

**RANGE AND CAPACITY REVIEW GROUP:  
SECOND REPORT**

**THE FUTURE CARE OF OLDER PEOPLE  
IN SCOTLAND**

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IN SCOTLAND**

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## CHAPTER 1: CONTEXT AND REFERENCE TO FIRST REPORT

This is the second and final report from the Scottish Executive Health Department's Range and Capacity Review Group

The National Delayed Discharge Action Plan (March 2002) highlighted the need to carry out a range and capacity review of community care services for older people, and led to the establishment of this Range and Capacity Review Group.

The first report of the Group *Projections of community care service users, workforce and costs* was published on 16 July 2004. This was modelling work that presented 7 scenarios and then, for each of these scenarios, set out statistical projections of the numbers of community care service users and of workforce and cost implications at a Scotland level up to 2019.

It did not set the context for care, nor did it make recommendations about the way forward. We address these matters in this report, working to the remit below.

This report does not provide, as some might have expected, a detailed analysis of the different models that were outlined in the Group's first report. As our work progressed it quickly became apparent that, as a national review group, we could not decide what should happen at local level.

Of the scenarios in our first report, scenario 7 (the joint future model) is the one that fits best with the direction of policy and practice in Scotland. But the way in which a joint future model is delivered in one area will be different from that in another area, because of the mix of existing services (and their inter-action, of which we say more later about a whole systems approach), and the local population and geography.

This report therefore sets out:

- our understanding of the big problems,
- the context in the light of recent, major reports (notably *Building a Health Service Fit for the Future* (the Kerr Report), *Delivering for Health, Better Outcomes for Older People*, and the *21<sup>st</sup> Century Social Work Review*), and
- a vision for care for the increasing ageing population in years to come.

The report is therefore neither an action plan nor a model of care, but it sets out principles, a vision for care that has to be worked out in detail at local level.

### REMIT

The Group's remit was –

- to examine evidence of the future health of older people and consider the implications for the provision of care services.

- to investigate the use of existing models of care and the use of other services and support as an alternative to long term residential care.

In fulfilling this remit, the Group sought to articulate and inform the development of a vision for care that provides services for older people as and when they need them. Accordingly the vision needs to:

- be flexible
- respond to changing circumstances, and
- be adaptable to local needs (linking in to local capacity planning at local authority/health board level).

## CHAPTER 2: CHANGE AND RECENT TRENDS

Services are not static, and there have been many changes over the last 20 or 30 years. Community care policy has long been to maintain those who wish to do so in their own homes, or in homely settings in the community, wherever possible. In support of that, the NHS has worked with local authorities to increase services to people in their own homes and has reduced long-stay hospital provision for older people.

Thus there has been a shift in provision away from

- NHS long-term care towards care homes and complex packages of care delivered at home
- nursing home care to care at home.

Our first report noted that

“From the NHS perspective, with advances in medical treatment, the Health sector has been moving towards shorter periods of treatment and shorter lengths of stay in hospital. With a more intensive use of beds and more rapid turnover, more people are being treated in hospital, but for shorter periods of time. There has also been a reduction in the number of continuing care beds and a move to care in the community.

Local authority models of community care have also been changing, with a move away from care in care homes to more support for people in the community to help them live as independent a life as possible in their own homes for as long as possible. There are some concerns, however, that these changes in the pattern of care have developed unevenly and have resulted in a gap in provision for some people between NHS hospital care and care at home or in a care home. There is a need for new models of care to be developed to recognise this, with more intermediate rehabilitation taking place to maximise the independence of the older people involved”.

To illustrate this:

- the number of NHS Scotland **geriatric long-stay beds** and patients increased over the 1980s, but showed a marked decline over the 1990s – indeed the number fell by more than 50% between 1990 and 2000.
- by contrast, **nursing home places** increased substantially during the 1980s and during the period 1990 and 1995, increased more gradually until 1998 before falling back slightly subsequently.
- provision of **special needs housing** for older people increased dramatically in the years to 1998, and has remained relatively constant subsequently.
- provision of **very sheltered housing**, while only accounting for a minority of all special needs housing for older people, is continuing to increase, but there were only 2,872 such dwellings in 2004.

Services will continue to change in the future, partly through population and technological changes and partly through the impact of national policies as they develop following, for example, the Kerr Report *Building a Health Service Fit for the Future*.

## **Drivers for Change**

There are many drivers for change, and these were set out in a paper prepared as part of the work leading to *Building a Health Service Fit for the Future* which can be accessed at [www.show.scot.nhs.uk/sehd/nationalframework](http://www.show.scot.nhs.uk/sehd/nationalframework)

This Report noted, and described in some detail, the following drivers for change:

- **Demography** – Scotland’s ageing population, the increasing numbers of older people expected in the next 10 and 20 years
- The **rise in the number of older people living alone**, which has been particularly rapid in the last ten years. Across Scotland as a whole, people living alone accounted for 29% of households in 1991, but 34% in 2004. More than a third of people in Scotland now live on their own (Registrar General’s household estimates for 2004 (August 2005)). Between 1991 and 2001 the numbers of people aged 85 and over who lived alone increased from 30,000 to 44,000, mainly reflecting a rise in numbers in the age group but also a rise in the proportion living alone (ISD Scotland, 2003).
- The **increased incidence and burden of chronic illness**
- **Rising patient expectations**
- Workforce pressures, including
  - an **ageing workforce**
  - fewer people coming into the labour market
  - more working **part time**, and
  - the **European Working Time Directive**, which stipulates a 48 hour maximum average working week.

## CHAPTER 3: OLDER PEOPLE

As with other segments of the population – young people, middle aged people – older people vary greatly, and have different needs. There are the:

- “Younger” older people, who tend to be fit, economically active and healthy or relatively healthy.
- “Older” people, who are still fit but not economically active, and may have regular but low-level calls on the health service to see, for example, a GP or pharmacist and will not need social care services unless they are carers looking after older family members.
- Frail older people, of whom there are:
  - those who manage to get by largely on their own, perhaps with support from family and with regular visits to the GP and sometimes low level support services.
  - people with high dependency needs who need specialist services and intensive support including personal care.

### Getting older, feeling young

The definition of “older people” is fraught with difficulty, and changes with the generations. The age of an older person in 1900, when grandparents were the exception, was much lower than in 2000, when grandparents were quite normal. It also changes with the views of the individual – according to *How Ageist is Britain?*, a research report commissioned by Age Concern (September 2005) a 24 year old believes old age begins at about 55, while a 62 year old thinks youth does not end until 57.

As people get older they delay the age which they think of as getting old and the Report noted “Subjectively we tend to think we are still young”.

*How Ageist is Britain?* records views from 1,843 adults and found very different views on the ages at which youth ends and old age starts. The average across those interviewed was that youth ends at 49 and old age begins at 65.

Trends seen already in the UK include that older people act and feel young, and that lifestyles traditionally associated with different age categories are being blurred. SAGA has built a large and successful business on providing holidays (including to destinations such as Vietnam) and other services such as insurance, to those over 50.

Research announced at the British Association Festival of Science in September 2005 stated that increasing life expectancy and better knowledge of ways of slowing

the effects of ageing on the brain were leading to a growing gulf between biological and chronological age – “our bodies are getting healthier and we are living longer. The main threat to being able to function effectively in old age is the functioning of our brains”.

This research noted strong evidence that for those over 50, the degree to which someone retains their functions is down to just a handful of factors – diet, exercise, mental stimulation, mental training and stress (moderate levels of stress can be stimulating, but very high levels are deleterious to health). It found that volunteers aged 65 and over who did 10 hours of training sessions to improve their memory, problem-solving and reaction times had mental abilities equivalent to people between 7 and 14 years younger than those who did not.

There is clear encouragement here for the aim of all health improvement work, which is that people reach older age as healthy as they can be. Those who are mentally and physically fit are much less likely to become dependent on others.

### **Health inequalities**

Health inequalities are an important issue. The British Medical Journal (30th April 2005) suggested that inequalities in life expectancy between rich and poor areas of the UK continued to widen in the first few years of the 21st Century, alongside widening inequalities in wealth, suggesting that more potent and redistributive policies are needed. The levels of social security benefit for those out of work are relatively low compared to EU poverty standards and too low to maintain good health. When 50% of the Glasgow population is in the most socio-economically deprived decile of the Scottish population, the extent of the issue is clear. Income inequalities also affect quality of life and ability to purchase services.

Health inequalities are dealt with in *Building a Health Service Fit for the Future* (Volume 2 chapter 6). The Executive has responded with the Prevention 2010 programme in Glasgow. This will proactively seek out people at particular risk of preventable ill-health, and provide access to services. It is a preventative medicine approach to deliver services to those at greatest risk in deprived communities.

### **Ageism**

There is an issue about ageism in the way in which social care and health policy is implemented locally in Scotland, perhaps largely related to the rationing of scarce resources. We note later in this Report examples of different approaches to the nature and standard and financing of social care provided to those under 60 and to those who are older.

Ageism can be very subtle, and the way the service is delivered is also important. Even when services for older people are tailored to their needs, services can nevertheless still make value judgements and pin-hole older people. Older people can also be very vulnerable, on their own, without close family advocates and may be less demanding of their entitlements than others. The result can be that services may not help older people as much as they could.

## **Changing perceptions and higher expectations**

Finally, we also note that future generations of older people will not be like those of today. Today's older people have known rationing during the war years 1939-45, running on subsequently into the 1950s. The next generation of older people have been used to services available instantly, a wide variety of choice, and diversity of supply. They will have different aspirations and a higher expectation of services than previous generations. This has clear implications for the vision for care we develop later, which needs to be flexible to meet expectations.

Input from service users in workshops run for *Personalisation and Participation: The Future of Social Care in Scotland* (final report November 2005) confirm that people:

- see care as a right rather than a privilege.
- do not want to feel they have lost control, because their lives are being run by other people, no matter how well meaning.
- feel entitled to a say in shaping services to suit their needs.

People will want services that give them a sense of dignity, confidence and control.

## **Personalised services**

The trend of the 21st century is towards greater individuality, choice and mobility. One response from the market place is towards personalised marketing, and personalised customer service. Further, people expect service to be available consistently – where, when and how people want it. This impacts on social care and health care, particularly when tomorrow's users are used to choice and service.

The call for services that meet people's needs is not new, and in recent years the emphasis has been on designing and delivering public services around the needs of individuals and, indeed, communities. Lately the term personalisation has been coined.

## **Personalisation**

This has come to the fore through publication of *Personalisation through participation* (Demos, 2005). Personalisation of public services has the aim of meeting better the needs and aspirations of service users, and it underpins much of current and developing public services policy. The distinctive thing about personalisation is that it is not just about the use of services.

Personalisation builds on the capacity of individuals and communities to find their own solutions and to self-care, rather than creating dependence on services. It puts the person at the centre as a participant in shaping the services they get, and allows them to work with professionals and their carers to manage risk and resources. It leads to collaborative forms of provision which are person centred, flexible, adaptive and supportive, and yet which are also affordable.

This requires services to develop greater diversity and flexibility of provision, re-focus the roles and skills of workers, and develop the expertise of the individuals and families who need help.

The *Report of the 21<sup>st</sup> Century Social Work Review* noted that personalisation means:

- more involvement of people who use services and their carers in designing and developing services;
- increased choice and flexibility in service delivery;
- increased recognition of the role of unpaid carers;
- a far greater emphasis on self assessment and self managed care;
- mobilisation of community resources; and
- the efforts of skilled professionals being increasingly focused on supporting those people who are unable to exercise choice.

*Delivering for Health* addresses similar themes, such as the development of informed service users, the importance of unpaid carers, the need to develop anticipatory care services and the need to streamline access to services.

The Care 21 Unit commissioned work from Demos *Personalisation and Participation: The Future of Social Care in Scotland* (final report November 2005). This found that people want a sense of dignity, and that they count as a person. Consequently services should be done with them, rather than to them: people do not want to lose control of what happens to them. They want a sense of dignity, to know they are listened to, and that their views count.

Participation of users is not an add on – they have much to give in developing, designing, providing in some cases, and monitoring services – so their participation is essential. An informed user of a service is an empowered one, and some of the decisions that person takes may be personal ones that contribute to health – stopping smoking, eating healthier food or taking more exercise. In this way people become participants and investors in their own care.

These are areas where people can make informed choices. Health care and community care services are dealing with quality of life, and only the person getting the service (and their family or carer) knows whether they are getting the quality of service they need.

## CHAPTER 4: POPULATION, DEMOGRAPHICS AND MORBIDITY

Future demand for care for older people will be determined by changes in the numbers of older people and any changes in ill-health and dependency. Future numbers of older people will be determined by demographic factors such as historical fluctuations in the birth rate and inwards and outwards migration and, crucially, future trends in life expectancy.

The impact of the increasing numbers of older people on the demand for care will depend upon future trends in age-specific levels of ill-health or dependency. In other words will an 80 year old in 20 years time be more or less healthy, more or less dependent, than an eighty year old at present. A core assumption of the projections in the first report of the Range and Capacity Review Group was that age-specific levels of ill-health or dependency would remain constant. This was a reflection of a lack of strong evidence of a sufficiently quantifiable nature to be incorporated in the model rather than of any evidence that age-specific levels of ill-health and dependency would remain constant.

How such changes will translate into actual levels of provision of care will depend upon a range of other factors including the availability of carers; the availability of services; care standards; the future of pensions, and government funding including free personal care; and how health and care markets develop. Apart from the first, these are not relevant to this chapter.

### **Increase in the number of older people**

The latest **population projections for Scotland** were published by the Registrar General for Scotland in **October 2005**. The projections concentrate on the period up to 2031, although for the first time the Government Actuaries Department is making available projections up to 2074. Projections that far ahead become increasingly more uncertain, however, because assumptions are being made in some cases about the behaviour of people not yet born.

The key points are that:

- the population of Scotland is projected to rise, peaking at just over 5.1 million in 2019 and then slowly declining, falling below 5 million in 2036 and reaching 4.86 million by 2044;
- the number of children aged under 16 is projected to decrease by 15% from 940,000 in 2004 to 790,000 by 2031;
- the number of people of working age is projected to fall by 7% from 3.18 million in 2004 to 2.96 million in 2031;
- the number of people of pensionable age is projected to rise by 35% from 970,000 in 2004 to 1.31 million in 2031;
- the number of people aged 75 and over is projected to rise by 75% from 370,000 in 2004 to 650,000 by 2031 (due in part to the baby boomers after

the Second World War entering their early eighties by 2031 and the effect of improved mortality rates.)

Scotland's population by age group over the years from 2004 to 2031, on the basis of the 2004 projections, is expected to be:

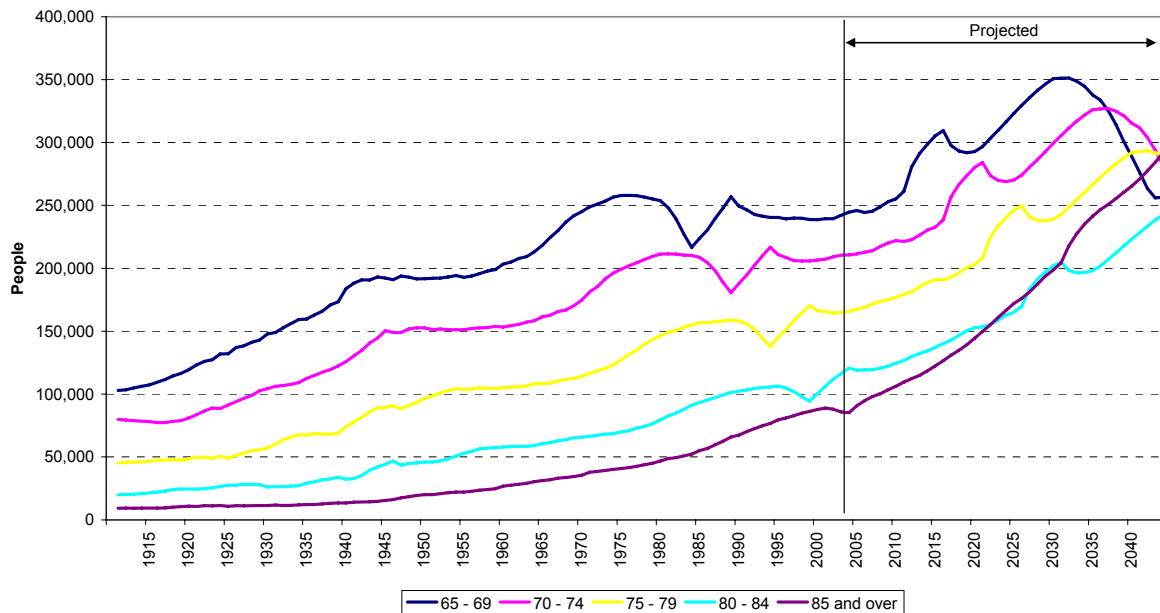
Age group	2004 (base)	2006	2011	2016	2021	2026	2031 (‘000s)
<b>All ages</b>	<b>5,078</b>	<b>5,108</b>	<b>5,120</b>	<b>5,126</b>	<b>5,127</b>	<b>5,109</b>	<b>5,065</b>
<b>Children under 16</b>	<b>935</b>	<b>919</b>	<b>865</b>	<b>838</b>	<b>828</b>	<b>814</b>	<b>793</b>
<b>Working ages 16-64/59*</b>	<b>3,175</b>	<b>3,205</b>	<b>3,208</b>	<b>3,225</b>	<b>3,207</b>	<b>3,096</b>	<b>2,963</b>
16-29	881	907	926	896	837	793	772
30-44	1,140	1,107	1,003	940	956	966	932
45-64/59*	1,154	1,192	1,279	1,389	1,414	1,337	1,260
<b>Pensionable ages 65/60* &amp; over</b>	<b>968</b>	<b>985</b>	<b>1,047</b>	<b>1,063</b>	<b>1,092</b>	<b>1,198</b>	<b>1,308</b>
65/60* - 74	596	602	631	606	581	603	657
75 & over	371	383	415	458	511	595	652

\* Pensionable age is 65 for men, 60 for women until 2010; between 2010 and 2020 pensionable age for women increases to 65.

Note: not all figures sum due to rounding.

These changes are illustrated graphically in the following chart (2004 projections):

**Scotland's older population by 5 year age groups, actual and projected, 1911-2044**



Interestingly the dependency ratio – the ratio of persons aged under 16 or over pensionable age to those of working age – is projected to remain around 60 per 100 from 2004 to 2021. It is only after 2021, and the completion of the change to the state pension age, that the dependency ratio rises, to 71 per 100 working age population in 2031, and eventually to 75 in 2044.

Projections are available from the Registrar General for Scotland by local authority area. This will be very helpful for health boards and local authorities as they undertake the capacity planning we recommend at Chapter 8.

### **Increasing life expectancy**

Compared with the position in 1900, when men and women who survived to 65 were a minority, life expectancy has increased greatly.

The **Registrar General for Scotland's 2004 population projections** contain assumptions about life expectancy. They base future improvements in mortality rates on the trend observed in the period 1961 to 2003. It is assumed that annual rates of reduction in mortality rates will tend towards a common reduction at each age of 1% a year by 2029. Thereafter the mortality improvement is assumed to continue at this rate (in contrast to previous projections where it was assumed to half every subsequent 25 years). In line with the long-term trends, it has been assumed that the mortality rates for Scotland will continue to be higher at most ages than those for England and Wales. Based on these rates, expectations of life at birth are projected to increase as follows:

	males	females
2002-04	73.8	79.1
2030-31	79.1	83.6

This is around 0.3 years more for males over 27 years (2003-2030), and 0.1 years more for females, compared to the assumptions used in the 2002-based projections.

It should be noted these are the expectations of life at birth, so do not impact on the numbers of older people living in 2030.

**The Actuarial Profession** published its latest Continuous Mortality Investigation in September 2005. This shows improvements in pensioner mortality in the UK since the work was last done in 1994. The work is based on data analysis for the 4 year period 1999-2002 and shows mortality rates around 30% lower than the 1994 work (based on the 4 years to 1994) for both males and females in their late 60s. They noted that

"Life expectancy has improved dramatically over recent decades but all estimates of future mortality carry considerable uncertainty. Issues of individual choice, such as diet, smoking or drugs have the potential to slow down or even reverse mortality improvements. Individuals, by making choices, have a big impact on how long they live."

The report suggests that if recent trends are simply extrapolated over the next decade, dramatic increases in life expectancy are likely. But while life expectancy is improving for all, it is going up fastest among those born in the mid 1930s – a so called golden cohort. These people are now just into their 70s, and may be skewing the results – a “cohort effect” on the mortality data that illustrates the uncertainty and difficulties of projecting mortality.

Factors contributing to longer lives are the virtual abolition of once common childhood illnesses such as scarlet fever, diphtheria, polio, measles and mumps, a decline in smoking and a general improvement in diet and housing. It is possible these factors have contributed particularly to the increasing life expectancy of those in their mid 60s during 1999-2002. No-one can confidently predict whether or not they will continue into the future.

It will be seen from this that the projections of mortality by The Actuarial Profession and the Registrar General for Scotland are made on quite different bases.

### **Life expectancy: future trends**

There are doubts about whether future generations of older people will be as fit and healthy as those who are currently pensioners. There is some evidence that the cohort of older people born into the privations of the 1920s and the Great Depression are healthier – and have greater longevity – than more affluent post-war cohorts. The increase in obesity and unfitness among younger people today is likely to affect their health status and longevity – and their prosperity - as they grow older. We had some discussion around this, thinking of the increased consumption of fast food and soft drinks, and the rise of a generation involved in computer games and other sedentary pursuits.

We were interested, therefore, when the **New England Journal of Medicine** reported on 17 March 2005 that while it had been assumed that life expectancy in the U.S.A would rise indefinitely, new data analysis suggests that this trend is about to reverse itself due to the rapid rise in obesity, especially among children.

The review concluded that, on a conservative estimate, obesity now reduces average life expectancy by about 4 to 9 months in the U.S.A. The researchers further conclude that if the current epidemic of child and adolescent obesity continues unabated, life expectancy in the U.S.A. could be shortened by 2 to 5 years in the coming decades.

UK specialists noted that the same trends could happen here. We note the point, and that concerns about future health are already leading to action to remove soft drinks from schools and to increase the nutritional value of school meals.

### **Trends in age-specific levels of ill-health and dependency among older people**

The previous section has described trends in life expectancy in Scotland. Future changes in life expectancy will be the most important determinants of how quickly the numbers of older people in Scotland increase in years to come. The first report of the Range and Capacity Review was a systematic attempt to model the impact of

projected changes in the number of older people on the demand for care. A core assumption in these models was that age-specific levels of ill-health and dependency would remain constant. In other words an 80 year old in 20 years time would, on average, experience the same level of ill-health or dependency – and thus generate the same demand for care – as an 80 year old at present.

How realistic is this assumption? What is the balance of evidence relating to whether older people of a given age will be more or less healthy in future? The first point to make is that there is a remarkable lack of definitive evidence about past trends in levels of age-specific ill-health and dependency among older people. About future trends there is even less certainty. Experts are extremely unwilling to make predictions about future trends.

Some useful context may be provided by assessments carried out as part of the analysis of drivers for change in the NHS in Scotland for the National Framework for Service Change. This was part of an attempt to assess the extent to which long-term increases in the levels of emergency inpatient admission among older people were a reflection of increased levels of age-specific ill-health among older people.

The balance of evidence, at an international, British and Scottish level, was that age for age older people have been getting healthier.

A recent analysis based on the relationship between hospital expenditure and proximity to death provided the most powerful evidence that future demand for health care is unlikely to increase as quickly as would be the case if age-specific levels of ill-health were to remain constant in future (Seshamani, 2004)

A high proportion of health care expenditure and in particular hospital expenditure occurs in the years immediately preceding death. For example, the 5% of patients in the last year of life generated approximately half the hospital expenditures for the population aged 65 and over in 2002 (Seshamani, 2004). Proximity to death is a much more powerful predictor of hospital expenditure than age alone.

This relationship between hospital expenditure and proximity to death provides the basis for an elegant calculation of the extent to which the impact of an ageing population on health-care expenditure is likely to fall far short of being proportional. Seshamani (2004) compared two methods of projecting future hospital expenditure. The first assumed that each age group would generate a constant per capita amount of hospital-based health care expenditure over the years 2002 to 2026. The second method incorporated per capita levels of expenditure specific to proximity to death. Incorporating the effects of proximity to death in the expenditure model halved the estimated increases in real national hospital expenditure over time.

This is another way of making the point that improved age-specific levels of health in the older population are likely to mitigate to a considerable extent the impact of growing numbers of older people on the demand for health care.

Of course, these analyses were carried out with reference to ill-health and health care costs. Caution should be exercised in extending their implications to the area of social and residential care.

However, in Scotland, Stearns and Butterworth (2001) carried out analyses directly relevant to the broader definition of care for older people as background to the work of the Care Development Group. They analysed data from the 1985 OPCS Survey of Disability among Adults in Private Households and the 1996/7 Disability follow-up to the Family Resources Survey. They concluded that

“Overall, disabled elderly people (in all living conditions combined) decreased as a proportion of the population between 1985 and 1996/7. The best estimate of the reduction overall is of 0.2 or 0.3 percentage points per year in the UK, though evidence indicates that the rate of reduction may have been slightly greater in Scotland”.

### **Healthy life expectancy and impaired health at the end of life**

In recent years, there has been increasing interest in a complementary perspective on levels of ill-health and disability among older people. This concerns the relationship between increasing life expectancy and changes in healthy life expectancy. In other words how many of the additional years of life contributed by increasing life expectancy will be lived in good health and how many will be years of ill-health or disability.

There are range of views about current trends and the likely pattern in the future. At the optimistic end of the spectrum the view is that the years of ill-health (and high requirements for care) at the end of life will become ever more ‘compressed’ into the final years (the ‘compression of morbidity’ hypothesis). A more pessimistic view is that medical advances will lead to greater overall life expectancy but not be able to delay the onset of disability or ill-health – and therefore most or all of the additional years of life will be years of ill-health and disability rather than good health.

Where the truth lies along this spectrum, we do not know for certain. The best current estimate is that healthy life expectancy is increasing – in other words some of the years of additional life will be healthy - but unhealthy life expectancy is also increasing – some of the additional years of life will be years of ill-health or disability. This view is reflected in a recent analysis of trends in healthy life expectancy carried out in Scotland.

However before looking at these results in more detail we must be very clear about the relationship between analyses couched in terms of trends in healthy life expectancy and the kinds of analyses couched in terms of trends in age-specific levels of ill-health and disability which have already been discussed.

In particular, the projections outlined in the First Report of the Range and Capacity Review were based on an assumed trend of no change in levels of age specific ill-health and disability.

In terms of the spectrum of views relating to trends in healthy life expectancy this assumption of no change in age-specific levels of ill-health is at the pessimistic end of the spectrum. An assumption of no change in age-specific levels of ill-health is broadly equivalent to an assumption that there is no change in healthy life expectancy and that all the extra years of life contributed by increasing life expectancy will be years of ill-health. Any increase in healthy life expectancy means that a person of a given age is, on average, more likely to be healthy than they were before the increase in healthy life expectancy – or in other words that there has been an improvement in age-specific levels of health.

Demonstration of any improvement of healthy life expectancy has, in broad terms, the corollary that age-specific levels of ill-health are declining and is evidence for a more positive out-turn than the assumptions incorporated in the model presented in the First Report.

The first published estimates of levels and trends in healthy life expectancy for the Scottish population appeared in *Healthy Life Expectancy in Scotland* by ISD Scotland in March 2004. This found that:

- the current life expectancy of a 65 year old man in Scotland is 14.8 years: 7.7 of these years (on average) will be spent free from limiting long term illness and 11.5 years will be in good or fairly good health.
- the current life expectancy of a 65 year old woman in Scotland is 17.9 years: 8.9 of these years (on average) will be spent free from limiting long term illness and 13.4 years will be in good or fairly good health.
- in general terms over the last 20 years healthy life expectancy at birth has not kept pace with increasing life expectancy – the proportion of years of life spent in less than good health has increased.
- the figures for those who have reached the age of 65 are better, however – their healthy life expectancy is generally keeping pace with increasing life expectancy, so the proportion of time spent in less than good health has remained the same.

*Healthy Life Expectancy in Scotland* did not make any projections into the future.

Perhaps of greatest relevance to issues of social, personal and residential care are the findings relating to trends in life expectancy with unassisted Activities of Daily Living. For women at age 65 the expectation of the number of years they would be able to live without assistance in Activities of Daily Living increased from 14.6 years in 1980 to 16.0 years in 1998. For males the increase was from 11.6 years to 12.6 years. At the same time there was an increase for both males and females in the number of years mostly at the end of life where they would require assistance with Activities of Daily Living. The implication is also that an older person of a given age in Scotland was less likely to require assistance with Activities of Daily Living in 1998 than they were in 1980.

This exemplifies the general tenor of the ISD Report which lies towards the middle of the spectrum of views outlined earlier. The extra years of life contributed by increasing life expectancy have contributed increasing years of ill-health and increasing years of health.

In terms of implications for trends in age-specific morbidity, it is the finding of increasing life expectancy which is important. This implies that age-specific levels of health have been improving. If this trend continues into the future, the out-turn will be more positive than that implied by the assumption of no change in age-specific levels of ill-health incorporated in the First Report.

### **Other points to note**

Finally it needs to be borne in mind that there is an increasing number of older people with long-term conditions such as **diabetes**, **dementia**, and **learning disabilities**. The number of people with dementia in Scotland was around 60,000 in 2001, and it is projected to increase to around 82,000 in 2020 and to around 125,000 by 2041: see Annex B. This is a function of both increasing life expectancy and the demographic increase in the number of older people expected over the next 20 years. And there have been quite dramatic increases in the life expectancy of people with learning disabilities.

### **Conclusion**

As its baseline model, the First Report of this group related future demand for care among older people to projected changes in the sizes of the age groups concerned – with an assumption that age-specific levels of ill-health and disability among older people would not change.

The actual out-turn will depend on future trends in age-specific levels of ill-health and disability among older people.

The balance of evidence relating to past trends is that age-specific levels of ill-health and disability among older people have been improving.

This is confirmed by evidence of increasing healthy life expectancy.

To the extent that these trends continue, the projections contained in the first report of this Group can be regarded as conservative (i.e. pessimistic).

The major determinant of increasing future demand for care for older people in Scotland will be demographic change involving increasing numbers of older people and in particular the oldest old. This is the factor which was modelled in the First Report of the group.

The precise out-turn may well be affected by changes in age-specific levels of ill-health and disability in the population and increases in healthy life expectancy. If past trends in age specific levels of ill-health and disability and past increases in healthy life expectancy continue, they will serve to mitigate to some extent the impact of an ageing population on the demand for care.

## CHAPTER 5: LINKS TO OTHER REPORTS

As we have been meeting, other work has been underway which has resulted in a number of reports. The most significant of these have been:

- *Building a Health Service Fit for the Future: the National Framework for Service Change* (the Kerr Report) (May 2005).
- *Better Outcomes for Older People: A Framework for Joint Services* (May 2005).
- *The future of unpaid care in Scotland: Report for the Care 21 Unit* (September 2005).
- *Report on Recent Trends in Capacity in the Care Home Sector in Scotland: Health Economics Research Unit, University of Aberdeen* (November 2004)
- *Changing Lives: Report of the 21st Century Social Work Review* (February 2006).

We have seen the same issues being grappled with in various contexts by these reports. The challenges faced are the same, and are being recorded in similar terms in the different documents, whether it is health or community care, the future of social work or the place of carers, or north or south of the Border.

These reports are highly relevant to our task of models of care to meet the needs of Scotland's ageing population, and the following sections set out the most important features of these reports that we see as contributing to future services.

### ***Building a Health Service Fit for The Future (The Kerr Report)***

*Building a Health Service Fit for the Future*, also known as The Kerr Report (May 2005), sets a 20 year plan for the NHS and shifts the emphasis from hospital-based care to preventative, anticipatory care rather than reactive management.

It has a number of key messages, and these include:

- the NHS should be seen as a service delivered predominantly in local communities rather than in hospitals. It notes that 90% of health care is delivered in primary care, but the bulk of attention is focussed on the other 10% – the current emphasis on hospitals does not provide the care that people are likely to need
- preventative, anticipatory care rather than reactive management. The NHS should work with other public services and with patients and carers to provide continuous, anticipatory care to ensure that, as far as possible, health care crises are prevented from happening;
- galvanise the whole system; more fully integrate the NHS (including the contribution of hospitals, general practice teams, social care providers, patients and their carers) to meet the challenges;

The Report is wide in scope and contains a large number of proposals. The top 10 include:

- All NHS Boards to put in place a systematic approach to caring for the most vulnerable (especially older people) with long term conditions, with a view to managing their conditions at home or in the community and reducing the chance of hospitalisation.
- Targeted action in deprived areas to reach out with anticipatory care to prevent future ill-health and help reduce health inequality.
- Support for patients and their carers to manage their own health care needs and to help others with similar conditions.
- Set a clear agenda for Community Health Partnerships to work across barriers between primary and secondary care and engage with partners in social care to shift the balance of care.

We welcome these key messages and recommendations. The whole thrust of the Report is in line with our own thinking as to the way we see services developing in Scotland over the next 10 to 20 years.

### ***Better Outcomes for Older People: Framework for Joint Services***

*Better Outcomes for Older People* (May 2005) is a framework for joint services for older people. The Framework:

- promotes the development and mainstreaming of joint and integrated services,
- sets out the requirements which the local partnerships of NHS Boards and local authorities should meet in developing and delivering joint and integrated services.
- acts as a tool in developing joint and integrated services which assist older people to lead more independent lives and have more personal control over their lifestyles, care and environment. It provides advice and good practice examples.

In particular, the Framework signposts the way that joint and integrated services should be provided – in partnership between individuals and their carers, health, housing and social care organisations, in the statutory and independent (voluntary and private) sectors.

Part 1 describes types of joint services for older people, sets out the foundations for effective joint services –

- strong leadership
- a supportive organisational culture
- easy flows of information between organisations and professionals
- staff with the right skills and experience, and
- team working,

sets out principles underpinning joint service design, and deals with commissioning and evaluating joint services.

Part 2 has sections on –

An Active and Healthy Life for Older People

Promoting Independence at Home for Older People (covering care at home, equipment and adaptations, day opportunities, housing solutions, extra care housing, and Supporting People)

Joint services for enhanced care

Joint services for carers of older people, and

Joint services for carers of older people with additional needs (learning disabilities, physical disabilities and sensory impairment, mental health, substance abuse, and dementia).

*Better Outcomes for Older People* is a valuable resource about the joint provision of services. Its use will help ensure older people get the services they need, regardless of which agency provides the service. It links into the Joint Performance Information and Assessment Framework (JPIAF) and Local Improvement Targets. It supports the Group's view that by improving the quality and access to many services outside the NHS, including housing, transport, social care, physical activity etc, then older people will gain an improved quality of life and health problems will be mitigated or prevented.

### ***The Future of Unpaid Care in Scotland***

The Care 21 Unit within the Social Work Services Division of the Scottish Executive commissioned work on the future of unpaid care in Scotland over the years to 2014. Its report *The future of unpaid care in Scotland* was published on 30 September and is based on a number of core principles. These include:

- the need to recognise carers as key individual care providers
- recognition that families and unpaid carers constitute Scotland's largest care force
- the need to harness the contribution of unpaid carers for future care provision
- the need to make caring a more positive life-choice, and
- strengthening independent living and self-care, and improving quality of life and the quality of care.

## Choice

Choice is a consistent theme emerging throughout the Care 21 work. Carers strongly request

- that they and the cared for person have more information and choice about the support available to them
- greater control over the solutions created to address their support needs.

The vision emerging from *The future of unpaid care in Scotland* is that by 2014:

- there will be a shift from crisis intervention to planned, preventative support
- unpaid carers will be better integrated in joint planning of care and service developments, and in local and national partnerships
- unpaid carers will be able to access a range of support provided by local community initiatives, and
- unpaid carers will enjoy good general health and well-being.

Demographic change means a growth in the number of older people with potential support needs, but also a growing number of retired people with energies and skills to contribute to community developments. Unlocking this potential within local communities to contribute to the development of flexible support services is highly desirable. Recommendations seek to harness better partnership working, volunteering, and capacity building for community support. *The future of unpaid care in Scotland* believes that supportive local communities can enhance 'self-care confidence' and that well supported community infrastructures and local care economies will enhance choice and local solutions.

The health needs of carers have already been recognised in *Building a Health Service Fit for the Future* (notably in chapter 5: Self-Care, carers, volunteering and the voluntary sector: towards a more collaborative approach), which makes 5 key recommendations. *The future of unpaid care in Scotland* makes recommendations that address these and other areas.

We fully support the direction set by this work for the years to 2014, which is entirely consistent with our own.

### ***Report on Recent Trends in Capacity in the Care Home Sector in Scotland***

One issue highlighted in the past was a view that the care home market has been largely left to the independent sector to develop, with the consequence that provision was patchy across the country. In some places it was thought to be very near its capacity, while in other places it was undeveloped.

The Executive therefore commissioned a study of recent trends in capacity in the care home sector in Scotland over the period March 2001 to March 2004 from the Health Economics Research Unit at the University of Aberdeen.

This found that

- The main factors that influence trends in the provision of care home places are: demographic changes; the health status of older people; the availability of alternative forms of care; socio-economic circumstances (e.g. the number of older people living alone); and financial factors.
- Over the same period there has been an expansion in alternative forms of care for older people, especially the provision of home care services.

There are wide differences between local authorities in the relative use made of home care places for their residents. Nationally there are some 87 residents in care homes for every 1,000 people aged 75 and over, but the highest was 129 per 1,000 older people (Glasgow) and the lowest 55 (Edinburgh).

- The balance of care between the different services provided for older people varies between local authorities – some provide much higher levels of home care than others, and this may reduce their need for care home places.
- There is some evidence that the use made of care home places tends to be higher in areas with relatively high levels of deprivation.
- Visits were made to 5 local authorities: Aberdeen, Edinburgh, Glasgow, South Ayrshire, and Stirling. These councils generally felt that the decline in capacity was in line with the Scottish Executive's policy aim of shifting the balance of care for older people away from institutional settings, and some of them have invested substantially in recent years in the development of alternative forms of care such as home care services.
- The visits also suggested that new and innovative forms of care for older people are being developed, and that some of these forms of care may not be fully captured by existing statistics on community care services for older people.
- Factors that will add to the demand for care home places over the next few years are
  - demographic factors
  - the continuing decline in the number of beds for older people in NHS hospitals, and
  - the ongoing pressure to reduce the number of delayed discharges.
- Factors that will tend to reduce the demand for care home places include the continuing development of alternative non-institutional forms of care. Improvements in the health of older people may also reduce demand for care home places, though such improvements are likely to be slow and gradual and the impact of this factor over the next few years may be quite small when compared with the large increase projected in the number of people aged 85 and older.
- The target adopted for increasing the percentage of older people receiving intensive home care to 30% of all older people receiving long term care should also reinforce the trend away from institutional settings.

- The net effect of these different factors on the demand for care home places over the next few years is uncertain. It may be that the additional pressures associated with (a) a sharp rise in the number of people aged 85 and over, (b) continuing pressure to reduce delayed discharges, and (c) a further decline in NHS beds, can be met by expanding alternative non-institutional forms of care. This is likely to require substantial investment in these alternatives, and also effective management of admissions to care homes to ensure that these places are used only for those in the highest dependency categories.

## **Forth Valley Studies**

We found that Forth Valley Health Board had done work that was of interest to us. There were 2 reports:

### **Community Hospital Bed Requirements (April 2004)**

The purpose of this work was to estimate how many community inpatient beds would be required in Forth Valley following a proposed service and facility reconfiguration. The study looked at acute, community and care home bed requirements for:

- the current service model, allowing for population changes
- an alternative service model of early discharge from both acute and community hospitals (acute to community hospital, and community hospital to care home).

### **Capacity Planning Exercise Phase 2: Community Services (February 2005)**

The principal aim of this study was to estimate the future requirements for community services. It found that if any of 3 growth rate assumptions fall true, then a large increase in the required levels of access to community health services will be required by 2013/14:

population and 1% access rate growth a year – 18% growth in community health services

population and 2.5% access rate growth a year – 37% growth in community health services

population and 5% access rate growth a year – 74% growth in community health services

It concluded by suggesting alternative ways of meeting these increases (without quantification), including Joint Future, Community Health Partnerships, ICT and new technologies.

These reports were the basis of early local developmental work in Forth Valley, and we felt they did not have implications for the rest of Scotland – each area has to do its own work to reflect local circumstances. But one fundamental lesson of the Reports is that even within closely defined parameters, and looking at a limited range of options, the outcomes vary widely (e.g. the difference between 18% and 74% growth in services).

## ***Independence, Well-Being and Choice***

*Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England* was published as a consultation paper by the Department of Health in March 2005. It is set in the context of the UK Government's reform of public sector services.

*Independence, Well-being and Choice* is a vision statement with an emphasis on giving people more choice, higher quality support and greater control over their lives.

It addresses many of the issues that we face across the UK –

- higher expectations
- an ageing population
- the increasing numbers of people who live alone
- the problems of improving recruitment and retention of the workforce
- the issues of joint working
- capacity building in the community, specifically through working with the voluntary and community sector.

There is a good deal of commonality between the issues addressed in the Green Paper, in the other publications noted in this section, and those we address in the course of our work.

## ***Changing Lives: Report of The 21st Century Social Work Review***

The 21st Century Social Work Review was an independent review, commissioned in summer 2004 to take a fundamental look at all aspects of social work in order to strengthen its contribution to the delivery of integrated services. The report was published in February 2006 and draws 3 over-riding conclusions:

- doing more of the same won't work. Increasing demand, greater complexity and rising expectations mean that the current situation is not sustainable: Tomorrow's solutions will need to engage people as active participants, delivering accessible, responsive services of the highest quality and promoting wellbeing;
- social work services do not have all the answers. They need to work closely with other universal providers in all sectors to find new ways to design and deliver services across the public sector;
- Social workers' skills are highly valued and increasingly relevant to the changing needs of society. Yet we are far from making the best use of these skills: Tomorrow's solutions will need to make the best use of skills across the care workforce.

## CHAPTER 6: NEED FOR A WHOLE SYSTEMS APPROACH

Our first report mentioned a need that had been identified to help stimulate the development required of the whole systems approach. This was seen as contributing to reducing both the incidence of delayed discharge and achieving the required shift in the balance of care from institutional to home-based settings and delivering faster access to better services and better outcomes.

The issue is the complexity of systems, for example in a health board or local authority area and between these bodies at local level, and the interaction of these systems. Any changes in part of the health system impacts on other parts of that system and often, and increasingly, on community care and housing providers (and vice versa). These services are provided by different providers in the statutory, voluntary and independent sectors. As these are interdependent, those who commission services needs to look across the range of services – the whole systems approach – and not just their own service or even their own organisation.

This has been picked up in different pieces of work, particularly in ***Moving on? An overview of delayed discharges in Scotland*** and ***Moving on? A handbook on modelling the whole system for delayed discharges in Tayside*** (Audit Scotland June 2005). The main findings of the Report bear repeating here.

These looked at the operation of local services for health and community care in Tayside. The specific focus of the work was on reducing delayed discharges, but the lessons go much wider and are for the planning and delivery of services for older people.

The first report noted (paragraph 20):

*Delayed discharges are a symptom of wider systemic problems in the delivery of health, social care and housing services, as our detailed work in Tayside demonstrates. Therefore, partnerships must:*

- *consider all aspects of their system when developing strategies to reduce delays, and integrate these strategies into mainstream capacity planning*
- *develop a shared, in-depth understanding of the way in which local health and social care services interact*
- *undertake detailed, long-term planning to take account of the projected growth in the older population*

All these recommendations are of particular relevance to our review group.

Audit Scotland noted the complexity of local systems, and the interdependence of health care and community care services. Consequently a change in any one part of a system could have a substantial effect on another part. Decisions made about services made for one purpose may also have unintended consequences for other parts of the wider health and social care system.

The first report states (paragraph 67):

*If the Tayside Partnership continues with its current delayed discharges strategies then the expected growth in the older population would lead to a steady increase in the number of older people admitted to Tayside's hospitals. This is likely to lead to more delays for patients being discharged from hospital. This means that the 'status quo' is not an option. The effect of a growing older population on existing provision will be of relevance to all partnerships in Scotland forecasting a growth in their older population.*

The work looked at a range of strategies aimed at reducing delayed discharges over a 5 year period, and found (Exhibit 14 page 23):

- Reliance on purchasing extra care home places, in isolation, produces the poorest performance overall.
- Shortening the assessment time in hospital appears to sustain reductions in delayed discharges for longer than any other single strategy.
- No strategy, adopted on its own, can sustain continued progress in reducing delayed discharges beyond 2005/06.
- Strategies pursued in isolation result in significantly poorer performance than adopting all of the strategies.
- Short-term reductions may be achieved by implementing a chronic disease management programme, or increasing home care provision or increasing specialist housing. Long-term reductions may only be achieved by implementing all of these strategies.

Thus the model showed the need to introduce a range of strategies and the necessity to redesign existing services, such as reducing the length of the assessment period in hospital, as well as increasing service capacity in the community.

The report notes in paragraph 70 that:

*Working together to reduce delayed discharges involves much more than local health and social care colleagues meeting to discuss discharge planning and to agree priorities for spending the additional funding from the SEHD. It is about ensuring that there is a shared understanding across the partnership of how the local system works; what the complexities and inter-relationships are; and how staff and services can influence what happens. Feedback from the Tayside Partnership showed that the whole systems approach we used enabled genuine joint working, where staff from across the four organisations in the partnership and a variety of professions came together to discuss a common issue.*

Key recommendations (paragraph 74) are that local partnerships should:

- *take a whole systems approach to developing a shared understanding of the interdependence of services*
- *ensure that all key stakeholders are involved in developing an understanding of the whole system*

- *link delayed discharge planning with mainstream capacity planning*
- *improve information on the cost, quality and provision of community care services.*

The report demonstrated the complexity of local systems, comprising

- different providers in health care, social work, housing and housing support services, and voluntary and independent organisations.
- staff from a variety of professions.

Some general conclusions were reached, which are appropriate to capacity planning generally. These were:

- it is important to provide a balance of strategies to achieve the desired aim.
- there is no single one size fits all solution (the 3 council areas in Tayside needed a mix of different strategies).
- changes in process are as important as investment in capacity, and
- (in the delayed discharge context) although each of the strategies produce reductions in delayed discharges, without redesign of processes there appears to be a level below which it would be extremely difficult to go.

As we have indicated already, the points repeated here go much wider than the immediate context of reducing delayed discharges. The lessons are for the planning and delivery of whole system services for older people, and we endorse them wholeheartedly.

*Building a Health Service Fit for the Future* notes its conclusion “that the current organisation and infrastructure of both health and social care - with health still split into acute and primary sectors and social care managed as a traditionally separate entity - is far from ideal for the necessary development of the whole-systems approach essential for the good care of older people, both individually and at a population level”.

They then state that “The introduction of unified NHS Boards and the implementation of Community Health Partnerships will provide a better context for flexible and innovative models of organisational integration”. (Volume 2 page 47).

*Building a Health Service Fit for the Future* has a section on whole systems working, that refers to work by the Audit Commission in their report "Integrated services for older people - building a whole systems approach in England". (Volume 2 page 61).

All this emphasises the need for a whole-systems approach in the care of older people. *Building a Health Service Fit for the Future* is health focussed, however, and does not attempt to set out the implications of its recommendations for those who provide community care and housing services. We return to this later.

In conclusion, a whole systems plan should encompass populations, strategies (e.g. reducing delayed discharge and waiting lists for health and care services), care models, costs of services, funding sources, finance and resource plans.

## CHAPTER 7: THE VISION FOR CARE

Given that part of our remit is “to investigate the use of existing models of care and the use of other services and support as an alternative to long term residential care”, we spent a considerable amount of time on the care that will be appropriate for the increasing numbers of older people expected on the basis of the demographic projections. This led to a vision for care that underlies models of care that will have to be worked out at local level.

Many older people are fit and healthy, or reasonably so, and have much to contribute to life. We welcome the attention being given in various ways and places to older people as contributors, able to play an active part in life. Many are part of the care arrangements for their grandchildren, others are carers, while others are actively engaged in community organisations.

Where people are living longer lives, some of those extra years of life will be complicated by chronic conditions: for those with long-term conditions, more health care and community care will be required. A major aim must be to encourage people to become participants and investors in their own care, rather than turn them into consumers of public service.

We felt that increased hospitalisation and institutionalisation amongst the oldest old is not inevitable, and noted that some areas of Scotland have shown recent reductions in occupied bed days for this group. A proactive approach is essential. An older person can become institutionalised very quickly – a frail older person might only be in hospital for a week or so before losing their independence and self-confidence. A rehabilitation programme or service will prevent a short-term crisis from sparking long-term dependency.

A good example of the proactive approach are some of the initiatives across Scotland being taken in palliative care, with so called gold standards to anticipate possible problems and deliver support at home. Such advanced care planning is of equal importance to those frail elderly dying of non-cancerous conditions (who are three times as many as those with cancer).

### **Principles**

In considering a vision for care, the following principles guided us:

- There should be an emphasis on health improvement. The task is to keep people well, and maximise their independence and well-being in later life, so they are healthy when they are older. The ideas of well-being and active citizenship in later life work together, so that people have a longer lifespan and a longer healthy lifespan.

- Care should be provided at home within an agreed risk assessment and resource framework, or provided in a homely environment which meets the person's needs and maximises their independence and well-being.
- This care would be consistent with the principles outlined in the Adults with Incapacity Act – that interventions should provide benefit, be the minimum required and should take account of the wishes of the person – and with risk assessment best practice.
- People should be in a level of care that is as low as possible – in the past many were in care homes because it suited, rather than because they really needed to be there (though this has changed in recent years), or people placed in continuing care beds simply because the beds were there.
- We need to keep the individual needs of the older person at the centre, so they get the service they need when they need it, regardless of who provides it. Consequently which organisation or profession provides the service should not matter – what matters is that the individuals providing the care have the right skills, knowledge and competencies.
- Citizenship – older people are citizens with important roles in supporting families and within communities. They are also the biggest providers of support to other older people. They have both rights and responsibilities; want to contribute to society; get involved and put something in. They should not be treated any different just because they are older. Services for older people need to be designed and delivered in a way that supports older people as citizens and enables them to participate in the wider community if they choose to do so.

These principles led us to the following conclusions:

- looking at the needs of the individual points to the need for a whole systems approach, looking across health care, community care and housing providers in the statutory, voluntary and independent sectors;
- we could not determine the range and capacity of services at local level, but we can set a framework of the way we believe health care, community care, housing, leisure and recreation, and lifelong learning services should be provided to meet the needs of older people;
- healthy living, living well and prevention have significant parts to play;
- new ways of thinking and providing services are required;
- more innovative models of care are needed, using equipment, adaptations and technology where appropriate and more flexible use of services eg care homes for short term breaks; and

- staff can be used more flexibly, and there is a need to be innovative and recruit and retain staff, not least in rural areas.

## Care for the future

Earlier we state that a new way of thinking and providing services is required by redesigning current services. There is always a need to keep the local strategy for care up to date, building on best practice, looking beyond the here and now. We think the Care Home Sector (private, voluntary and local authority) should be **fully** involved in this, so that they become more diverse and locally designed provision, closely linked to respite, care at home, extra care housing, GP out-of-hours services, community nursing etc. The Care Home Sector need to be part of the whole system redesign, recognising the part they play in the overall spectrum of care delivered to the local communities they serve.

We believe the need for services for increasing numbers of older people should be met through more flexible services, step up and step down, better use of equipment and adaptations, technology and Telecare, mainstreaming of Joint Future, and increasing emphasis on promoting active ageing and on prevention. Flexible services include the following:

active ageing and health improvement

anticipatory care of long term conditions, with greater emphasis on self-care, self management and advanced care planning

housing provision

helping people stay at home, with care packages of one kind or another –  
 care at home  
 domiciliary care  
 rapid response teams  
 day care and day opportunities

Step up and step down/rehabilitation/intermediate care – examples include  
 intensive care at home  
 community rehabilitation services  
 short stays in alternative accommodation – e.g. care home or  
 community hospital

Telecare

equipment and adaptations

falls prevention

care and repair

palliative care and improving end of life care

imaginative provision of leisure and community learning services/opportunities for isolated, vulnerable older people with mobility problems.

The following sections set out our thoughts on these.

- **Active ageing and healthy living and well-being.** Many older people are fit and well, active contributors in many aspects of life. They may look after grandchildren or provide care for others. Churches and voluntary organisations across Scotland organise activities during the day that may not be specifically for older people, but are held at times when retired people are free. These provide social contact, and for those living on their own have a particularly beneficial effect on their health to avoid depression.
- **Health improvement.** It is important that people reach older age in good health. Health promotion and well-being have a great deal to offer in reducing illness and extending independence. Individuals at every stage of life have their part to play by deciding to stop smoking, to drink sensibly, to eat a healthy diet and to take appropriate physical exercise. Physical activity helps maintain functional ability, and prevents disability and immobility. For older people it is particularly important in maintaining independence and reducing social isolation.
- *Building a Health Service Fit for the Future* and *Delivering for Health* emphasise enhanced primary care services, more anticipatory care and management of long term conditions. This will benefit older people disproportionately, and improve their health and well-being. Community Health Partnerships have a key role here.
- Local authorities have a key role in the delivery of health improvement in their communities. Libraries, swimming pools and leisure facilities, and opportunities for life-long learning, for example, all contribute to the health and well-being of older people.
- **Housing.** Housing has a significant contribution to make towards the care needs of older people, bearing in mind flexible services and the principle that interventions should be at the lowest level possible. It points up, for example, the role of extra care housing as a substitute for care homes, not just for long term accommodation but also for rehabilitation and intermediate care.
- There is a need for more creative housing solutions in all sectors. Some of these are already there, others may require better use of existing provision. There is some evidence that sheltered housing provided 30 or 40 years ago may not meet current needs, and are subject to voids. This may be partly due to changes in expectations – the great increase in owner-occupation in Scotland over the last 25 years means that people who have become used to owner-occupation may be very reluctant to entertain becoming tenants. Yet sheltered housing is an asset that should not be wasted. It may be possible to make better use of those developments that have become less popular with constructive solutions. These may involve appropriate re-development of the fabric and/or development of services.

Another, perhaps surprising, example is the provision of 24 hour support in multi-storey blocks in Glasgow:

### **Cathkinview**

This project provides support for 18 tenants of Glasgow Housing Association to maintain their own tenancies in two tower blocks. Carr - Gomm Scotland provides 24-hour person - centred housing, personal and social care support, to enable people to remain in their own homes as an alternative to residential or enhanced personal care in a care home. The project was established in 2002, and commissioned by Glasgow City Social Work Services, who identified a gap in services for older people with dementia and other support needs who wished to receive the equivalent of residential or enhanced residential support in their own home in preference to a care home. The flats where support is provided are spread throughout the blocks and the tenants have not been moved from their original homes into specific flats identified for those with support needs. All residents have secure tenancy agreements. The project reports to a steering group that includes social work, housing, community nursing, service users and local residents.

- The Dementia Services Development Centre has highlighted adaptations of sheltered and very sheltered housing to become more acceptably dementia friendly. These range from the simplest changes, through features that can be included in planned maintenance programmes, to the upper end where major alterations would require capital investment –
  - Effective colour contrasts: e.g. sanitary ware
  - General personalisation of environment
  - Visible storage
  - Assistive technologies
  - Improved signage
  - Floor coverings and thresholds
  - Visibility of toilets
  - Lighting levels and quality
  - External garden spaces
  - Wheelchair manoeuvrability, and
  - Additional activity spaces.
- Consideration can be given to “future proofing” of new buildings at the design stage, so that they can be used for different purposes in future as needs change. This ties in with the Strategy Forum *Equipped for Inclusion* report recommendation 10 for a lifelong approach. South Lanarkshire Council has at least 2 new care homes that have been designed to high space standards and high standards of interior design. This has allowed a wide range of needs to be addressed including respite and palliative care, and they could even be used as extra care or as hotels – depending on need.

**More flexible services.** Services must respond to people’s assessed needs. Traditionally services have been organised around the service, and what it can provide for the user. Increasingly, however, the client is seen as being at the centre with services tailored to meet their needs. This was fundamental to *The same as*

you? review of services for people with learning disabilities (May 2000), and recently in the personalisation agenda.

A service that responds to a person's needs has a very different focus and feel. It organises its view of policy and delivery around the person, and does whatever it can to support that. Looked at from the client's perspective and working back, the organisation that provides the service is relatively unimportant – the important factor is the client at the heart getting the service he or she needs.

It follows that services need to be much more flexible to meet the needs of the individual client. There is always a need to check whether:

- services are delivering what they are intended to do
- there are better ways of doing things.

This emphasises the need to continue to modernise traditional care services – e.g. development of overnight care services, shift to more intensive care at home, reviewing day services in the light of more personal services, joining up day centres and day hospitals, and more flexible use of care home provision.

On the last point *Better Outcomes for Older People Part 2* noted that:

*Residential care should increasingly be seen as a flexible and not necessarily permanent part of the spectrum of care. Speedy access to fast, responsive, flexible and adaptable services provided in day hospitals, community hospitals and care homes, which are able to provide care at night and the weekends, is crucial.*

We agree with that as an example of how existing care provision could be used more flexibly.

### **Step up and step down/rehabilitation/intermediate care**

We felt that with the increasing numbers of older people, there is a most pressing need for an increase in services that fall within this category. There is currently a lot of interest in this area, sometimes loosely described by the term “intermediate care”. We are wary of using this term, as it means different things to different people, and has a specific meaning in a healthcare context. It is a term that has been used in the health service in England, and indeed it became in effect another tier in the NHS with its own attendant waiting times etc. That is not what is intended.

What we have in mind are services for older people with complex and/or more intensive needs, that are able to respond to rapid changes in the personal needs or frailty of those people. Such services should:

- pro-actively support people living at home so they are not inappropriately admitted to a care home or hospital
- provide intensive rehabilitation prior to returning home
- actively support older people on returning home, and

- facilitate provision of appropriate specialist health support to people in care homes.

Many such services are in place, but they may operate as separate initiatives and not as part of a continuum of care. Examples of such services include:

- intensive care at home, including rapid response and early supported discharge;
- rehabilitation – particularly important in the interface between hospital and home;
- short stays for rehabilitation and respite – often known as intermediate care or step-up/step-down services, and again important between hospital and home.

### **Telecare**

Telecare is about using new technology to give people the peace of mind they need to live in their own home for as long as possible knowing that help is at hand if anything goes wrong.

### **Telecare: West Lothian**

West Lothian is regarded by many as an exemplar, and as at 2005 has the largest telecare project Europe, and possibly in the world. It aims to cover 3,000 houses during 2006.

West Lothian's programme, Opening Doors for Older People, replaced four out-dated and unsuitable care homes with a package of measures designed to enable older people to remain in their local community while receiving modern, person-centred care. The final output was:

- 4 new build housing with care projects;
- 2 existing sheltered housing projects changed to housing with care;
- 2 new care homes;
- a new home care package, with monitors in the home linked to a community alarm centre, and home care assistants working from a number of local bases.

This programme required significant integrated working and considerable capital investment. Major capital contributions came from housing, social work and health budgets and was supplemented by loan finance and charitable funding from housing associations. There was also significant re-alignment of revenue budgets to enable the programme to be effective.

People have a range of monitors in their own home –

- smoke detectors
- extreme heat (cold and heat) temperature sensors
- flood detectors (kitchen and bathroom)
- fall detectors
- others depending on needs such as epilepsy monitoring, wandering devices for dementia, and even medication reminders.

These sensors are placed unobtrusively in homes, with a small control unit in the home connecting to a call centre set up by West Lothian staffed 24/7.

This technology allows older people to stay at home when they would otherwise have gone into a care home. An example quoted is a couple whose consultant geriatrician said their needs were such they had to go into a care home: with the equipment installed they were able to stay at home for another 2 years. Users in West Lothian are very positive, from the user's perspective the Council is providing a better service, and there are reduced delayed discharges.

### **Telecare: wider application**

It is vitally important to consider the support service infrastructure that is around the technology. Installing monitors on their own, or even monitors and a call centre, does not provide the solution. It is the response mechanism – whether that is the neighbour who is prepared to be contacted at any time of the day or night, or on call staff – that allows frailer older people to remain at home.

We believe that the application of telecare should be replicated elsewhere. Unfortunately, this does not appear to be happening. It is not clear whether this is because there is a lack of confidence in the West Lothian example, or because of the absence of funding to make the necessary investment in change.

West Lothian carried out a radical re-provisioning of its care for older people. Telecare can be applied widely, however, and does not depend on new build housing and/or new care homes. Clearly its application has to be considered carefully, since it is not just about the purchase of clever monitors – there needs to be an infrastructure in place to support the technology. Investment in staff training is required, and the need to see what suits the person and the system. But there are significant benefits to be obtained.

We feel there is a need for a more proactive approach to the application of telecare in the homes of older people in Scotland. We have noted the announcement by the Department of Health in England of the **Preventative Technologies Grant**, under which £80m has been allocated over two years from April 2006 for innovative telecare services to help at least 160,000 vulnerable people live independently for longer.

On a population pro rata basis, £80m in England equates to £8m in Scotland – £4m a year. This is not a large sum and we believe there would be benefit in encouraging the roll-out of telecare more widely in Scotland by the provision of a sum of this order for a limited period. Such a sum could be issued in several ways:

- it could be part of the local authority revenue settlement for community care. We recognise the Scottish Executive would want to ensure that any extra provision was used for the purpose intended. Arrangements would need to be made through COSLA, or by other means, to achieve this.
- challenge fund arrangements would ensure that innovative applications were considered, and would possibly lead to deeper thought by local authorities on the application of telecare and how it would fit with the rest of their services.

It seems clear to us that there are significant advantages to be gained from the provision of telecare. Regardless of whether or not additional funds are made available for this purpose, we believe local authorities should consider the use of telecare as part of their response to the challenge of providing services for the increasing number of older people in Scotland in the future.

## **Equipment and Adaptations**

Equipment and adaptations are not given the attention they should be given, probably because they are seen as “low tech”. They have a very real contribution to make, however, in helping older people to stay at home safely for longer. They have positive effects on independence, self determination, and physical and mental wellbeing.

The potential of equipment and adaptations needs to be realised. The Audit Commission compared costs of equipment and adaptations with traditional care

services such as home care. They found that **equipment and adaptations are cost effective alternatives to other care services**. Examples they quote include that:

- the cost of redesigning a kitchen so that a disabled/older person is more independent and can prepare meals, snacks and hot drinks equated to 14 hours home care a week over a year.
- the cost of home care while waiting for a stair lift to be installed (delayed due to pressure on the equipment and adaptations budget) cost more than the stair lift. The stair lift cost £2,700 – an 18 months delay required 5 additional hours home care per week at a cost of £3,850.

Despite the evidence, kitchen redesign is rarely done; and too often people wait for equipment and adaptations, perhaps because that budget is under funded, without consideration of the costs of delay to other services.

There is a need for joined up working so that, for example, the local authority provides a ramp at a house where the NHS is providing a wheelchair for the occupant. Joint delivery and collection initiatives, e.g. shared storage and distribution, enable improvements to be made to service delivery.

Access to equipment and adaptations emerged as a key issue for carers during preparation of *The future of unpaid care in Scotland*. Carers requested that equipment and adaptations should be more accessible and visible in high street show rooms and on line stores by 2014. They acknowledged the need for professional advice, but believed equipment and adaptations should be available without unnecessary bureaucracy.

## **Falls prevention**

**Adding Life to Years**, the Chief Medical Officer's expert group report on the Healthcare of Older People (January 2002), recommended that NHS Boards should ensure that falls assessment services are available.

Facts:

- one in 3 people over 65 have a serious fall every year
- 62% of deaths in older people are caused by falls
- at age 65 and over falls account for 71% of serious injuries
- at age 85 and over falls account for 78% of accidental injury deaths
- falls are the biggest cause of accidental death in the UK

There is a good evidence base for falls prevention work. While we are aware of work proceeding in some areas of Scotland, it is likely the services are patchy with some areas having better provision than others. People in all parts of Scotland should benefit from a falls service in their area.

We believe falls prevention is a bit like equipment and adaptations discussed above, and is not given the attention it should be given because it is mundane and low profile. Yet it has potential to make significant difference to the lives of older people.

The housing and social care components of falls prevention – for example home safety audits, provision of handrails and grab rails, reorganising furniture – should also be addressed.

#### **Homecheck: Edinburgh City Council**

Older people often spend more time at home, and through failing eyesight, arthritis and poorer health are more at risk from having an accident in the home than younger people. Edinburgh City Council launched its Homecheck Service in October 2005 to reduce a large number of falls and accidents in the homes of older people.

Council staff will check older people's homes for potential danger zones, and give them advice on how to deal with any problems. Staff will look out for hazards such as dangerous floor coverings, badly positioned furniture, uneven steps or pathways, overloaded power points, faulty electric light switches or sockets, poor ventilation, and unsafe storage of medicines.

The free scheme is operated jointly by the Environmental Health Department and the Care and Repair Handypersons Service.

#### **Care and Repair**

Care and Repair looks at an older person's practical needs and considers how, if they are met, the person will be able to live at home. It is a major contributor to reducing delayed discharge and inappropriate admissions.

Good housing is fundamental to long term well-being, and even arranging simple things like changing light bulbs or tap washers can make a huge difference to an older person. Care and Repair is a person centred approach that ensures better outcomes for those who need it.

#### **Angus Care and Repair**

Angus Care and Repair provides free and confidential advice to older and disabled people to assist them to have repairs, improvements, or adaptations to their property so that it meets their needs and can remain at home in comfort. It is an independent company with charitable status: Angus Council and Communities Scotland provide revenue funding. It covers a wide range of work such as:

##### Angus Care and Repair

- works with social work and health to operate a fast track hospital discharge initiative to enable people to return from hospital to a suitably adapted home
- fits equipment and adaptations to avoid inappropriate admission to hospital
- is developing a strategy to carry out risk assessments in the home to help prevent slips, trips and falls
- does minor repairs that are difficult to arrange or afford – changing tap washers, fitting letter boxes, fitting window/door locks and changing light bulbs, and
- works closely with police, health, council and fire service personnel to provide an initiative promoting home safety and security

## **Palliative Care and Improving End of Life Care**

End of life care is important to an older person. At this stage in life, people have particular needs arising from, for example, dementia or chronic heart/chest conditions. They need to be kept well and also given a choice about end of life/palliative care.

The Gold Standards Framework for community palliative care (reference at Annex E) has done much to improve end of life care for people with cancer. The Framework was developed in primary care to provide a framework for GPs, district nurses and their colleagues to improve the organisation and quality of care in the community for patients in their last year of life. The Framework was intended initially for cancer patients, but is now being used for any patients with a life limiting illness, in any community setting.

The NHS End of Life Care Programme (reference at Annex E) set up in England in 2004 aims to improve the quality of care at the end of life for all patients and enable more to live and die in the place of their choice. There is presently no comparable programme in Scotland. Whilst the majority of people would like to die at home, only 20-30% do. Existing Palliative Care Managed Clinical Networks and others need continued support to encourage advanced care planning and develop necessary redesign of services.

The Scottish Partnership for Palliative Care issued a consultation document on best practice in palliative care in care homes. Its draft report is *National Palliative Care Practice Statements for Care Homes in Scotland*. It made recommendations on the Gold Standards Framework, which is being used in Scotland. The final *Care Practice Statement* is expected later in 2006.

It should also be noted that the capacity of care homes to support people who are dying has a major impact on the system.

We think that:

- consideration should be given to additional investment in improving palliative care services in Scotland, building on the success of the Gold Standards Framework and of the NHS End of Life Care Programme in England, and
- the effectiveness of such end of life care initiatives in Scotland should be evaluated.

## **Joint Future**

**Joint Future** deals with the interaction between healthcare and social work/housing or community care. It is about different organisations – NHS boards and local authorities, who have different structures and accountabilities – working together for continuous improvement so that the individual gets faster access to better services and better outcomes, together with more support for carers. There is much material available, but we point particularly to *Better Outcomes for Older People: A Framework for Joint Services* published in May 2005 as an excellent source of guidance on planning and commissioning services for older people.

## **Technology**

We have already noted that it is difficult to predict what technology will be developed over the next 10-15 years. It follows that it is difficult to quantify what effect technology will have. Indeed many of the communications and information technology developments of the last decades have been in unexpected ways (e.g. the cavity magnetron in domestic use as the microwave, the rapid rise in text messaging). Already mobile phones have revolutionised nursing on call arrangements.

The press reported on 29 August 2005 the use of mobile phones to monitor blood sugar levels to help diabetics to control their illness. One user said "I can't remember the last time I had to take advice about my blood glucose readings, because the indications are so clear" (full trial results released at a European Association for the study of Diabetes meeting in Athens September 2005). This is one illustration of the use of tele-medicine which, whether by mobile phone or otherwise, can be used to monitor a variety of health problems.

While we may not be able to predict technology, it is clear there will be benefits either by giving users more control and better information, or by saving work that would previously have to be done by a nurse or other member of staff.

## **Physical design issues: public buildings and spaces**

There is an interesting discussion around settings and bricks and mortar issues. There are well established views and principles but local partnerships need to determine what is required in their locality to meet the needs of both the local population and the individuals that require care and support who live there.

Small-scale integrated services are usually more flexible and acceptable to people, but the reality is that many vulnerable older people (including those with mental health problems and dementia) do not feel safe or accepted in using ordinary community facilities unless these can be designed and supported to meet their needs.

One of the challenges around future provision for vulnerable older people and for preventive services is ease of access to ordinary community resources and leisure and recreation facilities, retail outlets, and transport, to respond to the needs and preferences of older people with particular needs.

Many more older people could access mainstream facilities if these were made more accessible and attractive to them – this might involve special sessions, and additional support. Sometimes the results do not match up to intentions. Older people, for example, often find reception desks difficult because there is background noise, and they cannot hear the receptionist across the desk: small changes here can make a big difference to them.

Older people have concerns about safety and security in public spaces – architectural and planning responses are needed to address these issues. There is

the idea of 'third space' that older people can use that meets their needs for company, activity and support. Some specially built provision may be needed to do this, on smaller or larger scale. It is important that the needs of older people are addressed when facilities like healthy living centres are built. The Institute for Public Policy Research published a paper *Meeting Complex Needs: the future of social care* (October 2004) (e.g. learning disability, mental health and substance misuse) which argued for 'Connected Care Centres' built on the lines of Sure Start Children's centres, set in most deprived communities and those most vulnerable to experiencing complex needs.

### **Physical design issues: houses**

Houses can be designed to meet peoples' different needs and circumstances, which will change through a lifetime. Thus people can stay much longer in their existing homes, and avoid the trauma of a move when they are less able.

The Scottish Building Standards have required a 'visitability' standard for all new houses since April 2000. This generally requires level or ramped access to at least one entrance; a prescribed minimum size for corridors and doors on the entrance floor; and provision of a WC designed to be accessible to ambulant disabled people on the entrance floor. Additionally, flats more than four storeys high must have a lift. In practice many up-market flats lower than this height built in recent years also have lifts.

The Scottish Building Standards Agency issued a consultation paper on 1 March 2006 on access and use of both domestic and non-domestic buildings, including looking towards dwellings that are better able to address the different needs and abilities of occupants and visitors. This would allow people to stay in their homes for longer. The review is considering present non-statutory guidance, including the 'Housing for Varying Needs' criteria applied by Communities Scotland to all funded social housing in Scotland and the 16 'Lifetime Homes Standards' championed by the Joseph Rowntree Foundation in England and Wales.

As a condition of funding, Communities Scotland seeks compliance with the Housing for Varying Needs Design Guidance, so that newly-built, refurbished or adapted social housing achieve a degree of flexibility, suit people of different abilities, are convenient to use and fit for their purpose. Such housing currently accounts for around 20% of all new build in Scotland.

### **Our vision for care: conclusion**

We believe that the vision for care we have set out is the right one to meet the needs of the increasing numbers of older people who will be living in Scotland in the next 20 or so years. Its main features are:

- people helping themselves, through active ageing (physical and mental activity) and through healthy life decisions (e.g. stopping smoking, eating healthier food)
- enabling people to live as normal a life as possible in their own homes
- more flexible and imaginative services
- much more use of step up and step down

- more widespread use of equipment, adaptations, technology and Telecare
- greater emphasis on falls prevention
- more emphasis on providing better means of access to services for people with mobility problems.

Enabling people to live as normal a life as possible in their own homes is long-standing policy and was, for example, considered by the Care Development Group in its report *Fair Care for Older People* published in September 2001 (see Annex C).

More recently, *Building a Health Service Fit for the Future* set out the changes necessary to support our older population, and said that the key policy implications of an action plan included (first item mentioned):

There should be greater integration of health and social services focused largely on the care and support at home of Scotland's frailer older people with a commitment to optimal management of long term conditions, continuing illness and disability. (Volume 2 page 49).

We believe the emphasis in Scotland should continue to be towards enabling people to live as normal a life as possible in their own homes. Where they are unable to do so they should have the right to choose other housing options such as intensive support at home, various models of extra care, supported housing often involving assistive technology and telecare, sheltered or very sheltered housing, adult placement schemes, retirement communities and shared housing, cooperatives, specialist housing of various types and tenures, and care home.

There is a need to take into account the substantial increase in the numbers of older people in the years ahead, and recognise that as a nation we may not be able to afford to look after everyone in their own home. As a Group we felt we wanted to place less of an emphasis on care home provision, so that care home provision becomes a smaller proportion of total care. But the increasing number of older people may be such that the number of places in care homes remains much as at present, but become much more part of a whole system provision rather than a one-off final decision.

We are not in a position to forecast the balance of need between these options across Scotland over the next 20 years. Each area needs to undertake its own capacity planning taking account of

- where services are at the moment and of known developments,
- population projections
- the way forward set out in this Report
- the needs of the population in the years ahead, and the services that will be required to meet them.

The need for particular service provision will only be known when this has been done.

This vision for care is a development of policies that have been pursued for some time. It places an emphasis on more flexible services, and step up and step down. There is a remarkable consonance with similar emphases in *Building a Health Service Fit for the Future*, in *Better Outcomes for Older People*, in *The future of unpaid care in Scotland* and in the *Report of the 21st Century Social Work Review*. We have all been dealing with the same issues, if from different perspectives, and are reaching similar conclusions.

### **Our desired outcome and how we get there**

Our desired outcome is as set out above, with flexible services meeting the needs of a much larger number of older people, many of whom have high expectations.

The practical outworking of this in NHS boards and local authorities requires leadership and visionary thinking by people who can look across the board, and see what the local needs are and the services that can be delivered that, first and foremost, meet people's needs.

This approach will highlight new ways of working that will require staff to work in different, yet more fulfilling ways, as they see the needs of individuals being met better. Other ways of providing services may result in a release of staff time, so staff can be used more effectively.

As already pointed out, this requires a whole system approach to re-shape care to meet a desired aim. In 21<sup>st</sup> century Scotland, this means

- meeting people's needs better, and well;
- promoting independent living, so that people can stay at home where they choose to do so and where that is possible;
- avoiding or preventing hospital admissions; and
- reducing delayed discharges.

This requires capacity planning at local (local authority and NHS board) level, and to that we now turn.

## CHAPTER 8: CAPACITY PLANNING

Capacity planning is the first part of the commissioning process. It tells us what services exist and deals with future demand. It is an essential part of whole systems planning.

Capacity planning needs to be rooted in the realities set out in this Report – providing services that are labour intensive for a growing population of older people, when the labour is smaller and in a highly competitive labour market.

Early in our deliberations we came to the conclusion that we could not determine the range and capacity of services at local level. That depended on many things, notably:

- the pattern of existing services in the area – the Audit Scotland reports referred to earlier point out the complexity of local systems, and how they vary between local authorities in one health board area; and
- the population in the area, and that expected over the next 20 years (some areas are popular retirement areas; others had high growth as new towns in the 1960s and 1970s, with consequent large numbers of baby boomers retiring in 20 or so years' time etc).

All these factors mean that every area is unique, and that capacity planning must be done locally. But this must not be too local – because of the interaction of people and services, there needs to be a wide framework. In this context we believe that means health board level.

We were interested to note that although Lothian Health Board was doing capacity planning across its area, in practice there were different capacity plans for each local authority. So while there needs to be an over-arching view at health board level, there will usually need to be separate capacity plans for each local authority within the health board area.

We have set out a framework of the way we believe health care and community care should be provided to meet the needs of older people in the years ahead. We note that older people also need housing, leisure and recreation, and lifelong learning services.

Traditionally the model of care has been something like this:

- NHS continuing care for the most complex packages of care.
- care home environment – for a mixture of needs.
- sheltered housing – for people who need support but who don't need to be admitted to a care home.

The main thrust of our report is that services need to be much more flexible in future, and we have set out ways in which we believe this can be achieved. These need to be built into capacity planning at local level.

A capacity plan should set out:

- needs already known
- demographic changes
- current capacity – services, staffing and spend
- what is happening already
- the anticipated need for different kinds of services and types of accommodation in future, and particularly the increase or decrease in provision required compared with current provision to meet needs in 10 years time.

and for the future should take account of:

- the model of care to be used
- housing requirements – housing with care, sheltered housing, extra care housing etc – to meet people's needs (not forgetting special needs)
- transport, leisure and community learning facilities and provision
- the workforce
- finance – any capacity plan has to highlight revenue and capital requirements
- monitoring and evaluation – performance managing outcomes and the quality of care. Is what is done, and the model of care used, cost effective and value for money?

The capacity plan should also:

- set out the creativity needed to provide services in future – lifting eyes above the horizon to consider new ways of working, and of providing integrated services
- identify risks, e.g. on staffing (what happens if the required staff are unable to be recruited?)
- extend to the wider agenda and include, for example, the private sector, housing and hospices.

Capacity planning means a need to re-design services – e.g. reviewing what district nursing services do, considering if home helps can be re-trained as personal care workers doing a wider range of tasks. Could someone else provide that particular bit of the service? If so, what training is involved? What would district nursing services now do, to use their training and capabilities to best effect?

Capacity planning can be a powerful tool to implement the kind of service change we envisage in this report, linking into the changes that will result from the establishment of Community Health Partnerships and implementation of *Building a Health Service Fit for the Future*.

We do not know the state of capacity planning across Scotland. While we were meeting we were aware that some areas – e.g. Lothian – were quite advanced with new capacity plans. We believe that:

- every NHS board and local authority should have forward looking capacity plans that cover a significant period ahead (such as 10 years)
- where they do not already have such plans, a forward looking capacity plan should be prepared as a matter of urgency. This should be tied in to planning to implement *Building a Health Service Fit for the Future* and the Executive's response *Delivering for Health* since these, as already noted, have a considerable knock-on effect for community care and housing.

Annex D is a simple diagram that illustrates a process for reviewing the model of care and capacity. This is based on experience that these are the main elements that need to be worked through on an integrated basis, led by local authorities, with partners from health and representatives from the voluntary and independent sectors.

There may be a need to strengthen and support the skills required for effective capacity planning. The Joint Implementation Team at the Scottish Executive stands ready to provide advice and assistance if asked.

Once capacity planning has been completed, the service design and commissioning processes can begin. This is dealt with elsewhere, notably in *Better Outcomes for Older People*, and we do not repeat the ground here other than to reiterate the need for a whole systems approach. It also links clearly to the whole systems approach taken by the Joint Performance Information and Assessment Framework (Indicators JPIAF 10 and 11).

In taking forward capacity planning, a number of major building blocks were set in place in 2005:

- *Better Outcomes for Older People: Framework for Joint Services*
- *Building a Health Service Fit for the Future*
- *Delivering for Health*, the Executive's response to the above Report which makes it clear it is accepted as the basis for future planning
- the factors set out in this report relating to the future provision of services; and
- the Registrar General for Scotland's latest population projections.

Together these now provide a developed national framework in relation to population, and the nature and level of services. They must be the basis on which NHS boards and local authorities undertake capacity planning.

Capacity planning leads to commissioning. This involves working in partnership (involving users/ carers and the independent sector), making best use of resources (and joint resources), managing the market, effective contracting arrangements, and ongoing review and evaluation of services. This ensures that capacity planning is carried through.

Commissioning of services for older people is dealt with in depth in the *Better Outcomes for Older People* report. It should be noted that further work on joint planning and joint resourcing is being done by the Joint Resourcing Group as part of the Joint Future work.

## CHAPTER 9: WORKFORCE ISSUES

### The pressures

The question we have to face is how are we to provide improving services, that are labour intensive, for a growing population of older people, when there will be fewer people coming into a labour market that is increasingly competitive, with the NHS, education, social care, supermarkets and call centres pursuing the same people. There are 4 responses:

- reduce the labour input where possible – by avoiding duplication and by better organisation
- designing new roles to reflect changing patterns of service delivery – if we are delivering integrated services, shouldn't we be integrating jobs/functions/roles?
- better, more skilled workforce – pay and train the workforce better
- use of alternative types of care: equipment, adaptations, technology and Telecare.

The Drivers for Change Paper considers workforce issues, and highlights a number of factors that lend weight to the need for service change in the NHS in Scotland:

- Demography – fewer people of working age in the workforce.
- Work-life balance – flexible working will be important in attracting and retaining staff
- New Deal Contract and Work Time Directive
- Consultant Contract
- Skills shortages
- Remote and rural issues.

*Scotland's Social Care Labour Market Report* published in August 2004 covered much the same ground for the social services workforce. It provides much information on the social care labour market including:

- employment trends and the sector composition of the workforce
- workforce age profile
- gender, qualifications and job characteristics
- the private and voluntary sectors
- local authority employment growth and labour market adjustment, and
- demographic trends; implications for labour supply and labour demand.

The delivery of care services is within a mixed economy, with the voluntary and private sectors increasingly delivering more services. Thus while employment in social work activities grew significantly, from 96,000 in 1994 to 118,000 in 2003, independent sector employment grew from 37,000 in 1994 to 65,000 in 2003 and

overtook public sector staff late in 2000 (source: Scotland's Social Care Labour Market Report).

Local authorities have a key role in commissioning and purchasing care services. Consequently these issues are not unique to the NHS – local authorities and the voluntary and independent sectors face similar recruitment problems. Indeed in the draft report of the working group on the care of older people the point was made

*'Substantial workforce issues – in education and training, in career flexibility and life-long learning – must be addressed, with a new focus on competencies rather than traditional labels, in education, training and career development. A health and social care workforce that reflects demography and need, increasingly community based and less focussed than at present on acute and unscheduled care: with changes delivered via training, education and career paths; knowledge skills and attitudes; with more people working in teams and away from hospitals; and making maximum use of technology.'*

Although the Joint Future Model (Scenario 7) in our First Report starts to map a way forward, there are significant workforce issues which could essentially render the model unworkable if full recruitment is not achieved. The HM Government Report 'Opportunity Age' highlights

- helping unemployed and inactive people over 50 into jobs
- there should not be a cliff-edge between work and retirement
- opportunities to promote health and leisure to contribute to the community through caring and voluntary work
- flexible working, and
- helping people back to work.

### **Right people, right skills, right place, right time**

It follows that developing the social services workforce is crucial if we want to realise our ambition to encourage new and better patterns of service delivery to users of social services, such as older people. For this, we will need a competent, confident, flexible and highly valued workforce. The *National Strategy for the Development of the Social Services Workforce in Scotland 2005-2010*, launched in November 2005, aims to ensure that employers have the right people with the right skills in the right place at the right time. As well as addressing demographic pressures in common with healthcare staff in Scotland – for which we need to develop complementary workforce strategies to avoid unnecessary competition – the skills of social services staff need further specific development on:

- working with other organisations;
- working in equal partnership with service users and their families;
- strong leadership and management; and
- critical decision-making.

These skills gaps have also been identified by the *Report of the 21st Century Social Work Review* (February 2006) about the future role of social workers and the development of the social work profession. It makes detailed recommendations on

issues such as training and career development. The Strategy's action plan aims to make best use of projects, programmes and initiatives such as Leading to Deliver, the Scottish Credit and Qualifications Framework (SCQF) and the Framework for Supporting Frontline Staff (to name but a few) to address these deficits.

Employee development is the foundation on which the confidence and competence of staff is built. Employee development is for all posts and people within an organisation, not just for those with a professional qualification, and individuals must take responsibility for their own development. Within social work particularly, employee development involves:

- experiential learning, which takes place through life, volunteering and work experiences, and is often but not always unintentional learning;
- informal and work-based learning, often provided by or supported by employers, such as induction and in-house courses, job shadowing, secondment, coaching, mentoring and peer group learning;
- formal learning, normally leading to a recognised award within the Scottish Credit and Qualifications Framework;
- qualifications required for registration with the Scottish Social Services Council (SSSC) and other recognised regulators; and
- post-registration training and learning requirements necessary to maintain registration status.

The Strategy calls for employers and staff to use a mix of all these routes to validate the competencies and experience of their staff and to ensure that their organisations' standards of competence, experience and qualifications continue to rise as part of the overarching Scottish Social Services Council's agenda to upskill the social services workforce over the coming decade.

### **Inward migration**

There has been interest in the number of foreign nationals working in the care sector in Scotland, notably in care homes. Generally we do not have reliable data, and much of the comment is anecdotal about residential care workers from Eastern Europe coming to fill jobs in care homes.

The Scottish Social Services Council will have a better understanding once it has developed its workforce planning capabilities, and when it starts to register adult residential workers.

### **Inward migration – information about numbers: Accession 8 countries**

Meantime there is some information in the ***Accession Monitoring Report May 2004 – June 2005*** (see Annex A for full information) about the employment of nationals from 8 countries that joined the European Union on 1 May 2004 – the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia, known as the 'Accession 8'.

The report tells us that of 181,085 registered workers from these countries in the UK in the period July 04 – June 05 5,485 were working as care assistants and home carers.

Between May 2004 – June 2005 14,845 from the Accession 8 countries were employed in Scotland, of whom 755 were working in the Health and Medical sector. Of these around 580 were working as care assistants and home carers in Scotland.

These figures are only from the Accession 8 countries listed above, and do not include nationals from other countries such as South Africa and the Philippines.

While we do not feel it is within our ability to guesstimate the numbers of foreign nationals who will come to Scotland in the next decade and take up employment in the care sector, we anticipate the numbers will grow. These incoming workers may need education and training in the standards of care we expect older people to receive.

### **Inward migration – contribution to the workforce**

We believe the opportunities people from overseas have to work in the care sector in Scotland are positive, provided individuals are registered with the Scottish Social Services Council.

Where such workers are concerned, there are issues about:

- language comprehension – older people will often be hard of hearing, and may find communication difficult anyway. This may be compounded if the member of staff concerned does not have a full vocabulary of English, or if they have an accent that is difficult for an older person to pick up.
- cultural expectations and understandings – a foreign member of staff may not understand appropriate behaviour, and may behave inappropriately towards an older person in our cultural context; or may not understand normal behaviour in the UK and may accept inappropriate behaviour and practises taking place in a care home or in a care at home service.

Consequently there is a need for support for overseas care workers, with the aim of developing this available resource within Scotland to help fill identified shortfalls in service provision. As one example, UNISON gives people a comfortable forum to raise issues about their “new” environment. It should be added that there is no intention of depleting such developed resources from within Accession and Third World Countries.

Some of these overseas workers may not initially have all the necessary skills, but they may make a bigger contribution through their willingness to learn, their capacity for hard work, and their caring concern brought with them from their native culture. Training is vital in this context.

## **Workforce issues: conclusion**

This section skims the surface of a wide area. It is covered much more extensively in both the *Report of the 21<sup>st</sup> Century Social Work Review* and in the *National Strategy for the Development of the Social Services Workforce in Scotland 2005-2010* referred to above.

In community care and healthcare, as elsewhere, people are an organisation's most valuable resource. Without staff, at all levels, the changes we and others are advocating across healthcare and community care will not happen.

There could helpfully be a workforce development strategy that focuses on how to provide services effectively for older people. It could include the personalised approach, rights-based principles and specialist skills, for example for working with people with dementia.

All statutory agencies and the independent sector across health and community care need to be encouraged to work more closely in relation to workforce planning and workforce development in particular in relation to identifying new roles, joint training and collaboration on recruitment.

## CHAPTER 10: FUNDING ISSUES

### Different pots of money

A fundamental plank of our considerations is that the individual receiving a service should be at the heart of things, getting the services they need when they need them. When the person is at the centre, and services are organised around them, the organisation that provides the service becomes much less important.

While we have policies that promote integrated and partnership working there are, however, a range of funding streams that have created a financial infrastructure with different accountabilities that can run counter to the aims of these policies, and make it more difficult to join resources on the ground.

We believe we need to organise our view of policy and delivery around the individual receiving the service, and work back from that. So far as funding streams are concerned, the more they can be aligned so partnerships have flexibility and ability to use with the minimum of process, the better.

We can understand the desire to keep control of the very substantial amounts of funding provided for specific elements of the care and support system spent each year in Scotland. These include:

- resources allocated for NHS care;
- disability and other social security benefits;
- and the range of local authority funding streams for older people's services including
  - free personal care
  - care at home
  - residential care
  - direct payments and
  - housing support.

In particular Ministers want to ensure that funding is spent appropriately and not diverted into other uses; this is often achieved through the use of separate ring-fenced funding streams with their own audit, monitoring and accountability arrangements.

We understand this desire to direct funding to ensure investment in the type of services the Scottish Executive wishes to promote. Nevertheless, we believe the reporting and accountability arrangements arising from these different funding streams can create practical difficulties in providing person-centred services and result in additional administration, adversely affecting overall value for money.

We recommend therefore that the Scottish Executive reviews the impact of different accountability arrangements surrounding the care and support of older people, and the scope to promote more flexibility and integration in the planning and funding of

services for older people. We recognise the concerns though around the potential dispersion of funding into other services not related to the care of older people, and the considerable challenges in building safeguards around that, without separate accountability arrangements.

### **Value for money**

We will always need to consider value for money across the health and social care systems and across statutory, voluntary and private sectors e.g. in care homes. The present arrangement whereby some relatively low dependency care in council residential homes can cost significantly more than that given to nursing homes for very dependent people remains to be resolved. There needs to be some incentive to maintain independence, but also a reflection of objective need. Choice cannot be unlimited and the public, politicians and professionals have to be engaged in prioritisation and establishing clear, transparent objective grounds for prioritisation. The limited public purse cannot support a growing number of expensive care packages if these are at the expense of basic care and support for many. This applies across all ages.

There is a difficult balance to be made when a care package to support someone in their own home costs more than to support the same person in a homely environment in their local community. If the emphasis is on supporting people to stay at home for as long as possible, there will be a cost attached to this. This is particularly so where the “at home” care is much more costly than in, say, very sheltered housing or a care home.

Local systems will always have to assess local needs and priorities, and review these regularly, and we believe this can be facilitated within our conclusions.

### **Disinvestment in old buildings and services**

There is considerable experience in Scotland of disinvestment in NHS continuing care and local authority care home services. There is benefit in reviewing what happened, for example in order to close NHS long-stay learning disability hospitals, so as to apply lessons to changing the balance of care for older people.

We felt that in Scotland good practice in disinvesting from out of date NHS or local authority buildings and institutional establishments to provide better care services in appropriate settings is not applied universally. There is a temptation to continue using existing buildings, and sometimes services too, simply because they are there. But needs and expectations move on, and there is a fundamental requirement to be radical about disinvestment in old buildings and services.

The ongoing move away from NHS continuing care accommodation towards more appropriate non-NHS models of care that better meet people’s assessed needs is given added momentum by *Building a Health Service Fit for the Future* and by the Executive’s response *Delivering for Care*. Further thought has to be given both within the NHS, and in partnership working with local authorities, to funding (including joint funding) for the whole of the balance of care provision for local communities.

It is expected that NHS Boards, and particularly, but not only, their constituent CHPs, will work closely together with their community planning partners, and in their Joint Future arrangements, to ensure that opportunities for innovation and collaboration are identified and taken to maximise alternative uses for NHS sites that become surplus to requirements, or to rationalise and/or dispose of such sites timeously. In this way they can secure the highest level of resources for their partnership(s) that will support and add impetus to real practical progress in delivering agreed alternative models of care.

It will be important to learn from, and act on, the lessons from traditional hospital retraction programmes and avoid, for example, ad hoc re-use of vacant premises outwith an agreed strategic approach.

Similarly, as some local authorities de-commission directly managed care home facilities, resources released should be identified to the local partnership for joint discussion and agreement about future commitments in line with agreed joint priorities, together with any other resources available to agencies within the partnership to support change.

Partners should be able to display best value for the use of their collective resources in meeting the assessed needs of their population.

## CHAPTER 11: REGULATION AND INSPECTION ISSUES

Regulation has been established at different times and for different reasons. It usually has a number of purposes, which include:

- to protect people from unscrupulous operators or unsafe practices
- specifically in the health and community care field, to protect frail and/or vulnerable people who may not be able to speak up for themselves
- to ensure specified standards of services are delivered, whether in terms of physical design (e.g. of a building – care home) or competency of staff (minimum qualifications, training requirements) etc.
- a national system of care regulation ensures consistency of standards across the country, and a level playing field for all care providers
- to investigate complaints about care services.

In short, regulation is designed to ensure individuals receive high quality care delivered to nationally agreed standards. Across community care, health and housing we noted 8 regulation and inspection bodies, as follows:

**Care Commission** – regulation of care and support services.

**Scottish Social Services Council** – regulation of social service workers.

**Social Work Inspection Agency** – works with others to continually improve social work services, so that they meet the needs of the public; and the public has confidence in them.

**NHS Quality Improvement Scotland** – has the lead for improving the quality of care and treatment delivered by NHSScotland across all its services.

**Mental Welfare Commission** – mental health services (including learning disabilities and dementia).

**Accounts Commission** – ensures that the Scottish Executive and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

**Communities Scotland** – registered social landlords and supported living accommodation.

**HM Inspectorate of Fire Services** – for fire safety issues.

While this list may seem extensive enough, a housing association has to satisfy the following 13 bodies about its activities:

- Care Commission
- Scottish Social Services Council
- Mental Welfare Commission
- Communities Scotland
- Scottish Executive (Census material in Care Homes and Supporting People returns)
- Office of Scottish Charity Regulator (Charitable Status)
- Financial Services Authority (Company Accounts)
- Office of Public Guardian (Adults subject to AWI)
- Each funding local authority (Approved Provider Status, Supporting People funding, care at home funding, care home funding )
- Local authorities (Houses of Multiple Occupancy Licences)
- Local authority Environmental Health Departments (food preparation and handling)
- Each funding Health Board (Approved Provider and funding)
- Health and Safety Executive (any breaches in regulations)

It is interesting that in this list of 13 bodies, only the first 4 are in the earlier list of regulation and inspection bodies.

The purpose of regulation is to protect often vulnerable members of the public in specific situations in life, but the number of regulation/inspection/review bodies listed here raises the question of duplication between these various forms of registration and accreditation. One point of entry to these bodies would be helpful. There needs to be work about sharing of information, data standards, and how that is managed.

The questions are:

- what functions are required or are essential, and
- how we can make the system of regulation/inspection/scrutiny more coherent and joined up.

As far as older people themselves are concerned, a good starting point is where do they and their relatives take complaints.

The Better Regulation Task Force has attempted to measure the cost of regulation It estimates that the cost of regulation to the UK economy is more than £100billion – between 10% and 12% of Gross Domestic Product (the total national wealth). This is similar to the total annual revenue from income tax. Of this, two-thirds is the cost of achieving the policy objective, paying the minimum wage, providing maternity leave or constructing wheelchair ramps. The other third is administrative costs, inspection, form filling and the like. Thus across the UK as a whole we are probably spending at least £30billion a year on red tape. (Sir David Arculus, Chairman of the Better Regulation Task Force, quoted on 7 December 2005).

The Better Regulation Task Force was put on a permanent footing from January 2006 as the Better Regulation Commission, an independent advisory body set up by the Prime Minister and the Chancellor.

The percentage of total staff and management time spent on the bureaucracy of regulation, registration and inspection (filling in forms to satisfy audit trails, the time absorbed by inspection visits etc) in the care sector must be substantial. Our aim in Scotland should be to reduce these considerable pressures, whilst maintaining standards, allowing more effort to be directed to service provision.

We lighted on 2 other specific issues in relation to regulation:

- The definition of care services in terms of the Registration of Care (Scotland) Act may mean that under current arrangements providers who offer flexible services might have to register the same facility under more than one category of care service. This also means that they would be required to pay separate registration and continuation fees for the different care services provided. If we want care units/homes to be flexible, we need to recognise that the providers of the service (e.g. a care home owner) are being flexible and that they should not be disincentivised by the regulatory regime. The Care Commission has submitted this to the Health Committee inquiry as an issue it wishes to see changed.

This becomes even more of a problem in rural communities where the likelihood is that it would not be economic to have separate provision for a range of flexible services (e.g. it may be that the only service provided locally is a care home and that if any care at home service is going to be provided it only makes economic sense if that is developed as part of the care home service).

- The Regulation of Care (Scotland) Act 2001 defines regulated services on the face of the Act. The definitions therefore reflect the way services were delivered at that time (2001), when in practice service delivery moves on. New definitions can be added to the Act by secondary legislation, but the existing definitions cannot be changed. There could potentially be difficulty if some innovative service cut across definitions or did not fit with any of them.

While we are not currently aware of any such services, we flag up the issue as one to which consideration should be given as and when it arises. There could be 2 options:

- whether there is a need for changes to be made to the definitions of care services within the Regulation of Care (Scotland) Act 2001 and the requirement to separately register these different care service types; or
- whether the regulator can be "smarter" about the use of the definitions to meet the future agenda.

The Care Commission's purpose is to contribute to the improvement of care services, and by virtue of its vision is fully committed to being smarter.

## CHAPTER 12: BUILDING A HEALTH SERVICE FIT FOR THE FUTURE: IMPLICATIONS

*Building a Health Service Fit for the Future: A National Framework for Service Change in the NHS in Scotland* deals with health care services and has considerable significance for the development of those services over the coming years. With its emphasis on delivering care at the lowest level possible, however, and its vision of the NHS as a service delivered predominantly in local communities, the implications for community care and housing services are also considerable.

If people are going to be maintained at home whilst having NHS care, there will be a substantial need for other services from other providers – housing support services and care at home and other social work services provided by housing associations, local authorities and other organisations in the voluntary and independent sectors.

We have already drawn attention in this Report to whole systems working. The message from that is that if there is any rebalancing of care within the NHS, with patients being in the community much more than in the past, housing and social work services also have a part to play in helping to fulfil the Framework's vision. We have no doubt that housing and social work partners in care will be willing to respond to this challenge, but there are implications in terms of the ability of those services to respond, both in volume of service (with a need for greater financial resources) and workforce.

It is vital, therefore, that at local level a whole systems approach is applied from an early stage in implementing *Building a Health Service Fit for the Future* and *Delivering for Health*. At national level, the Scottish Executive needs to consider the implications for housing and social work, and how the consequential finance issues are addressed.

## CHAPTER 13: OTHER FACTORS

How Scotland looks after the increasing number of older people expected in the next 10 or so years is crucially dependent on a number of factors. These include:

- the economic health and wealth of Scotland as a whole. If Scotland in 10 years time is vibrant, with an open culture to learning and adopting best practice, the future will be very different than if Scotland has low economic growth, is pessimistic and inward looking.
- the take up of active ageing, and the extent to which individuals are prepared to take responsibility for their health and well-being.
- the extent to which reports such as *Building a Health Service Fit for the Future* and *Better Outcomes for Older People* are embraced and implemented at local level.

Better **quality** and more **person-centred** social care helps reduce demands on hospital/health care. Thus there are fewer emergency incidents and admissions when there is:

- self care and self management
- good care of skin and cleanliness, resulting in fewer bed sores
- good nutrition (many emergency admissions of older people are when they have become dehydrated and lost weight)
- good infection control
- care well-linked to community nursing
- good falls prevention
- palliative care in homes and at home, and
- good person-centred planning round dementia.

These are all aspects of good practice, operating at different levels within the wide range of care that meets the needs of older people. The message is that all parts of the system contribute to the care of older people; there is much good practice available; and that whatever part we play we all need to raise the standard so that good care is available to all who need it, when they need it.

## CHAPTER 14: CONCLUSIONS AND RECOMMENDATIONS

We believe this Report is timely. It brings together a wide range of information from a variety of sources, and we believe the Report will be helpful to NHS boards and local authorities throughout Scotland as they develop services to meet the increased number of older people expected in the next 10 and 20 years. It comes in the wake of 2 major framework documents published in 2005:

- *Better Outcomes for Older People : A Framework for Joint Services*
- *Building a Health Service Fit for the Future: A National Framework for Service Change in the NHS in Scotland.*

The Executive's response to the latter *Delivering for Health* made it clear the Executive accepts the National Framework, and set out a clear programme of action for the development of NHSScotland services over the next 10 years.

### We recommend

- the vision for care set out in Chapter 7, in line with the principles set out early in that chapter
- that this vision for care in Chapter 7 should be followed by the Scottish Executive, NHS boards and local authorities throughout Scotland as they develop services.
- the Scottish Executive should introduce a telecare grant of £4m a year for 2 years to encourage the introduction of telecare, operating on a challenge basis. (Chapter 7, page 37)
- regardless of whether or not a telecare grant is introduced, local authorities should explore the use of telecare. (Chapter 7, page 37)
- greater priority should be given to, and much wider use made of, equipment and adaptations in line with the recommendations of the Equipment and Adaptations Group. (Chapter 7, pages 37-38)
- consideration should be given to additional investment in improving palliative care services, building on the success of the Gold Standards Framework and also from the NHS End of Life Care Programme in England. (Chapter 7, page 40)
- the emphasis in Scotland should continue to be towards enabling people to live as normal a life as possible in their own homes. Where they are unable to do so they should have the right to choose other housing options such as care at home, supported housing, or sheltered or very sheltered housing. (Chapter 7, page 43)
- every community planning partnership should have a forward looking capacity plan as set out in Chapter 8, page 47.
- where they do not already have such plans, such a capacity plan should be prepared. (Chapter 8, page 47)

- all statutory agencies and the independent sector need to work more closely on workforce planning and workforce development in particular identifying new roles, joint training and collaboration on recruitment. (Chapter 9, page 52)
- the Scottish Executive should review the impact of different accountability arrangements surrounding the care and support of older people, and the scope to promote more flexibility and integration in the planning and funding of services for older people. (Chapter 10, page 53)
- We should support the aim to move to more proportionate and targeted regulation, registration and inspection, whilst maintaining standards, allowing more effort to be directed to service provision. (Chapter 11)
- Where the providers of a service are being innovative by offering services in new or flexible ways, the regulatory regime should not work as a disincentive. (Chapter 11, page 58)
- there is a need to keep the definitions of care services within the Regulation of Care (Scotland) Act 2001 under review. (Chapter 11, page 58)
- a whole systems approach is applied at local level from an early stage in implementing *Building a Health Service Fit for the Future* through *Delivering for Health*. (Chapter 12, page 59)
- all statutory agencies together with the independent sector need to consider the implications of *Building a Health Service Fit for the Future* and *Delivering for Health* for housing and social work, and address the consequential finance issues. (Chapter 12, page 59)

This report sets a direction for community care services in the years ahead, and for development across the interaction with health care services. It is entirely consistent with the 2 Framework documents mentioned above – *Better Outcomes for Older People* and *Building a Health Service Fit for the Future*.

Now is the time for action. Our hope is that this Report will help NHS boards and local authorities to develop the services needed in the years ahead for Scotland's ageing population.

23 March 06

## ACCESSION 8 NATIONALS WORKING IN THE CARE SECTOR

The Home Office and other Departments jointly publish the Accession Monitoring Report about the movement of nationals from 8 countries that joined the European Union on 1 May 2004. These are the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia – the ‘Accession 8’. The UK Government put in place transitional measures to regulate Accession 8 nationals’ access to the labour market (via the Worker Registration Scheme) and to restrict access to benefits.

The *Accession Monitoring Report May 2004 – June 2005* was published on 23 August 2005. In total there were 232,500 applicants to the Worker Registration Scheme in the UK between 1 May 2004 and 30 June 2005.

### Occupations of registered workers July 04 – June 05 UK

Process operative (other Factory worker)	40,270
Kitchen and catering assistants	11,800
Packer	11,650
Farm worker/ Farm hand	9,145
Cleaner, domestic staff	8,895
Waiter, waitress	8,660
Warehouse Operative	8,605
Maid / Room attendant (hotel)	6,510
<b>Care assistants and home carers</b>	<b>5,485</b>
Sales and retail assistants	4,965
Labourer, building	4,585
Crop harvester	4,010
Bar staff	3,395
Food processing operative (fruit/veg)	3,245
Food processing operative (meat)	2,715
Chef, other	2,535
Driver, HGV (Heavy Goods Vehicle)	1,920
Administrator, general	1,845
Fruit picker (farming)	1,805
Driver, delivery van	<u>1,315</u>
<b>Total top 20</b>	143,350
other	<u>37,735</u>
<b>Total</b>	<u>181,085</u>

### Characteristics of registered workers

- the vast majority are young and single: 82% were aged 18 - 34
- 95% had no dependants living with them in the UK
- only 2% had dependants under the age of 17 with them.
- 97% were working full time (more than 16 hours a week)

- the vast majority (80%) were earning £4.50 - £5.99 per hour
- 47% were in temporary employment, 50% were in permanent employment and 3% did not give information (the proportion varied considerably from sector to sector).

There is information for Scotland, though the basis (both the total number and the employment sectors) differs from that in the table above. It states that of 219,905 workers from the 'Accession 8' countries between May 04-June 05 in the UK 14,845 were in Scotland and employed in the following sectors:

Admin, Bus & Management	1,585
Hospitality & Catering	4,350
Agriculture	3,625
Manufacturing	735
Food/Fish/Meat Processing	1,860
<b>Health and Medical</b>	<b>755</b>
Retail	290
Construction and Land	815
Transport	270
Entertainment and Leisure	160
Others/Unknown	410
Total in Scotland	14,845

There is no breakdown of the Health and Medical heading for Scotland, but at UK level 77% were care assistants and home carers. Applying that percentage suggests around 580 care assistants and home carers from the 'Accession 8' countries were working in Scotland in the period May 04-June 05.

These figures are not a complete picture, as they refer only to 8 specific countries and do not include, for example, nationals from South Africa and the Philippines often mentioned in anecdote, but they shed some light on the picture.

**DEMENTIA**

Unless there are major advances in prevention, the number of people with dementia will double in the next 40 years, and the number of those 85 and over with dementia will treble.

The number of people with dementia in Scotland was around 60,000 in 2001, and is projected to increase to around 82,000 in 2020 and to around 125,000 by 2041 (*Drivers for Change* figure C6).

Efforts to improve the health of the population may not stop an increase in the level of dementia in the population. In August 2005 the press reported research by the Medical Research Council, with the findings being published in the *Public Library of Science Medicine*. It found that levels of dementia were surprisingly constant across England and Wales, and throws into doubt the hope that reducing risk factors for conditions like stroke would lower the risk of dementia.

The study followed 13,000 men and women who were 65 at the start of the study for 15 years. It found:

- no differences between men and women.
- for those 70-79, one in 70 people a year will develop dementia.
- for those over 85, one in 15 people a year will develop dementia.

The study found that there are 163,000 new cases a year (presumably this is England and Wales). The researchers were surprised that the incidence of dementia had been so consistent.

**Extract from the Care Development Group Report *Fair Care for Older People***  
(September 2001):

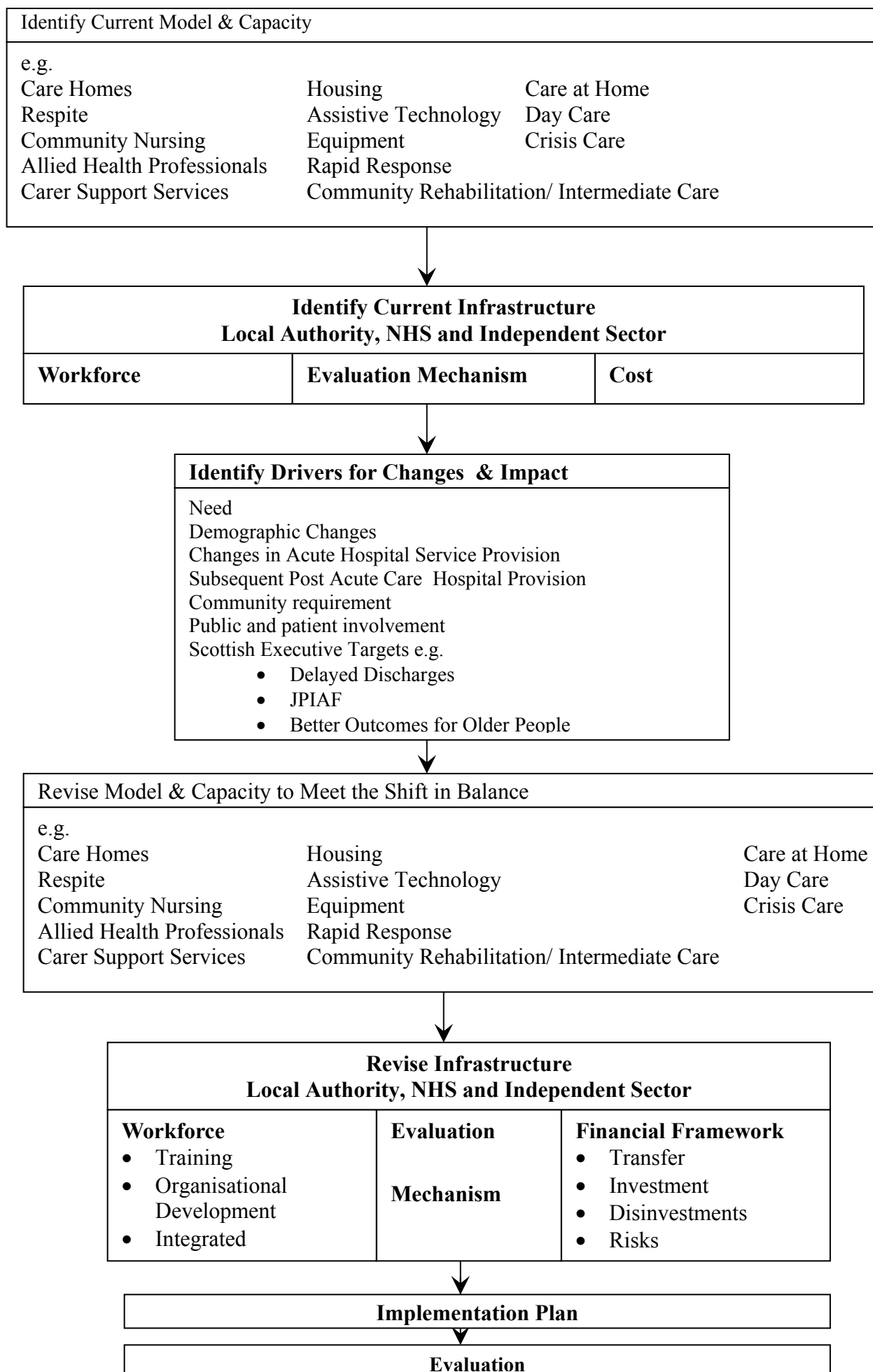
*3.4 The thrust of Community Care policy for the last decade has been to shift the balance towards providing more care for the individual in their own home and offering individuals more choice in the provision of their care. We felt it to be important at the outset of our discussions to consider whether we agreed as a Group with the policy of moving the balance of care towards care at home. We concluded that in principle the policy of providing more services at home was right and that the shift of balance in services towards more care at home was still the appropriate way in which to develop care for older people. This did not imply that there was no place for nursing or residential care homes in the spectrum of care for older people. There will always be those for whom these options will provide the most appropriate form of care or who will choose these options for themselves.*

*3.5 The proposals in this report are therefore based on the conclusion that the provision of improved and expanded home care services, including personal care services, should be a high priority for all service providers. The Group also believes that where individuals want to remain in their own home, the priority should be to enable that where appropriate.*

*We support the policy of providing more services at home and of shifting the balance in services towards more care at home.*

The Report also noted the Group's findings were consistent with current Scottish Executive policy, fitted well with the Joint Future work, and reflected public opinion.

**Illustrative Process for Reviewing Model and Capacity for Older People**



## REFERENCES

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## DEFINITIONS

**Amenity housing:** housing for older people, including all of the physical features of sheltered housing but not a warden or other support: also known as medium dependency housing.

**Assistive technology:** any device or system that allows an individual to perform a task they would otherwise be unable to do, or increases the ease and safety with which the task can be performed.

**Barrier Free Housing/Lifetime Homes:** individual houses built to a standard that easily accommodates adaptation for a resident with a disability and with built-in 'visit ability' for people in wheelchairs even when they are not adapted.

**Care Homes:** registered care homes providing accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need.

**Dependency Ratio:** the ratio of working age population to non-working age population.

**Equipment and adaptations:** a collective term for a broad range of products and changes to the fabric of a building that help people to carry out ordinary activities of daily life that have become difficult or impossible due to impairment, ill health, traumatic injury, the effects of ageing or a change in circumstances. It includes telecare, but does not include anything invasive to the body or used for medical treatment.

**Extra Care Housing:** provides 24-hour care and a full meals service for very frail older people within a housing setting. The characteristics are the same as Very Sheltered Housing (see below) except that the responsibility for the provision of care is transferred to the housing provider (usually a housing association) by contractual arrangement, and care is provided directly to residents. Extra care housing is likely to be registered and residents may have occupancy agreements and not tenancies (although they may have tenancy rights).

**Independent Sector:** includes the private and voluntary sectors.

**Informal Sector:** provision of care by family/friends who are not paid and therefore not represented in official employment statistics.

**Intermediate care:** used in this report fairly loosely to describe care falling between the traditional home/care home/hospital pathway. Bridging acute hospital and care in the community. It includes rehabilitation and step-up and step-down. We are aware that intermediate care means different things in healthcare and in community care. The Joint Implementation Team is working to agree a definition that would be understood commonly across Scotland.

**Mainstream housing:** the accommodation occupied by the person is not specifically provided in response to assessed social or medical care needs.

**Sheltered housing:** residents live mostly in individual flats, based on standards for general needs housing but with the addition of features that make the accommodation safer and easier to use for older people or people with disabilities, particularly those who are frail. This includes an alarm system, some communal facilities (e.g. common room, a laundry and guestroom) and often provision of a warden service. Residents are owners or tenants, and care is not inextricably linked to the accommodation: residents are charged separately for accommodation, living costs and care and support.

**Special housing:** housing with specific physical features to facilitate use by people with disabilities.

**Supported accommodation:** accommodation with staff support available. In supported or residential rehabilitation accommodation the care given is not inextricably linked to the accommodation itself; residents in housing with support can refuse access to the home, choose whether to receive care or not, and choose who they wish to receive care from. Care support element registerable by the Care Commission. Some residents are owners or tenants, but others are occupants of property owned or rented by the provider.

**Telecare:** equipment and detectors that provide remote monitoring of care needs by triggering human responses or shutdown equipment to prevent hazards. It includes alarm systems (smoke/gas/water/heat detectors, movement detectors that detect falls), and monitoring devices (pressure pads on beds and chairs; magnetic detectors on exit doors) which alert staff at a remote location.

**Very sheltered housing:** generally has all the features of sheltered housing but will usually also have special bathroom facilities and a greater level of care and support including the services of extra wardens to provide 24-hour cover, full-time carers or domiciliary assistants and the provision of at least one meal a day. Maximises independent living for residents, who should have tenancies and not occupancy agreements.

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