Integration of Health and Social Care in Scotland

Midlothian CHP and Midlothian Council (The Midlothian Partnership) Joint Response to the Scottish Government Consultation on Proposals

This response has been prepared following wide-ranging consultation within the Council, including Elected Members and staff in Community Care and Housing; within Midlothian Community Health Partnership; and with local Third Sector and Independent Providers of community care services.

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Annex G Consultation Questionnaire

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?*

Focus is crucial to ensure tangible progress, and demographic pressures provide a strong case for focussing on older people. However this should be viewed as the first stage of a programme of change across adult care. Whilst the proposed focus on outcomes for older people is understandable given the investment and costs associated with this grouping, (and the opportunities recognised already through Change Fund have allowed early exemplar work to be embedded) we believe it would be disruptive to people who use services, and to services and organisations, if a false age defined focus was applied. We also believe that this requires, as much as practicable, a whole system approach and not an incremental approach.

The significant change programme required to drive and implement integration needs to be recognised at all levels. The benefits should be evidenced across all adult care groups, and we believe that only in this way can we enable a more flexible and efficient approach to the deployment of staff and services in delivering the improved outcomes required and expected of us. The Midlothian Partnership therefore has a shared ambition to implement a "shadow" health and social care partnership in the very short term in order to deliver our desired outcomes for older people as soon as possible, with the explicit aim of adult health and social care integration by 2014.

There is, in addition, a view in some quarters that any improvements in commissioning care arising through the integration of adult health and social care services should also be extended to children's services. Transition between children's and adult services is an integral part of the continuum of care and the arguments in favour of integration are similar. However overall, whilst this argument is well rehearsed and understood, we believe that within the current limited capacity to manage the change programme across all sectors locally, we should learn the lessons from adult health and social care integration and harness this to effectively plan for the integration of children's services in the medium to longer term.

Within NHS Lothian there are currently a number of "hosted" services whereby services are provided on a pan-Lothian basis but hosted by one CHP. Examples include learning disability, substance misuse, Lothian unscheduled care service, prison healthcare and health promotion. Existing arrangements are currently under review and will need to be considered within the wider scope of the integration agenda. However, as a point of principle and where practicable, Midlothian Partnership would look to provide local integrated services in line with our current structures and care systems as much as possible.

Finally, the development of more effective services for older people in particular without additional government funding is highly dependent on the participation and appetite for service redesign in the acute sector. This needs to be very clearly stated to ensure successful management of change.

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?*

The proposals are reasonably comprehensive and reflect the necessary change in focus to outcomes as well as the development of strategic commissioning as an approach to the planning and delivery of services. This term – strategic commissioning – is, however, subject to significant differences in interpretation across the public, third and independent sectors and it will be vital that organisations working together on this agenda agree their understanding and clarify language and expectations at the outset.

The focus on health and social care is understandable but runs the risk of implying a lesser importance of the wider community planning approach. Housing, financial inclusion and transport are critical to the wellbeing of our population and new structures should enhance rather than diminish their contribution.

The value of involving patients, carers and the public in the development and planning of services has not been forcefully included in the proposals and this is a major omission given the legislative and policy requirements placed on both the NHS and Council. Council and NHS services, whether integrated or not, cannot work without the partnership of the people who use the services. Given the current Scottish Government consultations on proposals for the Community Empowerment and Renewal Bill as well as Self-Directed Support, it is a marked omission.

Good long-term commissioning strategies allow providers to plan services better to build more preventative services into their business plans. From the consultation document we note that each H&SCP will be expected to produce joint commissioning strategies and delivery plans over the medium and long-term. Whilst working in this way is new for many, particularly in the NHS, the early learning from Change Fund work will facilitate this although anxieties around financial pressures across sectors are early indicators of where robust and effective planning (and associated transparency) will be required for partnerships. This should be an early focus for development.

We particularly welcome the references to engagement of the Third and Independent sectors in the consultation document. However this sector will require ongoing support within and across partnerships to ensure they can fully contribute and be involved in a meaningful way for all.

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?*
We view this approach as welcome, timely and a necessary enabler in supporting the principles of integration. However it will be successful only if there are jointly agreed, jointly owned and jointly reported outcomes which lead to tangible improvements rather than partners working to these <u>and</u> their own individual agenda(s). Previous experience of

developing joint local improvement targets whilst also working to, for example, HEAT targets diluted the full commitment of all partners. The development of joint outcomes will also need to be reflected in national inspection regimes.

Full recognition at all levels of the significant investment which will be required in staff engagement and development and effective management systems across all sectors (as well as across sectors locally, regionally and nationally) to ensure a consistency of approach and understanding will be required.

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

This is a welcome approach to supporting and developing an integrated partnership, which builds naturally upon the thinking, values and aims of Single Outcome Agreements. This approach will ensure that account is taken of local pressures and demographic factors. There will be, however, a need to achieve consistency with the level of detail agreed for SOAs as a whole. It may be necessary to revisit the concept of indicators being below the "waterline" to avoid SOAs becoming too unwieldy.

The importance of building in a robust governance structure and removing duplication of reporting to enable scrutiny at the appropriate levels will be an early and required work for partnerships, and should be built into the comprehensive detail of Partnership Agreements.

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?*

The Midlothian Partnership understand and agree that local democratic accountability is key if integration is to be successful and effective – and in doing so ensures meaningful involvement of front line staff (including independent contractors and secondary care), managers, service users, carers, third and independent sector and the local population.

However, further work is necessary to understand the complexities and detail of the roles and functions required to deliver this. Accountability to Council Leaders, for example, does not ensure sufficient local democratic accountability which can only be fully achieved via the Council itself. In a similar vein, the accountability proposals for the chair and vice chair of the H&SCP require greater clarity.

Early discussion, with sufficient strategic support to "tease out" *whole systems* accountability to partnerships, particularly in those Health Board areas spanning multiple Health and Social Care Partnerships, will be required and could be viewed as a significant gap in arrangements. The need, therefore, to ensure engagement of all relevant partners in developing the exact detail of the Partnership Agreement, will be a crucial element of the governance and accountability structure.

Nonetheless, it is recognised that the current accountability arrangements for CHPs and the expectations of others of CHPs, has often presented challenges and clear guidance on enhanced local, democratic processes is welcomed.

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

We support the proposal. Whilst the benefits of co-terminosity are well rehearsed and understood, there is concern that small and sometimes specialist health services' viability may be at risk in small separate partnerships. This could have detrimental effects on outcomes. In addition the economies of scale possible across more than one Local Authority in partnership with health may not be achievable.

Equally, the value in developing shared partnership approaches where it can be demonstrated that this will lead to improved, productive and efficient service delivery in local communities should be recognised and the decision subject to local determination. We have positive experience of shared partnership approaches through our work in Public Protection, Calls Response Service and across numerous other services. Any such decisions, if taken, will require some flexibility to establish governance mechanisms that satisfy the needs of more than one local authority at the same time.

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

The proposals are not fully aligned with current statutory limitations on local authorities' decision making structures. There is a lack of clarity about the respective responsibilities of the Joint Accountable Officer and the Partnership body. Genuine democratic oversight would indicate that the JAO would account to the Partnership committee.

The proposed membership of the Health and Social Care Partnership committee is however helpful in that it partly addresses perceived problems with current CHP guidance which resulted in heavily populated, but unproductive committees within a complex governance structure. This does not reflect on, nor diminish in any way the significant contribution of patients, service users, third sector and carer's organisation to the work of CHPs; serious consideration on the best way to continue, if not enhance, this contribution will be a cornerstone of emerging partnerships.

Similarly, the NHS has a requirement for strong and effective working with Trade Unions, and Partnership Fora have formal representation within CHP structures. We believe this should be reflected in H&SCP governance arrangements. We recognise that there are, however, different structural approaches to staff engagement across sectors and we will actively work towards a shared solution to this, recognising the importance and value of the partnership role.

The Midlothian Partnership also believe there is a need to include appropriate representation of secondary care, with appropriate devolved responsibility, given their key role across the health and social care continuum and the influence of the acute sector on budgets.

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Finally, there is a risk with the proposed structure that services currently in CHPs but not within scope in partnerships are marginalised in some fashion and the importance of these services and integration with them is lost.

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?*

Further clarification is required in terms of how the performance management systems and requirements of each organisation will play into such arrangements, both jointly and severally. Equally, this is dependent upon what is fully within the control of the local Partnerships. The status of independent contractors would imply limited local control by Partnerships and the Acute Sector often covers more than one H&SC Partnership area. This could challenge the ability in the Partnership's capacity to take effective action in relation to acute/hospital services.

Close working with and support from agencies such as Audit Scotland, the Care Inspectorate and Healthcare Improvement Scotland will be necessary and valuable.

As outlined in the consultation, and most crucially of all, performance management must focus on outcomes and not structures or delivery.

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?*

Partnerships already vary significantly in terms of demography, need and influencing factors, and in terms of maturity and vision / ambition and capacity. Local planning, scoping, commissioning and decision-making should be carried out in the context of these parameters and permissive legislation put in place to enable such local ambitions within the agreed outcomes framework.

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?*

The question implies an over reliance on the benefits of structural change. The models may help but will not, on their own, deliver without accompanying cultural change towards outcomes, support and care at home and coproduction. Importantly, the reference to resource identity and the recommendation to eliminate the need to track this is welcome and does acknowledge that an outcome-based approach will lead to significant change in the way that we deliver care. In making this change in resource identity, the role of the Jointly Accountable Officer and the supporting structures put in place for accountability, governance and planning will be crucial.

However, further evidence is required to allow our understanding of which model allows the most effective and productive use of an integrated resource locally.

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?*

In our wide ranging consultation exercise we heard many examples of highly successful teams working across sectors in an integrated fashion for the benefit of our populations. These include Child and Adult Protection, Combined Mental Health Team, Rapid Response Team and Drug and Alcohol Team. There was a strong recognition in teams of the myriad of positive benefits of integrated working and of minimising duplication across sectors – indeed, an enthusiasm at service delivery level to embrace this proposal.

Commitment from strategic, middle management and from clinical/frontline staff is a prerequisite for success but the lack of a shared IT system reduces the effectiveness of joint working. Employment terms and conditions is a potential obstacle whereby staff employed in different organisations are perceived to be carrying out very similar roles but with varying terms and conditions. There was little success in addressing this issue through the Joint Future agenda and it will be important not to repeat the largely unsuccessful but very time consuming efforts to harmonise terms and conditions across large organisations.

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?*

Within our discussions in Midlothian there were a number of conflicting responses to this question. It was fully recognised that there must be a sufficient critical mass of budget in an integrated budget and its constituent parts to enable flexibility and efficiency and to support local planning and response for the partnership population; this should include elements of acute sector spend. Conversely, if the Ministerial direction is too limited the desired outcomes may not be achieved for that local population. A "one-size-fits-all" approach to integration as a concept should be avoided. The type and degree of integration should reflect programme goals and local circumstances. Approaches to integration require some flexibility, adapting to stakeholder views including those of front-line staff, users and managers and this should be reflected in guidance. However, the emphasis should be on what we need in order to deliver our outcomes safely and effectively – and what functions are needed to deliver these outcomes and not dedicated categories or services as such.

Equally importantly, evidence suggests that there should not be significant expectations, at least in the short term, that the integration agenda will reduce costs. Within this, the need for transparency across the statutory sectors in identifying and agreeing allocated funding will be a crucial enabler to the success of the new partnerships. We recognise that this identification of agreed allocations could be challenging for NHS Boards with multiple partnerships within their boundaries, and therefore unambiguous guidance and supporting information in order to help make informed financial decisions would be welcomed.

Local determination of budgets should be the norm, therefore minimum, not maximum, categories of spend should be determined.

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?*

We believe that proposals for financial authority of the JAO require further clarification and unambiguous direction. It is important that the arrangements for the authority of the Jointly Accountable Officer ensure that local democratic accountability is retained, if not strengthened.

Under proposals, the Jointly Accountable Officer will remain separately accountable, through the partnership, to the Local Authority and to the Chief Executive of the NHS Board, (which, in turn, have separate governance and accountability arrangements and may have different priorities for service delivery). Delegation of minimal powers of authority from statutory organisations to the JAO should be permitted by legislation, recognising the need for effective governance of the JAO.

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

The seniority of the Jointly Accountable Officer should not be nationally prescribed. It will by necessity vary according to the size and scope of the Partnership and there may be a case for more than one such position depending on what is within scope.

However, we recognise that such posts should be at a very senior level, with sufficient autonomy and able to operate as a Director of a significant public sector body. They should evidence appropriate demonstrable experience within the public sector in order to engender the confidence required to lead this significant policy change. Partners should ensure that appropriate funding is in place for the post and for supporting infrastructure.

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?*

We recognise that integrated care must be delivered quickly and at large scale. This requires work both across whole council area populations and at community level, as well as with a range of stakeholders. To achieve integrated care, and the expected outcomes, those involved with planning and providing services must include the user's and carer's perspective as an organising principle of service delivery *(Lloyd and Wait 2005; Shaw et al 2011).* This has been reinforced in national policy through Changing Lives, Self-Directed Support and most recently Co-production.

Too much government direction may restrict innovation and the development of effective community involvement. There should, therefore, be flexibility to take forward different

approaches in different areas with an ongoing requirement to continuously evaluate the impact.   Within this, the Midlothian Partnership recognise the ongoing review of community planning across Scotland, and the outcomes of this review should inform any proposals.

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*?

No single 'best practice' model of integrated care exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations. It follows, therefore, that these professionals should be pivotal in planning and reviewing service arrangements.

The Midlothian Partnership equally recognise that we should also invest in approaches that capture the voices and experiences of patients, service users and carers in relation to integrated care planning and whether services are being delivered that meet their needs.

In harnessing all this knowledge and input for local planning, strong clinical and professional leadership will be required to deliver the level of organisational intelligence needed. The duty placed on Health and Social Care Partnerships to involve and consult on service provision should therefore be clear, unambiguous, measurable and evaluated.

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?*

Two key changes are required. One is for practitioners to believe, and have evidence that their views are being heard and actively acted upon; this will only be achieved through positive experience and the development of effective pathways of care. The other is for the "task" of contributing to locality planning to be more clearly reflected in job descriptions and job contracts as constituting a legitimate part of a role.

Additionally, integrated care is unlikely to happen at scale unless those implementing it are given support. Whilst, particularly for GPs – but also, importantly for other professionals, users and carers – financial support to ensure involvement is important, other organisational supports also need to be considered. These could include:

> building leadership skills
> building commissioning skills and public health skills for prioritising investments
> supporting networks within partnerships to share learning and ideas

While much of this might be sought and delivered locally within partnerships, there is a need for the Scottish Government to equally invest resources and support the development of skills and competencies for integrated care, to promote learning and share ideas to support the adoption and successful application of integrated care.

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

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Whilst for GPs and Community Nurses this approach would make sense, locality planning should fundamentally be organised around natural communities. Economies of scale may prove a challenge to local commissioning on this basis but we have local experience to draw upon including "neighbourhood planning" designed to support community planning.

We know from evidence that approaches to integrated care are likely to be more successful when they cover larger populations and a range of groups - older people, people with particular diseases or conditions, and people requiring access to specialist services. For example, the evidence for case management and care co-ordination shows that it is less likely to succeed unless it is part of a 'programme approach' to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation, re-ablement and independent living – this supports the wider philosophy of good community planning The evidence shows that it is the cumulative impact of multiple strategies for care integration that are more likely to be successful in meeting the demands and improving the experiences of patients, service users and carers.

To this end, each partnership will look quite different in terms of urban / rural make up, or GP population sizes; nor do GP practice lists always fit neatly with local authority boundaries, so for many areas GP clustering would be challenging. So, in line with the response to Question 15, there should be flexibility to take forward different approaches to planning in different areas with a requirement to continuously evaluate the impact.

However, the Midlothian Partnership recognise that general practice *can* act as the hub of a wider system of care that takes a role in co-ordinating and signposting individuals to services within the NHS as well as beyond health care on a 24/7 basis; this is a pivotal role in an integrated care system and the value of general practice in delivering this cannot be underestimated. Ongoing discussions on the future of the GMS contract in Scotland may afford opportunities for more effective "cluster working" *across* practices, of sharing services and enhancing local provision, and Health and Social Care Partnerships should be ensuring ongoing discussions and planning with GPs to maximise this potential as and when it affords it.

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

Whilst we agree with the principle of devolving decision making as close to the point of delivery as possible, this cannot always be defined as there are a number of factors such as geography, level of need and deprivation and demography that will influence this.   There is a danger of raising unrealistically the amount of responsibility which locality planning groups could undertake and sustain without additional infrastructure to support planning and commissioning. The key shift is to ensure that locality groups have a real say in the design, implementation and review of new services/service redesign at a local level.

There is, however, also a need to fully recognise the value of existing structures and their history of delivering for local communities, and not simply "re-invent" new ways of working. The Midlothian Partnership has benefited from active involvement from our Public Partnership Forum and from Third Sector participation and the need to continue to harness this intelligence and give it credence is paramount.

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As indicated above it is only at partnership level that the critical mass to achieve integration will be delivered.

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?*

There are too many parameters to consider in a country of the size and diversity of Scotland. *No one size fits all* is a good mantra when dealing with the complex landscape that faces us; this should be a matter for local determination.

Do you have any further comments regarding the consultation proposals?

The broad principles of health and social care integration are warmly welcomed by the Midlothian partnership and we are eager to start planning our joint work programme to deliver improved outcomes for our population.

It is regrettable, however, that the consultation of necessity concentrates on the proposed new organisational arrangements. Structures may help but will certainly not deliver the step change required in the drive towards truly community based care and the shift in resources required to deliver this. Research and experience tells us that leadership and culture are critical.

The consultation document underplays the importance of strengthening an effective community planning system, focussing as it does on the health and social care dimension.

There is also a danger that the focus on the creation of Health and Social Care Partnerships becomes the dominating issue in the next few years rather than the continuing implementation of an "outcomes" approach alongside the transformation required to deliver Self-Directed Support.

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