Annex G Consultation Questionnaire

COMMENTS FROM THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

The case for change

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?

Yes ☒ No ☐

Comments

The Royal College of Physicians of Edinburgh ("the College") feels that the single biggest challenge to health and social care services is the rising number of frail elderly with multiple physical problems, cognitive impairment and increasingly complex care needs. Therefore an early focus on the elderly is logical, but the principles inherent in solving their issues should be applicable across the spectrum of adult care and these should be extended as soon as practicably possible.

Outline of proposed reforms

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?

Yes ☐ No ☒

Comments

Much of the framework is still too abstract to objectively assess at this stage.

For example, the statement on page 17 that "the role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened" is aspirational but too loosely defined – whilst it would be a mistake to be too prescriptive about how that might happen, the College feels there needs to be more emphasis on ensuring structures are put in place to do this in a meaningful way.

National outcomes for adult health and social care

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. 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?

Yes ☐ No ☐

Comments

The College has concerns that, whilst the consultation does not define what those outcome measures will be, a "flavour" of what they may be will be necessary to be sure that legislating for them is the correct approach.

The seven broad measures outlined in Annexe A are more statements of principle, not outcomes. Behind those principles there will need to be much more explicit measurable outcomes, otherwise it will be impossible to measure achievement or change. The outcomes need to be genuine outcomes that will make a difference.

It is, however, also worth bearing in mind that for clinical outcomes (eg mortality, morbidity, readmissions rate) measuring improvement in outcomes in the elderly, with multiple progressive chronic problems is harder than proving "cure" or "success" – proving a slower rate of decline or a slower increase in care needs is inherently difficult. Therefore, whilst the College has concerns that what is being proposed are not "hard measures", there is some merit in measuring qualitative as well as quantitative outcomes.

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

Yes ☒ No ☐

Comments

Yes, otherwise there is a risk of replicating some of the current inequalities and inconsistencies between Health Boards and Local Authority areas.

Governance and joint accountability

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?

Yes ☐ No ☐

Comments

Undecided. The College would like more information to be available on how this joint accountability would work in practice, and detail on how competing priorities for the different statutory organisations would be handled.

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

Yes ☒ No ☐

Comments

Yes. If these proposals are to be properly facilitative, they need to give sufficient flexibility to allow this to happen if needed – and given that Health Board areas often cover more than one local authority, it is hard to see how health and social care could be properly integrated without this.

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

Yes ☐ No ☐

Comments

The proposals, designed to facilitate partnership, introduce repeated and regular changes of role, which may be disruptive and inefficient.

The College is unclear on how arrangements will work where there is complex co-terminosity – will some Health Boards have to jointly establish several committees for different HSCPs, which may negate the suggested governance efficiencies?

The College welcomes the specific inclusion of primary and secondary care clinical

perspective, but questions whether this can be delivered through a single representative.

The College recognises the potential to streamline the committees involved through integrated HSCPs but, given that Health Boards have discretion whether or not to extend commissioning beyond care of older people at this point, and that the priority for integration will (correctly) rest with services for older people, asks whether the existing structures under CHPs may be still be required for some time and add to the pressure on health budgets and clinician time.

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?

Yes ☐ No ☐

Comments

The College is concerned that the data systems across Scotland to provide reliable performance management information for these new structures are available to achieve this laudable aim, particularly where the new HSCP link several local authorities to a single Health Board.

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?

Yes ☐ No ☐

Comments

There seems to be logic in this in order to avoid disruption to services currently provided under the aegis of CHPs in the transition to this model. It perhaps needs to be clearer how these budgets would otherwise be reallocated and managed – would they be repatriated or transferred to health boards or local authorities?

It would seem odd that where there are currently some budgets for successful services managed by CHPs this might be undone by this legislation. There would need to be some guidance on which budgets for what services might be included in HSCPs to ensure there isn't wide variation, or that the core purpose of HSCPs is not diluted.

Integrated budgets and resourcing

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?

Yes ☐ No ☐

Comments

They have the potential to do this if the models reduce duplication of effort, deliver the right care at the right time to the right people, in a timely way 7 days a week, and genuinely break down some of the unhelpful barriers between health and social care.

If, however, the Bill simply results in reorganisation of management structures rather than services themselves, then they will not.

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?

Yes ☒ No ☐

Comments

In general, where things work well it is because they are truly multidisciplinary, and where they do not work well, it is often because they are not.

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?

Yes ☐ No ☐

Comments

Minimum spend is only one driver – there is a risk that setting minimums gives HSCPs the message that the minimum is the target that should be aimed for, or result in a "drive to the bottom". If minimums must be used, the evidence behind how they are derived must be properly evidence based.

Jointly Accountable Officer

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?

Yes ☒ No ☐

Comments

Yes, but as well as having the power to enable that shift, the JAO needs to be able to demonstrate that that there is evidence for doing so.

The case for investment and shifting the balance needs to be properly made, evidence based, assuring continuity and ideally improvement of care, in addition to being sustainable and most importantly not destabilising other services.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes ☒ No ☐

Comments

No further comment.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes ☐ No ☐

Comments

The Scottish Government should provide a template for how it will happen, otherwise there will be too much local variation.

If the legislation is to produce more than simply an expensive reorganisation of health and social care, the Scottish Government needs to stipulate a clear framework for locality planning which requires professional, rather than simply managerial, led planning.

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?

Yes ☐ No ☒

Comments

The College does not feel this is strong enough. There should be a duty to *involve* rather than a duty to *consult.* GPs and consultants must be *involved* in planning service provision, not just consulted on the arrangements for planning.

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?

Comments

HSCPs must value senior doctor time sufficiently and commission GP and senior hospital doctor time for this task. The use of that time must be effective and valued, and resourced explicitly through job plans.

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

Yes ☐ No ☐

Comments

This could be of particular benefit in widely dispersed rural communities where needs and practical solutions may differ quite widely. The challenge of coping with GP practices where patient straddle different local authority and health board areas needs consideration.

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

Comments

Further information needs to be provided on examples of responsibilities that could be devolved.

The actual provision of, and management of, locality specific services would be possible, but for services which cover wider areas the HSCP should probably retain responsibility.

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?

Yes ☐ No ☐

Comments

This sort of size range may be appropriate in dispersed rural areas. However, further investigations should be made into suitability in an urban setting.

Do you have any further comments regarding the consultation proposals?

Comments

The College recognises that changing demographics and the resulting shift in pressures on health and social care services, combined with an extended period of financial restraint, mean that it is necessary to raise awareness of the challenges being faced.

However, the College feels that care must be taken not to pursue a strategy of admission avoidance to acute care which is not evidence based. Whilst the aspiration to reduce acute hospitalisation, particularly of older people, is laudable, the philosophy behind this policy is based on two unproven principles – that care of frail older people outwith acute hospitals will be less expensive and, crucially, will also be at least as effective as hospital care.

It is therefore important that there is recognition that a fine balance exists between promoting avoidance of unnecessary admission of older people and restricting appropriate access to best care at times of medical need.

Care should be taken not to rush into a service model where patient safety could be compromised until there is clear evidence that care of patients outwith acute hospitals will be less expensive and, crucially, will also be at least as effective as hospital care.

There is general consensus that the development of intermediate care services, from both the perspective of the user and those involved in delivering care to older people, would be simplified by the unification of health and social care budgets and management. However, it is important to recognise that there should be a structure of decision making which fully involves clinicians. Failure to properly engage senior clinicians in decisions about clinical services, which too often are made with non-clinical input, can mean services and clinical outcomes are adversely affected.

At this stage, the proposals are very much about organisational philosophy, rather than explicit plans and examples.

The College looks forward to receiving more detailed, clear information and examples of how services will be affected as the Bill drafting progresses.

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Do you have any comments regarding the partial EQIA? *(see Annex D)*

Comments

No comment.

Do you have any comments regarding the partial BRIA? *(see Annex E)*

Comments

No comment.