

## **Integration of adult health and social care in Scotland**

1. The aims (i) to see more elderly people cared for at home or in home-like settings rather than in central hospitals, and (ii) to produce a far more integrated service than currently exists, so that the recipient would not be aware of administrative or funding boundaries between primary, secondary, social and community care, are very much to be welcomed.
2. The paper proposes a joint funding and administrative model between Local Authorities and their local NHS Region to achieve integration of services. It gives extensive consideration to the accountability aspects of such an arrangement and remarkably little information on how the integration would be achieved and managed. The paper also says very little about how the initial funding contributions from the Local Authority and NHS Region would be decided, nor how the commitments would be maintained or expanded (to meet the anticipated increasing need) in the following years. Given the very different ethos and cultures of these two “sponsors”, their funding modes, working practices and terms and conditions of employment of their respective staffs, achieving effective integration will be a huge challenge. Indeed, it is not entirely clear just which staff from which organisations will be involved in the initial attempt at integration, although a separate Government paper looking at local hospitals suggests that their funding (and presumably functioning) will be committed to the integrated service. (Perhaps where suitable local hospitals exist, they should form hubs around which the service could be organised?)
3. Experience from England (King’s Fund analysis of the integration of adult health and social services in Torbay) suggests that ultimately a unified rather than a joint service better meets the requirements of integration, and although it may be that the staff themselves have to come to realise this conclusion to make it feasible, it is essential that nothing in the Scottish legislation prevents the possibility of establishing unified organisations to commission and/or to provide the integrated service. Given that the consultation paper suggests that different units may wish to operate in different ways, it may even be worth promoting the possibility of some unified units being established from the start as alternative models to the jointly run service.
4. GP practices do not receive extensive mention other than they might form clusters for administrative purposes. Patients at home receiving their seamless support under the new system seem likely to remain primarily under the care of their GP, yet the GP seems to be very much on the periphery of the proposed arrangements. Clearly, the consultation document has been written in a way that tries to take account of the different sensitivities of the Local Authorities, NHS Regions and GPs and in so doing pussyfoots its way around many sensitive areas. However, the nature of the relationship between the patient’s GP and the provider of the integrated care service does merit some specific consideration (it will be crucial for the patient), and should be addressed.
5. The consultation paper encourages a certain amount of local variation in precisely how the integrated service might be organised but in Paragraph 2.1 sets out a vision of a successfully integrated system, the first aspect of which is consistency. Consistency as an end in itself has little value – consistent mediocrity is hardly a vision to inspire

confidence. This raises the wider question of quality of care within the service. The NHS seems to be obsessed with quantifiable targets, which can be difficult to apply to quality attributes. (The consultation paper came out not long before the case of a dementia patient in Aberdeen received some publicity, in which he had been visited by over 100 carers within the last year of his life. That may well have met the “number of visits” target but failed any reasonable quality criteria for a dementia patient.) Minimum standards should be set that each new delivery service should be encouraged to exceed. Excellence should not be discouraged by a fixation with consistency.

6. Paragraph 2.2 points to the effort to achieve partnership working over the last decade. Many patients can point to failings, especially of communication, in the current system. The aim of “going further” should be not be at the expense of achieving the current very limited objectives on partnership, which have still not been met. A particular gulf seems to exist after hospital treatment when responsibility for the patient passes from secondary to primary care. Communication between the two can be poor, and may exclude involving the patient completely. It is absolutely essential that the proposed new system eliminates this failure.