Integration of Adult Health and Social Care in Scotland
Consultation document
Comments from Ayrshire and Arran Local Medical Committee

Ayrshire and Arran Local Medical Committee (LMC) who represent 260 active General Medical Practitioners working in Ayrshire and Arran welcome the opportunity to participate in this consultation exercise. The members of the committee have practical experience of working at the "coal face" and are actively involved on a daily basis at the interface of health and social care along with colleagues who have a local authority or NHS background. It is our experience that that the closest and most effective working for patients comes from locally developed schemes where "front-line" staff have the ownership not only of the delivery of the service but also in the planning and design. This was briefly recognised when Local Health Care Co-operatives which were "bottom up" organisations were developed in the late 1990s but the later model of the Community Health Partnership which was a top down management model did immense harm destroying much local work by not engaging with local clinicians, removing ownership from front-line staff and making it more difficult for local clinicians and other professionals to work together as teams to deliver seamless services for patients.

The committee welcomes any proposal to integrate Health and Social Care in Scotland but is somewhat nervous about yet another major management reform and system change. It is our experience that each time government decides on "reform", this involves an enormous amount of clinical and management time which would be better spent on developing and providing patient services and often inhibits the natural development and evolution of organisations.

There is no doubt that the committee, along we suspect with a lot of other organisations, does have reform fatigue and is somewhat sceptical about these proposed reforms and whether they will achieve was is intended. Many of the "problems" that these reforms intend to address result from government and management decisions made over the years both at a local and national level and the committee believes it would be best to address these issues and problems rather that undertaking wholesale change. A good example of this in Ayrshire is the disbanding of the primary care team by the local Health Board moving community nursing and health visiting from practice teams into localities to improve "efficiency". This goes completely against the whole philosophy of the changes now proposed by government.

Although the committee does have concerns about the strategic direction of these proposals, it does wish to comment on the consultation document and asks that its views are taken into consideration as the legislation passes through parliament.

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

With the developments in Health and Social care, the LMC believes it is wrong to specifically develop services for "older patients". This creates artificial barriers for patients and can cause problems with service delivery if a patient does not meet the criteria for a particular service. An example of this is in the field of mental health where a strict age barrier exists in Ayrshire and Arran meaning that younger patients with memory problems can have difficulty accessing services provided by the elderly mental health team and older patients with non dementia type psychiatric problems cannot access services from an "adult" psychiatrist.

Services should be developed holistically with patients at the centre, specialist services should be problem specific and age should not be a barrier. Patients and their general practitioners should have choice when accessing services and where possible should be able to access services from more than one provider. General Practitioners should be able to refer to the consultant of their choice and not be restricted by the Health Board as happens at present.

Following the emphasis on older people through the Change Fund, the committee believes that it would be helpful now to concentrate on other areas such as deprivation, smoking, drug and alcohol abuse and mental health issues which would allow a more holistic and population based approach to health care.

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

The committee would draw attention to its general comments (above) about these proposals and its concern about another (? fourth in 15 years) reorganisation with the resultant implications for the organisations involved.

From previous experience, there is little doubt that major structural change will divert attention, create a huge distraction both for clinicians and managers, cause organisational drag and will act as an obstacle to the development of locality services in the short term as the new arrangements are agreed and developed. A better approach would be to look and see where problems exist, look to see what has caused these problems and through a process of evolution allow for organisational change and development.

Although the committee supports the principal of caring for patients in their own home where possible, it is concerned that default position of reducing institutional care will mean that when people need institutional care it will be denied to them and that more packages will mirror the fifteen minute type carer visits that seem to form the basis of many care packages, leaving patients isolated and alone with a radio or

TV as their main companion. The committee would seek reassurances in this area that the decision for each patient would be primarily predicated on what that patient needs and not what is cheapest.

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care and for support to carers. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

The committee believes that the proposed model is doomed to failure – it simply will not work having these new bodies reporting to two completely separate and culturally different organisations. There will be confusion, ambiguity, problems with line management structures and difficulty in ensuring accountability as the new Health and Social Care Partnerships struggle to agree objectives and programmes of work.

If the government have chosen to go down this road, a more honest approach would be for it to make the decision of deciding whether the new partnerships should fall under the umbrella of the NHS or local government. If this is the intended future approach, this is the big decision which will need to be taken and the one government should have a view about.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

To avoid a "post-code" service, the committee agrees that there should be nationally agreed outcomes for adult and social care but these outcomes should be determined not by some remote national group but by patients and their locally based "front line clinicians and professionals. The outcomes need to be achievable, there needs to be a public debate about needs, wants and affordability and any nationally agreed outcomes need to be agreed locally by frontline staff.

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

The committee would draw attention to its comments in question 3 – as a nation we need to decide on the balance between local and central accountability and any decision regarding Health and Social Care Partnerships should form part of that debate. There is an argument that since the arrival of the Scottish Parliament, little decision making is left for local communities and any plan to alter that balance would

require discussion between local and national government along with the general public.

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Health and Social Care Partnerships should cover natural communities and that would not preclude them covering more than one local authority. Equally the opposite might apply with a local authority having more than one Health and Social Care Partnership. Depending on the model chosen, a Health and Social Care Partnership might overlap local authority boundaries as patients choose to access services in a way which is convenient to them

In Ayrshire and Arran, we have one Health Board, two district general hospitals, three local authorities and fifty nine GP practices, a significant number of which (through patient choice and geography) cover overlap local authority boundaries.

Health and Social Care Partnerships need to be locality based to be responsive to patients needs but equally they need to be large enough to allow for economies of scale. Different services may require different solutions.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

The committee does not believe that the proposed arrangements are appropriate to ensure governance of Health and Social Care Partnerships as the current proposals continue the mistakes of the current Community Health Partnership model by excluding front line clinicians and professionals from voting and decision making.

The committee believe that the majority of votes should lie with the frontline clinicians and professionals who work at the "coal face" with strong direct patient involvement. It also believes that the Health and Social Care Partnership should elect its own Chair and vice- Chair who would both have a vote and that the Chair should also have the casting vote in the event of a tie. The idea of a Chair revolving on an annual basis is flawed, it will not lead to strong leadership and the short-term nature of these positions will not give good strategic direction to these organisations.

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

The committee has no substantive view on this question – it can only be answered once the organisation structure is determined. There needs to be further consultation on this question at that time.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

In Ayrshire and Arran, Community Health Partnerships have no management functions. The committee would advocate an evolutionally approach to Health and Social Care Partnerships, initially with them controlling only minimal budgets. The decision to include other budgets should involve all partners, not just Health Board and Local Authorities, who should be involved in the decision making process and not just consulted once a decision has been reached.

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?

The committee believes that this is one way the objective "to use money to best effect for the patient" could be achieved but questions whether such a major organisational and structural change is needed to achieve these ends. The committee believes a better approach could be achieved by cultural change at management level and a more "bottom up" approach to the development and delivery of services to patients.

There is some concern that although the principle may be correct, what happens in practice will be dependent on subjective interpretation on the part of the person making the decision. Section 5.6 highlights the possibility of moving funding from Community Nursing to Social Care or vice versa. The relative values of the two services might be seen differently depending on the past experience of the person making the decision.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

There have been a number of local schemes in Ayrshire and Arran that have delivered on this agenda – the Irvine Valley integrated care scheme, the development of the single shared assessment process along with the locality based GP practice and social work meetings. All of these initiatives have been developed at a local level but have often been hindered by management or organisational change.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

The committee would caution against the concept of minimal categories of spend – if this is implemented, the reality is that organisations will be driven not by the health and social care needs to their patient population but by the necessity to make sure they have spent their budget – each Health and Social Care Partnership needs to draw up its programme of work agreed by all partners which is then signed off. Recurring funding must be put in place for the programme of work to move away from the project driven, short-termism of the past which did not embed core services within local infrastructure.

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

No – the Health and Social Care Partnership needs to involve all partners in its decision making and budget setting. It is important to balance the importance of ensuring core funding for essential services with the complete inability in the past to move money around the system. None of the models for moving money around the system in the past has worked – work has moved around the system e.g. from secondary to primary care but never any resources to allow primary care to develop to accommodate the extra workload.

The shift in the balance of care will only happen when both shifting the balance of care and shifting the balance of funding is discussed at the same time at the same table. Pump-priming resourcing will also be needed. This needs to be done on a consensus basis with agreed aims and objectives.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?
Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

It is unclear from the consultation document how senior the Jointly Accountable Officer should be. To achieve the outcomes set out in the consultation document,

these individuals would need to be recruited either from a senior management level within local government, the private sector or the NHS and would command a significant remuneration package but in this time of financial constraint it would be important to ensure that an expensive new bureaucratic structure was not being set up with highly paid managers delivering little of benefit to patients. To avoid significant variation of interpretation, government will need to set out detailed guidance on how these proposals are to be implemented.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

The committee would draw attention to its previous comments about the involvement of local professionals – consultation is simply not acceptable. Local professionals including general practitioners need to be at the heart of the decision making in these organisations both at a strategic level and also at a local patient level. The mistakes of Community Health Partnerships with their exclusion of clinicians must not be repeated.

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

The committee believes that embedded in the legislation there needs to be a clear pathway to involve front-line clinicians and professionals in the decision making and also the committee structure of Health and Social Care Partnerships. Clinicians who are actively involved in patient care (not those who primarily who have a management contract or role) need to be at the heart of decision making, they need to have time freed up or protected time to allow them to take part in these activities. There needs to be back-fill for independent contractors, their views need to be valued and they need to see the results of their work. There is no point in setting up a huge organisation with clinicians spending a lot of their time in planning service development to be told once development plan has been agreed that there is no money or resource for the new infrastructure or staffing required. There needs to be a commitment from government to make sure the resources are available to make this work.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Locality planning should be embedded around patients, all patients are registered with a GP practice and GP practices either singly or in groups are based in localities.

Locality planning and practices teams should be organised around GP practices which form natural communities of various sizes.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Locality planning groups should set the agenda for the Health and Social Care Partnerships and Health and Social Care Partnerships should be accountable to locality planning groups. To be responsive to patient needs, government need to accept that the model of setting up a top down organisation because it appears to be efficient has not worked in the past (this is why this reorganisation is taking place) and needs to adopt a new approach.

To ensure success of Health and Social Care Partnerships, local clinicians and professionals need to have "ownership" and need to buy in to the work they undertake. A "bottom up" approach will facilitate this approach.

Question 20: Should localities be organised around a given size of local population – e.g. of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Localities should be organised around communities and local populations. They should not be predicated by numbers. In Ayrshire and Arran the smallest locality will have a population of less than 5000 and the largest circa 50,000 but both will be viable and able to achieve their objectives. Groupings should be based on shared agendas and not size.

Do you have any further comments regarding the consultation proposals?

No

WMcA 060912