Health and Sport Committee Inquiry into Preventative Agenda

Scottish Care Response – February 2017

Scottish Care welcomes this opportunity to contribute to the Health and Sport Committee’s inquiry into preventative spend.

Scottish Care is a membership organisation and the representative body for independent social care services in Scotland.

Scottish Care represents over 400 organisations, which totals almost 1000 individual services, delivering residential care, nursing care, day care, care at home and housing support services.

Our membership covers both private and voluntary sector provider organisations. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations.

Our members deliver a wide range of registered services for older people as well as those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems.

The Scottish independent social care sector contributes to:

- The employment of over 100,000 people
- The employment of over 5,000 nurses
- The provision of 85% of care home places in Scotland
- The delivery of over 50% of home care hours for older people.

Scottish Care believes there are three key areas which the Health and Sport Committee should pay particular attention to in the course of its inquiry. These are:

- The unique contribution of care at home services and staff in the prevention agenda
- The role of the social care workforce in palliative and end of life care
- The importance of effective anticipatory care planning

The unique contribution of social care services and staff in the prevention agenda

Whilst all social care services play an important role in the preventative care agenda, the independent sector and its workforce, situated in care home, care at home and housing support services, have a significant contribution to make.

Firstly, staff in these services are uniquely placed to recognise changes in an individual’s condition or abilities, for example in relation to falls or medication, which other workers or services may fail to recognise. This is due to the frequency of visits and care input to individuals and the relationships and depths of personal knowledge which are built up over a period of time. Care staff are therefore often best placed to identify and communicate changes or concerns, subtle or significant, to other health and social care professionals in order that these can be addressed effectively. Failure to recognise and value this essential element of the complex role of social care workers often leads to individuals being admitted to hospital or other care settings, either unnecessarily or because these changes
haven’t been adequately addressed at an early stage and therefore health and social care input is escalated because the individual’s condition has further deteriorated.

Secondly, the independent sector care workforce is ideally placed to promote healthy lifestyles and positive re-enablement approaches to care. Care staff, including nurses working in the independent care sector, can contribute to the improvement of health and wellbeing through their day to day activities, but also through leading by example – e.g. promoting a healthy lifestyle, dietary choices and regular exercise. They are also in a privileged position to be able to educate the people they care for, and the team they work with. However, this requires appropriate supports to be in place in order to promote a holistic approach to social care, and means we need to give this workforce the time to understand and support the wider needs of their patients, wherever they are located. Care staff also need to be informed and supported around how to promote and protect their own health and wellbeing. As articulated in our Voices from the Nursing Front Line report\(^1\), Scottish Care believes that there are particular advantages of combining physical and mental wellbeing initiatives for the care workforce and the people they support in order that all the individuals that this encompasses can benefit from positive intervention and preventative informal supports to minimise their requirement for additional formal health and care intervention.

However, Scottish Care believes that presently there are a number of inhibiting factors which mean that independent sector social care services cannot contribute to the preventative care agenda as fully as they have the potential to.

In Scottish Care’s 2015 report, Home Delivery\(^2\), analysis of the concept of the ‘Care Pound’ highlighted that expenditure on care at home, combined with expenditure on residential care services, is less than what is spent nationally on emergency admissions to hospitals. The report found that the average cost of one emergency admission for an individual aged 65+ equates to caring for 27.7 care at home clients for one week or supporting an older person in a residential care home for 9.28 weeks.

What this highlights is that the prevention of unnecessary admissions to hospitals through better use of social care services (namely care at home, housing support and care home services) could result in positive preventative action and significant savings to the public purse. However this requires political will, at national and local level, to the releasing of resources from acute settings to community settings. It also requires sustainable, positive and increased engagement and utilisation of the independent care sector in order that both access to, and the quantity and quality of, hospital alternatives are assured. Care home, care at home and housing support settings need to be seen as an essential part of the solution to reactive spending and need to be able to engage further in the preventative agenda. It also requires an infrastructure which supports the preventative agenda, whereby GPs and other decision-makers have access to emergency care at home packages and step-up, step-down and respite care home placements in the same way they currently access ambulance and other health-based resources.

Scottish Care’s Home Delivery report also highlights the issue of increasingly tight eligibility criteria in relation to access to care at home services and how this links to the prevention agenda:

“\textit{In 2003/4, there were 24,892 clients with non-personal care needs such as domestic support. In 2013 the figure is now 3,204. This represents a dramatic reduction in the number of clients receiving publicly funded support for areas out-with the definition of ‘personal care’, such as ‘mopping and shopping’. The lack of provision of this type of support for care at home clients raises issues around the prevention agenda. In other words, services that are deemed to assist older people to live at home for as long as possible, help reduce early admission into care homes and prevent inappropriate admissions into hospital, are now in short supply.}”

In a landscape whereby only those with the highest level of need qualify for care at home services and therefore lower-level, preventative support is effectively eradicated, it is inevitable that others will access ‘upstream’ support

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instead, for instance by presenting at A&E departments. What’s more the commissioning environment for external care at home services, which currently prioritises ‘time and task’ inputs, negates staff’s ability to provide preventative care to the best of their ability and instead requires them to meet little more than basic care needs, to the detriment of the individual’s outcomes and to the public purse when these individuals then access more intensive forms of support.

The better resourcing of social care services, and care at home services in particular, would enable the independent care sector to contribute meaningfully and significantly to the preventative care agenda and for a relatively small outlay, would result in substantial savings overall.

**The role of the social care workforce in palliative and end of life care**

It is well documented that the most resource-intensive period of someone’s life tends to be in the later stages of someone’s life and particularly the last year of life. It is also known that the number of people with palliative and end of life care needs being supported by health and social services is increasing. As the Scottish Government’s Strategic Framework for Action on Palliative and End of Life Care 2016-2021³ outlines:

“In Scotland around 54,000 people die each year and over 200,000 people are significantly affected by the death of a loved one. In general we are dying at older ages, sometimes accompanied by frailty, dementia and multiple other conditions. Driven by population growth, the number of people dying each year will begin to rise from 2015. By 2037 the number of people dying each year will have gone up by 12% to 61,600. It is thought that up to 8 out of 10 people who die have needs that could be met through the provision of palliative care.”

The policy ambition to support more people in their own homes for longer inevitably means that more people will be supported up until their death by home care services. It also means that individuals who move into care home services are likely to do so at later stages in their care journey, predominantly for the last 18 months of their life. Wherever an individual’s palliative and end of life care is delivered, it is increasingly likely to be out-with hospital settings. At present, we know that 100,750 people work in independent sector care home and home care services, supporting over 63,000 people. This is a significantly higher number than those who are supported in hospital settings. Of these, nearly 83% are aged 65 and over. A significant proportion of these individuals are likely to be receiving palliative and end of life care, or will require it in the near future.

It is therefore critical that the role of the front line care workforce in delivering palliative and end of life care is understood and supported, particularly in how this workforce contributes to the realisation of the preventative care agenda.

If we want to increasingly support people to live up to their deaths out-with resource intensive hospital settings, this has significant implications for social care staff in terms of their roles, training, skills mix and support mechanisms. The social care workforce need to be sufficiently resourced and supported to deliver complex care in the community and by doing so, we are much more likely to prevent unnecessary hospital admissions near end of life and uphold people’s wishes to die at home – whether that is their own home or in a care home. There are a number of ways that the role of care staff could be better supported, as outlined in Scottish Care’s recent palliative and end of life care report⁴:

- Maximise the timely and effective use of palliative and end of life care resources at a local level, in order that health and social care professionals can work together to achieve the best outcomes for individuals
- Address the recruitment and retention issues facing the social care sector
- Highlight and develop the expertise of social care staff in the development of an integrated palliative and end of life educational framework

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• Ensure palliative and end of life care support and training is specifically targeted at the diverse needs of the front line social care workforce, in order that they can support people to remain at home regardless of geography or condition
• Commission services in a way that ensures sufficient resources and capacity are available within social care services to support people well in the community
• Rearticulate the role of a front line social care worker to reflect the multi-skilled, autonomous and professional nature of the role.

By focusing attention on valuing the role of the social care workforce, particularly in palliative and end of life contexts, it is possible to support more people to remain at home or in homely settings right up to end of life which not only has much more positive outcomes for the individual, it represents a much lesser resource outlay than an individual being in hospital. At present, the failure to adequately support staff in turn means they are unable to support individuals to the fullest degree and as a result of the pressure and strain on these services, individuals either return to or remain in acute settings at great personal and financial cost.

The importance of effective anticipatory care planning

Scottish Care’s recent research into palliative and end of life care has highlighted the critical and invaluable role of anticipatory care planning in ensuring individuals receive support which is planned and appropriate to their needs and wishes. Anticipatory care plans present an opportunity to ensure that people receive the support how and where they need it. By knowing an individual’s wishes, we are much more likely to reduce unnecessary admissions to hospital, prevent delayed discharges, and to avoid significant decisions around care being made in periods of crisis and distress which often result in the wrong decision being made or delays to that decision making process – all of which have financial implications.

Scottish Care believes it is fundamental for the enabling of a quality end of life experience based on individual choice and autonomy, and for the most effective and appropriate use of health and social care supports, that plans are developed as a matter of course. These plans need to be consistent, integrated and accessible. They need to be developed at an early enough stage in someone’s palliative care journey that they are able to contribute to it most effectively, for example if they have a diagnosis of dementia and communication may become more challenging at a later stage. In particular it is essential that information is communicated and transferable across different health and social care settings, and that an anticipatory care plan developed in one sector is given equal value and validity in another. Work needs to be undertaken as a matter of priority to address barriers which practitioners in the social care sector experience in relation to information being withheld on the grounds of confidentiality.

Scottish Care believes that a review of technology and the compatibility of existing systems across health and social care would present a significant opportunity to harness the innovation already evident around effective care planning in the independent sector and to ensure that smart technology is maximised in its potential to ensure positive, personal outcomes for individuals and the most appropriate use of supports.

The embedding of anticipatory care plans in all aspects of health and social care would also enable us to better achieve the ambitions of Realistic Medicine, particularly around reducing harm and waste. Anticipatory care planning prioritises the question, ‘What matters to you?’, and will often lead to forms of intervention and support which are much more holistic and lower-level than the presumption that people want to, or can, feel 100% well through significantly medicalised interventions or high level care packages. For instance, the existence of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in an anticipatory care plan means that individuals have more choice and control over how they want their support to be delivered at end of life, and moves us away from assuming that life in itself always takes precedence over quality of life or quality of death.

5 Ibid
Scottish Care would welcome further opportunities to discuss our submission with the Health and Sport Committee and if further information is required, would be more than happy to supply this.

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