment. This can include models utilising direct access and self-assessment tools.

Community equipment Store service models

- Store service arrangements should be designed and resourced to effectively meet the partner objectives, ensuring that the equipment service is strategically aligned across all relevant services to help deliver key aims related to supporting hospital discharge, and effectively maintaining people in the community.
- Store services should be resourced by partners with a funding 'pot' which allows the Service to procure equipment into the service, according to demand, throughout the year, with all equipment funded equally from this arrangement. Costs for the use of the equipment should then be charged to partners according to use by their services, rather than by type.
- Funding model should allow the store service to procure a wide range of standardised core equipment (and non-stock products as required) for people of all ages and needs (e.g. including equipment assessed for by all relevant Allied Health professionals (AHP's), nurses, care staff, staff working in Sensory services etc.), with an annually agreed budget which guarantees appropriate levels of funding throughout the year.
- Operational and strategic managers should be clearly accountable for overall expenditure and actively support the store service managers to achieve business efficiencies, as well as providing a responsive and effective operational service.
- Partnerships should utilise the **Good practice guide for the provision of community equipment**, and the new **baseline assessment tool**, to assess

current services and ensure their arrangements are in line with the aims of the national guidance.

Health & Safety

- Partnerships should follow the Manual Handling Operations Regulation 1992 which provides a general framework for tackling handling activities at work.
- Health and safety risk management must form an integral part of the care assessment.
- All care workers (including unpaid carers) must be suitably trained in safer handling techniques. It is the responsibility of the employing agency to provide appropriate training for their staff and the assessor/care manager should refer the unpaid carer to relevant support for moving and handling training.
- Care service providers, or employing agencies must ensure that the equipment is in good working order, and that all care workers are aware of and understand the appropriate application and limitations equipment.
- Partners and their Store service provider should ensure they have clarified what arrangements they wish to have in place as standard maintenance arrangements for all relevant equipment. It is then the store services responsibility to ensure robust servicing and maintenance arrangements are in place.
- Partnerships should have clear arrangements in place which identify the roles and responsibilities of all stakeholders, in the event of an incident, including reporting to IRIC.
- Store services should have arrangements in place for the circulation of relevant MHRA alerts, and appropriate responses to the alert.

Recycling

- Store services will have in place arrangements which ensure the robust decontamination, cleaning, and refurbishment of all equipment returned to the Stores service.
- Partnerships and their equipment and adaptation service providers should ensure they maximise the potential benefits from recycling of all equipment and relevant adaptations, and record and monitor the recycling benefits they deliver, as this information can be used to evidence savings and efficiencies as part of wider budgetary discussions.

Adaptations and Housing Solutions

- A national *Adapting for Change Action Plan* should be devised to compliment other policy work, and assist partnerships to drive forward the changes recommended from the original Adapting for Change report by the Adaptations Working Group.
- To assist with the practical implementation of the Adapting for Change recommendations, partnerships should implement **Housing Solutions** change programmes which assist all relevant partners to develop local Protocols, and deliver training programmes, which effectively promote:
  - Early intervention with full exploration of rehousing opportunities;

- Better planning for the delivery of barrier-free housing and an inclusive design/living approach;
- Robust joint governance, which provides a clear strategic direction and supports priority setting;
- Joint finance arrangements which help streamline service improvements (e.g. pooled budgets)
- Equity in the system, applying a **'**tenure neutral' approach;
- To address barriers in the system, removing the requirement for grant assistance for owner occupiers and providing 100% funding for the assessed adaptations;
- Removing the need for occupational therapists to provide an assessment for standard adaptations in housing association properties e.g. shower provision; and encouraging 'direct access' arrangements.
- Maximising procurement and recycling benefits to help deliver efficiencies.

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