



IMPROVING OUTCOMES by SHIFTING THE BALANCE OF CARE

Improvement Framework

Shifting the Balance of Care Delivery Group

July 2009

SHIFTING THE BALANCE OF CARE

IMPROVEMENT FRAMEWORK

Summary

1. The national Shifting the Balance of Care Delivery Group has brought together key policy strands and associated improvement work into an overarching framework that will help Health Boards and their Local Authority partners to describe SBC priorities and actions over the next few years. The Shifting the Balance of Care Delivery Group is a national partnership group with a key role in promoting knowledge transfer in relation to SBC and ensuring that policies and strategies are aligned effectively.
2. Eight SBC improvement areas have been identified as key to the delivery of national and local outcomes and targets. Health Boards and their Local Authority partners can use the approach to agree their baseline position and the range of actions that will lead to measurable shifts in the balance of care in selected areas of the Framework.

The eight improvement areas are:

1. Maximise flexible and responsive care at home with support for carers
 2. Integrate health and social care and support for people in need and at risk
 3. Reduce avoidable unscheduled attendances and admissions to hospital
 4. Improve capacity and flow management for scheduled care
 5. Extend scope of services provided by non medical practitioners outside acute hospital
 6. Improve access to care for remote and rural populations
 7. Improve palliative and end of life care
 8. Improve joint use of resources (revenue and capital)
3. The SBC Improvement Framework includes a menu of evidence based improvements that may have the biggest impact on SBC. These take into account the wide range of high impact changes and other improvement work that is currently in progress (e.g., Joint Improvement Team programmes, Long Term Conditions, 18 Weeks Referral to Treatment Programme) – most of which have improvement in the balance of care at their core.
 4. Health Boards and their Local Authority partners are encouraged to focus on the eight areas and prioritise local service redesign programmes and/or local investment plans to support agreed improvements. The changes included in this Framework are already happening. What is crucial to delivery is to move from small scale pilots/projects and incremental change to locally planned system wide implementation of evidence based improvement.

5. Demographic changes, and a challenging public sector financial settlement, will require Health Boards and their Local Authority partners to make better joint use of resources across the whole health and social care system. Work is underway on the development of an Integrated Resource Framework that will support local approaches to realigning existing resources to enable shifts in the balance of health and social care. The developing programme of work relating to [Reshaping Older People Services](#) will be a key driver for change in the way we support older people and their carers now and over the next 20 years (and beyond).
6. There is no single route map for shifting the balance of care. Recognising the local context is critical in defining priorities and measuring improvements. Health Boards will be expected to outline their SBC priorities in their Local Delivery Plans. These priorities should relate to the areas described within the Improvement Framework and support the delivery of NHS outcomes and targets and community care outcomes. These Plans should also have a clear line of sight into workforce development plans; eHealth and eCare strategies; and infrastructure investment plans.

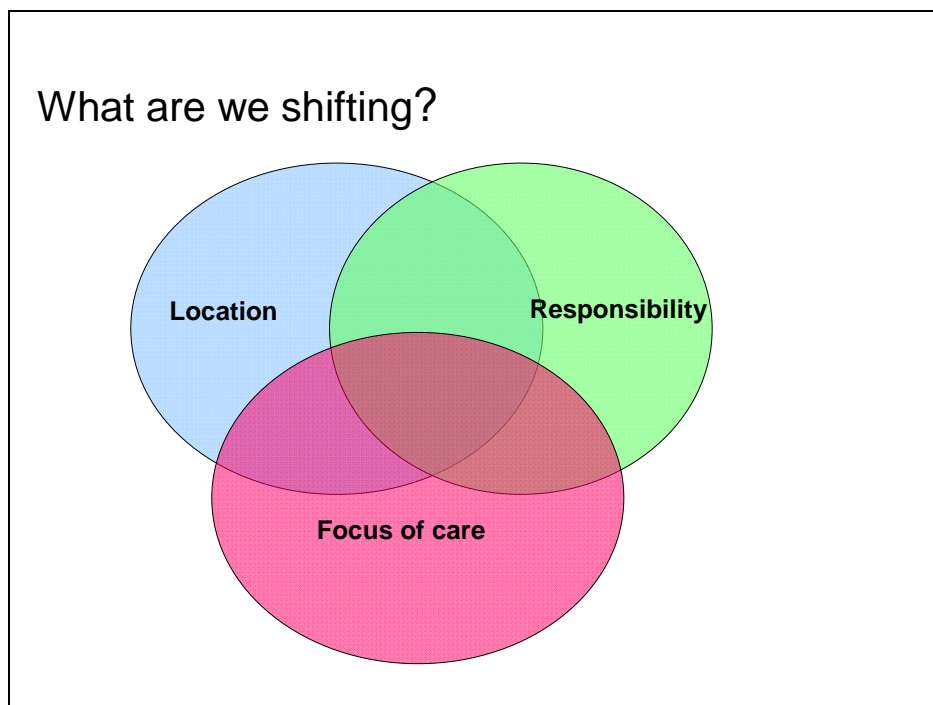
Shifting the Balance of Care Delivery Group
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1 What does Shifting the Balance of Care mean?

- 1.1 Shifting the Balance of Care (SBC) is a strategic objective for the Scottish Government, NHS and Local Authorities. Demographic pressures (particularly the projected rise in the number of older people); workforce issues; the need to improve health and social care outcomes, and the increasing cost of institutional care means that current patterns of care delivery are not sustainable.
- 1.2 SBC describes changes at different levels across health and social care – all of which are intended to bring about better outcomes for people, providing services which reduce inequalities, promote independence and are quicker, more personal and closer to home. This means we need to develop clinical and care pathways that may involve shifting location, shifting responsibility; shifting care and preventing or delaying more intensive and expensive interventions. These three components are not mutually exclusive.



- **Shifting the focus of care onto prevention** – by increasing the rate of health improvement particularly in deprived communities by anticipating and addressing the need for care at an earlier stage; changing the emphasis from services focused on acute conditions towards systematic and personalised support for people with long term conditions; developing continuous, integrated care rather than disconnected episodic care. This means identifying individuals earlier who might benefit from interventions that might sustain their independence and avoid/delay adverse events or illnesses.
- **Shifting who delivers care** – providing more care and treatment in the community, requiring professionals and staff to develop their skills, expertise and roles. This means moving away from the “independence” of individual practices and professionals towards extended primary and community care teams, which make better use of general and specialist expertise. This requires partnership working between organisations and professionals, and agreement on outcomes and care pathways delivered by community based multi agency

teams. It means shifting our view of individuals as passive recipients of care towards full partners in improving their health and managing their conditions.

- **Shifting the location of care** – by improving access to care and treatment through changes in the location of services; providing a wider range of diagnostics and specialist services in communities and maximising the use of new technologies. Here we expect to see some changes in clinical and hospital based activity as we develop the community infrastructure, information systems and workforce capacity.

1.3 Many of the most effective changes will shift the balance of care within all three areas. For example, the [Scottish Telecare Evaluation Report](#) by York Health Consortium highlights the positive impact on outcomes from shifts in the location of care into the home through remote monitoring of aspects of daily living, shifting responsibility by giving carers and families more independence and support and shifting the focus onto prevention by reducing the number of adverse events e.g. falls in the home.

2 SBC Improvement Areas

- 2.1** The SBC Improvement Framework brings together key policy strands and collaborative processes into an overarching framework that will help Health Boards, Local Authorities and their partners to deliver agreed SBC priorities. It has been developed as part of the work of the Shifting the Balance of Care Delivery Group and has the support of the Ministerial Strategy Group for Health and Community Care. The eight improvement areas are critical to working with stakeholders within acute, primary, social care and housing interests.
- 2.2** Eight SBC improvement areas (below) have been drawn from existing policy initiatives and wide stakeholder discussion (**Annex 1** describes each area in more detail). Within these areas each community will have strengths and weaknesses.

SBC IMPROVEMENT AREAS

1. Maximise flexible and responsive care at home with support for carers
2. Integrate health and social care and support for people in need and at risk
3. Reduce avoidable unscheduled attendances and admissions to hospital
4. Improve capacity and flow management for scheduled care
5. Extend scope of services provided by non medical practitioners outside acute hospital
6. Improve access to care for remote and rural populations
7. Improve palliative and end of life care
8. Improve joint use of resources (revenue and capital)

2.3 Evidence based changes

A number of [possible high impact changes](#) across the improvement areas have been identified by stakeholders (these include changes recommended by a number of national groups e.g. Long Term Conditions, End of Life and Palliative Care, Remote and Rural) and through research commissioned by the Scottish Government which is available on the [Shifting the Balance of Care website](#).

2.4 Prioritising what works

In order to prioritise what should happen locally, it is important to identify those changes (or combinations of changes) that will have the most impact on shifting the balance of care. The possible changes identified above were assessed against the following criteria:

Number of people affected

- Less than 100,000 (under 2%)
- 100,000 – 500,000 (up to 10%)
- More than 500,000

Scalability - how quickly change could happen, based on whether it:

- was already working across a whole system somewhere in the UK
- involved new legislation
- required new ways of working by a well defined group of people

Multiple impact of each change across improvement areas - some changes affect more than one SBC area. For example, supporting unpaid carers helps to maximise care at home, improve end of life care, prevent unscheduled admissions, provide better care in remote and rural areas and provide more care outside acute hospitals. The more SBC areas that specific changes supported, the more effective the change was considered to be.

When the above criteria were applied to the evidence based changes, a small number emerged as the most effective when implemented across a whole community ([‘long list of possible changes’](#)).

Local Priorities - while all evidence based changes (organisational, workforce and system changes) may contribute to shifts in the balance of care, few health and social care systems have the capacity or capability to make all the changes happen in all areas simultaneously. Local communities need to agree what actions should be directed at areas with the highest local priority in order to arrive at a manageable plan of action for improvement.

3 Realigning Existing Resources

- 3.1 In order to support shifts in the balance of care, the Scottish Government is providing support to Health Boards and their Local Authority partners to map health and adult social care resource allocation and utilisation at CHP and locality levels.
- 3.2 The first stage of the development of the [Integrated Resource Framework](#) (IRF) provides Health Boards and Local Authorities with a clearer picture of the cost implications of local health and adult social care professional decision making, which can be used to identify the resource implications of changes to clinical and care pathways. This will enable partners to fully understand the impact of change in one part of the NHS or adult social care sector on the whole system's ability to deliver agreed outcomes and targets. Additionally, it will inform local plans for realignment of resources to support investment decisions and/or changes in activity.
- 3.3 The second stage of the work will be focused on the development of protocols to underpin decisions about realigning existing resources to support the most effective changes in activity and commissioning for joint services.
- 3.4 The IRF provides an evidence base for understanding and reducing variation in practice and outcomes and making investments and disinvestments. It will provide partners with the information required to review services more effectively, plan strategically and enable resource realignment to support shifts in the balance of clinical/care activity based on agreement on clinical and care pathways.
- 3.5 Using the SBC Improvement Framework, together with the outcomes from the IRF work, and other relevant tools, will provide partners with a strategic focus for planning and delivering shifts in the balance of care, as well as a means of measuring the overall impact of the changes that are implemented.

4 Links to National Outcomes and Targets

- 4.1 The SBC Improvement Framework directly supports the delivery of [HEAT Targets](#) and [Community Care Outcomes](#) which inform [Single Outcome Agreements](#) and the [Scottish Government National Performance Framework](#). The diagram below and **Annex 2** show the links between the eight improvement areas and targets and outcomes.

Shifting the Balance of Care links to Outcomes

Improvement Areas

1. Maximise flexible and responsive care at home, with support for carers
2. Integrate health and social care and support for people in need and at risk
3. Reduce avoidable unscheduled attendances and admissions to acute hospitals
4. Improve capacity & flow for scheduled care
5. Extend range of services provided by non-medical practitioners outside acute hospital
6. Improve access to care for remote and rural populations
7. Improve palliative and end of life care (EOL)
8. Improve joint use of resources (capital and revenue)

Shifts/Impact (examples)

Improved individual experience

Increased independence and personal choice

Prevent adverse events by earlier interventions

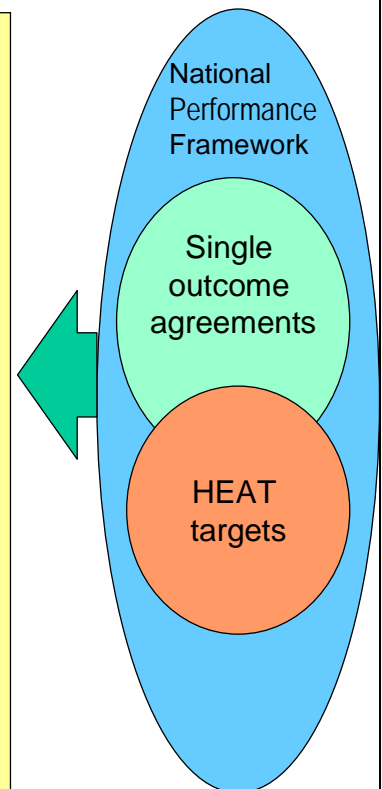
Decreased institutional beddays

Better use of medical and non medical professionals

Use existing technology as fully as possible

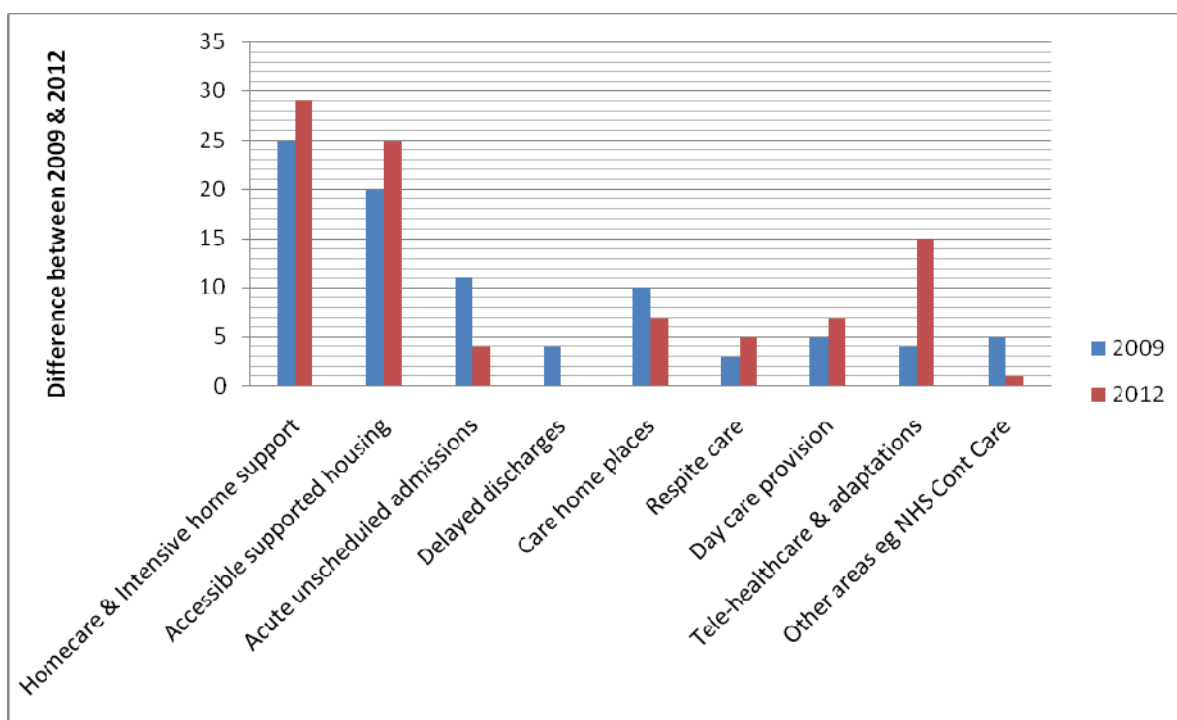
Reduced inequalities in time and geography

Reduced overall infrastructure costs and minimise carbon footprints



- 4.2** Partners need to get the focus and the pace of change right in their local areas. They need to use information on activity, quality, cost and inequalities to agree their priorities, and the consequential shift required in the level and range of services, care and support locally. Measurement of the level of improvement should underpin the whole process of shifting the balance of care.
- 4.3** Although there are no specific, new national measures for shifting the balance of care, all eight improvement areas are important. Services and care must continually adapt to the changing needs and aspirations of individuals and families and support the delivery of outcomes. SBC is therefore an evolutionary and ongoing process with no fixed end point.
- 4.4** Partners should agree and monitor how far and how fast the cumulative effect of SBC is locally and assess progress. For example, in relation to SBC Area 1, maximising care at home with support for carers, partners may wish to develop an overall strategic direction comprising a number of changes in a number of connected areas illustrated in the hypothetical chart below:

Hypothetical chart showing difference between 2009 and 2012 for some services that support maximising care at home with support for carers



5 National Support

- 5.1** The Scottish Government provides a range of improvement and development support for the changes outlined in this Framework. For example, the [Improvement and Support Team](#) and [18 week RTT Programme Board](#) support improvements in capacity and flow management for scheduled care; the [Joint Improvement Team](#) aims to improve outcomes for service users and carers through supporting better partnership working ; the [Long Term Conditions Collaborative](#) and [Mental Health Collaborative](#) support integration of health and social care for people at risk or in need; the [Living and Dying Well](#) Programme Board supports improvements in palliative and end of life care, and the [Emergency Access Delivery Team](#) supports improvements in unscheduled care, including reductions in inappropriate attendances at A&E.
- 5.2** Work is also underway, led by [National Education Scotland](#), [NHS Health Scotland](#), and [NHS QIS](#), to align their educational, training and development activities to support the shift in the balance of care priorities described in this Framework.
- 5.3** We will continue to discuss with SBC Health Board leads and their partners how we can best support them in taking forward the actions outlined in this Framework.

6 Shifting the Balance of Care Delivery Group

6.1 The national SBC Delivery Group has a leadership role in relation to SBC policy development and strategy implementation within and across health and social care. A list of members of the SBC Delivery Group can be found in **Annex 3**. The 2009 work plan focuses on three areas:

- **Knowledge Transfer** - ensuring that information about SBC, including definitions, research, high impact changes, and links across policy areas (incorporated into an SBC Improvement Framework) reaches partner organisations and individuals involved in shifting the balance of care;
- **Alignment** - ensuring that Health Directorate work streams support the agreed direction of travel. The Group will challenge policy leads on the impact of major strategies in relation to SBC principles and priorities. It will seek to join up areas such as Long Term Conditions and 18 Week RTT with SBC in order to make the policy coherent. The challenge function also relates to the development of HEAT targets and other outcomes;
- **Identifying and removing barriers** - including commissioning work to address perceived barriers to progress and working to ensure solutions to problems. A major part of this is developing an integrated financial resource framework.

6.2 The SBC Delivery Group will continue to work with established groups to share learning and promote change and innovation. A network/community of interest will be supported via a range of expert workshops and access to evidence based information to support improvement in the eight areas. Direct links to good practice in each of the eight areas will be accessible via the [Shifting the Balance of Care website](#).

7 Assessing Progress

7.1 From the health service perspective, it was clear from last year's Annual Reviews that Health Boards did not generally have a mutually coherent story to tell about their priorities for SBC or how service improvements were linked to outcomes.

7.2 The Scottish Government and the SBC Delivery Group would like Health Boards and their partners to take a more focused and systematic approach to SBC and to be clear about the measurable changes they expect to deliver in selected areas of the SBC Improvement Framework over the next few years.

7.3 Health Boards should agree their baseline position and quantify the SBC improvements to be made to support the delivery of specific HEAT targets and community care outcomes as well as other strategic priorities.

8 Community Health Partnerships

- 8.1** Ministers have reaffirmed the central role of CHPs in shifting the balance of care, improving health, and reducing inequalities. The Scottish Government has commissioned a study of CHPs, with the support of COSLA and NHS Boards, to consider the progress they have made in relation to their specific areas of responsibility, and to identify the factors that have facilitated or possibly hindered progress.

- 8.2** The study will report in March 2010 and the findings will be used to identify ways in which the capacity and capability of CHPs can be improved to enable them to fulfil their statutory duties and to inform the further development of policy. In the meantime, Health Boards and their Local Authority partners should be clear about their local plans to strengthen the role of CHPs in relation to health improvement and service delivery.

Annex 1 - SBC AREAS 1- 8

The eight SBC improvement areas outlined below form the scope of shifting the balance of care. More detail about each area is given on the [Shifting the Balance of Care website](#). The list of developments will continue to evolve and the examples given here are illustrative.

1. Maximise flexible and responsive care at home with support for carers

Most people want to be cared for safely in their own homes for as long as possible. The ideal situation is that packages of care should be assessed and planned with an individual (and their carer) and then reviewed and adapted to reflect their changing circumstances and/or growing dependency, thereby reducing or delaying the need for people to move out of their homes.

What are we trying to improve?

Maximising care at home aims to improve the quality and appropriateness of care as part of rebalancing the focus away from institutional care to re-ablement; improving flexibility and responsiveness in order to minimise the need to admit people to hospital at times of crisis, and delaying or avoiding the transfer to a care home.

The aim is to provide better support for individuals (with physical and/or mental health issues) and their carers and to improve their experience, deinstitutionalise care as far as possible, reduce risk and encourage personal choice and independence by:

- improving the experience for individuals (and families and carers) who want to remain at home;
- minimising risks and increasing safety for individuals at home using Telecare and Telehealth technologies wherever appropriate;
- increasing care planning to increase anticipatory care and reduce the number of falls and health crises at home;
- reducing the length of stay in acute hospitals/care homes ;
- empowering people (and their carers) to manage their own care, particularly older people and those with long-term conditions;
- enabling and supporting unpaid and paid carers to improve rehabilitation and re-ablement in people's homes, to maximise individuals' potential independence;
- improving pharmaceutical care and medicine concordance for people at home and in care homes;
- improving the quality of life of socially excluded people at home or in care homes, including those suffering from mental health problems or people with reduced mobility; and
- increasing access for adaptations to existing housing and to equipment to support activities of daily living.

What could success look like?

Health and social care partners will increasingly support people to care for themselves and manage their own health better. Home care services should be redesigned and refocused toward maximising people's independence. Home care teams could include a wider range of non medical professionals from different organisations as well as the individuals themselves. This multi agency approach should have a clear focus on rehabilitation which reduces the need for residential care and hospital care.

More care can be provided in people's homes through enhanced support to carers. Paid and unpaid carers will be better supported to manage care provided at home and they will have better access to respite care. Paid carers will become a key part of the professional team, supported by a wide range of non medical professionals, and will be able to administer medication when appropriately trained. There will be better support for carers through third sector organisations and others, including better carer networks that provide local knowledge and support.

The increased use of existing Telecare and Telehealth technology should help people to take greater responsibility for their own care and enable carers to continue with their caring roles. This can facilitate improvements in prevention and anticipatory care e.g. Falls Management. These technologies should become 'normal' components of care to minimise the risk to people remaining at home (including those with dementia), covering physiological monitoring, safety and security, information and support services and home based medical applications. Telehealth technology involving clinicians in remote physiological monitoring and consultation may also reduce the need for visits to hospital, particularly for those living in remote and rural locations.

More extra care housing should become available over time, but the lead time in construction may mean that it is quicker to adapt existing houses. Community planning partners will therefore seek to prioritise funding for equipment and adaptations of existing housing stock.

What is already going on?

- [Redesign of home care services transforming them into re-ablement services](#)
- [Telehealth projects](#) led by the Scottish Centre for Telehealth
- [Telecare programme](#) led by the Joint Improvement Team
- [Housing with care demonstrators](#) in Inverclyde, [West Lothian](#) and Highland
- [Intermediate Care Learning Network and Intermediate Care Demonstrator](#) programmes
- [Long Term Conditions Collaborative work](#)
- [Delivery Framework for Adult Rehabilitation in Scotland 2007](#)
- Examples of good carer practice are embedded in NHS Board Carer Information strategies. These are found on each Health Board's website.

2. Integrate health and social care and support for people in need and at risk

Many people find the maze of health, social care and housing services, benefits and procedures confusing. People with more than one long term condition, often with complex needs, may be visited or contacted by a number of different people from different departments in different organisations who may not fully understand the individual's holistic needs.

The number and proportion of the population with health and social care needs is increasing as the population ages. For example, later in life many people may be living with more than one long term condition and an increasing number of people will have dementia. People with cognitive and physical needs may be vulnerable and require integrated, personalised responses from statutory and third sector providers of care and support.

What are we trying to improve?

The aim is to move to a culture of 'doing with' rather than 'doing to' people, to enable the individual to experience a better quality of life.

The focus will increasingly be on self management supported by better information, often shared electronically with remote professional support. This will help improve communication for patients, professionals and staff working within and between extended teams.

The individual (family and carers) will be central to the care planning process and extended community care team. This should result in increased personalisation of care and improved patient (and family) experience.

Multi-disciplinary and multi agency extended community teams, together with care managers and third sector contributions, will be key to the delivery of improved health outcomes; increased participation and compliance with treatment; reduced length of stays in hospital; reduced unplanned admissions to institutional care and acute hospitals and improved patient/service user and carer satisfaction.

By integrating care pathways across organisational boundaries, and providing easier and quicker access to services through multi disciplinary and multi agency teams, individuals can be supported more effectively to self manage their conditions while living in the community.

What could success look like?

Care will increasingly be provided by extended multidisciplinary, multi-agency community teams often co-located in a shared workspace. These teams may include 'generic workers' providing routine straightforward nursing, rehabilitation and personal care. These teams may have care managers who will act as an interface between an individual and their care team and coordinate the care for that individual. Teams will share staff, equipment and information. Community teams will identify people who are not yet in crisis but at risk of getting to crisis point.

Single points of contact will have replaced multiple information sources about what health and social care services are available locally. Individuals will be finding the process of accessing support less complicated and time consuming.

People will be supported to do more themselves and increase their independence, working as full partners in managing their own long term conditions. There will be growth in personalisation and Self Directed Support to ensure that care packages meet individual people's needs and choices, particularly for those with complex needs. Different types of care, including housing needs, will be integrated seamlessly into personalised 'care bundles', with funding increasingly being managed through personalised budgets. Targeting these care bundles or packages towards people 'at risk' will move care 'upstream' and reduce the risk of crises and/or adverse events (e.g. falls).

What is already going on?

- The [Long Term Conditions Collaborative](#) has developed an action plan and a set of High Impact Changes that have been incorporated into the SBC Framework.
- [Ten approaches to help you deliver better outcomes and an enhanced experience of care for people living with long term conditions through self management.](#)
- [Rapid evidence review of services for LTC.](#)
- [Supporting People with Long-Term Conditions to Self Manage: An Essential Guide to Multi-Agency Knowledge and Skills.](#)
- [Changing Lives](#) is a review of social work which is providing a number of ways to encourage change and to increase personalised services delivered by a confident, competent and valued workforce.
- [Multi Agency Inspection of Older People \(MAISOP\)](#): These assessments apply to collaborative working between health and social work services.
- Development of [local area co-ordination](#) that supports individuals and families to develop strengths and capacities rather than the need for services.
- Development of targeting methods (e.g. [SPARRA](#) or [PEONY](#)) for aligning and targeting resources along care pathways towards people at risk to prevent them becoming more dependent.
- Development of a range of [intermediate care services](#) to reduce admission to hospital and facilitate timely discharge.
- [Self Directed Support](#) gives people the opportunity to manage their own support funding.
- Embedding of [Single Shared Assessment](#) sharing of information within local partnerships and application of the [Talking Points Personal Outcomes Approach](#).

3. Reduce avoidable unscheduled attendances and admissions to hospital

Emergency admissions and attendances at A&E departments have increased over the last decade despite the population size remaining more or less constant. Part of the increase may be due to the 'aging' of the population.

Studies have demonstrated that a significant proportion of A&E attendances are for conditions that could be better managed in the community by the patient, their GP or another member of the primary care team. People, particularly those who live close to an acute hospital, tend to use A&E departments as the first place to seek healthcare treatment, even though this may not be the most appropriate place to be treated. This is particularly true of people who seek treatment outside working hours.

Recent work mapping health care expenditure has shown that in many Board areas around 25-30% of NHS Boards' total budgets are spent on unscheduled admissions to acute hospitals. Of those who are admitted to hospital as an emergency, the majority are over 65 years old. Some people may be admitted because there are no 'safe' alternatives and not necessarily because they need specialist care.

What are we trying to improve?

The overall aim is to reduce unscheduled care by minimising avoidable attendances at A&E Departments and reducing emergency admissions and length of stay in hospital. There are various ways in which we are trying to do this:

- Increasing access to integrated community based urgent care systems, in hours and out of hours. This requires acute clinicians, SAS and NHS24 to work even more closely together with primary care and social care partners.
- Improving access to information, which informs people about what health and social care services are available locally. This will help ensure that they access the most appropriate services and receive the most appropriate care.
- Agreeing care plans with patients, carers and extended community teams that will anticipate crises and avoid some A&E attendance/admissions particularly for those with long term conditions and those who are in the last year of life. Measures could include home physiological monitoring and remote Telehealth and Telecare support.
- Identifying and targeting those people who are at risk of admission, and providing appropriate information, support and care for them in the community.
- Providing 'intermediate' care responses to prevent admission, managing more people locally and speeding up discharge.
- Increasing the capacity of emergency response teams using non medical practitioners where appropriate e.g. See and Treat teams.
- Developing care pathways across health and social care systems with the help of Scottish Ambulance Service and NHS24, to help ensure that only people who need specialist care are taken to acute hospitals.

- Delivering better pharmaceutical care to help increase concordance and avoid the effects of poly pharmacy.
- Meeting the delayed discharge standards and reducing length of delays for people in hospital.

What could success look like?

The aim is to shift the balance of care by developing an integrated system of unscheduled care, including a much wider range of partnership arrangements which will help reduce the pressure on A&E, and improve patient experience and staff satisfaction.

Intermediate care solutions, including admission prevention rapid response teams, will be available across more CHP areas. Community hospitals will be the focus of local care for local populations (not just those registered to certain practices) and will complement the role of acute hospitals in reducing avoidable A&E attendances.

There will be more emphasis on planning care and anticipating crises particularly for the last 48 hours of life, which will allow more of the 140 - 150 people who normally die in Scotland every day to die in their own homes or in their preferred place of care rather than in hospital if they so wish.

A greater system-wide understanding of how people access emergency care, and why certain choices are made, will allow local health systems to develop intelligence about avoidable attendances at A&E departments and target their responses accordingly. If this is managed well, perhaps using a social marketing approach, this will help shift the balance from dependency and demand for unscheduled care towards better scheduled/planned care interventions.

What is already going on?

The [Emergency Access Delivery Team](#) is working with NHS Boards and partner organisations such as [NHS24](#) and [Scottish Ambulance Service](#) to develop, evaluate and learn from local improvement strategies for delivering reductions in attendances at A&E. This work sits alongside other improvement work such as:

- [Long Term Conditions Collaborative](#)
- [Mental Health Collaborative](#)

4. Improve capacity and flow management for scheduled care

Reducing waiting lists and waiting times for scheduled care has been a focus of attention over many years, mainly for acute hospitals. It remains a priority for the Scottish Government, which has set out a whole patient journey waiting time target of 18 weeks from general practitioner referral to treatment by December 2011.

There is often a significant variation in the rate of referral for specialist scheduled care, both in terms of volume of referrals and the point in the disease pathway at which these referrals are made. While some of this variation is attributable to differences in demography and local characteristics of the population, some is also due to variation in clinical practice. This needs to be better understood, as variation can be very expensive unless it results in improved outcomes.

What are we trying to improve?

In redesigning care pathways to improve capacity and flow there are four main aims:

- to ensure that people receive treatment as early as possible in the disease trajectory, in order to avoid complications that may arise from late stage diagnosis or treatment
- to ensure patients move through the care system at a smooth rate to reduce number of steps in the care process
- to reduce the length and number of people involved in the pathway to improve the effectiveness of care, e.g. reduce peri-operative bed days for scheduled care
- to make the best use of available capacity in health and social care systems.

There is a significant number of evidence based Integrated Care Pathways already available which can be adapted for wider use by clinicians and professionals across primary and secondary care, to help ensure that patients receive the best possible care.

The redesigned care pathways will include earlier access to diagnostic tests, which, together with preventative/prompt treatment in disease processes, will help improve outcomes for patients. This will also help ensure that only patients who need specialist investigations or treatment are referred and that these referrals are made quickly.

It is usually GPs who "start the clock" of the 18 week Referral To Treatment HEAT target. While they are pivotal in ensuring referrals are timely, appropriate and patient-focused, there is evidence that changing permissions for referral to allow non medical practitioners and individuals themselves to make referrals may help reduce waiting times for treatment and reduce the number of steps in treatment pathways. For some pathways, screening and some treatments are already provided directly by non medical practitioners (e.g. eye-screening and back pain) and this could be extended.

Electronic referral systems will increasingly be used, and will play a vital part in promoting dialogue between clinicians and professionals involved in the care pathways.

What could success look like?

Overall, SBC will have been successful in this area if scheduled care has increased as a proportion of all care – i.e. more people will be treated on a scheduled basis rather than an unscheduled basis.

The 18 week RTT HEAT target will have been achieved and waiting times for scheduled care maintained at 18 weeks. This will result in a big improvement in patients' experience of acute care.

There will be changes in referral pathways and, while GPs will continue to make the majority of referrals, there will be self referral by patients to non medical practitioners, and referrals by non medical practitioners (e.g. physiotherapists, occupational therapists, optometrists) to specialists. This extension of the role of non medical practitioners will maximise their contribution and help reduce the length of care pathways, and will also enable GPs to spend more time managing more complex medical conditions in the community.

Community diagnostic capability and capacity for routine high volume tests will be extended. While this capacity will normally be in local care centres / community hospitals, in some places it may be cost effective to provide mobile diagnostic services, or diagnostics hubs for routine high volume imaging, scoping and pathology in a limited number of places.

There will be less variation in GP referral rates for specialist scheduled care and people will be referred more often for treatment with a diagnosis already established.

What is already going on?

- Significant effort by health systems is focused on achieving [18 weeks RTT](#). There has been a lot of hard work to shorten patient waiting times which will lead to earlier diagnosis and improve patient experiences. There is also a shift from individual stages in treatment to the whole pathway. The programme will also provide more continuity of care and a traceable patient journey.
- Quality Improvement Scotland (QIS) is constantly adding to and revising their integrated care pathways held in the Scottish Intercollegiate Guideline Network [SIGN guidance](#).
- There is work ongoing on [electronic referral to specialist care](#) in Scotland, which relates to online triage services. Using technology to improve the management of referrals supports the reduction of time from referral to treatment and the delivery of 18 weeks RTT.
- The [Quality Outcomes Framework](#) (QOF) in primary care, which is part of the new GMS contract, is being used to analyse variation in primary care. In Scotland, QMAS can be found at <http://www.qmasweb.scot.nhs.uk/>.
- [National Delayed Discharge Learning Network](#).

5. Extend scope of services provided by non medical practitioners outside acute hospital

The NHS, Local Authorities and third sector partners are responding to the changing needs of patients and local communities by providing more local services and more individualised packages of care for key groups.

Non-medical professionals (e.g. nurses, pharmacists, optometrists, chiropodists, physiotherapists, psychologists, occupational therapists, dieticians, dentists and speech and language therapists) have a pivotal role to play in providing care in primary and community settings. They have an extensive range of skills and knowledge that can enhance workforce capacity in communities and support delivery of more care outside acute hospitals. They are increasingly working as part of extended clinical teams, providing better access to information, advice and treatment.

What are we trying to improve?

Although GPs remain key clinical leaders in the provision of care outside acute hospitals, there is scope to widen the range of local services provided by non medical practitioners alongside existing medical services. This will enable GPs to maximise the use of their medical training and skills in dealing with complex clinical work as part of the delivery of more locally based services.

The provision of more screening, treatment, prescribing and rehabilitation by non medical practitioners will help to support delivery of integrated pathways of care and the 18 week RTT, and enable acute hospitals to focus on treating those requiring specialist or more complex treatment.

Extending the scope of services provided by non medical practitioners will make better use of highly trained clinicians' skills and expertise. It will also help to improve care, by providing access to the most appropriately trained professional, in a setting as close to people's homes as possible.

What could success look like?

GPs will be working more closely with a wider range of health professionals and will provide vital clinical leadership for the extended community team, particularly for patients with complex needs and long term conditions.

More screening, rehabilitation and treatment will be led and provided by non medical practitioners, such as nurse-led intermediate level services with specialist input from consultants, and non medical prescribing.

CHPs will take a more significant role in managing referral processes outside hospitals, using electronic systems. There will be greater access, with more self referral to non medical practitioners (e.g. to 'one stop clinics', for musculoskeletal problems). Non medical practitioners (e.g. optometrists, physiotherapists) themselves will increasingly be able to refer directly to secondary care.

What is already going on?

The following work is already in progress and will maximise the potential of non medical practitioners and support delivery of NHS and Local Authority strategic aims.

- The [Delivery Framework for Adult Rehabilitation in Scotland](#) gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation services to individuals and communities. The document focuses on core principles of rehabilitation specifically as they relate to older people, adults with long-term conditions and people returning from work absence and/or aiming to stay in employment.
- The [Review of Community Eyecare Services in Scotland](#) made recommendations in relation to the integration, quality and efficiency of community eyecare services. In addition, free [Eye screening by optometrists](#) is being broadened to provide a health assessment of each patient's whole visual system. This will allow for the treatment of a wide range of conditions in the community.
- Non medical Prescribing: Increasing the capacity of NMAHP prescribers is described in a strategy for NHS Boards, '[A Safe Prescription](#)', to be launched in 2009.
- [NES Scotland](#) helps to provide better patient care by designing, commissioning, quality assuring and, where appropriate, providing education, training and lifelong learning for the NHS workforce in Scotland. NES is also involved in creating competency frameworks for non medical practitioners.
- [The Right Medicine: A Strategy for Pharmaceutical Care in Scotland](#) outlined a commitment to work with the pharmacy profession to improve the public's health, provide better access to care, deliver better quality services for patients, users and carers, and develop the pharmacy profession by more fully utilising the skills of community pharmacists. Information and leaflets about the new services associated with this are available on the [Community Pharmacy Scotland](#) website.
- [Safe, Accurate and Effective: An Action Plan for Healthcare Science in NHS Scotland](#) details how healthcare scientists can increase their capacity to influence, shape and deliver services. The move to deliver more healthcare in local communities means that healthcare science may need to develop a greater community profile, with new models of service delivery and new and extended roles for individual scientists.

6. Improve access to care for remote and rural populations

Around 20% of Scotland's population live in areas that have been classified as remote and rural. Delivering high quality care in these areas is challenging and without careful planning and management could potentially lead to inequalities in access. Within the remote and rural communities of Scotland, the skills and expertise of health and social care professionals will need to be effectively deployed if communities are to have local access to the widest possible spectrum of care.

These issues were explored by a national working group who published a report '[Delivering for Remote and Rural Healthcare](#)' in May 2008. The recommendations are being implemented through the Rural and Remote Implementation Group (RRIG). The key recommendations include:

- integrated and co-located extended community care teams;
- increased use of Telecare, Telemedicine and Telehealth solutions to support local care delivery and diagnosis;
- more anticipatory care;
- the development of obligate networks linking rural communities and specialist care;
- the importance of the role of integrated community transport.

Remote and Rural Communities are often at the leading edge of what is possible in relation to shifting the balance of care, particularly in terms of what can be provided in a community setting.

What are we trying to improve?

The aim is to provide the highest quality of health care within local remote and rural communities, minimising the need for patients to routinely access clinical services outwith their locality.

What could success look like?

There will be more consistent high quality care available across Scotland. In particular, the development of Extended Community Care Teams will ensure that a robust system of local services is both available and sustainable. All remote and rural areas will also have access to intermediate care services, some within a Community Hospital (CH) and others delivered through augmented care within a patient's home.

Whilst many communities have access to a Community Hospital, others may have a Rural General Hospital (RGH), which may fulfil the Community Hospital function, or these may be separate. This should result in less travel to specialist centres for consultations and routine care, and thus a smaller carbon footprint.

More expert support will be available remotely (via Telehealth and [Telecare](#) technology) using improved broadband connections, building on the work of the [Scottish Centre for Telehealth](#). Remote support will enable local clinicians, families

and carers to look after people close to their homes for longer and reduce the need for referrals to acute centres for routine care.

Care planning and anticipatory care will reduce crises and adverse events which may be difficult to deal with quickly in remote and rural locations.

Obligate networks (clinical links with specialists which form part of contractual obligations) will become well developed, allowing local clinicians to develop closer working relationships with secondary and tertiary providers to increase access to specialist care when it is required.

What is already going on?

The Institute of Rural Health's "[Database of Good Practice in Rural Health and Wellbeing](#)" is an easily searchable website for organisations looking to improve service delivery and access to care for people living in rural communities. Examples of some of the wide variety of work that is underway to support the RRIG are on the database and include:

- development of Obligate Networks between remote and rural areas and larger centres, including diagnostic imaging, laboratories, child health and mental health, e.g. Mental Health Obligate Network Orkney-Grampian-Shetland;
- use of telehealth to support local care, e.g. Paediatric Telemedicine Network – NHS Orkney/Yorkhill;
- development of new models for emergency and urgent response to remote and rural communities; using the concepts from East Anglia Emergency Community Response System;
- development of extended community multidisciplinary teams, including skills mix, role extension and integration of teams, e.g. Development of GP/Physician Hybrid Role, Fort William; Generic Support Worker, Shetland;
- development of access to specific educational solutions and e-learning for people living in remote and rural communities;
- identification of limitations of the e-health infrastructure in remote and rural areas, and the impact of this on the use of e-health clinical solutions;
- integrated transport systems, e.g. Integrated transport solutions, Orkney; Strathclyde Transport Partnership Project.

The Joint Improvement Team Rural and Remote Programme has completed a [review of service development and innovation in the delivery of joint health and social care and support services in rural and remote areas](#). Development work on integrated out of hours and workforce is underway.

7. Improve palliative and end of life care

About 55,000 people in Scotland die each year. Some 60% of these people die in hospital.

In the past, many people died suddenly and at any age, usually from infectious diseases. Today, the majority of deaths are of people over the age of 65 and follow a period, possibly prolonged, of illness and/or frailty. This has wide-reaching implications for the type of care that will be required for people in future, and particularly in their last year of life.

Palliative and end of life care are integral aspects of the care delivered by all health or social care professionals to those living with and dying from any advanced, progressive or incurable condition. Palliative care is not just about care in the last months, days and hours of a person's life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards.

There is still inequality in access to palliative and end of life care. Most people with cancer have good access. However, it is also important to ensure that people who die of frailty and/or dementia also have access to good quality care and support.

What are we trying to improve?

The aim is to provide consistent, high quality palliative and end of life care to everyone in Scotland who needs it, on the basis of clinical need not diagnosis, and according to established principles of equity and personal dignity.

A palliative care approach should be used, as appropriate, alongside active disease management from an early stage in the disease process. Palliative care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.

We should ensure that everyone has a care plan in place that may change with their changing circumstances, and that includes their preferred place of end of life care. This will help increase the number of people who die peacefully and with dignity in a place of their choice. Additionally, this will help to avoid situations where people may be rushed to hospital, only to die there, when their preferred place of care is in a homely setting.

What could success look like?

There will be an increase in people dying in the place of their choice and with dignity in the midst of their family or friends. This may be achieved by:

- broadening palliative and end of life care to include everyone in the last year of life. This means increasing the number of patients and carers with their palliative and end of life care needs identified, assessed and planned with families and carers (and kept under review);

- increasing the number of patients with palliative care plans developed, implemented and communicated across care settings and systems to all involved professionals;
- increasing the number of people who die in the location of their choice;
- increasing the number of health and social care professionals with the knowledge, skills, competence and confidence to care for patients and carers with palliative and end of life care needs.

What is already going on?

There are numerous projects in palliative and end of life care described within [Living and Dying Well](#) and the [Audit Scotland report](#).

8. Improve joint use of resources (revenue and capital)

NHS Scotland and Local Authorities currently make significant investment choices that determine the way that health and social care services are shaped and delivered in order to meet the expectations of the Scottish public.

The dual pressures offered by demographic change and recent economic challenges make the efficacy and efficiency of those choices ever more important. The traditional planning and investment approach characterised by a focus on opportunities in the margins, whilst rolling forward budgets based on historic spend patterns, will not keep pace with challenges on this scale.

What are we trying to improve?

The overall aim is to achieve more effective use of resources across the public sector, particularly within the NHS and with Local Authorities and other partners. These resources include staff, buildings, information, and technology. These are 'enablers' for shifting the balance of care – and support the strategic directions set out in the other 7 improvement areas.

In particular, a specific focus on the joint use of resources across organisations will:

- enable greater efficiency of allocation and utilisation of resources;
- improve care pathways and communication across organisations in the public and voluntary sector;
- support the more effective use of the skills and capacity of professionals and staff;
- maximise the use of public sector assets;
- reduce the public sector carbon footprint, particularly by shared use of buildings.

Traditionally, each part of the public sector has tended to plan and manage its own resources independently of other sectors. Although progress has been made in aligning community health and adult social care budgets within CHPs and co-locating some services and staff, much more could be achieved. Each sector has its own staff, its own buildings and its own information systems, and this has not necessarily resulted in the most efficient and effective use of resources.

There is also wide variation in per capita spending within the NHS and between local health and social care systems, and this variation is still poorly understood or acted upon. Financial systems can and should be used to incentivise good locality based team performance.

Better joint planning, commissioning and investments by partners around clearly defined joint outcomes will improve the overall use of resources and avoid the potential for "cost shunting" from one part of the health and social care system to another. The overall effect should be to improve the efficiency of care systems and to make communities more sustainable by ensuring that there is equitable investment in local services.

What could success look like?

Partners will have a deeper understanding of how existing resource allocation and utilisation relates to local populations (clinical and geographical) and to individual outcomes. The relationship between resource inputs and outcomes will be more transparent as the evidence base develops.

The public sector will have taken opportunities for joint capital investments, and made better use of the capacity of existing buildings.

Shared information and electronic records will be commonplace, which will help improve communication across professions and organisations.

Technology of all types will be shared more widely together with integrated health and social care responses and maintenance support – through, for example, joint equipment stores, equipment libraries and community alarm systems.

The test sites for developing the Integrated Resource Framework will have been evaluated and results will have been implemented across partnerships, resulting in more effective use of health and adult social care resources across populations and along care pathways at CHP level. Resources will be realigned to support shifts in the balance of care.

There will be a greater role for joint commissioning of health and adult social care, with better commissioning arrangements which will provide transparent, practical mechanisms to allow resources to follow the patient.

Partnerships will have greater capacity and analytical skills for planning future service configurations, including economic, epidemiological, activity and modelling, to determine what services will be needed over which periods of time and in which settings.

The development of community facilities into multi-agency community facilities will enable multidisciplinary teams to be co-located. Integrated teamworking will be key to making the best use of the health and social care workforce.

What is already going on?

- The [Integrated Resource Framework](#) provides an evidence base for understanding and reducing variation in practice and outcomes and making investments and disinvestments. It will provide partners with the information to review services more effectively, plan strategically and enable resource realignment to support shifts in the balance of clinical/care activity based on agreement on clinical and care pathways.
- NHS Boards and some local authorities have made progress in mapping resources to local populations, allowing them to understand local financial resource utilisation patterns, and levels of variation in resource usage across localities. Many CHPs have aligned budgets for Community Health and Adult Social Care, and some CHPs have pooled budgets for a limited number of services.

- Work is also ongoing in a number of partnerships to improve [joint capacity planning and commissioning](#).
- Scotland's [eCare Framework](#) has been developed to enable information sharing between agencies for the care and protection of citizens. It permits authorised professionals to share personal data in a controlled and secure way.
- Development of community facilities across the public sector is being supported through the [HUB initiative](#), run by the [Scottish Futures Trust](#).
- NHS Scotland has set out the vision for the NHS workforce in "[A Force for Improvement: The Workforce Response to Better Health Better Care](#)". This describes the direction of travel for workforce planning and developments to support shifting the balance of care.
- The [Scottish Centre for Telehealth](#) are planning to mainstream Telepsychiatry, Telestroke and Telemonitoring for COPD. This, alongside the increased use of passive monitoring (Telecare) for supporting people in their own homes, reduces the risks involved with independent living.

Annex 2 – SBC Links with HEAT and Community Care Outcomes framework

Improvement Area	Core HEAT Indicator	SG Improvement and Support
Maximise flexible and responsive care at home with support for carers	T8: Increase the level of older people with complex needs receiving care at home	T8 community care benchmarking group Joint Improvement Team
	T9: Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.	Mental Health Collaborative
	Community Care Outcomes Framework	Joint Outcomes Team
Integrate health and social care and support for people in need and at risk.	T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.	Long Term Conditions Collaborative
	T12: By 2010/2012 NHS Boards will reduce emergency inpatient beddays for people aged 65 and over	T12 Advisory Group
	Community Care Outcomes Framework	Joint Outcomes Team Joint Improvement Team
Reduce avoidable unscheduled attendances and admissions to hospital	T4: Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009).	Mental Health Collaborative
	T10: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.	Emergency Access Delivery Team
Improve capacity and flow management for scheduled care	E4: NHS Boards to deliver agreed improved efficiencies for 1 st outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011.	18 weeks RTT Collaborative
	A10: Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 12 weeks from being placed on a waiting list to admission for an inpatient or day case treatment from 31 March 2010.	18 weeks RTT Collaborative

Extend scope of services provided by non medical practitioners outside acute hospital	T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.	Long Term Conditions Collaborative
Improve access to care for remote and rural populations	HEAT Target Development Group to consider proposals.	
Improve palliative and end of life care	HEAT Target Development Group to consider proposals.	
Improve joint use of resources (revenue and capital)	This is an enabler	

Annex 3 - National SBC Delivery Group Members

Name	Position	Organisation
Graeme Dickson (Chair)	Director of Primary and Community Care	Scottish Government Health Directorates
Fiona Mackenzie (Chair)	Chief Executive	NHS Forth Valley
Sue Brace	Head of Strategic Planning & Commissioning; Convenor of ADSW Standing Committee	City of Edinburgh Council
Kathleen Bessos	Deputy Director - Shifting the Balance of Care	Scottish Government Health Directorates
Dr Andrew Buist	Joint Deputy Chairman SGPC	British Medical Association
Deirdre Cilliers	Chief Social Work Officer	Clackmannanshire Council
Ron Culley	Team Leader - Health and Social Care	COSLA
Lynne Douglas	Associate AHP Director	NHS Lothian
Brian Durward	Director of Educational Development	NHS Education for Scotland
Derek Feeley	Director of Healthcare Policy and Strategy	Scottish Government Health Directorates
Michael Fuller	Regional Officer	Unite
Theresa Fyffe	Director	RCN
Janice Hewitt	Director of Community Services	SOLACE
Dr Neil Kelly	Clinical Lead	NHS Dumfries & Galloway
Dr Andrew Kilpatrick	Clinical Director	Glenrothes & North East Fife CHP
Dr Sheena MacDonald	RCGP Representative	RCGP
Harry McQuillan	Chief Executive Officer	Community Pharmacy Scotland
Gill McVicar	Chairman	Association of CHPs
Gerry Marr	Chief Operating Officer	NHS Tayside
Mike Martin	Deputy Director - Partnership Improvement & Outcomes	Scottish Government Health Directorates
Frank Munro	President	Optometry Scotland
Dr Alastair Noble	External advisor	
Mike Pratt	Chief Pharmacist	NHS Dumfries & Galloway
Dr Jonathan Pryce	Deputy Director - Primary Care Division	Scottish Government Health Directorates
Jacquie Roberts	Chief Executive	Care Commission
Dr Charles Swainson	Medical Director	NHS Lothian
Helen Tyrrell	Director	Voluntary Health Scotland