



## **BGS Scotland consultation response: Scotland Government's Integration of Adult Health and Social Care in Scotland Consultation on Proposals, July 2012**

### **1. About the BGS**

The BGS Scotland is a multi-disciplinary professional membership association that seeks to promote better health and care for older people. We do this by holding scientific meetings, producing clinical guidelines, sharing best practice and acting as an 'expert voice' on the care of older people and promoting better health in older age. The BGS nationally has over 2,500 members including doctors practicing geriatric medicine, old age psychiatrists, general practitioners, nurses, therapists and scientists. For more information please visit <http://www.bgs-scotland.org.uk/>

### **2. Background**

This consultation sets out the Scottish Government's proposals to inform and change the way that the NHS and Local Authorities work together and in partnership with the third and independent sectors. The proposals include changes to how adult health and social care services are planned and delivered, aiming towards a seamless experience from the perspective of the patient, service user or carer. It also outlines improvements to integrating health and social care services which are not limited to older people, but extend to all adult health and social care services.

The consultation asks for views on new legislation that will be introduced in order to enable the changes that Ministers propose.

The consultation ran between May to July 2012.

### **3. BGS overview**

#### **3.1 Context**

There are slightly more than a million people aged 65 and over in Scotland.<sup>i</sup> They make up just under a fifth of the Scottish population.<sup>ii</sup> This population is projected to grow by 62% by 2031. The number of people aged 85 and over will rise by a projected 144% by 2031.<sup>iii</sup>

As the population ages, so does the prevalence of illness and disability. Of the population aged over 65, 40% aged 65—74 have an illness or disability; this rises to 55% for people aged 75—84 and to 67% for people aged 85 and over.<sup>iv</sup> Two in five people in Scotland live with a long-term condition.<sup>v</sup> Many of these are older people. Expenditure on healthcare for older people in Scotland is expected to rise from the current spend of about £4.5 billion to £7.5 billion by 2031.<sup>vi</sup>

The NHS is facing unprecedented financial challenges at a time of increasing demand. Rising to meet this challenge will be complex and difficult. But looking after older people well is cheaper than looking after them badly.

### 3.2 Principles of care

The BGS believes that to treat and care for people effectively, respect their dignity and treat them as equal citizens, the NHS must structure and deliver healthcare on the following principles.

The BGS believes that care should:

- promote independence, and allow older people to live the lives they choose and be fully involved in their care and treatment plans, including at the end of life;
- be holistic and person centred;
- be evidence-based and focused on outcomes, not outputs;
- be based on a full and complete assessment and diagnosis;
- be compassionate and caring;
- be based on need, not age, and promote fair and equal treatment for older people;
- be multidisciplinary, regardless of setting, and integrate the services of health, social and community care professionals to provide a seamless service.

## 4. Credits

Prepared on behalf of the BGS by members of the Scottish Council of the BGS and Tom Thorpe, June 2012. This proposal also was put out to consultation with the membership of the BGS in Scotland.

## 5. Detailed response to questions

**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

We agree that from a service user perspective there are two key disconnects in the system of health and social care; that between NHS primary care and secondary care, and between health and social care.

We can see the argument that there is a financial imperative for change and currently there are some major problems with slow social work responses, even for home care requests.

Older people are the single largest user of NHS services, accounting for for 70% of bed days in NHS hospitals and 60% of admissions<sup>1</sup>. As Bernard Issacs said 'design

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<sup>1</sup> Dr David Oliver, 'Acopia' and 'social admission' are not diagnoses: why older people deserve better', *Journal of the Royal Society of Medicine*, 2008, 101, 168-174.

for the young and you exclude the old, design for the old and you include the young.<sup>2</sup>

## 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

There is lack of detail and there are potential risks and questions with the vision:

1. **Local variation.** Due to diversity within the Scottish health and social services care structure, urban versus rural and variable co-terminosity, BGS Scotland believes that there is a need for some local solutions. Allowing local areas develop local solutions may result in considerable variation in the way services are planned and delivered. This in itself may bring considerable variability in service quality and standards.
2. **Structural reorganisations don't necessarily bring integration.** Evidence from England shows that restructuring health services doesn't in itself bring integration. Additionally, research evidence suggests that successful integration is based on a range of factors including relationships, shared cultures, IT systems and shared end points.
3. **What is the role of the regulators?** It is important that the regulatory activities of the regulatory bodies for both health and social care services (e.g. Care Inspectorate) and health and social care professionals (e.g. GMC) are linked to the vision and that their regulatory activities don't duplicate that of health boards and local authorities.
4. **Too many in hospital?** There is a vague implication within the document that excessive numbers of older people are admitted into institutional care unnecessarily and that, in future, fewer resources should be directed to 'institutional care'. While we support the principle that people should be treated in the community and as close to home where it is clinically safe to do so, the assumption that older people don't need hospitals is potentially detrimental for certain parts of this population. We must ensure the frailest, most vulnerable patients, including those in need of 24 hour care are not let down. Can the Partnerships not decide the proportion of money spent in each area individually?

## 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,

<sup>2</sup> *Glasgow Herald*, 9 March 1989, 24.

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

The complexity of single large health boards such as Greater Glasgow and Clyde interfacing with as many as six local authorities will make integration more difficult. Accountability is still not clear in this context. National outcome measures for health and social care are an ambitious undertaking. The BGS Scotland cautiously welcomes this ambition. It important that they are:

- Simple, straightforward and measurable. They can be applied across different demographics and geographies.
- Evidence based.
- Are supported by robust IT and data systems from which solid and useful management information can be generated to allow quality improvement.
- Focus on appropriate output measures as outcomes. For instance ensuring older people have a comprehensive geriatric assessment could be a potential outcome but it can be seen as an output measure.
- Not seen as an end in themselves and health and social care services are structured to achieve them at the expense of care and the patient (e.g. a tick box culture.)

**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

No comments.

### **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

No comments.

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

Yes  No

Sharing co-terminus areas between health and social care services can help provide better integration: however there may be a case to widen areas in particular circumstances which would be difficult to call without a clear understanding of the context.

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

Yes  No

No comments

**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

It is not clear from the description how exactly the performance management arrangements would work. For instance, how do these arrangements dovetail with the current health and social care regulators that exist.

**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

There will be a need to differentiate between currently funded service provision and current unmet need such as services for younger physically disabled patients, younger patients with movement disorders, etc. Many people of working age who have significant levels of disability or disease (e.g. people with early onset Parkinson's Disease and younger new stroke victims) could benefit from the arrangements proposed for services which may be used by older people. Services need to be determined on need rather than age.

### **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

For example, in a patient with new onset Parkinson's Disease comprehensive, geriatric assessment can provide the correct diagnosis and management plan and avoid premature and unnecessary social care.

**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

There are several examples. The Hospital at Home pilots in Fife, the ASSET Team in North Lanarkshire, geriatricians input to care homes in Aberdeen. In all 3 cases Consultant Geriatricians are directly involved in new community services that are still being evaluated. Our members have significant experience of working in both acute and community settings delivering integrated care. We would be happy to share examples of this work.

**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

There will be significant clinical service risk especially in the secondary care sector at the time budgetary changes are made. Specialist secondary care services for older patients are closely integrated with, and mutually reliant, on other specialist hospital services, principally medical, surgical, orthopaedic and radiological. Many older patients are reliant on these 'acute based' services for access to specialist assessment, reviews and scans that could rarely be provided by any one partnership. The recent significant improvements in the standards of acute care of older patients and outcomes for patients with conditions such as stroke, femoral fracture and Parkinson's Disease could be put at risk as a consequence of unintentional budgetary driven service fragmentation.

### 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

No comment.

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

Yes  No

The jointly accountable officer will probably come from a Health or Social Care background. The key issue would be to emphasis impartiality. The officer needs to be more senior than described or he/she will merely bow to the more oppressive side.

### **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

This is a complex issue balancing the competing interests of the centre and local. The BGS suggest that the Scottish Government develop principles of locality planning (e.g. defining what is meant by duty to consult) for local determination.

**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 word 'duty' could mean many different things to different people. It is suggested that the duty should be made more explicit with principles of engagement and requirements to demonstrate that engagement.

**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?

We are reassured by the stated desire for strong and consistent clinical and care professional leadership as changes are implemented and we are encouraged by the intention to strengthen the role of clinicians within Health & Social Care Partnerships. Recognition of the importance and the potential benefits of strong clinical and professional leadership in local decision-making is welcomed.

However, it is very important to engage local professionals as their input is critical if the plans laid out in this document are to be realised. We believe that it could be

helpful to have a minimum requirement for involvement of health professionals, such as lead geriatrician in each Health Board area.

In engaging health and social care professionals a number of obstacles can be encountered. It is possible to have representation and engagement from a number of different perspectives including organisations (e.g. GPs practices), professions (e.g. doctors, OTs) or organisations (e.g. BGS). Balancing these tensions against getting a balance of opinion which is useful can be complex.

One possible step could be establishing reference group(s) of health and social care professionals which could be virtual or physical and would be a sounding board to answer questions of the local Health and Social Care Partnership. This could aim to represent professional opinion and would be the vehicle for submission of information, evidence or comment, collectively or individually, in response to local plans. This would require resources and support but would be worth considering.

Additionally, professionals (and others) would need to be engaged through clear information on the relevant website.

**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

This is a difficult to determine and may depend on local demography and geography. Using GP practices may a useful planning model in some areas but may not be applicable to all.

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

The extent of devolution of decision making will depend on local circumstances and personnel.

**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 are concerned that localities of 15,000-25,000 will be too small to work efficiently. They would not have sufficient clinical mass for efficient and effective working of key professional personnel. It is understood that similar models in South Wales are based around population clusters of around 70,000.



This proposal would also be likely to be disruptive to delivery of secondary care services. Most acute general hospitals in Scotland serve a population of between 200,000 and 250,000. Therefore each hospital could have up to 10 GP commissioning clusters, each with differing priorities influencing the planning and delivery of secondary care.

**Do you have any further comments regarding the consultation proposals?**

The BGS is delighted to respond to this consultation and looks forward to the published document but it is in the *implementation of the proposals* that will make the difference to the people that many of our members meet, treat and care for on a daily basis in their wards and clinics. We look forward to a robust, measurable and comprehensive implementation plan.

The BGS is currently working on what it considers are national outcome measures for the health and care of older people. It would be delighted to discuss these further with ministers or officials at the Scottish Government.

We believe that some aspects of the consultation document require further clarification and/or consideration. For example:

- On page 12, paragraph 1.5 the term ‘unnecessary’ admissions to hospital is followed in the subsequent paragraph 1.6 by the term ‘unplanned’ admissions. To the casual reader these 2 terms might be considered interchangeable. However they mean different things. The vast majority of ‘unplanned’ admissions to secondary care are a consequence of illness and the vast majority of these are ‘necessary’.
- The proposal that Health Board and Local Authorities will be required to devolve budgets made up from primary and community health, adult social care, and some acute hospital spend to the health and care partnership carries significant risk for hospital services. Specialist older people’s services in secondary care are closely integrated into other hospital clinical services. Attempts to separate portions of secondary care budget for specialist older people’s services could be overly bureaucratic and disruptive, and could have serious adverse impact on other secondary care services.
- While supporting the need for better integration in the interest of service users, we are concerned that the model being proposed is based on the example of Highland Partnership. The Highland Partnership arrangement has only been operational for a relatively short time, and it is too early to draw any conclusions about its cost effectiveness in the longer term. Similarly, Services that are being developed through Change Fund Bridging Finance are only just becoming operational and have not yet been evaluated for cost effectiveness.

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

No Comments

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

No Comments

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<sup>i</sup> There are 5.1million people in Scotland and 1 million aged 65 and over. Compiled from National Office of Statistics, mid-year estimates, 2009.

<sup>ii</sup> There are 5.1 million people in Scotland and 1 million aged 65 and over. Ibid.

<sup>iii</sup> The Scottish Government, *Caring together: the carers strategy for Scotland 2010–2015*, July 2010, 22.

<sup>iv</sup> 'NHS age discrimination "common"', *BBC News*, 27 January 2009, <http://news.bbc.co.uk/1/hi/health/7850881.stm>

<sup>v</sup> Long Term Conditions Alliance Scotland manifesto. [http://www.ltcas.org.uk/policy\\_manifesto.html](http://www.ltcas.org.uk/policy_manifesto.html)

<sup>vi</sup> 'Elderly care is "big challenge"', *BBC News*, 24 March 2010. <http://news.bbc.co.uk/1/hi/scotland/8585451.stm>