

A Response to:

Integration of Adult Health and Social Care in Scotland
Consultation proposals

Dr Elspeth Weir
Head of Policy and Development
Community Pharmacy Scotland
42 Queen Street
Edinburgh
EH2 3NH

Email: elspeth.weir@communitypharmacyscotland.org.uk

Tel: 0131-467-7766

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Consultation on Proposals for the Integration of Adult Health and Social Care in Scotland

Who we are

Community Pharmacy Scotland is the body recognised to represent Scotland's 1239 community pharmacy contractors which are situated across Scotland in a variety of settings. They offer unparalleled access for the public to health care advice and service. Community Pharmacy Scotland negotiates on behalf of contractors with the Scottish Government on all matters affecting terms of service and remuneration for contractors' NHS work.

Our prime focus in recent years has been the development of a new contract for pharmacy contractors, one which will call for the delivery of new services, potentially in novel ways, but continuing to place emphasis on the opportunity which community pharmacy offers in terms of access for patients to healthcare services throughout Scotland. The details and funding of this contract have been negotiated on a national basis. We are continuing to work on ways to secure greater integration and recognition of community pharmacy within the healthcare team and these proposals for integration will add a further layer of complexity to our work.

We welcome the opportunity to respond to this consultation on proposals for the integration of Adult Health and Social Care in Scotland. We recognise that there is a need for change as community pharmacy contractors already see increasing use of their services by the elderly and/or their carers plus pressure from social work staff for support in relation to the administration of medicines which can lead to conflicting interests between the health and social care strategies.

We have seen many attempts over the years to achieve better integration of health and social care. We welcome the focus being placed upon outcomes and we believe the integration agenda is the right one. We would like to see a clearer (restricted) definition of what is meant by integration and in turn what would be covered by the commissioning proposals. . Different people will interpret these issues in different ways and therefore it will be more difficult to achieve consistent outcomes. We have no objection to our comments being made freely available.

Questions

Q1 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?

Yes.

We do agree that there is a need to improve outcomes for older people and to achieve that it will be necessary to secure a shift in resource allocations. We think there is a need to concentrate on a fixed set of outcomes for a period and evaluate what has been achieved before proceeding to further integration.

It seems strange that there is not a question on whether what is being proposed is an appropriate route to travel. The proposals concentrate on one aspect of the current systems rather than a more fundamental restructuring. There is already considerable complexity and confusion as stated in the report from the Audit Commission and it is hard to see how what is proposed will simplify existing structures and ensure delivery of the outcomes desired.

Q2. 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?

No.

While we agree that greater integration is desirable we cannot see from the information given how it will be achieved in practice. The proposed framework calls for input from even more bodies, with more devolution of decision making and budgetary responsibilities and lacks clarity on how resource will be allocated between the new entities and other areas of health and social care provision. For example we are unsure as to what or even how the decision will be made on what is delivered as community health and adult social care via the new partnerships as opposed to through existing primary and secondary care healthcare and through social care

It is also unclear how these new arrangements will integrate with existing nationally negotiated contracts for independent health care contractors.

If there is a need to secure change quickly the Government should either have the courage of its convictions and be more radical and more directive in its approach, or accept that service redesign will be slow and complicated (this may not be in the best interests of patients and services).

We note that the proposal is for the roles of clinicians, social care professionals and the third and independent sectors to be strengthened. Feedback we have received would indicate that every one of these individuals is stretched to capacity and it is hard to see how time will be freed up without the input of significant resource to ensure they are able to support effective service/structural change. Our experience with CHPs and previously with LHCCs has shown us how difficult it is for community pharmacy contractors and their staff to secure meaningful involvement.

We note that the intention is to support the creation of new opportunities in the community – we feel community pharmacy has much to offer and we want to be sure that our input can be heard.

Q3. 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?

Undecided.

We agree that there is a need for the partners to be held jointly responsible. The key feature here is the desired outcomes and measures – unless these are realistic then change will not be achieved.

This is enabling legislation and will have to be accompanied with a willingness to implement. We query how compliance will be monitored and in the event of non-compliance which sanctions will be applied?

We note that local leaders will be free to decide upon delivery mechanisms and organisational structures to best suit local needs and priorities. We believe that is unlikely to deliver consistency of outcomes across Scotland or over time within an area.

Another factor is that the new arrangements add in another performance management mechanism and as such will require dedicated resource.

Q4. Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes.

We are not in a position to comment on how that will play out in practice.

Q5. 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?

Undecided.

A risk with joint accountability is that no party takes responsibility for their delivery. The aspect that both parties must deliver must be emphasised.

Our experience of change of this nature would indicate that there will be a surfeit of meetings, reports, accountability measures and little opportunity for actual delivery. Care must be taken to prevent the prospect of public disagreements between local and national authorities and the implications that has for public confidence.

Q6. Should there be scope to establish a Health and Social Care Partnership that covers more than one local authority?

Yes.

If the local authority covers a small area then there should be scope to ensure sensible use of stretched resources. Alternatively perhaps the time has come to look at the number of local authorities.

Q7. Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

No.

We'd like to see explicit recognition of the need for community pharmacy input given the high level of use of medicines in the elderly and the fact that inappropriate use can lead to unnecessary hospital admissions.

Q8. 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?

No.

We do not feel that if a member of the public has a legitimate complaint the arrangements are sufficiently robust to ensure that resolution will be achieved rather than either party deciding it is the other's issue to resolve.

Q9. 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?

No.

The crux of this whole matter is the size of the budget. If too much is placed in the budget then other activities could suffer. We therefore do not think that it is appropriate at this time to add in

other budgets. Because of complex funding mechanisms for pharmacy contracts and NHS Board resources we would wish to see medicines and community pharmacy local remuneration budgets excluded from the new arrangements.

Q10. 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?

Undecided.

It is a possibility but there is insufficient detail at present to allow us to assess whether it will happen. Community Pharmacy Scotland is however, keen the aim is delivered for the people of Scotland.

Q11. 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?

Yes.

We have been faced with increasing demand from social care for the provision of compliance aids to allow carers to administer medicines. Limited resource has been provided by social care and the NHS has been faced with picking up the costs for an increased workload.

Q12. If Ministers provide directions on the minimum categories of spend that must be included within the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Undecided.

That would seem a reasonable starting point but whether it will happen is impossible to say at this time. Any directions provided should be reviewed after a set period.

Q13. 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 shift the balance of care?

Undecided.

By giving the Jointly Accountable Officer role that authority it has the potential to effect change. Probably the more fundamental questions are where is the investment coming from, how will that impinge on other areas of service provision and is it sustainable without a full scale debate on how services should be funded long term.

Q14. Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes.

We anticipate there will be a significant cost attached to these appointments to ensure the calibre required of appointee is attracted to the position.

Q15. Should the Scottish Government direct how locality planning is taken forward or leave it to local determination?

Yes.

We would prefer to see direction given otherwise too much time is taken up in discussing what should happen. Experience from CHPs has shown that some local areas have delivered better than others. After a review of what has happened initially then the directions could be changed or removed.

Q16. 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?

Yes.

We would argue that the views of all local professionals should be taken on board. Previous experience has shown how difficult it is for this happen. The duty is strong enough - the problem is engaging meaningfully with local professionals, both from health and social care, who are already at or near capacity.

Q17. What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

The provision of an appropriate forum where they believe their opinion is valued. A willingness to recognise each other's strengths and weaknesses – job shadowing for a period may be a way to achieve that.

Q18. Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

No.

If health and social care is to be delivered in accordance with people's needs then we need to be clearer about which needs are or are not being met across the Health and Social Care Partnership. Planning should be about an overall assessment of need and allocation of resource rather than a link to a GP practice cluster.

Q19. How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Until the HSCP and the budgets have been set and operational for some time we do not think there should be any further devolution.

Q20. 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?

No.

We do not think it is sensible to try and set a given size. As the focus should be on populations and recognition of the size of a population where benefits can be achieved in a cost effective manner then the size of the locality may vary.