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Response to the Integration of Health and Social Care Proposals

The Royal Pharmaceutical Society (RPS) is the professional leadership body for pharmacists in Scotland, England and Wales. The RPS leads and supports the development of the pharmacy profession for the benefit of patients and improving public health.
This response comes from the Scottish Pharmacy Board (SPB), which is an elected body of pharmacists representing all sectors of pharmacy practice in Scotland. In 2011, there were 4266 pharmacists practising in Scotland, the majority of these employed in community, hospital or primary care settings with others in industry, academia and the prison service.

We are pleased to have the opportunity to respond to the Scottish Government consultation on the integration of adult health and social care in Scotland and believe that working in partnership, alongside our GP and other health and social care colleagues, pharmacists have an important role to play in ensuring successful patient outcomes and improved patient care.

The Scottish Government document: *The Right Medicine, A Strategy for Pharmaceutical Care in Scotland*, was instrumental in extending the role of pharmacists to make better use of their clinical skills within the NHS. Despite very little mention of the pharmacy profession in particular in this consultation we are confident that current Scottish Government policy will continue and the expertise of pharmacists in providing quality pharmaceutical care will be acknowledged as essential to successful integration and the best use of available resources.

As the professional body representing all sectors of the profession we would like to be more involved with the working groups and development of proposals and regulations. We are happy to discuss this further with Scottish Government.

The Role of Pharmacists

Pharmacists are experts in medicines and provide a unique contribution to improving patient care. With five years specialist training they possess the widest knowledge of the science and use of medicines of all the health professionals. The professional expertise of a pharmacist is essential to ensure maximum health outcomes wherever medicines are used. Provision of pharmaceutical care is a core element of the pharmacy role i.e., making sure the right patient gets the right medicines, in the right dose, at the right time and for the right reasons. A pharmacist is responsible for all aspects of medicines governance including:

- being responsible for the quality of medicines supplied to patients
- ensuring that the supply of medicines is within the law
- ensuring that the medicines prescribed to patients are safe, appropriate and effective.
- advising patients and carers about medicines, including how to take them, what reactions may occur, answering medicine queries and encouraging self care
- advising other healthcare professionals about safe and effective medicines use, safe storage, and secure supply of medicines
- ensuring integrity in the medicines' supply chain and ensuring pharmacy premises and systems are fit for purpose.

Pharmacy contractors provide NHS services as independent contractors in a similar way to GPs and the managed service of NHS Scotland employs pharmacists in primary and secondary settings with specialist pharmacists in many therapeutic areas.

Pharmacists also have a role in public health with health promotion and disease prevention. Aspects of the core community pharmacy role such as providing smoking cessation services and emergency hormonal contraception have a direct link to social care. Pharmacists in the community see people on a regular basis who do not routinely visit their GP and are hard to reach, making the accessibility of community pharmacies an important asset in any strategic approach to health and social care.

Current Practice Context

It is known that up to 7% of unplanned admissions to hospital can be a result of drug-related events and this can increase to 20% in the frail elderly population[1].Interventions need to be moved upstream into the community with the emphasis on disease prevention and quality pharmaceutical care. Between 30-50% of prescribed medicines are not taken as they should be [2] and this, combined with patients' lack of understanding of their medicines, contributes to adverse drug-related events.

The consultation acknowledges the current disconnect between primary and secondary care. Presently community pharmacists are not routinely informed of patient discharge information. Communication to GPs can be delayed and reasons for changes to medication are not always made clear. This can lead to delays and errors when people are discharged and ultimately can result in harm and re-admission to hospital. It has been shown that adverse drug events occur in up to 20% patients after discharge and is estimated that 11-22% of hospitalisation for exacerbations of chronic disease are as a direct result of non-compliance with medication.[4]

Pharmacists in secondary care are heavily involved in the Scottish Patient Safety Programme, in medicines' reconciliation and in initiating safer working practices to reduce the use of high risk medicines. However, they do not have the resource capacity to intervene and review all high risk patients and an increase in resources in this area would decrease the number of medication related incidents and hospital re-admissions.

Future Strategic Approaches

Given the influence which prescribing and medicines have on all aspects of patient care RPS believes that pharmacy representation is essential at all strategy planning tables and true integration of both community pharmacists and NHS employed pharmacists into the NHS teams is required to drive the improved patient outcomes' agenda forward.

Pharmacists have a unique role in the patient journey as the experts in medicines. The RPS's recent response to the Scottish Government Review of Pharmaceutical Care in the Community is attached and has recommendations for changes to the pharmacy business model which will ensure earlier interventions to improve patient safety, freeing up pharmacist time to provide the quality pharmaceutical care required to prevent drug-related events. Increased cross-sectoral working and better communication between pharmacy systems and personnel in primary and secondary care is required.

Pharmacists have a key role in the governance of medicines in the community. The NHS Scotland Chronic Medication Service, currently being rolled out in the community, provides a structure to support patients with long term conditions. It provides information to patients on the importance of medicines' adherence and informs pharmacists on how patients are managing at home but, in order to ensure the safest and most effective patient care is in place, and provide holistic care, increased liaison is required with social care colleagues. Changes in business models are required and the

integration proposals will provide a platform to initiate changes. RPS is happy to work with Scottish Government to discuss all implications of the care of older people in their own homes.

IT and Information Sharing

There are now many health professionals involved in patient care and it is essential that there is efficient sharing of information between those delivering care in the various patient care settings. Access and input to a single patient record will become even more important with closer working practices with social care colleagues. In addition to the infrastructure required to support this there needs to be a culture of sharing in the interests of person centred care, improving patient journeys and getting it right first time.

Responses to Consultation questions

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?

We appreciate the requirement to establish long term measures to support the ongoing demographic changes and support change measures in line with Scottish Government programme of Reshaping Care for Older People [6] as a priority.

It is important that individual HSCPs have autonomy to decide for themselves how best to implement change and, given the complexity of the integration agenda, it would seem sensible to approach in a stepwise manner and evaluate ongoing progress.

In particular, we would like more information on how the expenditure of “some acute services” will be calculated for transfer to the new partnership.

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?

We wish to comment particularly on the lack of detail overall while including specifics around some healthcare professionals. In particular, more detail is required on the scope of the proposals as to what will be explicitly included or excluded:

We draw attention to the inconsistency in proposing multi-disciplinary clinician-led leadership while singling out one profession, General Practitioners, to be key to the planning process. RPS and RCGP are agreed that a model based on GP commissioning would not be appropriate and that a true multi-disciplinary approach is required.

RPS would like to work with Scottish Government to ensure that the proposals, as they emerge in detail, include the appropriate pharmacy input required for a comprehensive, patient-centred approach.

The use of medicines is a frequent intervention in patient care and they are increasingly complex and expensive. Medicine related events contribute to I in 7 unplanned hospital admissions [5]in the older population. Integration plans must recognise the need for pharmaceutical input at both strategic and locality planning levels. The framework must include pharmacy expertise from the initial planning stages right through to delivery. Areas where pharmacist expertise is necessary include:

- clinical governance wherever medicines are used

- patient safety

- education and training of social care staff

- pharmaceutical care in care homes and care at home

- continuity of care between primary and secondary settings including discharge planning

- anticipatory and end of life care

- ensuring cost-effective evidenced-based use of resources.

At a local level it is important that pharmacists are engaged in the planning as well as the delivery of services. Established governance of prescribing budgets through primary care pharmacy teams and close working with GPs will need to continue as well as closer links with social colleagues and local collaboration. Pharmacists have an important role in training and education of social care personnel providing care at home to patients in the community.

Services provided by community pharmacists to support people to remain in their own home, e.g. medicines' adherence support, and medication review should be recognised as part of the package of care for people.

Local planning strategies must include wide representation from the health and social care teams allowing the protected time for "hands on" pharmacists and other clinicians involved in patient care to collaborate in the local planning of services.

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?

We support the principles outlined and welcome the outcomes-based approach with local flexibility to deliver services. All opportunities to build on previous experience should be taken with the emphasis on minimal structural change, concentrating on a framework which allows health and social care personnel to work together and facilitate ease and speed of decision making for patient benefit.

We support the statutory requirement for delivery of services and accountability as this provides the most robust approach to ensuring national outcome measures are delivered.

It is imperative that the clinical professions are represented fully in the planning of services. There needs to be ongoing and meaningful engagement and discussion on local delivery plans with the joint accountable officer to ensure successful delivery of agreed outcomes.

National guidelines/framework should be forthcoming on the principles of integration to ensure all planning is multi-disciplinary and the same professional groups are included to give consistency nationwide while allowing local flexibility of delivery.

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

In order to achieve the objective of reduction in variation of service provision across Scotland, national outcomes and measures are required and would be welcomed to give locality planning groups a robust framework to work within. The inclusion of these in the existing structure of the single outcome agreements should facilitate easy of approach for local authorities.

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?

It is our understanding that the democratic balance will not change from the current accountability in the respect that health boards are presently not democratically elected (other than pilots schemes), whereas local authority members are, and that equal numbers from both sides will be represented in the new committee structure.

Further clarity is required on how the roles of Chair and Vice Chair will be divided between the Local Authority Leader, Health Board Chair and the Minister.

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

Ideally borders should be co-terminus with only one local authority and one health board but economies of scale will prevent this.

Strategic objectives should align with those of the Quality Strategy and priority must be given both to ensuring equity of provision for patients and to minimising variation.

Cross boundary issues can cause confusion in delivery of services and unnecessary complications for patient care therefore a very robust national approach will be required to ensure equity regardless of patient's postcode.

There will need to be some consistency in the implementation of Nationally agreed services and policies for health, social care and the independent/private sector in order to avoid undue variation in methods of delivery .

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

With reference to consultation section 4.18 on non-voting members.

We would ask that given the role of medicines in the number of unplanned admissions to hospital, and the importance of the pharmacist's role (ref Q1), that pharmacists are explicitly included as professional advisors to the HSCP Committee.

There is currently a statutory requirement for a community pharmacist on the CHP. We request that a statutory requirement for a pharmacist remains in the regulations and suggest that to meet local needs, while allowing flexibility, the Area Pharmaceutical Committee should nominate that pharmacist, who would not necessarily have to be a community pharmacist. This will ensure the correct level of experience and strategic input is obtained. If this is not possible then, as an alternative, there should be a pharmaceutical advisory committee to provide advice and professional input to several HSCP committees.

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?

More detail on the performance management arrangements and how they will be monitored is required to make further comment.

The ability to react swiftly and make necessary changes in practice if arrangements are not successful will be paramount to sustaining quality person-centred care and ensuring public confidence in the new systems.

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?

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As above (Ref Q1) CHSCPs should have flexibility in local implementation if this makes delivery and implementation of services easier and less bureaucratic.

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?

In principle, yes, building on successful models elsewhere but a cultural change will be required with full commitment from everyone involved and strong leadership, sharing of best practice and leading by example.

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?

No.

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?

The proposed national outcomes and measures should give sufficient direction to ensure HSCPs organise their budgets accordingly and retain accountability. Too much direction from Government on minimum categories of spend will reduce the local flexibility to deliver services and reduce local responsibility and accountability.

We are concerned specifically with the subject of prescribing budgets which constitute a large proportion of health board spend in primary care and are under continual and increasing pressure as we successfully treat long term conditions and address the changing demographics in the population.

We support flexibility at local level to provide services adapted and pertinent to local needs within a national framework which will eliminate postcode prescribing and variation.

We have concerns if the prescribing budget is to be included in an integrated joint budget. Prescribing is a complex area of patient care and we have both national governance through the Scottish Medicines Consortium and local prescribing governance by pharmacy teams at health board level which provide the necessary pharmaceutical advice to deliver the best patient care while making efficient use of resources. These existing governance structures need to be retained and to have input into the key HSCP decision making forums.

We are happy to discuss this further with Scottish Government and to provide professional input to relevant working groups.

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?

There is not sufficient detail in the consultation to comment on the authority of the JAC

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

There is not enough detail in the consultation to provide comment on this post

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

As outlined above (ref Q3), there should be flexibility at local level to allow for differences in demographics. However, national guidelines/a framework should be forthcoming on the principles of integration to ensure all planning is multi-disciplinary and the same professional groups are included in local planning committees to give consistency and avoid postcode differences in quality of service.

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?

As above (ref Q 2, 3 and 7), it is important that there is strong leadership and direction at both strategic and local levels with a multi-disciplinary approach and sharing of the planning across all healthcare sectors.

There should be a statutory duty to ensure a multi-disciplinary approach.

Pharmacists should be explicitly included in the list of health professionals who must be included in locality planning and anywhere medicines are mentioned or discussed to ensure safe and efficient medicines' governance. (ref. role of pharmacists Q 1, 2)

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?

Protected time will be necessary to allow clinicians to attend relevant planning meetings and participate fully

The intervening time until integration takes place should be used to promote joint working and shared understanding of the role and remit of both health and social care professions.

As many opportunities as possible should be taken to involve key stakeholders at an early stage including patient groups to encourage local ownership of the upcoming changes and develop successful models.

Regular meetings should be arranged between relevant professional bodies to establish patient care pathways.

In our joint working statement and action plan: *Breaking Down the Barriers; how community pharmacist and GPs can work together to improve patient care*, RCGP and RPS have suggested the use of established local forums to share critical event analysis and learning with case studies straddling health and social care examples.

Methods of sharing learning between health boards should be established.

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

While GP clusters might be a suitable starting point in some localities this should not be seen as the exclusive way forward as local demographics could dictate the need for flexible local solutions.

Community pharmacies are also an important hub in the community reaching some of the population who do not attend GP surgeries and are otherwise hard to reach. Approximately 600,000 people visit a community pharmacy in Scotland every day.[3] A hub and spoke model using both GP surgeries and the surrounding community pharmacies would provide a more comprehensive approach and encourage and facilitate collaboration.

We must emphasise that where GP clusters are a suitable option around which to organise planning this should not lead to a GP commissioning model. No one group of professionals should be seen to be leading local commissioning of services and a multi-disciplinary approach will be necessary for successful integration.

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

The locality planning groups should be able to adapt services to fill local gaps and needs while allowing them to deliver the outcomes and measures required nationally. Locality groups need to be accountable to the HSCP to provide:

- consistency of provision across the HSCP
- maintenance of quality standards in service provision
- services which are suitable to local needs and which address identified gaps.

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?

This will depend on local needs as remote and rural situations will differ vastly from high density inner city areas and there will be variations within the deprivation index. A person-centred approach needs to be flexible but also needs to be balanced against extra administrative burdens.

Comments on Proposed Outcome Measures

Medicines play an enormous part in the health and well-being of our older population and this is increasing as we successfully treat long term conditions.

Outcome No 1. Healthier Living. All pharmacists can contribute to encouraging self-care and preventative lifestyle approaches to major disease states e.g. cancer and diabetes. We believe any long term strategy should channel resources into both these approaches and we welcome the statements in 4.11 of the consultation which commits to the promotion of early intervention and prevention. Accessibility of community pharmacies, in particular, and pharmacy support staff have an important role in their communities and can tailor lifestyle and public health interventions to support both prevention and self-care. Any health and social care integration proposals should also take account of the outcomes of the current review of pharmaceutical care of patients in the community. Our response to the recent consultation is attached.

Outcome No 3 Positive experience and outcomes We know that 20% of patients experience adverse drug events after discharge from hospital and that patients are especially vulnerable when transferring between settings. We refer to the RPS report: *Keeping patients Safe when they transfer between care providers – getting the medicines right*, and urge the Scottish Government to take note of these findings and recommendations. Long term strategies should be developed using the expertise of pharmacists to minimise errors along the patient journey and to maximise positive outcomes.

Do you have any comments regarding the partial BRIA? *(see Annex E)* The proposals at the moment are not detailed enough to predict any impact on business. As a professional body, the RPS does not have any comment to make on the potential impact on business; however we do recommend that, in the intervening time before integration, the change fund is used to pilot integrated models of care and the outcomes evaluated. Our work with RCGP and the recommendation in the RPS report: *Improving Pharmaceutical care in care* homes provides options to explore.

Chair – Scottish Pharmacy Board
Royal Pharmaceutical Society

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