Reshaping care for older people

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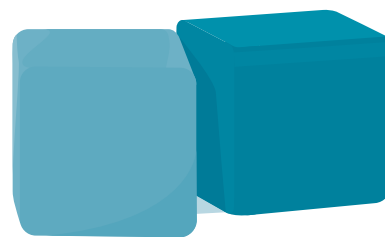- check whether they achieve value for money.

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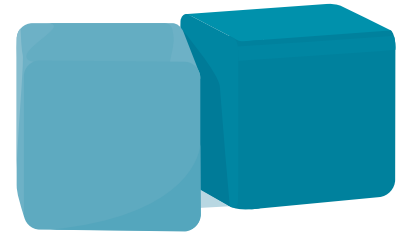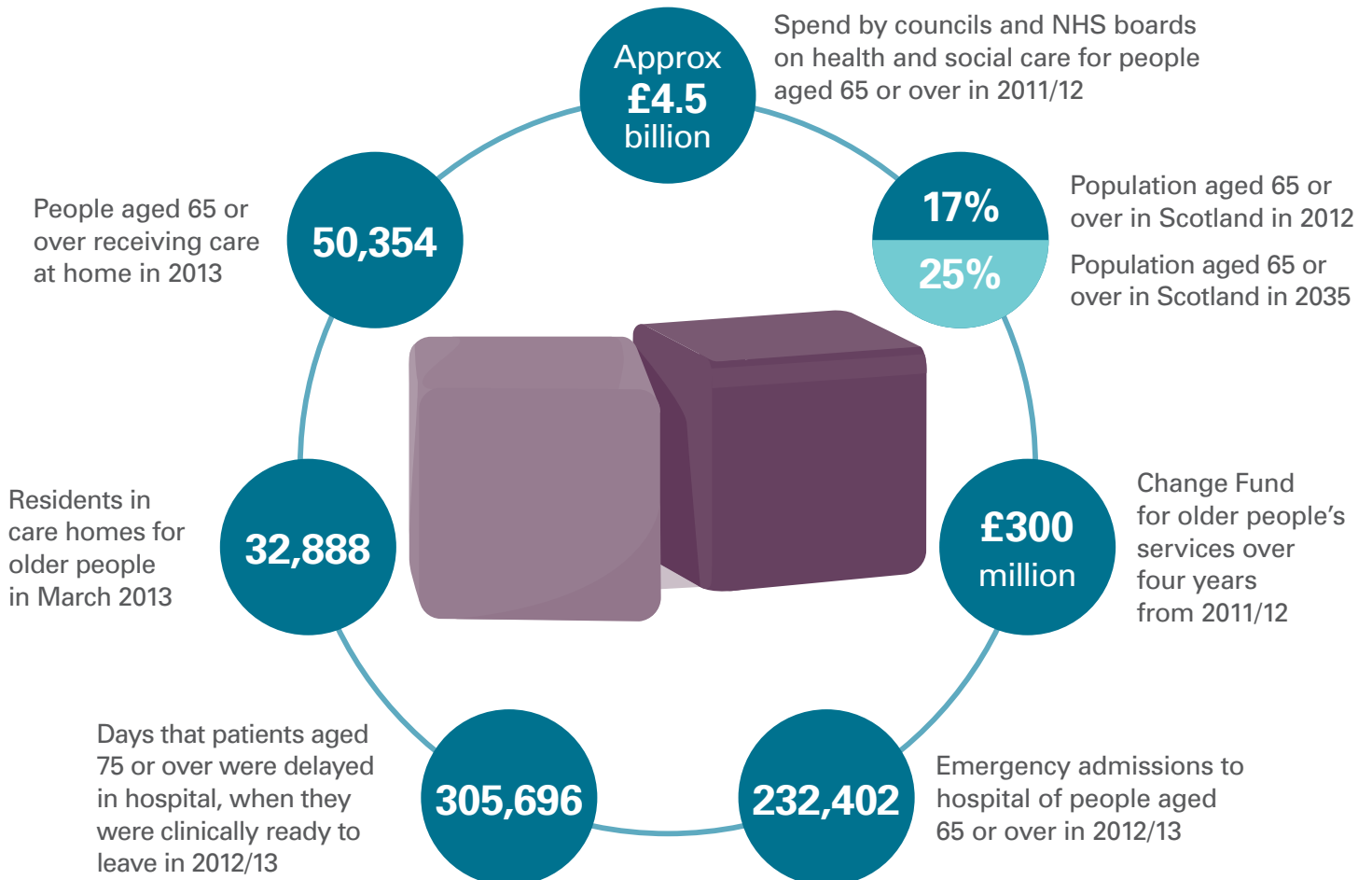
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Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Summary

Key facts

Approx **£4.5** billion
Spend by councils and NHS boards on health and social care for people aged 65 or over in 2011/12

17% Population aged 65 or over in Scotland in 2012

25% Population aged 65 or over in Scotland in 2035

People aged 65 or over receiving care at home in 2013
50,354

Residents in care homes for older people in March 2013
32,888

£300 million
Change Fund for older people's services over four years from 2011/12

Days that patients aged 75 or over were delayed in hospital, when they were clinically ready to leave in 2012/13
305,696

232,402 Emergency admissions to hospital of people aged 65 or over in 2012/13

Background

1. The public sector in Scotland faces significant challenges in reshaping care for older people, as it involves changing the way it provides services while continuing to meet current needs. People in Scotland, as in most European countries, are living longer. By 2035, a quarter of Scotland's population will be aged 65 or over, up from 17 per cent in 2010.[1] Many older people are in good health and do not need access to intensive or long-stay health and care services. In March 2012, nine per cent of people aged 65 or over, and just over a third of people aged 85 or over, received care at home or as a long-stay resident in a care home or hospital.[2] However, older people are more likely than younger people to be admitted to hospital in an emergency and to have multiple and more complex health problems. Many older people provide care and support to others; there are an estimated 657,300 unpaid carers in Scotland, of whom 20 per cent are estimated to be aged 65 or over.[3]

2. People are living longer with more complex care needs and this has implications for organisations that provide services for older people. In 2010, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) launched a ten-year change programme, Reshaping Care for Older People (RCOP). This aims to improve the quality and outcomes of care, and to help meet the challenges of an ageing population.[4] RCOP builds on a number of previous policies and focuses on giving people the support they need to live independently in their own home and in good health for as long as possible. It aims to improve the way that organisations work together to provide care and support for older people. In 2011/12, the Government introduced a fund, the Change Fund, specifically to help these organisations take forward this area of policy.

3. Initiatives in Scotland over several years have aimed to improve how NHS boards and councils work together to provide care services. In May 2013, the Scottish Government published the Public Bodies (Joint Working) (Scotland) Bill. The Scottish Parliament is currently considering the Bill, which will require NHS boards and councils to produce a plan for health and care services across the local area.[5] This will lead to significant changes in how health and social care services are planned and provided across Scotland. It means a much greater focus on the way that health and social care resources are used collectively at a local level to meet needs.

4. A number of broader challenges that we do not explore in detail in this report will also influence how services for older people are delivered. Some of these issues are likely to form part of future audit work and include:

- a move to give older people more control over the services they receive through self-directed support by having more influence over the money spent on the services they need

- implications for pensions from an ageing population

- the impact of welfare reform on public sector budgets.

older people need access to a wide range of health and social care services

About the audit

5. We are assessing progress with RCOP three years into a ten-year programme, and considering the impact of the Change Fund that has been in place for two years of the four years it is available. Our report shows that overall progress to date has been slow. RCOP is at an early stage but the core principles of supporting older people to live independently and improving partnership working have been a policy focus in Scotland for a number of years. This report is timely given current plans to integrate health and social care services. Implementing our recommendations will help the Scottish Government, NHS boards and councils increase the pace of change.

6. Our audit aimed to establish how much progress NHS boards and councils have made in improving health and care services for older people, including developments through RCOP. We looked at the extent to which care for older people has shifted towards communities and away from hospitals and care homes. We reviewed whether the Change Fund is helping to improve care for older people in ways that can be sustained. We also examined the challenges facing organisations that deliver services for older people and how well they are meeting them. In this audit, we use the term 'older people' to refer to people aged 65 or over. Where data was available, we reviewed information on health and care for older people aged 75 or over, and 85 or over.

7. We based our evidence on an analysis of national and local statistics, guidance and reports. We have included case studies to highlight progress at a local level and examples of good practice. We held focus groups with older people and their carers and with third sector organisations to find out how service changes are affecting people. We did not review specific service areas or conditions, such as dementia. We acknowledge the important role of broader services such as housing and transport in supporting older people and contributing to RCOP but have not reviewed these in detail. We did not assess the overall quality of health and care services in local areas, but we have used evidence from other audit and inspection work where it applies. Our audit methodology is in Appendix 1. Appendix 2 lists members of our Project Advisory Group, who gave advice and feedback at important stages of the audit.

**8.** This report has three parts:

- Part 1. Setting the scene

- Part 2. Spending

- Part 3. Progress with Reshaping Care for Older People.

9. In addition to this report we have published accompanying documents and supporting material on our website, including:

- Findings from our focus groups (PDF) with older people and their carers and the third sector.

- Self-assessment checklist (PDF) highlighting specific issues to help councils and NHS boards to improve support for older people.

- Checklist for non-executive directors of NHS boards and elected members in councils (PDF) to help them in their scrutiny role.

Key messages
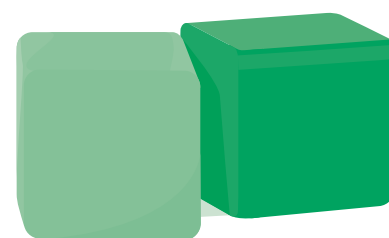
1. Reshaping Care for Older People (RCOP) is a complex programme of major transformational change affecting most health and social care services. Implementing the programme is challenging as organisations must continue to meet people's current care needs and plan future services while managing pressures on existing services. Strong national and local leadership is needed to take this significant agenda forward.

2. In 2011/12, the NHS and councils spent approximately £4.5 billion on care for older people. More needs to be done to target resources on preventing or delaying ill health and on supporting people to stay at home. 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 in practice. To implement RCOP successfully, partners need to make better use of data, focus on reducing unnecessary variation and monitor and spread successful projects.

3. The Change Fund represents 1.5 per cent of all spending on older people in 2011/12 and this has led to the development of a number of small-scale initiatives. Initiatives are not always evidence-based or monitored on an ongoing basis and it is not clear how successful projects will be sustained and expanded. The Change Fund has been successful in bringing together NHS boards, councils and the third and private sectors to develop and agree joint plans to improve care for older people in their local area.

4. For several years, there has been a greater focus on improving quality of care for older people in Scotland and providing services in a joined-up way, but progress has been slow. National performance measures have not kept pace with policy changes and a greater focus on outcomes is needed. There is no clear national monitoring to show whether the policy is being implemented successfully and what impact this is having on older people.

Key recommendations

The Scottish Government should:

- set out clear measures for success when a new policy is introduced. The Government should monitor progress and publicly report on performance against these measures and use them to underpin local commissioning and scrutiny. These indicators should include measures that cover outcomes, quality, community services and services to prevent or delay ill health

- make information on the quality of care for older people across Scotland more accessible and easier to understand. In doing this, it should continue to support the development of joint inspections by Healthcare Improvement Scotland and the Care Inspectorate, particularly in light of plans to integrate health and social care services.

## The Scottish Government should work with NHS boards, councils and their partners to:

- improve and maintain data on cost, activity and outcomes for health and care services, particularly community-based services where there are key gaps. This information matters as it helps local decision-makers to decide where to spend, and not to spend, public money. It should be set out clearly as part of joint strategic commissioning plans

- do more to understand the reasons why activity and spending on services for older people vary across Scotland. They need to work with local practitioners to help:
  - use information to benchmark activity and costs
  - identify areas for improvement
  - identify good practice

- set out clear plans for how resources will shift to community services in the short and longer term.

NHS boards, councils and their partners, supported by the Joint Improvement Team and other national bodies, should:

- make better use of available data, focusing on understanding reasons for variation in activity and spend, and reducing unexplained variation

- monitor and spread successful projects by ensuring that initiatives aimed at improving services for older people have evaluation built in from the start to show how cost effective they are and how they are performing

- identify initiatives that have had a positive impact on older people and:
  - specify how much they cost and the impact on other services
  - be clear how they can be sustained in the longer term.

Part 1
Setting the scene
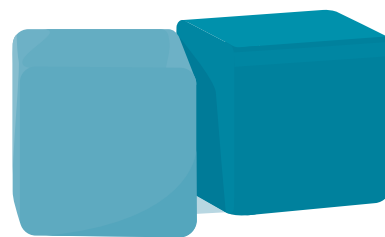
Key messages

1 Across Scotland and other European countries, people are living longer and in better health, but some older people have more health and care needs. The ageing population will affect the wider economy, and the availability of people to pay for and provide care services.

2 RCOP was introduced to support changes to services for older people along with a number of other national policies. It is a complex programme requiring joint action by a number of organisations if it is to be successful.

People are living longer and this has implications for health and care services

10. Scotland's population is ageing. Between 2010 and 2035:

- the percentage of the population aged 65 or over is projected to increase from 17 per cent (879,492 people) to 25 per cent (1,430,628 people)

- the percentage of the population aged 75 or over is projected to increase from eight per cent (405,635 people) to 13 per cent (737,871 people)[6]

- the number of people aged 100 years or older is projected to increase by 827 per cent, from 820 to 7,600.[7]

11. Similar population changes are happening across the rest of the UK and Europe. Across 27 European Union states, the percentage of the population aged 65 or over is predicted to increase from 17.5 per cent in 2011 to 23.6 per cent in 2030.[8] Projections suggest that, as a percentage of Scotland's population, the number of people of pensionable age will be 2.9 percentage points higher in 2035 than in 2010. The comparable figure across the UK is 1.7 percentage points.[9]

12. In Scotland, the number of older people aged 65 or over is projected to increase in all council areas by 2035. The extent of these increases varies between council areas (Exhibit 1, page 10). For the population aged 75 or over this variation is even greater, with a projected increase of 36 per cent in Glasgow City and 146 per cent in West Lothian by 2035.[10]
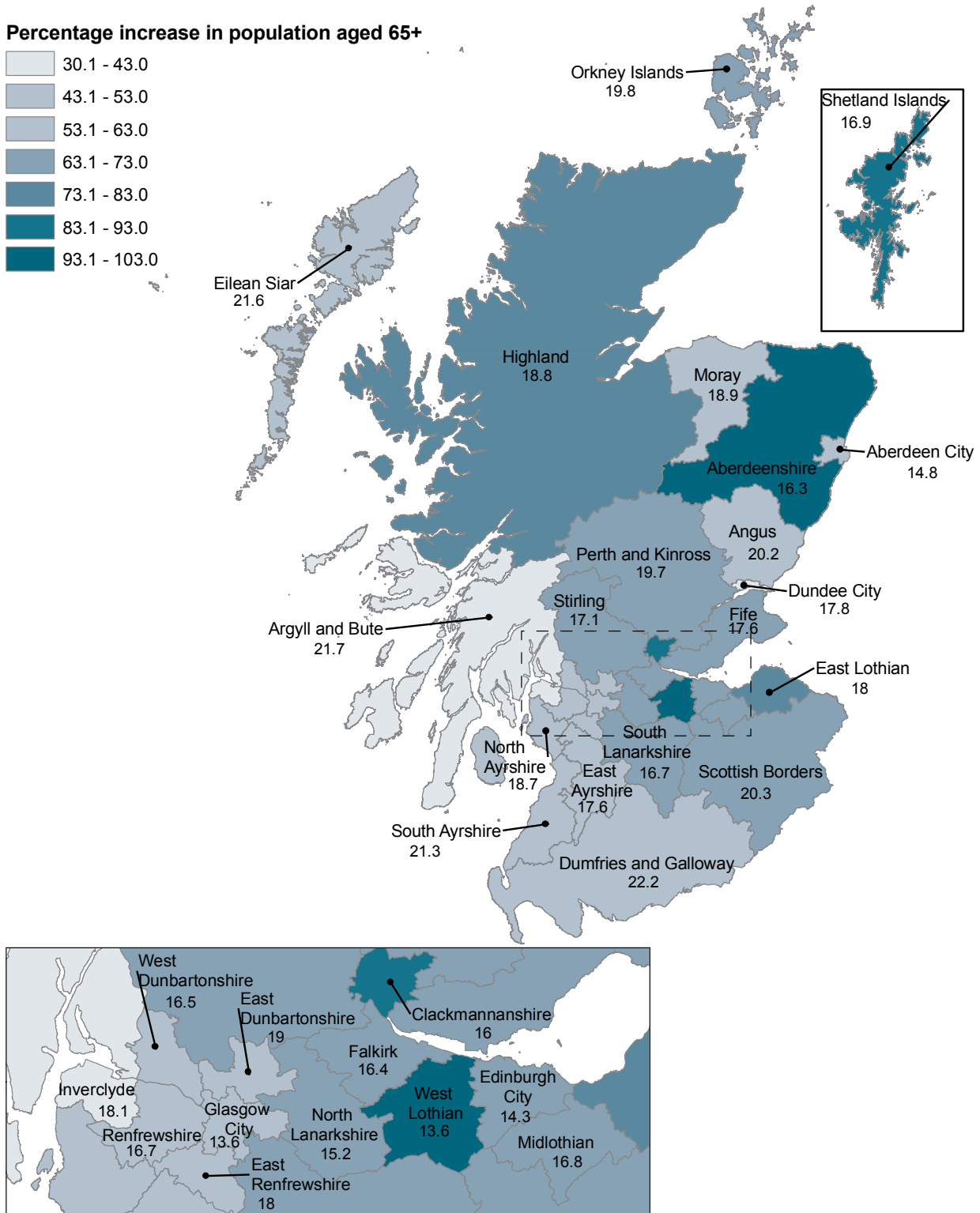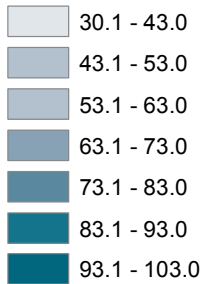
Reshaping Care for Older People aims to change many NHS and care services

Exhibit 1

How Scotland's population is expected to increase, by council area

The percentage of people aged 65 or over in the population is projected to increase across all council areas between 2010 and 2035.

Percentage increase in population aged 65+

- 30.1 - 43.0
- 43.1 - 53.0
- 53.1 - 63.0
- 63.1 - 73.0
- 73.1 - 83.0
- 83.1 - 93.0
- 93.1 - 103.0

Orkney Islands 19.8

Shetland Islands 16.9

Eilean Siar 21.6

Highland 18.8

Moray 18.9

Aberdeen City 14.8

Aberdeenshire 16.3

Angus 20.2

Perth and Kinross 19.7

Dundee City 17.8

Stirling 17.1

Fife 17.6

Argyll and Bute 21.7

East Lothian 18

North Ayrshire 18.7

South Lanarkshire 16.7

East Ayrshire 17.6

Scottish Borders 20.3

South Ayrshire 21.3

Dumfries and Galloway 22.2

West Dunbartonshire 16.5

East Dunbartonshire 19

Clackmannanshire 16

Falkirk 16.4

Inverclyde 18.1

Glasgow City 13.6

West Lothian 13.6

Edinburgh City 14.3

North Lanarkshire 15.2

Renfrewshire 16.7

East Renfrewshire 18

Midlothian 16.8

Note: Figures on the map refer to the percentage of the population aged 65 or over in 2010.

Source: Contains Ordnance Survey data © Crown Copyright and database right 2013. National Records of Scotland, 2012

13. As well as increasing demand for health and social care, the ageing population is likely to have a broader impact on the economy and wider society. It is also likely to affect the number of people available to provide care and support. In 2010, there were 32 people of pensionable age for every 100 people of working age. This is projected to rise to 38 by 2035.[11]

Some older people have greater health and care needs

14. The length of time people live in good health, known as healthy life expectancy, has not increased in line with life expectancy.[12] This means that some people will live longer with multiple and long-term health problems, such as diabetes. The number of long-term health problems that people have increases significantly with age (Exhibit 2). Health problems tend to increase with age, but available data mostly focus on people aged 65 or over, rather than older age groups. Higher levels of deprivation and ill health in some areas of Scotland mean that people need more access to health and care services, and need this at an earlier age. We know that these factors significantly affect health and care services. For example, the biggest factors explaining variation in the number of drugs prescribed by GP practices are patient age and deprivation.[13]

Exhibit 2
Ageing and health
The number of long-term conditions that people have increases with age.
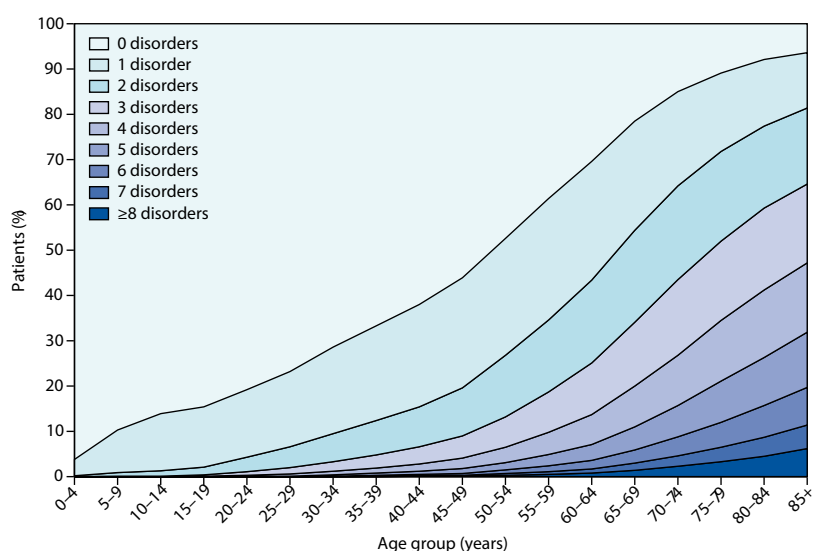
Note: Long-term conditions, sometimes called chronic conditions or disorders, last a year or longer, limit what a person can do and may require ongoing medical care.

Source: Reprinted from *The Lancet*, Vol. 380, Barnett, Mercer, Norbury, Watt, Wyke and Guthrie, Epidemiology of multi-morbidity and implications for healthcare, research, and medical education: a cross-sectional study, 37-43., Copyright (2012), with permission from Elsevier.

Predicting demand needs to take account of various factors

15. Predicting the number and type of health and care services that older people might need is challenging and needs to take account of various factors. Increasing life expectancy due to healthier lifestyles and social conditions may mean that older people spend longer in good health. Alternatively, increases in life expectancy might result from medical treatments that prolong life, but not necessarily good health.

16. Predicting older people's health and care needs is not just about estimating future numbers of older people. The services and health problems that older people have in future will be different from today. In general, the way that hospital services are delivered has also changed over time, for example more day surgery and shorter lengths of stay for in-patients. Health and care costs tend to increase in the last year of life. On average, about a third of a person's lifetime hospital costs are spent in the final year of their life.[14]

National policies have aimed to improve services for older people over several years

17. RCOP highlights that current arrangements for older people's care are not sustainable because the number of older people and the demand for services are increasing and the quality of services needs to improve. RCOP states that older people need to have more say in the services they receive and sets out high-level aspirations, including:

- There needs to be a shift from measuring how many services are provided for how many people, to how many people receive the support they need to manage without NHS or care services.

- Services for older people should focus on the impact that they have on individuals' lives.

- Everyone has a role to play in supporting and caring for older people, not just health and social work services.

- There is a need to accelerate the pace of sharing good practice.

- Health and social care providers should reduce variation and provide more consistent and fair access to services.

- All partnership agencies and bodies involved in services for older people should work together to ensure they make best use of available resources.

- Additional funding is needed for care for older people.

18. The Scottish Government has been working with organisations across the public, private and third sectors for many years to improve support and care for older people (Exhibit 3, page 13). In addition to implementing RCOP, NHS boards and councils must implement other national policies that affect older people. These include plans to integrate health and social care services, policies focused on specific conditions such as dementia, and wider policy developments such as housing, lifelong learning and transport.

19. These initiatives all acknowledge that older people with complex and multiple health problems need access to services provided by different organisations and professional groups. They highlight the need for better joint working between primary, community and hospital services and focus on:
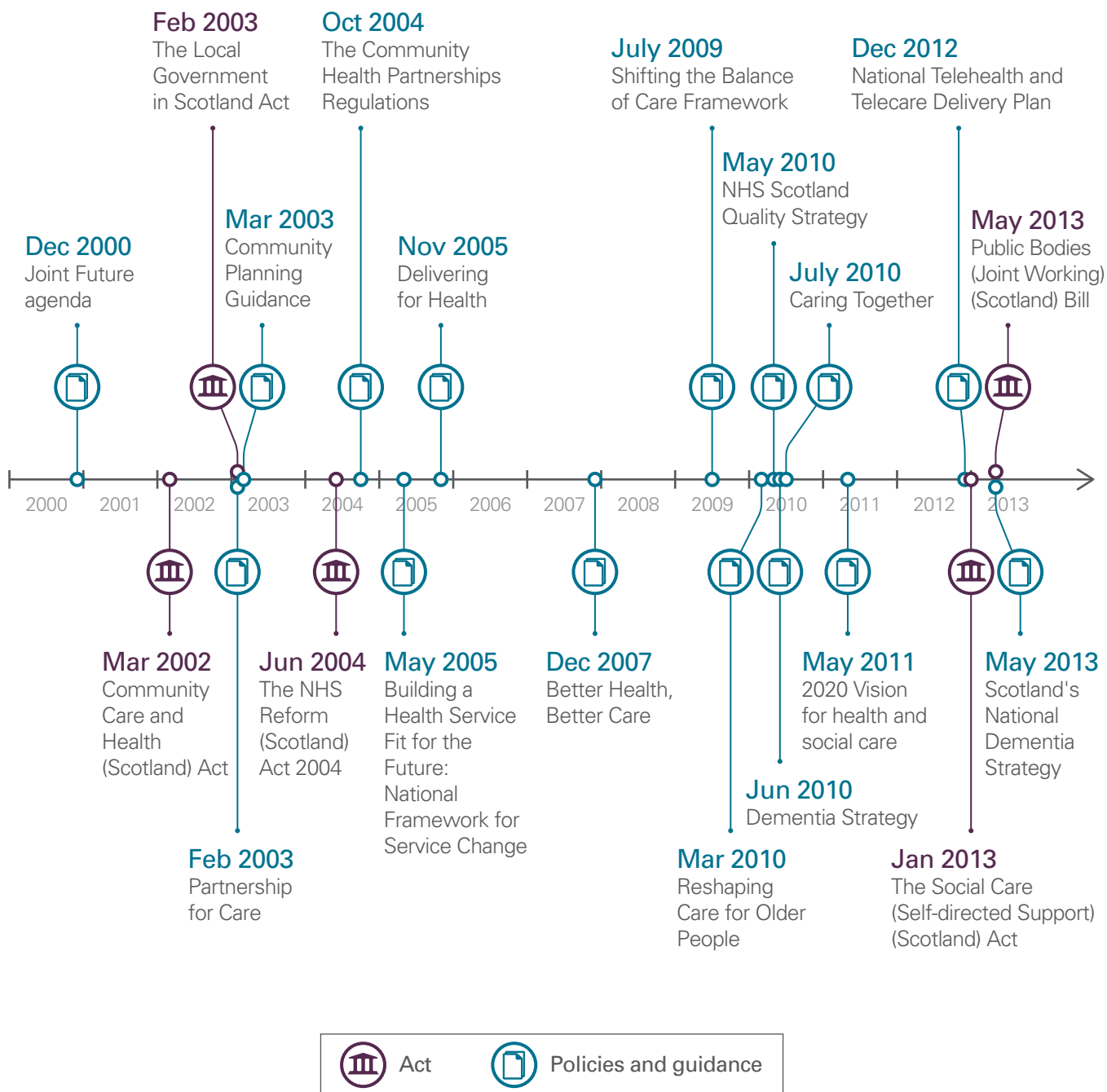
- reducing how often and how long people stay in hospital

- providing more care in or closer to people's own homes

- delaying or minimising ill health or harm

- improving how services and professional groups work together to provide more joined-up care for older people and make the best use of available resources

- providing care to best meet people's needs and improve their quality of life.

Exhibit 3
National policy context for older people's care
Various policies over recent years aim to improve services for older people.

Feb 2003
The Local Government in Scotland Act

Oct 2004
The Community Health Partnerships Regulations

July 2009
Shifting the Balance of Care Framework

Dec 2012
National Telehealth and Telecare Delivery Plan

May 2010
NHS Scotland Quality Strategy

Dec 2000
Joint Future agenda

Mar 2003
Community Planning Guidance

Nov 2005
Delivering for Health

July 2010
Caring Together

May 2013
Public Bodies (Joint Working) (Scotland) Bill

Mar 2002
Community Care and Health (Scotland) Act

Jun 2004
The NHS Reform (Scotland) Act 2004

May 2005
Building a Health Service Fit for the Future: National Framework for Service Change

Dec 2007
Better Health, Better Care

May 2011
2020 Vision for health and social care

May 2013
Scotland's National Dementia Strategy

Feb 2003
Partnership for Care

Jun 2010
Dementia Strategy

Mar 2010
Reshaping Care for Older People

Jan 2013
The Social Care (Self-directed Support) (Scotland) Act

Act | Policies and guidance

Source: Audit Scotland

Reshaping Care for Older People is a complex change programme

20. Councils and the NHS plan and deliver health and social care services, along with their third and private sector partners. Almost all existing health and care services are available to older people (Exhibit 4, page 15). Health and social care services need to be joined-up as decisions made by one organisation can affect other organisations as well as people using services. For example, a lack of support services in the community, such as health monitoring equipment, might result in people staying in hospital longer than necessary. There are important gaps in information, particularly on preventative and community services, which need to be addressed to understand how to improve services for older people.

21. Given the scale of the changes envisaged by RCOP, strong national and local leadership is needed to implement the policy. Organisations need support to help them work differently and improve services while meeting existing needs. The Joint Improvement Team (JIT) is a partnership between the Scottish Government, NHS Scotland, COSLA, the third sector, the private sector, and the housing sector. The JIT has a broad programme of work to help local partners to improve services for older people. This includes help with planning services, running workshops and shared learning events, and developing performance and outcome measures. The JIT is convening a group to bring together all improvement organisations and national partnerships in Scotland to help promote a more joined-up and coordinated approach to supporting RCOP.

Part 2
Spending
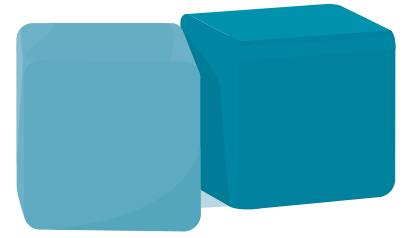
Key messages

1 In 2011/12, the NHS and councils spent approximately £4.5 billion on care for older people. There is limited evidence of progress in moving money to community-based services. To strengthen how services are commissioned, more funding needs to be focused on preventing or delaying ill health and supporting people to stay at home.

2 National data shows significant variation in how NHS boards and councils use money to provide services for older people across Scotland. This variation can only be understood at a local level.

3 To implement RCOP successfully, partners need to make better use of data, focus on reducing unnecessary variation, monitor and spread successful projects and have clear plans for shifting resources to community-based services.

The NHS and councils spend about £4.5 billion on services for older people but current service models are unsustainable

22. While demand for services is likely to rise due to demographic changes, less money will be available to pay for services. The overall annual Scottish Government budget will continue to decline until 2015/16 and is not expected to return to 2009/10 levels until 2025/26.[15] The Scottish Government predicts that spending on health and social care for older people will need to rise from approximately £4.5 billion in 2011/12, to nearly £8 billion by 2031. This is unless there are changes to the health of the population and to the way that public, private and third sector organisations deliver services.[16] This means that the Scottish Government, NHS boards and councils need to:
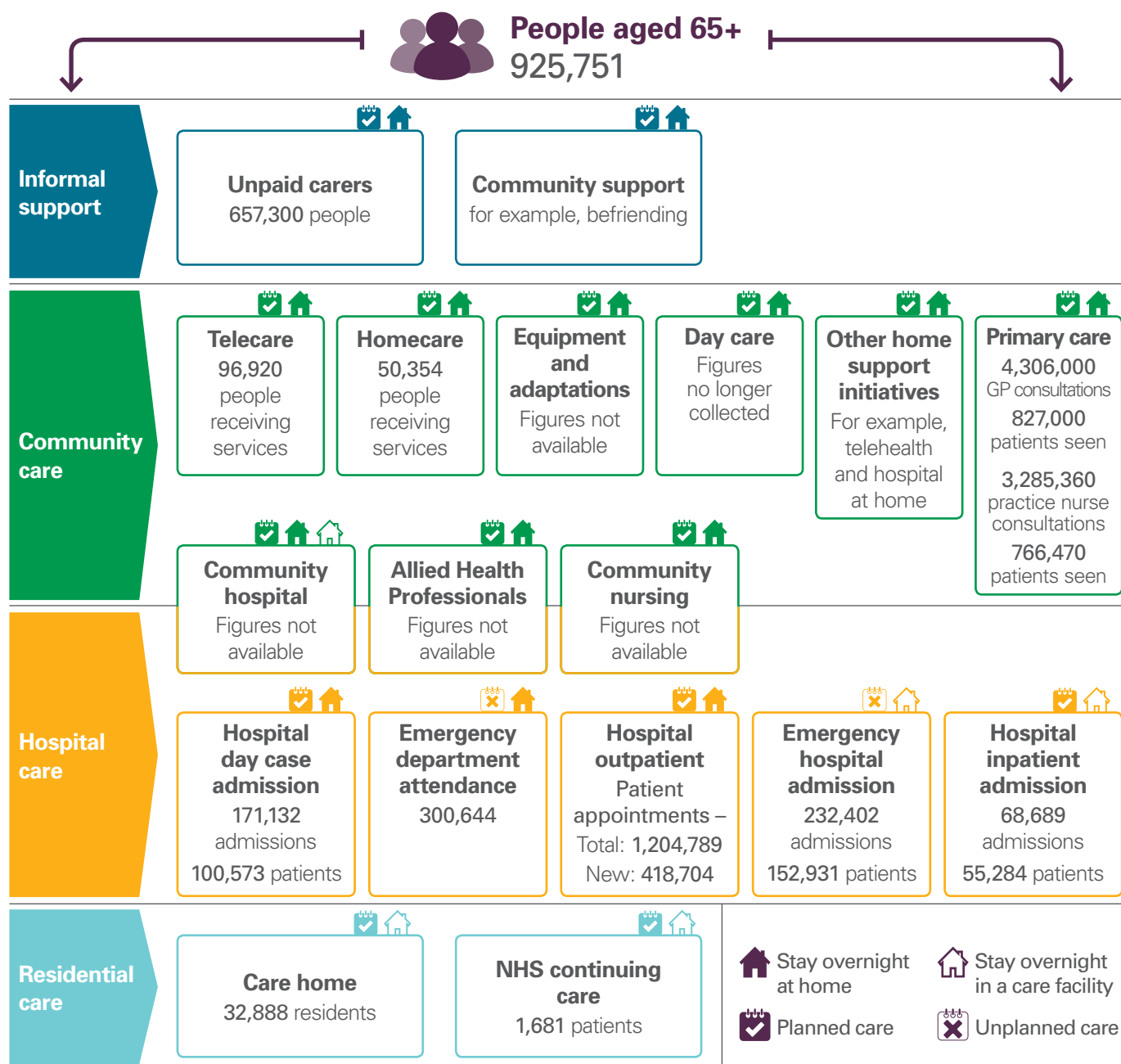
- agree priorities at national and local levels, involving the local population and the third and private sectors

- decide how to use available resources most effectively.

23. Between 2002/03 and 2009/10, council spending on social care services for older people increased by almost 40 per cent, from £0.95 billion to £1.33 billion. These figures are in real terms, that is, allowing for inflation. By 2011/12, this had reduced to £1.26 billion, 11 per cent of overall council spending in that year.[17] Available information suggests that the amount the NHS spends on healthcare for people aged 65 or over increased from £3.2 billion in 2010/11 to £3.3 billion

the NHS and councils spend a significant amount of money on providing care and support for older people

Exhibit 4
Health and social care services for older people in 2012/13
Many health and social care services are available to older people.

People aged 65+
925,751

Informal support

Unpaid carers
657,300 people

Community support
for example, befriending

Community care

Telecare
96,920 people receiving services

Homecare
50,354 people receiving services

Equipment and adaptations
Figures not available

Day care
Figures no longer collected

Other home support initiatives
For example, telehealth and hospital at home

Primary care
4,306,000 GP consultations
827,000 patients seen
3,285,360 practice nurse consultations
766,470 patients seen

Community hospital
Figures not available

Allied Health Professionals
Figures not available

Community nursing
Figures not available

Hospital care

Hospital day case admission
171,132 admissions
100,573 patients

Emergency department attendance
300,644

Hospital outpatient
Patient appointments –
Total: 1,204,789
New: 418,704

Emergency hospital admission
232,402 admissions
152,931 patients

Hospital inpatient admission
68,689 admissions
55,284 patients

Residential care

Care home
32,888 residents

NHS continuing care
1,681 patients

🏠 Stay overnight at home
🏠 Stay overnight in a care facility
☑ Planned care
✖ Unplanned care

Notes:
1. Where information was available, we have included figures to highlight the number of older people using each service. From national information, it is not possible to identify separately specific services such as rapid response community teams, falls prevention initiatives and virtual wards, where specialist teams provide care in a patient's own home. There may be some overlap between the categories shown here, as the data is not always clear. For example, some NHS continuing care may take place in care homes and some homecare may take place on an unplanned basis.
2. NHS activity and care home figures are for people aged 65 or over in 2012/13, data from ISD Scotland. The exception to this is NHS continuing care where the figure is for 2011/12. GP information is taken from Practice Team Information from ISD Scotland and is an estimate based on data from a sample of about 60 GP practices.
3. Homecare and telecare figures are for people aged 65 or over from the Scottish Government Social Care Statistics, March 2013. The number of people receiving homecare does not include people who use direct payments to buy homecare.
4. Population information is based on National Records of Scotland's mid-2012 population estimates of people aged 65 or over.
5. Unpaid carers figure is estimated from the Scottish Household Survey 2007/08.
6. NHS continuing care beds are for patients who need regular specialist clinical supervision due to complex or intense needs; or need frequent, but not predictable clinical interventions; or routinely need treatment or equipment that requires specialist NHS staff; or have a rapidly degenerating or unstable condition that needs specialist medical or nursing supervision.

Source: Audit Scotland

in 2011/12.[18] Longer-term trend information on how much the NHS spends on services for older people is limited because the NHS reports how much it spends by specialties or services rather than by age groups or conditions.

Better use of cost and activity data is needed to fully implement RCOP

24. The Scottish Government introduced the Integrated Resource Framework (IRF) in April 2008. The IRF gives an overview of how money is spent on health and social care across health boards, councils and Community Health Partnership (CHP) areas. It was tested in four areas (Case study 1) before being implemented across Scotland in 2012. The IRF provides cost information at an individual patient level across Scotland, and is built from information on activity and costs for both the NHS and social care. Organisations are starting to use the IRF to underpin strategic commissioning plans but need to use this information to inform decisions about how to reconfigure services.[19]

Case study 1
Integrated Resource Framework test sites

Four IRF test sites were established in 2010 to map the health and social care activity and costs for their local area. The test sites involved four health boards and 12 councils across Ayrshire and Arran, Highland, Lothian and Tayside. Between 2010 and 2012, the Scottish Government provided each site with £400,000 to map out how they use their money.

All test sites mapped local health and social care costs for the first time using both local and national data. However, they used various approaches, making comparison between sites difficult. Lothian and Tayside calculated costs to a patient level while Ayrshire and Arran and Highland calculated the costs of services to the level of GP practice, locality and CHP area.

An evaluation of the test sites identified some lessons from mapping spend in this way. These included:

- differences in how council and NHS systems categorise overheads

- examples of data sharing between partners, such as data on people using NHS and care services

- a lack of information on community-based health services.

Test sites reported using IRF data to identify variations in spending, improve outcomes and increase efficiency. In addition to mapping expenditure, IRF test sites examined methods for transferring money between health boards and councils. They made less progress in moving money between health and social services, and between acute and community health services, than in mapping costs. This was because of the small-scale nature of projects in most test sites and uncertainty about the future of integration due to changes in national policy.

Source: *Evaluation of the integrated resource framework test sites*, Scottish Government Social Research, 2012

Two-thirds of spending is on institutional care, such as hospitals and care homes

25. National IRF data shows that 64 per cent of combined council and NHS spending on care services for older people is on institutional care: 19 per cent on planned and long-stay hospital care; 31 per cent on emergency hospital care; and 14 per cent on care homes (Exhibit 5, page 20). There will always be a need for hospitals and care homes, particularly as people get older and the policy focus is on ensuring that these specialist services are used appropriately to meet people's needs. In part, this is because older people with care needs tend to become less independent if they spend an extended period in a hospital or care home.

26. The IRF presents information about the patterns of spending on health and social care, for different population groups across a local area. Since 2010/11, NHS Information Services Division has produced the IRF information for all partnerships. A tool is now available so NHS boards and councils can access IRF data and produce reports to help them make more use of the available information. This addressed some of the limitations with the previous approach but some issues remain:

- Like other information, the IRF is only reliable when it is built on accurate data. Information on hospital services is more accurate than data on long-stay and community health services. The Scottish Government, NHS boards, councils and partners need to improve data on community services if the focus is on improving and delivering more community-based services.

- The IRF is currently only centrally available for 2010/11 and 2011/12. Prior to that, organisations used different approaches to inform the IRF. This means that there is limited scope to compare IRF information between organisations and to assess any changes over time.

- IRF information is available for three age groups: all ages, people aged 65 or over and people aged 75 or over. This level of detailed information is available for NHS services. Council spending is less detailed, as information on people aged 75 or over is not separately available for all areas.

27. It is important that the information generated by the IRF is at the heart of planning and delivering services for older people, and that it is used to help decide where best to target resources in local communities. Local partners are beginning to make use of IRF data to help inform how they plan and deliver services (Case study 4, page 42).

There is limited evidence of progress in moving money from institutional to community care

28. One of the more significant challenges in RCOP is for organisations to identify areas for disinvestment. This is difficult as resources can be committed, for example to buildings, but identifying areas for disinvestment is central to transforming how services are delivered. Since 2004, the Scottish Government has had a policy objective to 'shift the balance of care'. This means shifting from institutional services, such as hospitals and care homes, to care at home or in the community. It also means having a greater focus on services that prevent or delay ill health, such as services to help prevent older people from falling at home. However, there is a lack of evidence of progress in shifting resources into the community. Acute hospital services are expensive to deliver, and advances in modern medicine and technology mean that new treatment options become available over time. Relatively small

reductions in spending on hospital services could release money for community services. Increasing the amount spent on community-based services for older people is desirable because:

- admitting an older person to a hospital or care home can reduce their independence and lead to further deterioration in their overall health and quality of life

- people may achieve the same or better outcomes if they receive care in the community or their own home.

29. Shifting resources from hospitals to community-based services can only happen if there is:

- a good understanding of how resources are being used at a local level

- clarity about what works to deliver positive outcomes for older people

- a mechanism to move resources

- a clear plan about what resources will move and when this will happen

- routine planning and good engagement with local clinical and social care staff.

30. The Public Bodies (Joint Working) (Scotland) Bill aims to address the issues set out above. Currently, a number of mechanisms could be used to shift resources, such as pooling budgets and transferring resources, but these are not widely used and tend to focus on specific services or initiatives. Some building blocks to support the Bill are already in place, such as the IRF. Under the Bill, NHS boards and councils will have to join up their budgets for adult health and care services. They will be required to create an integration plan for the council area, which will cover adult services but other services may also be included.

31. While frontline services for older people have changed over time, from the information available it is not possible to see these changes in the ways resources are used. For example, the percentage of money that the NHS and councils spent on community-based services for all age groups changed only slightly over the last nine years. Limited trend data is available on NHS spending on acute or community care for older people through the IRF. However, in 2003/04, 42 per cent of NHS spending for all age groups was on community services and this increased to 44 per cent in 2011/12.[20] We have reported previously on the overall lack of evidence of shifting resources from hospitals to the community.[21]

32. Council spending on homecare has increased from 26.3 per cent of older people's social care spend in 2003/04 to 31.4 per cent in 2011/12. The amount that councils spend on other social care services for older people, such as meals and equipment and adaptations, has remained largely unchanged since 2003/04 **(Exhibit 6, page 21)**.[22,23]

33. Much of the growth in councils' spending on homecare has resulted from increased spending on free personal and nursing care.[24] The cost of free personal care at home has risen in real terms from £162 million in 2003/04 to £347 million in 2011/12. This increase means that the cost of free personal care has risen as a percentage of total spending on homecare, from 59 per cent in 2003/04 to 87 per cent in 2011/12.
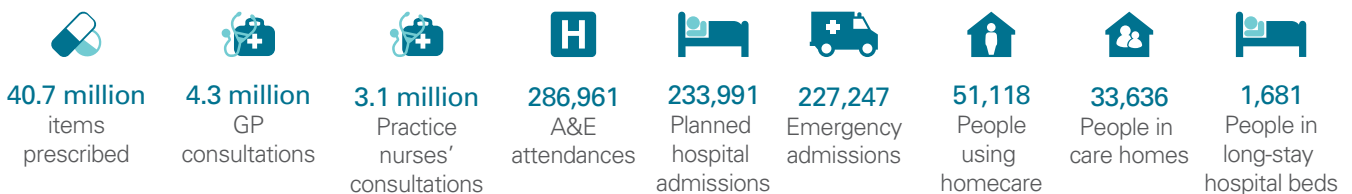
Exhibit 5

Breakdown of combined NHS and council spending on care services for people aged 65 or over across Scotland, 2011/12

Almost two-thirds of spending on older people's care is on hospitals and care homes.

General practice
£198m (4%)

Accident and emergency
£35m (1%)

Other council spending
£223m (5%)

GP prescribing
£379m (8%)

Emergency hospital admissions
£1.4bn (30%)

Homecare
£395m (9%)

£4.5 billion
Spending on care services for people aged 65+

Community healthcare
£439m (10%)

Planned and long-stay hospital care
£847m (19%)

Care homes
£637m (14%)

Care services for people aged 65+

| 40.7 million items prescribed | 4.3 million GP consultations | 3.1 million Practice nurses' consultations | 286,961 A&E attendances | 233,991 Planned hospital admissions | 227,247 Emergency admissions | 51,118 People using homecare | 33,636 People in care homes | 1,681 People in long-stay hospital beds |

Notes:
1. Chart shows total spending of £4.5 billion. 'Planned and long-stay hospital care' includes hospital care other than emergency care, including non-emergency acute inpatient, non-emergency geriatric long-stay, non-emergency outpatient and non-emergency hospital-based mental health services. 'Community healthcare' includes a wide range of community-based services including physiotherapy, occupational therapy, district nursing, out-of-hours general practice and community mental health services. The methodology used means that spending on emergency hospital admissions is likely to overestimate actual emergency activity.
2. Emergency admissions show how much is spent on admitting people to hospital in an emergency. This is different to Accident and Emergency, which shows how much is spent on people who attend an accident and emergency department and may or may not go on to be admitted to a hospital.
3. Council spending figures are net of any income such as charges for services.

Sources: Financial information from Integrated Resource Framework, 2011/12. NHS and care home activity figures for 2011/12 from ISD Scotland. Homecare figures from Scottish Government Homecare Statistics, March 2012

Exhibit 6
Council spending on social care for older people, 2003/04 – 2011/12
Care homes account for the largest element of councils' spending on care for older people.
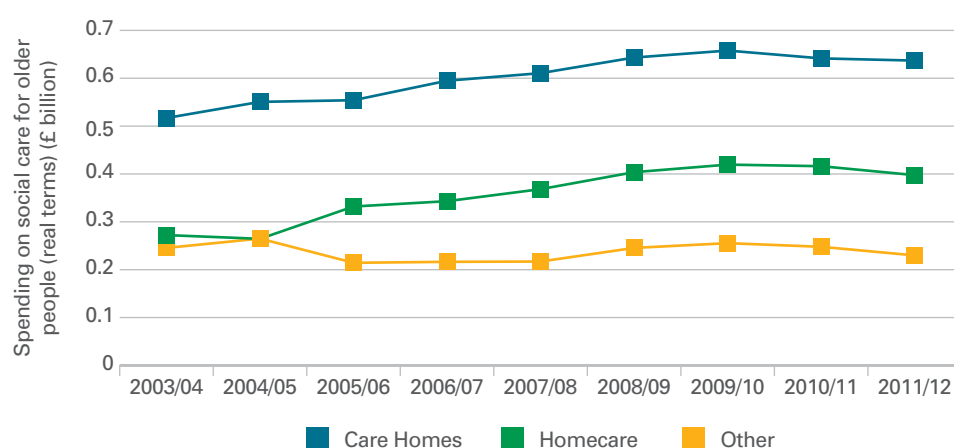
Notes:
1. The figures are in real terms, that is, adjusted for inflation.
2. Figures are net of any income such as charges for services.

Source: Audit Scotland analysis of Free Personal and Nursing Care and Local Financial Return statistics, 2003/04 to 2011/12.

There is unexplained local variation in activity and spending on services for older people

34. The amount that NHS boards and councils spend on care for older people varies significantly across Scotland and the reasons for these differences are not always clear. Excluding the islands, the average amount spent per person aged 65 or over on health and social care in mainland council areas ranges from £4,260 in South Lanarkshire to £6,674 in Glasgow City (Exhibit 7, page 22). Orkney Islands, Shetland Islands and Eilean Siar spend more per head than all mainland areas. The higher cost of providing NHS services to remote and rural communities, for example due to extra travelling time or allowances paid to staff, is recognised in the National Resource Allocation Committee (NRAC) formula for distributing funding to the NHS. Similarly, these higher costs are reflected in a remoteness and islands allowance for councils.

35. Spending varies considerably both between and within council areas. As we highlighted in our report on health inequalities, these local differences are key to planning services but make it difficult to plan across an NHS board or council area.[25] For example, IRF data across the Lothian area shows that the ratio of money spent on planned hospital care ranged from about half to almost three times the amount spent on emergency hospital care (Exhibit 8, page 22). Organisations need first to understand why there are local differences and then, if there are specific local problems, such as areas of deprivation, they need to plan how they spend money to deal with these differences.

36. From the available information, real terms spending on social care for each person aged 65 or over increased in almost all council areas between 2002/03 and 2010/11.[26] The increase over this period in mainland council areas ranged from just over one per cent in Highland to 53.5 per cent in West Dunbartonshire.

In more recent years, spending increases are less common. Only four councils increased spending on social care for older people per head of population aged 65 or over between 2010/11 and 2011/12, in real terms.[27]

Exhibit 7
Spending by NHS boards and councils on care for people aged 65 or over, 2011/12
The money that NHS boards and councils spend varies considerably.
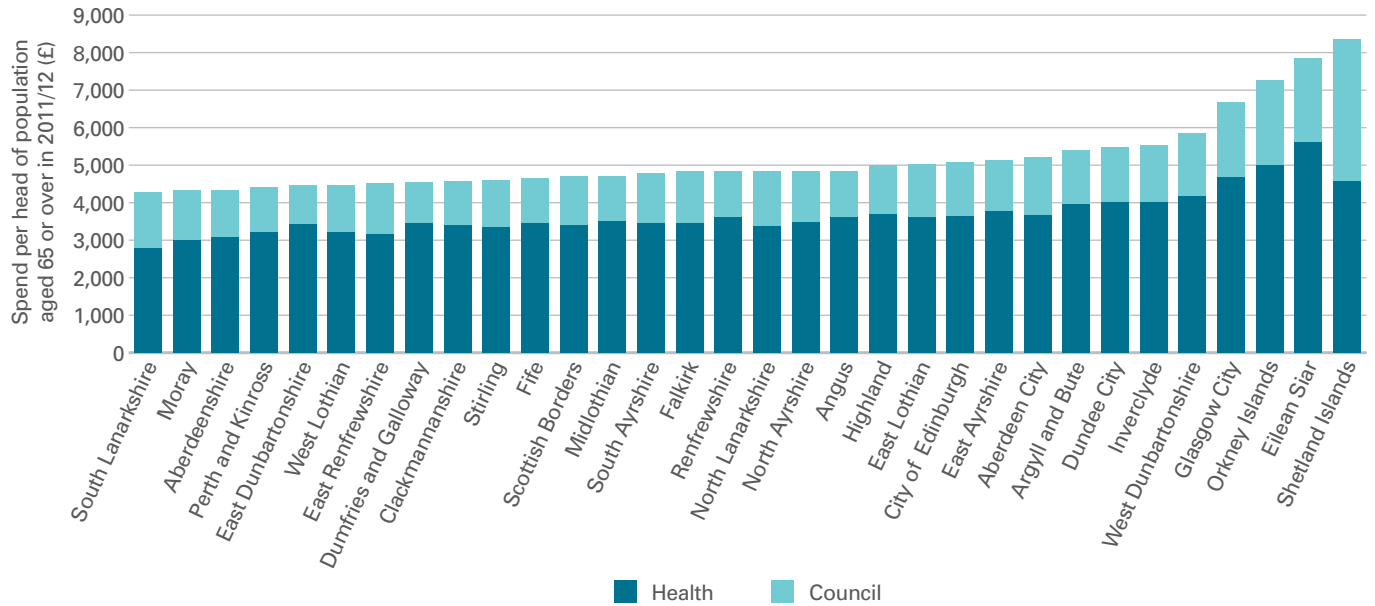
Note: Council spending figures are net of any income such as charges for services.

Source: Audit Scotland analysis of Integrated Resource Framework data, 2011/12 and mid-2011 population estimates from National Records Scotland, as at May 2012

Exhibit 8
Ratio of planned to emergency spend on hospital care for people aged 65 or over in Lothian, 2010/11
The ratio of money spent across local areas on planned or emergency hospital services varies considerably.
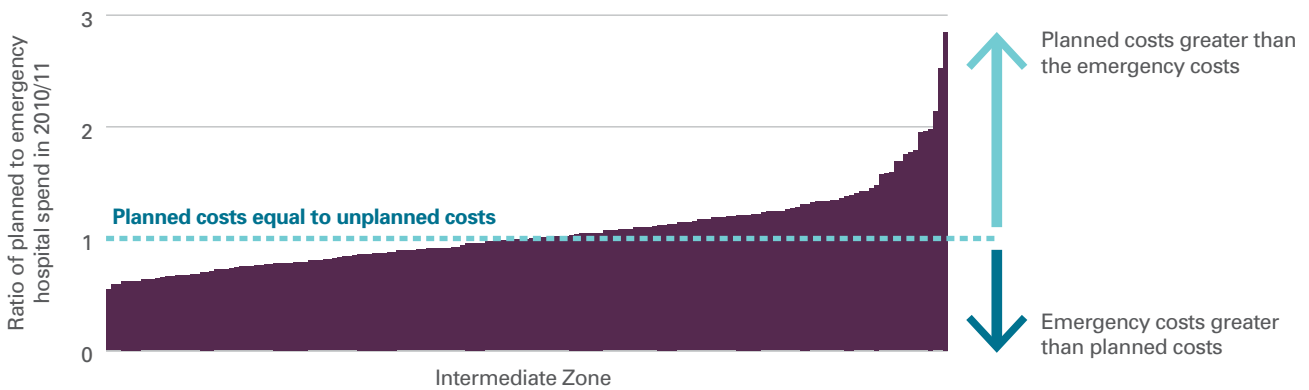
Note: An intermediate zone is a geographical area containing on average 4,000 residents. There are 177 intermediate geography zones in the Lothian area.

Source: Audit Scotland analysis of IRF data supplied by NHS Lothian

37. Both levels of spending and the way money is used vary significantly (Exhibit 9). While we would expect a degree of variation, it is not clear, based on available national data, that these differences are reasonable or in response to different local needs. It is important that NHS boards and councils have a better understanding of local variations in the types and costs of services provided to older people so that they can plan, change and monitor services as they implement RCOP.

Exhibit 9
NHS boards' and councils' spend on services for people aged 65 or over, 2011/12
How money is spent varies considerably.
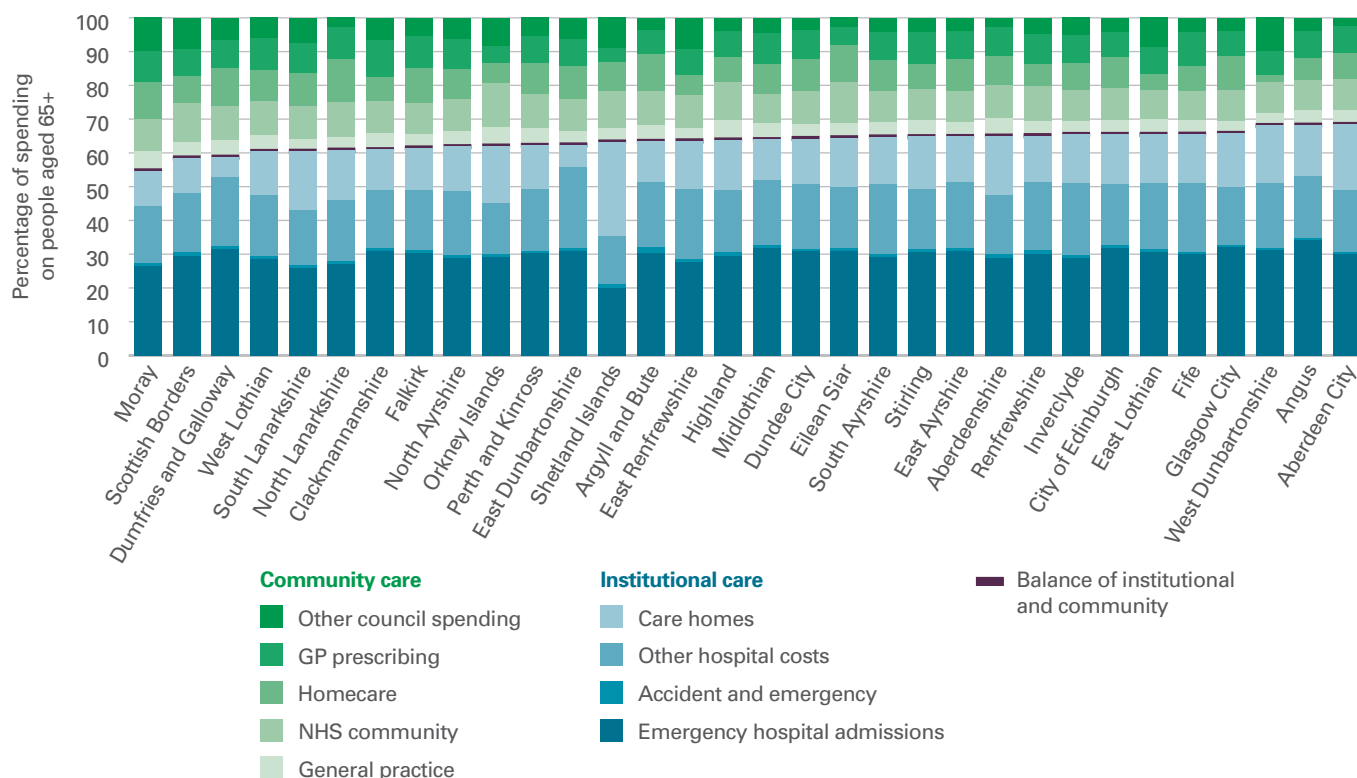
Note: Figures are net of any income such as charges for services.
Source: Audit Scotland analysis of Integrated Resource Framework data, 2011/12

38. We used available national data to estimate the percentage of older people using a range of care services in each council area in Scotland (Exhibit 10, page 24). It is not possible to tell if a person is using more than one kind of service as NHS and social care data is not linked in most areas. It is difficult to conclude much about whether money is being spent on the right services from this information due to the way it is recorded. It is also not possible to determine the extent to which people are being supported so they do not need to access traditional health or social care services. Information on the number of hours of care people receive at home is often used as a proxy for need (with more than ten hours of homecare being considered 'intensive homecare'). Census figures indicate that the percentage of homecare clients receiving intensive homecare has increased from 24 per cent in 2005 to 32 per cent in 2013. However, the numbers of people receiving homecare have fallen over this period.

Exhibit 10
Percentage of the older population using hospital and social care services, by council area
There is wide variation between councils in the percentage of older people using different services.

Hospital day case patients aged 65+

Hospital inpatients aged 65+

Emergency admission patients aged 65+

Homecare clients aged 65+

Residents in care homes for older people
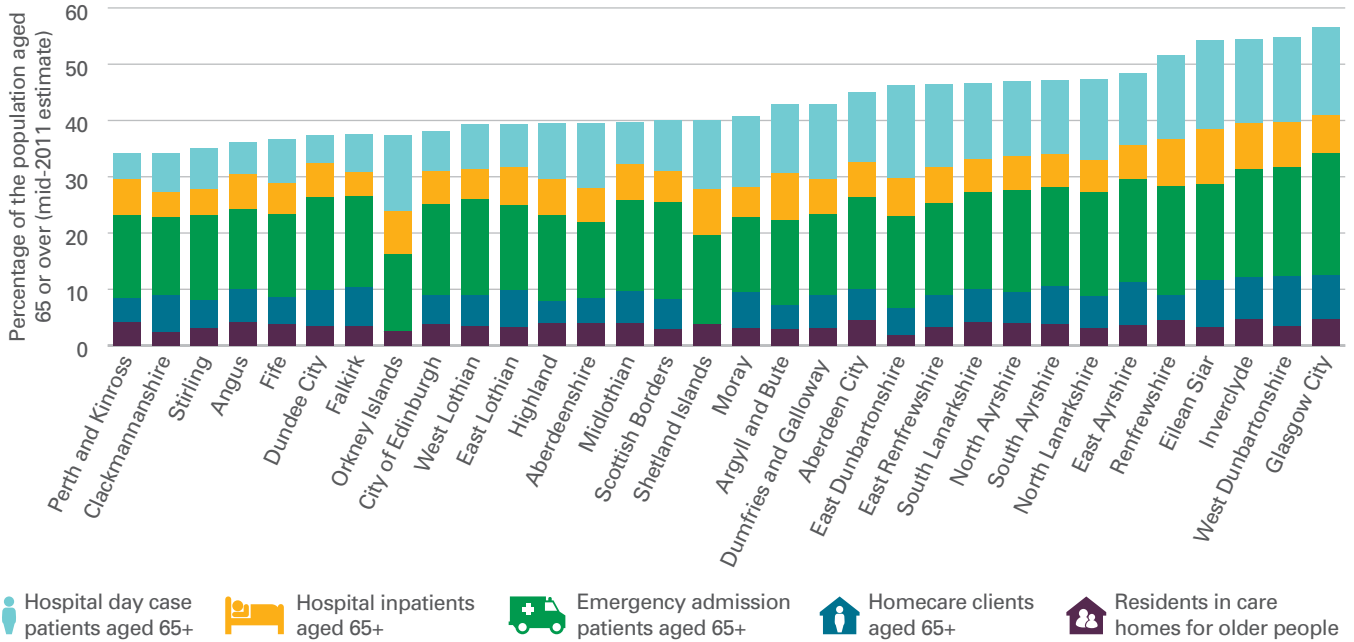
Notes:
1. Information on hospital patients is measured over the full year 2011/12. Homecare and care home clients are measured in an annual census in March 2012. We have used this data as an indication of activity.
2. As NHS and council data is not linked, there will be an element of double counting. It is not possible to say if the same people are accessing various services.
3. Information on the number of homecare clients aged 65 or over in the Orkney Islands and Shetlands Islands in March 2012 is not available, as the small numbers could threaten client confidentiality.
4. Homecare clients will not include people who use direct payments to purchase homecare.

Source: Audit Scotland analysis of ISD Scotland data and Scottish Government homecare census data and mid-2011 population estimates from National Records Scotland, as at May 2012

39. The aim of RCOP is to keep people supported at home with minimal access to services. This means that all partners need to review high levels of hospital care and more intensive homecare to ensure that this is making best use of available resources and meeting people's needs.

40. NHS boards and councils are still at an early stage of understanding potential reasons for these variations. They need to review a number of factors that may contribute to local differences when planning and managing services. These factors may include:

- Differences in people's health needs might lead NHS boards and councils to provide a different mix of services. For example, more hospital care may be needed for older people in areas with higher levels of ill health.

- Existing facilities and historical patterns of providing health services may vary. We highlighted in a previous report that the closer people live to a hospital the more likely they are to attend.[28] Similarly, people living in rural areas may have less access to services.

- In England, the Audit Commission found that 80 per cent of the variation in spending on social care for older people between council areas could be explained by several main factors outside council control:
  - higher costs were associated with councils that qualified for additional funding to meet higher costs of providing a service, for example due to variations in local rates of pay
  - higher costs were also associated with councils serving areas with a larger percentage of the older population living alone, renting their homes and claiming income-related benefits
  - lower costs were associated with areas having a higher proportion of older people in the population, suggesting possible economies of scale.[29]

Recommendations

The Scottish Government should work with NHS boards, councils and their partners to:

- improve and maintain data on cost, activity and outcomes for health and care services in local areas. This information matters as it helps local decision-makers to decide where to spend, and not to spend, public money. It should be set out clearly as part of joint strategic commissioning plans

- ensure that joint strategic commissioning plans clearly set out how partners will move resources to improve services for older people

- develop more consistent information on how much NHS boards and councils spend on different types of care for older people and the impact that services are having on older people. This is needed to implement RCOP and show how services are shifting from institutional to community care

- collect data to monitor costs and activity of health and care services for older people, specifically data on community-based services where there are currently key gaps

- do more to understand the reasons why activity and spending on services for older people vary across Scotland. They need to work with local practitioners to help:
  - use information to benchmark activity and costs
  - identify areas for improvement
  - identify good practice

- set out clear plans for how resources will shift to community services in the short and longer term.

NHS boards and councils should:

- use existing IRF data, along with information on needs and demand, to help them make decisions on how and where best to invest public money locally, and set this information out clearly as part of joint strategic commissioning plans.

Part 3
Progress with Reshaping Care for Older People
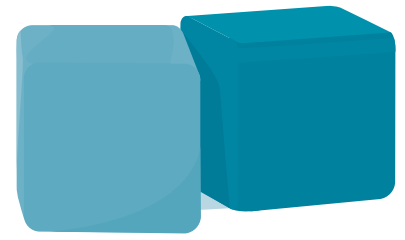
Key messages

1 There has been a focus on improving care for older people for a number of years, but the RCOP programme has yet to demonstrate how significant changes will be achieved. There is no clear national monitoring to show whether the policy is being implemented successfully and what impact this is having on older people. Strong national and local leadership is needed to take this challenging agenda forward.

2 The Scottish Government introduced the Change Fund in 2011/12 to make money available to organisations implementing RCOP. The fund is worth £300 million over four years, and the focus has been on developing partnership working and small-scale initiatives. Initiatives are not always evidence-based or monitored on an ongoing basis and it is not clear how successful projects will be sustained and expanded.

3 NHS boards and councils need to make changes at the same time as continuing to meet people's current care needs and provide services that help to prevent or delay ill health. Evidence shows that some services are under pressure. This will make changes harder to achieve.

4 NHS boards, councils and their partners must jointly plan more effectively and better understand the needs of older people and the costs associated with providing services. It is important that at a local level, health and social care staff understand and contribute to plans to improve services for older people.

5 Key barriers to change include a lack of data on community health and social care services and on services that focus on preventing or delaying health problems.

> stronger leadership and better understanding of services for older people is needed to underpin decisions about transforming services

A clearer focus is needed on what works and how to put this into practice

41. RCOP affects most health and care services. Many of the changes envisaged through RCOP require coordinated action by NHS boards, councils and the third and private sectors. The changes envisaged are often interrelated, for example emergency admissions to hospital might rise if there are not enough social care services in the local area. The policy aims to help support people so they need less access to formal services, but planning and managing community-based services is challenging, given the range of staff, different services and various locations involved.

42. We found that organisations have made some progress against the RCOP commitments but the Scottish Government does not collect information to report on progress with all of these commitments (Exhibit 11, page 28). The Scottish Government issued a progress report on RCOP in September 2013. This gives examples of local initiatives and ongoing work to develop outcome measures. It also recognises that services still need to work better together.[30]

43. For the RCOP commitments to be achieved, the Scottish Government, NHS boards, councils and the third and private sectors need to have a clearer focus on initiatives that have been shown to work, what impact the changes aim to achieve, how this will be achieved in practice and progress monitored. Scottish Government research shows that partnerships are working locally to develop mechanisms to monitor the impact of initiatives focused on improving services for older people. Organisations need to ensure that robust evaluation, including a clear focus from the outset on cost effectiveness and outcome measures, is an integral part of local initiatives and that staff have the skills to carry out evaluations. RCOP requires major system changes and NHS boards and councils are at the early stages of implementing RCOP (Case study 2, page 30).

44. Over previous years, the Scottish Government has set up a number of different groups and initiatives to improve services for older people. In 2013, the Scottish Government reduced the number of groups that were involved in supporting RCOP. The Older People's Development Group, which includes representatives from public, third and private sector organisations, is the main group for taking the policy forward. The group is working with the JIT and others to monitor the progress that local partnerships are making with RCOP.

45. We have previously reported on the slow progress with commissioning social care services in Scotland.[31] Good commissioning is essential to change how services are delivered and resources used locally. In 2013/14, NHS boards, councils and third and private sector partners were required to work together to produce Joint Strategic Commissioning Plans for the first time in Scotland. These set out the services they planned to commission. The JIT reviewed these plans and reported:

- well-analysed information about population health and wellbeing, although there was still room for improvement

- good engagement with service users, carers and members of the public

- few details about how hospital resources, such as money but also clinical staff, would move into the community through RCOP

- a lack of information on the costs of services or on the services that people need

- most plans mentioned outcomes, but these were not always well defined and it was unclear how they would be monitored in practice.

Exhibit 11

Progress against RCOP commitments

Some progress has been made against RCOP commitments to date

	Commitments	Direction of travel	Progress
1	We will double the proportion of the total health and social care budget for older people that is spent on care at home over the life of this plan.	↓	Based on IRF figures, in 2010/11, 9.2 per cent of the total health and social care spending on people aged 65 or over was spent on homecare. In 2011/12, this reduced slightly to 8.7 per cent.
2	We will build the capacity of third sector partners to help them do more to support the experience, assets and capabilities of older people.	↑	The Change Fund means that the third sector is now more involved in planning local services. But the Change Fund represents only a small percentage of the money available for older people's care.
3	We will introduce a £70 million Change Fund for 2011/12 and in the region of £300 million over the period 2011/12 to 2014/15 to stimulate shifts in the totality of the budget from institutional care to home and community-based care and enable subsequent decommissioning of acute sector provision.	↔	The Change Fund has been introduced but as yet there is no evidence that it has stimulated organisations to spend more on community-based services rather than on institutions such as hospitals. The IRF is included in strategic commissioning plans but this is at an early stage and few partnerships have set out how they plan to reduce acute hospital services.
4	We will shift resources to unpaid carers, as part of a wider shift from institutional care to care at home.	↑	The Change Fund has provided about £35 million to help unpaid carers, directly and indirectly. This includes paying for respite carers or day services so carers can take a short break from their caring responsibilities.

Overnight respite care for people aged 65 or over increased by seven per cent from 37,607 weeks in 2010/11 to 40,326 weeks in 2012/13. Daytime respite care also increased by one per cent over this period from 65,645 to 66,406 weeks. |
| 5 | We will improve quality and productivity through reducing waste and unnecessary variation in practice and performance with regard to emergency admissions and bed days across Scotland. | ? | Emergency admissions for older people have increased. See below for information on changes to the amount of time patients spend in hospitals. The Scottish Government has not defined what it means by 'waste' and 'unnecessary variation'. |
| 6 | We will aim to reduce rates of emergency bed days used by those aged 75 or over by a minimum of 20 per cent by 2021 and at least ten per cent by 2014/15. | ↑ | Rates of emergency admission bed days in Scotland for people aged 75 and over have decreased by 9.5 per cent from 5,396 per 1,000 population aged 75 or over in 2009/10 to 4,881 in 2012/13.

The current HEAT target is to reduce the rate of emergency admission bed days for people aged 75 or over by at least 12 per cent between 2009/10 and 2014/15. |

Exhibit 11 (continued)

Commitments	Direction of travel	Progress
7 We will ensure older people are not admitted directly to long-term institutional care from an acute hospital.	**?**	National data is not available to measure this. However, the rate of long-stay residents in care homes has decreased over time.
8 All older people aged 75 or over will be offered a telecare package in accordance with their assessed needs.	**?**	Rates of telecare for people aged 75 and over have increased from 185.1 per 1000 population in 2011 to 186.4 in 2013. There is no centrally available information available on assessed needs to determine whether all people aged 75 or over with an assessed need for telecare received it.

⬆ Improving ⬇ Not improving ⬅➡ No evidence of change **?** No evidence

Note: The HEAT performance management system for the NHS in Scotland covers indicators relating to Health improvement, Efficiency, Access to services and Treatment appropriate to individuals.

Sources: IRF data 2010/11 and 2011/12, ISD Scotland; Homecare statistics, Scottish Government, 2012; Social care statistics, Scottish Government, 2013; Audit Scotland analysis of 2012/13 Change Fund Plans, 2013; Respite care statistics, Scottish Government, 2012; Emergency admissions for patients aged 75 and over, ISD Scotland, 2013

46. The Scottish Government has identified that strategic commissioning is an important area for development for NHS boards and councils to address RCOP and take forward the integration of health and social care. To progress this, the JIT launched a support programme in May 2013, which includes a learning framework to support better skills in strategic commissioning and targeted support to local partnerships where specific gaps in commissioning skills have been identified.

47. The JIT has an important role to support NHS boards and councils to implement RCOP. To date, the JIT has facilitated local discussions and supported partnerships to develop their approach to improving services for older people and share examples of local practice. Given the scale of the RCOP programme, it is important that the JIT has a clear focus on supporting NHS boards, councils and their partners by identifying what works, the impact that initiatives can have on older people and other services, and on ensuring that these successful initiatives are rolled out across Scotland.

Case study 2
RCOP in Perth and Kinross

The population in Perth and Kinross is approximately 149,500 of which about 20 per cent of people are aged 65 or over. Perth and Kinross has the highest projected growth rate of older people in Scotland and the number of people aged 65 or over is expected to increase by 40 per cent between 2011 and 2027.

NHS Tayside and Perth and Kinross Council have shown clear leadership in taking this agenda forward and are working together to promote the independence and wellbeing of older people at home or in a homely setting. The NHS board and council have developed a joint commissioning strategy. Underpinning this is a focus on:

- redesigning systems to ensure people can get home from hospital as quickly as possible

- providing community-based alternatives to admission to hospital or long-term residential care to increase the options available for people including support for carers

- improved support for people with dementia and their carers

- working with communities to develop services to enable older people to remain active.

A number of services have been established in the area to support RCOP, including a rapid response service; a hospital link coordinator; and a chronic obstructive pulmonary disease (COPD) home support service. These aim to support carers and older people and help to keep people cared for at home as long as possible.

The NHS board and Perth and Kinross Council are using patient-level IRF data to work with local GPs to understand how services are being used and to try to change how older people receive care and support in Perth and Kinross. This work is at an early stage and the impact this could have is as yet unknown, but reflects a focus on changing the culture across the health and care system.

Staff from the NHS board and the council have met with a small number of GPs to talk through local IRF data for their GP practice. This information shows the costs of health and social care provided to the older people registered at the GP practice. These discussions are a useful first step in working with local practitioners to better understand the impact that clinical decisions have on resources and to help identify gaps in services and better ways of using resources at this local level. This approach needs an investment of time from the NHS board, council and the GP practice, and a shared interest in learning from the local data to consider how best to change services to improve care for patients.

Source: NHS Tayside

It is not clear what effect services are having on older people

48. In April 2011, the JIT published core measures to help partnerships track their progress in implementing RCOP; these measures were not intended to be reported nationally. It developed the core measures in consultation with national and local stakeholders and aimed to link them to existing performance measures including:

- the Quality Measurement Framework

- the Community Care Outcomes Framework (CCOF)

- the National Performance Framework (which includes the performance framework for the NHS – known as HEAT).

49. JIT's mid-year review in 2011/12 found that partnerships did not understand some of the measures set out above or use them well. In April 2012, the Scottish Community Care Benchmarking Network and the JIT produced a report on their review of the CCOF. They concluded that organisations are not reporting outcomes comprehensively or consistently. They recommended that a single set of outcomes and indicators are developed for both RCOP and the integration of health and social care. A draft single set of health and care outcomes was included in the consultation document for the Integration of Adult Health and Social Care in May 2012. The intention was to ensure that all organisations are working to the same national outcomes.

50. In December 2012, the Scottish Government published revised Single Outcome Agreement (SOA) guidance. This directed Community Planning Partnerships to focus on six national priorities when developing their local outcomes. Only half of the SOAs submitted to the Scottish Government in 2013 contain local outcomes that are specific to older people.

51. NHS Health Scotland is currently developing a series of outcomes to underpin RCOP which will be published in spring 2014. Links between these outcomes and those set out for health and social care integration need to be clearly set out. In November 2013, the Scottish Government issued a survey to a sample of older people in Scotland to inform the development of outcomes. Without good information on outcomes, it is not possible to determine how RCOP is improving the lives of older people in Scotland.

52. In 2001, the Government introduced National Care Standards. The standards explain what people can expect from any social care service, are written from the point of view of the person using the service and show how to raise concerns or complaints. The standards have not been revised since they were introduced and the Scottish Government is currently reviewing them. This review needs to take account of changes to the way services are delivered and consider how to reflect outcomes from integrated health and care services.

The Change Fund has brought partners together but has yet to demonstrate how lasting changes will be achieved

53. In 2011/12, as part of RCOP, the Scottish Government introduced a £70 million Change Fund for older people's care. The fund will operate until 2014/15, and it is worth £300 million over the four-year period. The Change

Fund represents 1.5 per cent of all spending on older people in 2011/12. The Scottish Government distributed the Change Fund to local partnerships through NHS boards.[32] The annual amount allocated to individual partnerships in 2012/13 ranges from just under £370,000 in Orkney Islands to about £9 million in Glasgow City. The Scottish Government designed the Change Fund to help organisations develop new ways of delivering services. To get access to the fund, each partnership must submit a Change Fund plan each year, showing how the money will improve outcomes for older people.[33]

54. Partners did not have long to prepare initial Change Fund plans and this contributed to delays in starting local projects. Twenty-four out of 31 partnerships reported that they did not spend their full Change Fund allocation for 2011/12.[34] The total underspend was about £22 million (30 per cent of the fund). Partnerships were allowed to carry this forward into the 2012/13 allocation of £80 million.[35] Partnerships report that they expect to spend 93 per cent (£140 million) of the total Change Fund that was allocated in the first two years (£150 million).

55. The Scottish Government issued guidance on the information that partnerships were required to submit in their Change Fund plans, and requirements were different in each year. This made it difficult to compare how partnerships spent their money, and what they spent it on, over the two years. The JIT analysed partnerships' 2011/12 Change Fund mid-year progress reports to indicate the main areas of investment. However, due to inconsistencies in the way partnerships reported information, the analysis does not account for the full Change Fund allocation for 2011/12. The Scottish Government will publish an evaluation of the Change Fund in 2015. When issuing future Change Fund resources, it is important that the Scottish Government sets out clear criteria for success. These should focus on ensuring that the money is used to deliver measurable improvements to services that can be sustained in the longer term and then spread to become part of routine core business.

The Change Fund has brought partners together to think about how to design services for people in the local area

56. The main achievement reported by partnerships in 2012/13 mid-year progress reviews was improved partnership working. Partnerships also reported that the Change Fund had helped people who use services and their carers to be more involved in developing services to better meet their needs. While organisations have been working in partnership for some time it is clear that the extent of this has been variable across Scotland.[36] The Change Fund has helped improve the involvement of the third sector in planning services in many areas of Scotland. In terms of changes to services, partners highlighted initiatives to support local communities and help prevent ill health.

57. The most common challenge that partners identified in progressing Change Fund initiatives and delivering improved outcomes was how to increase the pace and scale of change required. Other challenges included:

- the length of time taken to establish partnership arrangements and new working cultures

- recruitment difficulties, for example skills shortage or being unable to recruit staff as quickly as required

- getting private sector organisations more involved in the plans and new ways of working.

58. Partnerships' mid-year progress reviews of their Change Funds demonstrate little evidence that they are moving towards the significant change called for in RCOP. We examined the mid-year progress reviews and found:

- most initiatives funded by the Change Fund have been short-term and small-scale. It is not clear how partnerships are planning to sustain these changes in the longer term

- few partnerships have demonstrated how the Change Fund will reduce institutional care, for example in a hospital or care home, or increase community-based services such as care at home

- there is little evidence that the Change Fund is significantly influencing spend on care for older people. A number of partnerships stated that it was too early to demonstrate a change in spending, or they did not have enough evidence to decide to stop spending in a particular area of institutional care. Twelve partnerships provided examples of how they had stopped spending on some services, such as reducing the amount of money they spent on care home places or by closing beds in community hospitals

- the performance information that partnerships provide in their Change Fund plans is not consistent. Some partnerships include data without referring to baselines, targets or trend data. This means that it is not possible to assess either individual partnership performance or to draw conclusions about national performance against RCOP

- a lack of detail about the impact that initiatives are having on reshaping care for older people. A number of partnerships stated that it was too early to demonstrate impact, or that they needed better performance management systems. The JIT is helping partnerships to demonstrate the impact of initiatives, but recognises how difficult it is to attribute improved performance to Change Fund initiatives alone as these are often part of a wider programme of activity.

59. In November 2013, after the fieldwork for this audit was complete, the JIT published a progress report on the Change Fund based on self-assessment from local partnerships. The report shows signs of progress in several key areas. Partners reported:

- how Change Fund allocations were spent, against a series of categories: 26 per cent on preventative and anticipatory care; 26 per cent on proactive care and support at home; 23 per cent on effective care at home at times of change; 12 per cent on hospitals and long-stay care homes; and ten per cent on enablers, for example developing joint commissioning.

- they are using information from the Change Fund projects to help inform how they commission services in the future

- few had applied options appraisal processes but all had developed structured assessment criteria for new projects

- examples of evaluating the effectiveness of initiatives supported by the Change Fund and in some cases where initiatives were found not to have worked the projects were stopped or put on hold

- challenges in recruiting staff to support Change Fund initiatives

- the extent to which they have plans to spread new approaches and initiatives where these have been assessed as demonstrating a positive impact on older people. About half of partnerships reported that they had spread a series of initiatives to all areas, including early diagnosis of dementia, respite and support for carers, timely assessment and specialist support for care homes.

The Change Fund reflects the important role of carers but better information is needed on the fund's impact

60. RCOP highlighted the important role that carers, and the wider local community, have in supporting older people. Ensuring that carers have the right kind of services when they need them may allow them to care for longer. This, in turn, reduces the need for formal care services for an older person. Carers in our focus groups were reluctant to take up services and, in some cases, were not aware that services were available. As part of the Carer's Week campaign, a partnership of national charities explored the impact that caring has on people's lives.[37] Based on responses from 150 carers in Scotland, the partnership found that:

- 77 per cent of carers are not prepared for all aspects of caring

- 83 per cent of carers are not aware of the support available

- 35 per cent of carers had received wrong advice about the support available.

61. In 2012/13, the Scottish Government added a requirement that partners spend at least 20 per cent of the Change Fund on supporting carers. This amounted to almost £50 million between 2012 and 2015. There was a significant focus on resources for carers, but less of a focus on whether partnerships were investing the Change Fund where it was most needed or checking that it was having the biggest impact on outcomes for older people and their carers. The JIT reviewed the 2012/13 Change Fund plans and reported that partnerships were spending more than the required 20 per cent on supporting carers. The JIT also developed guidance, helped share good practice and worked with partners on improvement plans in relation to work on carers.

Local communities have an important role in supporting older people

62. Supportive local communities can help to care for older people and allow them to live with greater independence. They can also help reduce isolation and loneliness, improve health and wellbeing and delay the need for more formal care services. Community support includes initiatives such as transport, activity groups, lunch clubs and respite care. The JIT reviewed NHS board and councils' work with communities and concluded that it is very difficult to measure any impact that these initiatives have had.

63. In order to try and address the difficulty in assessing impact, third sector organisations in Midlothian, West Lothian, East Lothian and City of Edinburgh are taking part in *A Stitch in Time*. This project aims to help the third sector evidence how they help older people to avoid future use of health and care services and how they improve older people's lives.

Making major changes to services while demand rises is challenging

64. Organisations tasked with improving services for older people need to do this while managing current demand for NHS and social care services. Our analysis of all national information on care for older people indicates rising pressure on the system, particularly on hospital services (Exhibit 12). It is unclear from available data if some of these changes are evidence of improvements or pressures on services. Achieving significant changes to the care for older people while dealing with more demand for hospital services, such as emergency and planned admissions, is challenging.

Exhibit 12
Changes in hospital activity 2002/03 to 2012/13
There is rising demand for hospital services.

Hospital services	Admissions for patients aged 65 or over	Increase/decrease 2002/03 – 2012/13
Short emergency admissions[1]	Admissions for less than one day increased by 79 per cent	▲
	One-day emergency admissions increased by 26 per cent	▲
	Emergency admissions lasting at least two days increased by 4 per cent	▲
Emergency admissions	The rate of admissions to hospital increased by 10 per cent However, between 2011/12 and 2012/13, rates for people aged 65 or over decreased slightly	▲
	The increases in emergency admissions reflect the increasing number of patients who are admitted to hospital in an emergency on multiple occasions	▲ multiple admissions
	Emergency admissions to hospital increase with age	▲ with age
Planned admissions	Planned day case admissions to hospital	▲
	Planned inpatient admissions	▼

Note: 1. Short emergency admission increase/decrease dates from 2003/04 to 2012/13.

Source: Audit Scotland analysis of data requested from ISD Scotland, 2013

65. Effective primary care may be able to prevent an emergency admission to hospital for a series of conditions. These are sometimes referred to as potentially preventable hospital admissions and include influenza, pneumonia, hypertension, and ear, nose and throat infection. The rate of potentially preventable hospital admissions has remained relatively stable, from 4,552 per 100,000 population aged 65 or over in 2002/03 to 4,550 in 2012/13.[38] NHS boards should continue to focus on reducing admissions for these conditions. We have highlighted in previous reports the important role of the GP and that they are responsible for directing significant health and care resources. Some local areas are beginning to work with GPs to better understand how resources are being used and to start to change the way services that older people receive are delivered.

66. A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. This can be distressing for patients and their families. Delays also reduce the number of available hospital beds for other patients.[39] Minimising delayed discharges involves effective working between health and social care services. Older people are more likely to experience a delay in their discharge. In each census between January 2009 and July 2013, at least 90 per cent of patients experiencing a delay of more than three days were aged 65 or over and between 40 and 50 per cent were aged 85 or over.

67. In the July 2007 census, 937 people aged 65 or over were delayed in hospital by more than three days. This had fallen to 583 in the July 2013 census.[40] For delays of more than three days, the most common reason was that the patient was waiting for an assessment to see what kind of support they need to go home, such as help at mealtimes.[41] The most common reason for a delay of over six weeks was waiting for a care home place.

68. Despite progress towards successive delayed discharge targets, 305,696 bed days were occupied by patients aged 75 or over whose discharge was delayed in 2012/13.[42] This is the equivalent of over 837 hospital beds being occupied for a year by patients aged 75 or over who are clinically ready to leave hospital.

National data has not kept pace with policy changes

69. The Scottish Government collects data on hospital and care services at a national level but the available data has limited capacity to monitor performance, progress with RCOP or to help identify good practice and areas for improvement. Data show a lot of local variation but do not help to understand whether services are good or need to be improved. For example, high levels of activity, such as people being admitted to hospitals, may show that people have access to the services that they need; or it could mean that people are using a service that they do not require. Low levels of activity could suggest that people are not receiving health or care services that they need; or this may show that older people have been helped to live independently and do not need access to NHS or care services. Tools that can assess people's care needs in the community in a standard way are not currently widely used (Case study 3, page 37).

Case study 3
Using the Index of Relative Need to measure dependency

The Index of Relative Need (IoRN) is a tool developed by the Scottish Government and ISD Scotland in 2003, to assess how independent or dependent the older person is at the time of an assessment or review. A person is assigned to one of nine dependency groups based on answers to a series of questions about themselves. A modified version of the IoRN can measure dependency in older people in a care home setting.

Professionals can use this tool to check a person's results over more than one assessment. They can also use it to measure a person's independence over time. So, for example, they can compare a person's IoRN score before an intervention such as reablement, and then compare it with a score later on, for example a month, six months or a year. There are some concerns that IoRN may not be sensitive enough to capture levels of dependency for people who need lower levels of support, the JIT are piloting a revised tool to try to address this concern.

Councils can submit IoRN scores on homecare clients to the Scottish Government so it can build up a national picture. Not all councils provide this information. In 2012, only eight per cent of older people's records that councils sent to the government contained this information, although locally many councils do collect data.

Source: Joint Improvement Team

A better understanding of data on community services and workforce is needed

70. Partners need to better understand data in several important areas to improve services and meet needs:

- Care at home: there is a lack of information on the need for care at home. NHS boards and councils need to use available data and consider if these show that services are effectively focusing on the people who need them most, or if these suggest some people are not getting access to shorter, less intensive support to help support them at home. There are other problems with homecare figures, for example they do not include people who use direct payments to buy homecare.

- Primary care: this is often the main point of contact between patients and the NHS, with GPs playing an important coordinating role in managing a person's health. However, national data on primary care services is limited. The only nationally available information on patients consulting their GP is an estimate based on data from a representative sample of 60 GP practices in Scotland. ISD Scotland stopped collecting these data in September 2013. A replacement for this information, which will improve the data gathered from GP practices by collecting more comprehensive information, is under development. This is planned to be available by the end of 2014. There is a lack of information on the work undertaken by important NHS primary and community services such as district nurses, health visitors, chiropodists and podiatrists. During 2014/15, ISD Scotland will work with local partnerships to improve the availability of national data on community services.

- Initiatives to support people at home: there is no national data on specific services that aim to support people in their own homes, such as reablement services. Reablement is a service that helps people learn, or relearn, skills they need to live at home. Many local initiatives attempt to improve care for older people. But these are often small-scale and there is not strong evidence to show their impact on people, costs and wider resources such as the NHS (Exhibit 13, page 39).

- Joint data: NHS and social care data is not linked. This makes it impossible to tell if the same people are using NHS and council services at a national level. There are examples of local systems in use to help staff to support people who access both health and care services. Two areas, Lothian and Tayside, have started to deal with this issue (Case study 4, page 42)

- Workforce: there is a lack of information on the current workforce, specifically for community services, and on the skills and staffing needed to deliver different services in the future. Integrated workforce planning across health and social care services is needed to support RCOP.

There is a greater focus on quality of care and joint inspections are being piloted

71. Significant changes to the inspection arrangements for older people's services have been made. In 2012, Healthcare Improvement Scotland (HIS) introduced inspections of the care of older people in acute hospitals. These inspections assess NHS boards against a range of standards and best practice statements. The clinical standards for older people in acute healthcare have not been updated since 2002. Twenty inspections have so far taken place in 11 NHS boards.[43] HIS publishes an individual report on each hospital inspection and six-monthly summaries of results.[44] Across all inspections to date, HIS identified:

- 76 areas of strength, including improved services for patients with dementia

- 242 areas for improvement

- 31 areas for continuing improvement, many of which relate to the need for more personalised care for older people.

72. The Care Inspectorate assesses how well councils develop and deliver their statutory responsibilities for social work services. It also regulates and inspects registered care services across Scotland, including over 900 care homes for older people. In 2008, a new grading system was introduced which evaluates services against four quality themes: care and support; environment; staffing; and management and leadership.[45] The Care Inspectorate publishes reports, which include quality grades, for each inspection it carries out.

73. Detailed reports are available on the quality of older people's care, but these are separate for health and social care services (Exhibit 14, page 40). There is also a lack of focus on community-based NHS services, which have a key role to play in improving care for older people. To prepare for health and social care integration, the Care Inspectorate and HIS are testing joint inspections of older people's services in Scotland, beginning with the three partnership areas of Perth and Kinross, Inverclyde and West Lothian. The new integrated health and care system needs to be underpinned by joint scrutiny, focused on consistent measures of quality and performance.

Exhibit 13

Local initiatives to improve care for older people

There are a wide range of local initiatives aimed at supporting older people at home.

Hospital at home	Patients are referred to the service, often by their GP or the emergency department. Members of a multidisciplinary team visit them in their own home, with the aim of avoiding an admission to hospital. For some patients, this can have the same outcomes as inpatient care with similar or lower cost.[1] Some evidence suggests older people receiving hospital at home are more likely to be readmitted to hospital.[2] There is evidence from North Lanarkshire that indicates a hospital at home model may help to avoid hospital admissions for older people.
Reablement	This time-limited service (usually about six weeks) helps individuals to learn or relearn skills necessary for daily living. Older people may be referred to the service from the community, or as part of the hospital discharge process. The majority of people need fewer hours of homecare following reablement.[3] There is evidence that this reduction can be sustained over a year.[4] People with fewer hours of homecare prior to reablement tend to have better results. There is evidence of improvements in wellbeing following reablement.[5] Higher upfront costs may negate future savings through reducing homecare, meaning the costs for reablement users and regular homecare users are similar over a 12-month period.[6]
Virtual ward	Patients at high risk of an emergency hospital admission are targeted for this intervention which aims to reduce the chance of hospital admission. Patients receive care in their own home from multidisciplinary community teams. The teams use daily routines similar to hospitals to monitor and care for patients. There is no evidence of reduction in emergency admissions in three different evaluations.[7]
Telecare	This involves a range of technologies and devices, such as alarms and sensors, fitted in a home. These can be remotely monitored with the aim of detecting problems and responding in an emergency. Some research found no difference in the numbers of people being admitted to hospital in an emergency or being admitted to residential care over 12 months between people given telecare and those who were not. There were also no differences in hospital or social care costs between the two groups.[8] An evaluation of the telecare development programme in Scotland found that 60 per cent of telecare users sampled thought their quality of life was 'a bit better' or 'much better' than before they had telecare equipment. Ninety-three per cent of respondents felt safer and almost 70 per cent felt more independent.[9]

Notes:

1. 'Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data', S Shepperd, H Doll, R M Angus, M J Clarke, S Iliffe, L Kalra, N Aimonio Ricauda, V Tibaldi, A D Wilson, *Canadian Medical Association Journal*, 2009.
2. *Hospital at home admission avoidance*, Cochrane Review, 2010.
3. *Evaluation of City of Edinburgh Council Reablement Service*, Scottish Government Social Research, 2009.
4. *Reablement: a cost-effective route to better outcomes*, Social Care Institute for Excellence, 2011.
5. *Home care re-ablement services: investigating the longer-term impact*, Social Policy Research Unit/Personal Social Services Research Unit, 2010.
6. Ibid.
7. *Evaluating integrated and community-based care: How do we know what works?* Nuffield Trust, 2013.
8. *Effect of telecare on use of health and social care services: findings from the Whole Systems Demonstrator cluster randomised trial*, Age and Ageing, 2013.
9. *Evaluation of the Telecare Development Programme*, Scottish Government, 2009.

Source: Audit Scotland

Exhibit 14
Summary of findings from HIS and Care Inspectorate reviews of services
Healthcare Improvement Scotland and the Care Inspectorate have identified a number of areas for improvement.

Healthcare Improvement Scotland (acute hospitals)	Care Inspectorate (care homes)	Care Inspectorate (homecare)
Coverage:		
Between January 2012 and October 2013 there were 20 inspections, comprising 16 announced and four unannounced inspections. 17 hospitals inspected across 11 health boards.	Inspects about 900 care homes for older people. A risk-based assessment is used to determine the frequency and intensity of inspections.	Inspects about 800 homecare services. A risk-based assessment is used to determine the frequency and intensity of inspections.
Summary of positive findings		
• In most cases, staff treat older people with compassion, dignity and respect. • Patients and their visitors are generally positive about the care older people receive. • Hospitals are improving services for dementia patients. This includes adopting the National Dementia Champions' Programme, appointing specialist nurse consultants and improving the hospital environment (eg, better signage)	• 21 per cent of care homes for older people were rated very good or excellent across all four quality themes at 31 March 2013. This is an improvement on each of the four previous years. • 18 out of 905 care homes were rated unsatisfactory or weak across all four quality themes at 31 March 2013. • The percentage of care homes rated as good, very good or excellent has improved since 2008/09 for each of the individual quality themes.	• 39 per cent of homecare services were rated very good or excellent across all four quality themes at 31 March 2013. This is an improvement on each of the four previous years. • 16 out of 814 care at home services were rated unsatisfactory or weak across all four quality themes at 31 March 2013.
Summary of areas for improvement		
• The care delivered to patients is not always person-centred, for example staff do not always consider patient confidentially and sometimes use inappropriate language in front of patients.	• For each of the individual quality themes the grading profile for older people's care homes is poorer than for other adult care services, including day care and care at home.	• 202 complaints were upheld, or partially upheld, against homecare services in 2012/13. This figure has increased year on year for the past four years.

Cont.

Exhibit 14 (continued)

Healthcare Improvement Scotland (acute hospitals)	Care Inspectorate (care homes)	Care Inspectorate (homecare)
Summary of areas for improvement (continued)		
• There is a lack of personalised care plans or personalised information about patients identifying their specific needs, for example: – patients are not always screened for cognitive impairments – nutritional care plans are not always developed – assessments to identify patients at risk of developing pressure ulcers are not consistently carried out. • As a result, the care patients receive is not always as effective as it should be, as the most appropriate treatment to meet their needs is not known.	• 557 complaints were upheld, or partially upheld, against care homes for older people in 2012/13. This is more than any of the previous four years. • 14 care homes for older people had five or more complaints upheld in 2012/13, including one with 12. • At 31 March 2013, 193 care homes for older people were regarded as high risk. This was an increase from 158 at 31 March 2012. • In 2012/13, 20 enforcement notices were issued against 14 different care homes for older people.	• Nine homecare services had five or more complaints upheld, or partially upheld, in 2012/13, including one with 13.

Note: Homecare services are not exclusively services for older people.

Source: Healthcare Improvement Scotland and Care Inspectorate data

Case study 4
Sharing data in Lothian

NHS boards and councils in the Lothian area have linked their health and social care data at individual level through the Integrated Resource Framework (IRF). This data is anonymised, but allow the board and councils to track how individuals are using different services.

In Lothian, research and information managers at the City of Edinburgh Council have used this linked data to establish a series of indicators. These show the pattern of how older people, who are receiving social care services, use the health service. The linked information has also been used to track the care of individuals who move to residential care. This allowed partners in Lothian to look at where most care activities, such as care homes and other services, are located.[1] They can then identify:

- how these locations fit in with where patients live

- the varying costs of services being provided by independent service providers

- the potential for offering an appropriate alternatives to the existing services.

NHS boards and councils in Lothian are in the early stages of interpreting their data. This information will help them understand how older people living in their area move between services, and how this affects costs. It will also help the NHS boards and councils make decisions about how to change services, and evaluate the impact of any changes.

Note: 1. *Evaluation of integrated resource framework test sites*, Scottish Government, 2012.
Source: NHS Lothian

Recommendations

The Scottish Government should:

- set out clear measures for success when a new policy is introduced. The Government should monitor progress and publicly report on performance against these measures and use them to underpin local commissioning and scrutiny. These indicators should include measures that cover outcomes, quality, community services and services to prevent or delay ill health

- learn from the approach taken to the Change Fund, ensuring that, for any new initiatives, arrangements are put in place to monitor, routinely and consistently, impact and how public money is being used

- make information on the quality of care for older people across Scotland more accessible and easier to understand. In doing this, continue to support the development of joint inspections by Healthcare Improvement Scotland and the Care Inspectorate, particularly in light of plans to integrate health and social care services.

The Scottish Government should work with NHS boards, councils and their partners to:

- ensure that for the remainder of the Change Fund, it is clear how the money has been spent, the impact initiatives have had on older people and other services, how much initiatives have cost and how successful initiatives will be spread

- use a consistent tool to assess dependency in older people. This information is important to ensure that needs are met and to help inform planning future services

- produce integrated workforce plans for health and social care services, that underpin RCOP, to ensure staff with the right skills and experience are in place to deliver the care needed in each local area.

NHS boards, councils and their partners, supported by the Joint Improvement Team and other national bodies, should:

- make better use of available data, focusing on understanding reasons for variation in activity and spend, and reducing unexplained variation

- monitor and spread successful projects by ensuring that initiatives aimed at improving services for older people have evaluation built in from the start to show how cost effective they are and how they are performing

- identify initiatives that have had a positive impact on older people and:
    - specify how much they cost and the impact on other services
   - be clear how they can be sustained in the longer term.

Endnotes
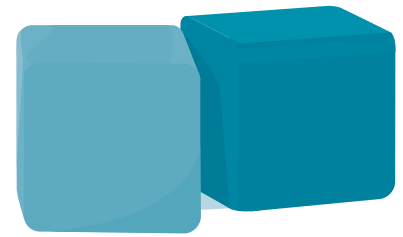
◀ 1 Population estimates by National Records of Scotland. People aged 65 or over account for 17 per cent of the population in 2010 and 2012. Population projections up to 2035 are based on 2010 figures, so we have used the 2010 figure here for comparability.

◀ 2 Audit Scotland analysis of Homecare Statistical Release 2012, Care Home Census 2012, Balance of Care/Continuing Care Census 2012, and National Records of Scotland 2012 Mid-year Population Estimates. This figure includes long-stay residents in care homes and patients in NHS continuing care beds, that is, beds for patients who need regular specialist clinical supervision due to complex or intense needs; or need frequent, but not predictable clinical interventions; or routinely need treatment or equipment that requires specialist NHS staff; or have a rapidly degenerating or unstable condition that requires specialist medical or nursing supervision.

◀ 3 *Caring in Scotland: Analysis of Existing Data Sources on Unpaid Carers in Scotland*, Scottish Government, 2010. The age estimate is based on figures from the 2001 census.

◀ 4 *Reshaping Care for Older People – A Programme for Change 2011–21*, Scottish Government, COSLA and NHS Scotland, 2010. The programme reflects the Scottish Government's *20:20 Vision* (September 2011) and *Healthcare Quality Strategy* (May 2010) policy documents. The *Healthcare Quality Strategy* aims to help 'deliver the highest quality healthcare to the people of Scotland and ensure that the NHS, local authorities and the third sector work together, with patients, carers and the public, towards a shared goal of world-leading healthcare'. The *20:20 Vision* is underpinned by the *Healthcare Quality Strategy.*

◀ 5 The Bill will replace Community Health Partnerships. NHS boards and councils will need to develop one of two models available. The body corporate model involves the NHS board and council delegating functions to a joint board headed by a chief officer. Through the lead agency model, the council and NHS board can delegate functions to each other under the oversight of a joint monitoring committee.

◀ 6 *Population Projections for Scottish Areas (2010-based)*, National Records of Scotland, 2012.

◀ 7 Finance Committee Demographic Change and Ageing Population Inquiry – Submission from National Records of Scotland, 2012.

◀ 8 *Population structure and ageing*, Eurostat, 2012 (excludes Croatia).

◀ 9 Finance Committee Demographic Change and Ageing Population Inquiry – Submission from National Records of Scotland, 2012.

◀ 10 *Population Projections for Scottish Areas (2010-based)*, National Records of Scotland, 2012.

◀ 11 Ibid. This projection takes into account changes, due between 2010 and 2035, to the criteria on who can claim state pensions and when.

◀ 12 *Health Expectancies in the United Kingdom, 2000–02 to 2008–10*, Office for National Statistics, 2010.

◀ 13 *Prescribing in general practice in Scotland* (PDF) Audit Scotland, 2013.

◀ 14 *The London School of Economics companion to health policy*, McGuire and Costa-Font, 2012.

◀ 15 *Outlook for Scottish Government Expenditure: June 2010 Emergency Budget Update*, Scottish Government, July 2010.

◀ 16 *Reshaping Care for Older People – A Programme for Change 2011–21*, Scottish Government, COSLA and NHS Scotland, 2010.

◀ 17 Figures in real terms 2011/12 prices. Audit Scotland analysis of Local Financial Return statistics 2002/03 – 2011/12.

◀ 18 Real terms in 2011/12 prices. The Integrated Resource Framework does not include expenditure on the State Hospital or general dental, general ophthalmic and other prescribing costs in family health services.

◀ 19 Commissioning social care is more than councils organising and buying services. It is also how councils and NHS boards work together to plan services to meet future demands and make effective use of their combined resources. This joint strategic approach to commissioning can help provide joined-up services to people and prevent, delay or shorten a stay in hospital. Ultimately, jointly planned investment in social care can save expenditure on unnecessary, and relatively expensive, hospital or residential care. From 2013/14 NHS boards, councils and their partners have been required to produce Joint Strategic Commissioning plans.

◀ 20 Audit Scotland analysis of NHS Costs Book data. Spending on community, family health services and resource transfer, as stated in the costs book, has been counted as being spent in the community.

◀ 21 *Review of Community Health Partnerships* (PDF) 🖱 Audit Scotland, 2011;
Overview of the NHS in Scotland's performance 2008/09 (PDF) 🖱 Audit Scotland 2009;
Financial overview of the NHS in Scotland, 2007/08 (PDF) 🖱 Audit Scotland, 2008.

◀ 22 Audit Scotland analysis of Free Personal and Nursing Care and Local Financial Return statistics, 2003/04 to 2011/12, Scottish Government. Figures have been converted to real terms in 2011/12 prices.

◀ 23 Council spending figures are net of any income such as charges for services. Increases in spending may have been larger, but offset by increased charging. Overall levels of charging for services by councils have increased over time.

◀ 24 Figures in this paragraph are in real terms 2011/12 prices. *A review of free personal and nursing care* (PDF) 🖱 Audit Scotland, 2008. In July 2002, Free Personal and Nursing Care was introduced in Scotland to bring social care for older people into line with the principle of free care based on need applied to medical and nursing care in the NHS. This care can be provided to a person in their own home, or in a nursing home. When someone aged 65 or over has been assessed as having personal care needs, councils may not charge for the service. Personal care includes help with personal hygiene, eating and drinking, managing medication, and immobility problems. Nursing care is any service that requires the knowledge or skills of a trained nurse and cannot be charged for.

◀ 25 *Health inequalities in Scotland* (PDF) 🖱 Audit Scotland, 2012.

◀ 26 Real terms spending did not increase in Angus.

◀ 27 The four councils that increased spending, in real terms, on social care for older people per head of population aged 65 or over between 2010/11 and 2011/12 were Moray, Scottish Borders, East Renfrewshire and South Lanarkshire. Council spending figures are net of any income such as charges for services.

◀ 28 *Emergency departments* (PDF) 🖱 Audit Scotland, 2010.

◀ 29 *Social care for older people: Using data from the VFM Profiles*, Audit Commission, 2013.

◀ 30 *Reshaping Care For Older People – Update Paper*, Scottish Government, September 2013.

◀ 31 *Commissioning social care* (PDF) 🖱 Audit Scotland, March 2012. Commissioning social care is more than councils organising and buying services. It is also how councils and NHS boards work together to plan services that will meet future demands and make effective use of their combined resources.

◀ 32 Change Fund allocations are based on the National Resource Allocation Committee (NRAC) distributions for the Community Care Programme, based on NHS board populations for the 65 or over age group and also local authority Grant Aided Expenditure (GAE) distributions for older people's services. Local partnerships are made up of the NHS, council, private and third sector organisations.

◀ 33 Partnerships were required to produce a Change Fund plan for 2011/12 and again in 2012/13. To access the 2013/14 Change Fund, partnerships were required to provide specific information from their 2013/14 Joint Commissioning Strategies for Older People.

◀ 34 There are 31 Change Fund partnerships in Scotland, one for each council area, with the exception of Clackmannanshire and Stirling where organisations worked together to produce a joint plan.

◀ 35 *Change Fund 2012/13 Mid-year Progress Report*, Joint Improvement Team, November 2012.

◀ 36 *Review of Community Health Partnerships* (PDF) 🖱 Audit Scotland, 2011.

◀ 37 *Prepared to Care? Exploring the impact of caring on people's lives*, Carers UK, 2013.

◀ 38 Potentially preventable hospital admissions are sometimes referred to as ambulatory care sensitive conditions. There are 19 conditions in total. Audit Scotland analysis of data requested from ISD Scotland, 2013.

◀ 39 *Moving on? An overview of delayed discharges in Scotland* (PDF) 🖱 Audit Scotland, 2005.

◀ 40 Data from ISD Scotland (2013) excludes 'code 9' delays. These are delays for patients waiting for a place to become available in a high-level needs specialist facility for whom an interim move is not appropriate or is considered unreasonable. It also applies to adults who may not have the ability to make the decision, as defined under incapacity legislation. In these circumstances, discharge may take longer to arrange and the normal standard does not apply. Unless we note otherwise, we exclude 'code 9' delays.

◀ 41 Data from ISD Scotland, 2013.

◀ 42 Bed days occupied by delayed discharges, ISD Scotland, August 2012, November 2012, February 2013, May 2013.

◀ 43 This includes information up to October 2013. The 11 boards are NHS Ayrshire and Arran, Borders, Dumfries and Galloway, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, Tayside and Western Isles.

◀ 44 *Care for Older People in Acute Hospitals Six-monthly Report (February-July 2012)*, Healthcare Improvement Scotland, 2012;
Care for Older People in Acute Hospitals Overview Report (August 2012-April 2013), Healthcare Improvement Scotland, 2013.

◀ 45 Each theme is graded using a six-point scale: 1-unsatisfactory; 2-weak; 3-adequate; 4-good; 5-very good; 6-excellent.

Appendix 1
Audit methodology
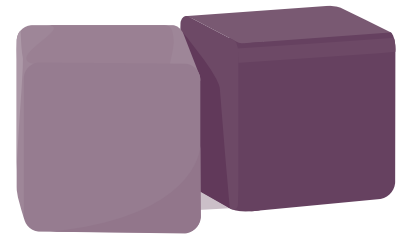
We reviewed a range of published information to inform our audit, including the following:

- Scottish Government documents on the Reshaping Care for Older People programme, partnerships' 2012/13 Change Fund plans and mid-year progress reports and the Scottish Government's reports on plans and progress

- Community Planning Partnerships' Single Outcome Agreements

- Care Inspectorate reports on councils' social work services and Healthcare Improvement Scotland's inspection reports on older people's care in acute hospitals

- Academic papers and published reports from voluntary and research bodies and from other bodies such as the King's Fund

- Evidence gathered by the Scottish Parliament's Finance Committee into the impact of demographic change and an ageing population on Scotland's public finances

- Councils' Assurance and Improvement Plans.

We analysed published and unpublished financial, performance and activity data including the following:

- NHS Information Services Division (ISD) data

- National Records of Scotland data

- Scottish Government Health and Community Care and Local Government Finance data

- Scottish Index of Multiple Deprivation

- Integrated Resource Framework financial information

- Linked health and social care finance data from NHS Lothian

- Scottish Public Health Observatory data

- Statutory Performance Indicators.

We interviewed staff from:

- the Joint Improvement Team at the Scottish Government

- the Care Inspectorate and Healthcare Improvement Scotland

- NHS Information Services Division

- organisations in Lanarkshire, including North Lanarkshire Council, South Lanarkshire Council, and the North and South Lanarkshire community health partnerships

- organisations in Ayrshire and Arran, including North Ayrshire Council, NHS Ayrshire and Arran and the North, South and East Ayrshire community health partnerships

- NHS Lothian and NHS Tayside.

We commissioned ODS Consulting to carry out focus groups with older people and their carers to gather their views on the quality of services in their areas and on the RCOP programme. ODS Consulting also carried out focus groups with representatives from the voluntary sector. We have published a report on this work on our website www.audit-scotland.gov.uk.

Appendix 2
Project advisory group
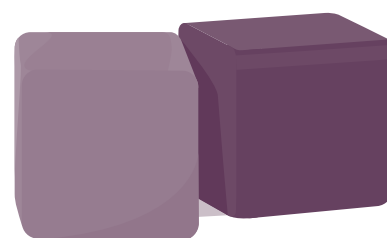
Audit Scotland would like to thank the members of the project advisory group for their input and advice throughout the audit.

Karen Anderson	Care Inspectorate
Kathleen Bessos	Scottish Government
Susanne Cameron-Nielsen	Age Scotland
Ron Culley	Convention of Scottish Local Authorities
Dr John Duncan	Royal College of General Practitioners
Dr Anne Hendry	Joint Improvement Team/NHS Lanarkshire
Peter Knight	Joint Improvement Team
Annie Gunner Logan	Coalition of Care Providers Scotland
Ranald Mair	Scottish Care
Robbie Pearson	Healthcare Improvement Scotland
Elaine Torrance	Association of Directors of Social Work and Scottish Borders Council
Dr Margaret Whoriskey	Joint Improvement Team

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Reshaping care
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