Health and Social Care Strategy for Older People

Analysis of Consultation Responses

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Scottish Government
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Contents

1. Background

The Scottish population is ageing and in 2020, there were an estimated one million Scotland residents aged sixty-five years or older. By 2040, this will rise to an estimated 1.4 million, or 25% of our population[1] . Older age offers great opportunities for us as individuals, for communities, for society and for our economy. Older people provide a valuable contribution to our society through employment, spending, volunteering and often through unpaid caring.

However, older age can bring disadvantage too. Currently in Scotland people aged over 70 years live with an average of three chronic health conditions[2] [3]. People aged 65 years and over account for 70% of emergency admissions to hospitals. Over time, older people are taking a greater number of medications, attending more healthcare appointments and being admitted to hospital more often and despite all this, are experiencing poorer health and more delays in discharge than younger people.

Scotland must adapt to our increasingly older population and ensure that older people are afforded the opportunity to age well and be resilient. We need to address inequalities in this age group and support those most in need, no matter where they live.

The COVID-19 Pandemic has shone a spotlight on older people, who were amongst the worst affected by the virus in society. As we rebuild and remobilise the NHS in Scotland, we have a significant opportunity to ensure that older people are at the centre of that recovery and to focus on a preventative, joined up approach to healthy ageing.

It is clear that many older people's health and social care services need to adapt now to ensure that health and social care services can adapt to the increasing ageing population and the complex health care needs that older people can have.

In March 2021, we published our Statement of Intent, setting out our plan to develop a new integrated health and social care strategy for older people. We committed to developing the strategy with older people, and the people and organisations which support them.

1.1 Consultation and Engagement 2021

As we committed to in our Statement of Intent, we have engaged with a wide range of older people from a range of organisations and groups that support them, as well as individuals through a questionnaire which ran from September-November 2021. Due to COVID-19 pandemic restrictions, this engagement took place online. We recognise that this may have led to many older people being disengaged in this part of our engagement – however, this was the initial part of our engagement, and, as

[1] National Records of Scotland Population Statistics - NRS Website
[2] Barnett K et al. Epidemiology of multi-morbidity and implication for health care, research, and medical education: a cross-sectional study. Lancet 2012;380:37-43
[3] Guthrie, B. et al. The rising tide of polypharmacy and drug-drug interactions: population database analysis 1995–2010. BMC Med 13, 74 (2015).

set out later, we will engage further on this consultation paper to ensure we get a wide range of views.

During these sessions we listened and gathered views from attendees on the priorities set out in our Statement of Intent

Views and opinions expressed during this engagement process were used in the development of a formal written consultation paper and the questions within it.

2. Overview of Respondents

The Scottish Government launched its written consultation on a Health and Social Care Strategy for Older People on 8 March and it closed on 27 June 2022. Responses were received via citizenspace (the Scottish Government's consultation platform) and by email.

The consultation process also included 30 online and in person engagement events which took place between May and August 2022. The views from these events are included in this analysis.

A total of 127 responses were received, with 119 of these providing permission for their responses to be published. These were published on 20 July 2022 and are available at Health and Social Care Strategy for Older People - Scottish Government - Citizen Space (consult.gov.scot).

The 127 responses can be broken down as follows:

	number of responses	% of total
individuals	40	31.5%
organisations	87	68.5%
Total	**127**	**100%**

Of the 87 organisations, they can be further broken down as follows:

Third Sector Organisations	34
NHS Health Boards, Local Authorities and Health and Social Care Partnerships	19
Professional Bodies	18
Other Statutory Bodies	3
Other organisations	10

Details of the organisations who responded are included in **Annex A**.

We also held 30 online and in person engagement events as part of the consultation process. Details of these are in **Annex B**

3. Analysis of Responses

There was broad support for the development and overarching aims of the strategy, however a wide and diverse range of views was expressed.

This analysis is structured around the four consultation sections and their consultation questions and also includes points covered at the online workshops.

As this is a wide ranging strategy covering many different policy areas, the majority of respondents did not answer or comment on all of the questions, but instead focused on those most relevant to their specific interests.

Where respondents indicated agreement or disagreement, it should be noted that this was not always supplemented by supporting comments.

3.1 Place and Wellbeing

There were 13 questions within Place and Wellbeing covering:

- Third sector and voluntary support;
- Advice and support on physical health;
- Mental health services; and
- Housing.

Question 1: Do you have examples of communities, voluntary/third sector and public sector organisations working together to improve older people's health and wellbeing and reduce any health inequalities which they experience?

71 respondents answered this question, providing information on the range of services available in their area including door to door voluntary car services providing accessible transport, dementia friendly walking and strength and balance programmes. 32 responses were from individuals and 39 from organisations.

However, it was clear from engagement events that some areas do not have any local services, and examples were provided of older people having to go further afield to access social interaction.

There was also discussion on the fact that many excellent services are provided by the third sector, however these services are over-relied upon, and are not sustainable.

There was a general view that more needed to be done by national and local government to help voluntary and third sector organisations to provide local, targeted services.

Question 2: Thinking about your physical health, what kind of advice and support would you need to help you make decisions about your health, care and treatment?

53 respondents answered this question. 33 responses were from individuals and 20 from organisations.

Access to local physiotherapy seemed to be a particular issue for older people, and if this was more readily available then it would assist older people to remain active.

Social isolation and loneliness was also a factor in older people's health and well-being. Ensuring that older people can access services and resources was an important aspect of this. Also ensuring services were not scattered, making it easier for older people to access services.

From our engagement events it was clear that the majority of older people would contact their GP surgery for advice and support if they experienced a new health problem – with many stating that their GP would be their first port of call.

Other sources of information, advice and support older people accessed prior to visiting their GP included NHS Inform, local pharmacies, and searching the internet.

A reoccurring theme throughout most of the engagement events was access to GPs – whether this was about being able to get a GP consultation, or about how these appointments take place, by phone, online or face to face. The vast majority of older people preferred to have face to face consultations with their GPs, either in the doctor's surgery – or a house call if housebound.

This highlights the importance of GPs and community health provision in supplying people with prompt and good quality information about their health and social care and support.

Question 3: What kind of people or organisations would you like to help you with this?

51 respondents answered this question, 32 responses were from individuals and 19 from organisations. The majority of respondents, online and at engagement events, felt that pharmacies and primary care in the local community were best placed to help with this as they were aware of what was available in local areas, and in the case of primary care they knew their patients well.

Question 4: Thinking about your broader wellbeing, what kind of support and activities would help you to stay socially connected with other people in your community?

51 respondents responded to this question. 31 responses were from individuals and 20 from organisations.

There was a broad range of services which older people use to stay socially connected including lunch clubs, day centres, sports and fitness classes and walking groups. Befriending services were also used by specific communities including disabled and LGBTIQ+ people.

However, there was an issue raised, especially at our engagement events, about awareness of these services and how information is made available to older people on the services which are available – online not being the best option with digital exclusion an issue.

Questions 5: How could local organisations and places such as community groups, cultural centres such as libraries, museums and art galleries and leisure/sports centres, help you with this?

50 respondents answered this question. 31 responses were from individuals and 19 from organisations.

There were many ways in which older people thought that information could be shared ranging from local community notice boards (if in a small rural setting) to the use of local libraries and council buildings.

An issue which was raised throughout the engagement events was accessibility in regard to public transport and buildings. If in a rural community there could be no, or a very infrequent bus service, then older people were having to rely on taxi's or community transport (dial a bus, for example) at a cost. The accessibility of public transport, if available, was also an issue, with older people with sensory impairment having particular issues when trying to access buses.

This was an issue in relation to social interaction, but also in relation to attending medical appointments, at large out of town hospitals, for example.

Accessible parking and access to buildings (street furniture causing issues for people with sensory impairment) was also raised as an issue.

Question 6: If you were worried about your mental health who or which (health or care) services would you approach for advice and support?

50 respondents answered this question (30 individuals and 20 organisations), with nearly all respondents saying they would seek advice from their GP in the first instance if they had any concerns with their mental health.

Older people with diagnosed health conditions may seek advice from specialist nurses or seek the advice of a voluntary organisation which represents their community, LGBTIQ+ for example.

Question 7: What impact do you think the pandemic has had on your ability to access mental health services if you needed them?

There were 51 responses to this question, with 30 from individuals and 21 from organisations. Most respondents commented that the pandemic had a huge impact on the ability to access mental health services, with many older people not able to get GP consultations to have an initial discussion and many mental health services being halted or held online.

The pandemic and the restrictions put in place had a direct impact on older people's mental health, increasing social isolation and loneliness, meaning that many older people have been badly affected by the pandemic. This has had a lasting impact on many of the older people we spoke to.

Question 8: What could we do to improve your access to mental health services if you needed them?

51 people responded to this question, split by 29 individuals and 22 organisations.

The views were that mental health services must be resourced properly and fully integrated with all other aspects of health needs.

Mental health services need to think more broadly about an individual's overall needs. Any service provided must be adaptable for individual patients. Due to an ageing population, there is going to be a rise in numbers of people diagnosed with dementia and other age-related neurological conditions, all of whom will need support to manage their condition.

Question 9: Is there anything else you would like to add about mental health services for older people?

From the 49 responses to this question (27 individuals and 22 organisations), additional comments included more on raising awareness of local mental health services, waiting lists to services and education to reduce stigma.

Question 10: Tell us about your current housing.

From the 43 people who responded (32 individuals and 11 organisations), answers to this question provided useful background information on the different types of housing older people currently reside in. This was a range of home owners in family homes, downsizing to smaller privately owned property, housing association accommodation, sheltered housing, and social housing and care homes.

Housing, and the availability of accessible housing, was a big issue that came up in our engagement events – with many older people who live alone planning for the future and the lack of one level/low level housing (bungalows for example) being an issue when older people may not be able to live in their own homes.

Adaptations to current homes was also raised, with older people not sure who to contact when living in their own property. Many older people wished to stay in their own homes for as long as possible, but need more advice and support (including financial) to enable adaptations to be made so they can do so. More information on who to contact would be helpful.

Question 11: What kind of housing, and adaptations and/or equipment for your housing would assist you in living independently at home for as long as you wish?

45 people responded to this question. 30 of these were individuals and 15 organisations.

The respondents provided details of a number of adaptations and equipment that could assist them to live in their own homes independently. This included:

- Handrails on staircases and bathrooms;
- Installations of wet rooms;
- Stair lifts;
- Downstairs bathrooms;
- Ramps.

Question 12: Who would you like to be able to provide and support you to get the kind of housing and adaptations you need?

There were 43 responses to this question (29 individuals and 14 organisations), with the majority of those responding saying that local authorities (including social work) would be best placed to help as they know the local services. There was also a possible role for occupational therapists.

Question 13: Is there anything else you would like to add about Place and Wellbeing for older people?

There were 54 responses to this question, 25 from individuals and 29 from organisations, covering a variety of issues, including:

- More safer, accessible places for older people including good lighting and CCTV;
- Accessible housing;
- Improved walking and wheeling conditions, including reducing pavement clutter, providing toilets, seating, signage, safety improvements, improved crossings and basic path and pavement maintenance;
- Improved access to local amenities, ensuring the planning system prioritises and delivers development within walking distance of local facilities as part of the 20-minute neighbourhood agenda.

3.2 Preventative and Proactive Care

There were 10 questions within Preventative and Proactive Care. These covered:

- Health and social care services for older people;
- Access to leisure services and physical activity; and
- Anticipatory Care Plans.

Question 14: When thinking about health and social care services for older people in Scotland, what do you feel has worked well in the past?

There were 54 responses to this question with 28 responses coming from individuals and 26 from organisations. There were a number of responses covering:

- Access to GPs;
- Third sector support;
- Warden supported sheltered housing;
- Regular health checks when you reach a certain age (75, for example).

Question 15: What is currently working well?

49 respondents answered this question, 26 being individuals and 23 from organisations. Responses included:

- Free public transport;
- Free prescriptions;
- Administration of COVID vaccines; and
- Management and delivery of repeat prescriptions.

Question 16: How do you think services could be improved?

There were 60 responses to this question, 31 from individuals and 30 from organisations. A number of issues were raised, including:

- A local list of services where older people can look for local services in their area;
- More targeted, community activities, especially in rural areas;
- Return to NHS funded podiatry services which would benefit older people's mobility and access to services;

- Aligning care with and investing in Community Transport services; and
- Better access to GPs

Question 17: Access to leisure facilities or any other type of physical activity – what would make this easier

55 respondents answered this question. 30 of these responses were from individuals and 25 from organisations.

The responses from individuals included the costs to attend physical activity classes, and the cost and availability of accessible transport and respite services to allow carers to attend, as being barriers to access.

Responses from organisations were similar as those from individuals, but also included self-referral to such services.

At engagement events, the cost of living was raised several times as a barrier to access to leisure facilities, with any participation cost and travel costs having to be considered, and more so in the winter months. It was thought that social isolation and loneliness may increase as some older people may not socialise as much due to the costs involved.

Question 18: How much do you know about Anticipatory Care Plans?

There were 50 responses to this question, 31 from individuals and 19 from organisations.

From the 31 individuals, just under half had not heard of Anticipatory Care Plans (ACPs). Of those who had, this was because they work in the health and social care sector or were individuals who had an ACP discussion, or who had one in place. There were views that more awareness raising of ACPs should be made and they should be mandatory once you reach a certain age.

Of the 19 organisations, 3 had no knowledge of ACPs. The organisations that did have knowledge of ACPs raised that it was encouraging to think ahead as opposed to waiting for a crisis, and prevention is better than cure. These organisations were keen to increase the uptake of ACPs.

Question 19: How do you feel about having an Anticipatory Care Plan yourself?

42 respondents answered this question, 30 individuals and 12 organisations.

The majority of individuals would be open or happy to have an ACP discussion and a plan in place. Five respondents would not be happy with this, at the moment.

Of the organisations who responded, most said that this was personal choice, however the perceived issue of how Do Not Resuscitate (DNR) orders were handled during the COVID pandemic, meant that, if approaches were made from medical professionals they would need to be made carefully. There was a role for awareness

raising but it should be for patients to determine whether they wished to have an ACP.

Question 20: What do you think about this Anticipatory Care Planning aspect of care?

There were 47 responses to this question with 28 of these from individuals and 19 from organisations.

Individuals and organisations generally commented that ACPs were a good idea, especially to allow for planning before people reach crisis point, especially those who may have long term conditions and to assist people to self-manage their conditions.

Question 21: If you would consider having an Anticipatory Care Plan, who would you like to discuss it with?

From the 45 responses to this question, 28 were from individuals and 17 from organisations.

Individuals commented that they would prefer to have these discussions with their GPs, practice nurses or advanced nurse practitioners, social workers and family.

Organisations felt that discussion should take place with family and GPs

Question 22: When is a good time to have discussions about Anticipatory Care Planning with older people?

53 respondents answered this question with 29 of those being individuals and 24 organisations.

All individuals felt that these discussions should take place as early as possible, when a condition is diagnosed or when people are well and able to articulate their wishes. This should not be left to crisis point.

Organisations agreed, with discussions having to take place as quickly as possible, with one suggestion that all adults should have one – not just ‘older people’.

Question 23: Is there anything else you would like to add about preventative and proactive care for older people?

There were 63 responses to this question.

From the 30 individuals who responded, a number of issues were raised, including:

- Not enough preventative care provided by the NHS in regard to diabetes, obesity, arthritis etc.
- Power of Attorney needs to be highlighted more to the public and there needs to be consideration of making this free to allow all older (and not older) people to have this in place.

From the 33 organisations, comments included:

- Malnutrition in older adults is a key topic. There has been increasing attention on malnutrition in older adults nationally, which is welcome. However, this often focuses on undernutrition only. We believe a focus on malnutrition in all its forms is more appropriate.
- An annual check-up for all those aged 75 and over.
- Any preventative and proactive care should include meaningful occupation as an important factor, and also important is staying connected with communities to prevent isolation and loneliness.
- Digital exclusion can be a source of inequality in accessing care, and has been exacerbated by the pandemic and pressure on costs of living. This cause of inequality needs to be acknowledged and taken into account in planning. The use of technology enabled provision can be expanded to enhance support and an enablement approach that takes into account the person's assets and their value as expert by experience.
- Development of leisure spaces / activities / programmes / events which are safe for the ageing LGBTIQ+ population to attend. This particularly includes spaces which are visibly trans inclusive and affirmative.
- Promoting spaces / activities / programmes and events as inclusive of older LGBTIQ+ people. This should include encouragement from the Scottish Government of training on LGBTIQ+ identities within the older population to those developing and delivering services.
- Ensuring spaces / activities / programmes / events are accessible to all. Including disabled people, those on low income, those from minority ethnic backgrounds and those with additional access needs.

3.3 Integrated Planned Care

Within Integrated Planned Care there were 21 questions on:

- Experience of social care;
- Management of long term health conditions;
- Alternative methods of consultation; and
- Palliative and end of life care.

Question 24: Tell us about any social care or other outside help with everyday living that you (or a family member) have received in your own home?

There were 45 responses to the question, with 30 of those from individuals and 15 from organisations.

The individuals gave a range of comments on the social care and outside help that they have received in their own home. This ranged from care from unpaid carers, like spouses and other family members to paid for carers attending homes several times a day to provide personal care.

Organisations provided information on the services they were aware of, and indeed provided, including befriending services to a day centre who adapted to offering a

day care at home service during the pandemic. This worked well alongside care at home services for practical/task orientated support, like grocery shopping, one-off tasks in the home (changing curtains, for example) and food prep and meal sharing.

Question 25: What was your experience of these services?

Of the 40 responses to this question, 29 were from individuals. There were comments ranging from the inconsistency of carers, with a range of different staff providing care to older people, to the inconsistent times of visits. There were also comments on the assessment process to receive care at home, with the time taken for care packages to be put in place inconsistent across health and social care partnership areas.

Individuals also commented on the inconsistencies in care, with personal care being provided, but when needs changed (i.e. help with feeding and repositioning in bed) these could not be met by the care team. There was feedback from some on how invaluable care at home services are, allowing some patients to live at home with a multitude of conditions.

The 11 organisations who commented made similar comments to the individuals, including inconsistencies across geographical areas.

Question 26: As an older person, what are your experiences of health and social care services working together?

36 responses were made to this question, 24 from individuals and 12 from organisations.

Of the individuals who responded, there was clear feedback that health and social care services did not work well together, especially when sharing information. There were examples given of hospital discharge where no discharge information was provided to hospital at home or care at home services, and acute settings not being able to access social work assessments, and vice versa. This led to a disjointed service for older people.

From the organisations, there were similar comments. It was thought that while some parts of Scotland demonstrate good joint working between health and social care services, functionally speaking integration is fragmented, with inconsistent joint working between different parts of the health and social care system.

Question 27: What could be done to improve joint working between health and social care services?

There were 56 responses to this question with responses being equally split by individuals and organisations.

From the individuals there were a range of comments, including:

- Better communication and sharing of information between the two;

- One digital patient file, accessible to all the services jointly, with all the patients' information and history contained therein;
- More joint training of staff and more public engagement with involvement with older people's organisations.

From the organisations who commented, the comments were similar, with better communication and sharing of information the biggest issue. Other comments included:

- Improvements to social care as a career (terms and conditions and pay for example) to make it a more enticing career.
- A clear multi-disciplinary team plan across both health and social care, including clarity on finance and budgets is needed. This must include a national framework to ensure delivery of support through health and social care, providing the same level of care for all older people, irrespective of where they live.
- Better, joined up IT systems, so that records and patient information can be shared and accessed quickly.

Question 28: Do you live with a long term physical or mental health condition or illness?

Option	Total	Individual	Organisation
Yes	20	17	3
No	20	13	7
Not Answered	87	10	77
TOTAL	**127**	**40**	**87**

Question 29: If yes, how do you feel about the way your health is monitored and reviewed? If no, how do you feel about your ability to access regular health checks?

40 responses were received for this question, with 24 responses from individuals and 16 from organisations.

The majority of individuals reported that their conditions were not regularly monitored or assessed by health professionals, with a lack of appointments with GPs and regular health checks being cancelled during the COVID pandemic, being some of the reasons.

From organisations, the response was similar with lack of GP access and the pandemic being reasons that health checks with health professionals were not taking place.

Question 30: Where would you prefer that regular health checks are provided and who by?

From the 42 responses to this question, 28 were from individuals and 14 from organisations.

Of the 28 individuals who responded, 24 said that they would like their checks to be done locally – either by their GP, practice nurse or other health practitioner based in their surgery or clinic. The other 4 respondents preferred checks by specialists in their condition, in their own home or at outpatient services.

There were similar views from the organisations. One view was that regular health checks provided in the community would be an excellent way to support people living at home in later life as well as the value of trusted GP surgeries, based in local areas, and of Community Links Practitioners, who can support people with a varied of issues within the same setting.

Question 31: What support would you need to assist you in self managing your general health or any long term health conditions that you have?

There was 41 responses to this question, 26 from individuals and 15 from organisations.

From the 26 individuals who responded, the majority were looking for further information, about their condition and what services were available to them, whether provided by the NHS or through the third sector. Some respondents would like referrals to be made to other health services, which they believe would help them better manage their conditions.

The organisations that responded believed that regular health checks and better information and communication with patients was key.

Question 32: Tell us about your experience of any health care appointments you have had in the last 2 years:

- **which healthcare services did you use?**
- **what type of appointments did you have (e.g. face to face, phone, video)?**

43 respondents answered this question, 30 individuals and 13 organisations.

Individual's experience of health care appointments mostly consisted of consultations with GPs – by telephone, online and face to face. Some had had specialist appointments (at hospital) and at specialist clinics.

From the engagement events we held, many older people told us of their frustration of not being able to get a consultation with their GP, or having long waiting times to see one. Many GP's surgeries required a telephone call first thing in the morning with long waiting times for calls to be answered. There were also cases where GPs were still not offering face to face appointments, with telephone consultations the only option.

However, there were also some cases of GPs and practice nurses carrying out home visits for their most frail patients.

From the 13 organisations that responded to the consultation, access to GPs was the most popular experience of health care appointment, but there were still the same barriers to these. Respondents to the ALLIANCE's primary care survey highlighted some key areas for improvement. Practice booking systems were a recurring topic. Recurring concerns included: the length of time taken to get through to GPs (with many respondents having made several attempts); inability to book appointments in advance in some instances; limited availability of on the day appointments despite calling at a specified time; having to call several days in a row to secure an appointment; and online booking systems no longer available in some practices who had had them previously.

Question 33: What additional support would you need to make it easier?

There were 43 responses to this question, 29 from individuals and 14 from organisations.

Individuals reported that improved telephone processes at GP surgeries would be better, both for making an appointment and when awaiting a call back from a doctor. For those who preferred video/online consultations, a choice of which platform to use which was familiar to them would be helpful, rather than having to use a specialist platform which they may be unfamiliar with.

From the organisation's point of view, access to broadband was an issue (with it being unreliable or non-existent – making video/online calls difficult), more GPs and NHS services should use the NearMe platform and information should be provided in a range of accessible formats.

Near Me is the public-facing name for the video consulting (VC) service used across health and social care in Scotland.

Online and telephone medical appointments do not work well for people who have cognitive, mobility (fine motor co-ordination) psychological or speech and language difficulties - which means that they do not work well for the majority of people with a neurological condition.

Question 34: What would make it easier for you to know who to contact when in need of advice, support or assistance for a health issue?

44 respondents answered this question, 28 individuals and 16 organisations.

Most individual respondents said that information was key, whether that be on what was available locally, to who best to contact in which situation (minor ailments clinic, optician, pharmacist etc). One stop shops were mentioned, where people could call, or visit to get all the information they need on health services, with signposting to other services available.

Organisations also had similar views on information which was produced locally, and the promotion of the use of pharmacists.

Question 35: What is currently working well to support planned health care and treatment?

There were 45 responses to this question. 24 from individuals and 21 from organisations.

From the 24 individuals, 9 did not think that any aspect of planned health care and treatment was working well. From those who did think that some things were working well, they reported that hospital at home had worked well (2), three were happy with the service from their GP and others had used specialist services, orthopaedics for example.

Organisations reported good feedback on support provided by third sector organisations, hospital at home and the Pharmacotherapy Service, which is part of the GMS contract. This is provided by pharmacy teams working in GP practices and supports patients with medication reviews, medicines reconciliation, managing repeat prescriptions and acute prescription requests. This is beneficial to older people who may have accumulated medication over several years which may no longer be necessary or appropriate.

Question 36: What needs to be improved?

From the 42 responses to this question, 24 were from individuals and 18 were from organisations.

From the 24 responses from individuals, 10 specifically mentioned access to GPs as the biggest issue, as well as other primary care staff. Waiting times and access to multidisciplinary teams was also mentioned.

The biggest issue raised by organisations that responded was access to patient transport (5) and the inconsistences or non-existence of provision. They also raised access to fracture liaison services not being consistent across the country.

Question 37: Is there anything else you would like to add?

There were 30 responses to this question, 17 from individuals and 13 from organisations.

Of the 17 individuals, 10 provided no comment, or had nothing to add. From the remaining responses some commented that the use of telephone appointments with specialists (rather than travelling to out of town hospitals) would be beneficial for some older people. There were also comments that the COVID vaccination programme had gone well.

Organisations commented that there was excellent support and advice provided by the third sector and this should be maintained, developed and supported further. There was also comment that the number of Community Links Practitioners (CLPs) should be extended - as many older people seek information about accessing a wide variety of health and social care support from them, particularly around community

connections. As such, immediate work to expand the provision of CLPs on sustainable and long-term contracts is particularly important.

Question 38: When you, or a family member approach end of life, what care and support would you want?

There were 45 response to this question with 30 coming from individuals and 15 from organisations.

The responses from individuals included provision of a range of settings and support that older people would like when they approach end of life. This included in their own homes, and in specialist palliative care settings. Being free from pain was an important issue for those who responded, and being able to make their own decisions when the time came and decisions needed to be made. It was clear that people wanted to be treated with respect and dignity.

Organisation responses were generally consistent with those comments from individuals.

At our engagement events we heard from specific groups of the population, including the LGBTIQ+ community. Their view was that it was important that care and support delivered to LGBTIQ+ older people towards the end of their life is human rights focused and trauma informed. Concerns for those within the older LGBTIQ+ community include worry around their treatment, the treatment of their partners, and the rights of their partners in supporting and caring for them towards the end of their life. There was also comment that older LGBTIQ+ people are less likely to have children and more likely to be estranged from their birth family and are more likely to have non-traditional support networks made up of friends, partners and other members of their community.

Question 39: When thinking about palliative and end of life care in Scotland, what is working well?

There were 43 responses to this question. These were split as 25 from individuals and 18 from organisations.

11 of the individuals had no experience or no particular comment. The 14 who did comment said that outreach palliative teams and multidisciplinary hospice services in specialist environments worked well. There was also mention of the increase in hospice accommodation with specialist care, which had been good, but that should not rely on independent organisations nor on the fundraising efforts of the staff and trustees.

Organisations commented that specialist palliative care by multi-professional teams was working well – with this service helping people with more complex palliative care needs. This service is provided by specially trained multi-professional specialist palliative care teams who are generally based in a hospice, an NHS specialist palliative care unit or an acute hospital, but whose expertise should be accessible from any care setting and at any time.

There was also comment that access to equipment and services is prioritised for palliative and end of life care and tends to happen promptly. The terminal phase (end of life) works well, and the desire to maintain people in their own home rather than admitting to hospital or hospice has resulted in different models of Hospice care being provided on an outreach basis.

Question 40: What could be improved?

44 respondents answered this question, with 26 being individuals and 18 organisations.

Individuals commented that care at home could be better, with more palliative and end of life care being provided at home, including the availability and provision of certain medicines and ensuring there was adequate staff.

Better communication between all services involved in the provision of palliative and end of life care would make it an easier process for patients and their families.

More information and discussion at the Anticipatory Care Plan (ACP) stage with the patient and carer/family could provide details of the options available. This would assist families when decisions on care and treatment may have to be taken at short notice and it would be better if as much as possible could be planned in advance.

Community Pharmacies specifically mentioned access to the appropriate IT systems, which would allow fast, efficient, and safe communication across healthcare professions, to support the delivery of excellent patient care. In addition, they commented on the need for pan-Scotland access to full Electronic Care Summary (ECS) records, Key Information Summary (KIS), Clinical Portal and the facility to read/write access on patient records. This would allow CPs to work independently, without relying on others, including GP colleagues and NHS 24, for specific information about patients and would save time for all healthcare professionals which could be spent on patient care.

Organisations also commented that it was vitally important that any person with a non-curative condition lives well and dies well, irrespective of their condition or care setting. Palliative and end-of-life care should be person- centred and take a holistic approach to planning, co-ordinating and delivering high-quality reliable care, enabling people to retain control, dignity and, crucially, choice in how and where their care is delivered to the end of their life.

Question 41: Is there anything else you would like to add?

There were 31 responses to this question, 15 from individuals and 16 from organisations.

Of the 15 individuals, 11 made no additional comment. Of the remaining 4, there was comment that work is needed to educate and inform the public about death, dying and chronic illness, as well as the provision of a leaflet about the practicalities, and about the emotional challenges faced both with the patient and the family in mind. This should also signpost support and help available.

Organisations commented on the role of pharmacies: the most accessible healthcare professional who will come in to contact with carers, pharmacists and pharmacy teams are ideally placed to highlight sources of support for a person and their families. They can also appropriately refer to other sources of health and social care support that are open to their patients.

Pharmacists should be embedded in all multidisciplinary palliative care teams to input expertise on prescribing, de-prescribing and use of medicines. Pharmacists and the pharmacy team have particularly important roles following a person's diagnosis of a palliative illness to ensure that the medicines regimen is optimised, as well as to help coordinate the care and medicines supply for patients as they move from one care setting to another. Specialist palliative care pharmacist teams should also be in place in all localities and known to generalist practitioners as a source of advice on medicines issues.

There was also mention of the role of speech and language therapists who can provide rapid response for people at end of life in order to advise on eating, drinking, swallowing and communication in order to support the patient and their families. This can help prevent unnecessary admissions and stress at a difficult time.

Question 42: What would assist you in having discussions with family or medical professionals about how you would like to be cared for, as you approached the end of life?

There were 38 responses to this question, 26 from individuals and 12 from organisations.

Individuals listed a number of ways they could be supported and assisted on in having discussions on their palliative and end of life care. This included a leaflet to take all involved through a discussion of wishes and desires in a supportive way. Consideration should be given to cultural and religious sensitivities, and the use of advocacy services

The organisations that commented suggested the sharing of a good example of an Anticipatory Care Plan (ACP) and a leaflet about particular prompts for discussion with an emphasis that planning for end of life was not about being old.

Communication should be clear, accessible, and handled sensitively. Consideration of the needs of people nearing end of life should also be included in any process for conversations around support planning.

Question 43: Who would you prefer to have these conversations with?

36 respondents commented on this question, with 24 being individuals and 12 organisations.

Individuals provided a range of people they would like to have these discussion with. These were:

- GP;
- Consultant;
- Family or friends;
- Palliative of End of Life Care Specialist;
- Medical professional leading on provision of care.

Organisations said that family, friends and carers were most appropriate to have these discussions as well as GPs.

Question 44: Is there anything else you would like to add about integrated planned care for older people?

In total there were 39 responses to this question, 20 from individuals and 19 from organisations.

From the individuals a range of issues were raised, including:

- Dignity and respect need to be central aspects of any strategy. Having experienced the current approach to care and support, it at times appeared less about the person and more about their financial ability to pay. Personal care was anything but joined up and effective, leaving the person involved distressed, disoriented and feeling that they didn't matter.
- Accountability for delivery of care and not ‘pass the parcel’ between services as to who is responsible when things go wrong. One dedicated worker as-point of contact to address issues.

Organisations’ views included:

- The ideal care, particularly for the elderly, is accessible, holistic, close to home, and with familiar people. All of this is offered by a GP, but we need a more joined-up approach particularly to wider services and specialist services. Understanding and managing frailty is key and we need to understand better the evidence base for what works, and have that reflected in planning processes. There are new approaches to eFrailty which have not been widely rolled out in general practice and we need to know how well frailty interventions work: there is ongoing debate about their cost-effectiveness.
- Key to looking after the elderly is maintaining and growing GP teams, and in addition we also need more and better premises, longer GP appointments with 15 minutes as standard, and funded protected learning time (PLT) for GPs and their teams to come together within the working week. Medication reviews and de-prescribing can also hugely benefit the elderly and their quality of life, but this is also time-consuming work.
- There needs to be increased access to GP/medical/Allied Nurse Practitioner support at home to avoid attendance at front door/ avoid admissions. We have a hospital at home model in place but need the infrastructure to support this. We know from speaking to people in the community that people would like this support to be in place to stop them having to come into an acute setting to receive treatment however we need the staff force in place to make this possible for the community.

3.4 Integrated Unscheduled Care

In the Integrated Unscheduled Care section there were 7 questions covering:

- Urgent or emergency care;
- Post-surgery support; and
- Hospital at Home.

Question 44: What is currently working well to support older people who require urgent or emergency care?

48 respondents answered this question, 25 individuals and 23 from organisations.

There was general consensus from the individuals that responded, that emergency care was not working well – with long waiting times for ambulances and attendance at accident and emergency departments. However some commented that they received excellent care, with the 111 service and home alarm service working well.

Organisations commented on the Hospital at Home service, Frailty at the Front Door service in Falkirk, dementia outreach teams and community rehabilitation.

Question 45: What could be improved?

There were 55 responses to this question – 29 from individuals and 26 from organisations.

Comments from individuals included a need for more physiotherapy and nutrition support, especially for those leaving hospital. There was also an ask for more older adult specific wards which would ensure specialist geriactric assessments would be carried out, compared to a general or surgical ward stay.

Timely, relevant and appropriate early intervention for people at risk of falls was also raised, as well as investment in community geriatricians and community teams working with GPs, specialist nurses, pharmacy, AHPs and mental health services.

The organisations who responded mentioned more enhanced training for all staff.

Question 46: Is there anything else you would like to add?

36 respondents answered this question, 20 individuals and 16 organisations.

Individuals noted the need for more support for GPs to enable them to carry out house calls. Organisations noted issues with delayed discharge, out of hours emergency services and independent advocacy for older people.

Question 47: What support do older people need after surgery?

There were 46 responses to this question. 28 were from individuals and 18 from organisations.

Individuals commented that better discharge and post-surgery support at home should be provided – especially in regard to caring for wounds and ensuring they are able to manage at home with their mobility.

Organisations also commented on access to rehabilitation and district nurses carrying out home visits. This could include more access in the community to multidisciplinary teams (MDTs) based in primary care. After surgery people will require support from an array of health care professionals including, in particular, district nurses, physiotherapists and occupational therapists.

With particular reference to patients who have lost a limb, there was comment that post-surgery patient support is inconsistent, with anecdotal evidence of situations where recovery and patient experience has been challenging. The Amputee pathway tends to be a linear end-to -end journey, with departments working in silos. The system needs to be more integrated and coherent between departments (e.g. hospital, social care, physio, OT and limb centres), which would allow for the pathway to be cyclical and cohesive.

In regards to discharge post-surgery, there was comment that a clear needs assessment and support package should be in place before an older person is discharged from hospital, to avoid some of the many challenges experienced in meeting essential everyday needs. This includes those discharged to sheltered, amenity or mainstream housing.

Question 48: Do you have any experience of Hospital at Home? What are your thoughts on the service?

43 respondents answered this question – 27 individuals and 16 organisations.

From the 27 individuals who responded, 15 had not heard of, or had any experience of the Hospital at Home service. Those who had used it, deemed it to be a great service. There were comments on it not being available in certain areas.

From the 16 organisations who commented, 4 had no experience of Hospital at Home. From those 12 who had, comments included that patient feedback had been excellent. Parkinson's UK Scotland would be interested to see whether hospital at home can be delivered throughout Scotland, including in remote areas of the country, where staff may not be able to travel between homes easily.

Question 49: If you have no experience of Hospital at Home, do you think this is a service you would use if needed and benefit from?

There were 33 responses to this question. 23 were from individuals and 10 from organisations.

The majority of individual respondents (20) agreed that Hospital at Home would be a service they would use and benefit from. Comments included that it would provide better outcomes for patients.

From the organisations who responded half (5) had no experience or knowledge of the service so did not comment. Of the five who did, all agreed that it was a good service and supported people to recover or receive end of life care at home.

Question 50: Is there anything else you would like to add about integrated planned care for older people?

37 respondents answered this question, 20 individuals and 17 organisations.

Comments from individuals included:

- There needs to be more emphasis on the discharge processes so that delayed discharge (referred to as bed blocking by some respondents) is minimised by ensuring that any care packages are available timeously.
- More consideration should be given to carrying out occupational therapy assessments in the patient's own house.
- Make better use of the Telecare system. It should be accessible to all and wider used.

Organisation's comments included:

- Older people may have complex requirements and so a local multi-disciplinary team approach would work best. This is a high-need, high-cost population. Capacity to manage the different needs of older people is at the crux of the problem and so we go back to the need for robust resourcing.
- The Key Information Summary (KIS) is a useful means of sharing information across services and particularly with out of hours services, as it includes a section for palliative care and anticipatory care plans. The KIS programme itself needs upgraded and modernised as it is clunky and not particularly user friendly.

General Comments

Final Question: Please use this space to highlight or raise any other areas you feel should be included in the new health and social care strategy for older people.

In total 51 respondents commented on this question.

From the 19 individuals who commented, there were comments on social care, delayed discharge, GP contracts and patient transport.

From the 32 organisations, several comments were concerned with information governance and its barriers to partnership working. There were also comments that improved collaboration across housing, health and care can improve planning and delivery of services for older people, with opportunities to work together to support people to remain independent at home, avoid unplanned admissions and support timely discharge from hospital .

4. Next Steps

Whilst we have been consulting and engaging on this strategy and analysing responses, more detail on the scope of the National Care Service (NCS) has been emerging including the introduction of the National Care Service (Scotland) Bill[4].

The Scottish Government has been considering how a Health and Social Care Strategy for Older People might benefit from improvements realised through a new NCS, and how the views that have been gathered through this consultation can best inform the NCS development discussions.

Given this context, we propose to extend the timeframe for development of a Health and Social Care Strategy for Older People in order to take account of, and contribute to, the development of the NCS. This is especially important since the National Care Service (Scotland) Bill proposes including making provision for the establishment of care boards to carry out Ministers' functions in relation to social care, social work and community health.

We will continue to develop a new national strategy for palliative and end of life care and again the responses to this consultation will inform[5] that strategy.

Ministers remain committed to developing a Health and Social Care Strategy for Older People informed by this consultation analysis, once we have fully considered the implications of the National Care Service Bill.

We will also consider areas which affect older people's health and social care which we can progress in the meantime.

[4] National Care Service (Scotland) Bill – Bills (proposed laws) – Scottish Parliament | Scottish Parliament Website

[5] fairer-greener-scotland-programme-government-2021-22.pdf

Annex A

Organisations That Responded

Aberdeen City Health & Social Care Partnership
Aberdeen Health and Social Care Partnership
Ability Borders, SBC's Borders Older People's Planning Partnership, NHS Borders Joint Health Improvement Team and the Borders Older People's Forum
Advanced Care Research Centre
Age Scotland
Argyll and Bute Health and Social Care Partnership
Bield Housing and Care
Blesma, The Limbless Veterans
BMA Scotland
British Geriatrics Society's Scotland Council
British Red Cross
Care Inspectorate
Carers Trust Scotland on behalf of the National Carer Organisations
Chartered Institute of Housing Scotland
Christina's Home Care Services
Clackmannanshire & Stirling Health & Social Care Partnership
Community Pharmacy Scotland
Community Transport Association
COSLA
Dumfries and Galloway social work services
East Ayrshire Health and Social Care Partnership
East Dunbartonshire Health and Social Care Partnership (four responses)
East Renfrewshire Health and Social Care Partnership
ENABLE Scotland
Equality and Human Rights Commission
Food Train
Glasgow City Health and Social Care Partnership
Glasgow Council for the Voluntary Sector (GCVS)
Hanover (Scotland) Housing Association Limited
Health & Social Care Moray
Healthcare Improvement Scotland
Independent Age Voluntary Health Scotland
LGBT Health and Wellbeing, with comments from Scottish Trans Alliance
Libertus Services
Live Borders
Luminate
Macmillan Cancer Support
Marie Curie
Mental Health Foundation
Mydex CIC
Neurological Alliance of Scotland
NHS Ayrshire and Arran
NHS Education for Scotland
NHS Forth Valley
NHS Highland NMAHP Advisory Group

Obesity Action Scotland
Parkinson's UK Scotland
Paths for All
Perth and Kinross Health and Social Care Partnership
Pilmeny Development Project
Playlist for Life
Port of Leith Housing Association
Queens Cross Housing Association The National Community Hearing Association Scotland
Queensferry Churches Care in the Community
Royal College of Psychiatrists Scotland
Royal College of General Practitioners Scotland
Royal College of Nursing
Royal College of Speech and Language Therapists
Royal National Institute of Blind People (RNIB) Scotland
Royal Osteoporosis Society
Royal Pharmaceutical Society
Royal Society for the Prevention of Accidents
SCIO
Scottish Association of Social Work
Scottish Care
Scottish Commission for Learning Disabilities (SCLD)
Scottish Federation of Housing Associations
Scottish Older People's Assembly (SOPA)
Scottish Partnership for Palliative Care Partners in Advocacy
Seniors Together in South Lanarkshire
Social Work Scotland
South Ayrshire Health and Social Care Partnership
South Lanarkshire Health and Social Care Partnership
sportscotland
The Health and Social Care Alliance Scotland (the ALLIANCE)
The Royal Society of Edinburgh
TotalMobile
Voice of Experience Forum
Voluntary Action South Ayrshire (VASA)
Volunteer Scotland

Annex B

Engagement Events Held

Tuesday, 22 March – HIS Frailty Network Session - online
Wednesday, 30 March – Wellbeing in Late Life Co-Lab – online
Wednesday, 4 May – Edinburgh H&SCP and Be Able Programme - online
Friday, 6 May – British Geriatrics Society Scottish Spring Meeting – in person, Glasgow
Monday, 9 May – Voluntary Health Scotland – online
Tuesday, 10 May – Royal Osteoporosis Society – online
Tuesday, 10 May – Older People's Housing Forum – online
Wednesday, 11 May – Generations Working Together – online
Thursday, 12 May - Fife Voluntary Third Sector Health and Social Care Forum – online
Thursday, 12 May – SWS Older People's Subgroup - online
Tuesday, 17 May – Scottish Older People's Assembly – online
Wednesday, 18 May – LGBT Health and Wellbeing – in person, Edinburgh
Monday, 23 May – Argyll and Bute Adult Health and Wellbeing group – online
Tuesday, 24 May – East Renfrewshire H&SCP staff – online
Wednesday, 25 May – Scottish Borders H&SCP – online
Monday, 30 May – Dementia Friendly East Lothian CIC, Gullane - in person
Tuesday, 31 May, Food Train Group, Livingston – in person
Wednesday, 1 June – RNIB Scotland Group – online
Wednesday, 1 June – Edinburgh Voluntary Organisations Council – online
Monday, 6 June – Wing Hong Chinese Elderly Group, Glasgow – in person
Monday, 6 June – Pollockshields Development Agency, Glasgow (Pakistani community) – in person
Wednesday, 8 June – Scottish Pensioners Forum – online
Thursday, 9 June – Voluntary Action South Ayrshire Seniors Action Group, Ayr – in person
Thursday, 23 June – Argyll and Bute Older Adult Reference Group – online
Monday, 27 June – Perth and Kinross H&SCP – Blairgowrie – in person
Tuesday, 28 June – Fife Voluntary Action, Glenrothes – online
Wednesday, 29 June – Two events with Perth and Kinross H&SCP – Perth – in person
Thursday, 21 July – Glasgow Disability Alliance – Glasgow - in person
Tuesday, 23 August – Forth Valley Sensory Centre – Camelon - in person
Thursday, 25 August - Sight Scotland – Linburn - in person

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