Integration of health and social care

BMA Scotland

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 [insert ref to Audit Scotland report] 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

**Barriers and enablers to more joined up care pathways**

In December 2011, the BMA published an interim report on “Doctors’ perspectives on integration in the NHS”. This report contained the findings of two surveys of BMA members to uncover their views and experiences of integration. It should be noted that although this report is a UK-wide document, it is set against a backdrop of a very different health care system in England and many of the recommendations reflect the situation in England. Nevertheless, some of the findings of this report are equally applicable to the Scottish situation.

The surveys of doctors found that:

- Conflicting organisational priorities is the most important barrier to achieving joined-up care pathways (47.8% of respondents)
- A lack of coherent IT systems was considered a further barrier (19.2% of respondents)
- A collaborative culture is considered the most important enabler to achieving joined up care pathways (29.9%). Good professional relationships (28.2%) and effective clinical leadership (26.8%) are the second and third most important enablers.
- The most frequently cited reason as to why pathways are not more effective was poor communication between organisations and professionals within them. Buy-in and engagement were also identified as problems. This suggests that pathways alone are not sufficient; it is the relationships within them that make them work.
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.

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