INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND CONSULTATION ON PROPOSALS

NHS TAYSIDE CONSULTATION RESPONSE

Introduction

NHS Tayside believes that in the delivery of both health and local government services, there is undoubtedly room for improvement, and accepts that a strong collegiate relationship is required between health and local government. That is something which must be driven, not by the need to save money, but by the need to redesign/ reconfigure services to make them better for the public, and to make more effective use of the money which is available.

The integration of health and social care is a starting point for the delivery of that collegiate relationship. It is not just another initiative. It is a fundamental change in how we do business with our partners - a fundamental change of culture.

We support the principles underlying the Scottish Government proposals and in particular:

- An outcomes focus, with public support necessary for the identified outcomes. We need to agree what quality shared outcomes look like.
- Engagement with the public, clinicians and staff generally is essential in order to achieve ownership of the direction of travel.
- One size will not fit all, and local flexibility will be required to suit local circumstances.
- There is a need for all partners, including the government, to accept the necessity for preventative/ anticipatory spend.

NHS Tayside has a strong track record of working together through Community Health Partnerships (CHPs) and engaging positively with Community Planning Partnerships (CPPs) to provide timely and appropriate services and we see the core principles as a means of providing the opportunity to move to the next stage of developing these achievements and believe that there are a number of areas we would want to draw attention to.

Public sector services are now experiencing an increase in demand as a consequence of demographic change which has been predicted to affect service demand. We are aware in Tayside that were we required to configure within the existing model of care, we would be required to build a new, additional 500 bed hospital by 2030. Changing the model of care in partnership with Local Authorities, the 3rd Sector and the public will allow us to deal with this increasing demand without building a new facility.

Our view is that successful Health and Social Care Partnership working will allow more people to retain their independence at home. However, we will see the acuity of patients in acute and community hospitals increase and it is important that it is understood that as well

as the demand for acute hospital beds increasing there is also the need to meet increasing demand in other areas such as community hospitals. There will also be increasing demand in community hospitals, care homes and in individuals homes. New arrangements should be based on an understanding of flow through acute, primary care, social care and peoples' homes. There should be significant focus on the need to provide clear and focused patient pathways and ensure timely flow through these pathways to enhance the patient experience and outcomes of care

Over recent years significant in-roads have been made into the control of infection. A significant challenge for most NHS services has been the need to provide higher environmental standards including a greater footprint per acute bed. We therefore believe we will not see a shift in resources from secondary care to community but rather a more efficient pathway which will meet demand in terms of both the number of patients and quality indicators such as the patient experience and infection control.

Non-statutory Partners
It is our belief that partnerships need to take the opportunity to increase the level of third sector involvement in shaping and designing new pathways of care and services. The third sector has a long history of innovation and is driven by the voices of people who use local services and support. Including the third sector as a key strategic partner will be vital to the design and delivery of appropriate, cost-effective services that are responsive to patient need and which enhance the patient experience.

Carers continue to play a significant role as key partners and it is now widely acknowledged that carers devote very significant parts of their lives to the support of relatives and friends. Helping to support, sustain and grow this capacity is essential if we are to achieve better outcomes.

It is also necessary to support individuals, families and communities to take responsibility for their own health and well-being. An asset-based approach focusing on positive outcomes and prevention of ill-health will be required to achieve this now and in the future.

Community Engagement
It is important for everyone to have the opportunity to get involved and have their say on issues that affect or interest them. There will be a need to involve communities and other interested parties at all stages of redesign. NHS Tayside has a strategic framework for involving patients and public in the redesign and development of services. It aims to ensure that patients are at the centre of the care and services we provide and that we involve them, carers and the people of our communities in the planning of those services.

Direct Payments
Direct Payments is a mechanism that can give people more control and choice over decisions about their care and treatment. Our view is that this should be explored in order that the issues and process can be properly understood and evaluated in order to make a decision about a wider application to NHS services.

IT
The future of Health and Social Care integration will be very reliant on information technology to share information between partners, and in the absence of the National eCare Program being unable to deliver and sustain products to do this, it will be important to ensure that this work is not lost in this challenging agenda.

We welcome the Sixth eHealth Strategic aim and the small amount of recurring funds that come with it to try and start to support this agenda, but would ask that further work is undertaken to enable easier information sharing, build joint eHealth infrastructure between Health and Council colleagues and ensure a single identifier is used to allow us to move forward in the future.

Workforce
Developing a motivated and capable workforce is necessary to underpin high quality services and to promote the principles of personalisation and an asset based approach. One of the key challenges for the new Health and Social Care Partnerships will be the need to address cultural differences between statutory and non-statutory partners. In order to address this it will be essential to work constructively with staff and staff organisations.

Reducing unwarranted variations in services and service quality
It is already recognised that there is significant variation in experience and quality of services. Organisations need to demonstrate their ability to tackle and reduce unwarranted variation and improve quality. This should be the criterion on which we judge them and on which basis we would seek to give them more areas of responsibility.

Population data and analysis
It is recognised that demographic change will have a significant and challenging demand on services. Knowledge of this demographic change and the predicted impact of this on services will be key to ensuring appropriate services can be designed and delivered. For example, it is estimated that there are 5,999 older people in Tayside with dementia with the number predicted to rise to 6,582 by 2020. The increasing numbers of older people in the population who have higher incidence of adverse conditions, higher levels of severity for those conditions and poorer rates of recovery present particular challenges for the delivery of services. Increased levels of need, and particularly unmet need, within communities with higher levels of deprivation also need services to be targeted effectively which clearly benefits from in-depth demographic intelligence.

Consumption Fund
Councils and NHS Boards will need to ensure that joint decisions are taken around the management of mutually committed resources such that investment and, especially, disinvestment in health and community care services are effectively planned and co-ordinated. Identification and effective use of these consumption funds will be essential to effective partnership working.

The Purpose of Commissioning
The purpose of Commissioning is to ensure that all services are working together to shift the balance of care and enable more people to be supported to live independently in their own home. It is not a budgetary process although understanding the consumption of resources and the cause and impact of variation from optimal pathways of care is vital. The Commissioning plan needs to be able to articulate how a General Practitioner is able to access a range of service options without the need to engage in a large level of bureaucracy. This means either being able to commission services direct from the consulting room or though a single point of contact. The Commissioning Plan should clearly articulate the shift from the current model of service to a more optimally based pathway of care.

Scotland is proud of its decision to abolish the internal market. This has slashed transition costs and has promoted joint working across traditional boundaries. It is imperative that this new model of commissioning does not result in the introduction of additional costs of bureaucracy and a shift to more elaborate management arrangements.

Conclusion
The areas highlighted above need to be addressed to ensure effective integration of health and social care. However, it is vital that we do not simply focus on what needs to be done at the expense of how the transformation is achieved. At the earliest stages it is important to consider how we will make the required changes, how we can best work together between organisations, with individuals and communities and identify how this can be done on a large enough scale. These aspects are equally important and we believe partnerships need to be challenged to demonstrate that they can deliver on the integration agenda.

RESPONSE TO 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?

Yes   **No**   □

We believe it is important to new Health and Social Care Partnerships to be allowed to build on successes gained through the Change Fund Initiative and to have the opportunity to demonstrate the sustainability of these changes and improvements in the outcomes for older people. We believe it is important to do this in advance of any proposal to extend beyond Older People's Services. We see Older People's Services being defined by an individual's stage and state of health rather than their chronological age. This does not in any way prevent NHS systems from continuing to improve and develop services across Health and Social Care boundaries within existing arrangements. It is important that Health and Social Care Partnerships are given flexibility to progress the integration agenda in a way that is consistent with existing local practices and experiences. Opportunities for further integration should be available flexibly to fit local circumstances within a national framework.

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?

Yes   □   **No**

The references in the current document to acute services do not provide sufficient guidance. It is important to give this clarity to ensure partnerships do not have unrealistic expectations. The NHS in Scotland has a strong track record in delivering specialist services through regionally and nationally managed networks. These networks of specialist services are integrated within core secondary care provision. Such services would not be appropriate to be placed in a Health and Social Care Partnership but need to be considered in conjunction with those services which are placed within the Partnerships, as part of the overall care bundle.

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?

Yes   in parts   **No**   □

We believe that it is necessary for us to put in place a robust local performance management system which is jointly agreed across organisations. We recognise the role that Community Planning Partnerships (CPPs) have in working to support Health and Social Care integration, however we do not believe that CPPs have an appropriate legal framework which would allow them to be the mechanism through which Health and Social Care Partnerships could report. We believe that Health and Social Care Partnerships should each be able to report back through their own host organisations / boards.

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

Yes   **No**   □

Yes. We fully support the nationally agreed outcomes as set out in the consultation document. We believe that these could appropriately be included in local Single Outcome Agreements (SOAs). However, we believe accountability and performance management around the SOAs need to link back to their respective Boards and Councils as Community Planning Partnerships are not legal entities and therefore cannot be held accountable for the actions of the partnerships. It will be important to understand how Audit Scotland and other national scrutiny organisation will discharge their role within these new arrangements.

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?

Yes   **No**   □

The NHS has clear lines of accountability to Ministers and the joint accountability set out in this document is one with which the NHS would be comfortable. We recognise this may be a more contentious issue for Local Authorities. This would leave political accountability with Ministers, Local Authority Leaders and NHS Chairs and performance accountability with Chief Executives in both the NHS and Local Authorities.

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

Yes   □   **No**

Whilst we believe there is nothing in principle to prevent such a move, in NHS Tayside we have three extremely strong and developed partnerships each of which have been developed with a single Local Authority. We would therefore prefer to continue these close partnerships within the Health and Social Care Partnerships matching Local Authority boundaries.

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

Yes   □   **No**

We believe that there is value in scoping out clear performance and governance arrangements for Health and Social Care Partnerships. However, these governance arrangements need to link back to the accountable officers in each of the organisations. We would be supportive of the idea of an annual review where members of the partnership are collectively held to account for their performance. We are aware that the Convention of Scottish Local Authorities (COSLA) and the Association of Directors of Social Work (ADSW) have raised concerns about democratic accountability. There is already a formal arrangement within the NHS whereby a number of Board members are appointed by the respective councils who are democratically elected members.

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?

Yes   □   **No**

We believe more detailed work is required to develop appropriate and effective performance management arrangements across the whole system.

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?

Yes   **No**   □

We believe it is important that partnerships should first demonstrate their ability to deliver on Older People's Services. This is a large and complex area and an ability to improve patient and client experience and deliver efficient and effective services for older people is a vital prerequisite to adding other CHP services to the partnership. We believe that the scope to extend to include other budgets should be left to local discretion. This will allow partnerships to develop at a pace and scope which is appropriate to local circumstances.

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?

Yes   □   **No**   □   Not sure

We believe the focus of our attention should be on improvement of services with outcomes for patients and clients, rather than a focus on structure. There is scope within Older Peoples' Services for more effective use of funding by encouraging Health, Social Care and 3rd Sector workers to operate more effectively in the interest of their patients or clients.

The differing positions for the NHS and Local Authorities in respect of the ability to recover Value Added Tax (VAT) may become a barrier to re-profiling spend. Where local NHS systems accept responsibility for specific social care services, they risk exposure to additional VAT costs on consumables. This is a specific area that will require to be addressed and it is understood that concessions have been made in England by Her Majesty's Revenue and Customs (HMRC) for joint public bodies.

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?

Yes   **No**   □

Yes, across each of the three partnerships in NHS Tayside there are examples where we have already made better use of resources by operating in a more flexible fashion. The future development and use of consumption funds is important to understand how we currently use resource so that we can consider ways in which we might improve this. The Change Fund has been a good example of making flexible use of resources across the health and social care system as it has promoted integrated working and created pressure for change to improve care pathways.

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?

Yes   ☐   **No**

We do not believe that it is necessary for Ministers to provide direction on the minimum categories of spend.   This should be subject to local discretion and linked to our improvement ambitions for each Health and Social Care Partnership.

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   ☐   **No**

NHS Tayside has worked closely with its partners to improve services over a number of years. Understanding collectively our budgets and the consumption funds are vital in terms of the way forward. This can be achieved co-operatively and we would have concerns about delegating such a large level of spend to new organisations (Health and Social Care Partnerships) which have not yet been the subject of the rigorous process of scrutiny, for example, that put in place with the establishment of Community Health Partnerships.

We do not believe it is necessary to legislate for a Joint Accountable Officer. A formal accountable officer exists in both NHS and Local Authority services. These officers have a strong track record of jointly commissioning services across agencies to deliver agreed outcomes.

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

Yes   ☐   **No**

If a decision is made to appoint a Joint Accountable Officer we believe that the size of the pooled resource (consumption fund) may vary in each partnership and therefore the seniority of the posts should be locally determined.

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?

Yes □ **No**

We strongly believe that this should be left to local determination. Each of the three partnerships of NHS Tayside have well developed locality planning arrangements which make sense to local people and we would be concerned should the government seek to direct this in a way which would undermine this.

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?

Yes **No** □

Yes, we believe the duty as specified in the consultation is sufficiently strong. However, the consultation document does lack detail about how this would be enacted. It would be helpful to debate and gain clarity on this issue. We believe it should be a statutory duty placed on GPs to engage with Health and Social Care Partnerships. This would compliment the duty on Health and Social Care Partnerships to consult with local professionals including GPs. We recognise such a duty would need to be taken forward as part of changes to the Scottish GP Contract. It would also be helpful to have clarity about the governance role of the medical and nursing directors in terms of clinical service, and about the ways in which senior clinicians will be able to influence the agenda within the structures specified in the document.

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?

It is important that clinicians, social care professionals and professionals working within the 3rd Sector are involved at an early stage, alongside members of the public, in developing the improvement agenda. The involvement of GPs in particular is fundamental and this may require some resource allocation to achieve. We believe that the level of engagement that we already have locally in NHS Tayside will greatly influence the Joint Commissioning Plan, with the role of governance being to hold Health and Social Care Partnerships to account for improvement in outcomes resulting from joint commissioning.

We believe co-production and the personalisation agenda need to feature more prominently. We also believe that the consultation is not sufficiently ambitious around co-production and asset-based approaches. Furthermore it is silent on the role of volunteers.

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

Yes   ☐   **No**

This is a complex issue. In each of the three CHP / Local Authority areas we have agreed to work with natural communities. In some localities this provides a direct link with GP practices. However in other areas, for example in the city of Dundee, there are practices with patients from across the whole of the city. We believe we need to have the flexibility to work with local GP practices and communities to come up with appropriate solutions which maintain the opportunity for patients to exercise choice over which GP practice they use.

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

We believe it is important for us to make an orderly transition from the current accountability to Health and Social Care Partnerships. This should be based on their ability to meet stringent governance and accountability criteria. We would support the view that Health and Social Care Partnerships should be able to demonstrate their ongoing dialogue and involvement of locality planning groups. However, at this early stage, we do not believe the devolution of responsibility in decision making to locality planning groups to operate independently is appropriate. If local elected members are to be involved in locality planning, there should also be input from non-executive Board members.

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?

Yes   ☐   **No**

We believe that Health and Social Care Partnerships should build on the strong locality work which is already in place. This is determined by local geography, history and effectiveness. It is not determined by the number of people in a locality.

Do you have any further comments regarding the consultation proposals?
Developing a motivated and capable workforce is necessary to underpin high quality services and to promote the principles of personalisation and an asset based approach. One of the key challenges for the new Health and Social Care Partnerships will be the need to address cultural differences between statutory and non-statutory partners. In order to address this it will be essential to work constructively with staff and staff organisations.

Given the likely changes and expansion to the roles of individuals, such as those proposed for GPs, in areas of responsibility where they may not have previous expertise or experience, it will be essential to ensure that all staff are supported through provision of appropriate education, training and professional development activity to ensure their

readiness for the proposed changes at the time of implementation and beyond.

Do you have any comments regarding the partial EQIA?*)*
No

Do you have any comments regarding the partial BRIA?
No