Health and social care series

Changing models of health and social care

Contents

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.

Key facts

Health budget in 2014/15

£11.86 billion

£10.8 billion

Scottish Government funding for councils in 2014/15

Number of people receiving ten or more hours of homecare per week in 2014

21,700

Number of emergency admissions in 2013/14

553,000

3.91 million

Number of hospital bed days from emergency admissions

Proportion of GPs aged 50 and over in 2015

34%

64%

Increase in population aged 85 and over between 2014 and 2030

Summary

Key messages

1 The growing number of people with complex health and social care needs, particularly frail older people, together with continuing tight finances, means that current models of care are unsustainable. New models of care are needed. With the right services many people could avoid unnecessary admissions to hospital, or be discharged more quickly when admission is needed. This would improve the quality of care and make better use of the resources available.

2 The Scottish Government has set out an ambitious vision for health and social care to respond to these challenges. There is widespread support for the 2020 Vision, which aims to enable everyone to live longer, healthier lives at home or in a homely setting. There is evidence that new approaches to health and care are being developed in parts of Scotland.

3 The shift to new models of care is not happening fast enough to meet the growing need, and the new models of care that are in place are generally small-scale and are not widespread. The Scottish Government needs to provide stronger leadership by developing a clear framework to guide local development and consolidating evidence of what works. It needs to set measures of success by which progress can be monitored. It also needs to model how much investment is needed in new services and new ways of working, and whether this can be achieved within existing and planned resources.

4 NHS boards and councils, working with integration authorities, can do more to facilitate change. This includes focusing funding on community-based models and workforce planning to support new models. They also need to have a better understanding of the needs of their local populations, and evaluate new models and share learning.

the shift to new models of care is not happening fast enough to meet the growing need

Recommendations

The Scottish Government should:

- provide a clear framework by the end of 2016 of how it expects NHS boards, councils and integration authorities to achieve the 2020 Vision, outlining priorities and plans to reach its longer-term strategy up to 2030. This should include the longer-term changes required to skills, job roles and responsibilities within the health and social care

workforce. It also needs to align predictions of demand and supply with recruitment and training plans

- estimate the investment required to implement the 2020 Vision and the National Clinical Strategy

- ensure that long-term planning identifies and addresses the risks to implementing the 2020 Vision and the National Clinical Strategy, including:

  – barriers to shifting resources into the community, particularly in light of reducing health and social care budgets and the difficulties councils and NHS boards are experiencing in agreeing integrated budgets

  – new integration authorities making the transition from focusing on structures and governance to what needs to be done on the ground to make the necessary changes to services

  – building pressures in general practice, including problems with recruiting and retaining appropriate numbers of GPs. The role of GPs in moving towards the 2020 Vision should be a major focus of discussions with the profession as the new GP contract terms are developed for 2017

- ensure that learning from new care models across Scotland, and from other countries, is shared effectively with local bodies, to help increase the pace of change. This should include:

  – timescales, costs and resources required to implement new models, including staff training and development

  – evaluation of the impact and outcomes

  – how funding was secured

  – key success factors, including how models have been scaled up and made sustainable

- work to reduce the barriers that prevent local bodies from implementing longer-term plans, including:

  – identifying longer-term funding to allow local bodies to develop new care models they can sustain in the future

  – identifying a mechanism for shifting resources, including money and staff, from hospital to community settings

  – being clearer about the appropriate balance of care between acute and community-based care and what this will look like in practice to support local areas to implement the 2020 Vision

  – taking a lead on increasing public awareness about why services need to change

  – addressing the gap in robust cost information and evidence of impact for new models.

NHS boards and councils should work with integration authorities during their first year of integration to:

- carry out a shared analysis of local needs, and use this as a basis to inform their plans to redesign local services, drawing on learning from established good practice

- ensure new ways of working, based on good practice from elsewhere, are implemented in their own areas to overcome some of the barriers to introducing new care models

- move away from short-term, small-scale approaches towards a longer-term approach to implementing new care models. They should do this by making the necessary changes to funding and the workforce, making best use of local data and intelligence, and ensuring that they properly implement and evaluate the new models

- ensure, when they are implementing new models of care, that they identify appropriate performance measures from the outset and track costs, savings and outcomes

- ensure clear principles are followed for implementing new care models, as set out in Exhibit 9 (page 30).

Information Services Division (ISD) should:

- ensure it shares and facilitates learning across Scotland about approaches to analysing data and intelligence, such as using data to better understand the needs of local populations.

Background

1. We have reported previously that NHS boards and councils are finding it increasingly difficult to cope with pressures facing health and care services. Our recent progress report on health and social care integration found that significant risks need to be addressed if integration is to fundamentally change the way health and care services are delivered. Evidence suggests that the new partnerships with statutory responsibilities to coordinate integrated health and social care services, integration authorities, will not be in a position to make a major impact during 2016/17. Many integration authorities have still to set out clear targets and timescales showing how they will make a difference to people who use health and social care services.

2. We have produced this report, building on our previous work on health and social care, to identify new local models of care and to help increase the pace of change. It aims to support new integrated authorities to implement new ways of working and address the challenges facing health and social care services.

3. We have produced two supplements to accompany this report:

- Supplement 1 [PDF] 🖰 is a handbook for local areas and includes:

  - case studies referenced throughout the report

  - a system diagram of the types of new care models being introduced across Scotland

  - links to useful documents and checklists.

- Supplement 2 🖰 is a model of East Lothian's whole-system approach to introducing new ways of working and the data analysis and intelligence that local partners are using to inform their work.

About the audit

4. This audit builds on key pressures identified in the demand and capacity work undertaken as part of the NHS in Scotland 2013/14 audit. It assesses how NHS boards, councils and partnerships might deliver services differently in the future to meet the needs of the population. Our report highlights examples of some of the new approaches to providing health and social care aimed at shifting the balance of care from hospitals to more homely and community-based settings. It also considers some of the main challenges to delivering the transformational change needed to deliver the Scottish Government's 2020 Vision for health and social care and actions required to address them.

5. We gathered evidence for the audit by:

- analysing national and local information, for hospitals, councils and community-based services to identify pressures in the system, including performance, activity and financial data

- carrying out projection analysis to estimate the potential effect of increasing pressures in health and social care

- conducting desk-based research to identify examples of new care models outside Scotland

- working closely with one partnership area to illustrate the types of changes required and how this affects different parts of the health and social care system

- interviewing staff from NHS boards, councils, the Convention of Scottish Local Authorities (COSLA), the Scottish Government and other relevant organisations, such as professional and scrutiny bodies.

Part 1

Health and social care in Scotland

Health and social care services are facing increasing pressures

6. In recent years, demands on health and social care services have been increasing because of demographic changes. People are living longer with multiple long-term conditions and increasingly complex needs. At the same time, NHS boards and councils are facing increasingly difficult financial challenges. There is general recognition that changes are needed and that NHS boards and councils need to support more people in the community.

The proportion of older, frail people is increasing

7. The proportion of older people is growing more rapidly than the rest of the population; this is a major factor contributing to the pressures on health and care services. The biggest changes are predicted in the 75 and over population (Exhibit 1). From 2002 to 2020, data shows an increase of around 6,600 people aged 75 and over each year. From 2021 up to 2039, it is estimated there will be around 16,000 more people aged 75 and over each year.[1] The 85 and over population is estimated to double by 2034.

> health and social care services need to adapt to cope with the effects of the changing population

Exhibit 1
The projected population of older people in Scotland, 2014-30
The percentage of the population aged 75 and over is set to increase considerably over the next 15 years.

75+ Population

↑**48%**

2014
433,235

2030
640,129

85+ Population

↑**64%**

2014
114,375

2030
187,219
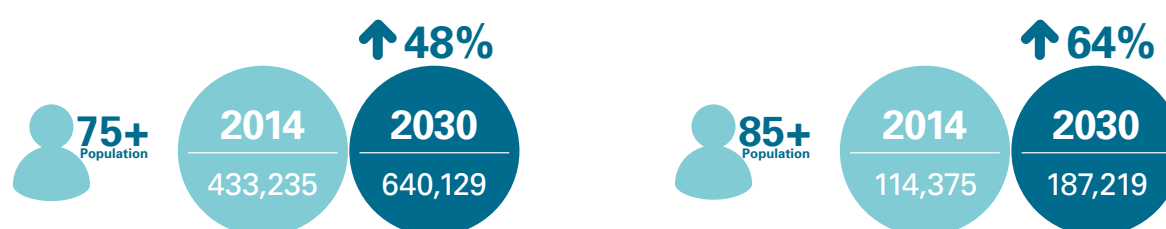
Source: *Projected population of Scotland (2014-based)*, National Records of Scotland, 2015

8. Although the population is ageing, overall healthy life expectancy (the number of years people might live in good health) has improved. Over time, this may help to reduce some of the pressure on health and social care services. Average healthy life expectancy increased between 2002 and 2008. It has remained at around the same level between 2009 and 2014. In 2014, average life expectancy for men was around 77 years and healthy life expectancy 60 years, and for women it was around 81 and

63 years.[2, 3] However, healthy life expectancy for men in the most deprived areas in Scotland still remains 18 years lower than those in the least deprived areas. GPs working in deprived areas face significant challenges in tackling health inequalities. GPs working in practices serving the 100 most deprived areas in Scotland (Deep End project) reported the following:

- They treat more patients with multiple health problems than GPs working in less deprived areas.[4]

- They are constrained by a shortage of consultation time with patients that limits the opportunity to provide appropriate treatment, advice and referral to suitable services.[5]

9. As people age they are more likely to have multiple conditions and become frail. Frailty is a decreased ability to withstand illness or stress without loss of function. For frail people, a minor injury or illness can result in a significant loss of function. Common conditions, such as dementia, also contribute to frailty.[6] In Scotland, an estimated ten per cent of people aged over 65 are frail and a further 42 per cent are at risk of becoming frail.[7]

10. Not all older people need support from health and care services, but for those that do, it is important that these services are well coordinated. They should focus on preventing ill health and where possible reduce the need for hospital-based care. Older people make more use of hospital services than the rest of the population, particularly unplanned care such as A&E services and emergency admission to hospital. Older patients are more likely to remain in hospital for longer. The majority of people who are nursed at home, and get help with daily living activities such as washing, dressing and eating, are aged 75 or older.[8]

The number of emergency admissions to hospital is increasing

11. The number of people admitted to hospital in an emergency is an important measure that can indicate problems in other parts of the health and care system, such as a lack of social care support in the local area. Of all admissions to acute hospitals, around 85 per cent are emergency admissions. Around 30 per cent of emergency admissions relate to surgical specialties, such as orthopaedic surgery or urology. The majority of these admissions are not preventable and these patients require hospital treatment. However, there is scope to reduce emergency admissions by providing more preventative and community-based services. This includes emergency admissions in medical specialties such as general medicine, geriatric medicine, psychiatry of old age, rehabilitation medicine, and GP beds. The number of people admitted to hospital in an emergency between 2005/06 and 2013/14 increased by almost 80,000 (17 per cent), to 553,000. The number of emergency admissions increased by 17 per cent for people aged 65-74, by 19 per cent for people aged 75-84 and by 39 per cent for people who were aged 85 and older (Exhibit 2, page 11). Older people are more likely to be admitted to hospital in an emergency than people aged under 65. In 2013/14, 71 per cent of emergency bed days were occupied by people aged 65 and over. Of these:

- 18 per cent were occupied by people aged 65-74

- 29 per cent were occupied by people aged 75-84

- 23 per cent were occupied by people aged 85 and older.

12. The number of emergency bed days for older people admitted to hospital three or more times in a year is increasing. Between 2005/06 and 2013/14, the number of bed days occupied by people aged 65 and over from multiple emergency admissions increased by 38 per cent to over 685,000 bed days. For people aged 65-74, the number of bed days increased by 18 per cent, for people aged 75-84 by 35 per cent, and for people aged 85 and older by 76 per cent (Exhibit 2).[9]

13. Although the overall number of emergency bed days has been reducing, the number of emergency admissions has been increasing along with the associated costs. Patients admitted to hospital in an emergency have a shorter length of stay, but most costs are incurred in the first few days when tests,

Exhibit 2

Increase in emergency admissions and multiple emergency admission bed days, by age group, 2005/06 to 2013/14
The number of older patients admitted to hospital in an emergency and the number of bed days for multiple emergency admissions (three or more admissions in one year) have increased considerably.
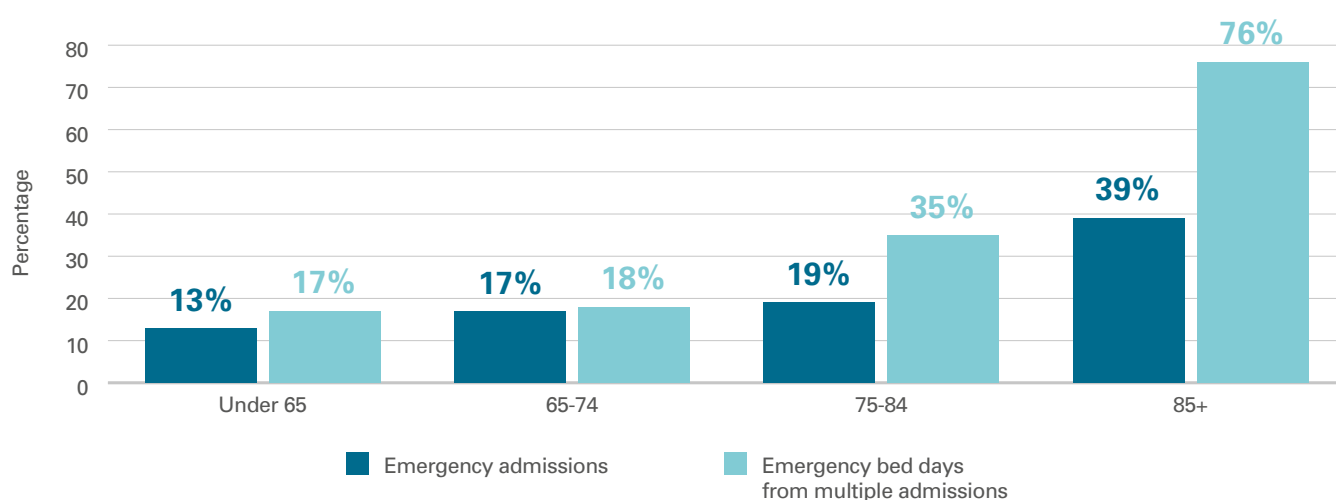
Source: SMR01 activity analysis provided to Audit Scotland by ISD, November 2015

investigations or treatments are carried out. An emergency admission to hospital is more expensive than a planned admission. This means that although the percentage increases in the number of all admissions to hospital and in the number of emergency admissions are similar, the percentage increase in costs for emergency admission is higher (Exhibit 3, page 12).

14. There is more to be done to ensure that people are receiving the best care and treatment, rather than being admitted to hospital as an emergency, and to reduce hospital costs to allow more effective use of resources. An example is putting in place models of care to support older people in the community and prevent admission to hospital where possible. We highlight examples of this happening in some areas later in the report. To address the current challenges in relation to emergency admissions, a number of partners across the health and care system need to work well together. This includes GPs, community nurses and social care staff.

Exhibit 3
Changes in admissions to hospital and associated costs and bed days, 2010/11 to 2013/14
The total number of emergency bed days has been decreasing, but the number of emergency admissions has been increasing along with the associated costs.

H Admissions to hospital				Hospital bed days	
Number		**£ Costs**		**Number**	
All admissions	Emergency admissions	All admissions	Emergency admissions	All admissions	Emergency admissions
752,000	**553,000**	**£3.35 billion**	**£2.57 billion**	**4.61 million**	**3.91 million**
5% ↑	6% ↑	1% ↑	5% ↑	4% ↓	3% ↓

Source: IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2013/14, ISD Scotland, March 2015; SMR01 activity analysis provided to Audit Scotland by ISD, November 2015

Health and social care services need to adapt to cope with the effects of the changing population

15. Pressures on health and social care services are likely to continue to increase over the next 15 years. It is difficult to know the extent of this growth but NHS boards and councils are finding it challenging to cope with the present demand for health and social care services. These increasing pressures have significant implications for the cost of providing health and social care services and challenges in ensuring that people receive the right care, at the right time and in the right setting. To address this, local partnerships need to redesign services to avoid unnecessary admissions to hospital. Where hospital admissions cannot be avoided, support needs to be put in place to get people home as quickly and as safely as possible. Local areas are developing approaches involving targeting both small numbers of individuals who use high levels of resources and prevention in the broader population.

16. To help to explain the complexity of the health and social care system, and the potential impact changing demographics will have on services over the next 15 years, we have prepared Exhibit 4 (page 13). It shows projected rises in activity arising from a growing, ageing population. These are based on applying projected increases in the population to key measures that can indicate how well the system is working. The health and social care system is inter-related. If anything goes wrong in one part of the system, it can affect other parts of the system. The growing population will affect all parts of the health and social care system. If the population increases as predicted, and services continue to be delivered in the same way, the impact across the system is significant and highlights the need for change. Based on our projection analysis, in 2030, compared to 2013, there could be an additional:

- 1.9 million GP appointments and 1.5 million practice nurse appointments

Exhibit 4

Pressures on health and social care services, 2013-30

If current rates of activity continue, it is unlikely that health and social care services will be able to cope with the effects of the changing population unless they make major changes to the way they deliver services.

↑ **12%**

2013 16,301,615 **2030** 18,200,000

GP consultations

↑ **33%**

2013 61,060 **2030** 81,000

Homecare clients

↑ **31%**

2013 20,529 **2030** 26,800

Homecare clients receiving 10+ hours of care per week

↑ **18%**

2013 8,049,120 **2030** 9,500,000

Practice nurse consultations

↑ **35%**

2013 34,933 **2030** 47,000

Long-stay care home residents

Projected change in the age structure of Scotland's population (2013-30).

All ages ↑ **5%**

Age group	Change
0-15	2%
16-64	-3%
65-74	32%
75-84	44%
85+	68%

Age groups

↑ **26%**

2013 1,017,925 **2030** 1,280,000

Acute emergency bed days from patients with 3+ admissions

↑ **14%**

2013 452,359 **2030** 514,000

Acute day cases

↑ **28%**

2013 3,910,221 **2030** 5,000,000

Emergency bed days

↑ **16%**

2013 553,211 **2030** 640,000

Acute emergency admissions

↑ **9%**

2013 1,645,914 **2030** 1,800,000

New outpatient appointments

Note: Each indicator (eg, number of emergency admissions) is calculated as a rate of the population by using National Records of Scotland mid-year population estimates. The rate in 2013/14 is assumed to continue over the projection years. Over each of the projected years, the estimated rate is multiplied by the estimated projected population to find the number for that indicator.

Source: Audit Scotland analysis, 2016

- 20,000 homecare clients and 12,000 long-stay care home residents

- 87,000 emergency admissions to hospital and 1.1 million associated hospital bed days

- 62,000 hospital day cases and 154,000 outpatient appointments.

17. A number of factors will affect how much these pressures continue to increase, including: the ageing population; levels of deprivation and health inequalities; changes in healthy life expectancy; and the extent to which new ways of providing services are adopted, particularly preventative and community-based services. However, it is clear that health and social care services will need to be delivered differently to cope with the increasing pressures associated with the growing population.

NHS boards and councils are facing increasing financial pressures

18. The Scottish Government has estimated it would need an annual increase in investment of between £422 million and £625 million in health and social care services to keep pace with demand.[10] Its assumption is based on current service models remaining the same and demand increasing in line with the growth in the older population and changes in healthy life expectancy. This level of investment is not sustainable in the current financial climate. Budgets for health and social care services are reducing. Over the period 2010/11 to 2014/15:

- The health budget decreased by 0.6 per cent in real terms, that is allowing for inflation, to £11.86 billion.[11] The draft health budget is set to increase by 3.6 per cent in real terms in 2016/17. It includes £250 million of funding in NHS boards' budgets for integration authorities aimed at improving outcomes in social care.[12]

- Scottish Government overall funding for councils decreased by 5.9 per cent in real terms to £10.8 billion. Between 2010/11 and 2013/14, spending on social care services increased slightly by two per cent to around £3 billion.[13, 14] In 2016/17, Scottish Government funding for local government is set to decrease by 7.2 per cent.

GPs are central to developing new types of care, but pressures are building in general practice

19. GPs have a key role to play in coordinating care for patients, involving other professionals such as nurses, occupational therapists, physiotherapists and social workers as required. Owing to increasing pressures on GPs' time, new models of care will need to ensure patients are referred to the most appropriate professional based on needs, allowing GPs to focus on patients with complex needs.

20. There is currently a major gap in information about demand and activity for most community health services, including general practice services. Until 2012/13, the Information Services Division (ISD) of National Services Scotland collated practice team information (PTI). This will be replaced by a new system, Scottish Primary Care Information Resource (SPIRE). A phased roll out of SPIRE is due to start in March 2016 and complete by January 2017. It is essential to have good information on the patterns of use of general practice and demand for services to be able to design new models of care.

21. In the absence of published demand and activity data, a number of other indicators point to pressures building in general practice. These include patients' declining satisfaction with access to general practice, increasing patient visits to general practice, recruitment and retention issues, and dissatisfaction among GPs (Exhibit 5, page 16). These all have implications for the quality of care patients receive and their health outcomes. The National Audit Office has found that similar issues also exist in England.[15] The Scottish Government is in the process of negotiating a new contract for 2017 with GPs, partly to address some of these concerns.

The Scottish Government has set out an ambitious vision for health and social care

22. In September 2011, in recognition of the challenges facing health and social care, the Scottish Government set out an ambitious vision to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[16] This vision aims to help shape the future of healthcare in Scotland in the face of changing demographics and increasing demand for health services. Central to the vision is a healthcare system with integrated health and social care, and a focus on prevention, anticipation and supported self-management. Some of the main principles of the policy, particularly in relation to shifting more care and support into the community, are:

- focusing on prevention, anticipation, supported self-management and person-centred care

- expanding primary care, particularly general practice

- providing day case treatment as the norm when hospital treatment is required and cannot be provided in a community setting

- ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

- improving the flow of patients through hospital, reducing the number of people attending A&E, and improving services at weekends and out-of-hours

- improving care for people with multiple and chronic conditions

- reducing health inequalities by targeting resources in the most deprived areas

- planning the workforce to ensure the right people, in the right numbers in the right jobs

- integrating adult health and social care.

Integration of health and social care is integral to delivering the 2020 Vision

23. Health and social care services in Scotland are currently undergoing reform. Under these arrangements NHS boards and councils are required, as a minimum, to combine their budgets for adult social care, adult primary healthcare and aspects of adult secondary healthcare. This accounts for more than £8 billion of funding that NHS boards and councils previously managed separately. The new integration authorities are expected to coordinate health and care services and commission NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided, with a greater emphasis on preventative services and

Exhibit 5
Indicators of building pressure in general practice
There is a lack of data on general practice activity and demand for services. But available indicators show pressures on general practice continuing to build.

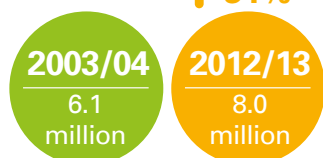### General practice activity

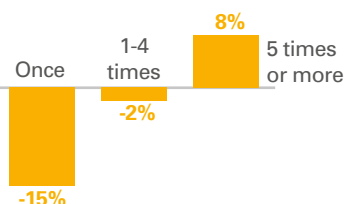**11%** increase in patient contacts between 2003/04 and 2012/13 to 24.2 million

67% of contacts were with GPs in 2012/13

This increase is primarily driven by a rise in practice nurse contacts of ↑ **31%**

2003/04 6.1 million

2012/13 8.0 million

Change in patients contacting their GP practice 2011/12 to 2013/14

Once **-15%**
1-4 times **-2%**
5 times or more **8%**

24.2 million GP contacts (2012/13)

1.6 million A&E and Minor Injury Unit attendances (2012/13)
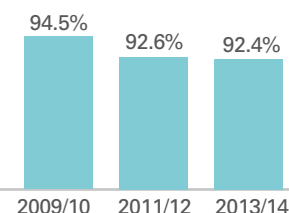
0.9 million Out-of-hours contacts (2014/15)

Patient experience 2013/14

1 in 6 patients found it difficult to get through to their GP practice on the telephone

The percentage of people able to see or speak to a doctor or nurse within 48 hours has decreased

94.5% 2009/10
92.6% 2011/12
92.4% 2013/14

78% of patients said they were able to book appointments 3 or more days in advance

2015 BMA survey of 1,800 GPs in Scotland

25% of GPs described their workload as unmanagable

69% felt workload had a negative impact on their personal commitment to their career

a third would like to retire by 2020

17% of practices had at least one vacancy

Workforce

Around 1 in 2 community nurses were aged 50 and over, compared with 1 in 3 hospital nurses in 2015

34% of all GPs were aged 50 and over in 2015, compared with 29% in 2005
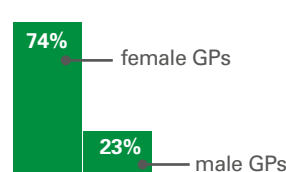
↑ **37%** increase in female GPs over the ten-year period to 2015

↓ **15%** decrease in male GPs over the ten-year period to 2015

Percentage of GPs working part-time in 2013
74% female GPs
23% male GPs

GP partners aged 50 and over
33% 2005 vs **42%** 2015

allowing people to receive care and support in their home or local community, rather than being admitted to hospital. The integration authorities will be responsible for delivering new National Health and Wellbeing Outcomes.[17] These focus on the experiences and quality of services for people using those services, carers and their families. Examples of the outcome indicators include the percentage of adults able to look after their health very well or quite well, and the percentage of people with a positive experience of the care provided by their GP practice.[18]

24. Our recent report on progress towards integration of health and social care services confirms that the new integration authorities are expected to be operational by the statutory deadline of 1 April 2016. However, there are a number of issues that the integration authorities need to address if they are to take a lead on improving local services. These include agreeing budgets, and setting out comprehensive strategic plans, clear targets and timescales to show how they will make a difference to people who use health and social care services. They will also need to deal with significant long-term workforce issues and ensure that complex governance arrangements, including the structures and processes for decision-making and accountability, work in practice.[19]

Part 2
New ways of providing health and social care

New approaches to delivering health and social care are emerging

25. We have identified a number of new models across Scotland that are designed to deliver more care to people in community settings in line with the 2020 Vision. We have identified different types of care models in local areas, including:

- community preventative approaches

- better access to primary care and routine hospital treatments

- enhanced community care models

- intermediate care models

- initiatives designed to reduce delayed discharges.

26. We have not reviewed all new models in all areas of Scotland. We have selected a number of examples in some areas of Scotland to illustrate the different types of models that exist and to highlight particular aspects of good practice (Exhibit 6, pages 20-21). These include ten primary and community care 'test sites' referenced in the Scottish Government's Programme for Government, published in September 2015.[20, 21] Some of these are at an early stage of development and others are more established. They include:

- local GP surgeries working together for faster appointments

- GPs and health professionals, such as nurses, physiotherapists and pharmacists, working together in multidisciplinary teams

- providing treatment that patients currently have to travel to hospital to receive.

27. The Scottish Government intends to work closely with the ten test sites over the next two years to offer support and guidance and share learning.

28. We have produced a supplement to the report containing case studies (Supplement 1 [PDF]). There are hyperlinks throughout the report to the relevant case studies.

29. Most new care models are designed to relieve pressures on the acute sector but have an impact on different parts of the health and social care system. A high-level system diagram showing where the new models of care described in Exhibit 6 sit within the overall health and social care system is set out in Supplement 1 [PDF] .

new care models are emerging but there is a lack of evidence about what works

New models need to be implemented and evaluated properly

30. A common issue with many of the new care models being introduced across Scotland is a lack of evidence about the impact, implementation costs, efficiency gains or cash savings, and outcomes for service users. Some new ways of working are based on similar models from elsewhere, either another part of Scotland or other countries. But it is still important to monitor any new models to assess the impact on local systems and assess the costs, savings, outcomes and sustainability. This will help to assess the value for money of new models, whether the benefits justify the costs and if they should be rolled out more widely. For many of the new models that have been introduced in Scotland, it is too early to assess their impact. We were not able to carry out a cost benefit analysis for the care models described in Exhibit 6 owing to a lack of local cost information.

31. Many organisations highlighted the lack of time, resource and skills as a barrier to carrying out major change and also to properly evaluating new models. Senior managers in local bodies need to recognise that a successful change programme requires strong leadership and experience in change management to take forward major changes to services. Also, sufficient resources need to be included in the business case for changes to be properly implemented and evaluated.

More can be learned from the innovation of others

32. Although not all the models and approaches listed in Exhibit 6 will be directly transferable in their entirety to other areas, they each include aspects of innovation and improvement which can help inform how services could develop in other areas. In the following paragraphs we explore particular aspects of some of the models in more detail to provide a flavour of the new approaches being taken in some local areas.

Using a model of care focusing on the whole population to achieve a sustainable service

Population health models of care aim to improve the health of the entire population, rather than targeting specific age groups or certain conditions. Within this model the focus is on preventative measures and reducing inequalities. Case study 1 [PDF] provides details of a GP practice in Forfar developing a model of care focused on the whole population to improve access, health and wellbeing and to sustain services in the longer term in the light of the pressures we highlighted in Part 1.

33. The Nuka model of care from Alaska, also described in Case study 1 [PDF], has influenced the model the Forfar GP practice is developing. Native Alaskans create, manage and own the whole healthcare system. Multidisciplinary teams provide integrated health and care services in primary care centres and the community. These are coordinated with a range of other services and combined with a broader approach to improving family and community wellbeing.

Multidisciplinary teams working together to keep people at home

34. Recent work by the King's Fund suggests that collaboration through place-based systems of care offers NHS organisations the best opportunity for tackling the growing challenges facing them. This is where organisations work together to improve health and care for the local populations they serve.[22] There are examples of place-based care in Scotland in Tayside (Case study 2 [PDF]) and Glasgow (Case study 3 [PDF]).

Exhibit 6
New models of health and social care in Scotland
We have identified different types of new approaches to delivering health and social care in Scotland.

Community preventative approaches

These help people to stay in the community, in particular people with multiple conditions and complex needs. These approaches aim to help people self-care and to reduce people's demands for healthcare in the longer term. Examples of self-care include changing diet, taking more exercise or taking medicines at the right time.

- Two GP practices in Forfar are planning to merge into one of the largest practices in Scotland. Patients will be allocated to one of five multidisciplinary teams within the practice, each delivering a patient-centred model of care. Each multidisciplinary team will include GPs, nurses, healthcare assistants, an administrator and a named community nurse. The patients are encouraged to manage their conditions and self-care (Case study 1 [PDF]).

- The House of Care model is being tested in Lothian, Tayside and Glasgow. This approach encourages people living with multiple, long-term conditions to self-manage their care through joint planning, goal-setting and action planning.

- Patients with complex and/or multiple conditions from deprived areas in Glasgow may be eligible to be part of the CAREplus initiative. Inclusion allows patients longer consultations with a GP or nurse. This enables them to discuss their problems in more detail and make a list of priorities (Case study 3 [PDF]).

- The Links Worker Programme has placed community links practitioners in GP practices in deprived areas of Glasgow. They are not medically qualified, but link practices and patients with community-based services and resources such as lunch clubs and self-help groups based on individual patients' needs (Case study 3 [PDF]).

Improved access to primary care and routine hospital treatments

These approaches are designed to improve access to care for local people by health professionals working together, or in a different way.

- New community health hubs in Fife and Forth Valley: Patients will be able to get access to a range of services that they would normally have had to travel to an acute hospital to receive. A new type of doctor will be part of the healthcare team. They will be qualified GPs with an extra year of training to give them the skills they need to work across primary and acute care. This training began in autumn 2015.

- The new model of delivering healthcare for the Small Isles (Canna, Rum, Eigg, Muck and surrounding islands) is a combination of telehealth facilities and improving local skills to deal with healthcare needs. This is alongside a visiting service provided through NHS Highland's new rural support team, initially led by two GPs based on Skye. The rural support team includes GPs, nurse practitioners and paramedics.

Enhanced community care

This is a multidisciplinary team approach aimed at keeping people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Some models also support quicker discharge from hospital.

- The Tayside Enhanced Community Support Service enables GPs, with the support of a multidisciplinary team, to lead the assessment of older people with frailty and at risk of unplanned hospital admission, and to respond to any increased need for health and social care support (Case study 2 [PDF]).

Cont.

Enhanced community care (continued)

- **East Lothian service for the integrated care of the elderly (ELSIE):** This whole-system approach offers access to multidisciplinary and multiagency emergency care at home, or the place people call home, to older people. The service offers a single point of contact for both people who are at risk of being admitted to hospital, and to actively facilitate the discharge of people from hospital (Supplement 2).

- **Forth Valley's Advice Line For You (ALFY)** is a nurse-led telephone advice line to help older people remain well at home. Nursing advice is available 24 hours a day, seven days a week (Case study 5 [PDF]).

- **The Govan SHIP project** aims to reduce demand for acute and residential care and improve chronic disease management. Four GP practices in Govan Health Centre provide a multidisciplinary approach to patients of any age who are known to be vulnerable (Case study 3 [PDF]).

- **Community-based dementia care:** In Perth and Kinross, the closure of a number of community hospital dementia beds allowed increased investment in community mental health teams that are looking after more patients in their own homes (Case study 8 [PDF]).

Intermediate care

This involves time-limited interventions aimed at promoting faster recovery from illness and maintaining the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care.

- **The Glasgow Reablement Service** provides tailored support to people in their own home for up to six weeks. It builds confidence by helping people regain their skills to do what they can and want to do for themselves at home (Case study 8 [PDF]).

- **Bed-based intermediate care** is provided across most health and social care partnerships. Step-up beds are for people admitted from home for assessment and rehabilitation as an alternative to acute hospital admission. Step-down beds are for people who are well enough to be discharged from acute hospital but need a further period of assessment and rehabilitation before they can return home.

Reducing delayed discharges

These approaches aim to increase the understanding of the reasons for delays in patients being discharged from hospital, and find ways to reduce this. A number of models combine reducing delayed discharges with providing enhanced care in the community to prevent people being admitted to hospital in the first place.

- **Tayside Enhanced Community Support Service** (as above)

- **East Lothian Service for the integrated care of the elderly (ELSIE)** (as above)

- **The Glasgow 72-hour discharge model** ensures patients who are considered fit for discharge from hospital are discharged within 72 hours. Their options for discharge are to go home, or home with support in place if needed. Another option is for people to go to a temporary care bed for a maximum of four weeks where they will be assessed and rehabilitated and a care plan will be developed and agreed for them.

- **The East Lothian 'Discharge to Assess' service** is delivered by physiotherapists and occupational therapists who provide early supported discharge and assess patients at home, rather than in an acute setting. This includes arranging equipment, active rehabilitation and developing packages of care. The service is an integral part of ELSIE (as mentioned in the above section: 'Enhanced community care').

Source: Audit Scotland

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35. A number of areas across Scotland have recently introduced an enhanced community support model. This tends to involve multidisciplinary teams delivering an enhanced level of care, working together to keep people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Tayside has combined this model of care with a local area-based approach that aligns consultant geriatricians to GP practices (Case study 2 [PDF]).

36. Most enhanced community support service models are targeted towards older people. However, in one area of Glasgow, three new linked approaches to delivering health and social care are facilitating an enhanced service for anyone in the local population who is judged to be vulnerable. This includes people with mental health problems or people who use services frequently and people with complex needs. Case study 3 [PDF] ⬚ provides more detail of these three approaches and includes patient stories to illustrate the difference the new approaches have made to people using the service.

Nurse-led approaches that maximise the population's resilience

37. The Buurtzorg model of care from the Netherlands is an example of an effective nurse-led approach to delivering health and social care that maximises people's resilience (their ability to withstand stress and challenge) (Case study 4 [PDF] ⬚). Health and social care organisations can help to build people's resilience by: supporting them to look after themselves; providing preventative services that keep them well in the community; and by ensuring they know how to access help if things go wrong. Forth Valley has introduced some of the elements of this approach in its Advice Line For You (ALFY) model (Case study 5 [PDF] ⬚).

38. The ALFY model's *Your Plan* enables people to take responsibility for the challenges they face and to use their own skills and abilities, and friends, family and people who care for them, to develop resilience. This echoes the Buurtzorg service that promotes self-care, independence and the use of informal carers. The Buurtzorg model has improved the quality of patient care through round-the-clock access to a district nursing team by telephone or a home visit service. Results have shown:

- a correlated decrease in unplanned care and hospital admissions

- better patient satisfaction, when compared to other homecare providers in the Netherlands.[23]

Longer-term strategic approaches

39. We have found evidence of longer-term programmes supporting the 2020 Vision, where organisations have built on previous work, identified priority areas to focus on and are working on scaling up a number of models:

- The Scottish Ambulance Service's strategic approach to patient care involves closer working with primary care teams to ensure patients are referred to the most appropriate service, and to avoid admission to hospital wherever possible (Case study 6 [PDF] ⬚).

- The Scottish Centre for Telehealth and Telecare's Technology Enabled Care Programme encourages more use of established technology to help improve health and wellbeing outcomes (Case study 7 [PDF] ⬚).

Taking a whole-system approach

40. East Lothian partnership is taking a whole-system approach to understanding its local population and planning health and social care services and has the following long-term objectives:

- to increase the percentage of over 65s living at home

- to increase the percentage of spending on community care compared with institutional care

- to increase years of healthy life.

41. East Lothian recognises a number of challenges to providing health and social care services to its local population. East Lothian is developing intelligence about various parts of the health and social care system and using it to improve the way it delivers services. An analysis of East Lothian's population and primary care data shows:

- an ageing population with increasing levels of frailty and complex health needs

- increasing hospital admissions in some local areas from younger people with increasing long-term conditions and ill-health

- the groups of people who use a disproportionately high level of health services are those who are nearing the end of their life, are in care homes or have mental health needs

- relatively low numbers of people being admitted to hospital in an emergency, but high rates of occupied bed days and delays in discharge from hospital

- variety in the quality of access to GPs in different practices across East Lothian

- a predicted shortage of GPs owing to an ageing workforce

- preliminary information on the demand levels on GPs, such as the percentage of the practice population presenting to the GP each week.

42. To meet its objectives, East Lothian is focusing on:

- understanding the pattern of service use by high resource users and working out ways of intervening earlier to improve the support people receive and reduce unnecessary demand for services

- expanding ELSIE for people who are at risk of admission to hospital or have just been discharged from hospital to 24 hours a day, seven days a week

- supporting primary care services to meet demand to improve access for patients and to promote early intervention and prevention

- conducting a comprehensive bed modelling exercise to address the problem of delayed discharges, bring patients from Edinburgh hospitals closer to home and ensure efficiency and effectiveness of services.

43. East Lothian is bringing together growing intelligence about its population, how people access services, and various strands of work which all aim to improve how it delivers services. This is allowing the partnership to build a comprehensive picture of the needs of its local population. It is also taking into account how changes to services affect different parts of the health and social care system and how these are linked. However, the partnership still has to fully evaluate the impact of new ways of working it has recently introduced. The different elements of East Lothian's whole-system approach to health and social care are summarised in Exhibit 7 (pages 24-25). An interactive version of this exhibit is set out in Supplement 2 and provides more detail on the overall approach.

Exhibit 7
East Lothian's whole-system model
In East Lothian intelligence on various parts of the health and social care system is being used to change the way that services are being delivered.

Exhibit 7 continued

Sheltered housing

Very sheltered housing

Engaging housing departments

Bed modelling work

Intermediate care step-up beds (planned for Roodlands Hospital)

New Community Hospital East Lothian

Hospitals (within and outside East Lothian)

Delayed discharge

Delayed discharge prediction model (planned)

Delayed discharge mapping

Care home residents, analysis of pathways and understanding hospital admissions

High costs of Health and Social Care

Limited care home capacity

Care homes in East Lothian

ELSIE model

Care home liaison team

Discharge to Assess

Hospital TO home

Hospital AT home

Intermediate care step-down beds. 20 step-down beds at Crookston Day Centre

Emergency Social Work Service

Lack of home care capacity

Stronger links between ELSIE staff and Marie Curie hospice (eg secondments)

End of life care model (planned)

De-centralising District Nursing team (planned)

Ageing population and frailty

People at end of life: analysis of patient pathways. Understanding preventable hospital admissions

End of life care (high number of acute bed days in last six months of life)

Care at home

NHS 24

GP out-of-hours service

Home Service

Out-of-hours centre

Understanding out-of-hours admission patterns

Planned review of out-of-hours team requirements

People with mental health needs: analysis of patient pathways. Understanding preventable hospital admissions

Mental health conditions

Other Community Health Services including pharmacy, occupational therapy, physiotherapy

Volunteer services for older people

Third Sector Community Capacity Building Projects

Older people's resource centre

Community health transport

Community networks

Day centre development

GP telephone access pilot

Federation of GP practices for same day demand. GP practices joining together to improve same day access for their patients

GP practices

Assessing link between demand and capacity and practice income

Understanding same day demand and complex care demand

Practice risk assessment tool

Variation in access and service across East Lothian

Future capacity issues in GP workforce

Primary care strategy to develop a triage system where patients are referred to the most appropriate professional based on needs

High-level training for 14 Advanced Nurse Practitioners (eg, qualified for home visits)

Legend:
- Core service
- Local data/intelligence
- Project/new intervention
- Flow of people
- Influence of intelligence or a new intervention
- Intelligence icon
- East Lothian Service for Integrated care of the Elderly (ELSIE)
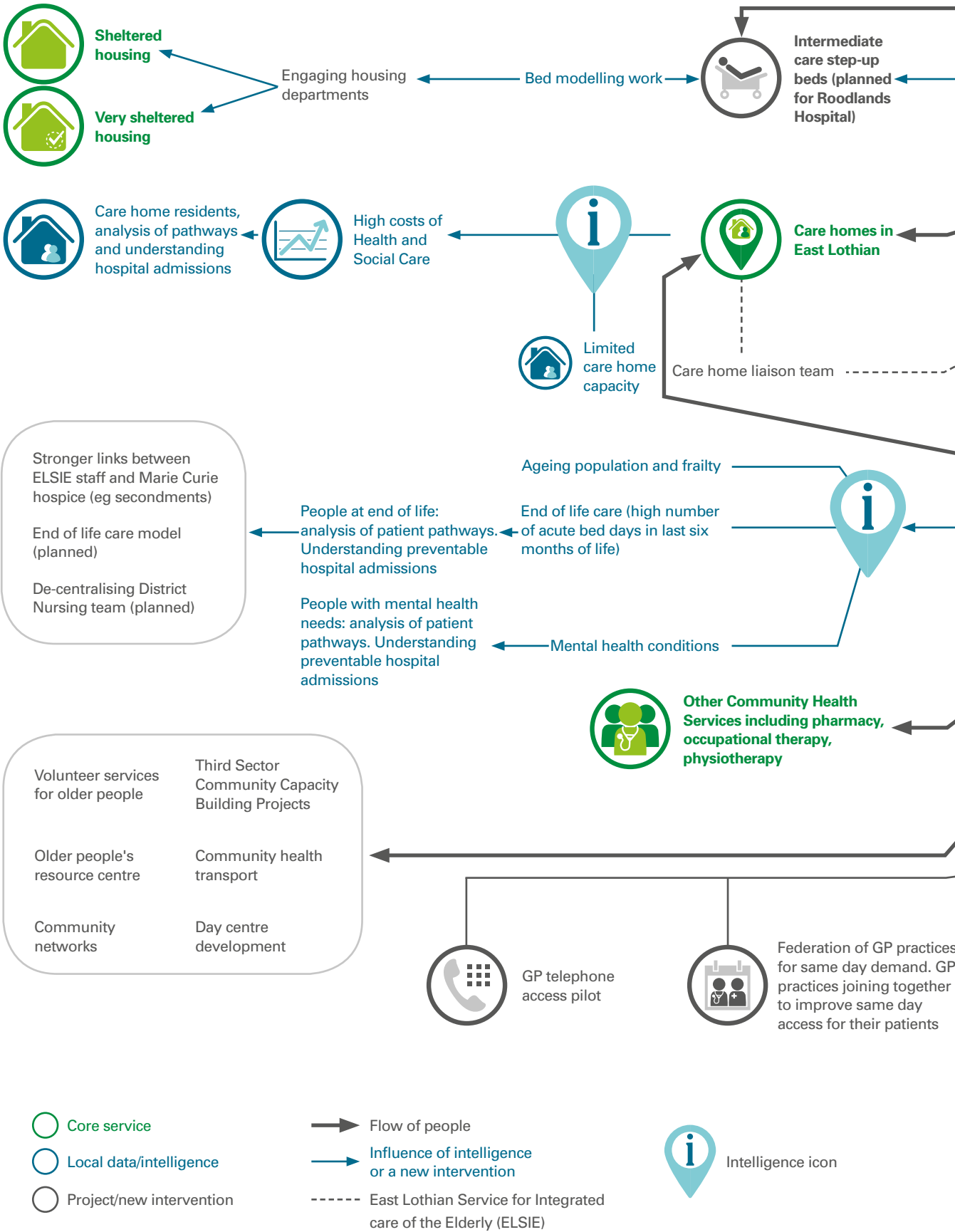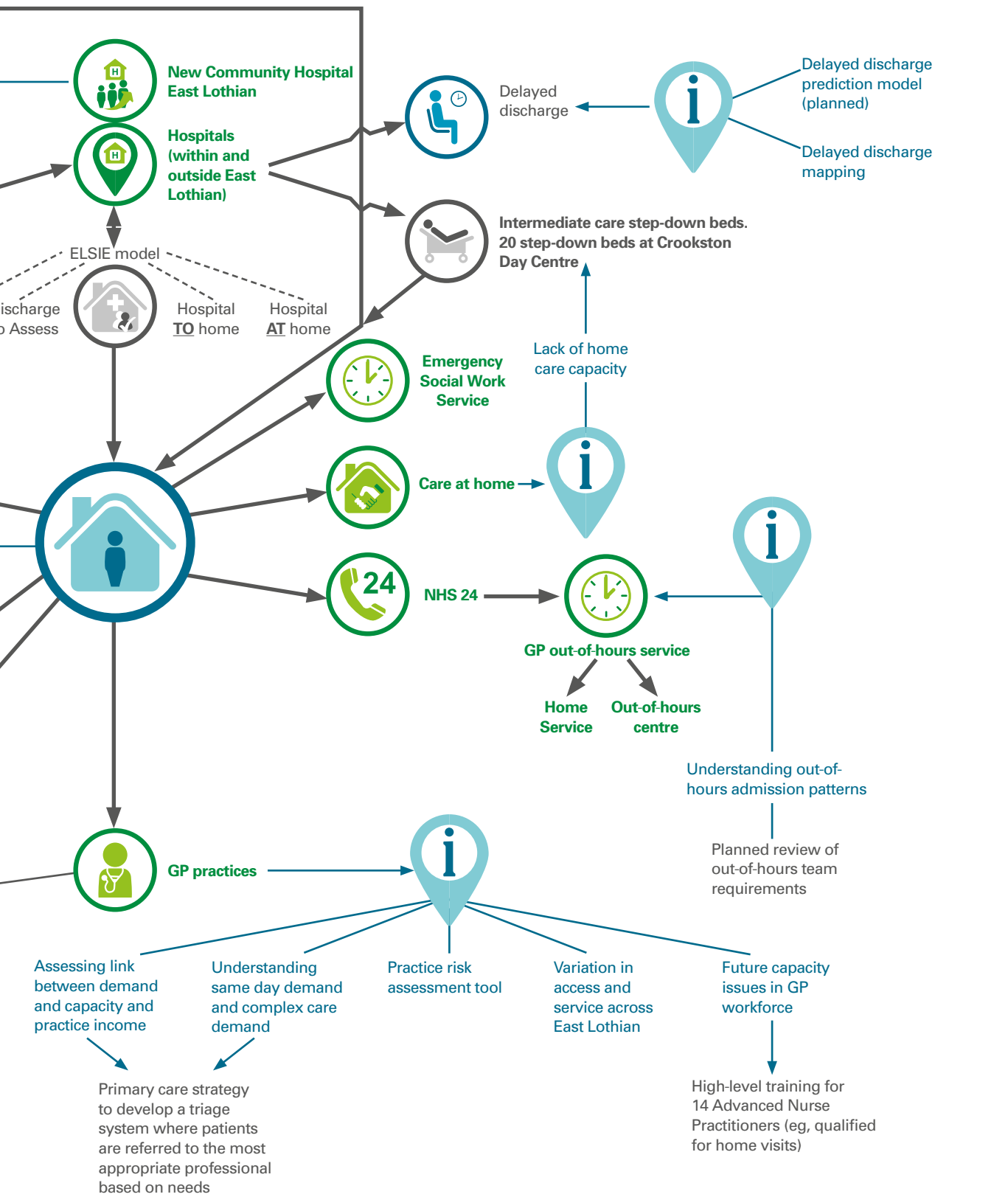
Source: Audit Scotland

Part 3

Making it happen

The transformational change required to deliver the 2020 Vision is not happening

44. Public sector bodies have continued to deliver health and social care services in an increasingly challenging environment. This includes tightening budgets, changing demographics, growing demand for services, increasing complexity of cases and rising expectations from people who use these services. Alongside these pressures, NHS boards and councils are implementing major service reform to integrate adult health and social care services. It is clear that services cannot continue in the same way within the current resources available.

45. Transformational change is required to meet the Scottish Government's vision to shift the balance of care to more homely and community-based settings. NHS boards and councils need to significantly change the way they provide services and how they work with the voluntary and private sectors. Traditionally there has been an emphasis on hospital and other institutional care rather than the community-based and preventative approach outlined in the 2020 Vision. We have highlighted in previous reports that despite the Scottish Government's considerable focus and resources aimed at shifting the balance of care over a number of years, this has not changed to any great extent.[24] We will monitor trends in the balance of care as part of our ongoing work on health and social care integration.

46. Over the four-year period from 2010/11 to 2013/14, the balance of expenditure on institutional services, such as hospitals and care homes, and on care at home or in community settings, has remained static. The percentage of total expenditure on adult health and social care (around £11.7 billion) has remained at 56 per cent for institutional-based care and 44 per cent for community-based care (Exhibit 8, page 27).
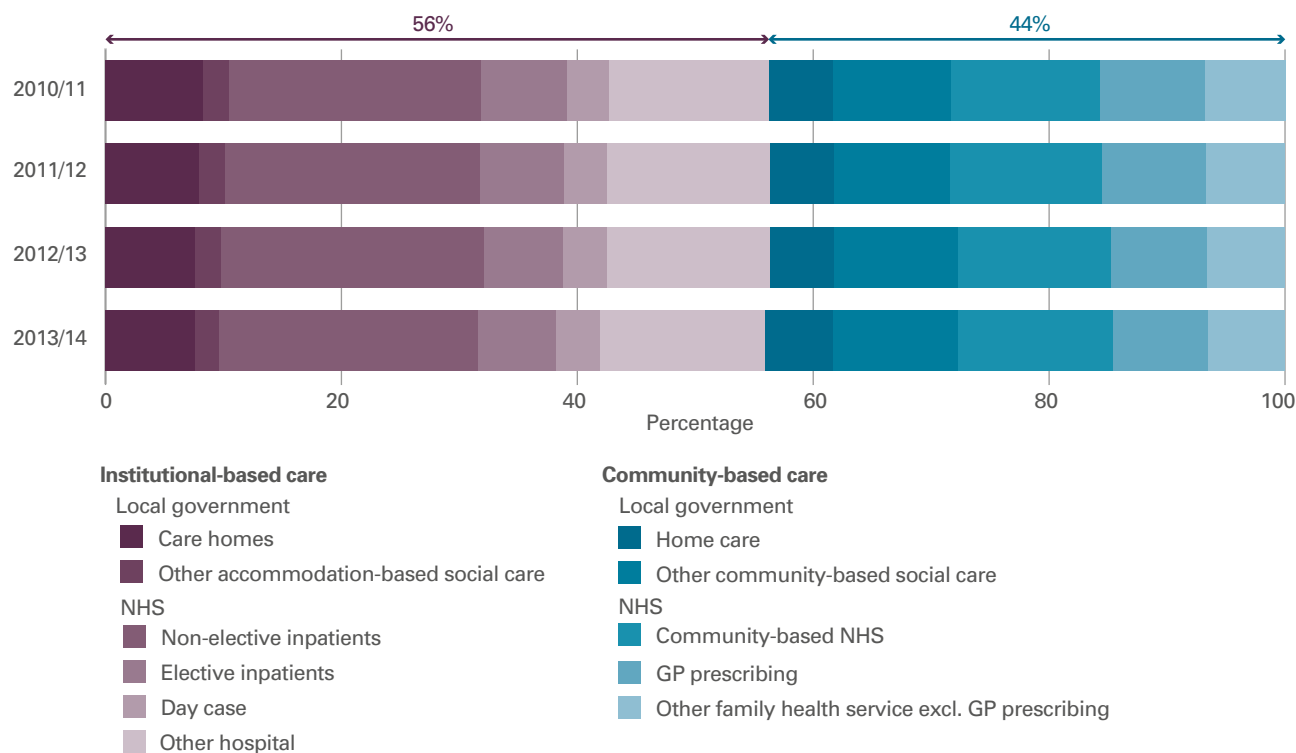
47. Our 2015 annual report on the NHS in Scotland highlighted that the Scottish Government has not made sufficient progress towards achieving its 2020 Vision of changing the balance of care to more homely and community-based settings.[25] In this audit looking at changing models of care, we found that there are many small-scale models and pilots across Scotland delivering new approaches to health and social care. However, there is limited evidence of transformational change happening on the scale required to meet the objectives of the 2020 Vision. Most initiatives are at a relatively early stage and have yet to be fully evaluated. This means the potential outcomes for service users and impact on resources are still to be fully established. Currently clear plans are lacking at a national and local level about what is needed to sustain new models of care. Examples include the funding, workforce and long-term planning requirements that are needed to ensure successful pilots are continued and scaled up.

the Scottish Government needs to provide stronger leadership by developing a clear framework to guide local development

Exhibit 8
Breakdown of adult health and social care expenditure, 2010/11 to 2013/14
The proportion of expenditure on institutional and community-based care has remained static.

Institutional-based care

Local government
- Care homes
- Other accommodation-based social care

NHS
- Non-elective inpatients
- Elective inpatients
- Day case
- Other hospital

Community-based care

Local government
- Home care
- Other community-based social care

NHS
- Community-based NHS
- GP prescribing
- Other family health service excl. GP prescribing

Note: **Other accommodation-based social care** includes sheltered housing, hostels and supported accommodation. **Other community-based social care** includes meals, community service, prison social work, youth crime and youth work services. **Other hospital** includes maternity inpatients, special care baby units, outpatients and day patients. **Other family health service excl. GP prescribing** is General Medical Services expenditure.

Source: IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2013/14, ISD Scotland, March 2015

48. In June 2015, the Cabinet Secretary for Health, Wellbeing and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress towards delivering the 2020 Vision. At the same time, the Scottish Government announced plans to launch a new national conversation on the future of healthcare in Scotland. The Scottish Government decided to consider a longer-term plan, beyond 2020, to make more progress and increase the pace of implementing the vision and to expand the current focus of the vision.

49. The Scottish Government has engaged with staff, service users and other interested groups about improving the health of the population and its plans for health and social care services. It published a National Clinical Strategy in February 2016 setting out its plans for health and social care in Scotland over the next 10 to 15 years. The Scottish Government has published this strategy to help partners as they implement the 2020 Vision. The strategy also comments on the direction of travel beyond 2020. The new strategy describes a number of new proposals and changes to current services. GPs will focus on care that is more complex and the wider primary care team will develop extended skills and responsibilities. A new structure is proposed for a network of hospital services with more specialities planned and provided on a regional or national basis. There is also a strong focus on the need to reduce waste, harm and variation in treatment and making more use of technology to support and improve care.

The Scottish Government needs to provide stronger leadership and a clear plan for implementing the 2020 Vision

50. The Scottish Government's overall aim of enabling everyone to live longer, healthier lives at home, or in a homely setting, by 2020 is widely accepted. In May 2013, the Scottish Government set out high-level priority areas for action during 2013/14.[26] This lacked a clear framework of how it expects NHS boards and councils to achieve this in practice, and there are no clear measures of success, such as milestones and indicators to measure progress. The cost implications of implementing the 2020 Vision are unknown and there is a lack of detail about the main principles of the policy (paragraph 22). There is also slow progress in developing the workforce needed for new models of care and a lack of information about capital investment to support the 2020 Vision.[27] The recently published National Clinical Strategy is intended to provide a clearer framework, but it does not detail how the high-level proposals will be implemented or contain any milestones or indicators or financial analysis.

51. The introduction of health and social care integration means there is now much more flexibility for partners to develop local solutions to local problems as they develop services and support systems to help people to live independently at home or in a homely setting. There is still an important role for Government to set the strategic direction and then to provide the support local partners need to ensure they are able to implement more effective models of care, if the pace of change is to increase.

52. In order for the 2020 Vision and the National Clinical Strategy to be realised, the Scottish Government needs to clarify:

- the immediate and longer-term priorities for local bodies to focus on

- a clear framework to guide local development of new care models, including the types of models to be tested, the resources required (such as funding and skills, job roles and responsibilities of the workforce), and how new models will be tested and rolled out in a coordinated way

- long-term funding plans to help implement the 2020 Vision and the National Clinical Strategy, to allow local bodies to plan and implement sustainable, large-scale changes to services

- how it will measure progress, for example by setting milestones and indicators.

The Scottish Government needs to identify priorities and risks

53. The Scottish Government needs to provide a clear plan now about what needs to be done to reach its longer-term strategy up to 2030. It should identify short, medium and long-term priorities for delivering its vision over the next 15 years. Examples include focusing on implementing high-impact changes to providing services in the short term, identifying the funding and other resources required for the medium term and achieving improved outcomes for the population in the long term. In its plans, the Scottish Government needs to identify and take into account specific risks to delivering its 2020 Vision and longer-term strategy. This should include the following:

- The risks we have highlighted in our report on health and social care integration. Up to late 2015, the focus has been on getting the structures and governance in place for health and social care integration. The Scottish Government will need to ensure that the new partnerships make the transition to focusing on what needs to be done on the ground to make the necessary changes to services.

- Health and social care budgets. Real-terms reductions in NHS and council budgets will pose risks to implementing new models and shifting more care into community-based settings. Council budgets have seen significant cuts in recent years and although new integrated health and social care budgets should allow funding to flow from NHS to social care budgets, it is not yet certain this will happen in practice. Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities.

- The building pressures in general practice, including problems with recruiting and retaining the workforce. The new GP contract that will come into effect in Scotland in 2017 will be crucial in managing the role of general practice in helping to implement the changes required to meet the 2020 Vision. The role of GPs in moving towards the 2020 Vision should be a major focus of the discussions between the Scottish Government and the profession as the new contract terms are developed.

The Scottish Government should outline clear principles for implementing new care models

54. Various principles should be followed for new care models to be implemented, tested, evaluated and rolled out successfully. If local bodies are to expand and roll out new models, they must have thorough information on the costs involved for planning and ensuring the models are sustainable. The Scottish Government has not provided an estimate of the investment needed to implement its 2020 Vision and longer-term strategy, and whether it can be achieved within existing resources. It needs to model how much investment is needed in new services and new ways of working and if it can be achieved within existing and planned resources.
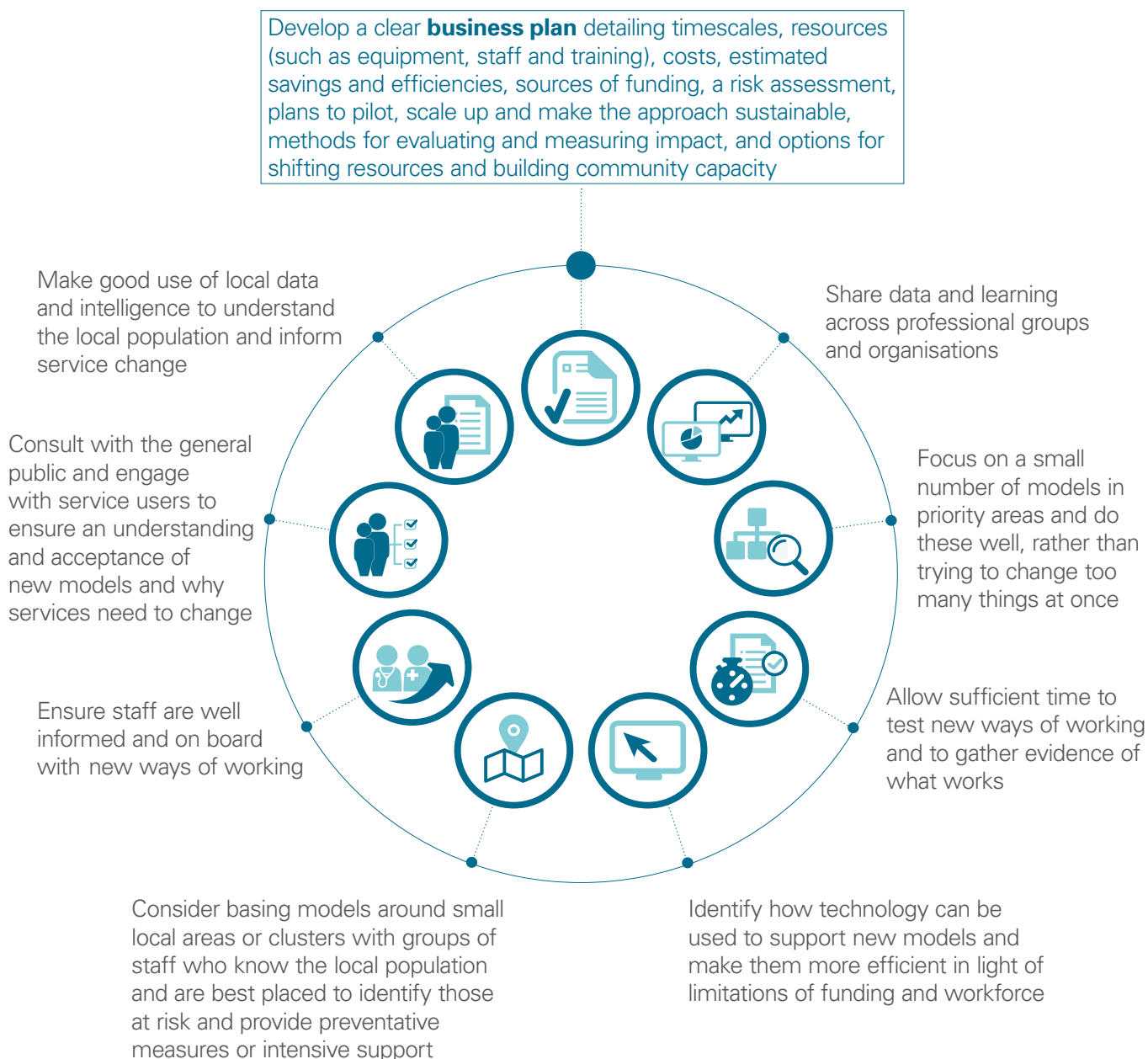
55. Staff implementing new models should have a business plan that clearly details how they will implement, monitor and review them. Exhibit 9 (page 30) summarises principles for implementing new care models. It draws on the information collated from our fieldwork and the learning shared by local bodies and other organisations. Links to toolkits and reports that may be useful for NHS boards, councils and integration authorities for implementing new models of care are included in Supplement 1 [PDF] ⬉.

56. Few of the models outlined in Exhibit 6 have been fully costed or properly evaluated. In several cases, it is too early to assess the impact of new ways of working. However, sometimes this is due to the lack of good monitoring data or the lack of skills and resources to carry out an evaluation. Generally, there is a lack of evidence of community-based models having a major impact and clarity about what works. This is a common problem, not unique to Scotland, but a crucial one to address so that local areas can efficiently identify and implement the most effective models.[28]

Exhibit 9
Principles for planning, implementing, monitoring and reviewing new care models
New care models should be properly planned, implemented, monitored and evaluated to ensure value for money and sustainability.

Develop a clear **business plan** detailing timescales, resources (such as equipment, staff and training), costs, estimated savings and efficiencies, sources of funding, a risk assessment, plans to pilot, scale up and make the approach sustainable, methods for evaluating and measuring impact, and options for shifting resources and building community capacity

Make good use of local data and intelligence to understand the local population and inform service change

Consult with the general public and engage with service users to ensure an understanding and acceptance of new models and why services need to change

Ensure staff are well informed and on board with new ways of working

Consider basing models around small local areas or clusters with groups of staff who know the local population and are best placed to identify those at risk and provide preventative measures or intensive support

Share data and learning across professional groups and organisations

Focus on a small number of models in priority areas and do these well, rather than trying to change too many things at once

Allow sufficient time to test new ways of working and to gather evidence of what works

Identify how technology can be used to support new models and make them more efficient in light of limitations of funding and workforce

Source: Audit Scotland

Mechanisms to support a significant shift in resources from acute to community settings are needed
57. Moving towards more community-based care is central to the 2020 Vision, but the balance of care is not shifting (Exhibit 8). To achieve the transformational change required to meet the 2020 Vision, the Scottish Government needs to

identify mechanisms that will drive a significant shift of resources from acute to community settings. Some local partnerships have found innovative ways to overcome barriers to improvement, but more can be done to facilitate change locally. The Scottish Government has an important role to play in supporting local bodies make these changes.

58. There are tools that can facilitate the transfer of resources across a local system, demonstrated in the examples seen in Tayside, Glasgow and Highland (Case study 8 [PDF] 🖻 and Case study 9 [PDF] 🖻). Scotland could apply learning from other countries. For example, Canterbury, New Zealand, shifted the balance of care through strong leadership, a clear vision, and a collaborative and whole-system approach. An important factor was its focus on 'one system, one budget'. It prioritised spending on those in greater need to reduce relying on residential care and to keep people in their own homes for longer. This had the effect of reducing demand and costs for hospital and other institutional care, and allowed for more investment in the community (Case study 10 [PDF] 🖻).

59. The Scottish Government needs to identify what balance of care it wants to achieve, what this will look like in practice and the financial implications of achieving this. The Scottish Government should challenge local partnerships to be clear about their specific ambitions in relation to the balance of acute and community care in their local areas, with clear timescales and milestones for achieving it.

60. The continued focus on targets in the acute sector is counterproductive to moving more funding into the community. NHS boards are under significant pressure to meet challenging hospital waiting time targets. This means that the acute sector continues to absorb considerable resources to meet these targets. A focus on short-term funding and increasing use of the private sector to help meet targets does not demonstrate value for money. The focus on annual targets does not help to achieve the longer-term aims and objectives of the NHS. Integration authorities are required to deliver outcome measures. This recent development with a greater focus on improving people's experiences of health and social care services is more helpful than focusing on narrow performance targets.

61. The Scottish Government needs to identify adequate and timely longer-term funding to support transformational change. It has provided multiple short-term funds to help local bodies implement change, but these do not provide the level of funding or certainty to make large-scale sustainable changes.[29] It has announced a £30 million transformational change fund to 'support creativity and transformation' in its draft budget for 2016-17.

62. In 2014, we reported on progress of the Scottish Government's policy of reshaping care for older people.[30] As part of this audit, we considered the impact of the £300 million Change Fund over four years, introduced by government in 2011/12 to support its policy. We found that the Change Fund had led to the development of a number of small-scale initiatives, but that they were not always evidence-based or monitored on an ongoing basis. It was unclear how successful projects would be sustained and expanded.[31]

63. Similar challenges in transforming services to have a greater focus on community-based care are also evident in England. There may be lessons to learn from the approach NHS England is taking to testing and rolling out new models of care, but it is too early to assess the effectiveness of its approach.

The Health Foundation and the King's Fund have recommended that existing disparate strands of funding for transforming services in NHS England should be pooled into one transformation fund. They also recommend that a single body, with strong, expert leadership, oversees the investment for transformational change and that ongoing evaluation should be a core activity of the fund. They advise that the fund must be properly resourced to support investment in the four key areas that are essential for successful transformation: staff time, programme infrastructure, physical infrastructure and double-running costs.[32]

There is a lack of coordinated, clear and accessible learning

64. The current fragmented approach to implementing new ways of working means that the learning within individual organisations, and the work carried out by various national bodies, is not being consolidated. The Scottish Government needs to coordinate new ways of working and information at a national level to ensure a more efficient and effective approach. The Scottish Government should draw on successful improvement models it has implemented in other areas, such as its patient safety programme.

65. Support for service change and improvement has been available to local bodies from a number of national organisations, such as the Quality, Efficiency and Support Team (QuEST) within the Scottish Government, Healthcare Improvement Scotland (HIS), ISD, the Scottish Centre for Telehealth and Telecare, and the Joint Improvement Team (JIT). However, the activities of these various organisations are not well coordinated. They all have slightly different roles and the learning from the work they do with local bodies is not drawn together. A significant amount of information is available on the various organisations' websites, but it is not always easy to navigate or identify the key information partners should use when they are considering implementing a new model of care. This information could be used to better effect to help increase the pace of change.

66. From April 2016, QuEST, HIS and JIT will combine into one integrated improvement resource. Its overall aim is to support and facilitate NHS boards, integration authorities and their partners to deliver care and support that will improve health and wellbeing outcomes for their populations.[33] This new integrated improvement resource is a positive step and will facilitate a more coordinated national approach and will make better use of improvement resources available to support partnerships.

The public's perception of health and social care services needs to change

67. The Scottish Government first set out its vision for a different health and social care system in 2011, but the system remains largely the same, and the public has not seen major redesign of local services in many parts of Scotland. NHS boards, councils and integration authorities will need to adopt innovative models of care and ways of working that are quite different from traditional services to provide opportunities for better care. They will need to exercise much more flexibility in how they use resources, such as money; assets, including buildings and equipment; and their workforce. This involves making difficult decisions about changing, reducing or cutting some services. Services cannot continue as they are and a significant cultural shift in the behaviour of the public is required about how they access, use and receive services. The introduction of health and social care integration provides an opportunity to engage more directly with communities about services and the need for change.

68. Local communities have strong ties to existing services which can make discussions about changes difficult, for example discussions about changing how hospital services are delivered. There are recent examples in NHS Tayside where the board consulted extensively with the public about closing community hospital beds. The board explained why it needed to close beds and the benefits of providing services differently. It also engaged with patients and their families about their needs and how they could best be met in the new care model in a more homely setting. By closing care of elderly and dementia beds in a number of community hospitals, NHS Tayside has been able to shift more resources into community teams. This has allowed many more patients to be supported in the community and they are now receiving care in their homes instead of being admitted to hospital (Case study 8 [PDF]). It is important that NHS boards, councils and partnerships involve staff and local people as they develop new models of care. The Nuka model of care illustrates the benefits of staff and local people being closely involved in developing their local services (Case study 1 [PDF]).

69. The Scottish Government cannot make the significant changes that are required on its own. Local bodies also need to work closely with staff to develop and implement new ways of working. Fifty-five per cent of staff in NHS Scotland responding to the 2015 national staff survey reported that they are kept well informed about what is happening in their NHS board. Only 28 per cent of staff reported that they are consulted about change at work.[34] A focus on local populations within integration authorities will have an important role in reforming how to deliver services. This should bring together local GPs and other health and care professionals, along with service users, to help plan and decide how to make changes to local services.

NHS boards and councils can do more to address barriers and facilitate change

70. Staff within NHS boards and councils still face many barriers to making the level of changes required. We highlighted in Part 2 some examples of new care models being introduced across Scotland. Staff leading these often faced difficulties getting these in place or rolling them out. But new models have been successfully implemented where staff have taken a strategic approach with clear plans, aims and outcomes. Some of the main challenges to implementing new models include:

- overcoming structural and cultural barriers when bringing together staff from different parts of an organisation or from different organisations

- freeing up staff time to develop and implement new care models

- securing funding for new approaches owing to limited evidence of what works

- having resources for a long enough period to be able to fully test new models to demonstrate any benefits and outcomes for service users

- lack of robust evaluation of new models and being able to identify the attributable impact of a particular approach alongside other services and programmes

- temporary funding and staffing preventing the models continuing or expanding

- shifting resources from acute to community-based settings to allow new care models to develop significantly in line with national policy.

Funding needs to be focused on new community-based models

71. At the same time as dealing with increasing demand, NHS boards are facing a tightening financial position and councils are experiencing budget cuts (Part 1). The NHS is finding it difficult to release funding from the acute sector to increase investment in the community. Councils are finding it difficult to fund the level of social care services required to meet current demand, and the demands on health and social care services are likely to continue to increase. Barriers to releasing funding to invest in new care models include the following:

- Some NHS boards are overspending against their planned hospital budgets owing to pressures on hospital services. This makes it more challenging to release any funding to invest in community-based services. For example, NHS Highland has overspent on its budget for Raigmore hospital over the last five years (£9.6 million in 2013/14) and NHS Fife has overspent on its acute services division budget for the last two years (£10.6 million in 2014/15).[35, 36] In August 2015, NHS Greater Glasgow and Clyde reported spending levels of £5.3 million over its projected acute services division budget. The board had aimed to be £1.7 million over of its budget at that point in the year to be able to achieve a breakeven position by the end of the financial year.[37]

- Investment in NHS community-based services has not increased at the same rate as investment in hospital-based services. Between 2010/11 and 2013/14, spending on community-based services increased by 4.9 per cent in cash terms, but reduced by 0.5 per cent in real terms. Spending on hospital-based services increased by 8.4 per cent in cash terms and by 2.8 per cent in real terms.[38]

- Making improvements in preventing hospital care can increase costs in the community. For example, new care models to prevent admission to hospital increase the costs in community-based health and social care services, such as additional homecare, but the savings in hospital care are often not realised or transferred.

- New community-based care models may place additional pressure on councils already struggling to cope with demand for social care services and are not sustainable without a shift in funding.

- Public and political resistance to closing local hospitals or wards makes it difficult to release significant amounts of funding to invest in radically changing the way services are delivered.

- Closing a small number of hospital beds, or one or two wards, releases limited cash as many of the overhead costs remain or are only slightly reduced. Examples of overhead costs include theatre costs, input from staff covering a number of wards or specialties, cleaning and porter costs, and heating and lighting costs.

72. We did find some examples of local areas overcoming these difficulties and finding innovative ways to direct more funding to community-based care models. In Tayside, closure of community hospital dementia beds has allowed increased investment in community-based teams that are looking after more patients in their own homes. In Glasgow, the reablement service is helping more people to live independently and freeing up more resources for homecare

services (Case study 8 [PDF] 🖥️). In Perth and Kinross and Highland, local areas are using tools to manage scarce resources and competing demands (Case study 9 [PDF] 🖥️). There are also lessons from other countries. In Canterbury, New Zealand, a long-term transformational programme and integrated system has increased investment in community-based care and shifted the balance of care (Case study 10 [PDF] 🖥️). The introduction of health and social care integration brings opportunities for partners to overcome barriers to shifting resources to more community-based and preventative services.

Changing models of care have implications for the structure and skills of the workforce

73. NHS boards and councils face major challenges in ensuring that staff with the right skills are able to provide new community-based models of care to meet the needs of the population. Recruiting and retaining staff on permanent contracts remains a significant problem for the NHS and the social care sector. In the NHS, vacancy rates, staff turnover rates and sickness absence levels all increased during 2014/15. Our *NHS in Scotland 2015* [PDF] 🖥️ report stated that a national coordinated approach is needed to help resolve current and future workforce issues. It highlighted that the approach should assess longer-term changes to skills, job roles and responsibilities within the sector as well as aligning predictions of demand and supply with recruitment and training plans. This is necessary to help ensure the NHS workforce adapts to changes in the population's needs and how services are delivered in the future. We plan to carry out further work on the NHS workforce during 2016/17.

74. Over many years, councils have had difficulties recruiting and retaining care home and homecare staff. Organisations in areas such as Edinburgh and Aberdeen, with high living costs, have had particular difficulties. There is a need to develop a valued, stable, skilled and motivated workforce. We plan to publish a report on Social Work in Scotland in Summer 2016. This will examine issues with recruiting and retaining social work staff in more detail.

75. To shift to more community-based services and care in homely settings, the availability and development of community-based staff with the right skills is crucial. But the balance of community-based staff has not increased significantly in recent years. For example:

- Between 2009 and 2013, the estimated number of GPs in post in Scottish general practices increased by less than one per cent, from 3,700 WTE to 3,735 WTE. The Royal College of General Practitioners in Scotland has calculated that an additional 740 GPs are required in Scotland by 2020, based on predicted population growth.[39]

- Between 2009 and 2014, there have been some changes in the number of people in the social care workforce. Adult day care services staff decreased by nine per cent. The number of adult care home staff increased slightly (one per cent). Staff providing housing support and care at home services increased overall by four per cent, however decreased by three per cent between 2009 and 2013, and only increased again between 2013 and 2014 by six per cent.[40] Between 2010 and 2014 the number of people receiving homecare fell by nearly seven per cent to 61,740, while the total number of homecare hours rose by over seven per cent to 678,900. The number of people receiving ten or more hours of homecare per week, those with more complex needs, increased by four per cent to 21,700.[41]

76. A number of other workforce issues were raised in our fieldwork, including the following:

- Limited capacity in general practice to cope with increasing demand.

- An increasing workload for GPs and the wider primary care team from monitoring patients on long-term medicines.

- GPs do not have protected time for service development, research and strategic meetings. This makes it difficult for GPs to get involved in developing new care models.

- Fewer junior doctors are choosing general practice as a profession.

- Problems recruiting nurses in specialty areas linked to caring for frail and elderly patients.

- A need to train more nurses who currently work in hospitals so they can work in the community.

77. Some local areas are finding solutions to the workforce issues we describe above. We found examples of different groups of staff getting involved in new community-based care models to reduce the pressure on limited GP capacity. Different professions are also working together in multidisciplinary teams to provide more efficient and better quality care, for example in Glasgow, Grampian and East Lothian (Case study 11 [PDF] 🖱️).

78. BMA Scotland has set out a new role for GPs. It has proposed that GPs should be the senior clinical decision-makers in the community, become more involved in making improvements across the system and focus on complex care in the community. This would mean GPs being less involved in more routine tasks and other health professionals in the wider community team taking on extended roles.[42] This is a proposal in the new National Clinical Strategy. A review of primary care out-of-hours services also recognises the importance of a multidisciplinary team approach and the contribution of the wider team. It proposes a new model for patient access to out-of-hours care.[43]

79. In June 2015, the Scottish Government announced it was providing a primary care investment fund of £50 million over three years to help address workload and recruitment issues in primary care. It is a modest amount and represents around 3.5 per cent of the Scottish Government's primary and community services budget.[44] The Scottish Government anticipates that it will provide an initial impetus to encourage GPs to try new ways of working over the next three years. But it is not clear how its effectiveness will be monitored.

80. Key elements of the three-year fund include the following:

- Primary Care Transformation Fund allocating £20.5 million to GP practices to test new ways of working to address current demand. The Scottish Government is developing a framework for the fund and is inviting health boards and integration authorities to develop proposals to test new ways of working in primary care. Information on the application process and selection criteria was made publicly available in February 2016.

- An investment of £16.2 million for Pharmacist Independent Prescribers to recruit up to 140 new pharmacists. The aim is that they will work with GP practices to help care for patients with long-term conditions and to free up GPs' time so they can spend it with other patients.

- A GP Recruitment and Retention Programme of £2.5 million to explore the issues surrounding recruiting and retaining GPs. The programme will implement proposals to increase the number of medical students who choose to go into GP training and encourage GPs to work in rural and economically deprived areas.

- A £6 million Digital Services Development Fund to help GP practices put digital services in place more quickly. This includes developing online booking for appointments and implementing webGP, an electronic consultation and self-help web service hosted on a GP practice's website.

- The balance of just under £5 million will be used to fund:

  – equipment to enable optometrists to screen people for glaucoma

  – changes to front-line services so that Allied Health Professionals, such as physiotherapists, can better support active and independent living

  – a leadership programme to equip GPs with the necessary skills to play a leading role in developing local integration work

  – additional research and training through the Scottish School of Primary Care.[45]

81. In February 2016, the Scottish Government announced a further £27 million investment over the next five years to develop the NHS workforce. This includes £3 million to train 500 advanced nurse practitioners and over £23 million to increase the number of medical school places and widen access to medical schools. A new entry-level programme will be introduced to support and encourage more people from deprived backgrounds to study medicine.

82. Many general practices are struggling to recruit and retain staff. During 2015, NHS boards had to support nine practices that were not able to continue as successful businesses and provide the services required to their local population. This may become an increasing problem in light of the building pressures we have outlined throughout this report what impact it has on. Where NHS boards have had to step, it is not clear what impact this has had on the performance of practices and the services provided to patients. The Scottish Government should monitor these practices for any improvements or deterioration in the way services are provided, and share any learning.

A better understanding of the needs of local populations is required
83. NHS boards, councils and partnerships need to have a good understanding of their local population and how people use different services so they can provide services that effectively meet local needs. This understanding can help to identify where resources, including money and staff, are being directed and if they are using these resources in the best way. It can also help to identify changes required to the way services are delivered and how resources can be redirected to priority areas.

84. We found that NHS boards, councils and partnerships are at varying stages with this kind of analysis and taking different approaches to it. However, integration authorities will all have to carry out needs assessments of their local population, and this is an important step in improving local analysis. The organisations that are making good use of their local data are starting to think differently about how they can best deliver and redesign services. They are identifying a small number of priorities to focus on, which is much more manageable than trying to fix everything at once. It is also more effective than having too many small-scale projects that are difficult to manage and unlikely to demonstrate a significant impact.

Health and social care data is improving

85. ISD is developing an extensive database of linked data on health and social care activity and costs and demographic information. It is making this information available to NHS boards, councils and partnerships to help them gain a better understanding of the needs of their local population, current patterns of care and how resources are being used. The Health and Social Care Data Integration and Intelligence Project (HSCDIIP), now known as Source, is a long-term project that aims to support integration authorities by improving data sharing across health and social care.[46] From April 2015, the central team has begun sharing local data in the form of an interactive dashboard that contains easy-to-read information summaries. This has required local areas to sign an information governance agreement to enable NHS boards and councils to view each other's data across a local population. Some partnership areas have taken some time to get these agreements in place and therefore gain access to the analysis. As at February 2016, five partnerships had finalised these agreements and undergone training for the software that will allow them to access and analyse the linked data for their local area (Angus, Borders, Dumfries and Galloway, East Renfrewshire, and Midlothian). This is the first time this linked data has been available and this is a valuable resource for partnerships.

86. ISD is also providing data and analytical support through a Local Intelligence Support Team (LIST) initiative. This allows partnerships to have an information specialist from ISD working with them in their local area. The central team can also provide additional support and tailored analysis. This includes forecasting costs, pathway analysis to show how individuals move from one service to another, and the resource associated with the use of different services at a local population level.

87. Some areas have made good use of the support provided by the Source team to better understand their population and also the data that has been made available to them. This includes Perth and Kinross, East Lothian, and West Dunbartonshire (Case study 12 [PDF]).

88. These examples demonstrate how detailed analysis of local data at a local area and individual level is crucial in understanding the needs of a population, how people are currently using services and how costs are incurred. This then provides local areas with the information they need to identify how services can be provided differently and more efficiently to provide better outcomes for people and reduce costs. Using this information to identify the individuals at most risk of their health deteriorating allows preventative measures to be put in place or for care to be provided in a more effective and efficient way. This has the potential to free up resources across the whole system. If local areas do not have this level of information, they will not be able to properly plan or transform services in the future.

89. ISD is in a good position, through the Source and LIST work, to share good practice about data analysis across all partnership areas. ISD held a conference in September 2015 to share early learning from across Scotland. ISD should continue to share good practice. This could include:

- hosting further national events

- publishing good practice examples on its website to illustrate how local areas are making good use of data

- developing toolkits to assist partnership areas to identify appropriate approaches to analysing and understanding local data.

Endnotes

◀ 1   *Projected Population of Scotland* (2014-based), National Records of Scotland, October 2015.

◀ 2   There is a discontinuity in healthy life expectancy (HLE) data owing to a change in methodology to align with the European Union. This results in estimates of HLE at birth from 2009 onwards being over eight years lower than in 2008 for each sex.

◀ 3   *Healthy life expectancy: Scotland*, Scottish Public Health Observatory, December 2015.

◀ 4   *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study*, K Barnett, S Mercer, M Norbury, G Watt, S Wyke and B Guthrie, Lancet, May 2012.

◀ 5   *Patient encounters in very deprived areas*, G Watt, British Journal of General Practice, January 2011.

◀ 6   *Frailty and the geriatrician,* Age and Ageing, vol 33, no 5, pp 429–30, Rockwood K, Hubbard R, 2004.

◀ 7   *Think Frailty: Improving the identification and management of frailty*, Health Improvement Scotland, April 2014.

◀ 8   *The care of frail older people with complex needs: time for a revolution*, The King's Fund, March 2012.

◀ 9   SMR01 activity analysis provided to Audit Scotland by ISD, November 2015.

◀ 10 Scottish Government analysis of projected health and social care expenditure. Provided to Audit Scotland in February 2016.

◀ 11 *NHS in Scotland 2015* [PDF] 🖥, Audit Scotland, October 2015.

◀ 12 *Scotland's Spending Plans and Draft Budget 2016-17*, Scottish Government, December 2015.

◀ 13 *An overview of local government in 2015* [PDF] 🖥, Audit Scotland, March 2015.

◀ 14 *IRF-NHS Scotland and Local Authority Social Care Expenditure-Financial Years 2010/11-2013/14*, ISD Scotland, March 2015.

◀ 15 *Stocktake of access to general practice in England*, National Audit Office, November 2015.

◀ 16 *2020 Vision: Strategic Narrative*, Scottish Government, September 2011.

◀ 17 http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes 🖥

◀ 18 *Core Suite of Integration Indicators*, Scottish Government, March 2015.

◀ 19 *Health and social care integration: Progress update* [PDF] 🖥, Audit Scotland, December 2015.

◀ 20 *A Stronger Scotland: The Government's Programme for Scotland 2015-16*, Scottish Government, September 2015.

◀ 21 The ten test sites are in Glasgow, Edinburgh, Fife, Tayside, Forth Valley, Campbeltown, West Lochaber, Islay, Mid-Argyll, and Clackmannanshire.

◀ 22 *Place-based systems of care,* The King's Fund, November 2015.

◀ 23 *The Buurtzorg Nederland (homecare provider) model, Observations for the United Kingdom (UK)*, Royal College of Nursing, 2015.

◀ 24 *NHS in Scotland 2013/14* [PDF] 🖥, Audit Scotland, October 2014; *Reshaping care for older people* [PDF] 🖥, Audit Scotland, February 2014; *Review of Community Health Partnerships* [PDF] 🖥, Audit Scotland, June 2011.

◄ 25 *NHS in Scotland 2015* [PDF] 🖱, Audit Scotland, October 2015.

◄ 26 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

◄ 27 *NHS in Scotland 2015* [PDF] 🖱, Audit Scotland, October 2015.

◄ 28 *Evaluating integrated and community-based care: How do we know what works?*, Nuffield Trust, June 2013.

◄ 29 From 2015/16 to 2017/18, the Scottish Government is providing the following funding to local bodies to support improvements in health and social care: £300 million integrated care fund; £100 million to reduce delayed discharges; £30 million for telehealth; £60 million to support improvements in primary care; £51.5 million for a social care fund.

◄ 30 *Reshaping Care for Older People: A Programme for Change 2011-2021*, Scottish Government, August 2012.

◄ 31 *Reshaping Care for Older People* [PDF] 🖱, Audit Scotland, February 2014.

◄ 32 *Making change possible: A Transformation Fund for the NHS*, The Health Foundation and the King's Fund, July 2015.

◄ 33 *Laying the Foundations for an integrated improvement resource,* Healthcare Improvement Scotland, Quality and Efficiency Support Team, Scottish Government and Joint Improvement Team, September 2015.

◄ 34 *NHS Scotland Staff Survey: National Report*, Scottish Government, November 2015.

◄ 35 *The 2014/15 audit of NHS Highland: Update on 2013/14 financial management issues* [PDF] 🖱, Audit Scotland, October 2015

◄ 36 *NHS Fife 2014/15 annual audit report for the board of NHS Fife and the Auditor General for Scotland* [PDF] 🖱, Audit Scotland, June 2015.

◄ 37 *Financial Monitoring Report for the 5 month period to 31 August 2015*, Board Papers, NHS Greater Glasgow and Clyde, October 2015.

◄ 38 *IRF-NHS Scotland and Local Authority Social Care Expenditure-Financial Years 2010/11-2013/14*, ISD Scotland, March 2015.

◄ 39 *A Blueprint for Scottish General Practice*, Royal College of General Practitioners Scotland, July 2015.

◄ 40 *Scottish Social Service Sector: Report on 2014 Workforce Data*, Scottish Social Services Council, August 2015.

◄ 41 *Health and Social Care Datasets-Social Care Survey*, Scottish Government, 2015.

◄ 42 *Redesigning primary care for Scotland's communities*, BMA Scotland, December 2015.

◄ 43 *Main Report of the National Review of Primary Care Out of Hours Services*, Scottish Government, November 2015.

◄ 44 *Scottish Budget: Draft Budget 2015-16*, Scottish Government, October 2014.

◄ 45 *Primary care investment news release*, Scottish Government, June 2015.

◄ 46 http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/docs/health-and-social-care-information-flyer-141211.pdf 🖱

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