APPENDIX 2: LOCAL AND NATIONAL POLICY CONTEXT

1.1 Introduction

Demographic and financial pressures have combined to ensure that the provision of care and support for older people is a current political and policy priority.

From the range of recent strategies and policies a number can be highlighted as important drivers to our joint commissioning strategy.

IRIS draws out the main points of the national documents which influence and shape this strategy:

1.2 Shifting the Balance of Care and Reshaping Care for Older People

Demographic factors have prompted one of the major current policy drivers, *Reshaping Care for Older People, A programme for change 2011-2021*.

A two-thirds increase in the number of older people is projected over the next 20 years, with the number of people over 65 expected to be 21 per cent greater in 2016 than 2006. For those 85 and over, the group particularly likely to require care and support, the numbers are expected to rise by 21 per cent by 2016 and by 144 per cent by 2031. If the current baseline of health and social care provision were to be continued, this would require an annual increase in health and social care investment of £1.1 billion by 2016 and £7.5 billion by 2031. Moreover, of the current annual expenditure of £4.5 billion on health and social care for people over 65, emergency admissions absorb £1.4 billion. Homecare accounts for less than seven per cent of the total.

Reshaping Care for Older People is set within the broader context of *Shifting the Balance of Care*, This programme, defined within health in 2008, has eight improvement areas and directly supports the delivery of HEAT targets and Community Care Outcomes. Shifts are sought in the focus of care, in ways of working, and in the location of care. Four of the eight improvement areas can be cited by way of illustration:

- Maximise flexible and responsive care at home, with support for carers
- Integrate health and social care and support for people in need and at risk
- Reduce avoidable unscheduled attendances and admissions to acute hospitals
- Improve joint use of resources (revenue and capital).

Building on this context, a Ministerial Strategic Group on Health and Community Care was established in March 2009, the focus on 'optimising the independence and wellbeing of older people at home or in a homely setting'. Following a series of eight work streams, a *Programme for Change 2011-2021* for *Reshaping Care for Older People* has been produced. This addresses the following core elements:

- Co-production and community capacity building
- Care services and settings
- Complex care and care pathways
- Workforce
- Demography and funding
- Planning, improvement and support.

It seeks to address a number of challenges identified in existing practice: eligibility thresholds versus prevention; risk adversity, with a tendency to focus on incapacity and dependence; insufficient support to carers; lack of service redesign leadership; and lack of incentives to promote change. *Reshaping Care for Older People* operates within the broader context of community planning, the key overarching partnership framework which seeks to co-ordinate the range of initiatives operating within the local area and ensure they collectively address key structural challenges.

A priority of the programme is to value older people as an asset. Indeed it should be remembered that it is the minority who require formal support; 60 per cent of those aged 85 and over make no use of continuing care, care home or homecare provision accessed through social care. Moreover while 3000 individuals over 65 receive more than 20 hours of paid care per week, 40,000 in the same age group provide more than 20 hours per week in their role as unpaid carers. The underpinning objectives of

Reshaping Care for Older People can be encapsulated in the shifts that are envisioned.

Old care model	New care model
• Geared towards acute conditions • Hospital centred • Episodic care • Disjointed care • Reactive care • Patient as passive recipient • Self care infrequent • Carers undervalued • Low tech	• Geared towards long-term conditions • Embedded in communities • Team based • Integrated, continuous care • Preventative care • Patient as partner • Self care encouraged and facilitated • Carers supported as partners • High tech

Moreover the delivery of care and support is to be outcomes-focused, helping older people to achieve a good quality of life through feeling safe; having opportunities to meet and support each other; ensuring no-one is socially isolated or lonely; staying as well as they can; living where and how they want; being free from discrimination or stigma; and being listened to, having a say in the services they receive and being treated at all times with respect and dignity.

A Reshaping Care Improvement Network has been established for this programme of change and a number of targets to be achieved by 2021 have been set:

- double the proportion of the total health and social care budget for older people spent on care at home – 6.7% to 13.5%
- build the capacity of third sector providers
- the Change Fund to shift the balance of care
- shift of resources to unpaid care
- reduce emergency bed days used by 75+ by a minimum of 20% by 2021, by at least 10% by 2014-15
- no direct admission from acute hospital to long-term care
- All over 75s offered a telecare package.

The Reshaping Care programme aligns with a number of key national policies.

1.3 The Healthcare Quality Strategy for NHS Scotland

This is a development of *Better Health, Better care* which builds on the significant achievements already made over the last few years. It aims to deliver safe, effective and person centred care, supporting people to manage their own conditions and ensuring individual outcomes and experience are integral to services. The Strategy contains three quality ambitions:

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

1.4 Co-ordinated, Integrated and Fit for Purpose: The Delivery Framework for Adult Rehabilitation in Scotland

This joint document for health and social work was published in February 2007. It gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation or enablement services to individuals and communities. The vision underpinning the framework is the creation of a modern, effective, multi-disciplinary, multi-agency approach to rehabilitation services that are flexible and responsive in meeting the needs of individuals and communities in Scotland.

Reablement, recovery and rehabilitation, (the 3Rs) are concepts that are applicable to both older people and those with a long-term condition, across the spectrum of health and social care services. They are integral to the delivery of many of the health and social care policies and work streams, including the Reshaping Care programme, all aimed at enabling individuals to live healthy lives in a homely setting for as long as possible.

1.5 Caring Together: The Carers Strategy for Scotland 2010-2015

Acknowledges the vital contribution carers make to the health and social care system. Included in the actions is the need for training for carers to enable them to remain able to continue in their role. Intermediate Care has the potential to support carers by reducing the number and length of hospital admissions, and providing a range of services which can respond to, or avert, a crisis.

1.6 Maximising Recovery and Promoting Independence: intermediate Care's contribution to Reshaping Care

This provides a framework for local health and social care partnerships across Scotland to review and further develop Intermediate Care within their area. It identifies the common and key components that should make up these services. The framework also provides evidence of the benefits of developing intermediate Care as part of a range of enabling services, along with practical examples of successful services which include a range of functions which focus on prevention, rehabilitation, enablement and recovery.

1.7 Community Hospital Strategy Refresh 2012(draft)

Builds on the 'Developing Community Hospitals: A Strategy for Scotland and reflects on how current strategic priorities should influence the vision for community hospital development. It seeks to demonstrate, through examples of good practice, how community hospitals can become more effective in the delivery of improved pathways of care, especially with regard to supporting the older population. It

contains a number of actions for partners that will 'knit' community hospitals into the fabric of local care and support services, ensuring improved outcomes for patients

1.8 Dementia

Scotland's National Dementia Strategy was published in 2010. The aim of this strategy is to deliver world class dementia care in and treatment in Scotland, ensuring that people with dementia and their families are supported to live well with dementia. Two key change areas are identified for the next three years:

- Excellent support and information to people with dementia and their carers post diagnosis;
- Improved response to people with dementia in general hospital settings, including alternatives to admission and better discharge planning.

1.9 Change Fund

In order to support the implementation of Reshaping Care for Older People, a Change Fund has been created, www.jitscotland.org.uk/action-areas/reshapingcare-for-older-people/.

This will provide £300 million over the next three years, with £70 million allocated to the 32 local partnerships for 2011-12 on the basis of local plans designed to embrace the NHS, local authority, third and private sectors.Partnerships are also expected to develop joint commissioning strategies for 2012-2020 and use the Change Fund as a catalyst to reshape care.

1.10 Personalisation and Self-Directed Support

2010 saw the publication of *Self-Directed Support: A National Strategy for Scotland*. Consultation on the Self-directed Support (Scotland) Bill concluded in March 2011. The Strategy seeks to advance the personalisation agenda in Scotland as part of the wider reform agenda, with independent living one of four areas set as priorities for

co-ordination of action across the public sector. The key principles of choice and control are to be achieved through a process of co-production, with resource allocation in the form of a Direct Payment, Individual Service Fund or some combination of the two. This represents a major cultural shift and progress is currently being evaluated in three test sites.

Personalisation: principles, challenges and a new approach will be a key consideration as the Strategy is implemented must be the congruence between self-directed support and commissioning, including the development of outcomes-focused commissioning.

1.11 Long-term Conditions

'Gaun Yersel!' The Self Management Strategy for Long Term Conditions in Scotland, offers a not unrelated strategy led by health. It reflects the emergence of a focus on long-term conditions, supported by the Long Term Conditions Collaborative (LTCC) and the Long Term Conditions Alliance Scotland (LTCAS). Anticipatory care planning and the adoption of an assets based approach are also gaining currency, www.ltcas.org.uk/documents/AssetsAllianceScotlandEvent13Dec2010Reportpdf.pdf.

A proportion of those with long-term conditions are those who fall within the SPARRA group (Scottish Patients At Risk of Readmissions and Admissions) and experience emergency repeat admissions to hospital.

An interesting innovation in England (for example Croydon, Wandsworth and Devon) is the 'virtual ward', targeted at those at risk of frequent admission as identified through predictive models such as PARR (Patients at Risk of Readmission). Multidisciplinary preventive care is provided to individuals within their own homes, delivered through the same staffing, systems and daily routines as in hospital.

1.12 Commission on the Future Delivery of Public Services (Christie Commission)

The Christie Commission on the Future Delivery of Public Services in Scotland was established to set a road map for the future reform of public service delivery over the next five to ten years. The specific remit was to:

- address the role of public services in improving outcomes, what impact they make, and whether this can be done more effectively
- examine structures, functions and roles, to improve the quality of public service delivery and reduce demand through, for example, early intervention
- consider the role of a public service ethos, along with cultural change, engaging public sector workers, users and stakeholders.

The Commission was to pay heed to the importance of local communities and to the geography and ethos of Scotland, and 'should have clear regard to joint work already underway to take forward the increasing integration of health and social care and to develop sustainable police and fire services for the future'.

The Commission reported at the end of June 2011. Following consideration of the challenges facing public services, the Commission identified four key objectives to be achieved by any reform programme: support and commissioning, including the development of outcomes-focused commissioning. These are:

- public services are built around people and communities, their needs, aspirations, capacities and skills, ad work to build up their autonomy and resilience
- public service organisations work together effectively to achieve outcomes
- public service organisations prioritise prevention, reducing inequalities and promoting equality
- public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

A number of priorities have been identified. These include the need for co-designed services; the effective co-ordination of scarce resources; support to enable individual and community resilience; ‘delivering integrated services that deliver results’; prioritising preventative measures; targeting underlying causes of inter-generational deprivation and low aspiration; tightening accountability; and ‘driving continuing reform across all public services based on outcomes, improved performance and cost reduction.

Of particular significance in the context of this current review is their conclusion that: public service landscape is unduly cluttered and fragmented, and that streamlining of public service structures is likely to be required. But any proposal for reform needs to be driven by how best services can achieve outcomes, based on a comprehensive cost-benefit analysis. Otherwise we risk bearing the significant costs of structural change, without reaping any real rewards.

Recommendations from the Commission include a common set of statutory duties for all public bodies focused on improving outcomes; legislative provision to embed community participation in the design and delivery of services; a concordat between central and local government, backed by integrated funding provision, for the development of joined-up services; and promotion of service integration and a common public service ethos through joint training arrangements. Of particular relevance for the current review is the reference to proposals that ‘support the local integration of service provision and of the priority in service reform for preventative measures and greater integration of services to reduce the numbers and costs of unplanned admissions.

1.13 Community Care Outcomes

Following the Concordat of 2007, the Single Outcome Agreement (SOA) was introduced as the key reporting mechanism for public service delivery. The SOA requires local authorities to report to central government on their progress towards meeting the 15 national outcomes, drawing as appropriate to their local priorities on 45 local indicators.

The National Community Care Outcomes Framework has been developed at a voluntary level below the SOA requirements. It had been devised prior to the Concordat as part of the National Performance Framework linked to the NHS HEAT system (the measures and targets on which NHS Boards base their local delivery plans).

The Framework identifies four national outcomes – improved health, improved well-being, improved social inclusion, improved independence and responsibility – and 16 key measures with a specific focus on how NHS and local authority partnerships are improving outcomes for those who access community care services. The measures include, for example, the percentage of community care service users feeling safe; the percentage of users satisfied with their opportunities for social interaction; the number of patients waiting in short stay settings, or for more than six weeks elsewhere for discharge to an appropriate setting; and the percentage of carers who feel supported and able to continue in their role as a carer.

The extent to which personal outcomes are addressed has also been the focus of the Talking Points methodology (Miller et al, 2008). This adopts an outcomes approach rather than a service-led approach to assessment, planning and review and has now been implemented in some form in all but one of the 32 local authorities. Rather than a focus on deficits, the emphasis is on assets, strengths and aspirations.

The quality of life, process and change outcomes that form the Talking Points Outcomes include the outcomes which older people, both locally and nationally, have said are important to them.

Table 1: Outcomes important to people using services (source: Talking Points Personal Outcomes Approach, Joint Improvement Team 2012)

Quality of life	Process	Change
• Feeling safe • Having things to do	• Listened to • Having a say	• Improved confidence/morale

• Seeing other people • Staying as well as you can • Living where you want/as you want • Dealing with stigma/discrimination	• Treated with respect • Responded to • Reliability	• Improved skills • Improved mobility • Reduced symptoms