BNs members' briefing for older people's befriending services

Reshaping Care for Older People

Reshaping Care for Older People is a Scottish Government initiative covering the period 2011 - 2021, designed to respond to our ageing population by changing the way health and care services are provided. People are expected to live longer in future, so we will have more older people than we do now. We therefore need to change the ways in which health and care services are provided for older people to try to ensure that their needs can be met in the way they would like and that the country can afford.

Reshaping care designed to improve services for older people by shifting resources towards better anticipatory and preventative care, i.e. keeping older people healthier for longer and meeting their needs at home or in the community, rather than focusing on hospitals and residential care homes, where resources are prioritised at the moment. This means that there needs to be greater focus on increasing the resilience of older people, promoting social connections and participation in communities to reduce isolation and people of all ages need to take more responsibility for their own health. RCOP is ultimately about **shifting existing resources** to meet future needs more effectively but in the early stages there is a Change Fund available to help try out new services or ways of working, for example services which can support people at home or in the community and reduce the number of hospital admissions. These also focus on improving the resilience of older people to cope with challenges, by helping to build their social connections.

Third Sector involvement
One key commitment for older people's befriending services is to increase third sector involvement in the way in which care is provided:

"Building additional capacity in the 3rd sector is an essential component of the Reshaping strategy".

Reshaping Care for Older People - Update Paper. Scottish Government. September 2013

Related documents:
http://www.scotland.gov.uk/Resource/0039/00398295.pdf
http://www.scotland.gov.uk/Resource/0043/00434007.pdf

RCOP outcomes framework: Logic model

The model overleaf encompasses the outcomes of the programme (makes most sense if read from right to left!)

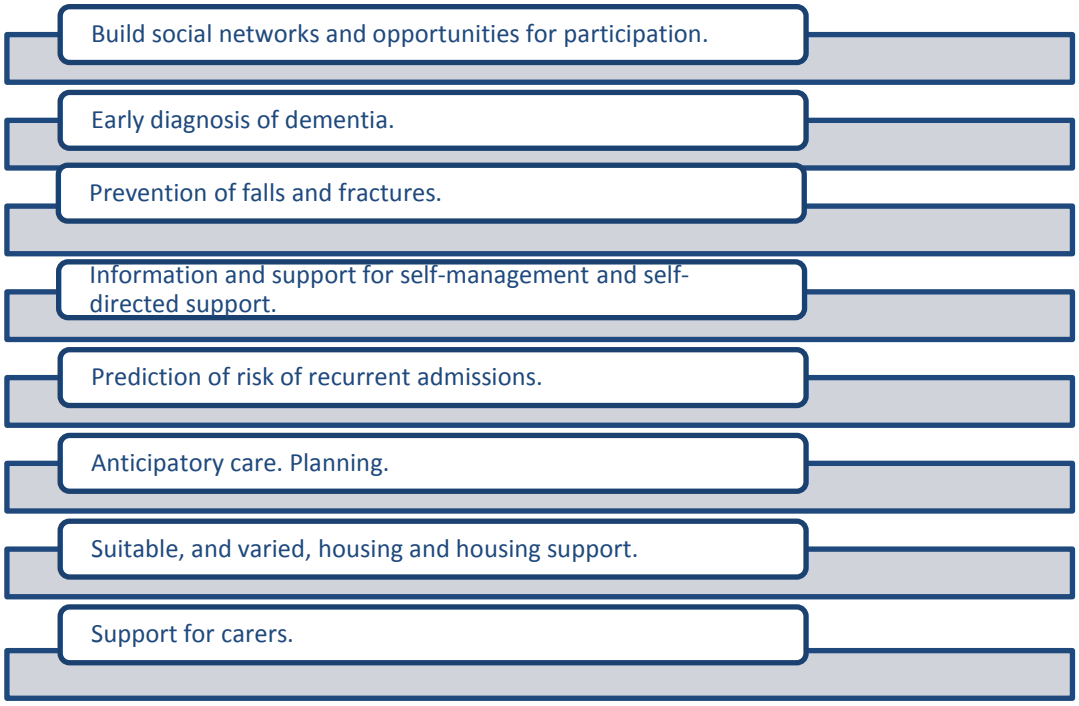
Source: http://www.scotland.gov.uk/Resource/0043/00434007.padf p26

RCOP partnerships in each local authority area are currently working with this model to continue to develop local plans for the evaluation of RCOP.

Reshaping Care Pathways
The 4 pillars of the Reshaping Care Pathway are:

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Times of Transition
- Hospital and Care Home(s)

The role of befriending services largely comes under the first of these. The elements of preventative and anticipatory care as follows:



Audit Scotland Report

In February 2014, Audit Scotland produced a three-year report on RCOP which can be downloaded from the following site: http://www.audit-scotland.gov.uk/docs/central/2014/nr_140206_reshaping_care.pdf

The **key messages** of the report include that:

- There is little evidence of progress in moving money to community-based services and NHS boards and councils need clear plans setting out how this will happen
- It is not clear how successful projects (funded through the Change Fund) will be sustained and expanded

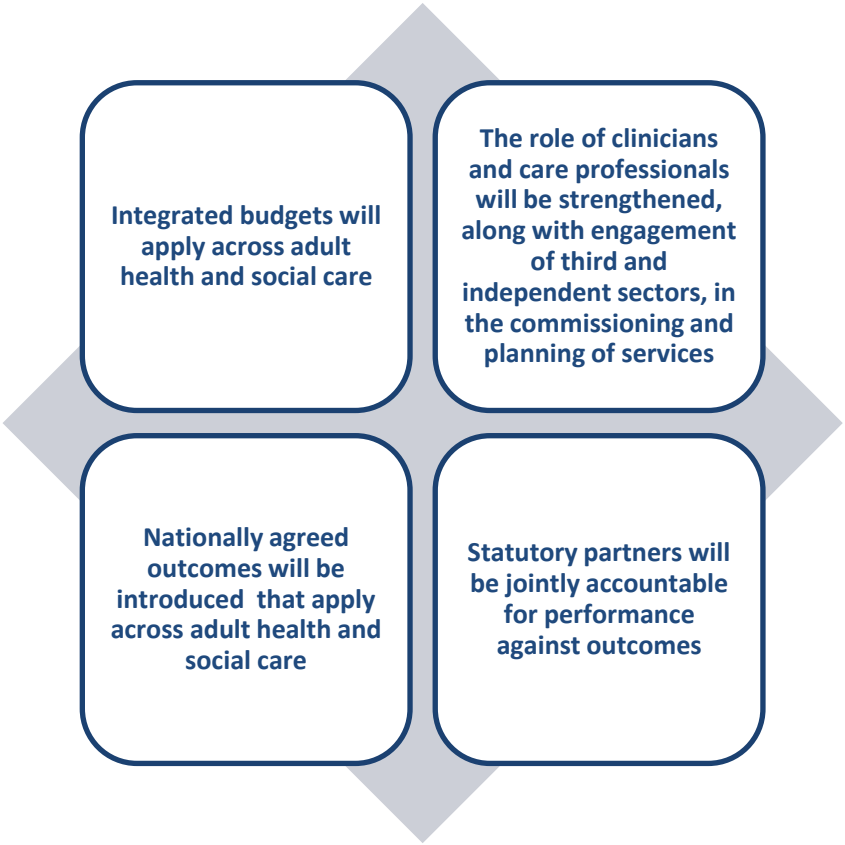
Key recommendations include that the Scottish Government should:

- Set out clear plans for how resources will shift to community services in the short and longer term
- Identify initiatives that have had a positive impact on older people and be clear how they can be sustained in the longer term

Integration of Health and Social Care

At the end of February 2014, the Scottish Parliament passed the Public Bodies (Joint Working) (Scotland) Act, which sets out the legislative framework for integrating health and social care in Scotland.

The proposals within the Act are based on four key principles:



The current arrangement is that health boards deliver health care and local authorities provide social care. Now, within each geographic area, health boards and local authorities will be required to establish integrated partnership arrangements. These new **Integrated Health and Social Care Partnerships** will replace the current system of Community Health Partnerships.

Local authorities and health boards must jointly prepare and submit an **integration plan** to the Scottish Government for approval. Third sector organisations continue to argue and make a case for their involvement in this planning stage. As part of this plan, the local bodies will be able to choose from **two models of integration**. The first option involves an agreement between the existing bodies as to how to transfer resources and functions between one another so that budgets and services become joined up. The second available option is for health boards and local authorities to create a new body to oversee integrated services.

It is expected that local integration partnerships will be fully operational from April 2015.

Transitional funding will be put in place for local authorities and health boards to implement their jointly agreed transitional/organisational plans.

The Act should be seen in light of wider public service reform, which has prioritised improvement, joint working, participation, and a focus on outcomes and prevention.

Messages for the Voluntary Sector

- Key contacts within current structures (such as Community Health Partnerships) may well change positions and new links may have to be made within the integrated body.

- Now that the legislation is in place, it is anticipated that there will be opportunities for third and community sector involvement in planning. Indeed the Act states that local authorities and health boards must consult with interested parties before submitting their integration plans. It identifies a range of groups that should be consulted, including health and social care users and their carers and all commercial and non-commercial providers of health and social care.

- All local authorities have now established **transitional leadership groups** to oversee the development of **Integrated Health and Social Care Partnerships.** Details of key contacts can be found on council websites.

Related documents

http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

Self-Directed Support

On the 1st of April 2014, the **Social Care (Self-directed Support) (Scotland) Act** 2013 came into effect, giving every local authority in Scotland the legal responsibility to offer 'self-directed support' SDS. The stated aim of SDS is to enable disabled people of all ages to have increased freedom, choice, dignity and control over the support they need to live an independent life.

Under SDS, the person needing support (or their carer in the case of children) takes responsibility for arranging that support rather than receiving services arranged by their local authority.

There are four SDS options :

- **Option 1 – direct payment -**
  individuals assessed as being eligible for a direct payment may use it in any which way they wish, so long as it secures the support agreed in the support plan.
- **Option 2 – the person directs the available support-**
  the support is selected by the individual but the local authority maintains control of the budget. The guidance suggests that individuals will be made aware of resources that are available to achieve their support plan.
- **Option 3 – the local authority arranges the support –**
  the individual has less responsibility for the budget but choice should remain in the support they receive. The guidance suggests that this will be the most used option.
- **Option 4 – a mix of the above**

It is not obligatory to take SDS. Support can continue to be arranged by the local authority if this is preferred.

Individual outcomes

SDS is outcomes-based. The professional conducting the assessment is required to work with the person in need of support to define their personal outcomes based upon a discussion of their future plans and an assessment of the support requirements required to enable them to reach this destination. This will lead to the creation of a **support plan,** which will contain a positive appraisal of how to manage any associated **risks** and of **resources** required.

The full set of guidance notes on the Act can be accessed here:

http://www.scotland.gov.uk/Resource/0041/00418585.pdf

The most recent available figures for Direct Payments in Scotland show that around one third of those choosing this option were aged over 65. Amongst the modest total in 2012 of 1,663, 223 were people with dementia, 360 had physical disabilities and 973 were described as frail older people. (Source: http://www.iriss.org.uk/sites/default/files/2014-03-13-iriss-jrf-delivering-a-better-life.pdf)

Related documents

http://www.legislation.gov.uk/asp/2013/1/pdfs/asp_20130001_en.pdf

Route Map: 2020 Vision

Published by NHS Scotland, this paper sets out a new and accelerated focus on a number of priority areas for action – arising out of the Healthcare Quality Strategy (2010) in the form of a 'Route Map' to the 2020 Vision for Health and Social Care in Scotland. It adheres to the same three Quality Ambitions of **safe, effective and person-centred care** as laid out in the Quality Strategy recognising, however, that the demands for health and social care and the circumstances in which they will be delivered will be radically different in 2020 to what they were in 2010. Scotland's ageing population is cited as one of the most significant challenges in this regard.

The strategic focus of the Route Map is set out below:

> **Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.** We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Of the **25 key deliverables** outlined in the document, the following are potentially of most relevance to older people's befriending organisations:

- 9. Out of hospital care action plan
- 13. Preparatory work with NHS Boards, local authorities, third and independent sector and the building of effective Integrated health and Social Care Partnerships
- 15. Through more detailed analysis of existing data, people will be identified as 'at risk' and anticipatory plans will be agreed
- 18. 'Deep-End' GP practices approach rolled out more widely across relevant areas[1].
- 24. A new procurement portal will be established to encourage working with SMEs and third sector

Related documents

http://www.scotland.gov.uk/Resource/0042/00423188.pdf (Route Map)

http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf (Healthcare Quality Strategy)

[1] See information on 'Deep End' GPs / Community Link Workers in the **And finally …** section below

And finally …

Some other recent documents and sites well worth perusing …

Delivering a Better Life for Older People with High Support Needs in Scotland

Jointly published by the Joseph Rowntree Foundation (JRF) and the Institute for Research and Innovation in Social Services (IRISS), this briefing paper explores the messages and challenges of ***A Better Life***, a five-year programme of work by JRF in the context of the current policy drivers in Scotland.

The full briefing can be read here:

http://www.iriss.org.uk/sites/default/files/2014-03-13-iriss-jrf-delivering-a-better-life.pdf

Information on ***A Better Life*** can be found at:

http://www.jrf.org.uk/topic/betterlife

GPs at the Deep End

GPs working in practices that cover the 100 most deprived areas of Scotland are at the cutting edge of new and more community- and socially-based approaches to healthcare. You can find out more about their work and read the 22 reports they've produced on their work so far at the following site:

http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

One of the most recent innovations delivered by GPs at the Deep End (in partnership with the Health and Social Care Alliance) is the creation of the Community Links Worker Programme, funded by the Scottish Government.

More information on available at:

http://www.alliance-scotland.org.uk/what-we-do/projects/linksworkerprogramme/

Active and Healthy Ageing: An Action Plan for Scotland (2014 – 2016)

Hot off the press, this action plan - published by NHS Health Scotland and the Joint Improvement Team – sets out a vision of how to create a society in Scotland in which we can all age healthily. Details of the principles, outcomes, actions and themes which form the plan can be downloaded from:

http://careforolderpeoplescotgov.wordpress.com/2014/05/13/active-and-healthy-ageing-an-action-plan-for-scotland-2014-2016/