

INTEGRATION OF HEALTH AND SOCIAL CARE IN SCOTLAND SCOTTISH GOVERNMENT CONSULTATION ON PROPOSALS

NHS EDUCATION FOR SCOTLAND RESPONSE

This response is submitted on behalf of NHS Education for Scotland (NES) and for your information:-

1. NHS Education for Scotland (NES) is a special health board responsible for supporting NHS frontline services delivered to the people of Scotland through education, training and workforce development. The work of NES helps to ensure that services are safe, effective and patient centred through a well trained workforce.

2. NES welcomes the opportunity to contribute to this important consultation by the Scottish Government into the Integration of Health and Social Care.

3. NES works closely with the Scottish Government Health Directorates, NHS Boards, UK Regulatory bodies, Scottish Funding Council, Scottish Colleges and Universities. In addition, key partners include the Scottish Social Services Council; Scottish Funding Council and increasingly other public sector organisations such as well as third sector organisations such as Alzheimer's Scotland; Institute for Research Innovation in Social Services (IRISS).

4. The unique organisational contribution that NES provides is that it supports the professions undergraduate, postgraduate and continuing professional development curriculums.

5. In supporting the integration of Health and Social Care agenda NES have been working in partnership with Scottish Social Services Council (SSSC). This partnership is underpinned by a Memorandum of Understanding. Current partnership workstreams include supporting a number of key government policy drivers namely the Dementia Strategy, Carers Strategy, Early Years and Reshaping Care for Older People by providing educational resources for the health and social care workforce.

6. In response to the questions specific responses have been noted where education implications have been identified:-

Consultation Questions

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?

Given the demographic challenges and the disproportion spend on unplanned admissions these are strong reasons for choosing older people services and support the initial focus on outcomes for this group. However, many of the services being delivered are universal for all age groups. Since older people may well access a range of services inc. drugs and alcohol services, criminal justice. By concentrating on older people an unintentional artificial divide in adult services may well be established and perhaps focus on long term conditions for adults such as diabetes, dementia, COPD and oral health may be more beneficial. But at a practical level it is acknowledged how integrated budgets and delivery arrangements around conditions can be implemented would be challenging.

There is a need to be flexible and think in terms of integration principles and look at measureable outcomes within a broader structure. The level of integration across the services will promote greater benefit and better outcomes.

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 framework provides some useful examples of integrated working in health and social care that already exists. It is important to recognise joint responsibility arrangements and integration that is founded on equity between organisations.

Knowledge is as important a resource as finances and people in redesigning and delivering services. The consultation refers to connecting systems and technology to improve flow of data and information about service users across health and social care. However, it is equally important to consider how we share our knowledge resources across the local authority, health, voluntary and private sectors in these health and social care partnerships. This includes sharing research knowledge, and knowledge from practice and experience. Currently NHS Scotland has well-established national and local knowledge support services, while these are less well defined in social care. How can we improve processes, roles, governance etc to share, and enable best use of knowledge by all partners involved? The prioritisation of resources at national level for leadership, education and training and perhaps 'doing this once for Scotland' this has been particularly highlighted in the joint partnership working between NHS Education for Scotland and the Scottish Social Services Council through a number of initiatives to support the education and workforce development for the health and social care service.

The framework should be underpinned by education. A need to understand the role of each profession/partner – learning about, with and from each other. Page 18 talks about 'New and potentially different job opportunities' in response to locally driven solutions. The only issue may be how this is supported educationally particularly if different HSCPs require different solutions – a challenge for national consistency.

The development of strong open partnerships will be crucial and will require time and resource as well as excellent facilitation. There are potential implications for the education and development of the preregistration workforce and their practice placement education. This will include opportunities to work within and across different sectors. Derived benefits will include enhanced understanding of the roles of a wider team and skills development for partnership working that needs to include enhanced communication and interpersonal skills. However the

existing workforce will need to understand the rationale behind these shifts and be supported to embrace different ways of educating the next generation of health and social care workforce.

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?

It is desirable that joint performance measures and outcomes are agreed and owned with joint reporting and accountability. The cultural shift that is required may well be significant: an example is the different culture regarding record keeping: NHS focus is on personal confidentiality (eg. Caldicott) based on a need to know basis which leads to medical notes only shared with small number of people. Social work focus is on confidentiality to the organisation and focus is on sharing information as widely as possible to minimise risk and harm. Both are principled positions but very different traditions.

Strategies that support integration strengthened and this may be provided by robust governance, decision making processes and consistency of data. Organisational leadership is a critical success factor. All these could be underpinned by multi professional, interagency education.

This governance challenge is multifaceted given the many drivers across the whole system, including health, social care, housing, education, political environment etc. These issues require depth of discussion locally but joint accountability could be empowering. Question of how disputes for example about resource allocation or risk and how they will be resolved is unclear. In respect to improvement perspective there is a need to balance local solutions with reduction in variations.

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

It is desirable that clearly stated intended outcomes will allow for measurement and lines of accountability. Often progress can be constrained by the culture and therefore a requirement to help the workforce understand what we are trying to

achieve for the future in order to gain a common set of cultures and values will support the achievement of outcomes.

Outcomes should all focus on the service user perspective. Including those that focus on employment e.g. service users should expect the staffs that deliver services to be well informed, valued and well trained and supported to do their jobs. Take the best employment principles and apply. NHS Scotland strives to be an exemplar employer and best principles e.g. PIN guidelines, staff governance, should apply across all services.

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?

This is a very complex area. In attempting to ensure accountability a requirement to address local government legislative powers will need to be undertaken. Since statute for local government identifies who can authorise decisions on behalf of the council. In addition the differences around Chief Executives of the health board and council being accountable for performance to the Council Leader; NHS Board Chair and the Cabinet Secretary when currently the Council Chief Executive is formally accountable to the full Council and not the Council Leader.

For this change to be sustainable and meaningful there must be a rethink of these traditional views of accountability. Attention to the cultural differences arising from these different approaches to accountability will require to be addressed explicitly. Essential that both understand the different ways of working with much goodwill and discretionary effort.

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

Yes - such a change will require considerable culture shift and differences between health and social care should be the focus. Flexibility at a local level that is based upon evidence that it is needed. It would be useful if Health Boards and partner Local Authorities could look to establish governance arrangements that would cross boundaries thus reducing risk of 'post code care', reduce repetition of meetings and planning and improve efficiency of joint accountable officers (and others) time to engage and influence change in culture and practice.

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

Yes - Health and Social Care Partnership Committee made up of equal number of health board's non executive directors and local elected members in principle appears to ensure equal and valued input.

It would be important to consider the role of patients, service users, the third sector, wider local and carer organisations and how they would make a contribution. In addition within the NHS, Employer Directors are present and enhance staff governance arrangements. A similar arrangement could be put in place by local authorities.

The paper identified Medical / Clinical Director role; could they be chosen from a range of clinical leads / professions with a specific role that they represent clinical perspective or perhaps consideration of the establishment of a clinical advisory board structure.

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?

Nationally agreed outcome measures across health and social care set in a single framework would improve alignment across the service. The inspection and regulation across the service should support the agreed partnership outcomes and not challenge it. Similarly the practical challenge of systems, data, records management need to be overcome and any risks mitigated.

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?

In the interest of individuals and communities the integrated service provided this should be possible as long as appropriate systems / governance are in place to track the spend. Desirable to develop a shift in culture to start thinking of the budget as shared money.

However, an unintentional consequence is that across the country Children's

service budgets are often subsidised by Adult Social Services budgets and if there was a restriction in financial virement this could impact negatively on Children's Services at a time when we are strongly promoting focussed investment on Early Years.

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?

It is welcomed and examples are evidenced in some current partnership regarding services which are shared across health and social care such as Mental Health and Learning Disability. The key is that the focus remains on the outcomes.

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?

NHS Education for Scotland has extended access to The Knowledge Network, its national online knowledge service, to social services staff in local authority, voluntary and private sectors. A tailored "view" has been created for social services. Key lessons learned from this initiative include:

- a. the extent of the common knowledge base that needs to be shared across health and social services in order to support integrated care.
- b. the importance of structuring and packaging knowledge in a way that supports embedding in practice for both health and social care practitioners – e.g. as summaries, pathways, checklists, decision aids.
- c. the importance of harvesting knowledge from experience of practitioners and service users as a basis for person-centred care and support, aligned with context and individual priorities.
- d. the importance of access to knowledge, and capabilities in finding and sharing knowledge, to empower practitioners and service users to work in partnership, make shared decisions, self-manage and take control over their health and wellbeing. Plans are in place to offer a single portal for Health and Social Care based on these experiences.

A number of educational projects that support Scottish Government policies and

initiatives have been undertaken between NES and other organisations such as Scottish Social Services Council and include Action Learning sets for CHPs and local Authorities, Reshaping Care for Older People 'Sliding Doors' drama along with educational resource for the health and social care workforce to support the implementation of the Dementia Strategy. Some of these have been supported by NES and SSSC funds others through PIDS to the Scottish Government.

If funding is available it is easy to get cross sector agreement to spend new money, but in times of resource on constraint agreement or priorities and allocation is very challenging. Agencies tend to retract to their core responsibilities and behave defensively and territorially when resources are tighter. The importance of leadership and development needs for senior staff, clinicians, and non exec / councillors in a very different culture will be crucial.

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?

Expectation that if this is the case then it should be clear that the expectation was to further joint spend related to local needs.

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?

Yes - In ensuring robustness of financial authority in the post of a Joint Accountable Officer they will be required to be highly knowledgeable and have demonstrable leadership skills; be provided with a governance framework in which to operate and have access to appropriate strategic education to support them within this role.

A national consistency for the job description for joint accountable officers along with selection criteria, assessment centres, induction, education and training would ensure that these post holders are prepared for what is a new and demanding role. The importance of leadership and development for this strategically important post is paramount.

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

Yes - the proposals support the appropriate level of seniority for the Jointly Accountable Officer once legislative challenges are addressed or overcome. To enable delegated authority to be enacted. Educational preparation will be core since it should not be assumed that people with all the skill set and the true involvement of other sectors will require a different approach to the one that we have at the moment.

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?

Scottish Government providing a national framework then leave it to local determination and planning in order to avoid major inconsistencies in care delivery.

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?

This venture requires a duty on all local professionals to work together to make this succeed this inclusive approach is required and not just assumed it is with one or two professionals. There is a richness of professional leadership that should be tapped along with public partnership forums, service users and the expertise of the third sector and carer organisations. All would have a duty to report concerns and experiences to the Health and Social Care Partnerships to ensure that all problems are recognised and acted upon at an early stage. However, a note of caution can be if it is everybody's responsibility then it can be no ones!

A range of national clinical leadership programmes are supported in NES through the National Leadership Unit, along with partnership work with NES / SSSC and NES RCGP Leadership Programme. The importance of leadership for clinicians as well as Non executives of NHS Boards, Councillors to exercise leadership in a complex health and social care system is paramount.

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?

The barriers to engagement by clinicians are sometimes related to capacity, time and finance. A robust workforce plan underpinned by organisational development which identifies a range of activity to address these issues is required. From the

onset a need to feel ownership with a focus on the professions, not on people at an individual level and involve public in a structured way to support both Community and Individual asset building. The use of regulation to help drive change may be of benefit.

The creation of learning and planning networks to bring together people in a collaborative manner, including opportunities to meet face to face to create ideas and solutions together. A recognition of the time (protected) it takes to get true involvement with a seat round the table and evidence of being listened to. The importance of allocating resources at a national level to support the education, training and workforce development for the health and social care workforce. Given the five level model detailed within the consultation document and the requirement to develop and deliver consistent national programmes to support education and training NES and SSSC are ideally positioned.

Clinicians and professionals will need to see the direct correlation between input and benefits in terms of quality of service provision. Perhaps demonstrating a focus in commissioning, planning and practice on specific changes where the evidence indicates high impact resulting from coordinated or integrated working across health and social care – e.g. specific integrated care pathways; best practice arrangements for intermediate care, 24 hour rapid response teams.

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

GP clusters would need to be developed with clear purpose and flexibility to allow for local circumstances.

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

A key issue is that devolved decision making is accompanied by devolved accountability. The aim of these proposals is to integrate across organisational boundaries, to deliver improvements, reduce the risk of a postcode lottery provision and address inequalities. All need to be managed.

A balance is needed to look at how we engage everyone in decision making, beyond these formal structures. Depends on the governance and accountabilities of local planning arrangements since if we want people to be involved then they should have major contributions to the planning, as the heart of services will lie

within their communities. If Health and Social Care partnerships does not honour this involvement one will question the value and commitment to it. Education for all involved may support a greater trust and shift in power of decision making again highlighting the importance of leadership development for senior health and social care staff.

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?

If clusters of GP practices are to be used then these may form a sensible population and size. It should be noted that these sizes may fit urban areas but rural areas have different challenges about fair access to services given the size of Scotland may need to be flexible but minimise duplication. Balancing population size with geographical access to health and social care services is important.

Do you have any further comments regarding the consultation proposals?

We welcome the intent to develop more joined up services. In particular we fully support the quote from the Christie commission given on page 13 where sharing services goes hand in hand with sharing best practices both in care and in employment.

“and our whole system of public services-public, third and private sectors- must become more efficient by reducing duplication and sharing services wherever possible”

We would recommend that workforce and organisational development (as outlined in Annex C) includes the generic skills of sourcing, sharing and applying knowledge in practice, as essential enablers for the workforce to meet the challenges of delivering care and support within this new partnership model, and to innovate where necessary

Leadership and development of the workforce whether clinicians, senior staff, non executive directors in NHS Boards, councillors are vital in order to support the emergence of a very different culture.

Do you have any comments regarding the partial EQIA? (see Annex D)

There is a risk that older people have been pigeon holed in the impact assessment. There is no recognition of families using multiple services e.g. older person who also accesses drug and alcohol dependency services or child care services

Do you have any comments regarding the partial BRIA? (see Annex E)