

ScottishCare 

The voice of the Independent Care Sector in Scotland

“Making the case for care”

A Manifesto for the future of care and support services for older people in Scotland



November 2010

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Section One

Executive summary

1. On behalf of both service providers and service users, Scottish Care presents this Manifesto as a means of highlighting current concerns and outlining our proposals for the way forward for care and support services. We see it as a contribution to both the *Reshaping Care for Older People* programme and the current *Spending Review for 2011-14*. As we see it, making the case for care is now a matter of real urgency.

2. Scotland faces a potential crisis in the provision of care and support services over the coming years, as competing pressures begin to bite:

- » Increasing levels of demand and complexity of need
- » Severe constraints in public sector finance
- » Increased cost of care and support delivery
- » Desire to shift the balance of care and support away from the acute health sector
- » Maintaining the commitment to personalisation and choice
- » The drive to improve outcomes and quality
- » The need to develop new models of service delivery
- » Creating a system of proportionate regulation
- » Recruiting, training and shaping the required workforce.

These pressures are likely to impact most clearly in relation to care and support of older people but will also apply to other areas of social care provision such as mental health, physical disability and housing support services.

3. The independent care sector in Scotland is a major industry employing a skilled and committed workforce of over 100,000 people with an annual turnover in excess of £1bn. It is a hugely important part of the economy both nationally and locally, with real potential for sustained investment and growth. The key to realising this potential has to be clarity from Government, local authorities and the NHS regarding the future shape and funding of care. The current lack of clarity, combined with the economic pressures, risks stifling growth and development and must be resolved as a matter of urgency. Political leadership is essential.
4. Meeting the challenges and avoiding crisis will require:
 - » Making full use of existing resources as the hub of future service provision
 - » Moving away from the current reliance on high cost in-patient provision and high cost local authority run services
 - » Building on the established partnerships with the private and voluntary sectors to develop new capacity, new models of service delivery and a shift in the balance of care and support
 - » Radical change in how care and support services are planned, funded and commissioned

Making the case for care is now a matter of real urgency

- » Leveraging change through the targeted use of funding and investment
 - » Ensuring a sustainable resource base which will allow for the continued delivery of high quality care.
5. Social and health care provision needs to be jointly planned, commissioned and funded by the social and health care authorities, as is the case in the majority of countries. Leaving the primary responsibility for social and health care planning and funding with local authorities, whilst expecting them make significant savings, will not grow any of the capacity required to seriously shift the balance of care or to meet other strategic requirements. The net result will be increased demand for in-patient provision. Health Boards have to be directly involved in the planning and funding of alternative non-hospital based care services.
 6. None of the radical change required is likely to happen without a clear policy framework, a clear strategy and clear political leadership. The *Reshaping Care* programme provides much of the groundwork for this but is likely to stall as vested interests and the need to make expedient budget decisions get in the way. Despite the electoral uncertainties, we need a clear plan and core elements of it need to be in place for the commencement of the Spending Review period in 2011. If any parts of the public services are to be given a measure of protection, we would argue that the care sector, as an integral part of the health care system, should be seen as a priority area. The *Reshaping Care* programme is a very positive and welcome start, but needs to be driven forward at pace.
 7. Scottish Care is the established representative body for the independent care sector across care home, care at home and housing support provision, and it is this sector that will have the key role in developing and delivering care and support services in the future. Scottish Care has demonstrated its commitment to working in partnership with Government and public agencies and its ability to deliver on change agendas. We believe that it is this partnership, rather than retrenchment and short-termism, which will allow creative and progressive solutions to the current challenges to be found.
 8. Care of older people has suffered from being low on the list of priorities for both local authorities and the NHS. We welcome the fact that there is currently a raised political profile regarding this area of provision. However, this now needs to be translated into a clear and integrated plan of action to safeguard services for the future. It seems clear that care of older people is, and will remain, a matter of significant public interest and concern. It is something that ultimately affects all families in the land. Getting it right for older people now and into the future is *do-able*, but only if we act now.
 9. Older people are not a *burden*, they are an *asset*. Scottish government figures highlight the fact that through informal care and volunteering, older people deliver much more care than they consume. Older people are also increasingly a political force which politicians will ignore at their peril. The partnership in planning and delivering future care services has, therefore, to be one which does things *with* rather than *for* or *on behalf of* service users.
 10. It is the independent care sector that is the key to getting this right. Only private and voluntary care providers can deliver the volumes, the quality, the cost, the flexibility and the innovation required to meet current challenges. Supporting and encouraging the independent sector to move forward is therefore essential at this point in time.

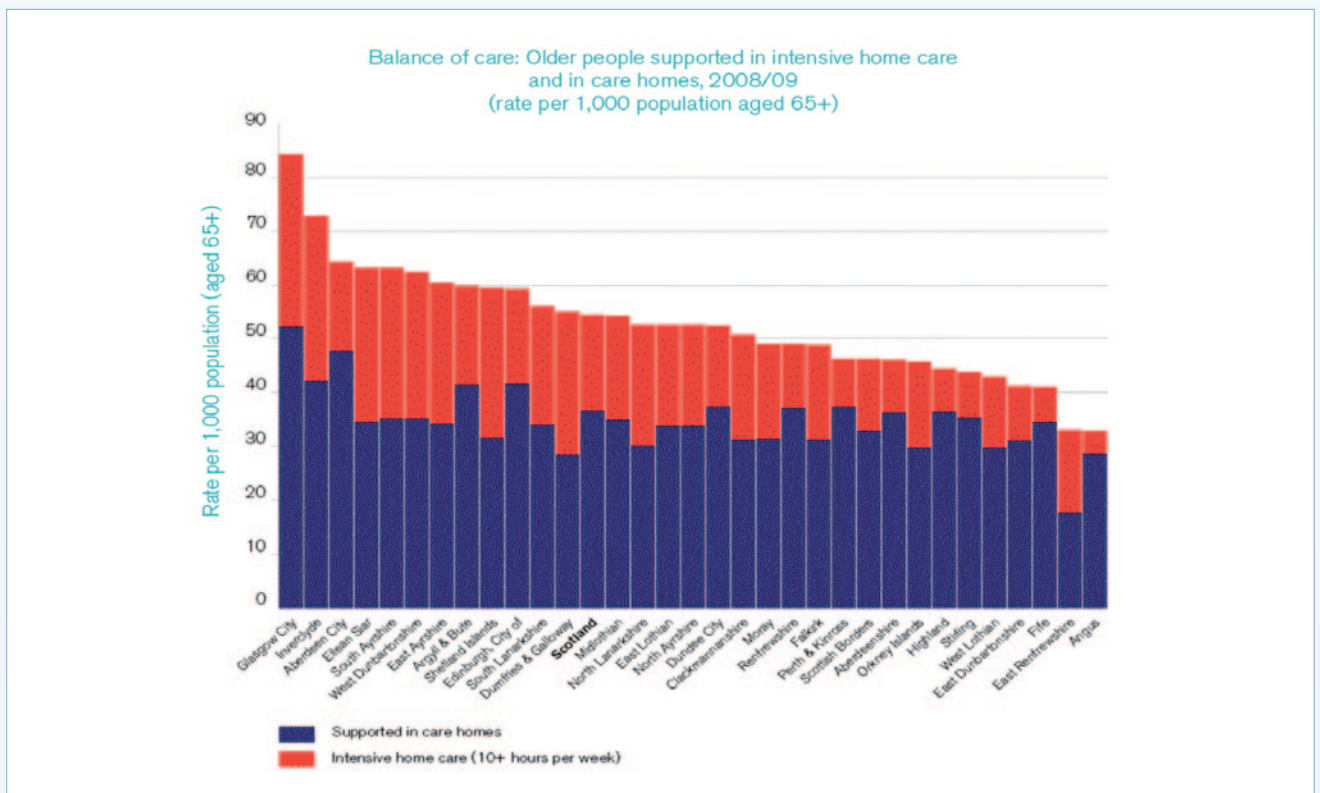
*Older people
are not a
burden, they
are an asset.*

Section Two

The independent care sector

1. The independent sector, by which we mean private and voluntary non-statutory provision, is now a leader in health and social care delivery in Scotland. This development has meant more choices for people, more savings for the public purse, an increasingly skilled workforce, the creation of local jobs, and a firm foundation for the changes required to meet new demands.
2. The mixed economy of care is now well established. The last two decades have seen a steady reduction in the level of publicly run in-house provision and consequently the growth of outsourced private and voluntary sector services.
3. Currently **85%** of care home places and over **50%** of care at home and housing support provision is delivered by the independent sector. This trend of outsourcing is likely to continue and the required future expansion to meet demand will come from private and voluntary providers. Evidence suggests that there has been and will continue to be limited capacity building within the public services sector, as the development of new provision will be driven by the urgent and pressing need for more cost efficiencies, savings, shared risk and best value.

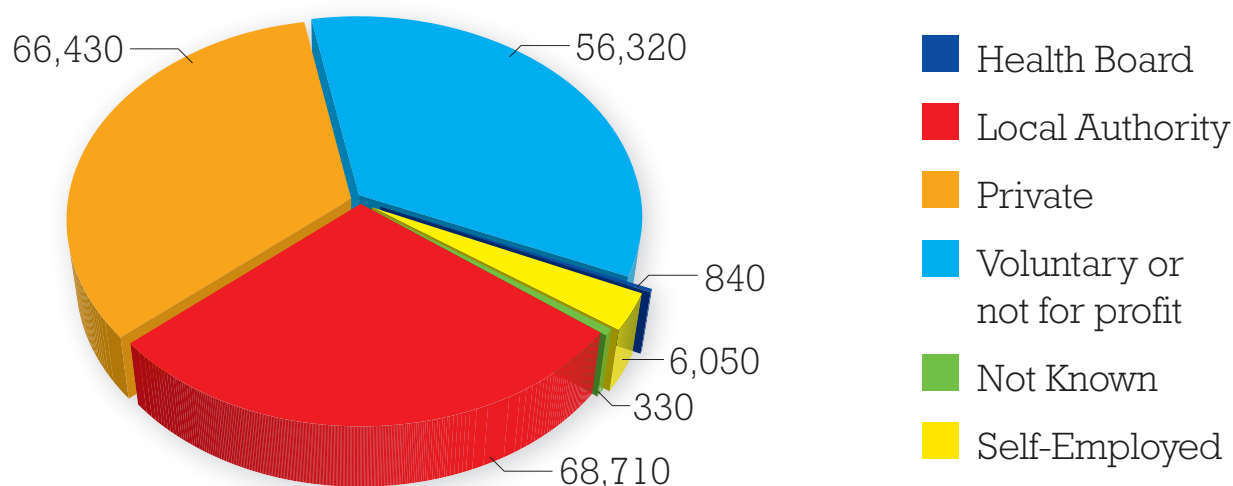
Provision of Care of Older People (SWIA: Improving Social Work in Scotland, 2010)



4. There have been two major shifts in service delivery over past 10 years: firstly an accelerated increase in the rights of individuals, and secondly the aforementioned decline in the public sector as a direct provider with a corresponding increase in independent sector provision. The independent sector accepts the need for change and improvement and has embraced developments in both policy and practice. Providers have responded to the importance of reablement, anticipatory care, prevention, maintaining healthy life expectancy and other policy drivers set by the Scottish Government.
5. Whilst external procurement and purchasing of community based services has increased over the past 10 years, the new social care procurement guidance, along with proposed legislative changes to self-directed support, will further challenge and change traditional models of care delivery, including any perception that this is still the preserve of local authority social work services.
6. The independent care sector has emerged as a significant national industry employing in excess of **100,000** staff and with an annual turnover of over **£1bn**. Furthermore it is a positive part of the economy with real potential for growth and capacity over the coming years. It is essential however, that looking forward, the sector is supported by a shared approach to establishing the volumes, models and options for service delivery as this will be necessary to attract sustained investment.

The independent care sector has emerged as a significant national industry

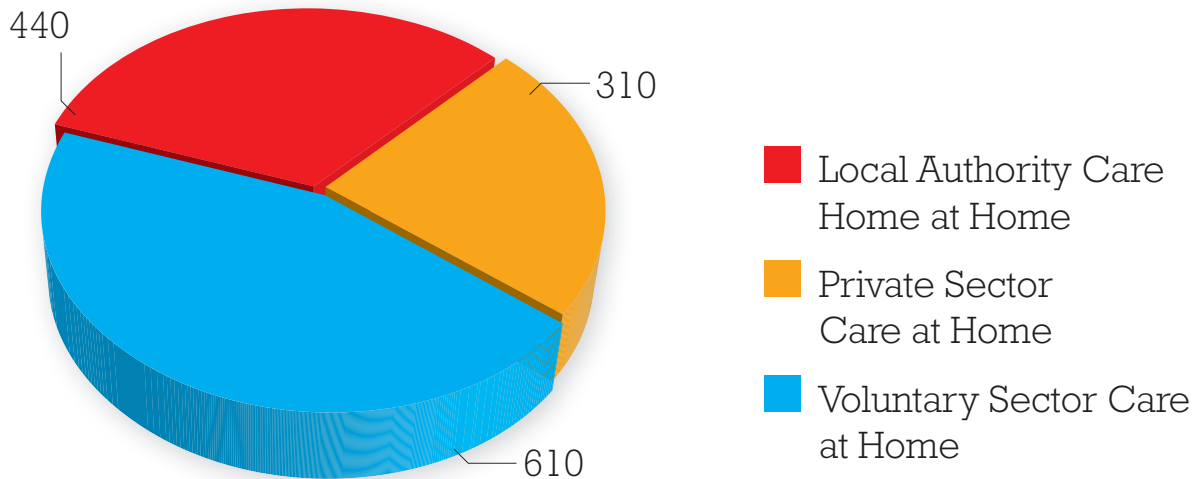
Staff Headcount by Sector



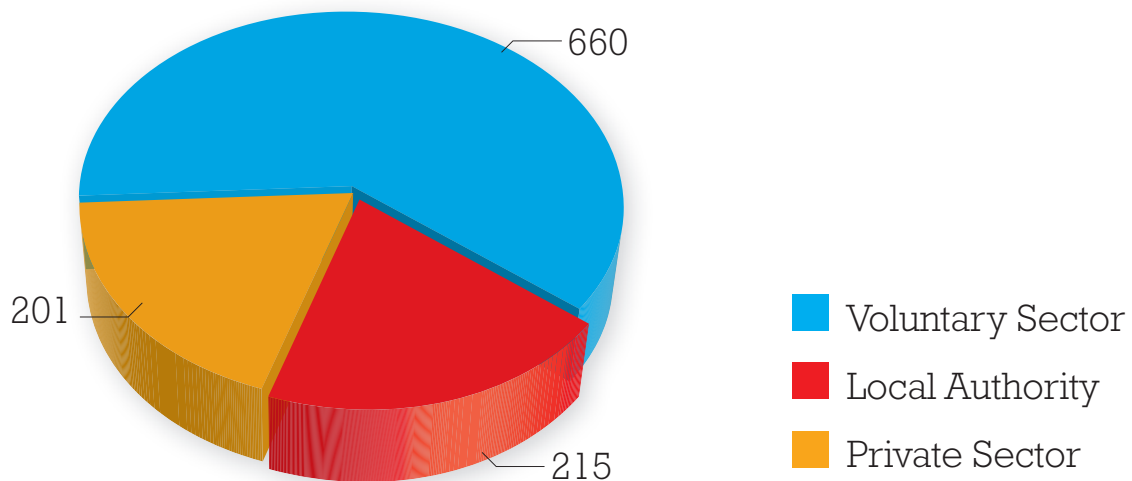
7. Despite current financial constraints, the care sector is one which will continue to grow and in which individual citizens have the scope to invest, within a commitment to *mutual care and co-production*. Regardless of any radical changes that may be proposed to current systems, benefits and entitlements, we do have a post war generation of mainly wealthier older people many of whom are likely to and will become both providers and consumers of care services. This will force market changes away from a *welfare-oriented* model towards a more *consumerist approach* that independent providers are well placed, and able to respond to.

8. Scottish Care is now the largest social care representative body in Scotland with over 1000 private and voluntary homes and services across care home, care at home and housing support provision. Scottish Care and its members have shown their ability to work in partnership on professional and policy issues and develop constructive relationships with key partners to deliver for the future.

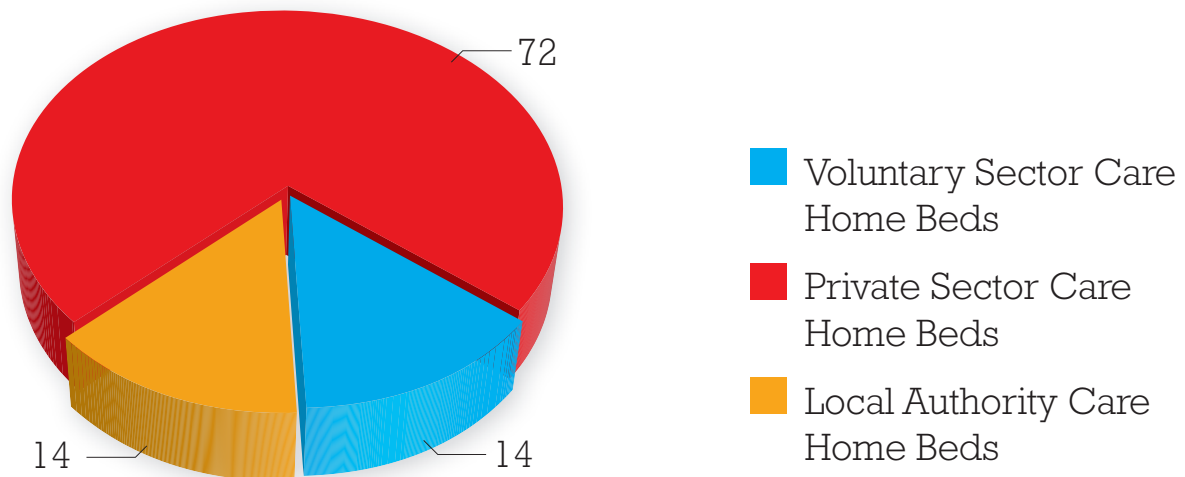
Care at Home Registration by Sector



Housing Support Registration by Sector



% Care Home Bed Provision by Sector



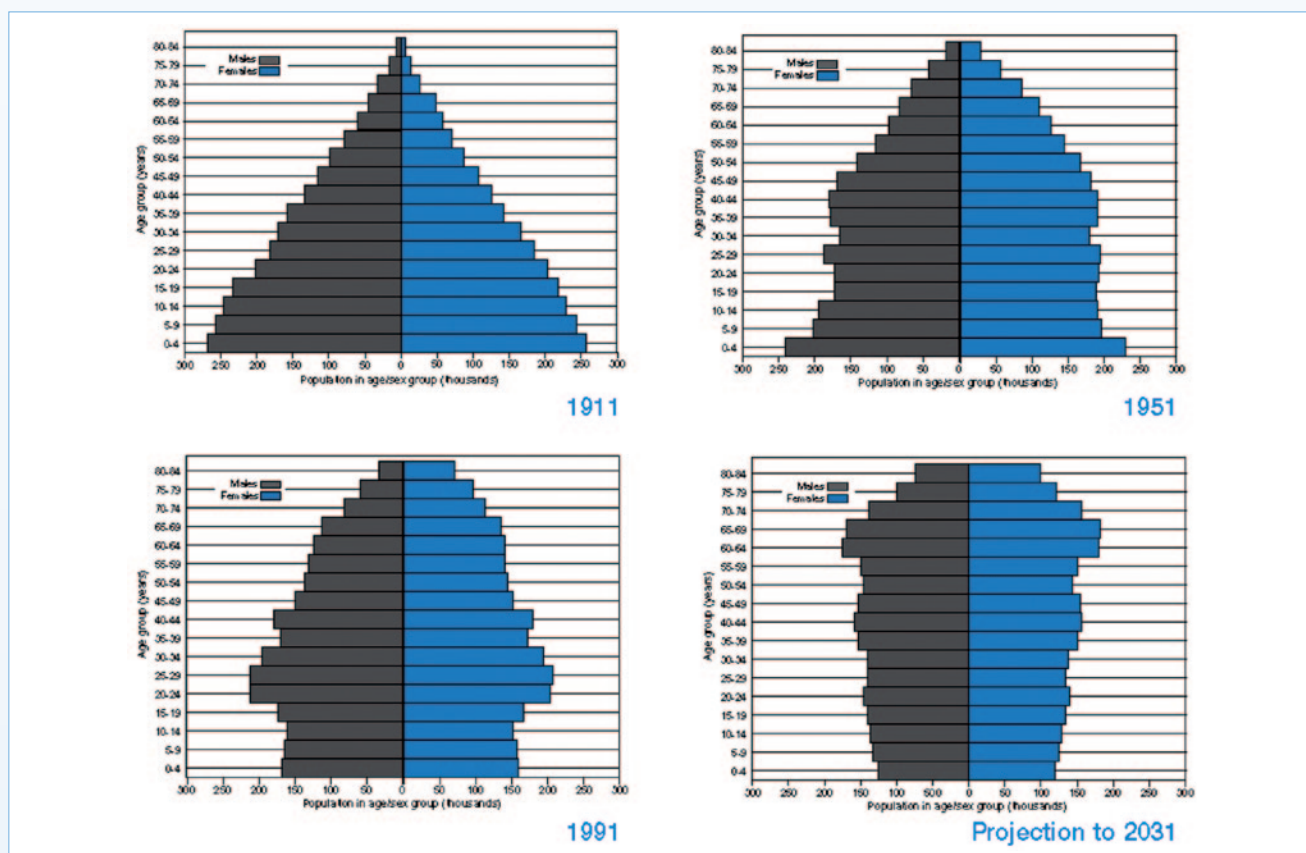
9. In addition to its membership activity, Scottish Care also hosts The *Workforce Initiative* supported by funding from the Scottish Government. The objective has been to develop the capacity of the private care sector to deliver on national workforce agendas. The Initiative has also helped members to make sense of a wide range of workforce connected activities and has ensured the sector's engagement with both policy and practice developments. The project has been running in its current form since October 2008 and has core funding until March 2011. Part of this work involves much greater alignment with the health service in relation to workforce development through close working with the Scottish Social Services Council (SSSC), NHS Education Scotland (NES) and other relevant parties.
10. The independent care sector can rightly be seen as a major Scottish industry providing significant employment and contributing to Gross Domestic Product (GDP). It is also well placed to respond to changing needs; to grow and develop despite the current economic challenges; to develop additional capacity in response to demographic demand and council outsourcing; to access capital for new developments; and to create flexible workforce capacity. However, this can only happen if the terms of funding and commissioning provide the basis for sustainable business.



Section Three

Current challenges and drivers in reshaping care

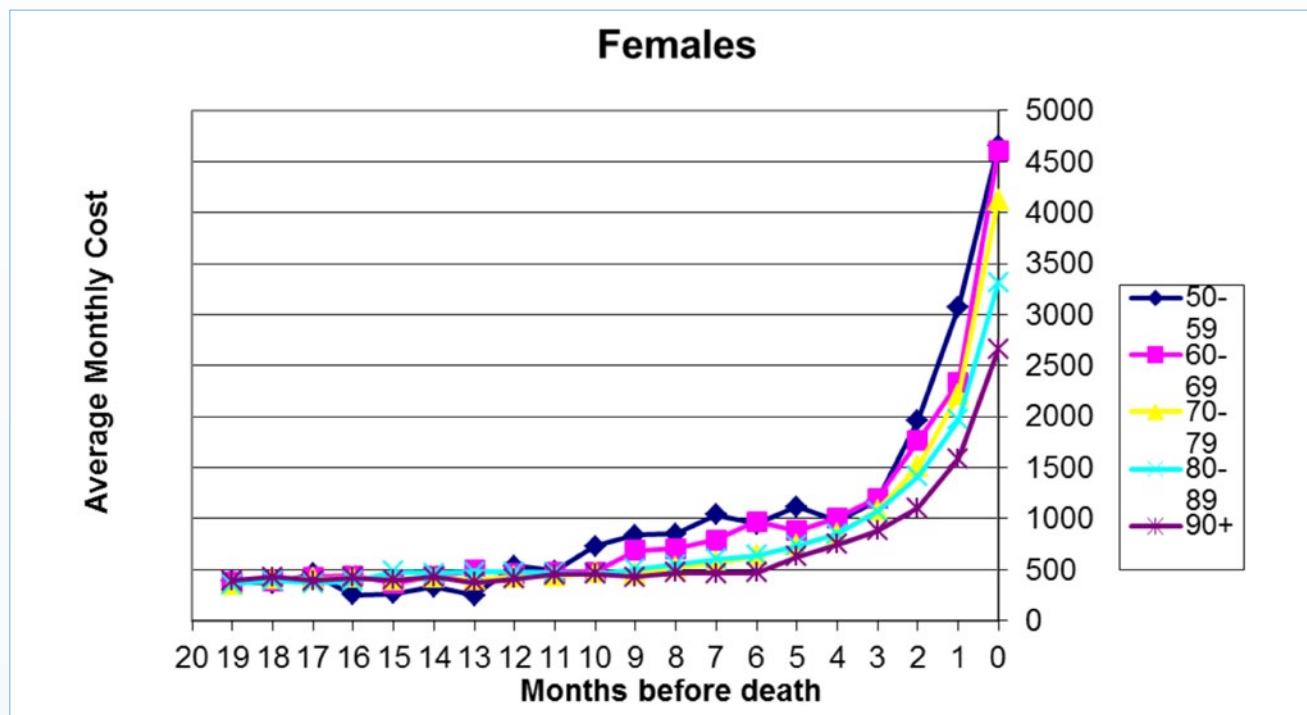
1. We are facing a demographic time bomb that threatens to stretch our service capacity and place us on financial precipice that can only be managed by radically reshaping the currently disjointed systems. Service design that places control back in the hands of service users, families and communities is the key to future delivery, with health and social care services being seen as a support without taking away responsibility and independence. *Mutual care and inter-dependence* are the name of the game. Correctly this includes developing *community capacity* to replace or augment the current levels of *informal care and support* being provided by families and neighbours. However, community capacity and volunteering cannot be seen as an adequate substitute for professional support and paid care.
2. “Estimates suggest our older population is going to rise by 21 per cent between 2006 and 2016 and by 62 per cent come 2031. More of the same would mean an extra 23,000 people needing care by 2016” (**Shona Robison MSP**, Minister for Public Health and Sport 24th March 2010).



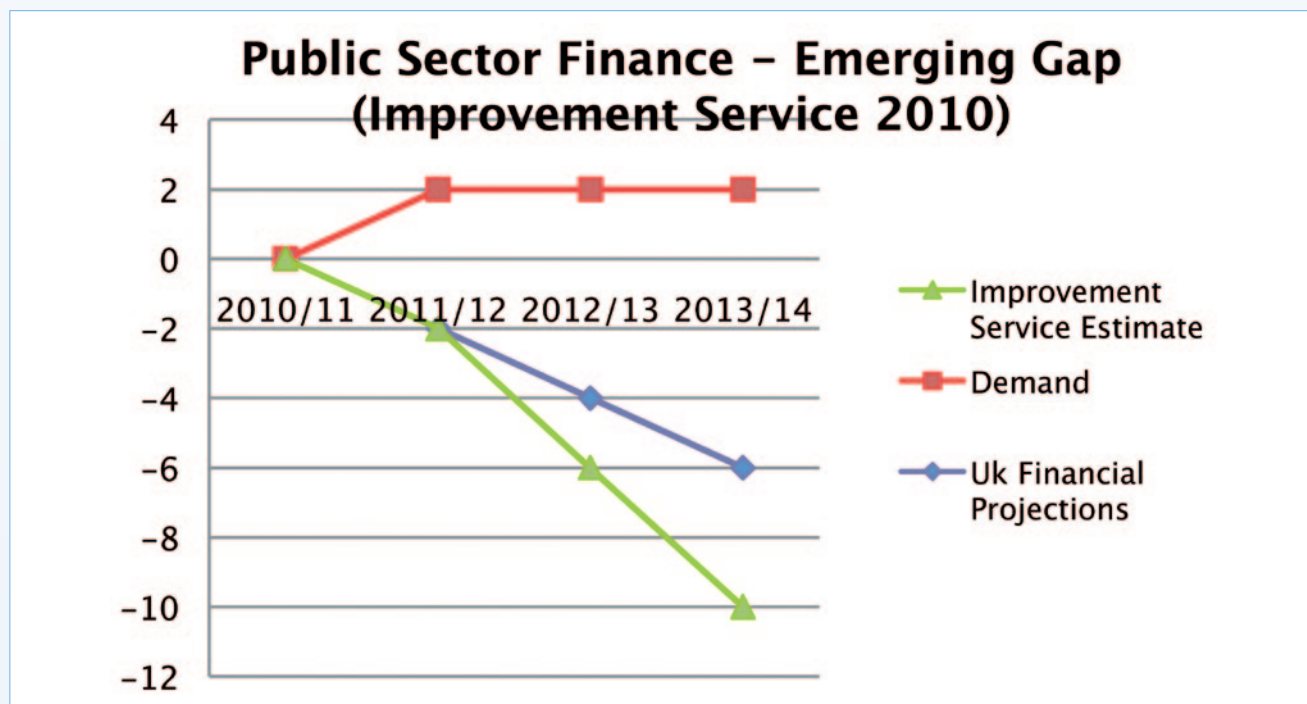
For the **85+** age group in particular, a **38%** rise is projected for 2016 and by 2031, the increase is **144%**. People want support to live well in their own homes and communities, or in supported living settings and we urgently need to develop the range of services which will enable this to happen.

- Despite an increase in healthy lifestyle, the demand for health and social care related services will grow as more people live longer, together with an increased incidence of age related long term conditions.

Concentration of hospital days towards end of life is reflected in costs



The current expenditure on health care is disproportionately located in the acute sector, particularly servicing emergency admissions and end of life care. In addition, financial projections suggest the current pattern is unsustainable.



An estimated savings requirement of at least **14%** over the 3 years of the forthcoming *Spending Review* period combined with a continued **2%** per annum growth in demand threatens to destabilise health and social care provision, particularly if at the same time we seek to maintain

the commitment to personalisation, choice and control. The challenge is to develop frameworks and models which will allow more care to be delivered at a lower overall cost whilst maintaining the journey towards personalised services.

The status quo is not an option

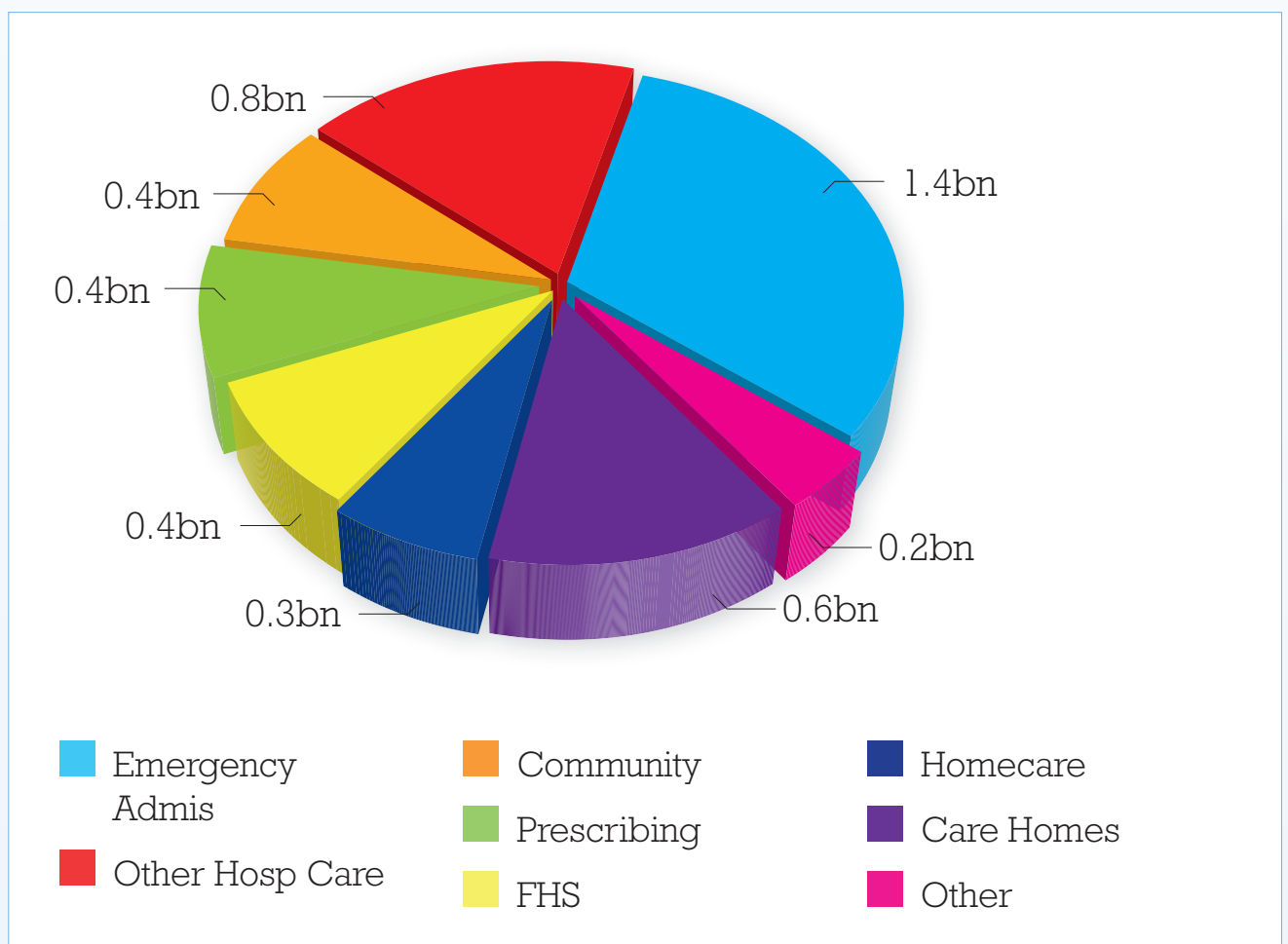
4. In the quest for survival it can be difficult to look to the longer term. However, crisis also creates opportunity, and providers endorse the active pursuit of the *Reshaping Care* programme, given the urgent need to make radical change that might not be possible under normal circumstances. This may well be the time to address structural barriers, vested interests and traditional systems that have previously been over-protected. The status quo is not an option.
5. Scottish Care has long believed that the key to real change and a better life for people who need and use services, starts with them being able to say what is important to them and then being heard. We therefore strongly support the crucial emphasis on personalisation as the basis for care and support planning and service delivery. Many feel that current bureaucracy is a barrier to both personalisation and the principles of self-directed support. However, the single biggest barrier is financially driven commissioning which seeks to reduce care delivery to the minimum time and task-focussed transaction possible. The danger is that quality of life and desired outcomes become secondary considerations to cost. Finding creative solutions rather than succumbing to short-term, financially expedient, non-strategic courses of action becomes the real challenge.
6. Public services in Scotland face substantial cuts. Estimates provided to the Independent Budget Review indicate that the resources controlled by the Scottish Government are projected to fall by 3.3 per cent per year on average in real terms over the next four years. In total, the Scottish Government's departmental (DEL) budget is expected to reduce by approximately £3.7 billion or 12.5 per cent over the next Spending Review period to 2014-15. This represents the largest reduction in spending since the Second World War. The impact of the public sector finance squeeze is also likely to be greater in Scotland than in the rest of the UK, since the Scottish Government's budget has seen sustained growth over the past decade.
7. This reduction is likely to be continue for many years and budgets may not revert to their 2009-10 level until 2025-26. This equates to £42 billion less in total spending between 2010-11 and 2025-26 – equivalent to nearly four years' spending on the NHS in Scotland and potentially takes us to the levels of spending on public services that existed just over ten years ago.
8. The negative impact on health and social care provision which is funded and commissioned by local authorities will also be greater, if under the spending review the NHS is afforded a larger element of budget protection by the Scottish Government. This highlights the anomaly of not having joint funding and commissioning. It could also be completely counter-productive.
If the services which are there to care and support people in the community are cut, whilst hospital spending is maintained, we will simply end up with more people in hospital.

This has now been recognised by the NHS in England as a major flaw in policy and steps are being taken to allocate NHS funds to supporting related health and social care provision in the community. In Scotland, the Scottish Government is proposing a small change fund to stimulate NHS/ local authority jointly-commissioned projects. Again this is to be welcomed as the start of a process, but in itself may not be enough to make the difference required to seriously shift the balance of care.

Section Four

Finding creative value-added solutions

1. The challenges being faced also present us with the opportunity to make a radical change in the way care and support services are configured. **Increasing capacity to meet rising demand, whilst at the same time reigning in public expenditure and maintaining quality and choice, is in fact possible.** What it requires is a move away from unnecessary reliance on high-cost provision and a willingness to do so on the basis of an integrated funding model which allows money to be directed to the types of provision that are agreed to be most conducive to meeting future need.
2. By far the biggest area of expenditure, almost 50% of the Older People's budget, is within the *acute health sector*:



3. Scotland currently spends £4.5 billion a year on providing health and care services for those over 65 years; £1.4 billion (30%) of this goes on emergency hospital admissions. If Scotland continues to provide services in the same way, current spending will need to increase by £1.1 billion by 2016, and by £3.5 billion, or 74% by 2031.

4. This would be perfectly acceptable and right to maintain if it were necessary for meeting need, but it is not. Indeed, in many instances people could have their needs met more effectively through non-acute sector services. We need to end:
 - » Unnecessary hospital admission for non-specialist assessment, intervention and care that could just as readily be provided in community settings
 - » Unnecessary lengths of stay for continuing care and rehabilitation, with the added risks of hospital acquired Infection and a reduced capacity for independence, could be avoided
 - » Unnecessary admission for palliative and end of life care that could be provided at home or in a more appropriate care setting, in keeping with the Scottish Government's policy framework *Living and Dying Well*.

These are all areas where we feel real gains could be made very quickly through shifting the locus of care away from the acute sector, providing there is a willingness to shift an element of resource at the same time.

5. Ending all continuing care in hospital settings would free the acute sector to concentrate on its primary function of specialist assessment and intervention. At weekly rates of **£1400+** pw for general hospital beds and **£2800+** for acute provision, even enhanced packages of care and support in care homes or care at home would be a huge saving to the public purse. Building on existing *step-down* and *re-ablement* models, it would make sense to locate rehabilitation teams in the community and move the locus of care away from hospital settings. The majority of care homes already have professional nursing staff able to follow through on medical intervention and care, whether under continued oversight of hospital staff, or from local GPs. Similarly, care at home combined with community nursing could provide effective support to people coming out of hospital.

Lengths of stay in hospital for older people are often less determined by clinical need and more by the time it takes to access an appropriate care package in the community. This is detrimental to the individual and hugely costly to the public purse.

6. Similarly, developing *step-up* and *step-down* capacity in community settings to provide emergency response, assessment and rehabilitation as an alternative to hospital admission has to be the way forward. GPs often seek hospital admission simply because they see it as the only option available to them. Ensuring that the full range of resources is available and accessible when needed would end unnecessary admission and help to maintain people in their own home or community. The emphasis should be on developing an integrated resource framework across GP services, primary care, community hospitals, care homes and care at home to create maximum flexibility and response.
7. The Scottish Government's *Living and Dying Well* strategy has served to raise the profile of palliative and end of life care, and the right for individuals and their families to dignity and respect. It has again highlighted that hospital settings are probably the least conducive environment for anticipated end of life care. The independent sector has responded to this by forming a workstream to promote palliative care in care settings and a very successful conference on the topic was held in September 2010. The willingness, the infra-structure and partnerships to deliver on this agenda are in place. However, this needs to be matched by a programme of public education to promote non-hospital end of life care, and a transfer of resource to fund capacity building in care homes and care at home.

8. Delivering on the care and support agenda will require the development of new models of service delivery. We need to create greater flexibility, we need to respond to changing and increasingly complex patterns of need, we have to move away from the traditional models of long-term care and we need to avoid duplication of infrastructure and management costs. A potential model for this is to use the existing service footprint to develop *Care Hubs*, with the capacity to deliver on the full range of community care and support services:

- » Residential and day care
- » Assessment and rehabilitation
- » Step-up and step-down care
- » Respite and crisis care
- » Palliative care
- » Outreach and care at Home
- » Meals and laundry services
- » Tele-health, tele-care and hospital links to reduce unnecessary outpatient and inpatient activity
- » community health, including dental, optical and podiatry
- » support to self-help, mutual-care, and community capacity-building.

Delivering on the care and support agenda will require the development of new models of service delivery

9. This idea of a one-stop shop *Care Hub* anchors care and support services firmly in the localities being served, brings services to the person rather than the other way round, and would maximise the flexibility of response to meet needs without complex referral processes, bureaucratic gate-keeping and the risk of getting stuck in the wrong part of the system. It would also allow the flexible deployment of skilled and experienced staff across care home, care at home and community provision.

Fig A: Care Hub - Service Model



The added-value of the Care Hub model is the contribution to local economy, local employment, and local capacity, and it is a model that could work equally well in both urban and rural settings. It may even be possible to explore community partnership models in the running of services and service users being able to have an equity stake in their care provision.

Given all the advantages, we believe it is a model worth pursuing.

Fig B: Care Hub – Community Added-Value



10. The other main area of high *cost* against the *volume* of care and support delivered is local authority directly provided care. In relation to care home provision for older people this is amounts to about **15%** of places; in relation to home care services it is around **50%**. Like for like cost comparisons are difficult, but for care homes the average local authority cost per place per week for non-nursing care is **£800** and the equivalent cost for a place under the National Care Home Contract is **£480**. Similarly, in relation to care at home and housing support the cost per hour for local authority provision is estimated at **£21-£25**, for the voluntary sector **£16-£18** and for the private sector **£12-£15**. The recent increase in competitive tendering has however reduced somewhat the gap between private and voluntary provision in the home care sector through downward pressure on cost.
11. We recognise that there may be parts of the country where the local authority remains the default provider, largely because the economics of delivering care in some rural and remote communities makes it harder for independent sector providers to operate on low-cost standard contracts. However, where there are viable alternatives, and a willingness to develop a more mature and stable contracting framework, it seems clear that pursuing a phased process of outsourcing has to be the most sensible option, potentially delivering higher volumes of care and support for the same or possibly reduced levels of expenditure. There is also no evidence that in general local authority delivered services are of higher quality, despite their higher cost.

12. Nor does outsourcing in relation to care and support services need to be about job losses. The Scottish Government's own calculation is that over the piece there will be a need to have more people working in the care sector than at present, and skilled staff will be particularly important to the on-going delivery and development of services. What we need to do, therefore, is to explore as a matter of urgency how outsourcing can best be carried out, and secure terms and standards of commissioning and procurement which balance *price, quality, strategic capacity* and *sustainability*. There are already good examples of local authorities beginning this process, Fife Council being a recent one. The dangers however are three-fold:
1. If it is purely about financial expediency on the part of local authorities, it may not create sustainable capacity to meet broader health and social care needs, particularly to assist with shifting the balance of care away from the acute sector
 2. Whilst the independent sector does have the capacity to respond rapidly and flexibly to changing local requirements, there also need to be a national plan that looks at future capacity requirements on a stable long-term basis
 3. The TUPE framework of transferring staff to a new employer may present some hurdles as there is currently significant disparity between the public and independent sectors in terms of pay and conditions.
13. Our dialogue with the Royal Bank of Scotland and other finance institutions highlights that independent sector investment is potentially available, but requires those bodies to have confidence that both individual projects and the sector as a whole have stable funding and predictable levels of usage. If provider organisations are to develop additional capacity to meet out-sourcing requirements it cannot simply be on a short-term basis.
14. Within an overall commissioning strategy is the commitment to *Self Directed Support (SDS)*. Providers strongly support the goals of *choice, personalisation, individualised outcomes and reduced bureaucracy*. We also feel SDS can help to create a more level playing field across the private, public and voluntary sectors and between publicly funded and self-funding service users. Members of the public should have an individualised budget to meet their care needs and desired outcomes, plus the necessary support to participate fully in the process of care and support planning.
- The *Talking Points* pilot in the Scottish Borders is a positive exploration of how that particular approach can be used in relation to care homes. At the same time, care needs to be taken when it comes to Self Directed Support as the default option. Many older people may neither want nor be able to discharge this responsibility themselves, and it could leave them even more dependent on the decisions made by family members or reliant on the services of care brokers.
15. Some areas in Scotland have Local Area Coordinators (LACs) as part of their strategy to improve independent living and draw on other community providers to offer their support services. North Lanarkshire Council has introduced LACs alongside a broader package of Self Directed Support to help people stay out of statutory care services by connecting them to local networks and support. Self Directed Support, however, has to be premised on ensuring each individual has access to the care they need and does not leave people inadequately provided for.
16. Tele-care and tele-health developments have real potential to enhance quality of life and create efficiency. This is already adding value to care at home and housing support. We believe that there could be significant gains in extending tele-health links into care homes, using the technology to provide a direct connection to clinics and hospitals, and preventing

unnecessary out-patient and in-patient visits. A great many routine tests and treatments could be carried out in-situ under the guidance and review of medical staff at the hospital end. The obvious caveat is that tele-health and tele-care elements complement rather than replace the input of trained and qualified staff.

17. West Lothian Council has started to demonstrate how tele-care and tele-health technologies can help people remain independent and avoid unnecessary admission to long-term care. West Lothian's Community Health and Care Partnership (CHCP) has developed an electronic self- assessment tool '*Safe at Home*' that has expert knowledge built in to calculate and provide a prescription of services targeted to the specific service user. This model would be readily transferrable to community based independent sector services.
18. *Time-banks* are reciprocal volunteering schemes, whereby individuals and their families can give time through volunteering and draw on this in the future as and when required. Time-banks could easily be attached to local services through the Care Hub model outlined above. In the Highlands, time-banks in Inverness, Lochaber and Badenoch and Stathspey already offer a way for people to get involved in community activities. Time-banks are an effective way of creating the incentive for participation and activity which has both physical and emotional benefits, as well as being part of community capacity building.
19. Finding solutions to current challenges also has to fit within the ongoing framework of regulation, the continued drive for quality improvement, and the promotion of the rights of service users. Providers have been proactive in supporting the Scottish Human Rights Commission in their focus on the rights of older people, and a new joint awareness raising programme, '*Care about Rights*', was launched on 9 September 2010.
20. It is very important, however, that the regulation of care supports service delivery and does not become an industry in its own right. Regulation needs to be proportionate to the care being delivered and flexible enough to respond to changing patterns of service delivery rather than becoming an obstacle to development. Providers welcome the potential of the new regulatory body, *Social Care and Social Work Improvement Scotland* (SCSWIS), to develop a fresh approach to regulation which looks at the experience of service users in the round, from referral and assessment to care delivery and review, ending the artificial divide which emanates from the current Care Commission - Social Work Inspection Agency division. We believe SCSWIS should be given time at the outset to establish its new approach and that it should not simply be more of the same from April 2011.

Section Five

Requirements for change

1. We believe the case for *care* and the case for *change* are clear. Building on existing provision and utilising a highly skilled and flexible workforce, there is the potential to develop a diversified care and support sector fit for purpose to meet the changing needs of Scotland's older people. We see the independent care sector as a significant Scottish industry with the potential for growth and development. In the same way as the Scottish Government has sought to support the construction industry, motor manufacturing or the renewable energy sector, so it should make clear its commitment and clarity about the future of the care services sector.

The case for care and the case for change are clear

2. Failure on the part of government to act now will risk the sector entering crisis as the need to make short-term savings drives down local authority spending. The net result of this will be to hold back the development of the new capacity required to seriously shift the balance of care and meet future need in the most cost-effective manner. As independent providers see it, getting the change agenda right demands:

Failure on the part of government to act now will risk the sector entering crisis

- » **A sense of urgency**
- » **Partnership**
- » **Clarity of direction**
- » **Radical change.**
- » **Leadership**

3. Much of this is agreed by all parties and has formed the basis of the *Reshaping Care* programme. The problem is taking the first steps in changing the status quo and not allowing the process to stall. Change will not simply happen or evolve, it has to be driven. Indeed the likelihood is that the current financial pressures will generate an atmosphere of protectionism and re-trenchment which may actually slow the process down and make transformation harder.
4. Failure to maintain the level of care and support funding will also potentially drive existing providers out of the market and deter new providers coming in. This has been highlighted recently by the journal of *Public Finance* as one of the likely knock-on effects of cuts in public sector finance. Major care providers in the UK have also signalled that cuts in care funding, whether in headline rates or the level of work, will seriously jeopardise stability and viability. This situation is likely to be accentuated in Scotland if the Health Service is to some extent protected from cuts and local councils have the *double whammy* of taking a larger hit in terms of the finance being allocated, whilst at the same time remaining solely responsible for health and social care procurement. It is health care in the round that should be protected and not simply the Health Service.

5. The key to unlocking things, therefore, has to be getting the flow of finance right. Maintain the current funding streams for health and social care and we will simply perpetuate the existing balance of care whilst trying to squeeze resource allocation. Making the Health Service a default partner with local authorities in the planning, funding and commissioning of health related care services would allow some pooling of budgets, incentivise change and resource the development of alternative community-based care and support. It would also allow the targeted use of funding to develop new capacity and models of service delivery in the areas most needed - *intermediate care, palliative care, assessment and rehabilitation, post-diagnostic dementia support, extra care housing, respite and community support*.
6. Shifting the balance of care requires shifting resources and without appropriate and sustained investment the required capacity will simply not develop. At a point of severe constraint, this means some redistribution of what is already there. Spending money in the right way, and on the right things, is the *win-win* approach. It will grow the capacity required to meet current and future need in innovative ways, and save the public purse in the longer-term by moving away from an unnecessary over-reliance on high-cost acute sector provision.
7. We would argue that a *Community Care and Support Services Programme Board*, including both provider and service user representation, fully empowered to drive forward the reshaping and funding agendas, should be established as a matter of urgency. Ideally, too, this should be agreed politically on an all party basis, so that progress is not dependent on the outcome of the Scottish Parliament elections in May, 2011.

It seems to us there is significant compatibility between the between the Reshaping Agenda and other proposals coming forward such as the development of a National Care Service. Moreover the challenges will remain the same.



Section Six

Provider commitment

1. In setting out the *Case for Care*, and being clear what we think the Scottish Government and other parties need to do, providers also wish to restate their own commitment to a number of key principles:
 - » The commitment to work in partnership with the Scottish Government, local authorities, National Health Service, regulatory bodies, service users and carers and other relevant parties to find positive solutions to the current challenges
 - » The commitment to pursue *best value* and *added-value* service developments with a willingness to respond flexibly to changing patterns of need. The future cannot simply be more of the same
 - » The commitment to work with local authorities and health boards on local and regional capacity planning, accepting that *right-sizing* capacity in the most cost-effective manner may mean addressing areas of over-capacity as well as growing new capacity
 - » The commitment to ensure that the drive for quality and the centrality of service users remains the top priority within a focus on delivering personalised outcomes
 - » The commitment to preventive approaches and anticipatory care planning, together with community capacity building, to keep the growth in demand for formal services at a manageable level
 - » The commitment to Scotland having *world class* care and support services for its older and more vulnerable people.

The commitment to Scotland having world class care and support services for its older and more vulnerable people

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“ Thank you for all the care and attention you gave to mum. It allowed her to live out her last years in a comfortable and loving environment. We are very appreciative of everything you did for her ”

