Partial Equality Impact Assessment (EQIA)

Integration of Adult Health and Social Care

The Scottish Government

Partial Equality Impact Assessment

Introduction

D.1. The public sector equality duty requires the Scottish Government to equality impact assess. It is a legislative requirement. More importantly, however, at the end of most policies, there are people. People are not all the same and policies should reflect the fact that different people have different needs. Equality legislation covers the characteristics of: age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

D.2. Equality impact assessment (EQIA) is all about considering how a policy (a policy can cover: activities, functions, strategies, programmes, and services or processes) may impact, either positively or negatively, on different sectors of the population in different ways.

D.3. A workshop was convened on 27 March 2012 to identify the areas of impact that the proposed Adult Health and Social Care Integration Bill, and the policy, would have on society. This report sets out the initial findings and delivers the first stage of an EQIA, which will be published alongside the consultation document and is a partial EQIA. It is being published to invite comment from those who respond to the consultation.

D.4. The workshop was the first stage of the EQIA of the policy. Findings are based on the knowledge and experience of those present at the workshop. This report is not a definitive statement or assessment of impacts but presents possible impacts that may require further consideration. This report also identifies some questions to be addressed to understand the impacts further. The purpose of further work following this scoping stage is to inform recommendations to improve any intended or consequential impacts on health and social care, enhance actions to reduce health inequalities, avoid discrimination and take action to improve equality and enhance human rights.

Rationale and aims of policy

D.5. There is a great deal to be proud of in terms of health and social care provision in Scotland. We recognise, however, that we should go further to ensure consistently good outcomes for patients, service users, carers and families. Separate, and sometimes disjointed, systems of health and social care will no longer adequately meet the needs and expectations of increasing numbers of people, particularly those living into older age, often with multiple, complex, long-term conditions, who need joined up, integrated support.

D.6. There has been very significant progress in improving pathways of care in recent years. Nevertheless, many clinicians, care professionals and managers in health and social care currently describe two key disconnects in our system of health and social care. The first disconnect is found within the NHS, between primary care (GPs, community nurses, allied health professionals etc.) and secondary care (hospitals). The second disconnect is between health and social care.

D.7. These disconnects make it difficult to address people's needs holistically and to ensure that resources follow patients' and service users' needs. Problems often arise in providing for the needs of people who access many services over prolonged periods, such as people with long term conditions, older people, and people with complex needs. Problems are also encountered at transition points, particularly as children with complex needs reach adulthood.

D.8. From the perspective of people who use the system – patients, service users, carers and families, the problems we are seeking to address can be summarised as follows:

- There is inconsistency in the quality of care for adults and older people across Scotland;
- People are too often unnecessarily delayed in hospital when they are clinically ready for discharge;
- The services required to enable people to stay safely at home are not always available quickly enough, which can lead to preventable and undesirable admissions to hospital.

D.9. Demographic change makes the case for change urgent. The Registrar General has projected that the number of people in Scotland aged over 75 will grow by around 10,000 every year over the decade ahead and that around one quarter of Scotland's population will be aged 65 and over by 2033. The changes in demography will vary in scale depending on location, with predictions suggesting that rural areas will be affected to a greater degree than urban areas. We know that:

- Even allowing for the possibility that people may live longer and in better health in the future and taking into account of our current emphasis on improving anticipatory and preventative care, Scotland will in future experience a material increase in the number of older people who need care. The resources required to provide support will rise in the years ahead;
- There is little association between the amount spent currently on health and social care services and the outcomes that are achieved – spending more does not necessarily result in better outcomes;
- We spend almost one third of our total spend on older people's services annually on unplanned admissions to hospital; and
- We spend more annually on unplanned admissions for older people than we do on social care for the same group of people.

D.10. Our current system of health and social care incorporates within it barriers in terms of structures, professional territories, governance arrangements and financial management that not only often have no helpful bearing on the needs of the large, growing group of older service users, but in many cases work against general aspiration of efficiency and clinical/care quality. We need to reform the system to deliver care that is better joined up and as a consequence delivers better outcomes for patients, service users and carers.

D.11. The Scottish Government's goal for integration of health and social care is to tackle these challenges and to address the disconnects described above. We know from clinicians and other professionals who provide health and social care support that, as far as possible, it is better for people's wellbeing if they are supported in their own homes or another homely setting in the community, rather than being admitted unnecessarily to hospital. The integration agenda will be key in continuing to drive forward the shift in the balance of care from institutional care to services provided in the community.

Objectives

D.12. The main objectives of the integration of adult health and social care agenda are:

- Consistency of outcomes across Scotland, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery;
- A statutory underpinning to assure public confidence;
- An integrated budget to deliver community health and adult social care services and also appropriate aspects of acute health activity;
- Clear accountability for delivering agreed national outcomes;
- Professional leadership by clinicians and social workers;
- It will simplify rather than complicate existing bodies and structures.

People present

D.13. The following were present at the workshop and contributed to the discussions:

Jo Marwaha Drew Millard Debbie Sigurson	NHS Health Scotland
Craig Bradshaw Kavita Chetty	Scottish Human Rights Commission
Tony Fitzpatrick	Carers Net
Hanna McCulloch	Capability Scotland
Milind Kolhathar	Edinburgh Voluntary Organisations Council
Elaine Torrance	Head of Social Care and Health NHS Borders
Diane White	Social Services Workforce (SG)
Fiona Hodgkiss	Analytical Services Division (SG)
Alexis Jay	Chief Social Work Adviser (SG)
Frances Conlan Alex Devoy David MacLeod Gill Scott Alison Taylor	Integration and Service Development (SG)
Chris Bruce Gerry Power	Joint Improvement Team
Gillian Barclay	Older People's Unit (SG)

Policy options (including a 'do nothing' option)

D.14. Ministers are consulting on proposals that would see new Health and Social Care Partnerships written into statutory legislation, replacing the existing Community Health Partnerships.

D.15. Evidence from the work taken forward on Reshaping Care of Older People, and from the Integrated Resource Framework, indicates that, given the changing shape of demography in Scotland, "doing nothing" is not an option. Changes are required in order to assure both the quality of outcomes for patients, service users and their carers and families, and also to assure the sustainability of service provision in the coming years. This is not a challenge that is unique to Scotland: changes in demography, and the need to change patterns of service planning and provision as a result, are common across developed countries.

D.16. Ministers' proposals will provide Health Boards and Local Authorities with some flexibility to enable them to establish local arrangements that best suit local needs. The consultation proposes options regarding the governance of Health and Social Care Partnerships, and how each Partnership manages an integrated budget, with a requirement to deliver jointly agreed outcomes.

Population groups considered

D.17. The group sought to identify potential differential impacts of the policy on different population groups. These impacts are noted below:

Population groups	**Potential differential impacts of the policy**
Older people, people in the middle years, young people and children	The consultation notes that the proposed legislation will enable Health Boards and Local Authorities to integrate planning and service provision arrangements for all areas of adult health and social care. It goes on to state that the initial focus, after legislation is enacted, will in terms of delivering outcome measures, will have a differential impact for older people because older people are high users of the health and social care system. This approach may carry a risk that other groups are overlooked, at least at first. If there is a shift in the balance of care to community care, there is likely to be an increase in the amount of health and social care services provided in the community. The point was raised that this could result in an increase in the number of individuals over 65 paying for social care support

	services. See also comments on Ageing population in rural areas below.
Women, men and transgender people (includes issues relating to pregnancy and maternity)	It is anticipated that women will be more significantly affected by this policy than men in a number of ways. Women tend to work in social care roles more than men; proportionately there tends to be more female carers (see carers section below for carer specific comments); and women are more likely to live longer and outlive male partners so they are more likely to access services in later life. Research suggests that female patients are more positive about community services, however, less positive about acute, therefore there is a positive impact on women's levels of service satisfaction.
Disabled people (includes physical disability, learning disability, sensory impairment, long-term medical conditions, mental health problems)	If there is a shift in the balance of care to health and social care partnership services provided in the community, there is likely to be an increase in the level and range of social care services commissioned. This could lead to an increase in the number of payments made on behalf of and by people who access chargeable social care services. This could negatively impact on disabled people, because they may be liable for more charges.
Minority ethnic people (includes Gypsy/Travellers, non-English speakers)	Access to language support services: will integration dilute the resources available, or make better use of existing resources? Could this lead to duplication? What are the levels of health and social care service uptake from minority ethnic communities? Current evidence indicates the numbers of minority ethnic people accessing services is low. Need to bring together workforce development on understanding of cultural outcomes.
Refugees and asylum seekers	A point was raised about accessibility: one point of access therefore individuals should find it easier to access services. There is an ongoing need for staff to have a cultural understanding of outcomes for individuals.
People with different religions or beliefs (includes people with no religion or belief)	See minority ethnic impact in terms of staff capacity and capability.

Lesbian, gay, bisexual and heterosexual people	No impacts identified.
People who are unmarried, married or in a civil partnership	No impacts identified.
People in different socio-economic groups (includes those living in poverty/people of low income)	This could impact on people from poorer areas where life expectancy is lower and the burden of disease higher. The policy could thus impact disproportionately in deprived areas in terms of the costs associated with the cared for. Ageing might be different across the population i.e. people in lower socio-economic groups being older in health but younger in age than higher socio-economic groups. This may have an impact on the age group classification.
People in different social classes	It was noted that there would be no change: that health care would continue to be free at the point of need, however, social care could be means tested.
Homeless people	It was advised that there was a developed social model for homelessness, particularly in urban areas. The question was raised over where this model would sit in an integrated system.
People involved in the criminal justice system	There were questions raised over where criminal justice health and social care will fit into an integrated system and whether any links already established would be weakened or strengthened. It was asked whether there is also a benefit from health care for prisoners, which is now delivered by NHS and therefore already in the fold in an integrated system. A question about how the policy would affect victims of crime was raised, with particular reference to the voluntary sector, given their role in this area and whether there would be an impact on any future funding.
People who have low literacy	No impacts identified.
People in remote, rural and/or island locations	The age profile of populations in remote and rural areas are increasing faster because people tend to retire to these areas and is, in some part, due to the migration of young people to urban areas for employment and educational opportunities.

	Therefore, there may be issues relating to delivery and accessibility of services for both staff and service users in these areas.
Carers	If there is a single point of access to services it will be easier and simpler for carers as they will not have to contact multiple service delivery organisations.
Staff (includes people with different work patterns, e.g. part-/full-time, short-term, job share, seasonal)	Issues relating to differing terms and conditions in Health Boards and Local Authorities were noted, with potential for consequential impact on staff and their respective representative bodies.
Others that may be relevant to the area of work (please add):	None.

Potential impacts on equality and health

D.18. The group identified the following potential impacts of the policy on equality and on health.

Example key areas of impact	Potential impacts of the policy and how the impacts may arise	Affected populations
Equality	A number of opportunities for promoting equality of opportunity were discussed when considering the differential impacts between population groups. In terms of the duty to promote good relations between groups, the policy needs to promote engagement with local organisations and co-production approaches to health and social care. The policy could also support promotion of more positive attitudes towards old age/illness/long term conditions (disability), women.	All
Lifestyles	The promotion of preventative care initiatives could have a positive impact on healthy diets/nutrition/exercise etc.	All
Social environment	Respite care for carers: Any changes or reductions to hospital facilities as a result of shifting the balance of care to the community, could have an impact on the number of facilities available which provide respite care.	Carers
Physical environment	Through promoting care in the community is it likely to be harder to control the spread of infectious diseases e.g. MRSA?	All
	Improved patient safety, with less movement from the home.	All

Potential impacts on human rights

D.19. The group identified the following potential human rights impacts.

Example article	Potential relevance	Affected populations
Life (Article 2, ECHR)	There will likely be an increase in community facilities so patients will have more options available to them, for example; to choose where they die.	Mainly adults
	Adult protection: There is a need to continue to ensure adequate provision and capacity of staff to provide support and information to enable patients to manage medication and stay safe in a homely setting.	Mainly adults
Freedom of expression (Article 10, ECHR)	No freedom of expression impacts were identified in the discussion	-
Private and family life (Article 8, ECHR)	The right to choose where you receive care, in alternative settings to hospital.	All
	There were concerns raised over the sharing and access to personal data.	All

Summary of key impacts, research questions and evidence sources

D.20. The following is a summary of the key areas of impact identified at the workshop, some possible questions to address in order to understand these, and suggested evidence sources to answer these research questions.

D.21. This is not a definitive or necessarily complete list of impacts and some may turn out, on further assessment, not to be relevant. The list is put forward as a starter to inform the next stage of the impact assessment, and is likely to be refined and explored further.

D.22. The work undertaken to explore these research questions should be proportionate to the expected benefits and any potential to make relevant and significant changes as a result.

D.23. Evidence-informed recommendations are key to a robust impact assessment; however, ‘evidence’ to support the development of recommendations can be thought of more widely than just formal research. Furthermore, a lack of available robust evidence should not lead to the impact assessment process being delayed or stopping altogether.

Often there is poor or insufficient evidence about the links between a proposal and health; there may, however, be plausible theoretical grounds to expect an impact.

Area of impact	**Research questions**	**Possible evidence sources**
Increased payments made for and by people who access these services.	Could there be an increased number of social care payments made for and by people, who access these services, particularly disabled people, and over 65s?	Explore further with appropriate stakeholders.
Accessibility to services for people from ethnic minorities.	How can workforce development teams be brought together to develop an understanding of cultural outcomes for individuals?	
Homeless people.	There is a developed social model for homeless people, particularly in urban areas, but where will these models sit in an integrated system?	
Potential implications for trade union and staff-side bodies representing health and social care staff.	How will differing terms and conditions of employment between Health Boards and Local Authorities, particularly if staff move between them or are within integrated teams, be managed?	Seek advice from relevant stakeholders including Scottish Government Health Workforce and Performance Management Director, Personnel Directors and Trade Unions. This could vary according to area, though national staff-side bodies may want to adopt particular views.
Promoting positive attitudes in communities and service users.	What evidence exists of effective approaches for promoting positive attitudes? What evidence exists to suggest that shifting care into the community promotes positive attitudes?	Census; Scottish Household Survey
Diet: better nutrition and exercise.	How will the policy positively impact on opportunities for better nutrition and exercise?	Census; Scottish Household Survey
Maximising available income for older people.	How will the policy maximise the income for older people?	Census; Scottish Household Survey

Area of impact	Research questions	Possible evidence sources
Create better networks between health and social care providers and carers.	How can data be shared between NHS, social care providers and carers?	Data sharing work under development by Scottish Government
Sharing and access to personal data.	What are the concerns of patients/staff over sharing personal data and how can they be overcome?	Examples from integration in England/elsewhere?
Improve patient safety: with minimum unnecessary movement from home. Impact of change on homecare capacity.	What are the hours of care per client or numbers of clients?	Homecare statistics publication; Scottish Health Survey .
Services would be provided in a person centred framework.	What would the experience be for the patient receiving the service?	GP/local NHS services patient experience survey
Adult protection.	Adult protection: There is a need to continue to ensure adequate provision and capacity of staff to provide support and information to enable patients to manage medication and stay safe in a homely setting.	Care home statistics; census. Scottish Health Survey
Older people.	Will the policy increase the system's ability to keep >65 year olds out of hospital?	> 65 emergency bed day rate per 100,000 population by Health Board (HEAT target) stratified by gender, age and deprivation.
Criminal justice.	What is the potential impact on reconviction rates? (age and sex breakdown where possible)	Scottish Government criminal justice datasets.
Carers.	What is the potential impact on respite care admissions?	Scottish Government health and social community care publications.

Who else needs to be consulted?

D.24. A range of key partners, relevant and interested parties were invited to the scoping workshop to support the assessment of the impacts of the policy and contribute to the development of the partial EQIA scoping report. After consultation the group identified no further parties for inclusion in the scoping workshop, or to assist with the scoping report.

Suggested initial recommendations

D.25. There were a number of suggested recommendations that emerged from the scoping workshop, these have been recorded and outlined in this document. As part of the consultation process we would welcome any comments you have on this partial EQIA.

D.26. Once the consultation closes, the scoping group will be reconvened to discuss and assess further impact aspects of the consultation responses and it is the output from this work which will contribute to the final EQIA.

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