

## **“WHAT CAN WE LEARN FROM THE ENLIGHTENED SCOTS?”**

Terry Findlay: Thank you very much for that kind introduction. You're absolutely correct: they come to Glasgow to drink. They leave usually through the accident and emergency department, but there are other flights that people can take out of Glasgow.

I've got 20 minutes - that's my challenge - to explain the Scottish system and what its relevancy is really to you and partnerships in general. The great thing is I don't really need to sell the benefits of partnership. It's been an absolute pleasure to sit here over the last day or so and just hear the commitment to partnership and the understanding of that, and there's many audiences and many settings that I go to where that isn't the case, so this really is a pleasure. So I'm going to focus on those bits that I think are different for you and hopefully something that you'll not necessarily learn from but I hope will provide some stimulus to your thinking.

Firstly, just looking at this picture, do you see that thing in the middle? It's called a river. I don't know if you've seen one of those. Certainly eight weeks back in Australia it is a different place after 10 years, and in terms of the dry I just thought you may not have seen that before.

What I'm going to do is describe the situation prior to integration in Scotland, and Greater Glasgow in particular, in two distinct phases. The first part is about primary care integration. Thankfully, Phillip didn't go on about definitions of primary care this morning. I think we were relieved at that. I'm certainly not going to do that, but when I talk about primary care I'm talking about it in its broadest sense and certainly not in a narrow focus. Then the second phase of integration is about primary care with social care, and I'm going to look at what some of the results of that are and some examples and some features of that partnership. I'm not going to do an awful lot on the features, because I think you know a hell of a lot about partnership challenges, but I will give you some concrete results.

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So before I start I do feel obliged to mention something that Julie mentioned to you yesterday, and that is talk a little bit about that place south of Scotland. You may have heard of it; it's called England. There is no national health service in the way that many speakers, particularly English speakers, will talk about. It is four nations, an increasingly divergent four national health services. Yes, as there are in the Federal system in Australia, there are some national arrangements that the four nations agree to and, therefore, you do get some national consistency, but there is an increasing divergence. I don't just say that as a kind of like chip on the shoulder because Scotland is a small country; I say that as it's quite important as I go on with this presentation to understand the differences in culture and the way in which the Scottish culture influences partnerships and how they work and how the system works compared to that in England.

So prior to integration this is what it was like. You know that feature, the silo mentality. In primary care terms, that meant that the four major strands of primary care were organised, their policy was developed and their direction was independently arranged. The first part of that, and the big part of that, is the national contracts with general practice, dentists, pharmacists and optometrists. Those were national contracts that were administered locally and essentially it was a back-room chore with little added value to it. It was focused on processing, focused on paying and particularly focused on finding the people who weren't doing the right thing. It was a non-cash-limited budget, and that meant that there was little local ownership.

The second key area is medicines management, or what you'd call the PBS. That was, similarly, a large national scheme with very little local involvement, some compliance and licensing work, but, apart from that, again it was basically monitoring a non-cash-limited budget.

Community-based health services were, as you would know, a variety of organisational forums, some of them vertically and horizontally integrated, others simply standing alone, some with

GP practice attachment, other models that you'd be more familiar with, like community nursing teams, but those were again all independently managed and organised. And the last kind of area was health improvement. Now, health improvement was very jealously guarded through the public health arena as another area of work, another silo essentially.

So there was no overarching primary care strategy. Contracts were administered, and certainly there was no value added to them in terms of achieving goals. The formal joint working was often described by people who experienced it as a war. So there were partnerships, but that partnership was about who could destroy each other's aspirations. This is what I'm told. There was no investment strategy, there was no infrastructure development, and the relationship with the acute sector really only had two features. One was through an individual referral from general practice, and the second one was discharge to in-home support services such as community nursing or other types of arrangements, and that's basically it. So that was the picture.

What happened then was actually just the same - and this is something I can go quickly over - as your circumstances. A series of drivers, the largest one being devolution, occurred. That's the Scottish Parliament, by the way, for those of you who don't recognise it. That sits in a small town about 40 miles east of Glasgow. It's called Edinburgh. Scottish devolution is very important, because I'll talk and you'll hear more about devolution, because it started with the creation of the first Scottish Parliament in 300 years and has moved forward through the system to regional devolution.

The thing that I was mentioning about the difference between the various nations is that devolution brought with it the ability for Scotland to begin to direct its health service in a way that it wanted to and actually reflected the culture of Scotland, and that one actually is quite an old-fashioned one, you'd probably find, of collegiate relationships, of partnerships, a mistrust of the private sector, and I think those reflect the public values really in Scotland.

So we don't go into, and never have gone into, the whole market-driven change to the system. It is a kind of logical, or so it's seen, planned and collegiate system.

So public sector reform was just like yours except possibly with one difference I'm hearing, and that is that the message came very loudly and very clearly that if agencies did not reform, did not achieve a partnership and achieve those improved results, then they would disappear, that there really wasn't any room for fiefdoms and for bureaucratic arrangements that were put before the objectives that were trying to be achieved. Now, that was really just talked about this morning, so I don't need to go any further into that, except that that imperative underpinned, I think, everything that happened subsequently.

Now, inequalities is the whole other driver in the system reform and integration in Scotland. This picture is an iconic photograph. You may have seen it at various times. It's either called 'The Glasgow Boys' or 'The Gorbals Boys'. You might think it came from the 1920s or 1930s. It's actually a photo of the 1950s. It is my own generation and is the kind of picture that you would have if you were brought up on a council estate in Scotland. The thing about averages masking the real situation: those two boys, if you didn't migrate, like I did, one of them statistically would be dead and the other one definitely would have multiple chronic illnesses. The difference in life expectancy within Greater Glasgow and Clyde between the richest and poorest is 12 years. That stunning and shocking figure is actually what drives much of the public sector reform change and primary care integration.

The last thing in the background is a rediscovery - and we seem to do it all the time, which is just wonderful - that health and well-being cannot be effected alone by the health system. That was renewed again today with that comment about the latest WHO report, and it's just wonderful that we keep rediscovering that truth. And so that again was an important thing.

So first-stage integration was to take those four streams that I described, those four major parts of primary care, and bring them

into one organisation, at that time known as the Primary Care Trust. So it was about regionalising, so taking from a national position a series of arrangements for contracts with contractors in the same way as you operate the MBS, except it's over probably a wider field, including dentists and pharmacists, and begin to operate that using more localised contract arrangements on a regional basis. It became similarly cash limited. So moving from that open-ended arrangement by which the national government in Westminster carried the can for any excess expenditure, it became a normal local budget. Similarly, medicines management - what you'd know as the PBS - became localised, became regionalised and then became subject to local arrangements. Now, it's not entirely a local scheme. Thankfully, I never had to negotiate with multinational pharmaceutical companies over price - something I quake at the thought of. So obviously there are things that are done on a national and often a four-nation basis, but when it comes to things like quality formularies, cost, et cetera, those things became local issues. All the primary care direct providers were joined into the Primary Care Trust as well as a whole series of specialised services. In order to deliver those, the Primary Care Trust, which in Scottish terms was very large compared with England - we're talking here about a million people who are covered by this trust - was divided into this thing called local health care cooperatives. The cooperatives are the way in which providers and the community were engaged in the system.

The thing about that arrangement is it's not like your partnerships that you've been describing. It's clearly not voluntary. It was an arranged marriage, effectively. All those things were brought together, like it or not, into a devolved regional arrangement. So that took care, really, of a number of the issues which I think we struggle with between levels of government in Australia.

The big thing that that affected - an example I'll give is exactly the same as what you've been doing - was chronic disease management or long-term conditions management. This is the big area that that integration affected. Nothing new in the areas that we covered, based on the conditions in the geographic area.

Those were the seven areas of disease or conditions that we addressed over a seven- or eight-year period.

The big thing, I suppose, is not that it's any different. As you know, the best practice standards for addressing these particular diseases are going to be exactly the same here as they are anywhere else in the Western world. The big difference really is the question of how do you implement it. I'll take diabetes as an example. Although it's relatively straightforward to decide the path for type 2 diabetes in particular, the arrangements that we would come to are that inside that pathway we would define the role of all providers within it regardless of where they came from, what sector, what profession, and then we would specify that into a series of contracts, negotiate a price, and then begin the delivery of it. The Primary Care Trust as a vehicle offers the opportunity really to control all of those various elements through the contracting system, either directly providing it or contracting for it.

The important thing, of course, is that it was feasible to implement, that it was negotiable and there was clinical confidence in those arrangements. As I was saying to someone just the other day, this is not a hands-off contracting arrangement; this is a very interdependent contracting arrangement by which you deal with people as people that you are dependent upon their results as much as you are as the purchaser.

All those guidelines and specifications, as I say, had clinical confidence based on really national and international standards, and all components were done simultaneously. So it wasn't like, 'Okay, we'll deal with the GP part, and then we'll deal with the podiatrist bit, and then we'll deal with the nutritionist, and then we'll deal with the specialist'; all of them are done at the same time, and the entire population had to be dealt with together. We also were able to deal with through the whole chronic disease management program the impact upon prescribing and the impact upon things like diagnostics, particularly laboratory arrangements.

So nothing really very different in the Scottish system about the need and the way of handling chronic disease management, but I

suspect the vehicle for implementing it and our ability to implement it in a consistent way across the system is different to the Australian context. It's an organised program with really most of the levers and incentives lying in one place. It's the opposite to a system of establishing a set of guidelines and throwing them out there and saying, 'Here's the best way to do it. Good luck.' We didn't, and I hope will not continue to, do that because it doesn't work. We know that for sure. It only works with a very small proportion of providers.

So we worked on the assumption that unless it's organised and unless you had the infrastructure and system around that organisation, then the chronic disease management for long-term conditions would not work, or it would only work sporadically. There is nothing worse in our experience of handling long-term conditions than to have a system in which only pieces of it are doing certain things. It's self-evident, I think, that if primary care cannot deal with, and consistently deal with, a particular condition a certain way, then the other parts of the system will get confused, namely, the hospital system gets very confused and is not able to be assured that certain things are occurring. We are lifting the standards of that chronic disease management year on year from fairly basic levels into something more rigorous.

Now, the second phase is something in which you are probably more advanced in some respects than we are. We took that amalgamation of primary care integration and in 2006 decided, yes, we've done well enough in that, we now need to integrate it organisationally, again on a regional level, into new organisations called community health and care partnerships, which joined social care with those elements of primary care that I've described. In addition, we added health promotion from the National Health Service, and we also added a number of specialised health services into that mix. So, again, another forced marriage in a sense.

It's a partnership not based on volunteer arrangements; it was a partnership based on the two large agencies or parent

organisations, that is, the city council and the National Health Service, choosing to abolish primary care trusts and reorganise into this scope of service - incredibly threatening, incredibly large in scale, this group of services. It made the first phase of primary care integration look relatively easy when we moved into this particular area. But what it did bring from a local authority perspective was a whole range of people, particularly care of the elderly, home care, nursing home places and placements and purchases, and a whole series of things - children's services, child protection and youth justice - that had very natural links with primary care.

I'm going to finish now really on the question of wider integration. So what I have described to you is a regional organisation which has wide scope, big in scale and highly delegated. So we're doing the MBS, we're doing the PBS, we're doing child protection, we're doing youth justice. We're doing all those things on a regional basis, but it isn't the kind of partnership you have embarked upon. It's not that wide, and, boy, no-one would want to continue to add to these organisations in a direct kind of managerial way this series of functions. This is more than wide enough in our experience. So obviously the next phase is really to do what you do, which is to join that organisation up in a series of formal networks with other agencies, and some of those are listed there, so a very similar scope to what you are doing. The difference, I suppose, is that the boundary of the community health and care partnership has become the boundary for every agency in Greater Glasgow and Clyde. So, like a steamroller, all were mandated. The police were the last to change earlier this year. So every major agency had to reconstruct to sit inside the CHCP boundaries, not become part of a managed arrangement but, like you, become part of a voluntary arrangement.

The final thing really is just to say a couple of things about what's produced as a result of this. I really liked that comment that was made about not overplanning it - I think yesterday that was brought up - because, actually, the kinds of things that came up were not the sort of things that you would have predicted, and it really is a

pleasure, actually, to see some terrific outcomes without thinking about it. So just the structure and process has produced it. So one of the initial areas was a very big change in the relationship between and the way in which home care, pharmacists and community nurses worked together in the whole management of medications for older people.

The child protection area and family support in general changed remarkably as the social work staff and the health visiting, which are community nursing-type staff, were brought together into joint teams.

Youth justice was another area that benefited from a wider partnership, and particularly those young people who were basically the recidivists in the system.

Transport was attacked very early on, and that was never predicted. It really came through the political involvement of a number of elected members. So the whole way in which transport was organised changed, employability, and, finally, which I haven't got time to go into now, the way in which the city dealt with the Glasgow airport bombing last year I think actually is testament to that.

My last comment is: for every new partner, for every new friend you make and you snuggle up to, there is always somebody that's going to be jealous. I don't know if you've noticed that in your partnerships. My particular example of that is when we combined particularly the children's services area from the local authority with the health services, the education department looked a bit like that little girl on your left, because there are different ways of integrating, there are different structures and models, and many people argued that those children's services should have gone with education, and if we had another half-hour, we could have that debate as well.

So I hope that was of some use to you, and I'm happy to do questions at the end of the session.

**END OF TRANSCRIPT**