Integration of Adult Health and Social Care in Scotland
Consultation on Proposals

BMA SCOTLAND RESPONSE

Background

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 doctors.

BMA Scotland welcomes the opportunity to comment on the Scottish Government's proposals for the integration[1] of adult health and social care in Scotland. An ageing population combined with a difficult public spending environment poses a major challenge for the provision of health and social care and there is a need to plan a co-ordinated system of community, hospital and residential health and social care to cope with a range of needs for an increasing number of older and very old patients. We welcome the Scottish Government's statement that engagement of the medical profession in the new health and social care partnerships is fundamental to their success and that the role of doctors will be strengthened in these new structures. Structural reform is not an end in itself and it is vital that these proposed new models for health and social care focus more on outcomes than management structures. The BMA in Scotland is against the reform agenda for the NHS in England and is keen to support and promote a model of care that encourages collaborative working between doctors working in both primary and secondary care to try to break down the barriers between the two service sectors.[2] Attached below is our response to this consultation and we look forward to continuing to contribute to this process.

> **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?**

The single biggest challenge to health and social care services both now and long-term is the increasing number of elderly people with multiple physical problems, cognitive impairment and increasingly complex care needs. BMA Scotland has consistently called for greater joint working between health and social care to address these issues. Projected future demand for elderly care services indicates that there will be 21% more people aged 75+ in Scotland by 2016, compared with 2006, and 83% more by 2031. Assuming demand increases in line with this growth and that current service models remain the same, this would require an average real increase in the NHS budget of 1.2% per year, every year. Healthcare spending is concentrated in the last year of life, but as people live longer, they are more likely to have more complex needs for both health and social care over extended periods.[3] Local Authority older people's social work budgets (or wherever these budgets are held) would also need to be increased significantly. An ageing population combined with a difficult public spending environment poses a very significant challenge, and we share the concern expressed in the Scottish Government's report on "Reshaping Care for Older People" that current arrangements are simply not sustainable.

As outlined in our paper *Older People's Services: A BMA Scotland position statement (*attached as Appendix One) we consider that there is an urgent need to plan a coordinated system of community, hospital and residential health and social care to cope with a range of needs for an increasing number of older, and very old (>85 years old) patients.

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[1] In our response, we have used the following definition of integration and integrated care: "**Integrated care** is an organising principle for care delivery that aims to improve patient case and experience through improved co-ordination. **Integration** is the combined set of methods, processes and models that seek to bring this about". Shaw D, Rosen R, Rumbold B, *What is integrated care?* London: Nuffield Trust 2011.

[2] *General Practice In Scotland – The Way Ahead Progress Report,* BMA Scotland (March 2012).

[3] "Funding health and social services for older people – a qualitative study of care recipients in the last year of life", Hanratty, B, Lowson, E, Holmes, L, Grande, G, Addington-Hall, J, Payne, S and Seymour, J, *Journal of the Royal Society of Medicine*, May 2012, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3360529/

We should also acknowledge that the current evidence regarding the impact of integrated care is comparatively limited. While evidence from North America and Europe does indicate that integrated health and social care systems for older people demonstrate positive results on many indicators,[4] researchers have highlighted specific and significant gaps in the existing evidence base in relation to costs, patient experience and clinical outcomes.[5] It is essential that care for individual patients is funded and provided as a whole package, for example ensuring that there are comprehensive and fully funded care plans in place and improved coordination following hospital discharge; fragmented care for older people should be replaced with an integrated care pathway co-ordinated across the spectrum of care providers.

Paragraph 1.5 notes that "we also know from clinicians and other professionals who provide health and social care support that, as far as possible, it is better for people's wellbeing if they are supported in their own homes or another homely setting in the community, rather than being admitted unnecessarily to hospital". We support the aspiration to reduce acute hospitalisation, however the promotion of admissions avoidance, particularly of older people, must not restrict the appropriate access to best care at times of medical need, and patient safety and quality of care must be prioritised at all times.[6] The overall intention should be to maintain as many people at home as is possible, safe and appropriate, but there also needs to be recognition of, and planning for, an expansion in the number of those requiring some form of residential care. While an increased proportion of patient assessment and care will be community based, quality hospital-based health care will need to be maintained and developed for those who need it. No matter how well community-based services are planned and delivered, many patients will continue to require hospital assessment and treatment. Growing numbers of frail elderly patients with multiple physical co-morbidities, and often with dementia, will produce significant pressure on hospital-based services, undermining the perception that the funding necessary for quality community-based health care can be found solely through the transfer of resources from secondary care. There is often an assumption that the only way to develop community services is to move funding from secondary to primary care, or health to social care, rather than considering the overall resource envelope and whether that needs to change.[7]

Due to already excessive levels of workload there is no capacity for general practice to take on any further planned (or unplanned) work without the addition of new resources, including significant investment in infrastructure. A comprehensive assessment is needed of the likely resources required to meet the needs in both primary and secondary care of a population with a higher proportion of elderly and very elderly patients and a rising prevalence of long term conditions. Without adequate planning and investment for both sectors Scottish Government aspirations to shift the balance of care and integrate adult health and social care may be unachievable[8] and general practice could buckle under the strain of an impossible and unsustainable workload.

A BMA report on the integration of health and social care published in June noted that the most likely improvements following integrated care activities are in healthcare processes. Improvements are less likely to be apparent in patient experience or in reduced costs and are not likely to be obvious in the short-term.[9] Paragraph 1.7 acknowledges that there remain barriers in terms of structures, professional territories, governance arrangements and financial management between health and social care, and while we believe that putting doctors at the heart of clinical service development is crucial, we are keen to avoid generating bureaucracy and additional costs through unnecessary organisational change. In particular the integration of adult health and social care will require very careful and robust workforce planning across the NHS and local authorities to ensure high quality patient care can be delivered effectively.

[4] *Clinical and service integration: the route to improved outcomes,* The King's Fund 2010, http://www.kingsfund.org.uk/publications/clinical_and_service.html
[5] *Integrating Services without Structural Change,* June 2012, Health Policy and Economic Research Unit, BMA.
[6] *RCPE Briefing: Inappropriate admissions to hospital: myth versus reality* (April 2012), http://www.rcpe.ac.uk/policy/parliamentary-briefings/rcpe-parliamentary-briefing-admissions-april-2012.pdf
[7] Appendix one: *Older People's Services: A BMA Scotland position statement*
[8] *General Practice in Scotland: The Way Ahead – Progress Report*, BMA Scotland, March 2012
[9] *The Integration of Health and Social Care*, Health Policy and Economic Research Unit, BMA, June 2012.

There is also an urgent need to improve the resilience and independence of elderly people who will make up this increase. There is a growing body of evidence that indicates that good social networks and increased levels of exercise significantly reduces the need for "care". This includes support that promotes health, well-being and quality of life in the communities where people live, the benefits of which are realised over a number of years.[10] The initial focus on the elderly is therefore logical but the principles inherent in improving and solving these issues should be applicable across the spectrum of adult care in future. However integrated care is not necessary for all forms of care, and should be targeted at patients and service users most likely to benefit.

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?**

While the proposed framework for integration puts in place broad parameters, some sections are comparatively loosely defined and at present seem largely aspirational. At this stage we would not want to be overly prescriptive, however there needs to be greater clarity on how the role of clinicians in the strategic commissioning of services for adults will be strengthened. Without this detail on how clinicians will influence service delivery there is a considerable risk that previous mistakes will be replicated. In a national survey of GP opinion conducted by the BMA in 2007, the lack of influence of CHPs was highlighted as a key factor in doctors' disengagement from this structure. Two-thirds of respondents considered the lack of effective communication between CHPs and general practice to be a barrier to effective GP engagement. 50.9 per cent considered the lack of shared vision between GP practices and CHPs to be a barrier to effective GP engagement. 48.7 per cent (495 of 1016) of respondents considered the lack of financial support to allow effective GP/practice staff engagement with CHPs to be a barrier to effective GP engagement. More recently Audit Scotland's review of CHPs[11] revealed significant failings in the governance of these organisations as well as a failure to achieve many of the organisational objectives. The new partnerships must be clinically driven and supported by management to avoid the failures of their predecessors which are well documented.[12] BMA Scotland would welcome the opportunity to enter into detailed discussions with policy makers on how clinical disengagement in proposed new structures might be avoided

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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 and for support to carers. 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?**

The consultation does not define the nationally agreed outcomes at this stage, but instead gives a general flavour of approach. Annex 3 outlines 7 broad measures which are largely statements of principles. Beyond these principles, it will be vital to ensure that these outcomes once drafted will effect genuine change which improves the wellbeing of older people. The success of integration will rely on the nationally agreed outcomes being based on clinical evidence and practical usefulness which needs to be significantly more specific than anything outlined in this consultation. However measuring improvement in clinical outcomes in the elderly, who will likely have multiple progressive chronic problems, will be harder than demonstrating "cure" or "success" – proving a slower rate of decline or a slower increase in care needs is inherently difficult. Therefore whilst we have concerns that what are being proposed are not specific

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10 *How can local authorities with less money support: better outcomes for older people?,* Joseph Rowntree Foundation, January 2011.
[11] Audit Scotland *Community Health Partnerships*, June 2011
[12] *General Practice in Scotland: The Way Ahead – Progress Report*, BMA Scotland, March 2012.

measures, we also recognise that there is some merit in measuring qualitative as well as quantitative outcomes. If the nationally agreed outcomes are too focused on a narrow number of specific measures, for example a reduction in hospital admissions, this may have an adverse impact on other areas of care and may increase pressure on general practice.

The consultation states that the specific outcomes will not be written into legislation as they will be expected to change and develop over the years to come. Given the significance of these outcomes as a mechanism to drive change, clarification is needed on which bodies will be involved in the development of these outcomes both now and in the future, and how agreement will be reached in the future on any subsequent changes. In December 2011, the BMA published a report "Doctors' perspectives on integration in the NHS' which included the findings of two surveys of BMA members that explored a number of issues relating to integrated care. This research clearly established that the two most important criteria for measuring the success of efforts to integrate services, from the perspective of doctors, were 'improved clinical outcomes' (84%) and 'better patient experience' (64%). 'Cost savings' it should be noted was only rated at 13% by contrast.[13] We believe that the medical profession must have a central role in advising and agreeing the development of nationally agreed outcomes for adult health and social care as they will have a greater chance of success if they are supported by clinicians.

Chapter 1 acknowledges that the two care systems have "adapted only slowly, reluctantly and separately and, despite the existence of a main task in common, have broadly failed to establish and generalise reliable, effective and cost-effective means of working together on their central challenge now and for the foreseeable future: that of care of older people, particularly those at home."[14] There has been a long history of the NHS and Local Authorities attempting to work together which have not been successful, despite statutory and governance arrangements being put in place to underpin this. Closer integration of health and social care has been a goal of successive governments. A variety of structural models have been suggested and implemented, ranging from measures to facilitate joint working and sharing of resources to enabling full structural integration.[15] Yet there has been relatively little progress towards achieving the kind of integration sought by successive policy makers.

This is therefore an ambitious and challenging approach, and as Paragraph 1.7 recognises, there are still many barriers in place between the current systems of health and social care in terms of structures, professional territories, governance arrangements and financial management that work against general aspirations of efficiency and clinical/care quality. To avoid the significant risk of another failed attempt at successful joint working in the face of such barriers, it is vital to clarify how this change will be achieved and sustained. In particular, careful consideration will be required of the measures that will be put in place to overcome the difficulties that have beset previous unsuccessful attempts to achieve seamless delivery of care services within an integrated NHS and local authority structure.

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

We would support the nationally agreed outcomes for adult health and social care being included within all local Single Outcome Agreements to ensure there is national consistency and to avoid the risk of replicating some of the current inequalities and inconsistencies between NHS board/Local Authority areas. Again, we would reiterate that these nationally agreed outcomes must be meaningful, well constructed and evidence based. To encourage doctors to play an active role in integration, schemes must be shown to be seeking the right benefits. The key measures of success of integration for doctors are improved clinical outcomes and better experiences for patients. An inability to demonstrate the centrality of these benefits will create a barrier to doctors' involvement.

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[13] 'Doctors' perspectives on integration in the NHS', BMA, December 2011.
[14] Paragraph 1.3, quoting Colin T Currie (Senior Lecturer in Geriatric Medicine, University of Edinburgh and Honorary Consultant Geriatrician, Journal of Integrated Care Volume 18, Issue 6, December 2010.
[15] *The Integration of Health and Social Care*, Health Policy and Economic Research Unit, BMA, June 2012.

We also agree that there must be room for local flexibility as outlined in Paragraph 3.2 "the underlying principle of these proposals is to provide national leadership in relationship to *what* is required – the outcomes that must be delivered – and to leave local determination *how* best to achieve these outcomes – the delivery mechanisms that will best suit local needs". As we have commented below, local determination will only prove successful if clinicians are meaningfully engaged – there are many examples of unacceptable CHP local arrangements not supported by clinicians. One size does not fit all and unique solutions are required to overcome the challenges of providing care in remote and rural communities, but outcomes should be nationally agreed.

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?**

We agree that there needs to be openness and transparency about this process, and a reduction in unnecessary bureaucracy. However there may be conflicting priorities if there are disagreements between local and central governments. We would welcome further information/discussion about how competing priorities would be dealt with both now and in the future. Paragraph 4.2 notes that these proposals introduce a model of integration that is based upon joint and equal governance and accountability between NHS boards and Local Authorities, and it is essential that ministerial accountability remains.

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

In order for this Bill to be properly facilitative and avoid unnecessary barriers to achieving successful integration, there must be appropriate scope for a Health and Social Care Partnership to be established that covers more than one Local Authority if this is necessary. At present, there is a lack of coterminosity in some areas where NHS board areas cover more than one Local Authority, particularly in the NHS Greater Glasgow and Clyde area. An example of forced coterminosity failing to achieve the desired outcomes is the persistence of ongoing difficulties following the forced transfer of responsibility for Rutherglen from NHS GG&C to a CHP in NHS Lanarkshire to match Lanarkshire local authority boundaries.

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

BMA Scotland would welcome further involvement in the development of governance arrangements for Health and Social Care Partnerships, and the opportunity to feed in to discussions on more specific guidance on who will sit on these committees and how they will be appointed. Without more detailed information it is difficult at this stage to comment on whether these proposed Committee arrangements are appropriate to ensure good governance of Health and Social Care Partnerships.

The membership of the health and social care committee is significantly management orientated at present. The voting members of the HSCP Committee will be made up of an equal number of NHS board Non-Executive Directors and local elected members, with a minimum of three representatives from each statutory partner with the mandate to act on behalf of their parent statutory bodies (Paragraph 4.17). We consider that clinicians with voting rights on the committee would help to ensure the confidence of the profession. Under Paragraph 4.18, voting members of the committee will be supported by a number of non-voting members, which will include professional advisers. Given the focus on older people's service, we consider that a GP and a geriatrician must have input, and psychiatry should also be represented. We also have concerns that while the HSCP will have voting members from NHS board non-executives and local executive members, the current view is that the clinical and professional advisers will be non-voting.

We have serious concerns that the minimum requirement for members in an advisory capacity on the HSCP includes both a patient and third sector representative but not a clinician from either primary or secondary care, although it notes that a minimum requirement would be an Associate Medical Director *or* the Clinical Director of the Partnership and the Chief Social Work Officer. From a health perspective, the interests of both the primary and secondary aspects of the integrated budget and care pathways are represented by the clinical adviser (Paragraph 4.18). The Audit Scotland report on CHPs noted that they are largely management run and bureaucratic and have failed to gain the support of GPs and senior secondary care doctors, and it is important to ensure that the transition to HSCPs addresses this.

We would also point out that there is a potential imbalance under Paragraph 4.16 "The Chair of the Health and Social Care Partnership Committee will have a casting vote were the Committee unable to reach a majority decision", while the Vice Chair does not have a vote. Given that the NHS Board and Local Authority will nominate a chair and vice chair for the HSCP which will rotate on an annual basis, there may be problems of potential bias with this voting structure in the future.

We would therefore welcome the opportunity to comment on more specific guidance on who will sit on these committees, who will choose them and the mechanism for electing these committees. In order to strengthen the role of clinicians in the strategic commissioning of services for adults we consider that GPs and senior secondary care doctors must be represented appropriately on HSCPs, and must have the confidence of local clinicians.

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?

It is difficult to say at this stage, and performance management arrangements are predicated on agreed, evidence-based, measureable and meaningful nationally agreed outcomes being in place, together with specifying what action will be taken if the new partnerships fail to deliver these outcomes. However there does seem to be sufficient high level governance outlined in the proposals, with greater focus at present on governance rather than what the HSCP will do in terms of managing and commissioning services.

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?**

Paragraph 4.4 states that the NHS Boards will have flexibility regarding whether to include the responsibilities of CHPs that extend beyond services for adults into the integrated budget. CHPs have responsibility for services outwith these proposals and Paragraph 4.22 indicates that it may be possible to apply the HSCP governance arrangements to the full range of current CHP budgets and service delivery. There needs to be greater detail regarding which other budgets are being referred to in question 9, and how these budgets would otherwise be reallocated and managed. In addition detailed guidance is required to ensure there isn't wide variation, or that the core purpose of HSCPs isn't diluted. Any facility to include budgets for other CHP functions would have to be managed carefully and supported by detailed principles and guidance to ensure that funding was not removed from successful services to address overspends or need in other competing areas. Safeguards would have to be in place to ensure consultation and agreement with the budget holders and service providers of any funding identified for possible transfer.

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?

In the absence of evidence it is difficult to predict whether these models will deliver this objective, however previous experience of Community Health Partnerships would indicate the extent of potential problems ahead. The models outlined in Chapter 5 have the potential to deliver this objective provided that they reduce duplication, that they ensure that appropriate care is delivered at the right time to the right people, and genuinely break down some of the unhelpful barriers between health and social care. If however the proposed legislation simply results in reorganisation of management structures rather than services themselves, then they will not.   Organisational integration alone is unlikely to deliver better outcomes and effort must focus on clinical and service integration. Evidence from the United States suggests that organisational integration may occur in the absence of clinical and service integration, the consequence of which is that integrated structures rarely integrate the actual delivery of patient care.[16] It is important that the autonomy of the Joint Accountable Officer is very clearly defined in order to avoid their accountability being referred back along individual lines of accountability in the partner organisations.

There must be a long-term commitment to an evidence-based approach. Both the NHS in Scotland and local government has entered a prolonged period of financial restraint and it will be a significant challenge to maintain the focus on quality and achieve concrete benefits for elderly people in such a difficult environment. Establishing new services or reshaping existing ones requires the right resources being made available at the right time.

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?**

GPs and senior secondary care doctors are essential components of delivering quality patient care – leading teams, developing services and sharing expertise. A report by BMA Scotland demonstrated the wide ranging tasks and roles undertaken by consultants, highlighted the various skills needed to be a consultant and showed why medical leadership in clinical care is essential for the NHS in Scotland.[17] One of the themes to emerge from this report was that, as well as specialised surgical and medical skills, senior clinicians provide leadership and a vision of how services can be improved by bringing together teams for the benefit of patient care. Team working is more effective for patients and families. Often people need resources that different professionals can offer, and senior clinicians are experienced in leading teams.

One issue which may arise is that while all services provided by the NHS are free at the point of access, some social care services are currently charged for on an individual basis. For this reason, we urge a clear distinction of social care so there is clarity about which services will be provided by the NHS and to ensure that no funding is moved from the NHS into services provided by commercial and voluntary providers

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?

Again it is not possible to predict whether ministerial direction on the minimum categories of spend will provide sufficient impetus and sufficient local discretion to achieve the Scottish Government's objectives. Minimum spend is only one driver, and there may be a risk that setting minimums gives HSCPs the message that the minimum spend and range of spend is appropriate. If minimum categories are used then the evidence behind how they are derived must be properly evidence based. How the minimum categories of spend are determined will be one of the key aspects that will determine the success or otherwise of HSCPs, although given the current financial constraints there may be the potential for both NHS boards and Local Authorities to minimise the transfer as far as possible.

[16]*Clinical and service integration: the route to improved outcomes,* The King's Fund 2010, http://www.kingsfund.org.uk/publications/clinical_and_service.html
[17] *Consultants in NHS Scotland: at the heart of patient care* (BMA Scotland), April 2009

Adequate funding must be made available in line with the level of health and social care that the Scottish Government wishes to provide, as it is increasingly clear that providing care to older people will require significant more funding in line with demographic changes (see above). As noted above in question 1, the most likely improvements following integrated care activities are in healthcare processes. Improvements are less likely to be apparent in patient experience or in reduced costs and are not likely to be obvious in the short-term.[18] According to Audit Scotland's recent report on commissioning social care, many current models of social care are unsustainable due to increasing demand, the changing profile of Scotland's population, reducing budgets and the move to provide services more tailored to individuals' needs.[19] The Scottish Government has made available the Change Fund to "[bridge] finance to facilitate shifts in the balance of care from institutional to primary and community settings".[20] However as the funding is bridging and not permanent it is difficult to envisage how it could be key in addressing the long-term demographic challenges. The Change Fund provides limited, short term funding of developments in health and social care and whilst it can be used positively in service development it can only ever make a small impact on the massive demographic pressures faced. SCVO has also raised concerns in its review of the Change Fund in year one that some money from the Change Fund has already been used to fill gaps in local authority funding. For example the reported use of almost £1m of Glasgow's £8m Change Fund share to buy in social care services from Cordia. There are also reports that Glasgow has 'allocated' substantial sums to purchase care home places.[21]

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?

The level of the financial authority of the Jointly Accountable Officer is dependent on the model for financial integration between the NHS board and the Local Authority that has been agreed (Paragraph 6.7 and Chapter 5). The JAO will have the authority to manage the integrated budget that they are given, but the decision of the extent to which there will be a shift in investment will have been largely pre-determined by the respective Chief Executives of the NHS board and Local Authority. As we noted in question 12 above, given the current and ongoing financial constraints there may be the potential for both NHS boards and Local Authorities to minimise the transfer as far as possible.

There may therefore be circumstances in which the JAO has insufficient power to shift investment. Furthermore, in addition to having the power to enable a shift in investment, the JAO must be able to demonstrate that there is clear evidence for doing so. There needs to be a clear evidence base for investment and shifting the balance, so that the JAO can ultimately assure themselves that this is evidence based, will assure there is continuity and improvement of care, is sustainable and will not destabilise other services.

There is a major demographic shift with not only larger numbers of elderly patients but much larger numbers of very elderly patients, many with multiple physical co-morbidities and a doubling of those with dementia. There needs to be increased secondary care provision as well as better and more effective 24 hour community care infrastructure with rapid response with appropriate numbers of appropriately qualified staff. The community infrastructure required cannot be paid for solely by shifting the balance of care, there must be careful, honest and accurate consideration of increased secondary care provision.

There is potential benefit in the integration of health and social care, conversely there is also potential for healthcare to be adversely impacted by these changes, as there is a gap between the demand for social care for older people and the funding available. Unmet need in social care is likely to result in increased pressure on primary and secondary health services which may come in the form of higher hospital admissions, delays in discharge from hospital and increased

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[18] *The Integration of Health and Social Care*, Health Policy and Economic Research Unit, BMA, June 2012.

[19] *Commissioning Social Care*, Audit Scotland, March 2012.

[20] Scottish Government, *'Reshaping care for older people – Change Fund guidance 2012/13'*, modified: 08.02.2012"

[21]SCVO Briefing: Change Fund, http://www.scvo.org.uk/policy/briefings-and-consultation-responses/briefing-change-fund

pressure on A&E and GP services. Audit Scotland's recent report noted that Councils' social care spending increased by 46% in real terms between 2002/3 to 2010/11. The number of older people in Scotland is projected to rise by 22 per cent over ten years (from 879,000 in 2010 to 1,075,000 in 2020), and by 63 per cent over 25 years (to 1,431,000 in 2035). The number of people aged 85 and over is projected to increase by 39 per cent over ten years and by 147 per cent over 25 years. These population trends will increase demand for health and social care services in future. The Scottish Government has reported that the amount spent on health and social care services would need to increase by £3.5 billion by 2031 if the systems remain as they are now.[22] There are risks that health funding may be used to fund a significant amount of social care provision before any resultant benefits in health are realised.

The Scottish Government and the NHS should encourage and support joint working between primary and secondary healthcare professionals on the redesign of patient pathways to achieve the optimum balance of care.[23] In a recent progress report, BMA Scotland has called for the impact of shifting the balance of care developments on primary care services to be anticipated and monitored by the Scottish Government and NHS Scotland to ensure that the necessary capacity and resources are available. Greater consideration must be given to the impact on primary and community NHS services of achieving 'efficiencies' in secondary care; for example the effects on primary and community care of early discharge of patients from hospital and of prescribing and referral decisions taken by secondary care doctors.[24] Furthermore, and as noted above, without a planned increase in the number of GPs working in Scotland which takes into account the need to provide care to an aging population and a rising prevalence of long term conditions, there is a risk that these aspirations on shifting the balance of care and integrating adult health and social care are unlikely to be achieved.

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

Chapter 5 seems to describe an appropriate level of seniority for the Jointly Accountable Officer. It may be advantageous to consider the appointment of high level individuals who have neither a Local Authority nor an NHS background in order to bring an independent perspective to the management of an integrated budget and the achievement of specified outcomes.

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

The Scottish Government should produce clear guidance and draft a flexible national template to achieve consistency and provide a clear framework for locality planning which requires to be professionally led. Without direction at this stage, there could be too much local variation and too much time spent on initial discussions around how locality planning may be taken forward. There must be an appropriate balance between central direction (for example the composition of clinician led commissioning committees, how members are elected, specification of nationally agreed outcomes), and local variations which take into account specific circumstances in different local areas. One of the greatest criticisms of CHPs by doctors was that in many areas they became largely management-run bureaucratic organisations whose responsibility was to roll out centrally driven initiatives. The Scottish Government must also ensure the appropriate involvement of primary and secondary care doctors, and provide clarity of expectation and examples of good practice to assist local partners in developing their integrated care schemes.

Some of the points that should be taken into account with regard to locality planning:
- Policy and system stability is essential to enable integration to become established.
- Communicating a collective vision, built on a strong foundation of evidence-based thinking and staff involvement and engagement, should be fundamental to any integration project.

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[22] *Commissioning Social Care*, Audit Scotland, March 2012
[23] *General Practice in Scotland: The Way Ahead – Progress Report*, BMA Scotland, March 2012
[24] *Ibid.*

- The creation of co-located integrated teams of professionals should be considered in all areas where integration is being discussed.
- To reassure doctors of the value of schemes to integrate health and social care, strategies must be clearly based on the benefits being sought for patients and service users.
- The ability to measure outcomes and experiences should be central to any plan to integrate, to make it possible to determine success or identify areas where further improvements are needed.
- The benefits of integration to patients must be stressed and must not be drowned out by messages highlighting the benefits to the system in terms of costs.
- Effective, stable managerial leadership is essential to develop partnership arrangements, show commitment to partnership working and bring staff on board.
- Senior and middle management should be engaged with each other from the outset, so they can set and agree the aims and objectives of the scheme and communicate these to other staff.
- Opportunities for clinical leadership should be made available in all integration schemes and should extend to doctors working in different settings.[25]

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?

A "duty to consult" is not strong enough. The Scottish Government has explicitly stated that "a central role for professionals in the planning and commissioning process is critical to the success of putting in place integrated pathways of care that focus in particular on preventative and anticipatory intervention" (paragraph 7.1). GPs and senior clinicians must be involved in how best to put in place local arrangements for planning service provision in order to effectively strengthen the role of clinicians. A duty to consult without a commitment to involve or implement on the basis of this consultation effectively distances senior clinicians from strategic planning for local service provision. There must be a robust system for meaningful engagement with GPs and senior clinicians in the planning of services.

The Scottish Government needs to ensure dialogue and consensus among local professionals about the shared objectives of integration and how to allocate resources to best meet local need. When developing services that operate across health and social care and primary and secondary care, decisions made in one part of the service can have significant impact elsewhere in the service, and clinical involvement is vital. GPs and senior secondary care doctors have a key leadership role, working together to plan and develop sustainable service needs. Therefore there should be more specific direction about the responsibility to involve clinicians from primary and secondary care who have experience and expertise in health delivery and 'duty to consult' replaced with 'reach agreement with' local professionals including clinicians. From a primary care perspective there should be a duty to consult and reach agreement with the Local Medical Committee, which is the only local, elected and representative body of general practitioners.

As we have noted above under Question 7, the membership of the health and social care committee is significantly management orientated at present. The minimum requirement includes both a patient and third sector representative but not a clinician from either primary or secondary care. The Audit Scotland report on CHPs noted that they are largely management run and bureaucratic and have failed to gain the support of GPs and senior secondary care doctors, and it is important to ensure that this change is different.

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?

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[25] *The Integration of Health and Social Care*, Health Policy and Economic Research Unit, BMA, June 2012.

There is an urgent need for greater medical involvement in the development of planning at a local level. There is an urgent and growing need for well-informed, strategic decision-making on what patient services are needed locally and how they can best be delivered. This is an area in which senior doctors in secondary care and GPs have the knowledge and leadership skills required to take on a crucial leadership role.[26]

The Audit Scotland review of CHPs revealed significant failings in the governance of these organisations as well as a failure to achieve many of the organisational objectives such as reducing emergency admissions, and called for GPs to be involved in planning services for the local population and in decisions about how resources are used and work with them to address variation in GP prescribing and referral rates.[27] We therefore welcome the Scottish Government's commitment to a strengthened role for clinicians, and it must ensure the new partnerships are clinically driven and supported by management to avoid the pitfalls of their predecessors.

In order to enable clinicians to both be involved with and drive planning at a local level, there must be a clear commitment to value senior doctor time sufficiently and make time available in secondary care job planning or commission GP time. The use of that time must be effective so that doctors feel that their professional views are valued, listened to and where appropriate acted upon. Expecting very busy senior doctors to carry out HSCP work effectively in their spare time, or in the case of GPs, at potential personal cost to themselves and their practices is unsustainable. The ongoing involvement of clinicians must be valued, resourced and invested in. Consideration should also be given to the timing of meetings in the working week to enable participation.

It is important that the HSCPs have the authority to make decisions to ensure ongoing clinical engagement. If individuals chosen to fill positions on HSCP committees have little experience or interest in certain healthcare areas this is likely to weaken support and interest from the stakeholders within that specific area.

The range of measures which we believe could promote greater clinical engagement at a local level include placing an obligation on HSCP to:

- produce a clear strategy for involving senior clinicians

- demonstrate how they are involving their constituent GP practices and relevant senior clinicians in setting local healthcare priorities

- engage clinicians who continue to deliver medical services, rather than relying on input primarily from clinicians predominately in managerial roles. Whilst we acknowledge that all key stakeholders should participate in HSCP activity, it is imperative that senior clinicians are engaged as they have extensive patient contact and hence a comprehensive awareness of the clinical needs of their practice population.

- Full clinician engagement would be best achieved by ensuring that clinical fora are clinician led with support from health and social care planners

A recent BMA survey shows that doctors believe collaborative cultures with shared values, good professional relationships and effective leadership are essential if integration is to get off the ground. These elements are also vital to securing what should be the key measures of success of efforts to integrate, confirmed by doctors in our survey – improved clinical outcomes and better patient experiences.[28]

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

Certainly in designing local community services it would make sense for locality planning to be organised around clusters of GP practices. However this needs to be balanced by both the cost of

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[26] Appendix 3,

[27] Audit Scotland *Community Health Partnerships*, June 2011

[28] *The Integration of Health and Social Care*, Health Policy and Economic Research Unit, BMA, June 2012

greater local involvement and the availability and enthusiasm to get involved. Greater clarity is required about the definition of a 'cluster of GP practices', and the size of clusters, geography, health needs of the population and available service provision are all significant.

An example of integrating care services to benefit older people can be seen in Torbay. Torbay has attracted increasing interest in recent years because of its work to integrate health and adult social care services to better meet the needs of older people, which has been based on health and social care teams aligned with GP practices. Teams worked closely with general practices to provide care to older people in need and to help them live independently in the community. The appointment of health and social care co-ordinators was an important innovation in ensuring the contribution of all team members in improving care. According to research done on the Torbay project, the results of integration include reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care, and was achieved by the creation of locality-based health and social care teams aligned with general practices.[29] Although this is a comparatively small-scale example, it reinforces the underlying principle that engaging GP practices will be critical to the success of this proposed integration in Scotland.

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

Again, this is difficult to answer specifically without knowing what might be devolved. The actual provision of and management of locality specific services would seem an appropriate approach, but for services which cover wider areas the HSCP should probably retain responsibility. Devolving decision making to locality planning groups to some extent may ensure that the process is more effective. However, many models for locality planning and locality arrangements have been tried within Scotland previously, and it is difficult to evaluate the extent to which these have been effective. The proposals to integrate adult health and social care refer to locality planning but without outlining any particular model at this stage, making it difficult to comment in detail.

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?

Final decisions must be made by the HSCP, but it would seem possible that the proposed sizes may be too small to be effective, although this may be appropriate in more rural areas. Decisions will be determined by geography and population density with natural areas of geographical clinical activity.

Do you have any further comments regarding the consultation proposals?

At this stage the Adult Health and Social Care consultation has focused on organisational philosophy and broad themes. While this is key groundwork, it is important that further detail is made available to analyse what this will potentially mean for services and patients to ensure that integration will provide high quality care that is safe, effective, based on patient experience and based on clinical evidence. More explicit examples of how integration will work in practice will be needed throughout the Bill drafting process to enable us to comment in greater detail. At present there is a lack of information about exactly how this integrated model will work in practice. For example, the identification and agreement of the funding allocation is critical to the long term success of these proposals and to avoid another organisational restructure in a few years' time.

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[29] *Integrating Health and Social Care in Torbay,* The King's Fund, March 2011.

One major concern that has not been addressed in this consultation exercise is the effect that restructuring could have on patient care if clinically led, GP practice based teams are disbanded in favour of a locality based approach. The organisation of services in the community must not lead to a situation where there is a disconnect between GPs and other staff. Moving primary care team members (e.g. community nurses) from a GP practice base to a locality base may reduce rather than enhance service integration and ultimately lead to poorer continuity of patient care.

In order to further inform our response, please find attached the following appendices:

- Appendix 1: Older People's Services - A BMA Scotland position statement
- Appendix 2: BMA Scotland written submission to the Health Committee Inquiry into the Integration of Health and Social Care
- Appendix 3: Medical Leadership in the Development of Clinical Services – a BMA Scotland Position paper (August 2011)

BMA Scotland
11 September 2012

Older People's Services
A BMA Scotland position statement

The Scottish Government's strategy document, "Reshaping Care for Older People" recognises that there will be 21% more people aged 75+ in Scotland by 2016, compared with 2006, and 83% more by 2031. Assuming demand increases in line with this growth and that current service models remain the same, it suggests this will require an average real increase in the NHS budget of 1.2% per year, every year. Local Authority older people's social work budgets will also need to be increased significantly. An ageing population combined with a difficult public spending environment poses a very significant challenge, and we share the concern expressed in "Reshaping Care for Older People" that current arrangements are simply not sustainable.

Overall we need to plan a coordinated system of community, hospital and residential health and social care to cope with a range of needs for an increasing number of older, and very old (>85 years old) patients. The key priority areas are:

- We need to finding a sustainable way of providing timely, high quality care to enable frail elderly patients to remain in their own homes as long as that is desired and appropriate, avoiding unplanned hospital admissions wherever possible.

- This will require well coordinated and integrated stepped care, including end of life care, and quality coordinated community multidisciplinary support available on a 24/7 basis. Rather than creating new teams or new types of staff, the skills of those currently employed across health and social care teams need to be deployed in a much more consistent and coordinated way, with clear leadership. The roles of community based nurses and allied health practitioners may need re-examined and in places reinvigorated, with clear links to the relevant medical staff. The evidence base for community based care makes a clear case for truly multidisciplinary care, not an approach invested in only one or two disciplines. That evidence base clearly demonstrates better outcomes, but is not necessarily less expensive.

- While the overall intention should be to maintain as many people at home as is possible, safe and appropriate, there also needs to be recognition of, and planning for, an expansion in the number of those requiring some form of residential care.

- While an increased proportion of patient assessment and care will be community based, quality hospital-based health care will need to be maintained and developed for those who need it. No matter how well community-based services are planned and delivered, many patients will continue to require hospital assessment and treatment. Growing numbers of frail elderly patients with multiple physical co-morbidities, and often with dementia, will produce significant pressure on hospital-based services, undermining the perception that the funding necessary for quality community-based health care can be found solely through the transfer of resources from secondary care. There is often an assumption that the only way to develop community services is to move funding from secondary to primary care, or health to social care, rather than considering the overall resource envelope and whether that needs to change.

- We need to do more to remove the barriers to appropriate rapid discharge from hospital when that level of care is no longer required. At present delayed discharge statistics concentrate on a headcount of those delayed, and especially those delayed over 6 weeks. Behind those statistics are a large number of patients delayed by a "short" time, but one that cumulatively adds up to a huge amount of NHS resource devoted to those who no longer need to be in hospital. More specifically, restarting or making adjustments to a patient's home care package, and transport availability often contribute to this issue.

- A specific issue arises when those with pre-existing, but not formally diagnosed, cognitive impairment need to be discharged from hospital. The time taken to secure intervention or guardianship orders, or to sort out financial or welfare power of attorney can lead very long in-hospital delays. We need to find ways of streamlining and speeding up these processes,

particularly when there is clear consensus amongst all involved with the patient, or in cases where there is no immediate risk, accepting that patients can and should be discharged with proceedings pending.

Senior secondary care doctors and GPs, working collaboratively are ideally placed to take a central leadership role in this work (as they make the decisions that have the greatest impact on the wider NHS and social care), developing more effective and efficient patient pathways locally rather than what currently happens with the piecemeal development of services by various parts of the NHS and social care that seek to solve their own individual issues rather than look at the wider patient journey. We urge the Scottish Government and individual NHS boards to enable doctors to take on this role.

We need to move away from the current situation where "new" but non-recurring monies are made available for projects, which then become ongoing NHS or social care services without the recurring funds to continue them. This is often why firstly services develop piecemeal and second result in knock on effects on other services when funding needs to be found from within existing budgets. It seems clear that a better strategic overview is required.

At the same time however, we recognise that no matter how effectively services are organised and delivered, adequately resourcing quality health and social care for an ageing population will inevitably require significant extra resources. How these resources are made available, including the extent to which social care services are funded from the public purse, is a matter which requires wider public debate, particularly given the current mixed economy of social care funding. To help them plan properly for the future, people need to know with some degree of certainty what care is going to be provided for them by the state should they need it, and what care they are going to have to fund for themselves, not just over the next few years, but over the medium and long term. We are keen to avoid the issue becoming a political football, and we therefore call for the establishment of an independent Scottish Commission on Health and Social Care Services for Older People to identify a sustainable long-term way forward.

BMA Scotland Written Submission:
Health Committee Inquiry into the Integration of Health and Social Care

Introduction
The BMA is disappointed not to have been invited to appear before the Committee to take part in the inquiry into the integration of health and social care but would welcome the Committee's consideration of this written submission as part of the inquiry process.

Background
The BMA represents doctors working in hospital, community and primary care environments across the country and as such, is very much aware of the challenges that exist in co-ordinating, planning and delivering health and social care services in local communities.

One of the greatest contributors to the failure to integrate health and social care services in local communities has been the failure of Community Health Partnerships to achieve their stated objectives, a failure that has only recently been acknowledged by the Government following the publication of a highly critical report by Audit Scotland. Since 2004, the BMA has been a leading voice in the calls to reform Community Health Partnerships and has continually raised concerns about their effectiveness. In 2010, BMA Scotland published a policy document "General Practice in Scotland: The Way Ahead"; in this report, the BMA highlighted the importance of medical engagement in such reform.

Integrating social care with primary and community care is important, but it is equally important that any review of the current system considers integrating all parts of the service, including secondary care, so that all sectors of the health service work in an integrated manner with social care services. As such, the BMA would encourage the Health Committee to consider the views of medical practitioners working in both primary and secondary care sectors as part of its inquiry.

In anticipation of the debate on health and social care integration, the BMA established a short-life working group to look into the issue seeking input from doctors working in general practice and in community and hospital based services. This submission focuses on the recommendations of this group.

Community Health Partnerships
CHPs were first established in 2004 with a remit to improve the delivery of health and social care in the community and create greater integration between primary and secondary care. These organisation should have become the cornerstone of the strategy to deliver more care closer to patients' homes and to prevent admission to hospitals, where possible. It was initially intended that these organisations would be clinician led and supported by managers; they would reduce bureaucracy and devolve responsibility and decision making to front line organisations working with patients, thus ensuring that services were tailored to local demand. Unfortunately, it is clear that these objectives have largely failed and the Scottish Government has finally announced its intention to reform CHPs and replace them with "Health and Social Care Partnerships".

One of the greatest criticisms of CHPs by doctors is that in many areas, they became largely management-run, bureaucratic organisations whose responsibility was to roll out centrally driven initiatives. Subsequently CHPs have failed to gain the support of doctors, particularly GPs, many of whom feel completely disengaged from these organisations.

Medical engagement in the development of clinical services
Financial constraints and demographic changes are placing increasing demands on shrinking resources in the NHS and local authorities. There is an urgent and growing need to improve decision-making on what services are needed locally and how they can best be delivered. Now more than ever, the NHS needs to effectively harness the unique skills that doctors have, by enabling GPs and senior secondary care doctors to take a central role in planning and developing clinical services, and work collaboratively to deliver real benefits for patient care.

When developing clinical services that operate across primary and secondary care, decisions made in one part of the service can have a significant impact elsewhere and it is vital to have a joined-up approach. GPs and senior secondary care doctors have a key leadership role, working together to plan and develop sustainable clinician and other services meeting patients' needs.

Working with their patients on a day-to-day basis, doctors have valuable insights as to what works on the ground, where the pressure points are, how resources could be used more efficiently and how clinical pathways could be streamlined to provide more effective patient care in the right environment at the right time.

One area in which senior secondary care doctors and GPs could work together to develop more effective and efficient patient pathways is in care of the elderly. Due to demographic changes, this is a service in which demand is increasing rapidly, resources are already stretched, and where despite repeated efforts, there remains a great deal of room for improvement in terms of service integration across primary, community and secondary care, and particularly between health and social care sectors. Different ways of working may result in aspects of health and social care being delivered by different parts of the service, and it will be important to ensure that funding and resources reflect that. It is clear from its "Reshaping Care for Older People" programme, and the work around the NHS Highland pilot that the Scottish Government recognises the need for major change in approach to how elderly care services are delivered, particularly to reduce unnecessary and potentially harmful interventions and hospital admissions and doctors are keen to play a leading role in this work.

The obvious route for medical engagement should be through CHPs. Whilst the BMA has been critical at times of CHPs, believing that other management structures might be more effective, we are keen to avoid, if possible, a major reorganisation which would potentially be disruptive and expensive. The key therefore is to refocus CHPs and reinvigorate them by re-engaging doctors from primary and secondary care to provide professional input into service development and delivery, outwith or alongside, current medical management structures. To that end, the BMA will seek to constructively engage with the Scottish Government on its plans to review CHPs and create 'Health and Social Care Partnerships'.

While the reform of CHPs (or their replacements) is our preferred option, if they cannot be refocused in a way that re-engages the medical profession, then alternative ways of providing the necessary local fora for medical leadership would need to be considered. One alternative approach could be to establish health board-wide "clinical service development boards" largely composed of senior secondary care doctors and GPs. Unlike the professional advisory structures that exist within NHS Boards (e.g. Area Medical Committees and Area Clinical Fora), these would need to be decision-making bodies, charged with making a formal recommendation to the NHS Board, probably at the level of an individual service e.g. elderly care.

Challenges for the integration of health and social care services

Whilst BMA Scotland sees potential benefit in integration, the potential for an adverse impact on healthcare is not hard to see. Unmet need in social care is likely to result in greater pressure on primary and secondary health services. This pressure may come in the form of higher hospital admissions, delays in discharge from hospital and increased pressure on A&E and GP services.

As well as the impact on health services, the BMA is also concerned that local authorities may need to use health funding to meet the costs of a significant amount of social care provision, long before any resultant benefits in health are realised. The impact of the current financial cuts on social care is likely to be considerable, and this could take a toll on NHS funding if resources are shared. The difficulties in creating seamless integration between health and social care in a tough economic environment should not be underestimated.

Whilst international comparison shows that an integrated, more local approach can yield substantial benefits for the public, it should also be remembered that much of the work that has already been done in other countries has occurred in different economic circumstances to those we face now, and over a long period of time. The cost of implementing changes is an inescapable element to considering how successful reform will be now and lessons from around the world must be considered only in light of the current fiscal circumstances, and the different cultures and structures that exist in other countries.

For joint working to be effective, the responsibilities of all entities will need to be clear. Joint working and service integration is not about indistinct boundaries between organisations; rather the opposite is required for organisations to provide seamless care. Uncertainty about where specific roles are assigned could cause service failures, and instances where individuals 'fall through the gap' between one service and another.

While all services provided by the NHS are free at the point of access, some social care services are charged for on an individual basis. For this reason, the BMA urges a clear definition of social care, as it is vital that the public and local authorities are aware which services will be provided by the NHS.

In developing policies, the parties should consider that enforced structural change can be counter-productive to joint working. It is important that the Committee acknowledges that integration is not only about structural change, which can be massively disruptive and expensive. Instead the focus should be on providing seamless services for the service user/patient. This can be achieved in ways that do not require structural change, but cultural change and it is important

that all options are considered to ensure effectiveness and positive outcomes for patients and service users.

Whilst national government should set the policy direction and parameters, good local working across health and social care could be better supported by decreasing the impact of central burdens on local innovation. There is a danger of unintended consequences associated with integration – breaking down structural barriers in one area could inadvertently recreate barriers elsewhere in the system.

In moving towards genuine integration, the significance of the difference in cultures between the health and social care sectors cannot be overlooked – this has been a factor in the difficulties previously experienced in integrating services in Glasgow, for example.

Conclusions
Demographic change and financial constraints are placing immense pressure on NHS and social care services in Scotland. In particular, there is a need for an honest political debate about how elderly care provision is going to be adequately resourced, across both health and social care.

There is an urgent and growing need for well-informed, strategic decision making on what patient services are needed locally and how they can best be delivered. This is an area in which senior doctors in secondary care and GPs have the knowledge and leadership skills required to take on a crucial leadership role.

In moving towards genuine integration, the significance of the difference in cultures between the health and social care sectors cannot be overlooked.

MEDICAL LEADERSHIP IN THE DEVELOPMENT OF CLINICAL SERVICES
- A BMA Scotland position paper

1. Medical development of clinical services
Financial constraints and demographic changes are placing increasing demands on shrinking resources in the NHS and local authorities. There is an urgent and growing need to improve decision-making on what services are needed locally and how they can best be delivered. Now more than ever, the NHS needs to effectively harness the unique skills that doctors have, by enabling GPs and senior secondary care doctors to take a central role in planning and developing clinical services, and work collaboratively to deliver real benefits for patient care.

When developing clinical services that operate across primary and secondary care, decisions made in one part of the service can have a significant impact elsewhere and it is vital to have a joined-up approach. GPs and senior secondary care doctors have a key leadership role, working together to plan and develop sustainable clinical and other services meeting patients' needs. Medical academics and those working in public health medicine are also able to provide valuable expertise.

The integrated approach that we have in Scotland through our NHS board structure, and the Scottish Government policy that NHS services should be both publicly funded and publicly provided, are both central to this collaborative approach. This is in marked contrast to the commissioning approach envisaged in England, which is based around a purchaser-provider split and a mixed economy of provision. The difference between the two systems is such that the very term 'commissioning' has become a loaded and rather unhelpful term in the Scottish context. We have also been able to avoid the massive restructuring taking place in England, which is proving to be a major destabilising influence and a significant drain on public finances with no evidence for improved quality of care or any financial savings in the long term.

2. What doctors can offer
There are a number of compelling reasons why GPs and senior secondary care doctors are ideally placed to take a central role in planning and developing local clinical services:

- Working with their patients on a day to day basis, doctors have valuable insights as to what works on the ground, where the pressure points are, how resources could be used more efficiently, and how clinical pathways could be streamlined to provide more effective patient care in the right environment and at the right time.

- The rigorous training that doctors undergo, and the demanding roles that they undertake, require them to regularly take difficult decisions and to take personal responsibility for the consequences of those decisions in a way that is unique within the NHS. This willingness to take decisions and be held accountable for them gives doctors a natural leadership role in any team.

- Doctors have the knowledge and clinical background to understand and interpret often conflicting research evidence, and to ensure that decisions are founded on a solid evidence base.

- Doctors work within a strict professional, regulatory and ethical framework, and are trusted by their patients and the public to design the most effective services within the resources available.

- Medical leadership within NHS Scotland has over the last 20 years concentrated to some extent on developing doctors' roles in managing, rather than developing services. Particularly in times of financial stringency, medical managerial roles have revolved largely around making savings and efficiencies within existing budgets, with a tendency to limit innovation as a result.

- BMA Scotland does not deny the need for medical management of this type, but the role of senior secondary care doctors and GPs in providing professional expertise and input into service development and redesign has become marginalised, and many doctors have disengaged, having found it increasingly difficult and frustrating to involve themselves effectively.

One area in which senior secondary care doctors and GPs could work together to develop more effective and efficient patient pathways is in care of the elderly. Due to demographic changes, this is a service in which demand is increasing rapidly, resources are already stretched, and where despite repeated efforts there remains a great deal of room for improvement in terms of service integration across primary, community and secondary care, and particularly between the health and social care sectors. Different ways of working may result in aspects of health and social care being delivered by different parts of the service, and it will be important to ensure that funding and resources reflect that. It is clear from its 'Reshaping Care for Older People' programme, and the work around the NHS Highland pilot that the Scottish Government recognises the need for a major change in approach to how elderly care services are delivered, particularly to reduce unnecessary and potentially harmful interventions and hospital admissions and doctors are keen to play a leading role in this work.

3. Securing medical leadership
While we believe that putting doctors at the heart of clinical service development is crucial, we have no fixed views on how this is best achieved. Indeed, we are keen to avoid generating bureaucracy and additional costs through unnecessary organisational change.

One obvious route for medical engagement should be Community Health Partnerships (CHPs). CHPs were seen as the means to improve delivery of health and social care in the community and greater integration of primary and secondary care. It was initially intended that CHPs would be clinician-led and supported by managers, would reduce bureaucracy and would devolve responsibility and decision-making to front-line organisations working with patients. Unfortunately this has not happened. Instead, as was highlighted by the recent Audit Scotland report[i] CHPs are largely management-run and bureaucratic organisations and have so far failed to gain the support of GPs and senior secondary care doctors who largely feel disengaged.

Whilst BMA Scotland has been critical at times of CHPs, believing that other management structures might be more effective, we are keen to avoid, if possible, a major reorganisation which would potentially be disruptive and expensive. The key therefore is to refocus CHPs and reinvigorate them by re-engaging doctors from primary and secondary care to provide professional input into service development and delivery, outwith, or alongside, current medical managerial structures.

This would very much be our preferred approach. However, if CHPs cannot be refocused in this way, then alternative ways of providing the necessary local fora for medical leadership would need to be considered. One alternative approach could be to establish NHS board-wide 'clinical service development boards' largely composed of senior secondary care doctors and GPs. Unlike the professional advisory structures, i.e. the AMC and the ACF, these would need to be decision-making bodies, charged with making a formal recommendation to the board, probably at the level of an individual service, e.g. elderly care.

Regardless of how medical engagement is structured, the following aspects are key:

- It is not enough just to see doctors as one group in a range of stakeholders who might have views to offer on how clinical services should be planned and developed. Medical input must not be seen as advice which can simply be taken or ignored – doctors must have a genuine role in decision making. This should not be seen as "doctor knows best" but a recognition that doctors, in leading clinical teams, are well placed to bring the views of their teams to the management and development of clinical services.

- We acknowledge that resources are tight, and many difficult decisions will have to be made. Doctors are willing to take their part in assuming responsibility for these decisions, providing

they have had a genuine role in deciding priorities and designing the configuration of services within budgetary constraints, and are not simply being asked to endorse service cuts that have already been decided elsewhere.

- At the same time, resources must be a key part of the picture. Demographic factors will continue to feed an increasing patient need for services. Coupled with tight public finances, the strain on already stretched secondary, community and primary healthcare and social care services will be ever greater. This will be a particular issue for elderly care services, where under the current model of care efficiency savings alone will not free up the kind of resources required to fully meet anticipated demand. There is a need for an honest political debate about how elderly care provision is going to be adequately resourced, across both health and social care. Doctors in primary and secondary care require time and resources and a meaningful role in leading change in the provision of services for the elderly.

4. Conclusions

- Demographic change and financial constraints are placing immense pressure on NHS and social care services in Scotland. In particular, there is a need for an honest political debate about how elderly care provision is going to be adequately resourced, across both health and social care.

- There is an urgent and growing need for well-informed, strategic decision-making on what patient services are needed locally and how they can best be delivered. This is an area in which senior doctors in secondary care and GPs have the knowledge and leadership skills required to take on a crucial leadership role.

- The provision of services for the elderly in both NHS and social care is one of the most urgent problems facing Scotland and would provide a suitable issue on which to pilot the medical leadership model.

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[i] *Review of Community Health Partnerships*, Audit Scotland, 2011