VION Food Group

FINAL REPORT

Care Farming in Scotland: understanding health and social care commissioning and procurement

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Executive Summary

1. Introduction

1.1. This study considers current health and social care commissioning arrangements in Scotland in order to provide a clearer understanding of the opportunities and challenges that face Care Farming. The primary focus is the context relating to services for adults and older people with particular needs, but much of the broad strategic and funding context described is relevant to services for other care groups such as children and homeless people. The study includes a survey of some of the Care Farmers currently operating in Scotland.

2. Background

2.1. Key features of the background to this study include the drive to integrate health and social care services, demographic pressures due to the growing proportion of older people in the population, public sector financial constraints and people's heightened expectations of the quality of care that they receive that is leading to a shift in focus to more personalised services that are designed to suit each individual user, rather than to offer a one-size-fits-all approach.

3. Strategic Commissioning

3.1. Strategic Commissioning is the term used to describe all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these into place. Joint commissioning involves two or more agencies working together to commission services across the whole system within which they work. Local authorities and NHS Boards have a shared statutory duty for the joint provision of care and support. As part of this overall process the views of service users and their carers are essential in the development of local policies and procedures for the procurement of care and support services and as an integral part of the procurement process itself.

3.2. This approach to commissioning has much more resonance amongst local authorities than in the NHS. Councils have historically been involved in service re-design to build the capacity and range of community based services, in involving users and carers and developing models in response to personal needs. Planning within NHS Scotland, however, is largely focussed upon the production of annual Local Delivery Plans (LDPs) which are about change at the margins and have not enabled the wholesale system re-design that is now required.

3.3. Other challenges that hinder the expansion of joint commissioning include investment by one partner delivering benefits and savings for the other and financial and performance incentives that differ between the two agencies and which drive a wedge between their ability to share resources in the pursuit of a joint objective.

4. Adult Health and Social Care Policy and Strategic Context

The policy and strategic context for adult health and social care contains 3 main aspects:

4.1. Policies which reflect the principles, values and objectives that are deemed necessary to meet the expectations of users and deliver the type of services that evidence shows are most effective. These include focussing upon the overall impact of services upon people's lives (outcomes), making services fit each user's needs and circumstances (personalised) and involving users in designing and developing services to meet their needs (co-production).

4.2. Strategies which improve the performance of services so that they deliver better outcomes for users, actively facilitate a move from institutional to community based services and address the needs of a range of particular needs groups within the overall direction of policy travel.

4.3. Arrangements which determine an individual's eligibility to receive a service depending upon their level of need provide for an equitable charging regime and ensure that services are affordable to the public purses.

5. Survey of Care Farmers in Scotland

5.1. The Care Farms in this study served a diverse range of clients including schoolchildren at risk of social and physical exclusion, those who have been unemployed or homeless and young people with additional support needs. They reflected a range of different governance arrangements, size and age of business.

5.2. The success of Care Farmers in securing business was contingent upon many factors including: personal motivations and professional background, the nature of clients supported, capacity to capitalise on existing networks/contacts and develop these further, whether the Care Farm is well established or newly founded, and the local funding/political climate.

5.3. Limited available evidence supporting the ability of Care Farming as a whole to deliver improved personal outcomes inhibited the scope for individual Care Farmers to build their business.

5.4. The absence of knowledge and awareness relating to commissioning amongst farmers made it challenging for them to interact directly with commissioners without prior specialist knowledge.

5.5. Pursuing a professional approach and more formalised arrangements does not fit with the aims and objectives of all Care Farms, some of whom prefer to seek grants or pursue a mix of contracts, grants and SDS payments in the belief that this allows them to remain as 'client led' (rather than 'contract led') as possible.

5.6. Potential roles for CFS in supporting the development of Care Farms as suggested by interviewees included: acting as an intermediary; facilitating better networking; and developing the evidence base to demonstrate the impact of Care Farms and lobbying decision makers.

6. Key Issues for a Viable Future

6.1. *Strategy Development* - Health, social care and most other public services operate within a strategic context which informs and shapes the means by which in-house or external services are commissioned. Care Farming needs the capacity to exert a credible, sustained influence across the health and social care market and to present its services in a way which is relevant and clear.

6.2. *National locus* - CFS is not located clearly within the national third sector infrastructure – either by membership of key umbrella/functional groupings or through partnerships with related organisations. This leaves it without access to the market intelligence and shared learning that such networks provide and outside of the national provider/commissioner networks that are developing. It also limits the benefit gained from the enhanced confidence and credibility that comes with working alongside other agencies.

6.3. *Variation* - Each Care Farm is different and this diversity ensures a localised presence that can potentially be tailored to reflect particular local priorities/opportunities. However, in the absence of strategic clarity regarding core aspects of the product, and a consistent marketing approach, too much diversity dilutes the brand, and can make it difficult to sustain an effective presence in the face of strong competition.

6.4. *Principles and values* - The principles and values which have come to be an inimitable feature of Scottish health and social care policy and of high quality services that meet the expectations and aspirations of service users must be embedded within the Care Farming approach at both a strategic and an operational level. Only by so doing will the concept and the delivered service be considered credible and acceptable by commissioners.

6.5. *Evidence base* - At present the perceived benefits of Care Farming are described in generic terms that do not explicitly align with key national policies/strategies. Commissioners and providers alike need to adopt an evidence-based approach to identifying service models and assessing their suitability for particular client groups and local circumstances.

6.6. *Business capacity* - Establishing and sustaining engagement with local commissioners and developing a better understanding of local populations, strategic priorities and competitors are vital to growing a Care Farming business and requires considerable flexibility, and adaptability from Care Farmers themselves. Any significance increase in the scale and profile of local Care Farm operations is likely to result in raised expectations regarding performance and service standards which will require suitably qualified or experienced staff to be engaged. Any greater differentiation of the Care Farming product range with more specialised placements/experiences being offered will further reinforce the need for relevant professional knowledge and experience.

6.7. *Business development* - Commissioners will expect to see business models which reinforce the role of users in the processes by which service/business decisions are made (co-production) as well as models which potentially involve and benefit the wider community (social enterprise). These approaches may be further strengthened by approaches which involve partnering between different agencies that have complementary skills/resources.

7. Looking to the Future

7.1. *Care Farming Scotland*

7.1.1. The health and social care commissioning landscape is complex and variable and constitutes a significant and important context for the future of Care Farming in Scotland. Engaging with strategic commissioners is challenging for individual Care Farmers and experience has highlighted the importance of strategic leadership and support being available to assist them to build networks and engage effectively. A combination of farming and specialist health and social care knowledge and skills will be required by Care Farmers as standards and the expectations of users and commissioners increase. In light of this CFS will need an understanding of national opportunities and requirements and also how these play out at regional and local levels.

7.1.2. Survey evidence reflects some support for an enhanced role for CFS in providing the strategic support and direction that Care Farmers

need, but further detailed consideration is required to determine the exact nature of such a shift. Any such shift would have to be supported by a practicable and sustainable funding model if any agreed future role is to be realised. If an enhanced role can be agreed some early priorities for action include: compiling a development strategy; strengthening governance arrangements, and building an evidence base reflecting the outcomes that Care Farming can deliver.

7.2. *Individual Care Farmers*

7.2.1. Individual Care Farmers will need to maintain a proactive approach, seeking out opportunities to discuss their service and contribute to wider planning processes and forums.

7.2.2. Farmers' knowledge and understanding of local needs and demand for services, as well as the profile of current services and re-design opportunities, must all develop further. For this work to be useful they must prepare to enter into detailed discussions with commissioners about developing their service and be able to present cogent arguments to substantiate their ability to deliver required outcomes at a realistic price.

7.2.3. Businesses should embed co-production as a key feature of their governance arrangements.

7.2.4. Monitoring and evaluation will enable them to develop a strong evidence base to demonstrate the benefits of the work that they do.

Introduction

This study considers current health and social care commissioning arrangements in Scotland in order to provide a clearer understanding of the opportunities and challenges that face Care Farming if it is to become a mainstream resource for adults and young people with a variety of health and social care needs. It goes on to outline the key aspects of health and social care policy, strategy and structure and reports on a recent survey of Care Farmers currently operating in Scotland. Finally it relates this contextual material to the role of Care Farming Scotland (CFS) and the challenges facing individual Care Farmers, identifying key issues and options for the future.

The primary focus of this report is the context relating to services for adults and older people with particular needs, but much of the broad strategic and funding context described is relevant to many other services including those for children and young people, offenders, unemployed people, homeless people and other disadvantaged groups. The organisational and commissioning arrangements for services to this broader range of client groups do however vary somewhat and in some cases the funding and procurement arrangements are located within the broader UK framework of public services where they have not been devolved to the Scottish Parliament. Detailed consideration of the various policy/strategy drivers for these services falls outwith the scope of this report.

The study is taking place at a time of unprecedented change across Scotland's public and third sectors, as public funding restrictions and major demographic shifts demand a major re-think, not only of the role and extent of the public sector but also of the means by which key aspects of the services that we have all come to expect when we are ill or incapacitated, are financed in the long term. Modernisation and improved efficiency are increasingly embedded within the structural and service re-design agenda that is being developed with the purpose of making public services fit for purpose in 21st century Scotland.

The survey of Care Farmers in Scotland has proved to be a crucial aspect of this study. The responses received from this vital group of stakeholders has assisted in shaping the analysis of issues in this report and has provided an important opportunity to verify the issues and options deriving from the policy/strategy review in order to scope the potential future role of Care Farming Scotland.

Whatever the client group concerned, the importance for Care Farming of developing a good understanding of how and why the public sector commissions services is crucial. The capacity to engage effectively and shape its development in ways that are both relevant and innovative will be vital if it is to have a viable and sustainable future in Scotland.

1. Commissioning and procurement

1.1. Background

Over recent decades there has been an increasing focus in Scotland upon integrating health and social care and to a lesser extent social housing. Current high levels of unplanned admissions to hospital and delays in people being discharged from hospital in a timely manner have resulted in a system that is unsustainable in the face of demographic shifts and financial pressures.

At the same time, people's expectations of the quality of care that they receive and evidence that most people want to remain in their own home and neighbourhood rather than move elsewhere as they become less able to manage, have heralded a shift in focus to more personalised services that are designed to suit each individual user, rather than to offer a one-size-fits-all approach.

In structural terms, the statutory health and social care landscape is comprised of Councils and NHS Boards with some joint governance bodies that together have responsibility for the whole system of health and social care services to adults. Ongoing political debate about the most effective future structure for commissioning and delivering health and care services may see responsibilities shift between sectors, but the fundamental job of determining what is required and how it can best be delivered, will remain largely unaffected.

At present, 36 Community Health Partnerships (CHPs) provide the principal mechanism through which integrated community health and social care services in local areas are planned. In many areas they have devolved powers to commission joint services, although in most cases the purchasing of services remains with the relevant local Council or NHS Board.

The recent Scottish Government Change Fund initiative provides bridging funding to enable older people's service re-design across the whole health and social care system. It will inject an additional £70m into the system during 2011-12 and a total of approximately £300m over the next 4 years. Commissioners are tasked with levering change and a shift of resource from acute hospitals to community services at a level which will at least match the Change Fund investment by the end of the 4 years.

The Change Fund has for the first time introduced an explicit requirement for third and independent sector agencies to be given the status of full partners, alongside Councils and NHS Boards, in approving plans and overseeing investment decisions. This requirement is intended to herald an altogether more substantial, but at the

same time challenging, role for non-statutory partners in delivering better outcomes and sustainable community services in the future.

1.2. Strategic Commissioning and Procurement

Guidance issued by the Social Work Inspection Agency (SWIA) is widely used as the basis for commissioning activity across Scotland's local authorities and also informs the joint commissioning arrangements that are in place between Councils and their NHS partners. Strategic Commissioning is defined by SWIA as:

> *'the term used for all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these into place'.*

The goal of a commissioning strategy is to achieve the best possible outcomes identified by individuals who need care and support now and at some time in the future, alongside those who care for them. It is necessary to ensure that a range of good quality services are available that meet individual needs and strategic outcomes at the best price. In addition they need to meet regulatory requirements and comply with the duties that a local authority has in relation to disability, gender and race equality.

In order to do this it is essential that the views of service users and their carers are considered in the development of local policies and procedures for the procurement of care and support services and as an integral part of the procurement process. Commissioning bodies also have a responsibility to ensure that services are procured in a way that is open, transparent and fair.

Joint commissioning involves two or more agencies working together to commission services across the whole system within which they work. Local authorities and NHS Boards have a shared statutory duty for the joint provision of care and support. The extent of this work varies locally and is in part dependent upon the governance arrangements of the local CHP.

The commissioning model (Figure 1, Below) below has been taken from SWIA's guide and describes a commissioning cycle which in turn drives procurement activity. The procurement activity in itself will also inform the commissioning process in the future.

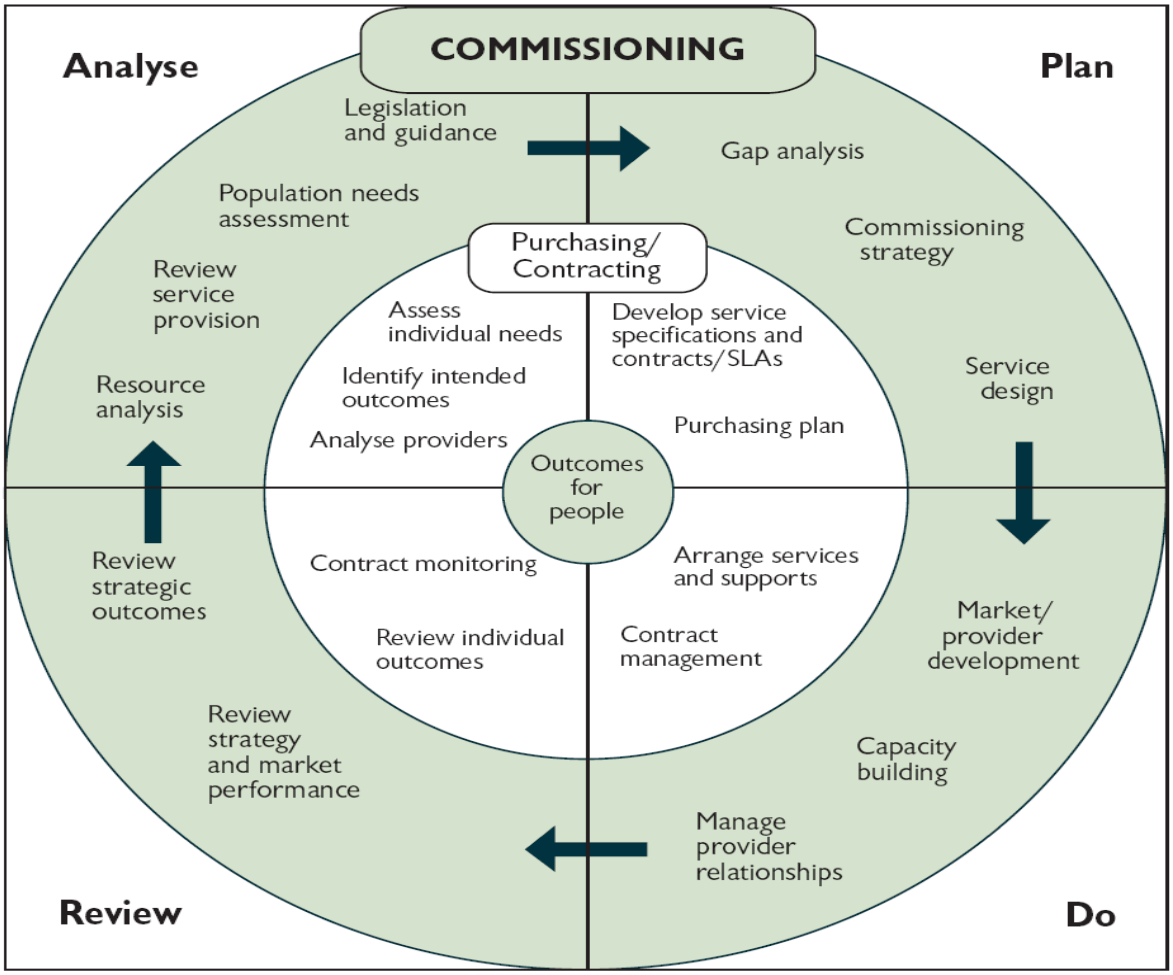


Figure 1: Commissioning Model and Cycle Source: SWIA Guide to Strategic Commissioning, Sept. 2009.

Public bodies should aim to have long term (10-15 year) commissioning strategies for all the main care groups which are supported by a detailed 3-5 year delivery plan. Delivery plans should include a statement of indicative purchasing intentions for the period covered and their detailed purchasing intentions for the year ahead. These statements should be developed in consultation with partners and other key stakeholders and should be published to assist the business planning of all providers, including services delivered in-house.

Whilst the exact form that strategic commissioning plans take varies from area to area, it is generally the case that Councils and CHPs set out their strategic vision, principles and objectives within a strategic framework document that is supplemented by service commissioning plans. These plans describe in more detail the direction of travel for services and the re-design and development proposals that comprise the local change agenda.

When developing more detailed commissioning plans, the key stages that they will normally work through are:

Analysis – This stage is about drawing meaningful conclusions from available data and from projections, including data from people about their needs, preferences and the extent to which the service is delivering intended outcomes. Analysis is one of the most important activities in the commissioning cycle as poor analysis of past or future trends will result in flawed commissioning decisions and wasted…

Planning – This stage is about working with strategic partners to make short, medium and long term decisions about how services need to change and how this will happen. Planning involves being clear about the options available in terms of investment and service redesign, and consulting on how to achieve the best outcomes and best value. Plans should result in SMART[1] commissioning strategies in order to address the outcomes identified in the analysis stage and work with stakeholders to create a picture of how services need to be shaped in the future.

Implementing – This stage involves maintaining a strategic overview of what you are trying to achieve, as well as developing or procuring new services, reshaping or ceasing existing services which are no longer as relevant to the outcomes which people want or need. This phase may require closer working with providers on an ongoing basis and that the market is developed or stimulated where necessary.

Reviewing – This is about taking an evidence-based approach to monitoring and reviewing progress, and making adjustments in the light of changing circumstances. It will involve reviewing whether the objectives of the commissioning strategy are being achieved, as well as the effectiveness of procurement arrangements. Feedback from people who use services and their carers and other strategic partners is an essential element of the evidence needed to review progress. Strategic commissioning should provide a clear rationale for future service development and procurement activity, whether they are Council or NHS provided services or services which are procured externally.

Procurement starts at the point where the Council or NHS decides that a service should be delivered by an external provider. The Scottish Government has recently issued guidance[2] on the procurement of care and support services which defines procurement as follows:

> *'..... the process by which public bodies purchase goods, service and works from third parties - one element of the wider commissioning process.'*

The guidance advises that procurement decisions should be made in the context of an overarching commissioning strategy and recognises that the procurement of care and support services requires special consideration because of the significant impact that it has on the quality of life, health and wellbeing of service users and carers.

The guidance contained a set of guiding principles on procuring social care which are set out below (Table 1):

[1] SMART refers to Specific, Measurable, Achievable, Realistic and Timely
[2] Source: Procurement of care and support services, page 5 Weblink: http://www.jitscotland.org.uk/action-areas/commissioning/procurement/

1.	Outcomes – achieve positive outcomes for service users and carers through the delivery of good quality, flexible and responsive services which meet individuals' needs and respect their rights.
2.	Strategic commissioning – place the procurement of services within the wider context of strategic commissioning, reflecting strategic and service reviews.
3.	Personalisation – secure personalised services which provide independence, choice and control for service users.
4.	Involvement – involve service users and carers as active partners in defining their needs and the outcomes they require and in the design of services.
5.	National Care Standards – ensure services meet the National Care Standards and adhere to the principles underpinning the Standards (dignity, privacy, choice, safety, realising potential and equality and diversity).
6.	Codes of Practice (Scottish Social Services Council) – ensure staff involved in procuring services promote the interests and independence of service users and carers, protect their rights and safety and gain their trust and confidence; ensure employers provide training and development opportunities which enable staff involved in procuring services to strengthen and develop their skills and knowledge.
7.	Best value – secure best value by balancing quality and cost and having regard to efficiency, effectiveness, economy, equal opportunities and sustainable development.
8.	Benefit and risk – base strategic decisions concerning the procurement of services on benefit and risk analysis of the potential effects on: the safety and well-being of service users and carers; the quality and cost of services; and partnership working with service providers and workforce issues.
9.	Procurement rules – ensure procurement exercises comply with relevant legislation and policies on procurement.
10.	Leadership – ensure senior managers give a high priority to the procurement of care and support services, setting clear strategic goals and managing performance.
11.	Workforce – ensure the procurement of services takes account of the importance of a skilled and competent workforce in delivering positive outcomes for service users.
12.	Partnership – promote collaboration between public bodies and partnership working across the public, private and voluntary sectors to make the best use of the mixed economy of care and bring about cultural change in all sectors.

Source: *Guidance on the procurement of care and support services,* Scottish Government, 2010.

1.3. Strategic Commissioning – Theory into Practice

Despite the coherent approach to commissioning that is presented above, the reality on the ground is somewhat different. The term 'strategic commissioning' has much more resonance amongst local authorities than in the NHS. A history within Councils of service re-design to build the capacity and range of community based services has resulted in widespread engagement with the complexities of involving users and carers and developing models in response to personal needs. Historically, Community Care Plans and client group service plans have provided a strategic basis for service development which, for all its faults, has enabled local authorities to grasp the strategic commissioning challenge and begin to make some headway in the infinitely more challenging financial and demographic context that they now face.

Planning within NHS Scotland is largely focussed upon the production of annual Local Delivery Plans (LDPs) and periodic strategic plans for each principal area of activity; acute, primary and community health services. LDPs reflect anticipated annual budget uplifts, projected efficiency savings and any service re-design that is required to deliver on the national Quality Strategy and performance targets. In the main this process is about change at the margins and to-date has not enabled the wholesale system re-design that it has now become apparent, is necessary.

With these 2 statutory players beginning the commissioning journey from very different starting points, the task of achieving progress on joint plans and joined up delivery has proved elusive. Whilst there are a limited number of excellent joint commissioning arrangements in some areas, in the main, commissioning and procurement continues to be undertaken by individual agencies and as such struggles to deliver joined up, flexible responses to the varying needs of individual service users.

A number of other challenges continue to hinder the expansion of joint commissioning including: investment by one partner delivering benefits and savings for the other, and financial and performance incentives that differ between the two agencies and which drive a wedge between their ability to share resources in the pursuit of a joint objective.

The Scottish government prior to the May 2011 election has supported a so called 'Lead Agency' approach which is intended to enable local statutory partners to overcome the biggest inefficiencies and administrative hurdles to combining resources in order to deliver improved outcomes. In light of the election result which gave a governmental majority to the Scottish National Party, it seems likely that this approach will be rolled out to more areas across Scotland and that it will provide the context within which much of future joint commissioning will take place. However, whatever structural changes occur, the greatest likelihood seems to be that aspects of NHS and social care budgets will be pooled as the basis for ensuring that resources can be more easily aligned to deliver strategic commissioning priorities.

1.4. Adult Health and Social Care Policy and Strategic Context in Scotland

A number of key drivers underpin policy development and service re-design across all health and social care groups in Scotland. The principals, approaches and factors that exert the greatest influence are as follows:

1. A focus upon **outcomes** as reflected in the overall impact that services have upon the lifestyle and opportunities available to users and carers;
2. **personalisation** and self directed support ensure that services and the way that they are contracted address the needs and circumstances of each individual rather than offering a 'one size fits all' approach;
3. **performance improvement** makes the link between better personal outcomes and strategic investment;
4. **shifting the balance of care** increases community based service options and reduces investment in hospital-based services;
5. **co-production** ensures that users and carers are able directly to influence the services they receive, including involvement in planning, developing and monitoring services;
6. **strategy development** identifies and addresses the needs of a range of particular needs groups through the development of focussed strategies;
7. **financial environment** requires approaches that recognise and respond to the tight financial climate within which public services in Scotland will be operating over the next 5-10 years.

More details regarding these key drivers are set out in Appendix One.

2. The view of Care Farmers – A survey on the preferred approach to future development

2.1. Introduction

In identifying the ways those involved with care farming activity have negotiated the health and social care commissioning and procurement landscape, semi-structured interviews with five existing care farmers were undertaken. Five key themes were addressed:

1. Who is your target client base?
2. How have you gone about getting clients/gaining referrals?
3. What processes have you had to go through to become a recognised, legitimate supplier of a service? What hurdles did you have to overcome? How did you do that?
4. What would you do differently next time and why, in terms of liaising with these agencies?
5. What would you recommend to other care farmers starting out, in terms of getting clients/gaining referrals and liaising with these agencies?

2.2. Key findings from the care farmer interviews

The Care Farmers in this study serve a diverse range of clients including schoolchildren at risk of social and physical exclusion, those who have been unemployed or homeless (or at risk of these) for an extended period of time, and young people with additional support needs. The Care Farms were either one component of a multi-method approach taken by well-established charitable organisations to providing services to their clients, or individual farms which had diversified into Care Farming or been established solely for the purpose of Care Farming. This diversity of organisational context has led to a great diversity of trajectories and stories, but also a number of common themes. These are summarised below.

2.2.1. Diversity of funding streams

The clients identified above may be facing multiple challenges which cannot be dealt with in isolation: long term unemployment may for example be a function of multiple factors and requires a holistic approach. This therefore means that funding streams are particularly diverse. Interviewees reported – at the national level - providing services to DWP contracts and the Future Jobs Fund, for example. At the Local Authority level, interviewees gained funding through social work and education departments in a wide range of forms including block grants, direct payments and Service Level Agreements. Finally at the individual level, Care Farms also charge on individual clients. Whilst the diversity of funding streams was sometimes a challenge to negotiate, it was also felt to be important in order to ensure the longer term

viability of the Care Farm. Multiple funding streams meant that should one contact not be renewed there remained alternative revenue.

For some charging for the services they provide was a challenging step-change in mentality. Indeed not all Care Farms sought to pursue such revenue streams, choosing instead to pursue grants to provide access to their services.

2.2.2. Importance of networking and professional capacity

Negotiating such funding and seeking referrals can be complex, precarious and contingent upon the qualities of individual care farmers, personal relationships and networking. For smaller Care Farms in particular, the lack of awareness of the Care Farming model amongst commissioners was a major hurdle. This was overcome in two main ways. The first of these involved interviewees having either pre-existing contacts in the commissioning landscape and directly lobbying these contacts. A second approach consisted of drawing on previous professional paid employment experience in the health or education sectors (and personal funds and/or ad hoc income) to develop the Care Farm to a point at which commissioners would engage. Reliance on individuals within commissioning agencies can mean that when that individual moves on, Care Farms have to rebuild relationships. More established Care Farms cited the value of the wider organisation of which they were part having a particularly strong reputation in the area, often meaning that as organisations they were directly contacted by potential commissioners.

For both newer or smaller, and longer established or larger Care Farms, networking and profile raising was a fundamental part of their stories and also of their recommendations for those looking to establish themselves as a Care Farm. Hosting farm visits enabled commissioners to see the farm ‘in action’, but also to identify others in the Local Authority who might already be commissioning services. Given the multiple funding streams identified above it enabled the ‘silo thinking’ of commissioners to be addressed. It also allowed for the profile of the Care Farm to be raised amongst the local neighbourhood and political community, with the support of both being seen as particularly fundamental to the ongoing development of the Care Farms.

2.2.3. The process of formalisation

The Care Farms discussed here are of varying formality. Some have chosen to remain relatively informal (directly contacting potential clients and negotiating with each organisation, for example in setting up school visits with individual head teachers). Others have changed in their formality of funding over time, an example of which is summarised below:

> *Following an initial approach to a Local Authority for guidance on establishing a Care Farm, the farmer was referred to the Scottish*

Government, who suggested that they liaise directly with local schools. The Care Farmer approached their Local Authority but decided to take the initiative and on basis of their own professional background, compile guidelines and processes for the development of their Care Farm.

Schools arrange for appropriate pupils to attend on an individual basis in negotiation with the head teacher. Placements are funded by the education department. Some individual clients attend without charge.

Individual clients began to choose to use their direct payment to pay for a placement and as a result a networking event led to commissioners visiting the farm, and raised awareness of the work of the Care Farm across Local Authority departments..

A Service Level Agreement is now established for a set number of days a week, in conjunction with supplementary funding streams. The SLA is seen as a mark of quality in itself in the absence of a single 'standard' of Care Farming, allowing additional funds from other sources to be won.

Generally, interviewees did not find the required formal procedures relating to such as health and safety measures or reporting, to be particularly onerous. Over time it appears that challenges are increasing however. In the context of the current economic climate it is becoming more challenging to secure or renew contracts, whilst some potential commissioners have formalised their contracting processes which has led to smaller companies feeling unable to bid. One example of this is the contracting of a small number of large organisations to deliver the Department of Work and Pensions (DWP) work programme. Invitations to subcontractors have felt, to place particularly onerous requirements upon them, disproportionately effecting smaller companies. Care Farms which operate as a private company rather than a as a third sector organisation also felt themselves to be less favoured by commissioners.

2.2.4. Role of intermediaries

Intermediaries that are able to mediate the relationship between Care Farmers and commissioners, were cited as being fundamentally important to the development of successful commissioning processes. Two examples of these include i) the Future Jobs Fund and the role of SCVO[3] in leading a consortium of over three hundred third sector organisations to combat potential long-term homelessness, and ii) the role of Local Partnership Managers in managing the relationship between providers and commissioners (in this case for DWP contracted work). It was strongly suggested

[3] See: http://www.scvo.org.uk/training-employability/future-jobs-fund/

that this intermediary role, facing toward both care farmers and commissioners, should be a central role for CFS.

2.2.5. Networking and promoting a Care Farm.

Interviewees made several observations regarding managing relationships with commissioners. Farmers need to be confident about the quality of the service they offer, and the value of that service to service users and the wider community. It is easy to undervalue themselves and the service they provide and as a result be undervalued by commissioners and the community. Farmers should be realistic about their expectations and clear as to their aims in moving into Care Farming: there was general agreement that a profit-motivated approach is inappropriate and unrealistic.

Networking is fundamentally important in terms of establishing links with potential clients, demonstrating the value of Care Farming to potential commissioners, raising the profile of the Care Farm amongst the local and political community, and in sharing best practice. A diversity of funding streams was viewed as offering longer term sustainability and flexibility, and greater resilience in weathering changes in the prevailing professional landscape. It was however also said to be important to have the confidence to decline inappropriate funding opportunities or client placements.

2.3. Conclusions from care farmer interviews

There is no singular route that the Care Farmers reviewed here have taken to negotiating the commissioning and procurement landscape. These routes are contingent upon multiple factors including: personal motivations and professional background; the nature of clients supported; capacity to capitalise on existing networks/contacts and develop these further; whether the Care Farm is well established or newly founded; and the funding/political climate.

It is clear, however, that there are positive examples of Care Farms in Scotland being supported through public sector funding for the delivery of health, employment and social care objectives through a diverse range of funding arrangements, partly a function of the multifaceted nature of the support needs of clients. This is inhibited however by limited awareness between Local Authority departments, or nationally, regarding the impact of the processes Care Farms are required to go through in order to be commissioned to provide services. Limited available evidence which outlines the ability of Care Farming in Scotland to deliver improved personal outcomes further inhibits the scope for individual Care Farmers to build their business.

The absence of knowledge and awareness about commissioning amongst Care Farmers and limited available evidence about delivered outcomes makes it challenging for Care Farmers to directly interact with commissioners without prior

specialist knowledge. This makes networking and the potential role of intermediary individuals/organisations particularly important. Not all commissioners are equally receptive or accessible when approached and for some interviewees it has been particularly challenging to establish a dialogue with the NHS.

At the same time, whilst pursuing a professional approach and more formalised arrangements may be appropriate for many farms, this does not necessarily fit with the aims and objectives of all Care Farms. Some prefer to seek grants whilst others pursue a mix of contracts, grants and SDS payments which they believe, allows them to remain as 'client led' (rather than 'contract led') as possible.

The key potential roles for CFS in supporting the development of Care Farms as suggested by interviewees include:

1. tackling 'silo thinking' amongst commissioners and demonstrating the ways in which Care Farming can make a difference across social work, education and Children's Panels for example;
2. raising the profile of Care Farms through facilitating networking;
3. developing the evidence base to demonstrate the impacts of Care Farms;
4. to lobby decision makers to consider Care Farming in their commissioning;
5. to act as intermediary facing both toward SG and commissioners, and Care Farmers themselves.

3. Care Farming in Scotland – Key Issues for a viable future

3.1. Scope of the Study

The scope of this study incorporates consideration of health and social care commissioning and its implications for Care Farming in Scotland. Whilst many of the issues considered are relevant to other areas in which Care Farming operates, this may not universally be the case. The strong resonance between the issues identified by the desk study, and those highlighted by the Care Farmers involved in the survey, is however particularly notable since none of the latter were involved in the mainstream health and social care market.

3.2. Strategic engagement

3.2.1. Strategy Development

Health, social care and most other public services operate within a strategic context that informs and shapes the means by which in-house or external services are commissioned. This being the case, if Care Farming is to engage effectively with strategic commissioners, it needs to have the capacity to exert a credible, sustained influence across the health and social care market and to present its services in a way which is relevant and clear.

If the evidence from the survey is at all representative of the sector overall, Care Farming in Scotland appears to have focussed to-date upon education, employment and vulnerable young people including homelessness and school exclusion. At the same time, the rapid rise in the over 65 population and related resource and demand pressures, have resulted in a substantial investment in planning and commissioning activity to shift the balance of care from institutional to community based models so that the health and social care system can be affordable going forward. The scale of Council spending on older peoples services relative to other care groups, as set out in Appendix One, highlights the potential importance of this market for Care Farming, if it is to take advantage of what is by far the largest area of health and social care spend.

At present the development of Care Farming appears to depend largely upon the interests, prior knowledge and experience that individual Care Farmers may have to offer, across Scotland. However, operating within this strategic context requires a combination of high quality, customer-focussed Care Farms supported by the strong leadership and strategic coherence that robust partnering, lead agency or national parent body arrangements are often best placed to offer.

3.2.2. National locus

To date, CFS has developed organically in response to the perceived needs of Care Farmers. In the absence of having a strong strategic role it has not engaged fully with the wider third sector and relevant professional communities. Although constituted as a company limited by guarantee and a registered charity, CFS is not located clearly within the national third sector infrastructure – either by membership of key umbrella/functional groupings or through partnerships with related organisations. This leaves it without access to the market intelligence and shared learning that such networks provide, outside of the national provider/commissioner networks that are developing. Further, CFS does not benefit from the enhanced confidence and credibility that comes with working alongside other agencies, some of whom may be potential collaborators as well as competitors.

3.2.3. Variation

Each Care Farm is different with regards to its governance arrangements, business financing and operating costs, scale of operation, range of activities, business infrastructure, marketing resources and local relationships. This diversity is an asset in that it ensures a localised presence that can potentially be tailored to reflect particular local priorities/opportunities. It also leaves individual Care Farmers free to exploit just the sort of market opportunities that are reflected in the case study farms that contributed to the survey. However, in the absence of strategic clarity regarding core aspects of the product and a consistent marketing approach, engaging locally with commissioners is made even harder if too great a diversity dilutes the brand, thereby making it difficult to sustain a strong presence in the face of shifting and/or flexible competition from other providers.

3.3. Current state of strategic commissioning

Developing an understanding of the strategic landscape on the part of those involved in Care Farming nationally is crucial to effective engagement and influencing and yet the considerable variation in commissioning practice within and across the NHS and local authorities presents a significant challenge. Any national understanding and capacity that is developed will need to be made available to support individual businesses and/or local groups of Care Farms so that they can engage effectively with commissioners and provider partners in order to address the particular local issues and priorities that shape the available business opportunities.

The survey responses served to reinforce the complexity of local commissioning arrangements and the challenge that they pose for Care Farmers trying to negotiate access into a market. They also serve to highlight the potential that exists for providing a service to commissioners of services for which control has not been devolved to the Scottish parliament – most notably the Department of Work and Pensions and employment.

Whilst the UK agencies seem to reflect growing pressures resulting from more rigorous commissioning arrangements and a drive to reduce costs, they do perhaps reflect a greater willingness to acknowledge the strengths of private sector providers than is the case in Scotland where a drive across government to instil a social enterprise, co-production ethos into commissioning arrangements is extremely influential at a local level.

In Scotland, any roll-out of the 'Lead Agency' approach, involving the NHS and local authorities will very likely result in change and some interruption to local commissioning processes and procurement activity. In particular the future of CHPs, which currently provide much of the impetus for joint commissioning, is as yet unclear under this model. In short any new commissioning arrangements will take time to bed in and will put further pressure on local operators to engage effectively.

3.4. Principles and values

The outline of key policies set out in Appendix One incorporates principles and values which have come to be an inimitable feature of high quality services that meet the expectations and aspirations of service users. They are fundamental to the way that services should operate and relate to their users. As such they must be embedded within the Care Farming approach – at both a strategic and an operational level – if the concept and the delivered service are to be considered credible and acceptable by users and commissioners alike. The key principles are co-production; personalisation - responsive and flexible services that are designed to meet the needs of each individual user; improved personal outcomes; promoting self care and self management; and maximising anticipatory and preventative potential.

The Care Farmers who participated in the survey emphasised the importance of their commitment to the concept in determining their ability to convince others of the merits of Care Farming and to generate interest and momentum in discussions with potential commissioners and service users. The marketing of Care Farming must locate the approach within this principles / values landscape and explain how these features are fundamental to the way a service operates and the improved outcomes that it delivers.

3.5. Evidence base

In addition to the demographic and financial challenges faced by health and social care services, they are also subject to the demands of the public service modernisation agenda, with its focus upon improving efficiency and effectiveness. Central to this agenda is the need to invest in services that are most likely to deliver improved outcomes. In order to do so, commissioners and providers alike need to

adopt an evidence based approach to identifying service models and assessing their suitability for particular client groups and local circumstances.

At present the perceived benefits of Care Farming are described in generic terms that do not explicitly align the concept with key national policies/strategies. Evidence as to the delivered benefits for particular needs groups by specific types of land based experiences is thin on the ground. In the context of seeking to identify and develop new service models that are proven to be effective, considerably more work will need to be done to demonstrate clearly why statutory commissioners should seek to engage with what is a largely unknown model / approach.

3.6. Product development

The Care Farm brand and its potential market have developed incrementally. Evidence from the survey demonstrates that in many cases the end product has emerged from discussions which sought to match up the Care Farmers' vision for the service they want to provide and the demand/economics that drive commissioners to see their approach as the right solution for individual users. The description of Care Farming currently provided in corporate CFS literature provides only a generic account of the benefits of land based learning and activity.

In short, the benefits that the various care groups might gain from Care Farms and which particular services / experience might best suit their needs are not sufficiently well articulated. Developing a clear proposition for each major client group and being explicit as to the particular benefits associated with the main service types/features offered by Care Farming will be crucial to establishing a clearer picture of Care Farming's potential benefits and the type of service that is likely to be best suited to particular clients.

Whilst Care Farming must always offer a personalised service that is capable of flexing to the needs of individual users, commissioners need help to better understand and appreciate the wider potential of what is on offer, for whom and to what effect.

3.7. Business capacity

3.7.1. Scoping the local market

Establishing and sustaining engagement with local commissioners and partner providers and developing a better understanding of local populations, strategic priorities and competitors is time consuming and requires a considerable degree of flexibility and adaptability from Care Farmers.

At just the time that key decisions have to be made about costs, price and contract conditions, the Care Farmer's likely understanding of future business costs and

pressures will be at its lowest. An important consideration, for instance, is that many commissioners do not reflect full cost recovery in their approach to determining the price that they will pay. Getting beyond spot-purchasing can be very challenging in the context of a drive to deliver more personalised responses. Indeed, as we have seen in some of the case study Care Farms, many prospective Care Farmers may not find the business aspects of the commissioning landscape at all attractive. Whilst SDS offers new opportunities to identify and negotiate service take-up by individuals, it may also serve to further fragment the market and make business sustainability no easier to attain.

In such a challenging business environment it is likely that many Care Farmers will look to support from a body such as CFS or perhaps a specialist partner provider. An indication to this effect by some of the Care Farmers involved in the survey, suggests that this is indeed the case. Similarly, evidence from other sectors indicates that issues such as establishing an evidence base, risk management, business sustainability, management processes and performance improvement can readily be enhanced with support from a national umbrella body.

3.7.2. Knowledge and expertise

Any significant increase in the scale and profile of local Care Farm operations, and fuller embedding within the range of commissioned services, is likely to result in raised expectations regarding performance and service standards. The issue is therefore likely to arise as to the need for qualified and experienced health, care and support professionals in delivering a service which is specifically designed to enhance health and well-being through a formal procurement process.

As we have seen in most of the survey Care Farms, a large proportion of current Care Farmers have relevant care/educational qualifications and/or experience. If the market is to expand, this situation is likely to change and in most cases suitably qualified or experienced staff will have to be engaged. Also, any greater differentiation of the Care Farming product range with more specialised placements/experiences being offered is likely to further increase the specialist nature of the support/interventions required and thereby reinforce the need for relevant professional knowledge and experience.

3.7.3. Business processes

Establishing the necessary business processes to meet the requirements of commissioners demands particular skills and expertise which in addition to actually delivering the Care Farm service is extremely challenging. Whilst some of the Care Farmers in the survey reported that they were able to deal effectively with such administrative hurdles, some will doubtless struggle with the this aspect and it is important to remember that the particular requirements and processes associated

with health and social care systems are particularly complex, bureaucratic and often very lengthy. They do not necessarily fit easily alongside those of smaller scale private or social enterprises.

3.8. Business development

Developing a viable Care Farming business will always be challenging in view of the breadth of knowledge, technical expertise, financial challenges and market dynamics associated with health, social care and related public service systems. Doing so at a time of particular financial stringency and tight strategic prioritisation of public investment poses particular challenges and may require new business models to be developed if the potential and risks within the market are to be addressed successfully.

The case study Care Farms illustrate the range of models that already exist in Scotland including private enterprise, a relatively large specialist charitable organisation and a non-charging small scale enterprise. In each case the model seems to reflect the particular motivations and preferred approach of the Care Farmer and/or the demands of the commissioners who have procured the service. Either way, these business models have rarely benefited from a consolidated business appraisal of the most effective/efficient model given the specific market and commissioning arrangements in each case.

We have already noted the importance of the Care Farm services/experiences needing to reflect the core principles embedded in most current health and social care policy. However, reflecting a coherent set of principles in how a Care Farm operates is only half of the picture. Commissioners will also expect to see business models which reinforce the role of users in the processes by which service/business decisions are made (co-production) as well as models which potentially involve and benefit the wider community (social enterprise). These approaches may be further strengthened by approaches which involve partnering between different agencies that have complementary skills/resources - a feature which, it could be argued, is particularly relevant for Care Farming, which brings together two such apparently disparate activities as farming and care/support. The question is whether this aspect of the policy context is perhaps less palatable to some farmers who, to a large extent, are used to being masters of their own destiny. If this is the case, it may present a significant hurdle to the expansion of Care Farming.

Developing a body of evidence and supporting advice relating to possible Care Farm business models, and setting these within different market conditions/procurement arrangements, is another aspect of the support that would benefit individual Care Farmers and further facilitate growth in the market.

Some of the business options that might need to be considered further include:

- CFS taking a lead in developing business intelligence and modelling for the Care Farm market;
- CFS taking the lead in developing a model Care Farm to act as a national exemplar;
- Partnering with a specialist support/care provider that could provide direct expertise in client support/care;
- Partnering with specialist skills/activity provider that could enable more specialist land based experiences to be offered, e.g. equine;
- Private or social enterprise business – determining a business governance model which maximises the desired benefits for the Care Farmer and is best placed to secure business;
- Specialist care/support provider takes the lead in dealing with commissioners and develops partnering relationship with host farmer.

4. Looking to the Future

The issues and analysis above contain implications for CFS and individual Care Farmers alike. This section draws out the more significant implications for both, and in so doing provides a basis for considering the future of Care Farming Scotland.

4.1. Care Farming Scotland – Conclusions

Conclusion 1 – The health and social care commissioning landscape is both complex and variable. It mirrors the position in other sectors with which Care Farming is engaged and as such comprises a highly significant and influential context that resonates for all Care Farmers and those concerned with its future.

Conclusion 2 – Engaging effectively with statutory commissioners presents significant challenges for individual care farmers due to the combination of knowledge and skills that are required, The survey evidence from non - health and social care Care Farms mirrors the learning that has emerged from this review of health and social care commissioning. In so doing, it reinforces the central importance of strategic leadership and the development of strategic capacity in establishing a viable future for Care Farming in Scotland.

Conclusion 3 – Survey evidence suggests that prior professional knowledge /experience of relevant non-farming sectors has to-date been vital to successful business start-ups. This is not a realistic basis for significant future growth in Care Farming activity. Consequently a more carefully planned combination of farming and specialist health and social care knowledge and experience will be required by individual businesses.

Conclusion 4 – Indications from the survey suggest some support for an enhanced strategic role for CFS, but the extent of such views and the exact nature and implications of any shift in role, requires further detailed consideration before they can be confirmed.

Conclusion 5 – Any future strategic role for CFS must be based upon a practicable and sustainable funding model if any agreed future role is to be realised. The process of reaching a consensus on CFS's future role and funding should build upon the intelligence gained already through the survey of Care Farmers, and should involve substantial stakeholder engagement in order to build ownership of any future proposals by Care Farmers themselves.

Conclusion 6 – If general agreement can be reached regarding the future role and funding of CFS, early priorities should include:

- Compiling a development strategy, thereby enabling it to establish a coherent programme which reflects a clear vision for Care Farming and clear targets regarding its own performance;
- Strengthening membership of the Board and revising governance arrangements that incorporate service users and Care Farmers at its core;
- Establishing a clear locus within the Third Sector in Scotland and aligning itself with appropriate partners and sector representatives;
- Scoping currently available evidence regarding the outcomes delivered for users by Care Farming in order to provide short term support to Care farmers who are facing contracting challenges.

4.2. Individual Care Farmers – An Agenda for Action

Using the SWIA strategic commissioning framework as a useful structure around which to scope priority actions for individual care farmers, this section fills in some of the detail regarding areas where Care Farmers are likely to need support from CFS or by another route, in the future.

Engaging with the Strategic Commissioning Process

- Engage with your local Third Sector Interface and any independent sector interface arrangements that are in place;
- Pro-actively seek out opportunities to engage at all stages of the commissioning cycle with statutory partners and potential collaborators.

Analysis

- Develop an understanding of relevant local populations, trends, current activities, costs, variations and gaps;

- Using the best available local analysis, prepare a 'care farming perspective' on gaps/opportunities, markets and development potential. Provide feedback to commissioners on the implications of this analysis for care farmers.

Planning

- Participate in co-production / provider engagement events/processes;
- Develop service model exemplars as a basis for development/re-design discussions, underpinned by a clear business model and cost structure;
- Pro-actively review/comment on emerging commissioning plans to highlight Care Farming's potential to fill gaps or improve outcomes;
- Build long term relationships with key individuals/services within local statutory bodies;
- Work with provider partners to identify/develop linked/mixed service models that add-value, extend user choice, address the requirements of particular needs groups and maximise efficiencies.

Implementing

- Be prepared to enter into detailed discussions about potential developments;
- Provide clear evidence of market knowledge and understanding related to key benefits and efficiencies, but also business pressures and financial 'bottom lines' in order to inform the procurement process.

Reviewing

- As a provider:
    - engage pro-actively with any contract-related or other commissioner service review process;
    - Develop robust user/carer feedback based on ongoing co-production arrangements;
    - Provide clear information about key aspects of the review agenda; performance framework and reporting – delivered outcomes, service improvement, workforce/OD investment, costs and efficiencies, innovation.

- As a prospective provider:
    - link with existing providers and commissioners to discuss adding-value to established approaches;
    - identify individual care profiles for whom current services may not provide the very best option;
    - use enhanced understanding of local populations, system dynamics and service gaps to encourage new thinking and appraisal of options.

Appendix One

Outcomes

The concordat between central and local government in Scotland is grounded upon Single Outcome Agreements (SOAs), which local authorities are required to prepare through their Community Planning Partnerships and which reflect a set of high level outcomes that each local authority considers to be fundamental to better meeting the needs of local citizens

In recognition of the need for a unified approach to community care, a Community Care Outcomes Framework (CCOF) has been developed which provides a link from the individual outcomes identified through frontline interactions with clients and patients into performance management and decision making at the joint management team level.

The CCOF has been developed as an outcomes-based performance reporting framework and includes four national outcomes and 16 performance measures. The four national outcomes are:

- Improved health
- Improved wellbeing
- Improved social inclusion
- Improved independence and responsibility

The 16 measures cover users' satisfaction with services and /or support, faster access, support for carers, quality of assessment and care planning, shifting the balance of care, unscheduled care and identifying 'people at risk'. The CCOF is currently being reviewed with a revised version likely to be produced in the autumn of 2011.

Personalisation and Self Directed Support

The Scottish Government has set out a simple definition of personalisation:

> '*It enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive.'*

The increasing numbers of people accessing social care and the range of individual needs mean that services and supports will have to continue to become much more flexible and responsive in the future. An important aspect of this change will be a cultural shift around the delivery of care and support, which views people as equal citizens with rights and responsibilities. It recognises that for individuals, carers and

providers alike, tighter financial pressures, and demographic changes mean that improved outcomes cannot be delivered with more of the same.

Self-Directed Support is one aspect of personalisation where an individual arranges some or all of their own support. It is not the name of a particular type of service, but a way to tailor-make community care that better suits each individual. Self Directed Support allows people to make purchases from outwith the traditional provider market and to spot purchase for more general goods and services. Individual Councils are developing local arrangements to deal with the practical aspects of self directed support, from the way in which they will assess and agree individual outcomes with people to the way in which this will be translated into an individual allocation of funding.

Councils recognise the importance of putting in place arrangements which will facilitate more choice and control over service provision. This increasingly means building in flexibility through reducing, where possible, the number of block contracts and introducing framework agreements that include the ability for individuals to purchase these services via self-directed support options.

Performance improvement

The outcomes approach is supported by other developments which are designed to complement and strengthen partnership's ability to deliver better outcomes and to be able to evidence their progress in doing so, namely the National Minimum Information Standards (NMIS) and Talking Points.

The National Minimum Information Standards (2008) are intended to promote quality in assessment, care and support planning, and review of community care services and support. They are increasingly reflected in the content of local Single Shared Assessment arrangements across health and social care.

Talking Points is a simple and yet potentially crucial link between outcomes and personalisation. It is an approach which enables commissioners to understand the extent to which the preferred outcomes of individual users are being met, most of which reflect a desire for something which is tailored to their particular circumstances. It enables this information to be collated in a consistent format across user groups and services and to be used as the basis for performance reporting and the establishment of strategic outcomes which can be used to improve performance and set an organisations direction of travel.

Shifting the Balance of Care

The Shifting the Balance of Care agenda aims to improve outcomes for people by developing and providing services closer to the person's own home and community. Reablement and preventative services are key to this shift as the focus moves

towards more personalised and community based services that encourage self-management and self-help where possible. This means reducing the reliance on care home and long stay hospital accommodation towards a range of new and more sustainable models of care in the community which include home care re-ablement, complex home care, Telecare, community rehabilitation, housing with support, care and repair, and community networks.

Recognition of the very substantial role that informal carers play in meeting the needs of friends and family, and supporting co-production approaches that utilise and build community capacity to enable people to remain independent and remain in their own home, are also at the heart of this programme. Whilst this work has centred largely upon older peoples services, the principles and approaches that it reflects are widely applicable to other care groups, such as people with mental health problems or a learning disability. This agenda has most recently been set out in the Scottish Government's Re-shaping Care 10 year Delivery Plan.

Co-production

By supporting the co-production of adult services commissioning strategies the Scottish Government is seeking to ensure that service users and carers can genuinely influence how services are provided. The process aims to ensure involvement is a positive experience for all who participate. To achieve this outcome Councils and the NHS are putting in place a variety of ways to enable service users and carers to get involved; ensure that information is provided in formats tailored to the individual or group needs of service users and carers and that service users and carers have the support they need to express their views.

'....Where activities are co-produced in this way, both services and neighbourhoods become more effective agents of change.' (Boyle and Harris December 2009)

Strategy Development

A number of national strategies for key care groups and approaches have been published in recent months. They provide an important backdrop to the implementation of national policy and local investment through health and social care commissioning. Some of the more important strategies are:

Healthcare Quality Strategy

The healthcare quality strategy provides the overarching strategic backdrop to all other health and social care national strategies and is designed to raise the overall quality of healthcare in Scotland. It is focusing upon 3 areas, which are:

- Improving person-centredness by delivering care based on mutually supportive relationships between staff, patients, carers and families

- Improving patient safety in all settings, including care homes and in the home
- Increasing clinical effectiveness through more effective partnership working with local public and third sector bodies

Carers Strategy

A new National Carers Strategy for Scotland was published in late 2010. It is based on a review of progress against the Care 21 recommendations. Additional resources have been committed over the next 3 years in order to deliver an increased number of available respite weeks each year. The strategy will see numbers grow by 2.000, 6,000 and 10,000 respite weeks in each successive year.

Dementia Strategy

A Dementia Strategy for Scotland was published in early 2011. It is based upon an ongoing review of service gaps and opportunities for change and improvement. It includes consideration of the quality of care for people with dementia living in care homes and will address issues relating to: treatment and behaviour management; assessment, diagnosis and patient pathways; improving the general service response to dementia; rights, dignity and personalization; and health improvement, public attitudes and stigma. A very recent set of new standards for dementia services has been published to support implementation of the strategy.

Self Directed Support Strategy

New Self Directed Support guidance was issued in late 2010 and a Scottish Self Directed Support bill will be presented to the Scottish Parliament later in 2011. Self-directed support in Scotland is part of the mainstream of social care delivery, targeted at empowering people. Self Directed Support is used instead of, or in addition to, support services that the local authority might otherwise have provided. It can buy support for a person to live in their own home, such as having a bath or getting washed and dressed. Out of the home it could be to support an individual in college, in the work environment or to enjoy leisure pursuits more. It may also be used to pay for someone to provide care and support to enable them to take a short break with the person.

Funding and Access to Services

All Scottish Councils operate a framework for determining eligibility for adult social care. These frameworks cover how they carry out assessments and reviews, and support individuals through these processes. The frameworks provide the means for ensuring that Councils can provide or commission services to meet eligible needs, subject to their resources and that, within their area, individuals in similar circumstances receive services capable of achieving broadly similar outcomes.

Eligibility is graded into four bands – critical, substantial, moderate or low - which describe the seriousness of the risk to independence or other consequences if needs are not addressed. Most Council's operate a threshold for services at the "critical or substantial" level of needs and risks, but in so doing, recognise the importance of supporting preventative services and affordable responses to needs that are below the eligibility threshold, to enable take-up of anticipatory and preventative services.

Steps to support the take-up of low level support include the promotion of well-being through universal services, including access to employment, physical recreation and leisure, transport, and advice; addressing barriers to social inclusion. In addition targeted interventions to support individuals at increased risk, such as re-ablement, Telecare, and housing support as well as and integrated services and joint planning are being developed. In the context of care and support services, the term "prevention" has at least three different meanings. Each refers to services, initiatives, and spending, that:

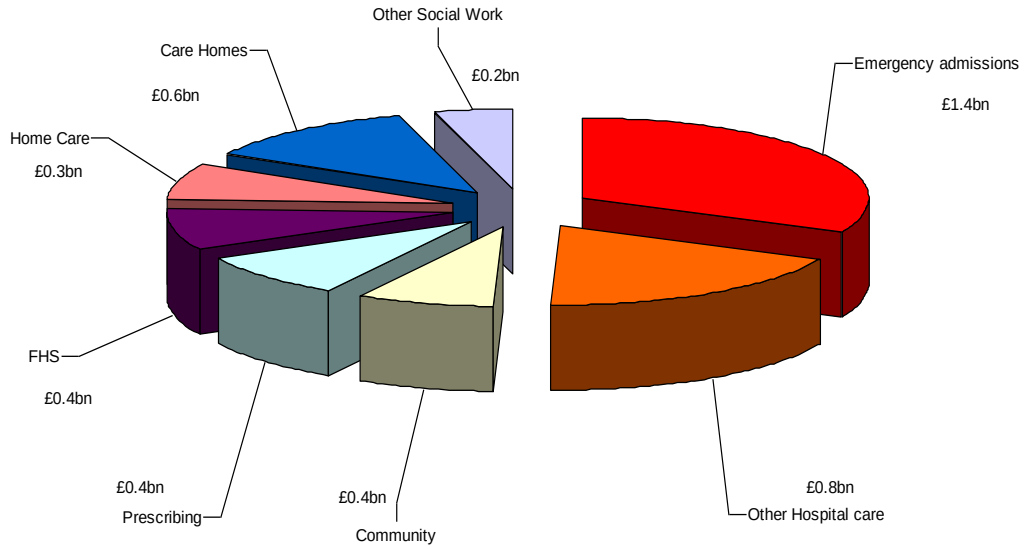
- prevent or delay the need for more costly health, housing, care and support services, by reducing people's ill-health or disability, or by increasing self-care abilities and resilience;
- promote and improve people's quality of life, independence, engagement with the community, learning, or which create healthy and supportive environments;
- prevent inappropriate use of more intensive services where needs could be met by lower cost services or interventions.

Financial Environment

The UK coalition Government's policy to reduce the UK current budget imbalance by the end of 2015-16, mainly through public sector expenditure reductions is reflected in the future funding available for Scottish local government, the NHS, and other parts of the public sector. Scottish councils are working on resource planning assumptions for 2011-14 based on a 12% real terms cash reduction.

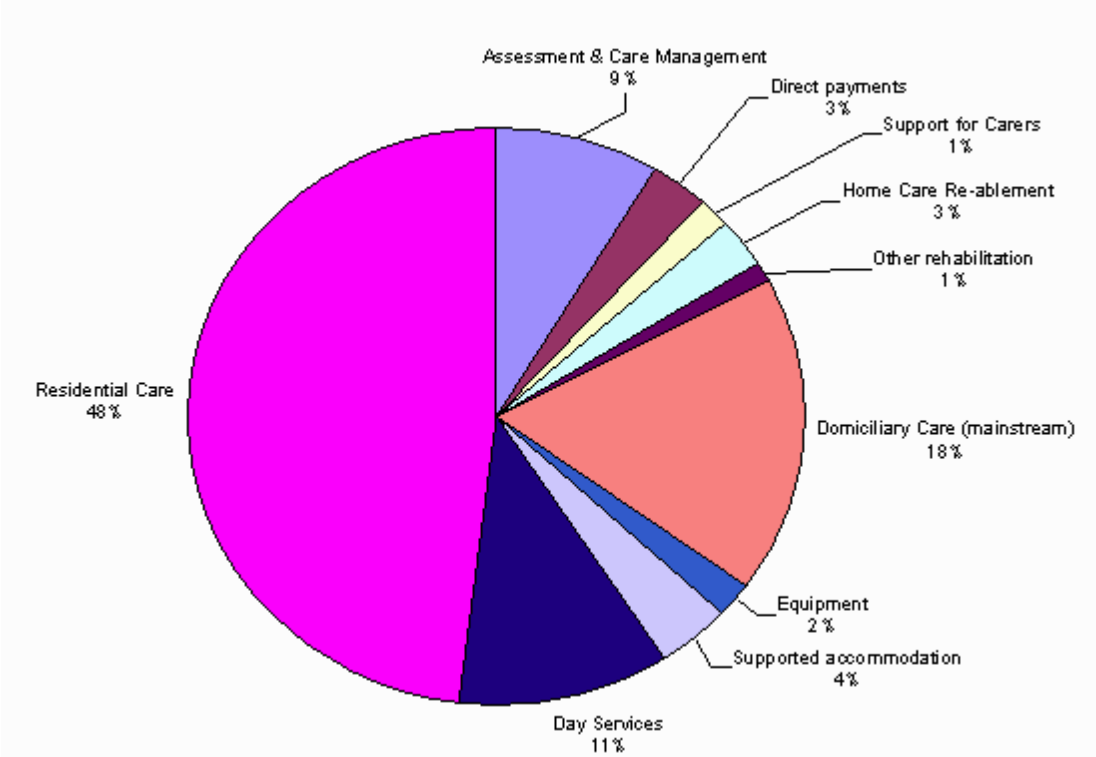
At the present time approximately £4.5 billion of public funding is spent each year on health and social care for those over 65 years across Scotland. Well over half (60%) of this is spent on providing institutional care in hospitals and care homes, and almost one-third on emergency admissions to hospital. Less than 7% is spent on home care (see chart below) in spite of the vision that older people should be helped to remain at home or in a homely setting for as long as possible.

Health and social care expenditure Scottish population aged 65+ (2007/08 total=£4.5bn)



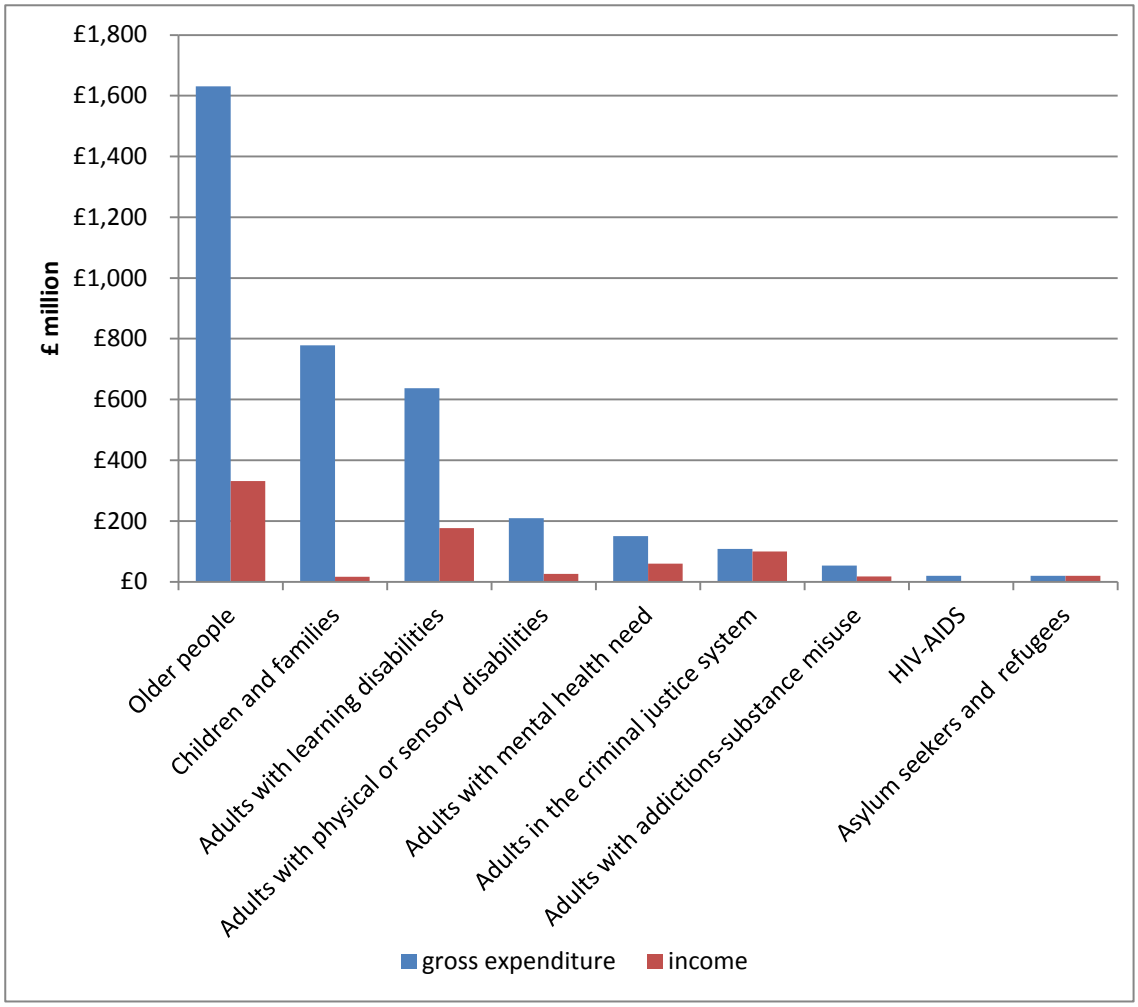
Whilst adult social care services continue to reflect a heavy dependence upon long term care home placements there is growing investment in new models of care at home, particularly re-ablement approaches, which aim to return people to full independence and regaining any skills lost during periods of hospitalisation, as quickly as possible. Further investment in integrated community services, intermediate care, re-ablement and rehabilitation services and use of Telecare and Telehealth are other important features of ongoing investment plans. Developing new roles for care homes and new housing-based models of support will also be significant features of the new community service landscape.

Typical Council adult social care gross budget allocation



The chart above illustrates a typical breakdown of expenditure across key areas of care services for older people.

It is important also to consider the overall scale of social work expenditure on the various client groups that receive public sector services. Councils spent £3.63 billion on social work services in 2009/10, £0.74 billion of which was recovered in income. The following histogram reflects the different levels of investment for each of a number of care groups.



Source: Scottish Local Government Financial Statistics 2009/10, Scottish Government.