Integration of Health and Social Care: Reshaping Care for Older People

Summary of key policies and glossary of commonly-used terms
Summary of Key Policies

Reshaping Care for Older People: A Programme for Change 2011-2021

The vision: “Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting.”

Reshaping Care for Older People aims to redesign services and increase the range of supports to ensure that they are sustainable for the future, and that they improve outcomes. Given the option, people want to stay in their own homes for as long as possible, and have care that is personalised to their own needs and preferences. Reshaping Care will promote community capacity building and new models of care that shift the balance of provision away from institutional care and towards care at home.

Self-directed Support: A National Strategy for Scotland

The vision: “Self-directed support should become the mainstream approach to the delivery of personal support...every person eligible for statutory services should be able to make a genuinely informed choice and have a clear and transparent allocation of resources allowing them to decide how best to meet their needs. The choice should be available to all but imposed on no-one.”

This 10 year strategy, published in October 2010, aims to help take forward the personalisation of health and social care services in Scotland by giving individuals more choice and control over the service they receive. Self-directed support may involve the use of Direct Payments, Individual Budgets / Service Funds, or a combination of these.


The vision: “to ensure that carers are supported to manage their caring responsibilities with confidence and in good health, and to have a life of their own outside of caring”

The Carers Strategy recognizes that the health and social care system would be unsustainable without the valuable contribution of carers. Identifying carers and increasing the uptake and quality of carer assessments and carer support plans should be prioritized. Training is needed across health and social care settings to make workers more ‘carer aware’, and the provision of information, advice and personalised short breaks for carers must be improved. Carers should have a voice in the strategic planning of services through representation on Community Health Partnerships and Scottish Government’s planned Health and Social Care Partnerships.
Scotland’s National Dementia Strategy

The vision: “People who have dementia and those who care for them are entitled to dignity and respect and should be able to access services that provide support, care and treatment in a way that meets their personal needs.”

The Dementia Strategy highlights the need for transformational change across the social and health care systems including improvement in post-diagnostic support and the care people with dementia experience in general hospitals. A person with dementia should only be admitted to hospital when the necessary treatment cannot be provided where they live.

‘Promoting Excellence: a framework for all health and social services staff working with people with dementia, their families and carers’ is the resource which identifies the knowledge and skills the workforce needs and ‘Standards of Care for Dementia in Scotland’ states what people can expect from the services and support they receive.

Living and Dying Well: A national action plan for palliative and end of life care in Scotland

The vision: “Good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate and equitable manner across all care settings in Scotland”.

Living and Dying Well emphasizes the importance of a person-centred approach to care and care planning, as well as communication, collaboration and continuity of care. Early identification of palliative care needs and holistic assessment of the physical, social, emotional, cultural, religious and spiritual needs of the individual and carer are central to this.

Talking Points: User and Carer Involvement

Talking Points has been developed by the Joint Improvement Team. It uses an outcomes-focused approach to assessment, planning and review, and aims to shift engagement with people who use services away from service-led approaches. The approach emphasizes the strengths, capacity and resilience of individuals, builds upon natural support systems and includes consideration of wider community based resources. A variety of Talking Points tools, guidance and resources are available from the Joint Improvement Team website: www.jitscotland.org.uk

The Change Fund

The Reshaping Care for Older People agenda aims to shift the balance of care provision away from institutional settings. The Health and Social Care Change Fund allocated £70m in 2011/12, £80m in 2012/13, with £80m committed for 2013/14 and £70m for 2014/15, to drive the development of
services and range of supports that optimise the independence and wellbeing for older people at home or in a homely setting. It aims to enable health and social care partners to implement local plans for making better use of their combined resources for older people’s services. The Change Fund provides bridging finance to facilitate shifts in the balance of care from institutional to primary and community settings. Building capacity within communities is essential to the success of this initiative.
Brief glossary/descriptions of commonly-used terms

Agenda for Change
Agenda for Change is the NHS pay system which applies to over a million NHS staff with the exception of doctors, dentists and most senior managers. The standardised pay system aims to ensure fair pay and a clearer system for career progression.

Anticipatory care
Anticipatory care can take many forms however it is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/anticipatory care planning is to support the individual to have greater choice, and control of care preferences through communication across the support team, across agencies and across care settings.

Co-production
Co-production refers to the delivery of public services as a result of an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, research suggests that both services and communities become more effective agents of change.

Community Capacity Building
Community capacity building activity supports people, particularly those who live in disadvantaged areas or are members of disadvantaged groups, to shape their own future and the future of their communities, and engage effectively with agencies to influence decisions and improve public services.

Community engagement
Community engagement refers to the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities.

Continuous Learning Framework (CLF)
The Continuous Learning Framework (CLF) was developed by IRISS in conjunction with the Scottish Social Services Council (SSSC) for the whole social services workforce. The CLF aims to improve the quality of outcomes for people using social services by supporting the people who are involved in delivering these services to be the best they can be.

Diversity
Diversity is about recognising and valuing difference. It focuses on creating working cultures and practices which respect and value individuals both as part of the workforce and the community. Diversity should be responded to in a range of ways including making services more accessible and sensitive to different cultures and tackling the discrimination and disadvantage some groups face that leads to inequalities in health outcomes.
Equality
Equality is about ensuring fairness in the way people are treated and healthcare services are provided. It can be considered in terms of equal access to services, fair treatment that meets the specific needs of the individual and equal health outcomes.

Equality Impact Assessment (EQIA)
Equality Impact Assessment is a tool which supports a process for improving the design and delivery of services to eliminate discrimination, promote equality of access and outcome and ensure that the needs of diverse groups are considered in service design.

Equity
Equity is about achieving equal rights and status for people who are marginalised or excluded because of issues such as disability, ethnic identity or gender. It is essentially about achieving social fairness.

Evidence based practice
Evidence based practice is an approach to work based on best available evidence as to how well something works, which is becoming increasingly more common in health and social services.

Health Inequalities
Health Inequalities is the gap which exists between the health of different population groups such as the affluent compared to poorer communities or people with different ethnic backgrounds.

HEAT Targets
The HEAT performance management system sets out the targets and measures against which NHS Boards are publicly monitored and evaluated. HEAT is an acronym for Health Improvement, Efficiency and Governance, Access and Treatment which are the four areas being targeted.

Intermediate care
Intermediate Care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living". (NSF for Older People, DOH, June 2002).

Knowledge and Skills Framework (KSF)
The NHS Knowledge and Skills Framework (KSF) defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. The NHS KSF and its associated development review process lie at the heart of the career and pay progression strand of Agenda for Change. They are designed to apply across the whole of the NHS for all staff groups who come under the Agenda for Change Agreement. That is, they apply to everyone
except doctors, dentists and some board level and other senior managers as there are separate arrangements for their development review.

**Long term conditions**
Long term conditions (LTC) are conditions that last a year or longer, impact on many aspects of a person’s life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category, so it covers children as well as older people and mental as well as physical health issues. Common long term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

**Mutuality**
Mutuality is a term adopted by the NHS to describe the Scottish Government's approach to the delivery of health services in Scotland. The vision is based on a shift from the current position where we see people as "patients" or "service users", to a new ethos for health in Scotland that sees the Scottish people and the staff of the NHS as partners, or co-owners, in the NHS.

**Patient Focus**
Patient Focus is a term which is often used interchangeably with 'patient centred' or 'people centred' which means that services or care delivered should be responsive to the individual's unique preferences, values and needs, identified and agreed in partnership with the patient.

**Palliative Care**
Palliative Care describes services and supports designed to improve the quality of life of people who have a life threatening illness.

**Personalisation**
Personalisation means starting with the individual as a person with strengths and preferences who may have a network of support and resources, which can include family and friends. Personalisation reinforces the idea the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

**Person Centred**
Person Centred is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

**Personal Outcomes Approaches**
Personal Outcomes Approach to assessment, planning and review aims to shift engagement with people who use services away from service-led approaches to approaches which emphasise the strengths, capacity and resilience of individuals. This involves everyone working together to achieve
the best possible impact on the individual's life, builds upon natural support systems and includes consideration of wider community based resources.

Reablement
Reablement is about giving people the opportunity and the confidence to relearn/regain some of the skills they may have lost as a result of poor health, disability/impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service users to gain new skills to help them maintain their independence.

Registration and Social Service staff
Groups of social service staff are required to be registered with Scottish Social Services Council according to their role/function. For descriptions visit: http://www.sssc.uk.com/component/option,com_docman/Itemid,486/gid,1169/task,doc_details/

Self-directed Support
Self-Directed Support describes an arrangement where the service user arranges some or all of their support instead of receiving directly provided services from local authority social work or services or equivalent. Self-Directed Support allows people more flexibility, choice and control over their support so that they can live at home more independently.

Step up and step down care
Step up care involves using care home facilities for local GPs and other professionals to send patients from the community who need some support to help manage their condition for a brief period and prevent them from needing a hospital admission.
Step down care is for people who have completed their acute hospital care but who require rehabilitation before going back home or to community care. People benefit from this better integrated care in the community receiving the support they need to fully recover before going back home or to their place of residence.

Supported self-management
Supported self-management and self-care are terms to describe how a person living with a long-term condition controls their condition and health themselves.

- Self-care is what each person does on an everyday basis, but which may be more difficult for a person living their life with a long-term condition
- Self-management is the process by which a person develops the skills to manage their condition

Support for self-management and self-care is the responsibility of health and social care providers and can often be provided by unpaid carers.

Telehealthcare
Telehealthcare is the convergence of telecare and telehealth to provide a technology-enabled and integrated approached to the delivery of effective, high-quality health and care services. It can be used to describe a range of
care options available remotely by telephone, mobile, broadband and videoconferencing.

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