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Dear Pauline

The Modern Outpatient: A Collaborative Approach 2017-2020

Thank you for the opportunity to comment on the draft document: *The Modern Outpatient: A Collaborative Approach 2017-2020*.

The Royal College of Nursing (RCN) appreciates that there are significant pressures on the entire health and social care system, including in existing acute-based outpatient services. For outpatients, this has been most publicly evident in recent headlines showing worsening performance against the Government's own 18 week RTT process targets. Importantly, we understand that there are significant gains to be made for people using services and their carers by re-designing many clinical pathways across the entire system with a focus on evidence, accessibility, effectiveness, shared decision-making and improved personal outcomes. And in the current financial climate, and in the face of increasing demand, there is a necessity to ensure value for money in delivering on those improved outcomes.

In broad terms, there are key messages in the *Modern Outpatients* document which align to RCN priorities. These include:

- A greater focus on the multi-disciplinary team to ensure that people see the right clinician in the right place, including explicit support for developing extended roles across the professions
- An emphasis on improved information sharing and decision making support for all clinicians providing care
- A focus on providing quality health care interventions as conveniently as possible for people needing services, to increase accessibility
- An emphasis on improving connectivity and digital supports that improve care
- An acknowledgement of the need for training and development opportunities to support a workforce that can deliver new models of care

However, the document sets out an ambitious programme of reform in just three years. We are concerned that these aspirations are reliant on:

- Effective delivery of other national and local programmes of major change, which are at quite different stages of maturity
- The public accepting the assumption of a new model of care focused on far greater self-management and reliance on family/community supports, without clear indications of either the appetite for such change or the impact of this shift on Scotland's significant health inequalities
- The relocation of work across settings and professions at a time of significant resource restraints

Our detailed comments on the draft document are below:

Success measures

Paragraph 3.9 states that the aim of the programme is to "reduce the number of hospital-delivered outpatient appointments by up to 400,000 by 2020, including reversing the year-on-year increase". This is slightly different from the metric provided at 12.1: "The net effect will be an ambition to stem the growth in outpatient in-hospital appointments and reduce overall numbers by 2020, releasing resources for reinvestment in out of hospital provision and enhance patient experience".

We contend that neither of these is the right starting point for the programme. Notwithstanding the interesting decision to place an upper cap on a quantitative process measure (3.9), this aim says nothing about the quality of care received by people needing to use outpatient services, nor the health outcomes of their interaction with clinicians in a transformed service. Indeed, it has the potential to set this reform, in the public's and staff's minds, in the context of saving costs rather than improving quality.

Paragraph 8.5 criticises "traditional ways of working which have no basis in evidence of better outcomes". Transformed ways of working should not be open to the same criticism in future years. We urge the Scottish Government to focus success on setting and measuring patient-centred outcomes and to ensure coherent links to the imminent recommendations of the national Health and Social Care Targets and Indicators Review.

Coherence in decision making to deliver these aspirations

The document does not address clearly enough how the different spheres of control in planning and resource allocation between NHS boards and Integration Authorities will cohere to support the transformation set out in this document.

Good clinical pathways for people will cut across settings. The document places a significant reliance on the wider primary care team in shifting more interventions, where appropriate, away from acute settings. However, the wider primary care team is now controlled by 31 separate Integration Authorities, who are already independently redesigning local services within very tight financial envelopes and pressures on clinical capacity.

For example, much has been made of the positive examples of community-based MSK services being redesigned to support improved outpatients pathways. However, at the same time as this consultation document was published, West Dunbartonshire Health and Social Care Partnership, whilst making critical statements about the limited funds made available to them, were deciding on whether to cut the MSK service they host across NHSGG&C by 8.3 WTE physiotherapy staff, withdrawing services from 14,500 patients and noting the potential for significant risks to quality. This is just one example of how difficult decisions are being made now for radical service reconfigurations that would impact negatively on delivery of the Modern Outpatient plan by 2020.

Furthermore, there may be significant issues in scaling up the sorts of local solutions used as examples in the document where variation in local service is a natural consequence of delegated decision making in the Public Bodies (Joint Working) (Scotland) Act. We are not yet clear how integrated pathways for any individual will successfully manage the interface between NHS board-wide, regional or national outpatient provision and the different local services, resourced by individual Integration Authorities. The document needs to do more to address this.

Finally, the RCN is not clear how implementation of proposals to regionalise or nationalise some acute specialties, as set out in the National Clinical Strategy, will dovetail with these wider reforms to outpatient activity. Changes to the location of specialties could have significant implications for the availability of specialist knowledge and resources in community settings, particularly where technological solutions to remote working are not easily available.

Investment in the transition period

In her foreword, the Cabinet Secretary makes reference again to the £500 million of extra investment going into the community by 2020/21. We welcome the focus on both general practice and the wider multi-disciplinary team for increased investment, in keeping with positive messaging about multi-disciplinary solutions. However, it would be helpful to have a more detailed explanation, at this stage in the transformation project, of how this money will be directed and phased. This is simply not clear to us at this point in time.

We are concerned that without adequate planning, aspirations to free up money from the acute sector to re-focus on community services will not be possible without first investing up-front in community capacity and capability at scale – much as happened when the balance of mental health care interventions moved away from institutionalised care towards an empowered, recovery model in the community. The RCN recently published a report on the lessons from this mental health care transition, which may be helpful. But without additional resources, we are clear that current community services cannot deliver on these aspirations.

It is essential that the success of this programme – particularly where cost-benefits are assessed – is not measured solely in acute sector resource savings, such as consultant time saved.

Workforce capacity and capability

The Scottish Government is currently consulting on its *National Health and Social Care Workforce Plan* and we note that *The Modern Outpatient* was not included in the policies to inform that document. The RCN would expect this to be rectified as both documents are finalised in tandem.

On a practical note, exhibit 1 suggests that nurses involved in managed care will all be specialist nurses providing “specialist” care. This may often be true, however, district nursing teams are already key players in supporting outpatients and whilst the district nurses within these teams will have specialist practitioner qualifications, they are skilled generalist practitioners, much as GPs are. We would also like to see a direct link made in Chapter 6 to the CNO’s Transforming Nursing Roles programme.
In more general terms, the document emphasises the programme is not simply about shifting workload, but we cannot see how, in practice, this will not be the case. In fact, this may be the appropriate thing to do to improve efficacy, efficiency and accessibility in the patient’s pathway, but we are concerned that this requires a far more explicit acknowledgement of the impact on staff if resources are to follow patient need appropriately.

Community capacity to deliver increased interventions is a significant concern. A recent review the RCN undertook of Integration Authority board papers and minutes showed us that many areas are struggling to recruit community nursing staff and/or are holding nursing vacancies open, often using this salary saving to fund other overspends such as equipment costs. In some areas we are seeing proposals to cut registered nursing posts. The community nursing workforce is also facing significant issues with retirals, with around one in two community nurses aged 50 or over at 2016, compared to one in three acute sector nurses (ISD). We face a significant loss of both numbers and experience over the next few years, just at the point when we expect to see an increase in the decision making capacity required in the community. We are not training sufficient community nurses, such as qualified District Nurses, to fill the increasing capacity gap.

The wider community team is also under immense workforce pressure. GPs, for example are experiencing high vacancies levels, an ageing workforce (particularly among GP partners) and a small, but increasing, number of GP practices requiring direct health board intervention to remain open at all. Increased pharmacy capacity and support to deliver genuine poly-pharmacy within primary care teams must be resourced and enabled to deliver on this plan. These are just two examples. In a team approach, all members of the team must be resourced to fulfil their role or none can operate effectively.

We would also note that the number of clinical nurse specialists in post – nurses who will in many cases be central to delivery of this work - decreased by 2.6% (53.6 WTE) to 1,981.7 WTE between September 2015 and September 2016 (ISD). Half of this workforce was aged 50 or over at September 2016, and the spread of this expertise across boards was variable.

The funding to train 500 new Advance Nurse Practitioners has not yet been distributed and we do not yet know where these posts will be located (either by geographic location, by acute or community sector or, where appropriate, by specialty). This additional workforce capacity may not be fully operational within the time frame of this programme.

The RCN has called on the Scottish Government to commit to long-term workforce planning across all health care services whenever a new health or social care policy is put forward. We believe that this will help to guarantee that multidisciplinary teams have the right number of staff, with the skills and knowledge they need to deliver for patients. It is essential that this outpatient programme is only taken forward when such an assessment of workforce need (capacity, capability, location) has been completed, risks identified and mitigated and workforce changes agreed in partnership. Our intent is not to slow down or block progress, but to ensure that effective planning is in place to deliver genuinely improved and sustainable health services for people who require them.

Equity of outcome

Just in this month (February 2017), we have seen ongoing evidence of the impact of deprivation on health outcomes. These figures have demonstrated that, over those in the least deprived areas, those in the most deprived are experiencing:

- A 42.3% higher rate of mortality from cerebrovascular disease (ISD)
- A smaller reduction in deaths from coronary heart disease (31.3% reduction compared to 38.5% in the least deprived) (ISD)
- A much lower uptake of bowel screening (44.2% compared to 66.2% in the least deprived) (ISD)
- Far greater rates of developmental concerns at the 27-30 month child review (1 in 4; compared to 1 in 9 in the least deprived) (ISD)
- Increased risk of cancer deaths (prostate: 98%; Breast: 89%; head and neck: 61%; colorectal: 45%; liver: 28%) (reported: Macmillan / ISD)

Whilst outpatient activity alone cannot turn these deeply concerning statistics around, access to diagnostics, specialist treatment and effective follow up is key for those who may not have the health literacy, technological competence or connectivity, the financial means, or the family/community support required to engage easily with health systems and clinicians. This is a particular concern where there is any presumption toward technological interaction or regionalisation / centralisation of services without explicit commitment to providing access support and resources to those who may require them.

The Scottish Government must do more to ensure that, in reshaping services for people around new clinical pathways, inequities in clinical outcomes are reduced. This should be included as a core element of the description of the programme in the final document, the metrics set for the transformation programme and the evaluation of it.

Technological support for change

This three-year plan places significant reliance on technology to support a more flexible way of delivering care. The RCN is clear that digital technologies have the potential to transform services and health outcomes and have long campaigned for improvements in this area. However, we are also aware that:

- Broadband and mobile connectivity is not available equitably across Scotland and, despite infrastructure investment, we are a considerable way off universal coverage for either patients or staff to access core health services in this way

- Neither all patients, nor all staff, have access to appropriate hardware or software to enable consistent and equitable access to digitally-reliant health services
- Neither all patients, nor all staff, have the digital literacy to make best use of technology to improve health and health care. Whilst this may change as the balance in the general population moves towards digital literacy and confidence, the RCN would note that a recent survey we conducted with the support of Age Scotland showed that 90% of older people living in remote and rural communities were not interested in using video-link technology to connect with their care team in their own home
- And the multi-disciplinary team still cannot access all the patient data they require to deliver the safest and most effective care across settings, as would be required by this programme. The recent joint response from primary care professional bodies to the Scotland Digital Strategy states: *It is vital that health professionals provide interventions on the basis of the best available information about their patient's care. All healthcare professionals routinely record important information about their patients' care which could often be useful or crucial to other health and social care professionals involved in their care but often the information held within these separate systems cannot be shared.*

We understand that Scotland's new digital health and social care strategy, which should drive change for the three years of this outpatient programme, will not be published until the autumn of this year. We remain concerned that aspirations are not matched by the speed of developments in this field.

Understanding the "programme"

Finally, the draft document states that it is setting out a collaborative programme to deliver transformation. However, we have not been able to clearly articulate what this "programme" is and how it will be taken forward in a planned and sustainable way with the full engagement of relevant stakeholders. Certainly we note very slight mention of the governance of this change programme and would be keen to hear more about how key stakeholders – including patient and staff representatives – will be able to provide expertise and oversight to the ambitions in this collaborative strategy and how robust and coherent links will be made between this and the wider transformation activity taking place in health and social care.

For further information or to discuss any of the points raised please contact Rachel Cackett on 0131 662 6180 or at rachel.cackett@rcn.org.uk

Yours sincerely,

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