

Integration of Adult Health and Social Care in Scotland

NHS Health Scotland response to consultation on proposals

Response Summary

1. We believe that Health and Social Care Partnerships offer innovative opportunities for bringing together the public sector response to the Christie Commission's ambitions to prioritise prevention, reduce inequalities and promote equality.
2. Addressing health inequalities and improving health are central to these ambitions and realising this potential. As are ensuring that future proposals focus strongly on locally agreed outcomes and less on the structures required to meet the challenges they present.
3. There are three main areas we believe should be included in the legislative framework and associated statutory guidance:
 - We propose that a **duty** is placed on the statutory partners to address health inequalities within their core responsibilities, including budget setting (based on public health needs assessments) and improving equality of access to and outcomes from services.
 - The Health and Social Care Partnerships should have clearly defined **leadership and accountability** responsibilities for addressing health inequalities and improving health and clearly defined mechanisms for partner accountability.
 - A more central role for **communities** in contributing to Health and Social Care Partnership action in making decisions about service development and resource allocation for the prevention of health and social problems

Introduction

4. NHS Health Scotland's role is to work with a broad range of partners and stakeholders to reduce inequalities in health and improve health for all in Scotland. Our strategy¹ for 2012-2017, "A Fairer Healthier Scotland", aims to ensure:
 - Improved and more equitable policy making
 - Improved performance and quality in practice and
 - Stronger support for action for prevention and better, fairer health.
5. Drawing on our expertise and experience of addressing health inequalities and improving health, we will focus our response on the potential for Health and Social Care Partnerships to reduce variability of health and social outcomes in their populations. While Scotland's health is improving, it is improving more slowly than for other European countries, and health inequalities in some cases are widening. There is increasing knowledge of the connection between social and environmental circumstances and health and consequently, we know that the needs of individuals cannot be met effectively without services taking these factors into account.
6. We have also considered the partial Impact Assessment carried out to meet the legislative duty on equality which identified a number of questions for Health and Social Care Partnerships including consideration of underserved population groups, social support, income, environment and human rights.

Question 1

¹ NHS Health Scotland 2012, *A Fairer, Healthier Scotland Our Strategy 2012 -2017*, NHS Health Scotland

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?

7. We can see the case for a focused approach to improving outcomes for older people is a strong one given the nature of demographic change. This could also be a practical approach as there are many national and local work programmes currently underway that can inform current and future planning and action.

8. However, we recognise that an initial focus for a new structure on a defined population group such as older adults could limit further development with other population groups. We recognise that it is for local partners to decide the scope and focus of their partnership and how this will develop. However whatever this initial focus and the extent of coverage for different age groups, we are proposing that the statutory partners have a duty for addressing health inequalities using a whole population approach with families and communities' playing key roles.

9. We are also aware of the importance of action in the early years for reducing population health inequalities at later lifecourse stages. We believe that the legislation could potentially create an artificial distinction between adults and older people and other lifecourse stages. The transitions between stages and services and the complexity of objectives within NHS structures and between the NHS and other agencies suggest that we should avoid creating new barriers between lifestages and between services. While some services might be best delivered for particular groups, others such as mental health, addictions, health improvement and community development cannot always be delivered effectively for discrete age groups particularly when we need to engage family or community support or to preserve the health and well being of carers.

10. The important existing and potential roles of families, communities and carers in designing and providing care should be central to maximising the impact of new structures delivering care within communities.

11. We need to maintain the local relationships that have already been established between health and social service providers where they are shown to work for the different needs of individuals and families across the life stages from the very early years right through to older age. Creating a separate structure at this time for specific population groups such as adults and older people with complex needs could compromise rather than strengthen these existing relationships. Even when focusing on any specific life stage, whole families and communities need to be engaged in improving health.

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?

12. There are 3 main areas we believe should be included and given higher priority:

A duty to address inequalities

13. We propose that a duty is required for reducing health inequalities. This requires clearly defined leadership and accountability roles for statutory partners and would be based on partnership working. It would ensure that the statutory partners (through the Health and Social Care Partnerships) were required within core service provision to address wider

inequalities in order to ensure a focus on prevention of poor health and well being, health improvement and equality of access to and outcomes from services.

14. Such a duty would clarify accountability and responsibility for decisions that improve or increase equality in access to and outcomes from services and joint financial accountability would be required to ensure joint governance. For example, budget decisions for health and social care should be based on a robust assessment of population need in order to work towards a reduction in unwarranted variation in access to and outcomes from services.²

Local leadership and accountability for prevention and health improvement

15. The potential for the Health and Social Care Partnerships to contribute to reducing health inequalities and improve health is missing from the consultation document and we believe must be included. Local leadership for the public health and health improvement workforce could be strengthened by using the Health and Social Care Partnerships as a jointly governed mechanism for bringing NHS and local authority actions closer together for the benefit of communities. This would result in a strong base for leading Community Planning Partners to jointly reduce health inequalities, improve health and establish equality outcomes for meeting legislative requirements.

16. We can learn from findings from reviews of Community Health Partnerships (CHPs) and Local Health Care Co-operatives (LHCCs), as well as from the Equally Well test sites and other demonstration projects as to how Health and Social Care Partnerships might engage local capacity for reducing health inequalities and improving health. Findings have identified good models of practice but also that these structures have not gone far enough to reduce health inequalities. There is an opportunity for the new Health and Social Care Partnerships to build on previous action and learning and to harness skills within local and parent bodies and within national organisations to focus more effectively on reducing health inequalities.

17. There are examples from all over Scotland of existing partnership actions for improving the public's health that are led by or interface with health and social services. However, there is variability across Scotland and variable consensus on leadership, public health workforce development and relationships between partnership and parent body actions. Omitting this potential from the new Health and Social Care Partnerships would miss an opportunity for strengthening leadership at local level for early intervention and prevention. Alternatively, including action on addressing health inequalities and health improvement in the Health and Social Care Partnerships for specific groups such as older people or adults alone could narrow their potential for population improvement.

Communities

18. There should be a stronger emphasis on the important roles that families, carers and communities can and do play in health and social care. Health and social care services sit within an architecture of determinants of health and wider social inequalities including poverty, complex health and social care needs, housing and environment as well as a complex web of community resource.

19. The contribution that housing makes to health and well being and to enabling older people to remain at home for as long as possible should be integrated within and through the Health and Social Care Partnerships. For example, the work of social rented housing

² Scottish Government 2010, *NHSScotland Quality Strategy – putting people at the heart of our NHS*, Scottish Government

providers on homelessness, development of the Scottish Housing Quality Standard, environmental improvements and on supporting tenants with benefits, training and employment can impact directly on health of individuals and communities and on social connectedness.

20. While accountability for spend cannot be shared by community members, statutory partners should be held to account for effective involvement in decision making of service users and members of the wider communities served by the Health and Social Care Partnerships. In this way, more effective mechanisms could be developed for engaging family and community resources and ideas for providing support and prevention activity for older adults in their own homes and communities.

21. There is a wealth of local and national experience of community engagement in Scotland that would be of direct relevance to the new Health and Social Care Partnerships, for example from recent Patient Focus Public Involvement (PFPI) and Meeting the Shared Challenge programmes and from the community initiatives that continue to thrive across Scotland despite the uncertainties of the financial climate.

22. NHS Health Scotland can offer support for development of all three areas above. Please see the 'further comments' section below.

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 and for support to carers. 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?

23. Yes, however we are also suggesting in this response that statutory partners through Health and Social Care Partnerships take greater ownership of improving equality of access to and outcomes from health and social care services as part of their statutory responsibilities. We are proposing that they build actions that address health inequalities and prevention into their core business in order to contribute to improving health in Scotland.

24. For these ambitions to be achieved there must be a formal requirement for Health and Social Care Partnerships to do so. Joint governance and joint financial accountability, along with careful negotiations to maintain the necessary relationships with NHS Board public health functions would be required for these ambitions to be achieved.

25. Previous structures have included recommendations for health inequalities and health improvement but reviews and evaluations of these structures and recommendations have identified a lack of achievement for these goals and have advised of a need for much clearer guidance and stronger leadership.

26. There has been variability around Scotland as to the respective roles of community planning structures, local authorities, community health partnerships and NHS Boards in driving local actions for addressing health inequalities. An inequalities duty on the statutory partners would create a clear locus for local, joint action on inequalities. They would be in an ideal position to pull together local and organisational capacity from parent bodies in order to develop more effective action to improve equality in services provision and to address health and social inequalities in the populations served.

27. In addition, there will need to be a strong mechanism in place to ensure the opportunities to engage GPs in the public health work of the Health and Social Care

Partnerships as well as the joint delivery of health and social care services are maximised for the benefit of the local population.

Question 4

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

28. Yes, all Single Outcome Agreements should identify adult health and social care as a priority. From a public health perspective, inequalities outcomes cut across all of the proposed outcomes for adult and social care within the consultation document as well as the existing national outcomes in the National Performance Framework. Statutory guidance should be developed to describe how the population public health needs assessment referred to in point 14 is reflected in the Single Outcome Agreement.

29. Health and Social Care Partnerships should lead community planning action for reducing inequalities and improving health for their population and locality area. The Health and Social Care Partnerships will be well placed to work with their parent Boards and Local Authorities and to collaborate with other agencies and structures to maximise action to reduce health inequalities, linked to the wider outcomes of the Single Outcome Agreement. Further work will be required to agree the inequalities dimensions of all the proposed health and social care outcomes. For example, gender should be considered particularly in relation to an outcome for carers, while involving people with disabilities and their carers should be central to the outcome on independent living.

30. Clear guidance will be required to establish the health inequalities and improving health outcomes the Health and Social Care Partnership is responsible for and those outcomes that are the responsibility of the Community Planning Partnership.

31. Robust guidance will be required to give a consistent approach to the use of measures and indicators for inequalities dimensions specifically for locally agreed health and social care outcomes that contribute to national priorities.

32. Based on evidence we strongly advise against marginalising health inequalities into an optional healthy living programme approach, (as suggested by the proposed outcome number 1). In this case Health and Social Care Partnerships will be unable to demonstrate an effective contribution to improving health for individuals, families, communities or for populations. There will be a risk of contributing to increasing health inequalities.

Do you have any further comments regarding the consultation proposals?

33. We have based our response on our experience of addressing health improvement and health inequalities and as such have concentrated on answering Questions 1-4. We are particularly keen to see that inequalities, prevention and health improvement are built into Health and Social Care Partnerships' core planning and service provision in order to have maximum effect on individuals and on the populations served.

34. One issue that was not covered in the questions was that of workforce. Professional carers are often amongst the lowest paid workforce in Scotland. These carers are mostly women, working on a part time basis sometimes holding other part-time, poorly paid jobs. We believe that this workforce in particular needs to be appropriately supported, trained and remunerated to ensure the best quality care can be provided to those who need it and to support a workforce that can be at risk of disadvantage. In addition, the ambition for Health and Social Care Partnerships to effectively address health inequalities will require the public health workforce to be included in engagement, design and delivery as the partnerships are developed and established.

35. Within our current work programmes NHS Health Scotland can offer concrete planning and developmental support for the elements of the Health and Social Care Partnerships that could strengthen prevention and reducing inequalities.
36. NHS Health Scotland can offer support relating to the following:
- Assistance with the development of statutory guidance for health inequalities and improving health
 - Further support for embedding the findings from impact assessment, including for health inequalities and human rights, into further planning and guidance
 - Data and profiling for local populations with Scottish Public Health Observatory (ScotPHO)
 - Data and evaluations for health inequalities, health improvement and community development
 - Access to academic research evidence including international research on all aspects of health inequalities and health improvement
 - Contribution to the development of outcomes frameworks incorporating robust evidence and logic
 - Working directly with a variety of local public sector partnerships, voluntary organisations and community projects on the prevention agenda in order to improve programme design, delivery and impact
 - Public health workforce development including health improvement staff, community members, non-medical public health specialists and Public Health Practitioners in NHS and non-NHS settings.