

Annex G Consultation Questionnaire

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes No

The National Osteoporosis Society believes that the Scottish Government should focus first on improving outcomes for older people. As the average age of the population of Scotland rises, conditions associated with old age such as osteoporosis and fragility fractures will become more prevalent.

Hospital admissions in Scotland for hip fractures are rising; between 1998/99 and 2007/08:

- the number of men admitted to hospital for a hip fracture increased by 39%

- the number of women admitted to hospital for a hip fracture increased by 8%

- the overall rise for both men and women was 15%

- the number of bed days attributed to hip fractures increased by 12%.

The National Osteoporosis Society's projections (set out in our 25th anniversary report) show that on current trends, by 2036 there could be as many as 19,000 hospital admissions for hip fracture a year in Scotland - this would be an increase of 43% on 2008 admissions. The number of bed days attributed to hip fractures will rise sharply; in Scotland, they will increase by 13% between 2008 and 2036.

If we do not take steps now to improve the prevention, diagnosis, treatment and care of people with osteoporosis, the number of people affected by fragility fractures will rise steeply in just a few years - the cost of treating and caring for hip fractures in Scotland could top £835million by 2036.

The Health Improvement Scotland document "Up and About - pathways for the prevention of falls and fractures " describes the comprehensive fracture prevention services that should be put in place for every local area in Scotland.

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes No

We believe that the framework for integration is comprehensive. Achieving a reduction in the rate of hospital admissions for fragility fractures among older people is an excellent example of a health outcome that will not be reduced without an effective partnership between the NHS and adult social care services. The NHS must provide comprehensive fracture prevention services (including Fracture Liaison Services) which identify, assess and treat older people who are at risk of fragility fractures. Social care providers have a vital role to play in ensuring that older service-users who fall and/or fracture are identified and assessed within the NHS. In care home settings. Providers must help to ensure that those residents who have been prescribed bone-sparing medication adhere and comply with their medication.

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes No

We agree with this proposal. We believe that positive health outcomes for people can only be achieved through integrated NHS, adult social care, public health and other relevant services. Requiring Health Boards and Local Authorities to jointly deliver and be held accountable for these outcomes provides the best opportunity to bring this about.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes No

We believe that this will ensure a consistent approach across Scotland and provide the greatest opportunity to minimise health inequalities.

Governance and joint accountability

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Yes No

N/A

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes No

We believe that the proposed Health and Social Care Partnerships will be most effective if they are co-terminus with Local Authority boundaries. This should provide opportunities for elegant structures of accountability and democratic involvement within partnerships.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes No

N/A

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes No

N/A

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes No

We believe that the planning and delivery of all health and social care services should eventually come within the remit of Health and Social Care Partnerships. However, we agree that they should begin by prioritising services for older people.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

Yes No

We favour funding models which ensure that care pathways can seamlessly span health and social care for the benefit of people with or at risk of osteoporosis and fragility fractures.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes No

N/A

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes No

N/A

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes No

N/A

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes No

N/A

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes No

We believe that this will ensure a consistent approach across Scotland and provide the greatest opportunity to minimise health inequalities.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes No

The National Osteoporosis Society has often found that the most successful examples of comprehensive fracture prevention services for older people across the UK have occurred when there have been strong lines of communication between health and social care professionals and those who plan and commission services.

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

NHs We call for pathway-specific groups to be set up to enable health and social care professionals to have an input into the way in which services are designed and delivered across a Partnership area. A falls and fragility fractures strategy group in each locality could, for example, provide a forum for professionals to meet local officials and to resolve any issues which may be preventing a seamless service from being provided.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Yes No

We believe that planning should take place at the Health and Social Care Partnership level. All GP practices within a Partnership area should be involved in this process.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

See our response to question 18.

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes No

We believe that localities should cover a population size of 500,000, which reflects the views expressed in the Royal College of General Practitioners' document 'Update on Commissioning Activity', produced in 2010. Evidence has shown that local health and social care communities in the UK provide populations of this size with effective care for osteoporosis and fragility fractures. The Glasgow Fracture Liaison Service expanded to incorporate the larger NHS Greater Glasgow and Clyde board area in 2005. It serves as an example of how the expansion of a primary care organisation can reduce health inequalities among those areas which it was not previously responsible for.

Do you have any further comments regarding the consultation proposals?

No

Do you have any comments regarding the partial EQIA? (see Annex D)

No

Do you have any comments regarding the partial BRIA? (see Annex E)

No