

**Area Psychology Committee Response to Health and Social Care Integration**  
**Paper – August 2012**

**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?

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Yes  No

We feel that it would be practical and helpful if the proposed changes were enacted on a sub-test of the clinical patient population initially and once this initial phase of implementation was completed and any outstanding issues resolved, the implementation could be rolled out across all other aspects of the care of the clinical patient population. Thus not only by implementing the proposals with older adult patients first would the Scottish Government be responding to the increasing urgency of addressing the increase in demographics in this increasing population but also it allows an opportunity to test implementation prior to a complete roll out.

However, we have some questions about how this will work in practice. For example, will budgets be partially implemented? If the adult budgets are integrated but outcomes only focus on the older adult populations, how will decisions regarding adult services be made and who will make them?

**Outlaw 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?

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Yes  No

Overall we thought the proposal was conceptually comprehensive but operationally not well defined. We feel that the current proposal does not contain enough operational definition to assess its current validity. It is not clear about whom will be involved in implementation and the processes that will be implemented are not

clearly defined. It also appears that the implementation is driven to meet targets rather than driven by a clinical need in the defined patient populations. Also, we feel, that processes across the country should be equivalent and not divergent as they have historically been and we would see the current proposed implementation as an opportunity to achieve harmonization of processes and this we feel should be captured.

Regarding the second part of Q2 we have a series of unanswered questions.

- The proposal suggests that the focus of how this is operationalised will be done at a local level within each newly formed Health and Social Care Partnership. Obviously the hope with this is that it is more population specific but does this leave the danger of a postcode lottery?
- What are the nationally agreed outcomes? How will these be operationally defined? Who will agree what these are? Will these reflect throughput of patients or clinically significant improvement/quality of care?
- Is there a difference in terms of how things are viewed by politicians and clinicians and how will this impact upon the proposed changes (e.g. their definition of what constitutes primary and secondary care is very different from ours).
- Have they consulted with a wide range of professional bodies – its not clear whether the HPC or other allied health professions have been consulted – mainly medical, nursing, social work etc.
- How much will it cost to implement all of this?
- What about additional funding and structure for carers. Less inpatient support will create additional strain on informal carers – provision needs to be made to try and protect the physical and mental health of carers e.g. respite services for carers.
- Additional reliance on independent sector – is this not leading to a privatisation of health and care needs?

### **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?

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Yes  No

Having considered the content of the proposal we feel that the processes to be implemented are likely to be robust mechanisms of change although it is impossible to confidently conclude that this would be an improvement until such

implementation has gone ahead and been fully assessed. Our main concerns are how joint responsibility would actually be achieved between two separate partners? Nationally agreed outcomes are likely to be different for different population groups. For example, more deprived areas will probably require additional local authority funding compared to more affluent areas, does this mean that more affluent areas get more money for health? This would lead to potential discrimination and postcode lotteries.

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

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Yes  No

Difficult to say – we feel there is not enough operational definition in the proposal to answer the question posed.

Nationally agreed outcomes tend to lead to a push towards a particular outcome with a potential neglect to other areas of need. Are the outcomes maintained after the emphasis has been taken away from them?

#### **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?

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Yes  No

We feel the document should contain more emphasis on clinical effectiveness and quality of clinical care as well as referencing efficiency of delivery targets.

There is a real concern from psychology that ministers and local authority leaders will be influenced by 'popular' vote winning issues and that the usual 'Cinderella' services of learning disabled and mental health will be sidelined.

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

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Yes  No

We feel there may be a risk here of over generalising from one part of the country to other parts with perhaps a lack of significant local understanding. Perhaps an overarching organisation to overview how different systems are working in different local authorities (to be able to learn from good practice) would help.

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

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Yes  No

We feel there is not sufficient information in the proposal document without, for example, knowing more fully in details the membership of the proposed committees. The proposed unionship does not address the previously experienced problems such a culture clashes between health and local authority that served to undermine the previous attempts of partnership between health and local authority.

**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?

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Yes  No

We feel there is not sufficient operational detail and definition in the document to provide a confident answer to the question posed.

For example, what time will be set aside to enable such “organisational development” as mentioned above. There is little mention of how to avoid the pitfalls of previous attempts at joint working.

**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?

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Yes  No

Although we feel it is likely to be a good idea we feel there was insufficient detail to confidently answer this question. This should be decided centrally to avoid a postcode lottery in terms of availability and provision of services

### **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?

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Yes  No

This is ideological in nature. Previous experiences have shown that the merging of health and local authority staff results in significant conflict and the cultures of the two organisations are inherently different. It would require time to be spent on addressing how these two organisations can work better together so that the best needs of the service user can be prioritised at all times. Theoretically we believe that the proposals could ideally lead to more effective decision making and to lead to using money to the best effect for patients or service users but it is difficult again to be entirely confident in this response without having more detail about how these processes will work.

How much is the proposal also about cutting costs?

**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?

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Yes  No

Historically, in Greater Glasgow and Clyde we feel there was some difficulty in making flexible use of resources across the health and social care system because there was no shared philosophy between the organisation running health care and the organisation running social care. Currently there are difficulties in implementing a more integrated system as, for example, the pressure that our social work colleagues are under in developing the personalisation processes has meant that there has been less joint communication and assessment of patients and service users simply because of pressure on time and time-labor intensive processing of applications for care. Our concern for the flexibility of integration in the future is that such pressures on each individual clinicians or social worker's time will continue and so to have properly integrated teams and services will pose a challenge to manage.

On a positive note: The National Steering Group for Chronic Pain has proposed an integrated (including primary, secondary, voluntary and social care) service model that might actually have a chance of being implemented under this legislation.

**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?

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Yes  No

We found this a difficult question to answer categorically and feel that while ministers could indeed employ with responsibility it would have to be whilst being fully informed by clinical practitioners of precisely the type and quantity of categories of patient they are dealing with, within the specified populations. Culture and ideological differences will make it difficult to get agreement re ways of achieving objectives.

### **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?

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Yes  No

We found it difficult again to provide a categorical response to this question as this proposal is as yet untested. A yes/no answer does not suffice – it depends on

their experience. Again in an idealised world the Jointly Accountable Officer would have clinical experience and local authority experience as well as management experience to allow for there to be sufficient trust in their judgement. They will be in an extremely powerful position.

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

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Yes  No

No comment

### **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?

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Yes  No

In general we feel that the provision of a more central direction is likely to be beneficial.

**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?

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Yes  No

We think that such a duty requires representation from all clinical disciplines involving the delivery of health & social care in the defined population. The constitution of these partnerships and steering committees and planning groups have not been adequately described in the proposal to allow a confident response to this question. Involvement of local professionals is imperative. Although GP's have a good overview of services given that they are the gateway to services they do not have the knowledge of how specialist services work so it would be inappropriate for them to comment on service provision for specialist services. The use of the word 'necessity' would be stronger than 'duty'.

**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?

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Initially we believe a recognition of the need to release time for all clinicians and social care workers to deploy the integration process is critically important. Also we feel that consultation with each of the disciplines regulatory bodies is critical so that it is ensured that implementation of any change in practices will not contradict regularity body directives. This is important for all professionals, not just GPs

**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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Yes  No

We feel that clustering by postcode would more accurately and sensitively lead to clinical and health and social care delivery because this would be driven by, for example, a recognition of the contribution of deprivation category scores, etc.

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

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Lots! We feel that a significant amount of decision making should be devolved from health and social care partnerships to locality planning groups.

**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?

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Yes  No

We feel there has been insignificant background research detail to support to provision of a specified potential number of local population ranges. Clearly while one wouldn't want to invest such an amount of management time and consultation to a very small population conversely one would not wish to invest with the management time and consultation to a population so large as to be unwieldy and ineffective. We feel that there may be data from previous population health care delivery research which could inform this figure and produce an accurate number which would provide a confident answer to this question. In terms of budget they would need to be deprivation category adjusted populations.

#### **FURTHER COMMENTS REGARDING THE CONSULTATION PROPOSALS**

**Comment:**

In general, while the philosophical content of the proposal is, we feel, ethically sound in that it clearly has a vision for improving the integration of health and social care to the benefit of all patients, we nonetheless found the lack of detail in the proposal led to some difficulties in reaching confident conclusions to your questions. We would like to comment further that the Scottish Government has defined Primary Care and Secondary Care not in the manner in which clinicians currently define these terms. It is clear from the content of the proposal that you refer to Primary Care as Community Delivery and Secondary Care as hospital delivery whereas the distinction upheld by practicing health care staff and social care staff would align the term Primary Care with largely GP related activity and Secondary Care with Specialist Consultation activity, for example, a GP referring a patient for an expert psychiatric opinion, or assessment or intervention.

We would unreservedly like to make ourselves accessible and available to all future stages of the consultation process so that we might make more informed responses to the difficult challenges that this proposal faces.

**Do you have any further comments regarding the consultation proposals?**

While we understand the ideology behind the proposals, we consider that much more thought is required before implementation of these plans. We think it is important that lessons are learned from previous attempts to integrate health and social care. Legislative and financial barriers were not the only challenges. There are major cultural barriers and it is important to reflect on the challenges and address these issues in order that services are able to work meaningfully and well together for the benefit of service users rather than simply force an integration.

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

Comments

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

Comments