RESHAPING CARE FOR OLDER PEOPLE

A PROGRAMME FOR CHANGE
2011 – 2021

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MINISTERIAL AND COSLA FOREWORD

Providing high quality care and support for older people is a fundamental principle of social justice and is an important hallmark of a caring and compassionate society. Demographic changes coupled with a decade of difficult public finances means this is one of the 3 biggest challenges facing Scotland – alongside economic recovery and climate change.

Supporting and caring for older people is not just a health or social work responsibility – we all have a role to play: families, neighbours and communities; providers of services like housing, transport, leisure, community safety, education and arts; and also shops, banks and other commercial enterprises. To address this challenge successfully, we need to build an enduring consensus across all sectors of society regarding both our philosophy of care and support and how this will be delivered.

There is widespread agreement that our vision is that 'Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting'. This aim must remain firmly in our sights as we develop and implement the Reshaping Care programme.

This document sets out our vision and immediate actions for reshaping the care and support of older people in Scotland. It has been co-produced through an extensive period of development and engagement with the people of Scotland and with political, organisational and community interests at both local and national levels.

Delivery of this programme will take collaboration, commitment, stamina, enterprise and innovation. Success has as much to do with shifting our attitudes and expectations as it has about shifting resources, care institutions, providers and workforce. Achieving these aims will require all of us to work together, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources; and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike – giving meaning to this mutual care approach.

The Reshaping Care programme is an important driver for implementing the NHS Quality Strategy and the vision and aspirations set out in this plan are consistent with and give meaning to the 3 Quality Ambitions: partnerships between the NHS and those seeking care and support; care that is reliably safe; and appropriate, timely and efficient care and treatment. The Reshaping Care programme is equally a key driver for implementing existing policies within social care services.

We will continue to refresh and update this framework to ensure it remains co-created, meaningful and achievable as we take the Reshaping Care programme forward. Further economic analysis and the future report of the Dilnot Commission on the long-term funding of care in the UK will inform the

development of a sustainable funding and policy framework that will help us to realise the principles set out in this document. Our analysis and proposals will be set out in a second volume.

This is an ambitious programme but, by working together across central and local government, the NHS and the third and independent sectors, we believe we can meet the challenges we face and continue to improve the quality of care and support we provide for our older population.

1. PURPOSE

1.1 In March 2009, the Ministerial Strategic Group for Health and Wellbeing (MSG) agreed to develop a strategy for reshaping care for older people in the light of a shared aspiration to improve the quality and outcomes of our current models of care; the implications of the projected demographic change which will increase service requirements; and financial pressures, which will reduce available resources.

1.2 The Reshaping Care for Older People programme provides a long term and strategic approach to delivering that change so that we can achieve our vision for future care for older people in Scotland. This change needs to be built on a strong and enduring consensus across all sectors and interests.

1.3 This document sets out our headline ambitions for Reshaping Care for Older People in Scotland along with the first wave of key actions required to deliver our ambitions. It sets out the national framework, within which local partnerships will develop joint strategies and commissioning plans and, most immediately, Local Change Plans to access the Change Fund announced as part of the 2011/12 Scottish Government Budget.

1.4 The framework sits comfortably alongside the ambitions of the NHS Quality Strategy and is a key driver to achieve the 'effective' ambition within this Strategy. It sits above, and supports the delivery of, other strategies for particular groups or issues including the Dementia Strategy[1], Carers Strategy[2], Self Directed Support Strategy[3] and Living and Dying Well[4]. Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

1.5 The vision, outcomes policy goals and specific proposals set out in this framework have been developed with our partners, reflecting the partnership nature of the Programme itself – a partnership between statutory sectors of Government, NHS and local authorities and also third sector and provider organisations. It has been informed by a review of evidence on the current arrangements and an extensive public engagement programme undertaken over a 6 month period during 2010 where over 5,000 people were reached and their views, ideas and reactions captured to inform the shape and content of this framework.

1.6 This document provides feedback to all who have contributed through the engagement process and provides the basis for building more detailed commitments and actions at both national and local levels over the coming decade. We will continue our dialogue with the people of Scotland as we develop our plans into more specific commitments, and review and update this plan on an annual basis. In addition, we will prepare a further report later

[1] http://www.scotland.gov.uk/Publications/2010/09/10151751
[2] http://www.scotland.gov.uk/Publications/2010/07/23153304/0
[3] http://www.selfdirectedsupportscotland.org.uk/
[4] http://www.scotland.gov.uk/Publications/2008/10/01091608/8

in 2011 on the funding and costs of care, following further economic analysis and the future report of the Dilnot Commission[5] on the long-term funding of care in the UK.

[5] http://www.dilnotcommission.dh.gov.uk

2. WHY WE NEED TO CHANGE

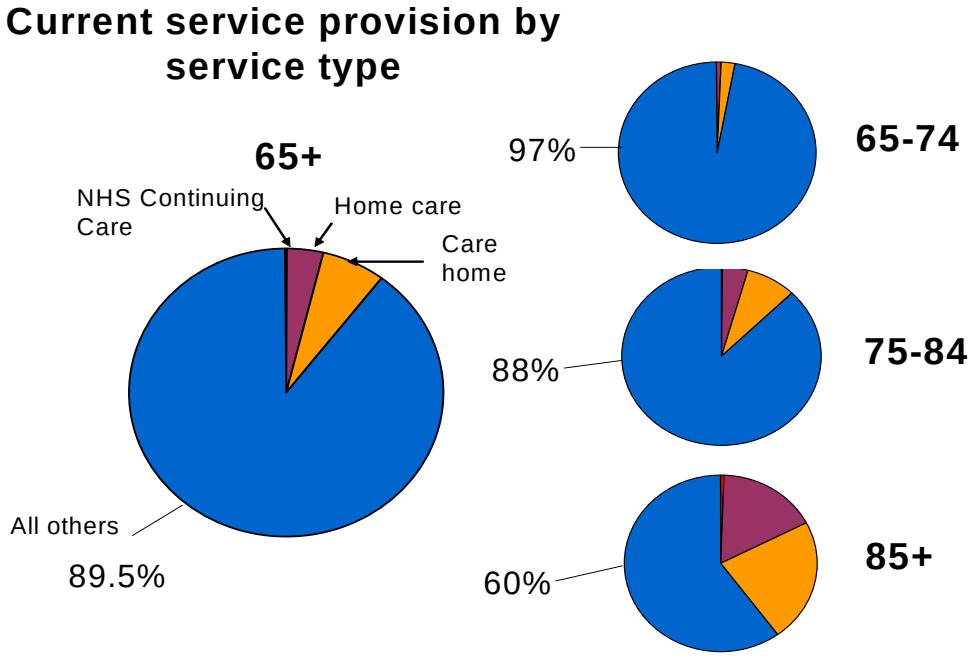
2.1 Our vision is clear and agreed:

> Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting.

2.2 Our health and social care services provide a vast range of high quality services that improve the quality of life for many older people. These services are however under considerable strain as resources are squeezed and demographic changes increase. We also know that at present the arrangements we have in place in Scotland too often fail to provide the service experience that people are looking for. Current arrangements are simply not sustainable; nor are they, in many instances, desirable.

The current landscape

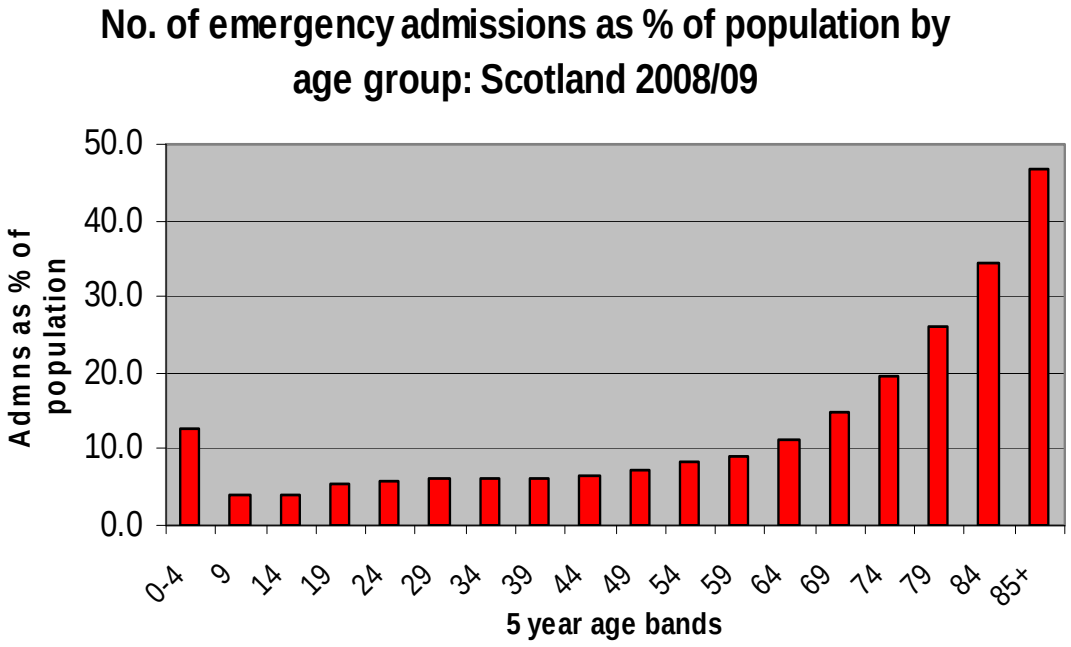
2.3 Most older people (89.5%) do not receive 'formal' care in NHS continuing care, a care home or a home care service organised by social care agencies. For many this is because they do not need any assistance, while for others assistance is provided by family and friends, or organised and purchased privately. Even though the proportion of older people receiving this type of formal care rises as people age, it is still well under half of those aged over 85 years.[6]



[6] Scottish Government Home Care Statistics Census (March 2008); Scottish Government Care Home Census (March 2008);ISD Continuing Care Census (Sept 2008); GRO (Scotland) population estimates 2008

2.4 It is also important to note that older people have a critical role to play in keeping other older people out of the formal care system and living independently at home: they actually provide far more care than they receive. It is estimated that just over 3,000 people over 65 years **receive** more than 20 hours of paid care per week while over 40,000 people over 65 years **provide** more than 20 hours unpaid care per week.[7] Helping to support, sustain and grow this capacity, as well as that of friends and neighbours, is essential if we are to achieve better outcomes for more older people during a period of financial constraint.

2.5 An important concern for older people is the increasing likelihood of unplanned or emergency hospital admission. An emergency admission to hospital may be the right course of action for someone who has a potentially serious or life threatening health problem that needs urgent specialist investigation or treatment in hospital. However for some older people an admission to hospital can be followed by complications such as a serious loss of confidence and confusion that prolong their stay, compromising their independence and ability to return home quickly. The probability that someone will be admitted to hospital increases with age (see chart) and the time spent in hospital after admission is also longer on average with increasing age.

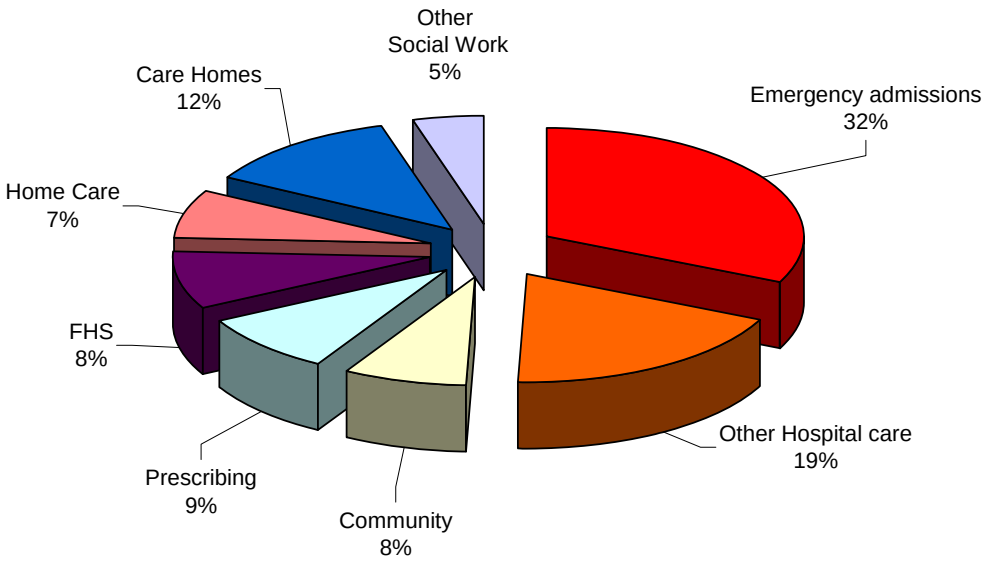


2.6 Many admissions are absolutely necessary and cannot be avoided. Some however can be avoided - if we take the right preventative action and if we ensure that good effective alternatives are available in the community.

[7] ISDScotland hospital discharge records (SMR01) (2008/09); GRO (Scotland) population estimates 2008

2.7 We currently spend approximately £4.5 billion of public funding each year on health and social care for those over 65 years across Scotland. Well over half (60%) of this is spent on providing institutional care in hospitals and care homes (and almost one-third on emergency admissions to hospital). Less than 7% is spent on home care (see chart below) in spite of our vision that older people should be helped to remain at home or in a homely setting for as long as possible.[8]

Heath and Adult Social Care Expenditure 2007/08 for Scottish population aged 65+ (Total=£4.5bn)



2.8 A key focus in reshaping care will be on reducing the number of bed days used as result of emergency admissions to hospital by older people, a proportion of which can be avoided. Overall, emergency admissions by older people absorb £1.4 billion each year and are expected to grow unless we intervene.

2.9 We also know that there are other aspects of the current arrangements for caring and supporting older people in Scotland which undermine achieving our vision:

- Social work agencies, operating in an environment of reducing budgets, required to apply higher eligibility thresholds to meet their statutory duties that have the unintended consequence of squeezing out low level preventative and anticipatory care;

[8] Calculated from National Expenditure Returns: for local authorities: Scottish Government returns LFR3 and LGF4a; For NHS: Cost Book (2007/08); NRAC cost curves (2007/08); Population projections: GRO (Scotland) 2006-based population projections

- Care based on an assumption that it will always be required rather than being designed to rehabilitate or re-able;

- Risk-averse interventions that deny choice and opportunity and limit participation;

- Long-term admissions to care homes, which could be avoided;

- Fragmented and disjointed care that fails to focus on and produce the outcomes that the older person seeks and needs;

- Assessment and care planning excessively based around incapacity and dependence rather than capability and independence;

- Insufficient support for unpaid carers, many of whom are older themselves, that limits their vital contribution to the health and well-being of the people they care for and restricts their own capacity for a healthy life;

- Lack of leadership or incentives to promote changes to the design and delivery of services and a reluctance to embrace change; and

- Lack of incentives to promote change and an infrastructure designed to perpetuate what exists.

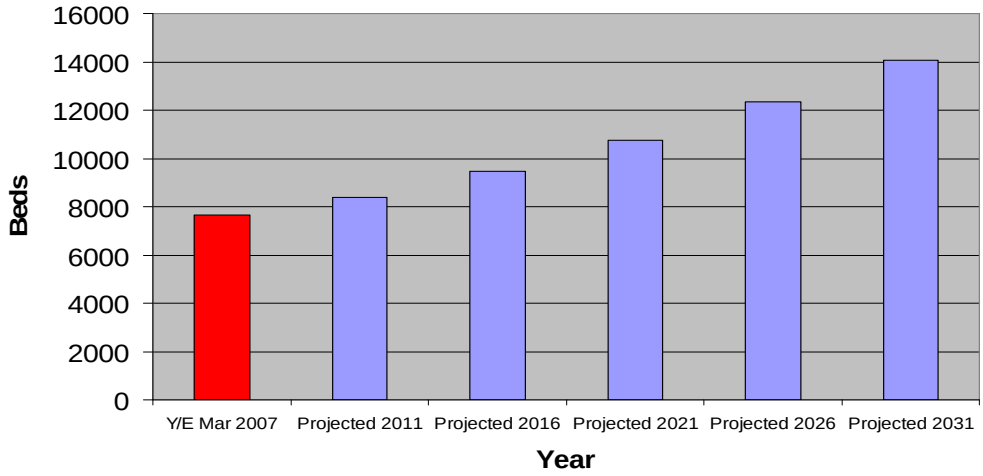
The challenge of a growing older population

2.10 Not only is there a need to change current services so as to better meet the outcomes that we seek, but it is also clear that the current arrangements are not sustainable. The projected growth in the older population will create significant additional demand on health, care and support services. We can show that, assuming that demand increases in line with the growth in the older population and that current service models remain the same, we would require an annual increase in investment in health and social care services alone of £1.1 billion by 2016. There will be additional demands on other services.

2.11 The demographic changes facing Scotland are well documented, with the number of people in Scotland aged over 65 projected to be 21% greater in 2016 than in 2006 and 63% greater by 2031; for those over 75, the projected increase is 21% and 83% respectively.

2.12 We can model the potential consequence of the growth in older people by looking at emergency admissions to hospital. The chart below shows the number of emergency admissions by people aged over 65 during 2007/07 and then the projected increase in this number in the years to 2031 if rates of admission to hospital and length of stay remain the same. There would be similar implications for social care services such as care home places.

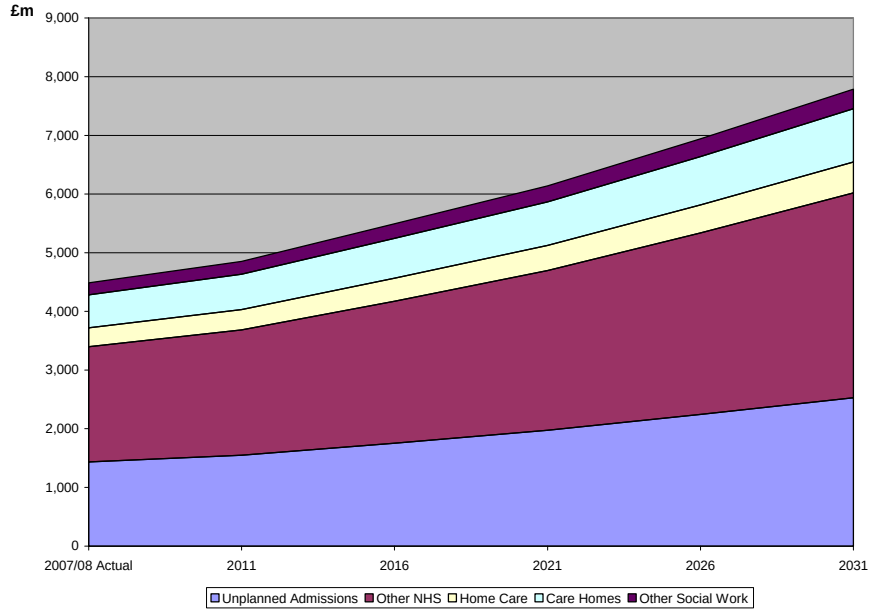
Demographic change for population aged 65+ Scotland
Potential impact on emergency bed numbers 2007-2031



2.13 Redesigning our services for older people can change this. We have already made some progress in this area, but we need to do more.

2.14 This potential increase in demand for services would also have cost implications. A baseline estimate for the projected increase in resources is shown below; this projection assumes no change to existing age/sex specific costs of health and social care (i.e. it assumes no health improvement and no improvement in quality adjusted efficiency in service provision).

Scottish Health & Social Care Expenditure
Projected Increase for Scottish Population aged 65+ (2007/08)



2.15 Assuming current service models remain the same, we will require an estimated annual increase in investment in health and social care services for older people of £1.1 billion by 2016 and £3.5 billion by 2031, a real increase of 24% and 74% respectively over 2007/08 levels. This represents an average real increase in the NHS budget (total for all ages) of 1.2% per year, every year; and of 2.7% per year, every year to Local Authority older people's social work budgets.

2.16 The extent of the increase in practice will depend on a number of factors, such as whether or not the increase in the number of older people translates to an increase in demand for services; and whether or not technological advances and quality adjusted efficiency improvements can reduce the unit costs of service provision.

2.17 The problem is made more difficult within the current fiscal environment, with councils already planning for a real terms reduction of 12% in their budgets across the next spending cycle. It is clear that Scotland will experience an ongoing reduction to the block grant over this spending cycle and it is projected that the Scottish DEL budget will not return to its 2009/10 level in real terms until 2025/26. To put it bluntly, we are presented with a huge structural and financial challenge that cannot be fixed through efficiency savings or marginal changes to service provision on their own.

Key messages

2.18 There are key over-arching messages which need to frame the further development, and delivery, of the Reshaping Care programme.

Key Messages

Older people are an asset not a burden – demographic change creates a challenge but these shifts also offer a potential solution in that older people provide far more care and support than they receive. By working together and supporting communities we can achieve better outcomes and better value.

We need a shift in philosophy, attitudes and approaches – we need to move away from measuring success by how much we do to how many, and towards measuring success by how many older people can be enabled to stay independent and well at home and without need for care and support.

We are adding healthy years to life – we need to push back our concept of older age, with less of a focus on "over 65" years and more on "over 75". We need to ensure that older people have benefited from health improvement activities throughout their lives so that they have fewer risk factors for long term conditions when they reach 65.

Supporting and caring for older people is not just a health or social work responsibility – we all have a role to play: families, neighbours and communities; providers of services like housing, transport, leisure, community

safety, education and arts; and also shops, banks and commercial enterprises. Our approach to achieving our vision must be 'whole system'.

Services should be outcome focussed – services which provide personalised care and support designed to optimise independence and well-being through an enabling approach.

We need to accelerate the pace of sharing good practice – there is lots of good practice across Scotland and beyond, but examples tend to be fragmented and narrowly focussed. We need to rapidly build, grow and spread these examples, reduce variance in practice and achieve greater consistency in, and equity of, support.

Now more than ever it is important to align partnership resources to achieve our policy goals – it is important to acknowledge that there will be considerable pressure on all public sector budgets over the next period which makes it an absolute imperative that we can demonstrate that all of the £4.5 billion currently spent annually on services for over 65 year olds is being used to optimal effect.

Additional funding is needed for care – while there is scope to improve the 'care system' to achieve better outcomes and make efficiencies, the extent of demographic growth will require more resources to sustain current levels of service. Essentially there are two mechanisms available to us for increasing expenditure on services; public spending and personal spending. This debate will be complicated by the need to distinguish between those financial choices that are open to the Scottish Government and those matters (relating to taxation and benefits) that are reserved to Westminster.

3. OUR VISION – WHAT SUCCESS WILL LOOK LIKE

What people want from care and support

3.1 Decisions regarding the future care of older people in Scotland need to be informed by a wide range of views. For this reason, the Scottish Government undertook an extensive programme of public engagement as part of the work of the Reshaping Care for Older People programme. This engagement programme aimed to ensure that as many people as possible had an opportunity to share their opinions[9]. There was also a public consultation undertaken in relation to the proposals from the Wider Planning for an Ageing Population, the workstream of the Reshaping Care programme which considered housing and support issues[10].

3.2 There were a number of very clear and consistent messages from stakeholders, which emerged during this engagement.

- Given the option, people want to **stay in their own homes** for as long as possible. Of all the questions raised at events, this one was received a near unanimous response, and was tempered with "for as long as people feel safe"; or "for as long as a person doesn't feel too cut off".

- People wanted to see a whole systems shift towards a greater degree of **personalisation**. Older people need to be much more involved in planning their own care and therefore needed to be **better informed about their options and choices**. Anticipatory care planning could not work unless older people were far more involved in decisions about their own care.

- At every event a sense of frustration was expressed over perceptions about **needless bureaucracy** and professional preciousness. This is most often referred to in terms of multiple assessments and repetition of the same or very similar questions by different professional groups. At a number of events, participants called for **more joined up working between health and social care**, in terms of service planning, service delivery and use of resources.

- Hospital admissions were often seen as creating more problems than solutions – although there were equally as many voices that spoke highly of the care they, or a relative, had received in hospital. However, there did seem to be a consensus that **prolonged hospital stays were not a good thing** for a person's general wellbeing, especially their sense of control and independence and that some admissions could be avoided if there were better community services.

[9] Further information on the engagement programme and more detailed analysis can be found at www.scotland.gov.uk/topics/health/care/reshaping .
[10] The analysis of responses to the Wider Planning's consultation paper can be found at http://www.scotland.gov.uk/Publications/2010/12/02134605/0

- **Greater support for unpaid carers** – including things such as short breaks, information and advice, tax breaks and entitlement to periods of leave from work.

- Proper funding and support for **pensioner networks of community groups**, self-help and action/activity groups

- People want a **consistency of paid carers** who visit older people at home. It is never good when a different person turns up each time at a person's home: there is no opportunity to establish a rapport or trust, or get to know and understand the person being cared for. It could not be good for carers' morale either, and many people wished that all carers, paid and unpaid, were given greater respect and recognition for the work they did.

- Many people wanted to see **regular health and wellbeing check-ups** for all people over 75, and most thought this should be delivered through GP practices. There should be a full register of all over 75s, and each practice should ensure all over 75s are seen at least once a year for a check up.

- More **specialist services for people with dementia** were frequently asked for at the public events.

- The most frequently mentioned physical infrastructure issue was availability of **appropriate housing.** There is very little choice for people who want to plan ahead and downsize or move into more appropriately designed housing. Local planners were considered to have insufficient regard for the demand for **sheltered and very sheltered housing**, or family homes with a granny flat annex.

- People were also frustrated by the poor response time for relatively **inexpensive equipment and adaptations** to people's homes to get them home from hospital, or to help prevent further need for hospital admissions through preventing falls.

- **Information** about a range of things were frequently asked for – what personal care people are entitled to for free and what they had to pay for? What are the side effects of different medications? What are my options for housing as I become less stable on my feet? People were seen to need help in navigating their way through the health and care system.

3.3 These are consistent with, and reinforce, what we already know about the outcomes that older people and their carers seek.

The outcomes we want to achieve

Our vision

Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting.

3.4 Achieving this vision involves helping older people to have the best possible quality of life by:

- 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.

3.5 It also requires statutory, voluntary, independent and third sectors to work together with older people and their carers in a way that empowers, enables and promotes their confidence and capability for 'supported self care and self management'. This mutual partnership is at the heart of outcomes focused and person centred care and support and is the basis on which we have developed and will deliver our Reshaping Care proposals.

3.6 Our policy goal is **to optimise the independence and wellbeing of older people at home or in a homely setting.** This will involve a substantial shift in focus of care from institutional settings to care at home – because it is what people want and provides better value for money.

3.7 Reshaping Care aims to design a new model of health and social care in Scotland that is fair, affordable and sustainable into the future. Assessing the size and scope of care services we will need over the next 10 years requires us to set out convincing outcomes-focused ambitions.

3.8 Specific outcomes that we want to achieve by 2021, to address the shortcomings of the current arrangements, are

1. A philosophy of co-production[11] embedded as mainstream practice in both the development and the delivery of all services for older people;

2. All care and support providing personalised care based on outcomes/goals agreed with the older person (and their unpaid carer) and on assessments which focus on personal outcomes;

[11] 'Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.' *The Challenge of Co-production: how equal partnerships between professionals and the public are crucial to improving public services,* NESTA & NEF (2009)

3. Services focused on prevention, maintenance of independence, recovery, rehabilitation and re-ablement, with a corresponding reduction in the need for emergency admission to hospital or a care home;

4. More older people living in housing which suits their needs and helps maintain their independence;

5. Community support for older people enlisted and mobilised, through volunteering, community enterprises and care co-operatives;

6. A readily accessible, comprehensive information, advice and support resource available for all older people to help them make decisions about life choices, including adoption of personal budgets for care and matters relating to housing choice;

7. Public sector resources from all sources (NHS, Councils, Benefits) available to jointly fund any agreed aspect of care;

8. Clear and agreed care pathways for all older people, particularly those with complex care and support needs, to enable them to move smoothly through the care system, accessing timely and effective community and hospital care as necessary;

9. Community based support for end of life care to increase the proportion of older people who are able to die at home or in their preferred place of care; and

10. An infrastructure designed to facilitate and sustain the changes and outcomes we want to achieve through the Reshaping Care programme.

Our commitments

3.9 The outcomes we seek as a society and these commitments can only be delivered with concerted and co-ordinated action across central and local government, and in partnership with older people, local communities and service providers. Through the process of engagement with the public, our partners and our stakeholders, we have identified the following commitments.

3.10 **We will double the proportion of the total health and social care budget for older people that is spent on care at home over the life of this plan.** Thus the share of the total spend accounted for by home care would rise from around 6.7% to at least 13.5%, with commensurate reductions elsewhere. This will support a shift to care at home which is what older people want and is safe, person centred, more effective and delivers better outcomes and better value for money.

3.11 **We will build the capacity of third sector partners to help them do more to support the experience, assets and capabilities of older people.** Older people actually provide far more care than they receive. It is estimated that just over 3,000 people over 65 years receive more than 20 hours of paid care per week while over 40,000 people over 65 years provide more than 20 hours unpaid care per week. Helping to support, sustain and grow this capacity is essential if we are to achieve better outcomes for more older people during a period of financial constraint.

3.12 **We will introduce a £70 million Change Fund for 2011/12 and in the region of £300 million over the period 2011/12 to 2014/15 to stimulate shifts in the totality of the budget from institutional care to home and community based care and enable subsequent de-commissioning of acute sector provision**. This Fund will be allocated to local health and social care partnerships where the partners (including 3rd and Independent Sectors) have prepared a local Change Plan. Specific guidance has been issued to indicate how partners can access and use their Change Fund. Work progressing across all partnership areas to develop an Integrated Resource Framework will assist this process.

3.13 **We will shift resources to unpaid carers, as part of a wider shift from institutional care to care at home.** During 2011/12, we will review the impact of the Change Fund and engage with stakeholders to agree the extent of resource shift to unpaid carers during subsequent years.

3.14 **We will improve quality and productivity through reducing waste and unnecessary variation in practice and performance with regard to emergency admissions and bed days across Scotland.** If all partnerships were enabled to perform to the level of the top quartile, approximately 11% of hospital beds would be surplus, generating scope for significant re-investment in community provision, and capacity for meeting increasing demand due to demographic factors.

3.15 **We will aim to reduce rates of emergency bed days used by those aged 75+ by a minimum of 20% by 2021 and at least 10% by 2014/15.** Achieving this will go some way toward achieving the increase in the proportion of spend on care at home. It should also allow us to absorb demographic growth, though may not support reduction in bed numbers within the acute sector. We will therefore need to review this target in the light of early experience to assess the scope for increasing our ambitions in bed day reductions. The ability to de-commission capacity from institutional settings will be as crucial as investment in community capacity. To achieve this shift in activity and resources local Change Plans will promote the development of a strong and responsive range of community based support and care services building on many of the current initiatives being developed. These will promote the Reshaping Care philosophy and approach to caring for older people described below as an integrated and comprehensive whole system framework.

3.16 **We will ensure older people are not admitted directly to long term institutional care from an acute hospital**. Currently too many older people are discharged from hospital to a care home at a time when their confidence is low following an acute illness. The presumption should always be that an older person will be discharged to their home or, where their needs make this inappropriate, we will promote intermediate care. We will also ensure that all community care assessments are completed at home or in an intermediate care setting.

3.17 **All older people over 75 years will be offered a telecare package in accordance with their assessed needs.** There is clear evidence of the benefits of telecare for both older people and their carers. Telecare should be seen as a core support that can assist people to optimise their independence and wellbeing.

4 WHAT WE WILL DO

4.1 The Reshaping Care Programme has already built significant momentum through raising awareness and interest in the challenges we face. We now need to build on this momentum to achieve a step change in the pace at which our services are transformed to meet our vision.

4.2 We need to work in partnership between those requiring care and support and those providing it to reshape our care and support for older people and to achieve our vision. This requires the statutory, independent, the third sector and unpaid carers to work together and to provide the information, advice and support to enable older people to remain in control of actions and decisions that affect their lives and to do as much for themselves as they can or want, with support where required.

4.3 There is a growing body of evidence on the interventions, approaches and services which are consistent with the principles of co-production and personalisation and which have been shown to contribute to the outcomes we seek. We set these out below, together with links to further information.

4.4 Our further work will be taken forward under the following themes

- **Co-production and community capacity building** –working with older people, their carers and the third sector to build an approach to providing care, based on co-production principles, to develop new community driven models of care provision, and to help older people maintain their independence wherever possible.

- **Care services and settings** – working with statutory and non statutory sectors across health, housing and social care to embed these principles and to ensure the physical and social environments and infrastructure of services support our shared goal to optimise the independence and wellbeing of older people at home or in a homely setting and enable them to remain in their communities.

- **Care pathways** – working across clinical (acute and primary) and care and support agencies to create coherent and integrated care pathways that improve our ability to support people, particularly those with complex care needs, to remain at home or to move smoothly between services and settings.

- **Workforce development** – developing a motivated and capable workforce to underpin a high quality care sector, through work led by NES and SSSC, promoting the principles of co-production and personalisation.

- **Planning, improvement and support** – supporting cross system leadership, strategic planning and improvement capacity, and use of

the Change Fund to lever a shift in the totality of the partnership spend on older people.

- **Demography and funding** – review and further analysis of funding arrangements, connecting as appropriate to UK Government interests, so plans are realistic, sustainable and responsive to the changing demography and financial context. Our proposed programme of work is set out in the next chapter.

Co-production and community capacity building

4.5 Our biggest opportunity and challenge is to reshape the attitudes, expectations, and aspirations of the people of Scotland, including, but not exclusively, our older people. This will be a long and incremental process of changing to an approach to providing care which focuses on providing 'personalised' support. Such an approach builds on the capabilities of the individual, on their potential for independence, and on what they can do for themselves (it is sometimes called an 'assets-approach'). It is different from the model we mostly have now, which focuses on the individual's lack of capabilities, their needs and dependencies and on what they cannot do for themselves (this is sometimes called a 'deficits-approach'). Our existing approach can sometimes shoehorn people into services we currently have rather than working with them to design the services that will truly help them. It will be achieved by nurturing the principles of co-production, participation, empowerment, and enablement.

4.6 Co-production transforms the relationship between those who provide services and those who receive them. Unpaid carers are already hugely important in supporting older people to live independently at home. They will be equal partners in realising our vision of care based on co-production principles, with support to them being available at the right time to achieve our vision.

4.7 Co-production most often refers to the partnership between the practitioner or paid carer with the person cared for and those close to them. NESTA have defined it as follows

> *Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are produced in this way, both services and neighbourhoods become far more effective agents of change.*[12]

4.8 It is increasingly used to refer to the process that **should** take place as each link is forged along the full 'value chain' of service planning, design, commissioning, managing, delivering, monitoring and evaluation activities. [13]

[12] *The Challenge of Co-production: how equal partnerships between professionals and the public are crucial to improving public services,* NESTA & NEF (2009)
[13] *Beyond Engagement and Participation: User and Community Co-production of Services,* Tony Bovaird for Carnegie UK Trust (2006)

4.9 This philosophy is at the heart of the NHS Quality Strategy and is central to the work being taken forward by the Scottish Government in its Independent Living programme[14]. It is also consistent with the aims of Self Directed Support[15] and the ambitions in the Carers' Strategy[16].

4.10 Supportive local communities which have the capacity to provide care and support with and for older people will be central to achieving this change in philosophy. Growing community capacity that focuses on preventative and anticipatory support will reduce isolation and loneliness, enable participation, improve independence and wellbeing and delay escalation of dependency and need for more complex care and support.

4.11 The better targeted use of resources will also help and through new forms of community enterprise such as care co-operatives and community businesses. Care and Repair, equipment and adaptations, community transport, social activities and respite care are all examples of support that can flow from this sector.

4.12 Growing capacity within communities to access that support has a particular synergy with the principles contained in the Dementia Strategy whose aims include ensuring people with dementia and their carers have the right to participate in decisions that affect them; that they should enjoy full respect for their dignity, beliefs, individual circumstances and privacy; that they should be free from discrimination based on age, disability, gender, race, sexual orientation, religious beliefs, social or other status; that they should have appropriate levels of care providing protection, rehabilitation and encouragement; and that they should have the full range of human rights respected, protected and fulfilled. .

4.13 Our approach will be to

- Grow societal support for the philosophy of a mutual care approach; both in principle and in practice;
- Support a shift in expectation away from institutional care settings, towards community and home-based care;
- Nurture a philosophy of care that embraces self management, supported self care and re-ablement;
- Adopt an asset approach that value and empowers older people and their communities; and
- Promote the development of third sector organisations which harness the energy of local communities and provide services responsive to the needs of local people.

[14] See http://www.ilis.co.uk/about-the-ilis-project/ for further information
[15] see http://www.selfdirectedsupportscotland.org.uk/ for further information
[16] The Carers' Strategy can be found at http://www.scotland.gov.uk/Publications/2010/07/23153304/0

Creating the right care services and settings

Health and well-being in later life

4.14 We will continue to develop approaches to support healthy ageing, with a focus on diet, exercise, falls prevention and building on lessons from the Keep Well and anticipatory care programmes. We will ensure that health improvement activities throughout adulthood support people in changing behaviour to reduce their risk factors for long term conditions and we will strive to achieve reductions in smoking levels, excessive alcohol intake and physical inactivity greater than those identified in current targets, but within current levels of health improvement investment.

4.15 By doing so we will significantly reduce the incidence of long-term conditions, including COPD, heart failure, stroke and osteoporotic fractures which lead to a significant burden of illness for older people, their families and carers, NHSScotland and care homes.

Unpaid carers

4.16 We will implement the Carers Strategy, Caring Together, which focuses on all carers, not just older people. This strategy has a 5 year time frame to 2015, but will be relevant to the Reshaping Care programme. Whilst the Carers Strategy contains action points on some of the key areas mentioned in this document, such as telecare, and equipment and adaptations, it also contains other key actions about support to carers.

Housing

4.17 A greater proportion of older people will continue to live in housing, rather than in care homes or hospital settings, as a result of our goal to shift the balance of care and there will be increased demand for the housing and housing-related services as a result. There is now a body of evidence which demonstrates the contribution which housing and housing related services (such as adaptations and housing support) play in supporting older people to live independently at home[17].

4.18 The great majority of the current population, not just those who are already over 65 years, will live their lives in houses which are already built. While new housing continues to be built, current rates of house building both in the private and public sector will only gradually replace and extend the existing stock of housing. The importance of existing housing for older people is a key theme of our housing workstream.

4.19 Even though new house building is likely to be limited, it remains a key objective to ensure that the housing that is built meets the needs of an ageing

[17] In relation to housing adaptations, see in particular *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations,* University of Bristol (2008) http://odi.dwp.gov.uk/docs/res/il/better-outcomes-report.pdf . In relation to housing support, see in particular *Supporting People: Costs and Benefits*, Tribal (2007) http://www.scotland.gov.uk/Publications/2007/12/14141444/0

population. We believe that new housing developments should include a variety of house types, reflecting local community needs and will encourage early engagement between house builders, local authorities, communities and the third sector to ensure housing meets the needs of the local population.

4.20 Our review of evidence has highlighted the main contribution that housing makes to the vision: we identified aspects of these areas where improvements are needed[18]. These are:

- ***Housing adaptations services***– streamlined and more effective alterations to people's homes to increase or maintain their independence and reduce the risk of an accident;

- ***Housing with care and support*** – extending the supply of housing with includes onsite support, particularly through making better use of our existing stock of sheltered housing, and specialist new provision.

- ***Low level, preventative services*** – explaining the benefits of greater investment in key low level services with a preventative focus, particularly housing support services and handyperson services.

- ***Equity release and shared ownership models*** – assisting older people to use the assets in their home to provide themselves with the housing which is most suitable for their needs.

- ***Building standards*** - working closely with public and private sector housing providers to review whether current building and design standards meet the needs of older people and others with particular needs in our communities.

Care homes

4.21 Care homes will continue to have an important role for people with more intensive and complex care and support needs. New models will be developed that bridge traditional care homes and extra care housing to provide homes for residents with particular requirements. Care levels may be tailored to particular needs, such as dementia care or palliative and end of life care.

4.22 We will look at ways to enable care homes to have a greater role in rehabilitation, intermediate and short term care. There is also capacity to link care home facilities to wider community care provision through the development of care hubs where capacity for additional services such as laundry, nutritious meals, and day activities might be better utilised by a wider community. Acknowledging the need to encourage new models of care, we have agreed a formal review of the National Care Home Contract.

[18] The Wider Planning for an Ageing Population group is taking forward the housing related issues in line with the Action Plan which has been developed. A national housing strategy is also being prepared. Further information can be found at http://www.scotland.gov.uk/Topics/Built-Environment/Housing/access/ROOPH

Equipment and adaptations

4.23 Equipment and adaptations play a vital role in improving the quality of people's lives. They can help people to live more independently in their own homes and can reduce the need for home care services. The provision of equipment and adaptations, as opposed to more costly interventions such as home care or residential care, can also produce significant savings for health and social care partnerships.

4.24 The provision of equipment and adaptations, including the opportunities provided by innovative technology, should be an integral part of mainstream community 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 from child to adult services and from hospital to community settings.

4.25 We have already undertaken significant work over the past two years, setting out a national framework in guidance and following this with information on good practice and providing practical tools. We will build on this work during the course of the Reshaping Care programme to ensure that equipment and adaptations across health, housing and social care operate in an effective and integrated manner to deliver the outcomes that we, and older people, need.[19]

Telecare and telehealth

4.26 There is now a significant body of evidence which shows the potential of telecare to support greater independence and improve the quality of life for carers. Importantly, telecare can also realise savings when it forms part of a re-design of services.[20]

4.27 Telecare should be seen as a core support that can assist people with low, medium and high level needs to optimise their independence and wellbeing. Telecare devices can also support good medication management which can both improve outcomes for users and reduce costs through minimising waste.

4.28 We must continue to invest in telecare and telehealth, as part of an increase in investment in care at home, and a main component in reshaping our services. At national level, we will work with UK wide bodies such as the Technology Strategy Board and with the EU to help generate inward investment and to position Scotland is a world leader in the development and application of telecare and telehealth.

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[19] A summary of the benefits of equipment and adaptations can be found at http://www.scotland.gov.uk/Topics/Health/care/EandA/ValueofAdaptations#_ftn2. Further information, including the most recent guidance and good practice information can be found at http://www.scotland.gov.uk/Topics/Health/care/EandA

[20] See in particular *Assessment of the Development of Telecare in Scotland 2006-2010* and *Exploring the Cost Implications of Telecare Services* both by Newhaven Research (2010) available at http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/

Transport

4.29 The provision of transport, its adequacy and ability to meet the needs and aspirations of the elderly and disabled features in every discussion on services and support with service users and their carers, in both rural and urban settings. Transport services are a major factor in meeting the expectations of service users within local communities to use services, to meet people and to participate in wider activity. The provision of safe, secure and efficient transport services makes a profound impact on the lives of older people, when provided at the right times, with the right supports, in personalised service provision. We will ensure that full account is taken of these important principles as we move towards implementation of the Reshaping Care programme.

4.30 Further suggestions about ways to achieve a more integrated and effective transport system for older people have been identified by the Joint Improvement Team.[21] The JIT also intend to publish a guide which will report more fully on developments across Scotland, provide some more focussed evidence about what currently works, and help partnerships to achieve best practice in transport with care.

Creating effective care pathways

Information, Advice and Assistance

4.31 Throughout the public engagement programme that informed this plan the challenge of understanding the complex care system and navigating through it to access the right care at the right time was raised as a real barrier. Good quality information is a cornerstone to empowering service users and carers and enabling them to take an active and effective role in outcome focused services. It has particular importance for those with more complex needs who need to access a wide range of services delivered by different agencies.

4.32 We will build on the National Community Care Information Service and NHS inform to develop, through local partnerships, 'one-stop' care information and advice services. Partnerships should signpost people to community and third sector resources that promote healthy ageing, enable participation and supported self management, and provide older people and their carers with comprehensive information and advice about the choices they have about their future care, support and housing.

Outcome focused assessments and support planning

4.33 A core feature of the Reshaping Care programme is that services should focus on the outcomes that are important to the people who use services, and their unpaid carers. This means engaging with people to find out what their priorities, strengths and capacities are. This shift has been

[21] The paper setting out these ideas can be found at http://www.jitscotland.org.uk/action-areas/integrated-transport-with-care/

welcomed by people using, providing and planning services and fits with initiatives seeking to personalise public services, maximise individual independence and support recovery, rehabilitation, well being and quality of life.

4.34 Although in some ways building on good practice, a move to focus on outcomes also requires a significant 'culture shift'. Practitioners tell us that an outcomes approach supports practice that has been undermined by the current dominance of service driven assessment and support planning. Making this culture shift requires sustained effort, and the involvement of all partner agencies. Partners need to be creative, flexible and solution-focused in developing supports and services that maximise outcomes.

4.35 Talking Points[22] is based on research which looked at the outcomes most important to users of services delivered in partnership between health and social care. Nearly all partnerships, and many providers, are already working with Talking Points. We will continue to promote its use across all partnerships as a key component of personalising our services and delivering the outcomes which are important to users and their carers.

Recovery, rehabilitation and re-ablement

4.36 The Reshaping Care Programme will include a clear focus on recovery, rehabilitation and re-ablement approaches that help older people attain their best possible health, wellbeing and independence. Guidance will be prepared describing the spectrum of approaches suited to different needs and circumstances; how to deliver these through an integrated approach; and providing a context to support staff training and development. This will build on the Rehabilitation Framework and emerging work relating to re-ablement and intermediate care.

4.37 ***Re-ablement*** - The benefits of a Home Care Re-ablement approach in reshaping care and care services for older people are already nationally recognised.[23] Essentially, re-ablement uses the same resources in a different way to redesign and provide the most efficient and effective service around service users and their houses. This addresses the growing number of older people in need of care and support and improves service users' health, and reducing pressure on NHS services.

[22] Further information about Talking Points, including the research on which it is based, the tools which have been developed and the work which is being taken forward across Scotland can be found at http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/

[23] Add reference

4.38 Some of the benefits are set out in the box below:

Re-ablement

- **changes the culture** of home care from 'task and time' to 'better outcomes';
- is about **"doing with" service users** rather than 'doing to' or 'doing for' them
- formulates packages of care around **goal plans;**
- encourages in people **confidence** that their current situation will improve;
- increases **self-worth** through making small successful improvements
- includes unpaid carers as partners;
- utilises home carers' **interpersonal skills;**
- provides **additional training** for home carers on Home Care Re-ablement;
- allows home carers to **record daily progress** and link to Occupational Therapists for expert advice;
- uses **weekly team meetings** to consider the progress on goals and adjust the package of care on a daily/ weekly basis;
- maximises service users' long-term **independence and quality of life**;
- provides **monitoring information** for the Care Manager undertaking review
- appropriately **minimises ongoing support** - thereby minimising the whole life-cost of care;
- And ensures **high standards** for handover to long term provision of care at home.

4.39 ***Intermediate Care***. Though there is no one definition for all services within the scope of intermediate care, it has been defined as a 'range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living'[24].

4.40 Intermediate care enables people to improve their independence by providing a range of enabling, rehabilitative and treatment services in community and residential settings. Better integrated approaches through intermediate care not only help to prevent unnecessary admission to hospital, or help facilitate early discharge, but they are also central to the priorities from the Reshaping Care programme and the need to ensure improved joint working between local authorities and the NHS in community care.[25] We will look at ways to support an extension of intermediate care, using both care homes and housing to provide settings which can support speedier discharge and faster recovery.

[24] *NSF for Older People*, DOH (2002)

[25] Further information about intermediate care, its role and approaches to providing it can be found at http://www.jitscotland.org.uk/action-areas/intermediate-care/

Complex care pathways

4.41 The impact of population ageing means that more people will live with multiple long term conditions.[26] Along with a predicted doubling in prevalence of dementia, it is clear that multi-morbidity will become the norm, frequently compounded by functional and cognitive impairment and poor socioeconomic circumstances.[27] These changes will inevitably lead to a sharp increase in the number of frail older people with complex and frequently changing care and support needs which challenge our health, social care and housing system.

4.42 Frail older people commonly present with falls, immobility and confusion.[28] Well over half (60%) of those aged over 75 attending Accident & Emergency are admitted to hospital. This may be entirely appropriate but in acute care they are susceptible to complications such as delirium prolonging their stay and resulting in high rates of mortality and institutional care.[29] The human costs of complications such as healthcare-associated infections, delirium, pressure sores, malnutrition, dehydration and side effects of medication[30] are potentially preventable and treatable.

4.43 System costs can be reduced and quality of care enhanced by effective interventions delivered through pathways that span primary, community and acute sectors. These prevent avoidable admissions[31], reduce length of stay[32], prevent complications and avoid or delay premature admissions to institutional care[33][34][35]. Yet there is considerable local and national variation in access and capacity of these interventions driving significant variance in rates of institutional care and emergency admissions and bed days for over 75s.

4.44 Building on the experience of implementing the Long Term Conditions Action Plan, Living and Dying Well, Rehabilitation Framework and

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[26] Department of Health. *Improving chronic disease management*. 2004 [cited 2010 Oct 11]; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4075213.pdf

[27] Rockwood K, Fox RA, Stolee P, Robertson D, Beattie BL (1994) Frailty in elderly people: an evolving concept. CMAJ, **150**, 489–95.

[28] Tinetti ME et al. *Shared risk factors for falls, incontinence, and functional dependence. Unifying the approach to geriatric syndromes.* JAMA 1995; 273: 1348-53).

[29] McCusker J, Cole MG, Dendukuri N, Belzile E (2003) *Does delirium increase hospital stay? J Am Geriatr Soc* **51**: 1539-1546

[30] *Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients* M Pirmohamed et al, BMJ 2004;329:15-19

[31] Purdy S, *Avoiding Hospital Admissions – what does the research evidence say?* King's Fund Dec 2010

[32] Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, Richards S, Martin F, Harris R. *Early discharge hospital at home*. Cochrane Database of Systematic Reviews 2009,

[33] Rubenstein LZ, Stuck AE, Siu AL, Wieland D (1991) *Impacts of geriatric evaluation and management programs on defined outcomes: overview of the evidence* J. Am. Geriatr. Soc., **39**:8S–16S

[34] Ellis G, Langhorne P. *Comprehensive geriatric assessment for older hospital patients*. British Medical Bulletin 2005; **71**: 45-59

[35] Stuck AE, Siu AL, Wieland D, Adams J, Rubenstein LZ *Comprehensive geriatric assessment: a meta-analysis of controlled trials.* Lancet, 1993; **342**: 1032–6.

Modernising Nursing in the Community and drawing on published evidence on Comprehensive Geriatric Assessment we have identified a suite of evidence based interventions that will improve quality and value, prevent or delay institutional outcomes, and decrease avoidable emergency admissions and bed days.

Effective Interventions to Improve Pathways
1. Health and social care staff systematically use risk prediction tools to identify people who are frail and those who are at greatest risk of emergency admission to hospital or institutional care.
2. CH(C)P health and social care teams deliver a proactive integrated care management approach that • targets frail older people with complex needs at greatest risk of emergency admission to hospital or institutional care; • provides a heart failure support service to those who will benefit • offers pulmonary rehabilitation to all who are eligible.
3. Care providers in CH(C)Ps support the use and sharing of Anticipatory Care Plans (ACPs): a summary or shared record of preferred actions, interventions and responses that care providers should make following a clinical deterioration or crisis in the person's care or support.
4. Increase the use of Emergency Care Summary particularly at times of transition to hospital. Progress implementation of the Chronic Medication Service through the CH(C)P, working with local GPs and community pharmacists, to ensure regular review and reconciliation of prescribed medicines for frail older people and the development of personalised pharmaceutical care plans that support them to take their medication safely.
5. Pathways through A&E and admissions wards are configured to rapidly identify frail older people, people with heart failure and those with COPD
6. The CH(C)P provides a range of Intermediate care services that act as a bridge at key points of transition in the journey from home to hospital and back home again, and from illness to recovery. These services include rapid access to safe and effective alternatives to hospital admission and target people who are frail, have fallen and those with COPD or heart failure.
7. Frail older people, those who have fallen, people with COPD and with heart failure admitted to hospital are streamed and pulled to the right specialty to be managed by the right team within 24 hours of admission.
8. Pathways for older people through acute hospitals are configured to minimise avoidable transfers, reduce boarding and deliver bundles of care that prevent, detect and effectively manage delirium.
9. Health, social care, SAS and independent providers work together to optimise use of estimated date of discharge, systematically improve discharge planning and eradicate delayed discharges, including delays in short stay specialty beds.

10. The CH(C)P has a coordinated and multi-agency approach to planning and spreading the use of telehealthcare for long term conditions. The approach segments the population to identify groups who require assistive technology to augment information, advice and support for self management

Workforce development

4.45 To achieve our objective of providing high quality care and support for older people we need to be sure that our health and social service workforces are properly educated and trained. The messages from the public engagement events show that people want to be able to live in their own homes for as long as possible. They want services to be personalised and delivered in a joined up way that offers continuity and meets their needs. This can only be done by a workforce skilled and properly prepared to meet the challenges.

4.46 In taking the workforce development issues forward in a joined up way the Scottish Social Services Council (SSSC) and NHS Education Scotland (NES) are working together with all interests to consider current and future workforce requirements.

4.47 There are three main areas that are being progressed, Demographics, Skills Requirements and Learning Provision and Support.

4.48 This will include further work building on our understanding of the impact of demographic shifts and making sure we have the right systems in place to gather, analyse and plan for the type of health and social service workers required now and in years to come. Drawing upon the best practice examples developing in various parts of the country and learning from the public engagement exercise we will work with all interests to ensure the knowledge, skills, values and attitudes to support a care workforce are the right ones to enhance self directed support and personalised care. We will also support the provision of effective leadership and promote cross sector employers alliances. This cannot be achieved without the help of those agencies that deliver learning and training. To this end we will work with Scottish Colleges and Higher Education providers to ensure the professional, clinical and vocational awards being delivered can and do reflect what will be required to deliver better services for older people.

Planning, implementation and support

Change Fund

4.49 A major concern during the consultation and engagement phase centred on the difficulty of investing in new community care and support services before being able to de-commission existing institutional care. The need for 'bridging finance' was identified as a priority and the creation of a £70 million Change Fund is a direct response to this call. The Change Fund will

enable the pace of change and development to accelerate over the next few years.

4.50 The Reshaping Care programme needs to be driven forward by local partnerships and the Change Fund should provide a purposeful catalyst for this. A requirement to ensure that 3rd and independent sectors are fully engaged as partners alongside councils and Health Boards will help ensure the principles of co-production are at the heart of developments.

Strategic joint commissioning strategies

4.51 The national partners are, through the Change Fund guidance, urging local partnerships to invest capacity in the preparation of strategic joint commissioning strategies for 2012-2020. This will require involvement for all stakeholders across statutory, community, 3rd and independent sectors – users, carers, providers and commissioners of care coming together to agree long term service development and investment proposals. These plans will also need to identify where and how resources should shift from current services and care models to new arrangements. The ability to de-commission will be as critical as the ability to commission. This approach will ensure there is both a strategic national and local focus for Reshaping Care throughout the next decade.

Engagement with partners

4.52 Continued attention will be given to sustaining public and stakeholder engagement.

4.53 A national reference group will be set up with representation from professionals working within the statutory agencies of government, senior representatives of those contracted to provide care and support to older people including housing services, and those who advocate on behalf of older people and their carers. Its purpose is to build consensus across all stakeholders on the way forward with respect to agreed outcomes of the Reshaping Care programme as they relate to the delivery of care.

4.54 The National Reference Group for Older People's Care will have interests in all aspects of the Reshaping Care programme.

Support to partnerships

4.55 The Scottish Government will provide support to partnerships as plans for the Change Fund and the wider delivery of the Reshaping Care programme are developed and implemented. Support will be available through the Joint Improvement Team with a named lead provided for each partnership, and from other parts of the Scottish Government and other national improvement bodies.

4.56 In addition, we will establish a Reshaping Care Improvement Network to enable partnerships to share learning, spread effective practice and

increase the pace of reshaping care. We will also consider how best to progress particular issues, such as skills development.

Key Actions

We will

- use the Change Fund to drive service re-design and enable shifts in core budgets;
- focus on outcomes and enablement, through promotion of Talking Points;
- support a shift in focus to 'support', and away from 'services';
- Support carers and communities to advance supported self care;
- Develop and extend low level preventative services, including equipment and adaptations, handyperson services and housing support;
- Put in place a community capacity building programme in collaboration with third sector partners;
- Develop information, advice and assistance to help older people make key decisions and navigate the care system;
- Create clear pathways into and through services, particularly for older people with complex needs;
- Continue to roll out the Integrated Resource Framework; and
- Provide support to local partnerships from the JIT in taking forward this challenging agenda.

5 NEXT STEPS: THE POLICY AND FUNDING FRAMEWORK

5.1 We have made significant progress over the past two years in building consensus that we need to change our approach to caring for older people in Scotland. This is both because we too often fail to deliver the best outcomes for older people, and demographic change and the public sector's financial circumstances mean that current service and funding arrangements are not sustainable.

5.2 We have set out in this document the outcomes we want to achieve and the interventions, approaches and services, consistent with the principles of co-production and personalisation, which have been shown to contribute to the outcomes we seek. We recognise, however, that there is further work to be done to put in place the policy and financial framework to support delivery of these outcomes.

5.3 In particular we are aware of the challenge posed by the increase in demand we face as a result of demographic change, made more difficult by the current fiscal environment. Two actions are required to address this challenge:

(a) We need to demonstrate that all of the current resources (approximately £4.5 billion per annum) spent on the care of older people is being used in the best possible way to meet agreed policy goals; and

(b) Consider how additional resources can be secured to support care services into the future. This might require the state to raise more money or to look at a range of options, and these options will be influenced by the UK Government's response to the recommendations of the Dilnot Commission in July 2011.

5.4 As regards the former, there is a need to achieve better outcomes from within our current resources, as part of a broader ambition to shift the balance of care. This might include tackling avoidable hospital admissions, avoiding premature admission to care homes, taking a more strategic approach to re-ablement and early intervention and simplifying the complex infrastructures that we have built up to govern our health and social care systems.

5.5 The biggest potential area of 'resource release' that could be redeployed is locked in the acute sector to fund emergency hospital admissions - this accounts for a third of the total costs of providing health and social care for older people. However, successive attempts to 'release' some of this resource have failed due to the inability to reduce the numbers of patients accessing A&E units; the lack of confidence among the public (and some clinicians) in effective alternatives in the community; and hence an inability to close wards, units or hospitals, in order to release funding to reinvest in sustainable community services.

5.6 As regards costs and funding, additional resources will be required to provide a good quality care system for those in need. We need to establish the size of the funding gap and identify whether the additional resource should come from the state (via increased taxation or stripping back existing policy commitments) or from members of the public, by directly contributing to the cost of their care.

5.7 In addressing the question of how much additional resource will be required, we have estimated (based on current service levels) that an additional £1.1 billion will be required over 2004/5 levels by 2016. The unknown at this point is how much that figure can be reduced if we can progress an enabling care system that reduces demands/costs and makes better use of existing resources. We have commissioned some economic modelling/forecasting work to help address this 'gap'.

5.8 We sought views as part of our engagement programme about who should be responsible for paying for care. Most audiences found it difficult to reach any real consensus, but there was often an acknowledgment that the current system was flawed because:

- It was **unfair to those who had saved and acted responsibly** throughout their lives – they seemed to be penalised for being frugal and careful with money, while those who had "lived life to the full, spending all their available income on enjoying living life (in the here and now" got all their care paid for by the taxpayer.
- The current system is **confusing and complex** and very different depending on whether or not you needed to go into a residential care setting.
- Some recognised that the **burden on younger generations** was too great, especially if more was to be provided free of charge such as in the NHS.
- When pressed, most audiences expressed a preference for a continued **dual contribution from the state with individuals** contributing to their own care where they could afford to do so.

5.9 We need to ensure that work taken forward in a Scottish context effectively engages with the issues raised by the UK Government. Any significant shift in the balance of funding between the state and the individual may require change to tax and/or benefits regimes, and these are reserved matters. In particular, we need to liaise closely with the Dilnot Commission, which was established by the UK Government to assess future options for the funding of care and support in England.

5.10 In summary, over the course of the next year, work will be undertaken to clearly articulate the funding options available to the Scottish public

- We will cost the model of care set out in Volume One of the 10 year strategy – our primary objective is to improve outcomes at less cost to the public purse;
- The UK Government will respond to the Dilnot Commission, indicating what fiscal levers will be used to fund care into the future;

- The Scottish Government will assess the levers that are directly within the control of the Scottish Parliament and come to a view about which of these can be used;
- The levers that are within the control of the Scottish Local Government will be considered, including charges for community care services;
- The policy architecture around older people's care will be considered and assessed against the outcomes we are seeking to achieve and the affordability of the current suite of policies;
- The procurement of care will be considered, including an assessment of whether current procurement routes deliver best value.

5.11 These are challenging issues to address. That is why we want to take more time to give full consideration to these issues as part of a second volume of work. We will prepare this for publication in autumn 2011.