

## Introduction

Age Scotland is pleased to respond to the Government's consultation on health and social care integration. Age Scotland supports the drive to develop an integrated system as it can help improve services for older people. However, we also recognise there are a number of challenges to overcome in seeking to implement this agenda.

For example, while integration can help deliver improved outcomes for older people and possibly lead to reduced costs in the long-term the evidence base for the latter is not yet fully established<sup>1</sup> and many report that integration as a process could lead to increased costs in the short term.

Recognising the lack of authoritative evidence about the outcomes of integration process, Age Scotland has in this response recommended areas where the Government should re-examine its proposals, to ensure they have the greatest impact on health and social care outcomes for older people.

### **Q1. 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 impetus behind health and social care integration has been concerning standards of care faced by older people rather than other health or social care users. Unexpected admission to hospital cost around £1.5 billion – a figure which has not moved in recent years; delayed discharges from hospitals, while falling, remain significantly higher than they were a number of years ago and older people often find themselves shunted between health and social care providers with no single body accountable for their care and wellbeing. The number of people aged 75 and over is expected to increase by 80% in the next twenty years and the challenge remains to address these issues before the associated costs of an ageing population lead to increasing unmet need in our care system and a vast increase in the cost of providing that care.

However Age Scotland is concerned that focusing integration on services received by the over 65's in the first instance before rolling out the process wider will not be the most effective way to improve health and social care outcomes. The 2011 Audit Scotland report into Community Health Partnerships detailed that the incremental approaches to partnership working have led the current position where there is a "*complex and uncoordinated set of partnership arrangements across Scotland*". Age Scotland is concerned that in creating an enabling framework the Government is developing another incremental approach to integration that will lead to social care outcomes varying widely from local authority to local authority, with partnerships working to their own local targets for under 65 services. If the Government does proceed with a staged approach to all adult integration then a clear timetable with clarity about expected outcomes is essential. Otherwise the Government's objective, to have consistency of all social care outcomes across Scotland, will be

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<sup>1</sup> Weatherly H, Mason A, Goddard M and Wright K (2010) *Financial Integration across Health and Social Care: Evidence Review*, Edinburgh: Scottish Government Social Research

undermined.

Further there is a legitimate question about the 64-65 year old tipping point. With almost £690m spent on meeting the health and care needs of 60-64s it is clear that many under the age of 65 have complex health and care needs that may not be best served by the current system. If the Government wants to create a new system to deliver social care then all care users should benefit from this. The creation of an arbitrary line where an individual cannot access integrated service one day and then can the next and having two systems running in parallel would ultimately be confusing to service users and potentially expensive. Recognising the recent figures from the Office of National Statistics that show healthy life expectancy for the over 65's in Scotland is actually falling, there is a clear need for full system integration that can improve the health and wellbeing outcomes for service users before they reach 65. The journey to the improved outcome expected from integration must begin when the person enters the care system not when they turn 65.

**Q2. 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?**

Before discussing the framework proposed there is, missing from the consultation, a coherent set of principles and values to govern change. Every good piece of legislation that has come out of the Parliament has principles that can govern and guide practitioners as they implement it.

Given the progress made embedding human rights principles into previous pieces of legislation it would seem a missed opportunity not to use human rights legislation to fill this void in values. In particular we believe the UN endorsed approach to human rights which generates the following principles is appropriate:

- Participation: Where individuals participate in all decisions about the care and support they are receiving be it participation in the commissioning and procurement of social care services by local authorities or participating in daily decisions about the care and support being received.
- Accountability : Where an organisation is accountable for the delivery of social care services and protection of an individual's rights.
  - Non-discrimination: Where older people rights are protected and there is the realisation that, at times, because of their age, older people are discriminated against in access to services or in opportunities to express their views.
  - Empowerment: Where everyone, including older people, understand what their rights are and how they can claim these rights
  - Legality: All rights are recognised and care service practices and procedures are grounded in human rights law.

Further any set of principles must include independent living. This principle is key to guiding practitioners that the driver behind integration is to ensure that older people are provided with a service that supports them to live for as long as they can in the community. Including this

principle in any Bill would be an important practical step.

Age Scotland is generally supportive of the framework in the consultation. Consistency, statutory underpinning, accountability and leadership are all characteristics that are necessary to develop an integrated system, but they are in themselves not sufficient. Underneath we have detailed a number of further attributes that we believe should be enshrined in the legislative framework.

Given reduced availability of public money and the Government's focus on public service reform as a way to improve the quality and economic efficiency of our public services, consideration should be given to whether prevention should be in the framework of the legislation. This is suggested more widely for adult social care law reform in a Law Commission's consultation submission in England and Wales. Their consultation response states that *"a principle might be based on a requirement that wherever possible support should be provided that removes or reduces the level of help that will be required in the future and builds independence"*. This would also build on the Power to Advance Well-Being that currently applies to local authorities in Scotland since 2003<sup>2</sup>. This discretionary power enables local authorities to do anything they consider is likely to promote or improve the well-being of their area and/or persons in it and the principle of prevention would fall under this power. Further this principle would build on the recommendations of the Christie Commission on public service reform and the work progressed by the Government in creating the Health and Social Care Change Fund.

Building on the recommendations of the Christie Commission and the Social Care (Self Directed Support) (Scotland) Bill, which is currently progressing through the Parliament, Age Scotland believes the framework should also highlight an increased focus on the personalisation of services. The Self Directed Support Bill details that where 1968 Act social care functions are delegated to NHS bodies the SDS Bill's duties will automatically follow alongside the 1968 Act duties. Following the integration of budgets across the country the opportunity will exist for service users across the country to combine **health and social care monies to meet their complex needs**. Although this opportunity exists right now it is seldom taken up. By placing personalisation within the integration framework the Government would highlight that they want older people to take control of their own health and care budgets and allow patients the opportunity to develop bespoke packages of support. This genuine personalisation has the potential to ensure that there is the appropriate level of continuing care after an individual's acute medical need are dealt with.

The Framework would also benefit from articulating the crucial role of the third sector as key partners in care, how the sector is a crucial enabler of integration and how Partnerships must work to support the sector. One of the clearest examples of such an enabler is community transport. Community transport plays a vital role in meeting the needs of many communities; particularly for rural and remote communities underserved by commercial bus routes and for the elderly or infirm who cannot manage the walk to a local bus stop. Community transport services make the difference by facilitating social networks, transporting individuals to medical appointments and allowing people the opportunity to get out of their home. If transport is not available it can result in missed or late appointments and people staying

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<sup>2</sup> <http://www.scotland.gov.uk/Resource/Doc/47237/0028847.pdf>

in hospital longer than they need to. While the ambulance service has a statutory duty to provide transport for people with a medical need to get to and from hospital only patients with a **medical need** are eligible for example, if their condition needs to be monitored or they are not mobile enough to travel any other way. Although NHS boards provide transport for healthcare for people who are not eligible for the Patient Transport Services or for when a patient is not able to get to their appointment or to get home from hospital this still leaves a large number of health and care users who fall outwith the eligibility framework. In these circumstances community transport often fills the gaps and supplies the transport for patients. A person centred framework that highlights the principles of human rights and independent living would be complemented by reference to the community transport sector specifically and the third sector more widely as crucial means to deliver an integrated system.

**Q3. This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?**

The issue of outcome-focused integration is something that must be addressed jointly by health boards and local authorities, and the process must deliver more resources for the community sector to deliver better outcomes for older people.

Given that any integrated system will, by definition, bring two different organisations and cultures together to deliver a shared objective, there is a fundamental requirement that good governance is in place to ensure transparency around decision-making and that there is a robust framework of joint accountability. Age Scotland welcomes the Government proposals on integration but believe any integration strategy must also contain a number of additional features to ensure it is effective, namely:

- Develop a strategy that focuses on measurable outcomes and not institutional processes which are defined and shared by all partners.
- Clear decision making process and accountability built into the structures.
- Reporting systems compatible with partner organisations.
- On-going monitoring of costs and effectiveness of initiatives.
- Commissioning plans based on local need.

However the Charity has its reservations about whether the new joint accountability arrangement will actually lead to a step change in local commissioning plans. Currently commissioning practices for social care are failing to meet the needs of services users and according to Audit Scotland only 11 of the 32 council areas have commissioning strategies covering all social care services in place. And yet few of these strategies examine what local needs is and what the cost and capacity is of providers to supply services. Fundamentally there is a significant gap in the skills and capacity of commissioning agents which needs to be developed further.

The experience of commissioning plans developed through the Change Fund suggest that facilitating a genuine shift towards community based services has to overcome significant cultural and institutional barriers, despite the Government establishing an enabling framework.

- Evidence from the first six months of last year's programme show that only 18% of the current spend had went towards preventative and anticipatory care. 19% went toward hospital and institutional care, 24% went towards support and care at home (some of which could be preventative) and 33% for care at time of transition (e.g. re-ablement, NHS 24, alternative to emergency admissions) and 6% on enablers like workforce development and IT.<sup>3</sup>
- Third Force News carried news of anecdotal reports about a council using change fund money of £1m to buy in social care services from their own in house provider to cover their own budget shortfall and £3m for two years and £2m in year three to purchase care home places.<sup>4</sup>

While Age Scotland's Freedom of Information research has shown that despite the guidance prescribing 20 per cent of funding be allocated for carers services in 2012/13, the reality is much less. There has also been a significant level of monies directed towards institutional homes and, despite its well evidenced preventative nature; few partnerships have allocated any money towards community transport services. For example

- In Aberdeenshire, only £153,000 is being spent on carers services in 2012/13 out of a budget of £1.9m;
- In Angus, only £204,000 is being spent on carers services out of £1.685m;
- In Shetland, only £30,000 is being spent on carers services out of £374,000 in 2012/13, with no money allocated to housing support in 2012/13 compared with £15k the previous year;
- In Angus, £374,000 is being spent on improving hospital discharge Strategy in 2012/13;
- In Aberdeenshire, £90k was spent on an older person communications officer;
- In Dundee, £138k in 2012/13 is being spent on additional support for care homes;
- In Perth, £172k on 2011/12 and then £280k on 2012/13 is being spent on care home placements;
- Lanarkshire NHS spent £250,000 on care home placements in 2011/12;
  - Dundee, East Lothian, Angus, Stirling, Clackmannanshire, South Lanarkshire, Orkney, West Lothian and Shetland councils all failed to include funding for any community transport services in their 2011/12 or 2012/13 Partnership budgets.

Change Fund plans initiated by local partnerships of health boards, local authorities and third sector partners are to invest in preventative services that keep older people out of hospital and residential accommodation. However despite the three partner sign off mechanism, in

<sup>3</sup> Reshaping care: change plans midyear report, October 2011

<sup>4</sup> <http://www.thirdforcenews.org.uk/2011/10/only-intervention-will-rescue-prevention-future-change-funds-need-to-be-managed-better/>

its first year much of the monies were not used to exclusively fund preventative programmes and instead were focused on institutional care. While the process, framework and sign off for the Change Fund is different than for the proposed Health and Social Care partnerships both are attempting to facilitate a shift in commissioning approach and it is overcoming institutional inertia that is particularly problematic.

The consultation also makes reference to engagement with the third sector, carers and service user as part of the locality planning process and that partnerships success will be measured against the seven outcomes detailed in the consultation paper. However Age Scotland believe there is not enough detail on what punitive actions the Government will take to correct the behaviour of any Health and Social Care Partnerships that are not appropriately consulting with external partners and /or not delivering on the outcomes. This process is critical to the Government's ambition to deliver on the national outcomes.

Further, while a guiding set of principles, an enabling framework and measurable national outcomes can provide the necessary structure to deliver an integrated health and social care system, they cannot by themselves deliver improved outcomes for patients, and unfortunately the Government's proposed national outcomes as they stand are un-measurable. The ambitions and commitments proposed in the consultation must be capable of being evaluated against specific, statistically measurable, indicators of success. The application of statistical targets against each outcome is a vital means of enabling Partnerships to adequately plan and resource their obligations under any Act. It will also evidence wider progress with the reshaping care for older people strategy and where more work may be required to meet the shared ambitions.

**Q4. Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?**

Nationally agreed outcomes must be measurable and commissioning decisions must focus on these outcomes and not on any institutional bias or culture. Once measurable national outcomes are developed the Charity welcomes the concept of building them into local Single Outcome Agreements. Age Scotland believes this will help ensure that Community Planning Partnerships are key partners in improving health and social care outcomes and that investment decisions will be made to complement the health and care needs of the local population.

However, as detailed in question 3, the major problem with the current system for commissioning care is that it simply results in poor quality care because there is the lack of quality data on services coupled with inexperienced commissioners. An earlier report on health and social care planning from Asthma UK found:

*“There are serious doubts about the analytical power of commissioners... It will require sophisticated economic, epidemiological, activity and cost modelling to determine what services will be needed over which periods of time and in which settings. Without this, services will change only incrementally – if at all and any imagined benefits for patients or*

*costs will not be realised.*<sup>5</sup>

Therefore, the challenge for the public sector is to provide accurate information on (a) how much is being spent and (b) which services local populations need. Potentially, the Integrated Resource Framework (IRF) developed by the Scottish Government will allow local care partnership to map their respective spends in order that it can be better utilised for the benefit of patients and communities. The Government piloted the IRF model in 4 test sites and reported in July 2012 that, although NHS hospital data on cost and activity is well developed, work is still required to accurately determine social care and community care costs. Most notably data protection and standardisation issues need to be overcome to allow for an accurate and credible analysis of spend.

While the potential of the mapping data to help define, measure and monitor outcomes is recognised it will remain underdeveloped until measuring and consistency issues are overcome. However, Age Scotland recognises and welcomes the IRF as a necessary and appropriate measure to analyse the efficacy of public spending on health and social care. We recommend the Government work with local authorities to resolve the issues raised by the IRF pilots to ensure it improves the commissioning decisions made by the new Health and Social Care Partnerships.

The ultimate goal is to ensure these changes (as well as training for commissioners and the mapping of local need) will lead towards outcome-based commissioning practices becoming the norm across the Scotland, but the IRF model will need to be rolled out nationwide so that informed decisions about the cost and quality of services can be made.

### **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?**

Different masters, separate budgets, parallel structures and different cultures have created a turf war between health and social care. When Age Scotland consulted with its members on the issue of integration, the main concern raised was that older people want to know why the Government cannot provide the same service regardless of the part of the country in which they live. While the means of delivering the service can, understandably, be different from one authority to another; there must be consistency in outcomes, quality and efficiency in every local authority and health board area and accountability up to Ministerial level as an appropriate mechanism to ensure national oversight.

Age Scotland's membership is very supportive of the Government's proposals to ensure shared accountability between local and national level. At a local level older people must have a single point of contact where they can discuss their care and support package and if needed raise concerns about the quality of the service. One simple, local test of accountability to review the effectiveness of service improvement could be around identifying whether people know where to turn to when requesting a care assessment or to look for help when things go wrong and that assistance is given in a timely manner.

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<sup>5</sup> Commissioning Toolkit for long term conditions (Asthma UK; BHF; Diabetes UK)

However the shared accountability between local partners and the Cabinet Secretary for Health is a very positive development which should encourage central government to take effective action where a partnership is under-performing as well as better facilitate the sharing of best practice. Although ultimately it is the relationship between the health board and the local authority and the genuine sharing of accountability that will be the determinant of whether integration delivers better results for older people.

This is why Age Scotland considers the appointment of a single accountable officer for each partnership a positive development. It should allow for local context and circumstance to determine what services are commissioned but still meet national and not institutional outcomes. Tying measurable national outcomes with joint accountability should end the standard method of passing responsibility between two different organisations, with neither acting in the service user's best interest. Indeed it is not possible to disentangle outcomes from accountability and with the new measurable national outcomes being the principal mechanism for determining if we have improved health and social care for older people, the responsibility is shared amongst local authorities, health boards and Ministers.

**Q6.Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?**

Age Scotland does not believe the case has been made at this time for further consolidation of the Health and Social Care Partnership landscape, and recommends that the new Health and Care Partnership mirror existing local authority boundaries. The current lack of co-terminosity between local authority and NHS boundaries could make it difficult for Partnerships to access the accurate high quality localised public health data they will need to commission effectively. Partnership should where possible be co-terminous with local Community Planning Partnership, this will ensure that the work of the local CPP will always be relevant to the Health and Care Partnership, where as a larger partnership would be served by a number of CPPs, some of which are likely to have a cross boundary reach.

Age Scotland believes there can be significant benefits of co-terminosity for Partnerships. This means that GP, public health and local authority priorities and agendas would be largely aligned, this alignment would be underpinned by local single outcome agreements and HEAT targets that span health, social care and health and public health while contributing to national outcomes.

While the importance of structure should not be overstated (and there are other more important features to integration discussed in this paper), co-terminosity is a feature that facilitates co-ordination across organisational boundaries. Over time Partnerships may wish to review the size and scope of their work arrangements and consider if larger boundaries are more appropriate such as one covering health board areas. However we believe that all Partnerships should mirror existing local authority in any legislation.

**Q7.Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?**

Age Scotland members are pleased to see reference to the role of the Third/ Independent Sector, Carers groups and patients in the consultation document, but disappointed to see that voting rights with regards to governance responsibilities are restricted to the local authorities and health boards. Throughout our consultation process with local groups our membership expressed concern about the lack of involvement the third sector would have in governance arrangements in the Partnerships, and considered the proposed voting rights a retrograde step from the existing Change Fund model.

Currently local Health and Social Care Change Funds demand three partner sign off, the reality is that in some case local authorities and health boards use their influence to pressurise the third/ independent sector sign off on change plans. It is in these cases that we have seen change fund monies allocated in-efficiently (see question 3 for more details).

This situation has developed in spite of more inclusive governance arrangements than proposed for the Health and Social Care Partnerships therefore the charity has its concerns that involving only two partners in voting decisions is not the most effective means to sign off strategic commissioning decisions. Although Professional advisers such as Chief Social Work Officer, patient/service users' representation, third sector representation and carers can lobby for particular decisions, without a governance vote they may find their ability to influence commissioning decisions minimal which in turn may lead to a withdrawal from the process. This is of course one of the main problems that CHPs and CHCPs encountered and as such we believe stronger arrangements are needed to ensure wider partners in care outside the statutory sector have a voting voice in governance.

Although it is the responsibility of the third sector to organise itself, Age Scotland believes the Third Sector Interfaces are best placed to represent the third sector within these new Health and Social Care Partnerships. As detailed above engagement from the Interfaces in the Change Fund plans is unfortunately somewhat patchy, therefore there would be a need for the Government to further support the capacity and skills issues of Interfaces so that they can fully meet the roles. The Government has recognised this in providing funding to the Long Term Conditions Alliance to boost the influence and impact of the sector within the Reshaping Care for Older People (RCOP) Change Fund. This funding will provide the following support for Interfaces

- a. provide a central policy, research and evaluation resource to the sector in relation to health and social care.
- b. support sharing of learning, exchange of good practice and 'scaling up' of successful approaches.
- c. build on existing research to provide a picture of the third sector's experience of the Change Fund and reflect this back to the Scottish Government.
- d. develop closer linkage between national and local third sector organisations, including Third Sector Interfaces.
- e. working with third sector organisations to increase the voice of older people and unpaid carers within the RCOP agenda.

This capacity building initiative is necessary but unlikely to be sufficient to ensure Third Sector Interfaces can play a full and authoritative role within the new Health and Social Care Partnerships. Age Scotland recommends that the Government work with third sector partners to identify what the gaps are in the Interface's capacity.

**Q8. 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?**

The consultation has detailed that *“where Health and Social Care Partnerships fail to deliver nationally agreed targets, performance support will be offered and, where critical, put in place to assure the delivery of targets.”*

However except from making reference to the importance of scrutiny bodies there is little detail on what practical support will be offered to any failings of struggling Partnerships. Age Scotland believes the Government must make clear exactly how performance management arrangements will be enacted if Partnerships fail to deliver and what the consequences will be for Local Authority and Health Board leaders. Age Scotland believes there is a clear need for any scrutiny bodies to be better resourced in order to meet the increased regulatory challenge. In the move to introducing at a least one unannounced inspection for all care services the Government increased the budget for the Care Inspectorate. We would expect to see similar undertaking made if the Government retain the proposal to give the Care Inspectorate the powers of performance review for Partnerships.

The success of any arrangements will be driven what resources are available and what the expectations are on Partnerships to improve outcomes. However, the reality is that coordinated actions across partner bodies will take some time to bed in and deliver improvements to the patient experience. There are a number of common issues found in failing partnership working that will have to be addressed by the Government in creating any new integration approach

- Clarity about outcome and timeline for delivery.
- A realistic approach to outcomes.
- The major driver for change.
- Money available to deliver a step change in outcomes.
- Ensuring there is strong local leadership

**Q9. 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?**

Aside from increasing the standards of care for patients the principal aim of the legislation is to provide a national framework for health and social care services to create greater consistency in the outcomes service users receive. Age Scotland's is concerned that allowing individual Partnerships the freedom to choose whether other CHP function should or should not be included in the scope of the Partnership will simply create inconsistency in the delivering and outcome of these services. Empowering all Health and Social Care Partnerships with the same set of responsibilities including health visitors and

mental health teams would provide clarity to service users, their carers and families about where they can access health and care services.

While Age Scotland recognises there is an argument that Partnerships should build on local context and cultures, and different partnership areas will be best placed to determine what additional budget control they should have, we believe such an approach will lead to a confusing health landscape.

However Age Scotland suggests that if there was an appropriate change in governance arrangements to better reflect the third sector then there is a strong case for transferring oversight responsibility for Change Fund plans to the new Partnerships.

The Charity also consider it to be critical that the Government give consideration to what is the most appropriate body to commission community transport services to facilitate increased access to health and social care appointments. In 2011 Audit Scotland report into Health and social care transport said *“Transport services for health and social care are fragmented and there is a lack of leadership, ownership and monitoring of the services provided. The Scottish Government, Regional Transport Partnerships, councils, NHS boards and the ambulance service are not working together effectively to deliver transport for health and social care or making best use of available resources.”* Community transport plays a crucial role in getting people, especially older people to medical appointments and given that the decreasing prevalence of Patient Transport services the role of the third sector will be even more important. While not all community transport journeys are for health appointments facilitating social journey’s has a proven impact on the health and wellbeing of older people, keeping them active and making it less likely they will need more expensive health and care interventions.

Finally as the new Health and Social Care Partnerships will be responsible for (a) the mapping of local need and (b) the commissioning of services it would also be appropriate for the delivery of Self Directed Support services to sit with the new Partnerships. Self-Directed Support options span services delivered by the NHS, local authority and Third/Independent sector and following the integration of budgets across the country the opportunity will exist for service users to combine **health and social care monies to meet the complex needs** (see above).

**Q10. 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?**

As detailed above the success of the new integration model will be determined by how successfully Partnerships map what local need is and commission the appropriate services. The ring fencing of a minimum % fund for the delivery of community based services (in excess of what the local authority is contributing to the Partnership) is welcome and should help ensure that there is not an overt medicalisation of the social care sector. This has unfortunately been the experience in Northern Ireland under their integrated health and care

model, and has curtailed a shift in resources from the acute to the community sector<sup>6</sup>.

We also recommend that the Scottish Government's Joint Improvement Team review whether the Change Fund has successfully catalysed a shift in wider health and social care spend into the community as hoped. Once the review examines all Change Plans to measure (a) outcomes delivered against specific funding streams within partnerships and (b) overall shift in service commissioning as a consequence of the spend, Partnerships will be able to determine how effective specific services are in shifting the balance of care and improving health and care outcomes for older people.

**Q11 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?**

N/A

**Q12. 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?**

Minimum spend direction from Government Ministers would help ensure that there is a focus on community based services. However the Government must learn from the Health and Social Care Change Fund, where guidance about spending 20% of monies on carers' services let alone directly all the money towards preventative services has been ignored (see above). Sanctions and other punitive measures must be enforced where Partnerships misuse money.

Yet ultimately the Joint Accountability Officer requires an evidence base to ensure decisions on spending respond to the local need and are the best value for money. It is crucial that each Partnership conducts this mapping exercise and that the problems inherent in measuring health and social care spend are overcome. Otherwise Age Scotland is concerned that despite guidance about minimum spend being in place Partnerships will continue to commission services that are not reflective of local need and have no significant impact on health and wellbeing outcomes.

**Q13. 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? Q14. Have we described an appropriate level of seniority for the Jointly Accountable Officer?**

See Question 12

**Q15. Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?**

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<sup>6</sup> An evidence base for the delivery of adult services, ADSW, August 2011

While Age Scotland is sympathetic to calls for local determination of priorities there is evidence of a lack of strategic planning being conducted by local authorities and health boards in planning for the health and care needs of their respective constituencies. Audit Scotland identified the following conditions lacking on in social care commissioning plans.

- a) an analysis of need and potential gaps in current service provision.
- b) consideration of quality and what impact services will make to the quality of people's lives, and how these will be measured.
- c) consideration of who might be able to provide the services needed (capacity).
- d) an analysis of costs and budgets for services (both in-house and externally provided).
- e) a summary of any planned improvements or different ways of working – timescales for implementing and reviewing the strategy.

Without having this information available it would be impossible for any bodies to commission the appropriate services. Age Scotland recommends that in addition to addressing the five issues above the Government instructs Partnerships to take the following approach.

- Include third sector representative in the governance of the partnerships with full voting rights.
- Provide a mechanism setting out how users, carers and providers will be involved throughout the commissioning process.
- Training Partnership commissioning staff in the appropriate skills.
- Draw on the results of change fund plans to see how effective different services have been in improving older peoples care outcomes.
- A duty to consult with professionals including GPs, social care staff, inspectors.

**Q16. 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?**

The lack of involvement from GPs is one of the major criticisms levied at existing Community Health Partnerships. It is considered that this is due to a lack of shared vision and priorities about the role of CHP and the lack of control that some CHPs have over budgeting decisions. Currently GPs often go round CHPs and work directly with health boards in order to have influence over budgeting decisions.

However these new Partnerships, which will replace CHP, are unlikely to have the same reputational issues and suffer from lack of engagement. The Government have made it clear that financial authority for decision making and achieving outcome will be devolved to the new Health and Care Partnerships and given that we as a country spend £5bn on commissioning health and care services for older people it is improbable that any GP practice would not want to engage with these multi million pound bodies. The experience of the CHPs show that GP's engage at the most effective level to influence budgeting decision and this will be with the new Partnerships.

Further the consultation speaks to consulting with GP's on the scope of GMS contract. Age Scotland welcomes this and believe any review of this would allow the opportunity to attached conditions about engaging effectively with the new Partnerships. However we also recognise that engagement from GPs will only likely to be sustained if Partnerships genuinely consult with outside bodies about how to best meet local need.

**Q17. What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?**

**Q18. Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?**

**Q19. How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?**

**Q20. 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?**

U/K

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

Age Scotland has called upon the views of our local member groups to inform the comments in this submission. While the feedback from panel members about the Government's proposals has been mostly positive, members have also raised a number of key issue which they feel have not been fully reflected in the Governments proposal. Ultimately while Age Scotland welcomes the consultation paper we and our local groups believe that it unfortunately sits in isolation and fail to address some of the wider issues about older people's care. Unless the remit of the Bill is extended beyond simply creating new Partnership and governance arrangements for these then the Government will fail to materially improve the standard of care for older people and shift the balance of care into community.

### **1. Care cost caps and finance**

One of the principal failings of both the Self Directed Support Bill and the proposed Health and Social Care Integration Bill is that there has been no discussion about the sustainability of funding of the health and care sector over the next 5 to 30 years. In England, in 2011, the Dilnot Commission produced a report that examined the financing of social care, including what contribution would be necessary from the individual, the State and what - if any - role there would be from the insurance sector. This report was drafted in response to three specific problems:

- People are unable to protect themselves against very high care costs.
- The currently, very limited, availability and choice of financial products to support people in meeting care.
- The current system eliminates any saving incentive, as individuals will get support from the state if they have little in the way of assets.

The report recommended an increase in the threshold for means-tested support to rise from £23,250 to £100,000 and that people should contribute a standard amount to cover their general living costs in residential care of between £7,000 and £10,000 per year up to a lifetime maximum of £35,000. It was considered that the cap on cost would create a market for social care insurance to guard individuals against having to sell their assets to pay for care. This proposal would cost an additional £1.7bn a year, and the UK Government included a draft Bill examining these issues in the Queens speech in June 2012.

While these proposals would clearly add to the overall cost of social care in England, it would create a greater stability and understanding about the expected contribution from both the state and the individual. In Scotland, the debate has been about improving outcome for patients and, while that is welcome, without sustainability in the funding model we will find that these outcomes are impossible to achieve. However, the Scottish Government have an opportunity when drafting the Health and Care Integration Bill to consider the wider funding system for care. Age Scotland encourages Ministers to make a Scottish response to the Dilnot report, specifically if there are any plans to review means-tested support thresholds or introduce a care cost cap.

## **2. Community Care Charging**

Age Scotland believes that social care services should be provided free at the point of delivery to people who need them. Such a system would provide consistency, clarity and equity in access to care and would avoid the discriminatory, unfair and resource-intensive means-testing and charging practices inherent within the current charging framework.

Recognising council are unlikely to abolish charges in their entirety Age Scotland and other disabled and older people's organisations have for the last year worked with the Convention of Scottish Local Authorities (CoSLA) on improving the guidelines on implementing community care charges. However the group is yet to agree guidance that would compel councils to provide greater consistency on

1. Services against which charges are levied
2. Levels of charges
3. Financial assessment used to determine charges
4. Eligibility criteria for services

Age Scotland support the introduction of more consistency and **uniformity** in local authority charging for social care services. Given there are thirty two separate local authorities delivering social care in Scotland, each with its own services and charging regime, it is inevitable there will be differences in the delivery – and even quality of social care – for users, depending on where they live. For a number of years, this has meant care users have been charged significantly different amounts depending on where they live. This local flexibility can undermine the desires of older people who need care services but are penalised by inequitable pricing and standards across the country as well as impacting on the portability of service users who are unaware about potential service charging costs of different local authorities. While recognising the inevitable tension between localism and equality Age Scotland members are clear that they support a greater equalisation and

uniformity of standards and charging rather than allowing diverging structures to be created in neighbouring local authorities.

Age Scotland believe that if the CoSLA care charging working group is unable to agree on terms the consistency of new guidance then the Scottish Government should use its powers under the Community Care and Health Act (Scotland) (2002) to prescribe **national eligibility criteria** for social care in the four areas detailed above. This would mirror the Charging for Residential Accommodation Guidance regulation which is issued annually to provide the framework for local authorities to charge for care that they provide or arrange in residential care homes.

Age Scotland would welcome the opportunity to contribute to a drafting of a non-residential CRAG. In particular the charity believe that putting a national weekly limit on the maximum costs people may face, as is the case in Wales, will allow individuals to plan ahead around how they might wish to meet their future care costs.

### **3.Older People's Housing**

Nowhere in the consultation is there a mention about the role of housing and adaptations to support older people to live independently but in line with our recommendation that independent living should be one of the principle underpinning any Bill, there is a need to make linkages for housing and adaptation services.

The 'Impact of Population on Housing' report published in 2010 <sup>7</sup> demonstrated that, all things remaining equal, the overall number of pensioner households requiring adaptations will rise from 66,300 in 2008 to over 106,000 in 2033. Furthermore, in order to maintain current ratios of provision to probable need, the combined numbers of sheltered and very sheltered housing stock will need to rise from 38,000 in 2008/9, to 45,900 in 2018 and to 61,400 in 2033, an increase of 23,400 units over the period. However, while we have data about the increasing pressures on local housing stock, the Government response to this problem has unfortunately been sub-optimal.

While Age Scotland welcomed the older people's housing strategy in December 2011 and worked with the Government to develop it, we remain concerned that the laudable content of the Strategy will not be put in to practice on the ground. Without the establishment of specific and measurable targets, the vital proposals of the Strategy will be reduced to mere recommendations upon which there will be little or no real compulsion for local authorities to act. Furthermore, we feel the lack of such directives or compulsion will lead to a 'Post Code lottery', with each council interpreting the Strategy differently, leading to 32 versions of the vision across Scotland. This, arguably, runs contrary to the Government's stated outcome of providing "a clear vision for housing for older people in Scotland", and will ultimately be detrimental to the interests of Scotland's older people. The lack of additional money further undermines the Government's vision of developing an effective and comprehensive national older people's housing strategy. Without additional money being available, local authorities will be unable to deliver much – if any – of the ambitions set out in the Strategy.

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<sup>7</sup> [www.scotland.gov.uk/Publications/2010/07/20125707/1](http://www.scotland.gov.uk/Publications/2010/07/20125707/1)

There would be a benefit to housing outcomes if (a) the development of and (b) the funding for local older people's housing strategies is included as part of the new Partnerships remit. Investment would provide an incentive to Partnerships local authorities to establish local housing plans which matched the Government's ambitions.

#### **4. Care Staff**

Age Scotland believe that – as a matter of urgency – the appropriateness of care staff selection, training, re-training of personnel and their financial remuneration must be examined. For example care home service providers are permitted to choose the type of care they provide – personal care, personal support or nursing care. They do not have to provide nursing care which means that staff responsible for the care of older people may be under skilled in supporting older people with **all** their care needs.<sup>8</sup> Care homes registered to provide nursing care only have to provide one qualified nurse on duty twenty-four hours a day to carry out nursing tasks.<sup>9</sup>

Age Scotland believe there is a need to drive up standards across all care services. Indeed The National Care Standards were introduced in 2001 and have not been reviewed since then. A full review of how to improve health and social care outcomes must consider the standards to which staff are working to, their working practices and their salaries. For example we suggest that in care homes outcomes could be in part improved by ensuring a higher minimum percentage of staff were registered with the Nursing and Midwifery Council to practise as nurses and include access to specialist nurses such as dementia nurses for care homes where dementia is prevalent amongst residents. Age Scotland would be pleased to work with the Government examining the issue more widely.

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<sup>8</sup> Parliamentary Question S2W -14392

<sup>9</sup> [http://www.careinfoscotland.co.uk/what-care-do-i-need/care-homes.aspx#Types\\_of-Care\\_Home](http://www.careinfoscotland.co.uk/what-care-do-i-need/care-homes.aspx#Types_of-Care_Home)