

# Integration of Health and Social Care

The Scottish Council for Single Homeless (SCSH) is grateful for the opportunity to respond to the consultation. SCSH is the Scottish body for organisations and individuals tackling homelessness in Scotland. Our comments are based on the deliberations of our expert policy committee and on a small consultation meeting held with interested parties.

## General Comments

Overall SCSH favours the principle of better integration of services and more efficient use of budgets across disciplines. We believe that the integration of Health and Social Care affords positive opportunities to improve outcomes for those who use services. However it also poses some major challenges, and we are concerned that, unless followed through carefully, it could lead to the unintended consequence of a worsening of the situation for homeless people.

### Housing as an equal partner

The most significant concern is that housing is mentioned as an afterthought in the consultation document. Much of the success of the outcomes anticipated for the integration of health and social care are dependent upon housing led or housing based approaches. It is therefore a serious flaw in the proposals that housing interests and budgets are not foreseen as equal partners in the strategic decision making bodies in this process.

This mirrors the flaws in the development of community care in the 1990s, where there was an expectation that housing would be at the core of the proposals, but housing interests were not included as key partners in the initial decision making. The current proposal offers an opportunity to learn from the shortcomings of that process. It must ensure that housing is an equal partner in the planning and strategic decision making (including budget deliberations) from the very beginning.

Every local authority already works with other housing partners in its locality to produce a Local Housing Strategy. If Health and Social Care is going to work effectively the Local Housing Strategy will need also to be integrated into the planning, implementation and budgeting processes. Housing interests therefore must have an equal place at the 'top table.' In SCSH's view, there should be an explicit requirement to integrate health and social care plans with local housing strategies.

### Build on existing areas of integrated working

The flagship homelessness legislation combined with the holistic cross-boundary work which has developed over the past 10 years provides a working model of how integration of services can work effectively in many areas. Health and Homelessness Standards already exist which are requirements for health boards, and local authorities already produce homelessness action plans, and homelessness prevention and alleviation are a corporate responsibility on each local authority. The Health and Homelessness Action Plans which each Health Board produces must be integrated with local authority Local Housing Strategies and Homelessness Action Plans. So this offers an effective model of integrated working which also includes housing as a key strategic partner.

The Scottish Government is also already rolling out GIRFEC (Getting It Right for Every Child) across Scotland. This involves joint work between health and social services amongst others. It is another example already being enacted, of better integration of health and social care. It would appear to be a pragmatic approach to build this into the first phase of integration, rather than have three different forms of health and social care organisation operating simultaneously: the proposed older people's services integration (with its own governance arrangements), GIRFEC (with another set of governance arrangements) and the non integrated services.

The Scottish Government set up a Substance Misuse and Homelessness Group some years ago. Amongst its activities was to commission research. This affirmed that better integration of health and social care services linked to housing was required to address the complex needs which many people with substance misuse problems face. People with complex needs represent a small cohort within the health and social care field, but one where many people 'slip through the net' because services and budgets are not integrated. They represent a group which would benefit enormously from being in the initial phase of integration.

SCSH therefore believes that there are a number of areas of work, which are currently relatively well developed, and which should be incorporated into the initial phase of the integration of health and social care.

It is our experience that the framework which is developed in the initial phase of any major shift in approach is very influential on the direction of the policy as it develops. Whilst we welcome the suggestion of including older people's services in the initial phase, we have concerns that this represents too narrow and specific a focus.

In general terms older people's services are concerned with a situation where the individual's needs slowly become greater. In many other areas where integration is required, such as mental health and addictions, where people's needs fluctuate – they may improve and then relapse, or improve to the point where services are no longer required.

SCSH believes it is important that the initial development of the integration of health and social care also includes representation of groups which fall within the category described above. We would propose that people with complex needs and homelessness also be included in the initial phase. Both are areas which require joint work to be effective. Both are areas where there has been some initial work, and both are areas where there is need for improvement and where the benefits of integration could be demonstrated relatively quickly. Both groups are also relatively small in terms of the general caseload of the NHS and Social Services, and both include the requirement of a housing based or housing led solution to their diverse needs. GIRFEC is a further area which should be considered, though we recognise that children's services are very different from adult services.

### **Linking Integration to 'Housing First' or 'housing based' approaches**

SCSH is aware of the growing recognition internationally of the value of 'housing first' or housing led approaches to a range of issues. We believe it is essential that health and social care integration embraces this approach from the outset. We are aware that Turning Point Scotland is involved in a European Peer Review process of different housing first models, relating to people with complex needs, and believe that health and social care integration, if it involves housing as an equal and key partner offers an opportunity for Scotland to be a European leader in developing this approach and embedding it in the formal structures. The approach in the US has already been proved to be both cost effective and to lead to constructive outcomes for service users.

The re-shaping of our approach to tackling people's needs in a more joined up fashion is a tremendous opportunity, and the housing led approach should be part of the initial design of the new approach.

### **'Medicalisation' of social issues**

It is perhaps symptomatic of the very different approaches in the health and social welfare sectors that the paper sees fit to use two different terms for those at the heart of services: 'patients' and 'service users.' They are the same people. This minor language issue raises a more significant issue which will need to be at the forefront of consideration of how best to integrate health and social care – the danger that social issues become inappropriately considered as 'health' or 'medical issues', and that a 'medicalised' approach is adopted to prioritise access to services and allocation of resources. SCSH recognises that the intention of the integration is to remove the distinction, but it is how the distinction is removed which will be the benchmark of whether the approach results in better and broader services, or simply a different typology

of rationing.

In relation to homelessness, which has been at the forefront of joint working across professional disciplines, it is extremely important that the advances are not lost as the focus moves onto other services, which are due for integration under the new scheme. It is also important that homelessness is not regarded as an issue only linked to health and/or social care.

We also have serious concerns that those services not included in the first tranche of integration will be a lower priority for funding. Lessons from abroad (for example Finland) demonstrate that if the political focus is removed from homelessness the policy stalls. It would do a tremendous disservice to the local authorities and other partners who have worked so hard on Scotland's world leading homelessness approach, if it were to be left out at this stage.

### **Dual systems**

Whilst SCSH recognises the complexities of integrating health and social care services, we also have a concern that, until such time as there is full integration, health board and social services will have to operate two parallel systems simultaneously – the integrated part, which has its own governance structures, and the non integrated part which will have different governance, and whose budgets will remain separate.

With energy and resources concentrating on the integrated services there is a real danger of residualisation of the non integrated services. Our particular concern lies in the field of homelessness. Our understanding is that in one of the pilot areas, Highland, housing and homelessness are now overseen by the Resources Committee in the local authority because the former social work and housing committee has been superseded by the joint governance arrangements for health and social care. We recognise that this has been a part of a broader governance review within the local authority, but it demonstrates the knock on effect of health and social care integration onto the governance arrangements of other areas of work which need to be linked closely to it.

Across Scotland there is a need for careful monitoring and the introduction of some form of safeguard to ensure that the 'residual' social and housing services are not marginalised during the long process which will ultimately lead to full integration of health and social care budgets and services. It is therefore extremely important that equal consideration is given to the implications for the governance of non integrated services during this process.

There will no doubt be expense involved in running parallel systems. At a time of restricted public finance it is essential that this is not undertaken at the expense of front line services.

### **Personalisation of services**

There is a welcome move towards greater personalisation of services within the social care field, which parallels greater service user empowerment in the housing field and the promotion of self directed support. There is no parallel within the health model. SCSH is very supportive of the move towards personalisation and self directed support and believes that this important 'direction of travel' must be ingrained within any integration of health and social care.

### **Regulation**

Health services, care services and housing services are all regulated in different ways. It is important that regulation is effective, transparent and not too burdensome for service providers, as well as simple for service users to navigate. SCSH believes that work needs to be undertaken to rationalise and streamline regulation services in line with the integration health and social care.

# Response to specific Questions

## Question 1

### **Is the proposal to focus initially on improving outcomes for older people practical and helpful?**

SCSH believes that integration in the initial phase should not only focus on older people's services. As outlined above we believe that the initial phase should also include some groups whose needs may diminish or fluctuate, and build on existing integrated work. In particular we recommend including homelessness (where Health and Homelessness Action Plans already exist in every health board and homeless strategies already exist in local authorities – and both are already required to be integrated with one another). We also recommend including complex needs (addiction, homelessness, mental health etc) in the first phase, as a group which is not too large, but whose needs are often not being met in a co-ordinated fashion at present, and who could benefit quickly from integration of services.

## Question 2

### **Is the proposed framework comprehensive?**

SCSH believes the framework fails to take account of the need for housing interests to be represented at the 'top table' in setting objectives, agreeing strategies, setting budgets and agreeing outcomes. There is an assumption in the paper that housing will simply be able to meet the needs. Many of the outcomes suggested for older people are founded on a housing based approach. It is therefore essential that housing is explicitly recognised as an equal partner.

SCSH has concerns about the proposed governance arrangements, which we will detail later on. At the most basic level we believe it is not good governance to have an officer accountable (effectively) to three bosses – the Minister, the Local Authority and Health Board. In our experience those who are accountable to too many 'bosses' are not in practice accountable.

## Question 3

### **Does the legal requirement for statutory partners to deliver nationally agreed outcomes provide a sufficiently strong mechanism?**

It has been our experience in relation to the National Health and Homelessness Standards that unless there is a clear reporting mechanism there is a temptation for that area of work to be given a lesser priority than those which do have to be reported nationally.

Our response therefore has several aspects. Firstly, it is useful to have nationally agreed outcomes and a requirement to report on them. Secondly, however, it is important that the national outcomes do not seek to micro manage the diverse needs and priorities which may exist in different parts of the country. That must be a matter for local authorities and local health experts to agree in consultation with local stakeholders. Thirdly, and perhaps most importantly, the question needs to be asked, what happens to those services which are not part of the national reporting framework e.g. adult services which have not been integrated? There is a danger that there will be a concentrated focus on achieving the national outcomes, but that other services, which do not have such outcomes agreed, will be diminished in order to allow national requirements to be met. It is also important that national outcomes are carefully framed to avoid the danger of a 'tick box' approach, rather than one based on evidencing (or being able to evidence) continuous improvement.

In the case of homelessness services, or services for people with multiple needs this could be very damaging and set back the tremendous progress which has been made over 10 years in meeting the needs of this group in an integrated fashion.

## Question 4

## **Should the nationally agreed outcomes be included in local SOAs?**

Logically this should happen, but the nationally agreed outcomes should not be prioritised above other local priorities, and it is difficult to see how that would be managed. It is very likely that the nationally agreed outcomes will be seen to have 'first call' on the budget and therefore distort the setting of local priorities.

### **Question 5**

#### **Will joint accountability to ministers and local authority leaders provide the right level and balance of accountability?**

As described in our response to question 4, it is likely that the outcomes which have to be accountable nationally will be seen as a higher priority than other locally set outcomes. The higher level of accountability for the sub set of services which have national outcomes attached may distort the way in which services are provided. Our concern is that services, such as those to people with multiple and complex needs or homeless people will be seen as a lesser priority because there is no 'national' accountability. There is a danger of creating two classes of service. We have already stated (above) our concerns at the 'Jointly Accountable Officer' in effect reporting to three bosses, which can put the officer in a very powerful position playing one 'boss' off against another.

### **Question 6**

#### **Should there be scope to establish a Health and Social Care Partnership which covers more than one local authority ?**

There are already difficulties in the model which is proposed. Health Board boundaries are not co-terminus with local authority boundaries. Some local authorities fall within the boundaries of more than one health board, and some health boards cover more than one local authority. The model as proposed does not address this which we believe to be a fundamental weakness. We feel unable to comment on the proposed structure further until there is greater clarity about this basic issue.

### **Question 7**

#### **Are the proposed committee arrangements appropriate?**

No. The crucial role of housing is not addressed in the proposed structures. In addition, equating non exec Directors of a 'body' with elected members will make for an unbalanced committee. Elected members are likely to have a diverse range of views rather than representing the corporate entity of the local authority, whilst non exec directors are more likely to follow a corporate 'line' from the body which they represent. This will result in a built in bias towards the health board in any decision which is under dispute. Given that a number of health boards link to more than one authority, if the same non exec directors are involved in different partnerships it will again bias the input in favour of the health board in any issues which are controversial.

### **Question 8**

#### **Will this provide public confidence that effective action will be taken if local services are failing to deliver properly?**

There is a danger of buck passing from one body to another with no-one (except the Jointly Accountable Officer) taking full responsibility. This should not simply be about delivering the agreed outcomes but also establishing a means by which the priorities of the general public are taken into account and acted upon. It is not clear what measures will really empower citizens to influence priorities and services (or get concerns addressed about quality or levels of service) in a simple and direct fashion. It will be important also to

ensure that the language used and description of outcomes are accessible and easily understood outside the health and social care professions.

#### **Question 9**

##### **Should health boards and local authorities be free to choose whether to add other services into the Health and Social Care Partnership?**

Yes. However, as described above there is a danger that those services which must meet nationally agreed outcomes will be the first priority for budgets etc, whilst other equally important services are likely to be secondary considerations.

#### **Question 10**

##### **Can the proposed models deliver the objective of using money to best effect for the service user?**

No. The proposals reduce the democratic accountability of the social work element. There is a fundamental problem in the governance arrangements which equate a non exec director of the Health Board, whose mandate is specifically to act in the interests of the health board, and a local authority elected member who is democratically accountable to their electorate and will also have a party allegiance. It is perfectly feasible, and indeed desirable for the local authority elected members to be selected on a multi party basis. In that case there may well be differences of view represented, whilst the health board directors have only one allegiance and are likely to present a united front. It appears that the only way to establish equivalence between the two roles is to introduce some form of democratic accountability to the health board reps, so that they too are bound to represent a broad range of views and interests and cannot operate as a 'bloc'. The Scottish Government did pilot some forms of democratic election to health boards in the past few years. It would be interesting to build on that experience to develop broader democratic accountability of health board representatives. It will be a test of how 'equivalent' these two sides are if either 'side' ever votes

#### **Question 11**

##### **Any experience of integrated resources?**

We have no direct experience but anecdotally, we understand there have been particular issues in relation to data sharing, especially in circumstances where staff previously employed by the health board become local authority employees, since access to health information is (rightly) restricted. So it is important to ensure that protocols on appropriate data sharing and training of staff are developed.

#### **Question 12**

##### **If Ministers provide direction on minimum categories of spend that must be included in the integrated budget will that be sufficient?**

It depends. It is important both to guarantee that each partner has an equal or proportional input to the budget, whilst at the same time recognising that this is not the only budget and these are not the only services which require funding from health or social care budgets. Any direction must ensure that local priorities are at least as important as nationally measured outcomes.

#### **Question 13**

##### **Financial Authority – is it sufficient to enable the shift in investment envisaged?**

The important question for us is not about the financial authority but about whether and to what extent the Jointly Accountable Officer is actually accountable, given that the accountability is diluted in three directions, all of which have equal authority.

#### **Question 14**

##### **Seniority of the JAO**

The JAO will need to have sufficient 'clout' to be influential in both the local authority and the health board when both separately are involved in budget development. Since the JAO will be responsible for only a part of the adult social services provided by the local authority and only part of the adult health services provided by the health board, and will need to have influence over the strategies relating to housing it is important that the position is both of sufficient seniority to have meaningful negotiations, but not so senior that it is above the other interests.

#### **Question 15**

Locality planning should be largely a matter to be determined locally, though the Scottish Government should offer some general guidance.

#### **Question 16**

##### **Is the proposed duty on partnerships to consult a wide range of stakeholders strong enough?**

The experience from GIRFEC seems to be that the duty on partnerships is strong enough, but that the Scottish Government may need to find a means of ensuring that all key stakeholders, including GPs participate fully.

#### **Questions 17, 18, 19**

No comment

#### **Question 20**

##### **Should localities be organised around a given size of population?**

Given the enormous diversity of population densities and geographical remoteness, simply basing localities around population size is inappropriate. The Scottish government should develop a suite of criteria to work around in establishing 'localities' which should include a minimum population size but should also include geographical area and criteria such as established local communities.

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3 September 2012