



Integration and Service Development Division
The Scottish Government
2ER, St Andrew's House
Edinburgh
EH1 3DG

14 August 2012

Dear Sir/Madam

**Integration of Adult Health and Social Care in Scotland:
Consultation on Proposals**

The United Kingdom Homecare Association is the professional association of homecare providers from the independent, voluntary, not-for-profit and statutory sectors. The Association represents over 2,200 organisations across the United Kingdom, including 79 in Scotland. We welcome this opportunity to respond to the consultation on the Scottish Government's proposals on the integration of adult health and social care in Scotland.

UKHCA supports the closer integration of adult health and social care to better meet the needs of individuals and provide an enhanced patient/user experience. We believe that integrated services are necessary to meet the increasing demands of an ageing population, especially in this time of economic austerity.

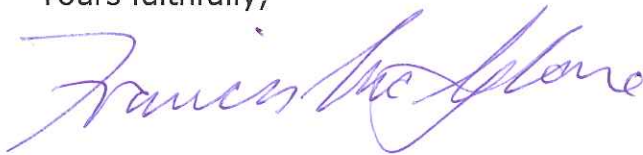
UKHCA is therefore pleased that the Scottish Government has developed proposals to integrate health and social services firmly around the individual. We particularly welcome:

- The replacement of Community Health Partnerships by Health and Social Care Partnerships, which will be the joint and equal responsibility of Health and Local Authorities, and will work in close partnership with the third and independent sectors and with carer representation.

- The new set of nationally agreed outcome measures and standards for adult health and social care, with a particular focus initially on services for older people.
- Requiring partnerships to integrate budgets for joint strategic commissioning and delivery of services to support national outcomes with integrated budgets including, as a minimum, expenditure on community health and social care services and, importantly, expenditure on the use of some acute hospital services.
- The appointment of a senior Jointly Accountable Officer in each Partnership to ensure that partners' joint objectives, including the nationally agreed outcomes, are delivered within the integrated budget agreed by the Partnership.
- Strengthening the role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults.
- Directing proportionately fewer resources in future towards institutional care, and more services directed towards community provision and capacity building.

We have not directly responded to the questions in the consultation paper as a number of the questions are outside our area of expertise and appear to be more appropriate for Health Boards and Local Authorities to answer. Instead, we enclose a short briefing paper reviewing some of the research studies carried out in England into the benefits to be gained from the integration of adult health and social care, as well as some of the dangers. This includes a summary of a report by the King's Fund and the Nuffield Trust produced for the Department of Health to meet the challenge of integrating care in England, which may be of interest to the Scottish Government's own proposals to integrate adult health and social care

Yours faithfully,



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UKHCA Briefing Paper:

The Integration of Adult Health and Social Care

Studies from a number of countries have shown a range of benefits particularly for older people from the greater integration of adult health and social care services including improved health outcomes, reduced use of nursing homes and hospitals, and some evidence of cost savings.¹ For example, a recent Audit Commission report estimates that Primary Care Trusts (PCTs) in England could save about £132 million a year if all the areas with high emergency admissions (a measure of the progress and impact of joint working of health and social care), after taking account of their population's characteristics; money which could be invested to help people live in their own community.²

The report did however identify a number of dangers:

- Structural improvements are unlikely, by themselves, to lead to improvements.
- Many NHS and social care partnerships can describe better working relationships. However, the Commission's research, and that of other organisations, highlights only a few examples where it is possible to demonstrate that partnership working has achieved efficiencies and positive impacts on people's lives.
- As financial constraints bite harder, there is a danger that organisations could retreat from joint working. This could lead to cost shunting and greater costs in the future, as well as worse outcomes for people.³

Successful cases of integration

A degree of integration of health and social care services already exists across a number of localities in the UK. The most cited example of successful integration of health and adult social care services is Torbay. Achievements there include reduced use of hospital beds, low rates of emergency admissions for those aged over 65 and minimal delayed transfers of care from hospital. Use of residential and nursing homes has fallen and at the same time there has been a

¹ C. Ham and N. Curry (2011) Integrated Care What is it? Does it work? What does it mean for the NHS?, The King's Fund.

² Joining up health and social care: improving value for money across the interface, Audit Commission, December 2011. <http://www.audit-commission.gov.uk/nationalstudies/localgov/Pages/joininguphealthandsocialcare.aspx>

³ Joining up health and social care: improving value for money across the interface, Audit Commission, December 2011. <http://www.audit-commission.gov.uk/nationalstudies/localgov/Pages/joininguphealthandsocialcare.aspx>

corresponding increase in the use of homecare services. There has also been increasing uptake of direct payments in social care and favourable ratings from the care regulator in England, the Care Quality Commission.⁴

However, it may be difficult to replicate the experience of Torbay as the area had some distinctive characteristics which will be difficult to reproduce elsewhere. In Torbay, there was an urgent need to improve the council's performance and the PCT was aware that more effective health care relied on improved social care. This meant that both the council and the PCT were receptive to change, and minimised any potential resistance to change.⁵

Another effective example of integrated care is diabetes care in Bolton where patients and staff have reported high levels of satisfaction with the services, and in 2005/06 the lowest number of hospital bed days per person with diabetes in the Greater Manchester area. Also, Chronic Care Management in Wales where three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent between 2007 and 2009. This represented an overall cost reduction of £2,224, 201.⁶

An integrated framework for England

The Department of Health is developing a strategy of integrated care for England. To support this development 'at scale and pace' the Department approached the King's Fund and the Nuffield Trust. The report produced by the two institutions provided a framework for the Department of Health to meet the challenge of integrating care in England.⁷ The report examined:

- The case for integrated care.
- What current barriers to integrated care need to be overcome and how.
- What the Department of Health can do to provide a supporting framework to enable care to flourish.

⁴ P. Thistlewaite (2011) Integrating health and social care in Torbay Improving care for Mrs Smith, The King's Fund. http://www.kingsfund.org.uk/publications/integrating_health_1.html

⁵ P. Thistlewaite (2011) Integrating health and social care in Torbay Improving care for Mrs Smith, The King's Fund. http://www.kingsfund.org.uk/publications/integrating_health_1.html

⁶ Both examples cited in N. Godwin, J. Smith, A Davies, C. Perry, R. Rosen, A. Dixon and C. Ham (?) A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together by the King's Fund and Nuffield Trust, p5.

⁷ N. Godwin, J. Smith, A Davies, C. Perry, R. Rosen, A. Dixon and C. Ham (?) A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together by the King's Fund and Nuffield Trust.

- Options for practical and technical support to those implementing integrated care, including approaches to evaluating its impact.

The case for integrated care

The King's Fund and Nuffield Trust report says that in common with numerous other reports and calls from different professional and organisations, including across a number of western developed nations, the ageing of the population and increased prevalence of chronic diseases requires a strong reorientation away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. However, the UK Government would have to accept and prepare for the consequences of such a change. Specifically, significant reform would be needed to develop capacity in primary and community care, and to prioritise investment in social care to support rehabilitation and reablement. The Government would also have to take forward the subsequent downsizing of activity undertaken in acute hospitals.⁸

In all of the successful integrated care projects the two institutions examined, additional and improved services outside hospital were required: "shining a light on the lack of current capacity and capability in community services to deliver care co-ordination and more intensive care in the home environment."⁹

The report makes a number of suggestions to support the case for integrated care:

- a new model of integrated care will require tackling waste and inefficiency in services in all settings to release resources for investment in new forms of care
- as integrated care means different things to different people, those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery
- there is no need for people to feel threatened by the possible consequences of organisation change brought about by integrated care as organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care

⁸ N. Godwin, J. Smith, A Davies, C. Perry, R. Rosen, A. Dixon and C. Ham (?) A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together by the King's Fund and Nuffield Trust, p3.

⁹ N. Godwin, J. Smith, A Davies, C. Perry, R. Rosen, A. Dixon and C. Ham (?) A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together by the King's Fund and Nuffield Trust, p3.

- no single 'best practice' model of integrated care exists – what matters most is clinical and service-level integration that focus 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
- integrated care is not needed for all service users or all forms of care but must be targeted at those who stand to benefit most
- it is important to define the ambitions and the goals of integrated care and to translate these into specific and measureable objectives
- approaches to integrated care are likely to be more successful when they cover large populations, for example a city or council, and range of groups, i.e. older people, people with particular diseases or conditions and, and people requiring access to specialist services
- the agenda should be developed at 'scale and pace'
- the delivery of care must become a clear political and managerial priority for action – there should be a clear measurable goal that is linked to patients', users' and carers' experience of integrated care and that must be delivered by a definite date
- any support framework must be permissive and based on 'discovery and not design' – hence the focus should be on removing the barriers to integrated care, avoiding being prescriptive about how it should be done.

Current barriers to integrated care

The report identified a set of systematic barriers to integrated care that need to be addressed:

- NHS management culture often talks about innovation yet demonstrates a fundamentally 'permission-based' and 'risk averse' approach to approving local service developments
- the divide between primary and secondary care in the NHS, and also that between health and social care, e.g. differences in staff contracts, employment arrangements and social care is means-tested
- the lack of time and sustained project management accorded to demonstration sites means that integrated care has often been restricted to short-term pilots

- the absence of robust shared electronic patient record that is accessible to and used by all those involved in providing care to people with complex conditions
- the persisting weakness of commissioning that means they have struggled to use their power as 'paymaster' to exert changes in how providers deliver services that might avoid fragmentation and duplication
- the Payment by Results approach to funding hospital activity mitigates against different providers coming together to develop and deliver new forms of integrated care – stronger incentives are required if providers are to collaborate to address the fragmentation and duplication in care
- choice and competition policy that at times appears to run contrary to the desire in many sites for more integrated care
- NHS regulation that focuses too much on organisational performance and not enough on performance across organisations and systems
- there needs to be a single outcomes framework against which performance will be assessed.

Overcoming the barriers to integrated care

To enable integrated care to flourish the report suggests:

- the crafting of a powerful network at both a national and local level about how services could and should be delivered for people with complex conditions – especially but not exclusively, frail older people
- as part of this narrative, there is a need for a clear articulation of the benefits to patients, service users and carers, backed up by regular and detailed assessment of their experience of NHS services
- significant investment in primary and community services, in particular for general practice to adapt rapidly so that it operates at a scale that can provide the platform for integrated care – the report says that this is a prerequisite to providing consistent, well-co-ordinated care for people
- payment incentives and new local currencies – this might include giving a capitated budget to a local organisation or using bundled payments for a range of services relating to a particular episode of care or care pathway
- aligning governance across the various health and social care providers to drive shared interests and accountability in care delivery for people

- commissioners changing the way that they procure services – moving away from contracts with individual organisations that specify items of delivery, to a focus on commissioning for outcomes. This includes commissioners having the ability to identify individuals in need of care and support, which includes a population- based approach with sophisticated tools to identify those with complex needs and to target proactive support and management of their needs
- innovative approaches to sharing data together with a commitment to developing shared clinical records
- formal ('real') integration of organisations – most important is the clinical and service integration that improves care-integration around the needs of individual patients and service users.

Realising integrated care

The report says that if the vision for a more integrated health and social care system is to be realised at 'scale and pace' then an enabling framework to guide integrated care must be adopted over the next five to ten years. It identifies the following ten key elements to this framework:

- provide a compelling and supporting narrative for integrated care – defining the ambitions of integrated care and setting out what it would look like in practice is the highest priority
- allow innovations in integrated care to embed – this will require sites delivering integrated care at scale (for up to five years) certain freedoms from national constraints. Providers from the independent sector and third sector should be encouraged to support innovations in integrated care
- align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies - the priority should be to develop ways of paying for care that reward good outcomes (e.g., evidence of well-co-ordinated care across the patient journey) and avoid perverse incentives that, for example, increase hospital activity
- support commissioners in the development of new types of contracts with providers – for example, based on pathways of care as experienced by patients, or using risk-sharing capitation-based contracts with integrated care partnerships of GPs, community health services, and specialists
- allow providers to take on financial risks and innovate – approaches to integrated care often work best when some of the responsibilities for commissioning services are given to those who deliver care

- develop a system governance and accountability arrangements that support integrated care, based on a single outcomes framework – there is a need to align governance and accountability arrangements centrally, and in particular the ways in which local organisations will be measured in respect of health and social care outcomes
- ensure clarity on the interpretation of competition and integration rules – both of these must be encouraged where this benefits patients and service users, with the independent sector playing an increasing part in the development of integrated care
- set out a more nuanced interpretation of patient choice.