

INTEGRATION OF ADULT HEALTH AND SOCIAL CARE

The above consultation document has been shared across all of the advisory committees within NHS GG&C with each committing to respond to the Scottish Government directly or to the Board for inclusion within its response.

As NHS GG&C Area Clinical Forum Chair, comments have also been proffered for inclusion within the National ACF Chairs Group response.

NHS GG&C Area Nursing & Midwifery Committee response is provided below.

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?

Fully accept that one of the main driving forces to integrate services is that of delivering 'seamless' and non fragmented care for older, vulnerable people and concur that a 'phased' approach to then extend to all areas of adult care. Of note is that there is no 'age' cut off for those with complex and long term health & social care needs – therefore would advocate the focus is on all adults and driven by needs assessment. We acknowledge wholly the empirical and practical evidence of the often deleterious psychological, social and physiological impact of extended hospital stays for older patients which frequently occur due to fragmentation of and limited access to necessary services to return to their community.

We add the caveat that the needs of vulnerable children and young people particularly at 'transition' periods will be at further risk by the focus and energy being subsumed into older adults followed by adults and this is considered a significant barrier to whole scale system change targeted at one population at least initially. When, if at all, will children's' services be incorporated?

There is an overriding assumption within the consultation that bringing health and social care services together under the one organisational 'umbrella' will 'enable' ...'better outcomes' to be delivered for all. Yet very poor consideration of exactly how this will be measured. Quality and outcome measures are a constantly evolving process within health organisations and have tended to be 'silo' focussed i.e. specific measures of care for acute inpatient care but not MH or LD inpatient stay. However we recognise that this situation is rapidly developing to a more integrated whole (health) system approach but have concerns that this development may now be 'distracted' by the need to focus on 'integrated health and social care' measures.

Overall, the consultation document lacks direction and clarity on the varying nuances of its content which is further quantified at points in the responses below. In principle, the language used and ethos therein are very high level and in itself the consultation is not conducive to robust consideration of risks to our

population and **effective** measures of improvement to service provision at the point of need. We are also concerned about the significant shift of resources at a time of escalating demand on services across health and no clear sense of how this will be 'managed'.

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?

Budget and planning to include 'appropriate aspects of acute health activity' is a critical element of achieving this whole system approach yet light weight in terms of definition and direction within the consultation.

Chapter 2 – 2.6: Assume which professional/ clinicians will be agreed at local level? It would be useful to have additional direction and guidance of who otherwise key 'specialists' etc. will be omitted. The consultation rightly attributes the critical nature of involvement/ engagement and leadership of professionals in planning/ commissioning 'integrated' services yet clouds this by attributing all of this to the specific involvement of GPs – thus detracting from the importance of including the 'right' professionals.

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?

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

Chapter 2 – 2.3: Timescales of setting these nationally agreed outcomes would be helpful. Will these outcomes cut across all 'health' settings and focus on the patient pathway/ journey?

Chapter 3 – 3.1: '...professionals who work in health and social care must be well placed to focus...' nebulous – it would be useful again for specific guidance here e.g. who, where at what level etc.

3.4: local variation although expected must be transparently accounted for also and urge this point to be considered fully, especially around when a variation becomes a major diversion or indeed gap and the action expected to address such. Accept that there is an expectation of aligning 'external scrutiny' to address such.

3.10: assume the 'locally agreed outcomes' for 'other areas of service' will be of a less 'pressing' nature? Examples here would have been useful.

What bearing will the SOA have on proposed HEAT targets?

We support nationally agreed outcomes as a strong incentive for health and social care to work together but urge contribution from all stakeholders are robustly supported (patients, carers, staff etc.) Outcomes are essential to measure not only the impact of the new arrangements but also patient/ public and staff experience of such. It is of note that the RAND evaluation of integrated health and social care in England reported a decrease in positive experiences of care in many services and it would be useful to know how in Scotland, we have learned from this within our approach.

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?

Joint accountability demands specific consideration. Absolute clarity of roles and responsibilities between the key partners is essential.

One of the perceived challenges locally is the scale/ geography of the service boundaries currently. How can local democratic accountability be achieved across this volume of population, services and professionals if 1 or 2 Health & Social Care Partnerships? Or if continue with the current structural CHP arrangements how then can this 'interact' or assume accountability for services (or commissioning of such) which are city wide/ acute care? Further complicated within section 4.5: in that devolved budgets will include'some acute hospital spend' and for other services that are centrally provided? How will this be agreed without risks to current provision? How will financial governance be assured/ enacted? Fully accept that demand for acute care must be better managed within communities and Health & Social Care Partnerships need to be fully accountable for this but also see this as a significant remit for the Board to interact and assure across the whole area.

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

Yes this has to happen within GG&C area otherwise service fragmentation will be further extended.

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

Chapter 4 – 4.16: Further guidance around 'good use' of a casting vote is welcomed.

Parity of committee 'voting members' is supported and accepted.

'Non voting' members signifies a change in our local Public Partnership arrangements. How will the 'clinical advisor' assure that input, advice etc is accurate, evidence based and encompassing of the many facets of specialism/ sub specialism required? How do we ensure that the 'clinical advisor' is the right

person to 'advise' with a comprehensive understanding of issues/ needs etc?

4.19: What methodology will be used for this 'sliding scale of support'? What triggers and timescales will be employed?

4.21: Important to seriously consider the risks to children's services and include where possible in this system change.

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?

More detail required as noted above.

IT systems and support to facilitate not only whole system sharing of information (clinical, social etc) but also to support and facilitate scrutiny, public interface and input etc.

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 make sense to include full / wider responsibilities but would be useful if central guidance/ direction were available to support.

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?

Again, crucial to this question (10) is point 5.7 and the 'enablement' of 'trustworthy and robust' information available to ensure 'best effect' at the material time in addition to effective planning. IT systems are of particular value here and require investment to ensure a 'single' system is in place to facilitate such.

There is poor definition and a limited amount of detail to assure confidence that of the 'models described' to 'successfully deliver' this objective.

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?

Lack of transparent systems, accountability and 'control' of decisions made offer significant barriers to clinicians. Mechanisms for accessing an 'integrated budget' must be crystal clear and impartial.

AWI is a specific challenge for older adults and the protracted legal process and 'medical dominance' that exists without due regard to impact of time involved.

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?

Critical. Local variation will be a significant challenge.

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?

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

This role is crucial to effective governance and service arrangements. Again more detailed direction around the appointment process, skills required etc. would be welcomed as varying high level influences can have a bearing here and given the fundamental requirements of this post, how this role is expedited will have a direct influence on the success or otherwise of the new 'partnership'.

Not enough detail to comment further.

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?

Central direction is required. Conscious that previous CHP 'Scheme of Establishment' clearly noted that a 'nurse' must be a member of the CHP Committee yet this was not consistently addressed with a number of Committees having a gap here. Stronger direction and specific 'integrated' framework is most definitely required.

As previously noted this direction should also include which professionals/ clinicians should be involved – accepting that some are mentioned by name in 7.2. The trick is how this will be managed equitably for all? Professional engagement and leadership has to be recognised and valued at the outset and consciously facilitated. The process to establish the 'who/ which professionals, where from (specialism or generic) needs specific consideration and catalysing to ensure effective leadership.

Equality and equitable access to health regardless of location is a priority and therefore requires central/ SG direction and/ or careful performance measures and scrutiny processes to assure.

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 – as noted above – explicit direction required as variation will be significant. We advocate that routes for all practitioners/ professionals need to be defined – not dominated by one particular profession.

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?

Our view is that equality of representation within partnerships within robust professional leadership arrangements and ‘advisory’ processes within a co production approach are critical.

We strongly disagree with tokenistic ‘engagement’ that contributes to a sense of ‘further retraction’ of professionals from strategic/ commissioning/ planning necessities and in mitigating this risk, HCSPs must have inclusion from the outset/ inception as part of local proactive risk management approaches to ensure ‘live’ influencing and interaction to shape/ develop services.

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

GPs and their practices are essential to locality planning being locally driven and generally are representative of local community populations from a health, and to a lesser degree social care perspective. These should be central but not to the exclusion of other primary care contractors, professionals etc. There are concerns around the variances in sizes of ‘communities’, resources within said communities and number of GPs/ Practices located within.

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

Surely this would be closely linked to the evolving legislation and organisational change requirements/ support that will inform this ‘devolved decision making’ as time progresses and systems and structures ‘bed in’. To do otherwise at an early juncture may well pose added governance and ‘business’ risks.

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?

See question 18 response.

Other Comments:

The successful shift to more people receiving care in their own home as opposed to hospital settings must be recognised in terms of the impact on current community services, skill mix and workforce planning. Future workforce planning must be cogniscent of this fact and fully involve professionals from both health and social care on the steps required to align workforce models to skill/ service delivery to a community setting.