RC GP SCOTLAND

RCGP Scotland response
Proposed Commissioner for Older People (Scotland) Bill consultation

1. Which of the following best expresses your view of the proposed Bill? Please note that this question is compulsory.

χ Fully supportive
χ Partially supportive
χ Neutral (neither support nor oppose)
χ Partially opposed
χ Fully opposed

Please explain the reasons for your response.

RCGP Scotland welcomes the opportunity to respond to this consultation. We exist to promote and maintain the highest standards of patient care. GPs are at the forefront of the delivery of improvements in the care of older people.

The College largely supports the proposal for the establishment of a Commissioner for Older People and agrees that this role would have the potential to proactively add to both discourse and policy action regarding Scotland's older people.

The Scottish population is undergoing distinct demographic change. Older people comprise an increasingly large portion of the Scottish population and this demographic shift has and will continue to impact on the healthcare system as it responds to the needs of this cohort of patients and the steep rise in multi-morbidity associated with age[i]: *"People aged 65 and over outnumber people under 15. It is important that we understand how our population is ageing so we can prepare for it. These changes will put greater demand on health and social care services."* (Jon Wroth-Smith, Director of Census Statistics, National Records of Scotland[ii]). The increase is not only in the old but in the very elderly where care needs are highest.

Primary care provides the vast majority of medical care to older people. The ideal care, particularly for the elderly, is accessible, holistic, close to home, and with familiar people. Continuity of care in general practice has been shown to be preferred by the older age group and has multiple proven benefits including reducing mortality and avoidable hospital admissions[iii] as well as reducing overall health service costs[iv]. All of this is offered through GPs, but to effectively deliver this a more joined-up approach particularly to wider services and specialist care is needed.

Care for older people entails greater complexity, and it must be recognised that it is reliant on a static and over-stretched GP workforce. Community nursing teams, community-based allied health professionals and social care workers are also working well over their limits. The Scottish Government's 'Reshaping Care for Older People 2011-2021' outlined that there needed to be a shift to community services. Instead, between 2013 - 2019 consultant numbers increased by 24%, whilst GP numbers remained essentially unchanged.[v] [vi] There has been a profound lack of data and need-informed workforce planning, which will now hamper our care in this area.

There are also inadequate support services in the community for caring for the frail elderly and those with complex health needs. Physiotherapy improves mobility, reduces falls and helps recovery from respiratory illness; good podiatry services mean people can safely maintain mobility and so these services are crucial in avoiding diabetic complications; similarly, occupational therapy can be a lifeline in helping individuals maintain their health and social independence.

Social care sits alongside healthcare in supporting people to remain at home and living as independently as possible: an excellent interface at both strategic and operational (grassroots level) is critical but often missing. In our feedback to the National Care Service consultation, we welcomed the possibility that the NCS might strengthen this (though also had major concerns that this might not happen, particularly for those working at the frontline). A Commissioner for Older People could usefully focus on improving that interface now, which could result in better services in the short term and support planning for the NCS should those proposals be taken forward.

Community (district) nurses are the vital support service for the ill in the community, however there are at present extensive workforce shortages, sometimes with that work then being picked up by general practice. Community nursing is another key workforce to care for our growing elderly population and so its capacity requires expansion through an enlarged workforce. In 2011 the King's Fund identified that council and social services were key to the achievements of those Health Authorities with the lowest emergency bed use in the over 65s[vii], yet delayed discharges and avoidable admissions for those struggling to maintain function in the home setting are still dominant in the Scottish NHS. That paper also showed that a single multidisciplinary team worked best, including both for emergency admissions and discharge planning. Still, GPs, already carrying a workload that exceeds their capacity, are often faced with having to make multiple separate referrals for an unwell or frail older person that they are trying to support in the community to avoid the harms of unnecessary hospital admission. GPs sometimes arrange admission simply because other options are not in place. Our health service design has failed to keep up with the evidence of what leads to positive outcomes for patients.

GPs and their teams are vital to the management of multimorbidity and polypharmacy, both of which are crucial for both better health and enhanced quality of life in older age. 'Realistic Medicine' is also essential. However, shared decision making, and other aspects of Realistic Medicine (especially when sitting alongside profound complexity or frailty)

are very worthwhile but time-consuming work; general practice must be properly resourced to undertake this area of care. Anticipatory care and frailty management are emerging themes of caring for older people but require an expanded primary care and that all specialties have a generalist perspective.

A Commissioner would ideally also help specialist care adapt to the aging population who form a large proportion of those admitted to hospital, particularly as emergencies. We know that hospitalisation when prolonged is profoundly damaging to older people, especially those with dementia, and we need to make not only the primary and community care adjustments and expansion necessary to ensure that does not needlessly happen. Hospital processes must be adaptable to support the change we crucially need. We believe a Commissioner should be able to consider and address these issues at a high strategic level and recommend the adjustments which have not been made to date. Doing so would not only improve the health of older people but would also support NHS and social care sustainability, too.

We are also aware from our everyday work as GPs of how difficult life often is for older people. Many in this age group felt especially isolated during the Covid lockdowns and feel that many of the services emerging since then are most easily accessed by those who are more technologically confident and adept with phone or IT services. We are aware of the role general practice plays in ensuring our patients are able to access and utilise these services effectively. We recognise that many older people have additional burdens of bereavement) or ill health as a result of the pandemic, and subsequent cuts to primary and social care budgets have hit them hard.

During the most restricted pandemic times GPs could not offer routine chronic disease management and feel that we are seeing the fallout from that now in terms of generally poorer health amongst the population, and with workforce shortages in the general practice team now making it difficult to always offer the care that is needed. The cuts in primary care mental health budgets will also have negative consequences for the elderly, as well as other sectors of the population. Much of the extended multi-disciplinary team expansion, which failed to be fully implemented, with subsequent withdrawal of underspend monies limiting further development, would have supported elderly care: ANPs who have been shown to successfully support anticipatory care planning, including in care homes, Advanced Physiotherapy Practitioners maintaining physical mobility and health, and pharmacotherapists rationalising prescribing and especially polypharmacy and de-prescribing. All these primary care roles are recommended in Scottish Government's healthcare framework for adults living in care homes[viii], yet removing the PCIF underspend funding will inevitably cut that current and future capacity.

Supporting older people and signposting to third sector services is one area in which Community Link Workers can make a significant difference. RCGP Scotland calls for the rollout of Community Link Workers (CLWs) to all practices in Scotland, prioritising initially those practices serving populations with the highest levels of deprivation. It is increasingly recognised that loneliness is a public health problem, requiring societal

approaches[ix] and that loneliness in the elderly is associated with depression (with the use of link workers being a recommended approach to address this)[x].

The support of a Commissioner would be welcome in improving the patient journey for older people. Growing old impacts the type of care an individual may need and it can also create new challenges in regard to access, digital exclusion, health inequalities, loneliness and other aspects of care. A Commissioner to represent the interests of this sector of the population and influence policy to ensure their needs are considered would be a welcome step.

GPs work closely with their specialist colleagues, especially Medicine for the Elderly and older people's mental health teams. For complex care for the frail elderly, it is crucial to have joined up working and this is the clinical area that would be especially well supported by better interface working and interface groups. All too often pathways are multiple and fragmented, despite long-available evidence that a more unified approach brings benefit. Interface working allows for the optimisation of patient journeys, including admission and discharge. This is key to sustainability, and we would like to see the Centre for Sustainable Delivery (CfSD) taking a strong lead in this area, particularly for care across the interface. It is for this reason that RCGP Scotland would like to see mandatory interface groups established in each Health Board area.

The factors that can prevent frailty and support 'person-centred care planning' are broad, but considering and actioning them would also enhance the lives of people of all ages, and especially those living with disability.

It would be crucial for the Commissioner to make recommendations with a holistic understanding of both the Scottish NHS and social care system, as well as the interface between these systems. We know from the evidence that there is much to be done in terms of prevention and 'upstream' work to support older people's health. This includes transport (the very elderly are less likely to drive and to avoid worsening inequalities that means we need good public transport), but also active transport throughout life as fitness and activity. A strong Commissioner would develop understanding and change in these areas: cross-departmental and sector work would be key.

We would hope that the introduction of a Commissioner for Older People could support the need for strategic NHS and wider workforce planning with Scotland's demographic in mind. The implementation and functioning of the Commissioner would benefit from close working with primary care. We recognise that there is a generic issue round the expansion of Commissioner posts, including that they may recommend new work (including by the health service), without appropriate consideration given, or influence over, the resources needed to fund or support such services. We are also aware that the necessity for a cross-sector approach may enhance but also dilute the role and that they may duplicate the work of existing bodies. We suggest that the outcomes and cost-effectiveness of Commissioner roles be under regular review to ensure they are delivering upon their investment. Generally, however, our feeling is that many have proved worthwhile.

It appears sensible to draw upon the experience from Wales and Northern Ireland and it would be beneficial to liaise withs stakeholders including RCGP Wales and Northern Ireland to learn what, if any, the commissioner's impact on general practice has been. and whether their suggestions and other recommendations have been integrated successfully. Our feedback is that their versions of older people's commissioners, while by no means 'silver bullets', have operated well alongside services and have supported the deployment of resources towards older people in a helpful way.

2. Do you think legislation is required, or are there are other ways in which the proposed Bill's aims could be achieved more effectively? Please explain the reasons for your response.

If an older people's commissioner is introduced, it would make sense for this to be done in a manner consistent with the nature of the Patient Safety Commissioner – we outlined some details in our response to that consultation.

3. Which of the following best expresses your view on whether there is a need for a specific, dedicated Commissioner focusing solely on older people's rights and interests?

χ Fully supportive
χ Partially supportive
χ Neutral (neither support nor oppose)
χ Partially opposed
χ Fully opposed
χ Do not wish to express a view

Please explain the reasons for your response, including your views on the list of proposed functions set out between pages 29 and 32 of the consultation document, and any additional functions you think the commissioner should have.

As we stated in our response to question 2, if an older people's commissioner is introduced, it would make sense for this to be done in a manner consistent with the nature of the Patient Safety Commissioner.

4. Which of the following best expresses your view on the age range of the proposed Commissioner's remit covering all those in Scotland aged 60 and over?

χ Fully supportive
χ Partially supportive
χ Neutral (neither support nor oppose)
χ Partially opposed
χ Fully opposed
χ Do not wish to express a view

Please explain the reasons for your response.

Focusing on older people who are frail, rather than those at a certain age, will ensure the benefits of the Commissioner are available for everyone and also reflect health inequalities too. Multi-morbidity occurs 10-15 years younger in the most - compared to the least - socioeconomically deprived in the Scottish setting, with profound consequences for health life expectancy.[xi]

The poorest in society aged in their mid to late 50s will have the frailty and limitations of people 20 years older, and that needs to be reflected, and would largely be by this definition. We would like consideration given to those populations - mainly those living in poverty - who are under 60 but have the life and health problems and limitations of someone much older. Considering, for instance, the burden of disease methodology (with its emphasis on disability-adjusted life years)[xii] would be one way of capturing that demographic group.

5. Which of the following best expresses your view on whether the proposed Commissioner should hold powers of investigation?

χ Fully supportive
χ Partially supportive
χ Neutral (neither support nor oppose)
χ Partially opposed χ Fully opposed
χ Do not wish to express a view

Please explain the reasons for your response including how the powers of investigation would work in RCGP Scotland largely supports the proposal for the establishment of a Commissioner for Older People..

We would welcome the proposed powers to lead investigations and would consider these crucial to the effective delivery of the ambition to drive improvements and secure outcomes for older people. The scope and limitations of these powers would, however, need to be expressly clear.

6. Given a number of other bodies have similar functions to some of those proposed for the Commissioner, which of the following best expresses your view on whether the proposed Commissioner's work can avoid duplication with existing officeholders?

χ Strongly agree
χ Tend to agree
χ Neutral (neither agree nor disagree)
χ Tend to disagree
χ Strongly disagree
χ Do not wish to express a view

Please explain the reasons for your response, including any views on how the Commissioner and existing officeholders can operate to ensure they do not replicate each other's work.

As noted above, an important consideration would be to ensure that the initiation of this new position not add needlessly to workload or oversight of the healthcare sector where it can be avoided. However, we do believe that the voice of older people, and the addressing of their needs, is not always heard or accounted for and the Commissioner would fulfil a unique role. They would also have a particular cross-sector view which we do not feel is necessarily maintained by other bodies.

Determination of the need for investigation by the Commissioner should draw upon actions, events or occasions in which older people were uniquely and adversely affected. Occasions in which there is a secondary impact, or when older people are only tangentially involved should not be investigated by the commissioner where other pathways are available for inquiries or action.

7. Which of the following best expresses your view on whether the proposed Commissioner should be independent of Government?

χ Fully supportive
χ Partially supportive
χ Neutral (neither support nor oppose)
χ Partially opposed
χ Fully opposed
χ Do not wish to express a view

Please explain the reasons for your response, including any views on what the accountability and governance arrangements should be for the Commissioner.

Again, consistency with the model of the Patient Safety Commissioner would be sensible here.

8. Any new law can have a financial impact which would affect individuals, businesses, the public sector, or others. What financial impact do you think this proposal could have if it became law?

χ a significant increase in costs χ some increase in costs χ no overall change in costs χ some reduction in costs
χ a significant reduction in costs
χ skip to next question

Please explain the reasons for your answer, including who you would expect to feel the financial impact of the proposal, and if there are any ways you think the proposal could be delivered more cost-effectively.

N/A

9. Any new law can have an impact on different individuals in society, for example as a result of their age, disability, gender re-assignment, marriage and civil partnership status, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

What impact could this proposal have on particular people if it became law? If you do not have a view skip to next question.

Please explain the reasons for your answer and if there are any ways you think the proposal could avoid negative impacts on particular people

N/A

10. Any new law can impact on work to protect and enhance the environment, achieve a sustainable economy, and create a strong, healthy, and just society for future generations.

Do you think the proposal could impact in any of these areas? If you do not have a view then skip to next question.

Please explain the reasons for your answer, including what you think the impact of the proposal could be, and if there are any ways you think the proposal could avoid negative impacts?

N/A

11. Do you have any other additional comments or suggestions on the proposed Bill (which have not already been covered in any of your responses to earlier questions)?

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[i] Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie. The Lancet: DOI:10.1016/S0140-6736(12)60240-2. 10 May 2012.
[ii] https://www.scotlandscensus.gov.uk/2022-results/scotland-s-census-2022-rounded-population-estimates/
[iii] Improving access and continuity in general practice. Practical and policy lessons. The Nuffield Trust. Palmer et al. November 2018.
[iv] Innovative models of general practice | The King's Fund (kingsfund.org.uk)
[v] https://www.gov.scot/publications/reshaping-care-older-people-2011-2021/documents/
[vi] Data Tables | Turas Data Intelligence (nhs.scot)
[vii] 6. King's Fund, Data Briefing, Emergency Bed Use – what the numbers tell us. December 2011.
[viii] https://www.gov.scot/publications/health-care-home-healthcare-framework-adults-living-care-homes/
[ix] We need a public health approach to loneliness | The BMJ
[x] Loneliness is strongly linked to depression among older adults, a long term study suggests | The BMJ
[xi] Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie. The Lancet: DOI:10.1016/S0140-6736(12)60240-2. 10 May 2012
[xii] Scottish Burden of Disease study, ScotPHO : https://www.scotpho.org.uk/media/2178/sbod-forecasting-briefing-english-november2022.pdf