Integration of Adult Health and Social Care in Scotland

Consultation on proposals for legislation

A response by Alliance Boots

Executive summary

- Alliance Boots believes that statutory Health and Social Care Partnerships will help further the integration of care for patients' health and social care needs. However, the governance structures appear complex and do not give a clear answer to the question "Who is in charge around here?" in an easy-to-explain way.
- The proposals for professionally-led locality planning appear to be underdeveloped. More work should be done on this before a separate consultation in future.
- Having more than one HSCP per Health Board area could lead to practical difficulties if local authorities decided to take different approaches. A single HSCP per Health Board, including two or more local authorities might avoid this.
- Jointly accountable officers should be called "Joint Directors of Finance" to clarity their seniority, authority and responsibilities.
- The Scottish Government should set out an overarching framework for locality planning, including its scope, to avoid duplication of effort.
- No single profession should be given a dominant role in local planning. Consultations should include a range of professional groups (including pharmacy) and practitioners who work in different settings within each profession.
- Locality planning should be based on clear geographical boundaries and not clusters of GP practices. This would avoid giving the medical profession a dominant position.
- The number and role of local planning groups needs to be given more consideration before they are established. There is no correct size for such groups, but the consultation proposals appear to be on the small side. There is a danger that this could result in the need for expensive administrative support and considerable overlap in work and outputs.

Alliance Boots

About Alliance Boots

Alliance Boots is a leading international pharmacy-led health and beauty group, employing over 62,000 people in the UK. The group's businesses in the UK include the Boots pharmacy chain and our full-line wholesaler, Alliance Healthcare (Distribution) Ltd.

Boots UK operates the largest chain of community pharmacies in the United Kingdom. It is synonymous with pharmacy in the public mind and Boots is one of the country's most trusted brands.

Our company has around 2,400 pharmacies trading under the Boots brand, of which over 260 are in Scotland. These are located in all the places where people live, shop, work and travel, with many open well beyond normal office hours and across weekends. Almost all of our stores hold contracts to provide NHS services.

Boots pharmacies are well distributed across the country. Our chain encompasses those which serve small local communities, including some of the most deprived locations in the country, and health centres through to high streets and those which are part of the largest retail and destination shopping centres. This provides easy access for the widest range of customers.

Alliance Healthcare (Distribution) Ltd is the only UK wholesaler delivering medicines to all pharmacies, dispensing doctors and hospitals, operating out of 12 service centres across the country, including a major depot in Livingston.

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General comments

Alliance Boots recognises that our customers have a complex and interacting range of health and social care needs. Medicines are the mainstay for managing people with chronic conditions in an aging population. Scotland is at the forefront of supporting the pharmaceutical care needs of patients through the development and roll-out of the Chronic Medication Service (CMS) as part of the community pharmacy contract.

Community pharmacies have great accessibility and outreach. Every day, hundreds of thousands of people visit pharmacies to seek trusted advice and care, provided from locations that are conveniently situated near where they live, work, shop and travel.

However, pharmacies are not yet well integrated with other NHS healthcare providers in primary or secondary care. Links to social care are even less developed.

Alliance Boots believes that the clarity of the Scottish Government's proposals to establish statutory Health and Social Care Partnerships (HSCPs) will help further the integration of care for the health and social care needs of the population. We look to these Partnerships to work inclusively with community pharmacies.

The proposals for professionally-led locality planning and commissioning of services (Chapter 7; Q15-20) appear to us to be rather vague and underdeveloped compared with the rest of the consultation (and also in comparison with recent developments around commissioning in other parts of the UK).

We believe that it might be more appropriate to undertake further work on this, and discussions with relevant clinical professions including pharmacy, and to have a separate consultation on commissioning at a later date.

Alliance Boots

Responses to specific questions

We have not answered all the questions. We have made comments to questions that are relevant to our business and our experience.

Q1. Is the proposal to focus initially … on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health ands social care, practical and helpful?

While we understand the desire to focus on the needs of older people, since this group takes up a large share of health and social care resource, we are concerned that this might become something of a bottomless pit, given demographic projections for the future. Other groups, including younger people with complex physical or mental health needs might find that they never become a priority. There is a danger that failing to focus on the needs of younger age groups could simply be storing up problems for when they get older. There needs to be a greater focus on healthy lifestyles, prevention, screening and early interventions in order to produce a population that is capable of playing a full part in society, regardless of age.

Q2. Is our proposed framework for integration comprehensive?

We believe that the legal clarity of the proposed framework will be helpful and will help both sides focus on their shared responsibilities through the Health and Social Care Partnership.

However, the proposed structures for governance could be difficult to grasp, especially for those who are not closely involved, such as patients and independent contractors to the NHS like community pharmacies. They do not appear to answer the question "Who is in charge around here?" in an easy-to-explain way.

Given that there are 14 Health Boards and 32 Local Authorities, some Health Boards will be involved in two or more HSCPs. There is potential for difficulty if local authorities decide to take different approaches within their HSCPs. This could increase the workload for Health Board staff and executives. It could also make it difficult for providers, such as Alliance Boots, who are operating across Scotland, adding to the costs of doing business.

Q6. Should there be scope to establish an HSCP that covers more than one Local Authority?

Yes. This might be the way to prevent some of the issues raised under Q2 (above).

Q13-14. What are your comments in the financial authority and seniority of Jointly Accountable Officers?

We think that a change of title to "Joint Director of Finance" or similar might be helpful in terms of clarifying the seniority and authority of this role.

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

The Scottish Government needs to set out a reasonable degree of direction in order to ensure that the process being carried out across Scotland is done to a high and consistent standard.

There should be an overarching framework for locality planning and a specification of what is (or is not) in scope for consideration. There should be a consistency of process to avoid duplication of effort locally. This should ensure that businesses operating in more than one area do not face additional costs.

Having a clear framework should also avoid costly legal challenges by ensuring that all parties follow a clear due process in reaching any commissioning decisions.

Q16. Is the duty [of consultation with local professionals] strong enough?

The duty of consultation needs to be clear on two fronts:

- A wide range of health care professionals, including community pharmacists, should be consulted about local plans. Consultations should give equal weight to all participants' responses
- Consultations should be timely, clear and meaningful. Due consideration should be given to responses received, including taking action or altering proposals if necessary

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

First, the legal duties and requirements of differing professionals need to be catered for. Under the Responsible Pharmacist Regulations 2009, each pharmacy has to be under the control of a named pharmacist at all times. This means that community pharmacists cannot be expected to attend meetings during working hours without appropriate locum cover being provided (or paid for).

Second, ensure that no single profession is (or is seen to be) dominant within the planning process. The planning process must be transparent, with full declarations of interest being made under Nolan principles.

Third, within each professional grouping there should also be efforts to engage with a range of practitioners from different settings. In pharmacy, for example, this could include those working in small local pharmacies, larger multiple pharmacies in cities and shopping destinations, and in hospital pharmacies.

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

No. Organising planning around GP practices would have the effect of giving the medical profession a pre-eminent or dominant position in terms of driving planning. This is unlikely to encourage shared responsibility across health and social care. The other difficulty is that

GP practice boundaries might not necessarily align with areas that would be commonly recognised by patients.

Instead we would suggest that the basis of planning has to be on distinct geographical subdivisions of the Health and Social Care Partnership (such as Local Authority wards).

Q19. How much responsibility and decision-making should be devolved from HSCPs to local planning groups?

Rather than allocating distinct areas to local planning groups from the beginning, we think that this should a gradual and evolving process. Each locality should decide on its key priorities and build up experience and responsibility over time.

HSCPs will need to retain a strategic overview for their areas, including having multidisciplinary and multi-agency inputs. This will be particularly important for any decisions relating to service redesign and impacts on local facilities. These controversial decisions cannot simply be agreed at a local level without their impact on wider health and social care provision being considered across a wide area.

Q20. Should localities be organised around a given size of local population?

Endless reorganisations of the NHS have shown that there is no perfect size for local structures. However, a population size of only 15,000-25,000 does appear to be small for locality planning. This implies that there would be around 200 such local groups across Scotland. The recent reorganisation in England has produced 212 new commissioning groups, with average populations generally at least 10 times larger than this. Some commissioning groups are much larger.

Our concern would be that this could be very resource intensive, with each group requiring its own administrative support, depending on how much responsibility is delegated to them. It is not clear that there is sufficient variation in local needs or local service provision (such as hospitals) to justify this level of grouping.

We would suggest that there be no more than two or three localities for each HSCP, if at all, giving around 80-90 such groups in Scotland at most. The need for such localities should be closely examined before they are established.

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