Glasgow LMC Ltd Response to the
Adult Heath and Social Care Integration Consultation Document

Annex G Consultation Questionnaire:

The Case for Change

Q1: ***Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, & then to extend our focus to improving integration of all areas of health & social care, practical and helpful?***

LMC Response: Yes.

LMC Comments: Leadership roles of health (& social care) professionals is welcome. Older people take up a great deal of GPs' workload, and the problem of revolving door patients who are re-admitted avoidably to hospital, because of a failed discharge package/plan needs urgent attention. However, how will the shared outcomes be meaningful to GPs? How will these outcomes dovetail with the main drivers of general practice, such as the nGMS Contract, enhanced services and patient demand? HEAT targets historically have little or no relevance to general practice.

Outline of Proposed Reforms

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?***

LMC Response: Yes.

LMC Comments: The framework seems comprehensive, but we have concerns about whether it is achievable. GPs would like clarity about how resources are proposed to be shifted from secondary to primary care, and be fully involved in the discussions around this. GPs are concerned that simply moving resources, without consideration given to the requirements for extra staff training, and for accommodation in practices for the extra workload will not be addressed.

National Outcomes for Adult & Social Care

Q3: ***This proposal will establish in law a requirement for statutory partners – HBs and Local Authorities – to deliver, & to be jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current separate performance management mechanisms that apply to HBs and LAs. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?***

LMC Response: Yes.

LMC Comments: This is welcome. However, GPS may feel that nationally agreed outcomes may in reality have little relevance to them at the front line of care delivery.

Q4: ***Do you agree that nationally agreed outcomes for health & social care should be included within all locally Single Outcome Agreements?***

LMC Response: Yes.

Governance and Joint Accountability

Q5: ***Will the joint accountability to Ministers & LA leaders provide the right balance of local democratic accountability and accountability to central government, for health and social services?***

LMC Comments: "The HB & LA will be required to devolve budgets from Primary care, adult social care and some acute secondary care to the new HSCP". We have concerns that this could lead to squabbling over budgets and consequent inertia.

Also, the Jointly Accountable Officer must have a full understanding of how general practices as independent contractors work, as well as how secondary care works.

Q6: ***Should there be scope to establish a HSCP that covers more than one LA?***

LMC Response: Yes.

LMC Comments: General practices have lots of cross-border patients, and hospital patients can be in a hospital different from their LA area.

Q7: ***Are the proposed Committee arrangements appropriate to ensure governance of the HSCPs?***

LMCComments: This remains to be seen.

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?***

LMC Comments: We will only know this once the new system is up and running. GPs, as the deliverers of many of the local services, must have confidence in the performance management arrangements also.

Q9: ***Should HBs & LAs 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 HSCP?***

LMC Response: Yes.

LMC Comments: but with caution and advice from clinical and LA leads.

Integrated Budgets and Resourcing

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?***

LMC Comments: We feel there is a potential for "nimbyism" and infighting if this is not carefully managed by the Jointly Accountable Officer. We would like to see robust and clear arrangements about integrated budgets in place. Also, till now, GPs have experienced a disconnection of the realities of patient care from CHPs' management structure. We do not wish this to be repeated.

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?***

LMC Comments: Not applicable to Glasgow LMC.

Q12: I***f Ministers provide directions on the minimal 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?***

LMC Comments: In principle, this seems reasonable. However, there may be problems if there are local disputes about spend.

Jointly Accountable Officer

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 achieve the shift in the balance of care?***

LMC Comments: This remains to be seen, and crucially depends on the personality of the appointee. The JAO will be the make-or-break person as to whether the HSCP will be a success or not.

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

LMC Response: Yes.

Professionally Led Locality Planning and Commissioning of Services

Q15: ***Should the Scottish Government direct how locality planning is taken forward or this to local determination?***

LMC Comments: This is better left to local determination. Practice-based Health Teams should be given a hub role, since they deliver care universally, and to 95% of the population as the recognised first point of contact. However, there is the potential for differences in priorities from health and social care (and third party agencies). A solution would be if social workers were attached to Primary Care Health Teams.

Q16: ***It is proposed that a duty should be placed on HSCPs 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?***

LMC Comments: GPs are excellently placed to offer advice about local service provision, since they have profound knowledge of local patient facilities (or lack of them), and their patients' needs. We know that GPs can play a significance role here. However, we are concerned about the expression "a duty to

consult", which is effectively meaningless. This should be replaced by "reach agreement" with local health professionals, social care teams and the third and independent sectors. We feel the relevant Local Medical Committee should be the GP body with whom HSCPs should reach agreement about general practice matters.

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

LMC Comments: GPs would be taken out of clinical duties if they are to be involved in any meaningful way in local planning. GPs are independent contractors, and locum cover needs to be arranged at the GP's expense to cover absence from clinical duties.

Therefore, we have concerns that to be properly engaged, GPs would wish the following questions answered:

- How much time would leadership role responsibilities take up?
- Who pays for the leadership role sessions?
- Will there be adequate recompense to provide the locum backfill required at practice level?
- Will the meetings take place at a reasonable time to suit those who need to attend? (GPs can more or less forget any meetings on Mondays, as Mondays are the busiest days of the working week).

If these questions are not satisfactorily answered, there will be no meaningful engagement with GPs.

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

LMC Comments: Clusters of practices may well have much in common in a locality, and it would make sense to organise planning along these lines. The evidence-based success of the Primary Care Health Team may also be a model. The Local Medical Committee could be a useful and important overarching body to guide clusters through planning processes.

Q19: ***How much responsibility and decision making should be devolved from HSCPs to locality planning groups?***

LMC Comments: This will vary from locality to locality depending on circumstances.

Q20: ***Should localities be organised around a given size of local population – eg., of between 15,000 – 20,000 people, or some other range/ If so, what size would you suggest?***

LMC Comments: We would suggest that health professionals should form localities as they see them naturally, which will nearly always fit in with mutually used local services.

Do you have any further comments regarding the consultation proposals?

LMC Comments: Glasgow LMC welcomes the opportunity to respond to this document. We welcome the recognition that CHPs thus far have failed to engage meaningfully GPs in their work processes, and we welcome the proposals to bring GPs fully into the front line regarding the setting up of HSCPs and their progress.

We have concerns that there will be no ring-fencing of resources for healthcare provision, and that social care could absorb the lion's share of available resources. ("He who shouts loudest…").

GPs must be able to devote full attention to the task. Therefore, they must be provided with adequate remuneration for their practices to cover absences from clinical duties. The paper acknowledges this.

We hope that by starting with older patients and sorting out the barriers to integrated care in this most important group, HSCPs can improve outcomes. This is a good starting point. However, it will take a great deal of investment in these days of fiscal austerity. We hope that the ambitions of the paper are realised.

Do you have any comments regarding the partial EQIA?

None.

Do you have any comments regarding the partial BRIA?

None.

Yours sincerely,

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