

Government Consultation on Health and Social Care Integration.

I believe anyone who has experienced, or who has participated in the care of someone who has experienced, continuing use of Health and Social Care will be wholeheartedly in favour of on-the-ground integration of Health, Social and indeed Personal Care services. As someone who has been involved in Public Engagement within the NHS for many years, I know that too many people have received less than acceptable service because their needs necessitated an integrated approach, and no-one other than a bureaucrat understood the boundaries.

However there are issues which are either not discussed at all, or are only mentioned in passing.

Answers to the numbered questions are at the end.

The Budget

The budget for the integrated body will come mainly, I understand, from the NHS with a smaller proportion from Councils.

Now, NHS Boards are funded under the NRAC formula, which is open, transparent, and has some evidence base. However, within each Board, the allocation of resources between its CH(S)Ps and its acute services is neither open and transparent nor has an evidence base. If the new nationally agreed outcomes are delivered, there will be a substantial decrease in emergency admissions to acute hospitals, which should release resources to be passed to the Community budget. There will need to be a mechanism to ensure that this happens – otherwise it won't.

On the other hand, Councils get most of their money via the COSLA funding formula, which is so complicated as to be not transparent. I am not aware if it has any independent evidence base. No Scottish Government has had the courage to commission research to develop a similar funding formula to that used by the NHS. The consultation document lists each Council's current expenditure in this area (Adult Care) without any comment. I am aware, through PPF members who have knowledge of those receiving care in many parts of the country, that the amount of care provided, and the charges levied, vary widely. It is essential that, at the very least, NRAC are commissioned to produce indicative budgets for what would be seen as the appropriate Council contribution to each joint body.

The GPs

The document seems to imply that GPs are eager to be involved in service planning and delivery, and are somehow impeded from participating. My understanding is quite different. As independent, private businesses, not directly managed by the NHS, they vary enormously in their eagerness to be involved. There are those – well known to the Scottish Government Health Dept. - who are at the cutting edge of Anticipatory Care and integrated working, and would almost consider it a failure if any of their patients ended up as an emergency in an acute hospital because their condition was not managed effectively. Unfortunately, there are many other Practices who continue to do what they have always done, and so continue to refer large numbers of patient to acute hospitals. (The statistics show an enormous variation between practices in their numbers of unplanned admissions.) It will not be possible for the integrated body, and its Accountable Officer, to be held accountable for the delivery of the national outcomes unless the GP contract is completely rewritten around the delivery of these outcomes.

Public Engagement

The document is very vague on the mechanism and extent of public engagement/ participation in the new bodies. Obviously, as the Chair of a reasonably successful PPF, I have a vested interest here, but I believe that any successful CHP will know that extensive formal and informal channels of public engagement make their job much easier because it creates trust between the public and those managing their care. Thus when changes are proposed, it is much easier to keep the public on board. Trust is a key word here – do the frontline staff trust the management; do the clinicians trust the care to be delivered by less qualified staff; do the patients/family carers/distant relatives trust the care packages? The vision for the future of health and social care requires the creation of a reliable system trusted by all concerned. Continuing public engagement creates a core group of lay persons who understand the issues concerning all the parties.

Specific questions from the Consultation

Question 1: (focus) No

At the public consultation I attended, there was considerable disquiet about this, which I share. While, in this Council at least, Children's Social Work services are now entirely separate from the adult sector, this latter covers, I believe, all adults, not just the frail elderly; while in the NHS, primary care covers all age groups. To split off care of the frail elderly from the rest of primary care, even if temporarily, would be counter-productive by creating fragmentation when the intention is to integrate. Indeed at the meeting I attended, just about the first contribution was a request that the Transport be included; in any rural area, access has always been the no1 issue, and since Social Work usually have their own adapted minibuses, the opportunity should be taken to remove Patient Transport from the Ambulance Service; until the localities are responsible for this it will always be easier and cheaper for them to take the patient to the care rather than the care to the patient.

Question 3 (and Qu16) No

As I have said before this is not possible unless there is a reciprocal duty for GPs to be involved, which will involve rewriting the GP contract.

Question 5 No

I am not at all clear how this three-way accountability – to the local Council, to the Health Board, and to the Scottish Government – can possibly work. There is an old Scottish Comedy about the The Servant wi' twa Maisters. Three beggars belief.

Question 6 Yes

Successive Scottish Governments have decided not to consider any redrawing of Council Boundaries even though they know that some are too small to be viable, and many boundaries in the Great Glasgow area were drawn to reflect the politics of the time. It might therefore be necessary not only to allow joint CHSPs but to allow portions of one Council to be part of the CHSP of another because that creates a more natural locality.

Question 9 Yes

This is of particular relevance to me, since Argyll and Bute CHP holds, effectively, its entire NRAC allocation, and purchases all its secondary care from other Health Boards, mainly GG&C. Although at present most of this is an unitemised block grant, it has the potential to address the issue I raised

at the start – of ensuring that some of the resource currently spent on acute admissions outwith the CHP is repatriated to provide enhanced care at home or in a homely environment.

Question 10/11 – no comment

Question 12 No

See my first comment on the budget

Questions 13-14 – no comment

Questions 15-20 (localities)

I believe it is key that the localities have ownership of the new arrangements, and therefore apart from minimal guidance – that there should be localities with real powers and responsibilities – these should be created locally by people representing all concerned. It will need to be part of the job description of the professionals that they fully participate.

While in rural areas the locality boundaries may be self-evident, with, say, all the patients being registered with one or a few GP practices, in urban areas it will be much messier. I do not believe that it would be helpful to set arbitrary population sizes.