

# **CHEST HEART & STROKE SCOTLAND**

## **RESPONSE TO CONSULTATION ON INTEGRATION OF HEALTH & SOCIAL CARE**

### **Introduction**

The consultation document asks for replies to 20 specific questions. Many of these appear to be concerned with the details of implementation of the proposals rather than the principles involved, or the direct impact on patient care. Others are relevant only to NHS Boards, Local Authorities, or community health partnerships.

The response below is therefore set out as a series of general comments under each of the chapter headings in the consultation document. It attempts to focus on the potential impact of the proposals on CHSS as a service provider, and on the interests of the service user groups we represent.

### **The case for change**

1. The document identifies the need for greater integration not only between health and social care, but also between acute and primary care services within the NHS. CHSS accepts that this is needed in some areas, but it cannot be achieved at the expense of the focus on specialist, condition-specific services along the whole of the patient pathway. In the area of stroke, for example, there is clear evidence of the benefits of specialist treatment at every stage of the patient's care.
2. CHSS recognizes the reasons for the initial focus on improving care for older people. Again using stroke care as an example, services in Scotland, particularly in the acute sector, have traditionally been located within older people's services, but 25% of stroke patients are aged under 65. We would therefore be extremely concerned if this proposal led to disruption in specialist stroke care for patients of any age affected by stroke, heart or respiratory disease. It may not therefore be feasible or desirable to focus exclusively on services for older people in the first instance.

### **Outline of proposed reforms**

3. Managed clinical networks (MCNs) have played a crucial role in improving services and outcomes for patients, initially in heart disease and stroke, and increasingly in respiratory conditions. They are not mentioned in the consultation document and this raises concerns that their importance has not been given due recognition. Wherever the organizational boundary lies, it is vital that the role and status of MCNs are preserved.

4. There is very little reference in this section to the impact on the current programme of preventative action, and associated expenditure, to help avoid future negative health outcomes – for example, the *Keep Well* programme in the area of coronary heart disease. In the longer term, it is important that these activities are included in the integration agenda, as they are essential to improving public health and quality of life, reducing health inequalities, and reducing future demand for both health and social care services.

### **National outcomes for adult health and social care**

5. As noted above, there has been very substantial progress in recent years in improving outcomes for patients through the work of MCNs. Much of this has been achieved through the implementation of detailed priority actions identified in, for example, the Scottish Government's *Action Plan for Heart Disease and Stroke*, monitoring of progress in each MCN by the National Advisory Committee on Stroke, and audit through the Scottish Stroke Care Audit. It is very important that this very detailed, condition-specific monitoring of outcomes is not lost through the focus on much broader national outcome agreements.

### **Governance and joint accountability**

6. Very little information is given on the details of third sector representation of the proposed Health and Social Care Partnerships, and the definition of 'third sector' appears to encompass private as well as voluntary sector providers. As the proposals stand, patient / service user and voluntary sector representatives are not given voting rights on partnership committees. It may therefore be difficult to attract full representation from patient groups and the third sector.

### **Integrated budgets and resourcing**

7. From the service user's perspective, the major issue which needs to be resolved here is that of charging. Under present arrangements, all NHS services and those of voluntary organizations such as CHSS are free at the point of use, whilst Local Authorities are free to charge for community services and private providers for residential and nursing care. Integration of budgets and resources will need to be implemented with great care to ensure that a 'postcode lottery' does not arise, with different charging policies for similar services in different H & SC Partnership areas.

## **Professionally led locality planning and commissioning of services**

8. A specific duty is placed on Health and Social Care Partnerships to consult with local health and social care professionals, including GPs, on how best to put in place local arrangements for planning, implementing and reviewing service provision. As with point (6) above, it is disappointing that no such specific duty is proposed for consulting service users, carers' representatives or the voluntary sector.

9. The process of integration of services at a local level will require professional staff to work together from different employers, who presently operate varying terms and conditions of service, professional accountability arrangements etc.

Experience even within the NHS suggests that this process will present major challenges. It is important that these are addressed, and attention of key professional staff is not diverted away from achieving the key quality ambitions which the NHS in Scotland has set itself.