



Dear Sirs

## **Response to the Consultation on Proposals: Integration of Adult Health and Social Care in Scotland**

Each of the statutory organisations in Forth Valley has prepared its own response to the consultation document. In addition, individuals, professional groups and stakeholders within each organisation have contributed to the responses of national groups, professions or representative bodies.

The Chief Executives and senior officers of NHS Forth Valley and Clackmannanshire, Falkirk and Stirling Councils have formed a Joint Executive Group expressly to take forward integration across Forth Valley. In this context, it is thought appropriate to submit a collective executive response to complement the responses of our individual organisations. By so doing, a signal is being sent about the longstanding commitment in Forth Valley to public sector joint working and shifting the balance of care in the interests of service users and patients. There have been a number of important outcomes from this joint work, including the closure of RSNH, the reshaping of the acute and community hospital provision in Forth Valley and a range of integrated services, particularly in the fields of mental health, learning disabilities and addictions. We believe this is a strong basis from which to face the opportunities and challenges ahead.

We would be pleased to discuss further the detail of this response.

Yours faithfully

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## **Forth Valley Joint Executive Group Response to the Scottish Government's Consultation Document on the Integration of Health and Social Care Services**

### **Overview and Context**

Each of the statutory organisations in Forth Valley has prepared its own response to the consultation document. In addition, individuals, professional groups and stakeholders within each organisation have had the opportunity to contribute to the responses of national groups, professions or representative bodies.

The Forth Valley Joint Executive Group comprises the Chief Executives and senior officers of the three Councils (Clackmannanshire, Falkirk and Stirling) and NHS Forth Valley. This Group has been drawn together expressly to take forward integration across Forth Valley. In this context, it is thought appropriate to submit an executive collective response to complement the responses of the individual organisations. By doing so, a signal is being sent about the longstanding commitment of the organisations in Forth Valley to public sector joint working and shifting the balance of care in the interests of service users and patients. There have been a number of important outcomes from this joint work, including the closure of RSNH, the reshaping of the acute and community hospital provision in Forth Valley and a range of integrated services, particularly in the fields of mental health, learning disabilities and addictions. We believe this is a strong basis from which to face the challenges ahead. For the avoidance of doubt, the views expressed in this paper are those of the professional and managerial leaders in the four organisations with accountability for service delivery.

Current joint work across Forth Valley is focussed on Reshaping Care for Older People. In that context, a Joint Commissioning Strategy for Older People's Services is currently in draft. At the heart of this strategy is the vision which underpins our commitment to working together to improve services for patients and service users.

“Forth Valley should be a great place to grow old - providing a safe and friendly physical and social environment with supportive communities. The strategy has a focus on promoting independence, choice and control for older people and their carers and providing high quality, responsive and personalised care services when and where required”.

There is therefore strong leadership support for the principles which underpin the consultation on the integration of Health and Social Care Services. The overview comments and detailed responses to the consultation questions are made with this as background.

We would like to take this opportunity to draw out a number of important themes at the outset as well as to make detailed responses to the individual questions. These themes are set out below.

The first theme is in relation to the concept of Integration itself and the approach to legislation. There are no national definitions of integration, older people's or adult services across Health and Social Care. The evidence is clear that successful integration is not a single event but rather a wide variety of interventions being taken forward at multiple levels and based on local circumstances. Integration from our perspective is not an end in itself nor is it the sole solution to the demographic and financial challenges we collectively face. Therefore we support strongly the "enabling" emphasis in the document and would like there to be maximum flexibility at a local level to focus on outcomes and to address issues from a local perspective. We are concerned that the "enabling" message is translated in the detail of the document to prescription and requirement: models, governance arrangements, integrated budgets, the jointly accountable officer. Focussing on the two models for integration set out in the consultation document, we have not expressed a preference for either model. While recognising why a legislative approach might be deemed to be required, we would ask that there is flexibility to agree locally which model might be appropriate to support improved outcomes. This local approach would encourage innovation but also so that we can build locally on existing integrated models.

A number of detailed points about the scope of the enabling legislation are made in response to question 1.

The second general point is in relation to the policy context and other connected drivers. In our view not enough connection is made in the consultation document to broader and connected agendas. The first and most important is to the developing review of Community Planning. In addition, there is no mention of e.g. Self Directed Support Bill nor the Community Empowerment and Renewal Bill.

In Forth Valley Stirling and Clackmannanshire Councils have already developed a Shared Services approach to Social Care and Education. Reflecting this, we would wish the enabling legislation to provide for the potential for partnerships to cover more than one Council area should this be a preferred local approach.

The third issue relates to accountability arrangements and the right balance of local democratic accountability and accountability to central government. The detailed response to these issues is set out in the response to questions 4 and 5 below. A related issue is the development of outcome measures. There is a recognition that enhanced consistency of service delivery for Older People across Scotland is desired and therefore the emphasis on national outcome measures. However, it would be helpful in the context of the developing thinking about Community Planning to be clear about the balance of local agreed measures in addition to the national outcomes to be reflected in the revised Single Outcome Agreement.

NHS Forth Valley's Integrated Healthcare Strategy, which was largely completed in 2011 with the opening of the Forth Valley Royal Hospital (FVRH), was based on delivering a major shift in the balance of care with an important work stream being the modernisation of the acute setting. The benefits associated with this element of the strategy have already been realised from the acute sector; there is local agreement that there are no bed associated resources which can be realised. It is clear from the operations of the hospital to date that the inpatient beds are largely emergency focussed and all patients in the hospital are individuals with complex needs requiring a multiagency approach to discharge, not just for elderly people. It would be helpful

and welcomed to have more national discussion and debate about the role of the acute hospital in the integration agenda and what is intended in relation to resource shift before moving to legislation. In addition, FVRH is a PPP and there is a requirement in that context to drive efficiency over the core hospital budget taken as a whole.

There is little reference in the consultation paper to the important supporting strategies which will enable integration at a local level. These include workforce development (not forgetting the terms and conditions issues), finance (including Board wide efficiency in the context of more than one Partnership), IT and Telehealth/care, data development and information sharing. There are also issues of professional leadership and care and service governance which need to be thought through. In that context, parity of professions and the statutory responsibilities of e.g. the Chief Social Worker also require to be addressed. Thought needs to be given to how a consistent approach to these underpinning strategies is possible for Health Boards supporting more than one Partnership.

It would also be helpful to have more discussion about the role of the housing department and its budget. This is raised in 1.17 of the consultation document but does not feature later under e.g. 5.3.

The paper and other related documents refer to the disconnect within Health between primary and secondary care but there are no detailed proposals in the paper in that regard.

In moving forward, recognising the complexity and risk as well as the opportunities in the integration agenda, we think it might be helpful before moving to definitive models if the pathfinder approach adopted in relation to GIRFEC was considered for the broader agenda of Health and Social Care Integration.

**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?**

We recognise the drivers identified in the consultation paper in respect of care for older people and the particular concerns identified relating to avoidable delays and undesirable emergency hospital admissions. We completely support the principles and agree that more progress has to be made to improve care pathways and to shift the balance of care. However, we would wish the emphasis to be on "enabling" legislation which would allow local flexibility to deliver local solutions. In addition, we would prefer enabling legislation that would allow local partnerships to take forward a broader agenda if there is the ambition to do so e.g. to encompass Children's Services. We believe that offering the ability to take a broader approach is important because it is at transitions of care across the board that many of the resource standoffs happen which the legislation is being designed to tackle.

In terms of the actual question, while absolutely supporting the improvement of outcomes for older people, it does not make sense from many perspectives to separate older people's services from broader adult services. Many universal services support both and it would be difficult to separate services for older people from those of adults with complex needs, including e.g. discharge from hospital and out of hours services.

This is true also for many of our third sector colleagues who would find it difficult to stream services in this way. We also support the point made in 1.12 in relation to transitions of care and the risks of creating artificial divides, particularly in the context of the outcomes of child and adult protection enquiries.

**Question 2: Is our proposed framework for integration comprehensive?  
Is there anything missing that you would want to see added to it?**

In line with the theme of local flexibility set out above, we think it would be most helpful not to have as an absolute requirement to create a single integrated budget covering all areas of adult health and social care. We suggest that it would be more helpful for legislation to provide enabling powers to integrate budgets in whichever way would be most helpful to serve the delivery of improved health and social care services. The difficulty with dividing universal services raised above is also important when thinking about an integrated budget for older people's services.

Some areas of the consultation require further detail and clarity. These include the role of and budgetary shifts from the acute sector. More detailed discussion about locality planning and the engagement of clinical and care professionals would be helpful. Greater clarity is required on how locality service planning fits with other strands of policy which relate to the engagement of communities and the creation of community capacity is not clear. Guidance on how to engage independent contractors and how national agencies such as NHS 24 and Scottish Ambulance Service will be engaged will be important due to their impact on local service delivery. It would also be helpful to clarify how the policy/legislation relating to Self Directed Support will translate across integrated services.

The emphasis on the important role of carers is welcomed. It would be helpful if the crucial role of the 3rd sector in the delivery of outcomes was strengthened. Many services for older people and for adults more generally are commissioned through the third and independent sectors. These organisations are also facing financial challenges but are seen as increasingly important in supporting the delivery of health and social care services.

**Question 3: The proposal will establish in law a requirement for statutory partners-Health Boards and Local Authorities-to deliver and 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?**

We would wish to emphasise the role and contribution of wider services to the outcomes for older people, for example housing, planning, leisure and policing services. The strategic role of community planning in ensuring that the contribution of wider partner agencies, including the third sector and community representation, to securing improved outcomes would benefit from further attention. In that context, further clarification would be helpful in relation to the relationship between Health and Social Care

Partnerships and Community Planning. In particular relative accountabilities need to be clear of Health and Social Care Partnerships to Community Planning Boards as well as to Local Authorities and Health Boards. Clarity in relation to the hierarchy of authority in this context would be important. It would also be helpful to review the relative performance management arrangements of Health Boards and Local Authorities to understand how current performance arrangements can be made into a coherent set of performance measures without multiple governance scrutiny. In this context we note that the NHS currently has to report performance nationally as well as locally and this needs to be teased out.

Merging the accountability and governance arrangements and seeing this as a powerful enabler in this context is clear. The logic of being jointly and equally accountable to Scottish Ministers, Local Authority leaders and Health board Chairs is understood but it would be helpful to have additional clarity about how would this work in practice. The principle must be that the governance arrangements will support the delivery of outcomes and not allow core purpose to be overwhelmed by bureaucracy. In addition, in all of the concern about governance and scrutiny the local connection to the population and its needs should not be lost.

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

We agree with this recommendation subject to the points made above about clarity of connection and accountability with Community Planning arrangements. There is also a concern to ensure that there continues to be flexibility to identify and agree locally defined outcomes.

**Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local accountability and accountability to central government for health and social services?**

Local Authority colleagues do not consider that this proposal provides sufficient local democratic accountability. The Council Leader is the leader of the Administration which is politically responsible and accountable to the electorate, therefore accountability is not vested in one individual. The suggestion is that the primary accountability should be to the full Council and full Health Board rather than to particular individuals as identified in the consultation.

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

Stirling and Clackmannanshire councils have established shared Social Care Services and are already working with the CHP and other partner agencies across the two Local Authority areas. We would strongly support therefore the scope within the proposed legislation to establish Health and Social Care Partnerships across more than one Local Authority.

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

The joint approach to the direction of resources across Health and Social Care is welcomed. However, it appears that the proposals have been framed in terms of dispute resolution rather than positively building on models both nationally and locally which have been evolving. It is clear that in the context of partnership working developments can only move forward on a consensus basis or progress *de facto* will not happen.

In line with comments made earlier in the response, we would emphasise our wish to have local flexibility to agree appropriate governance arrangements to support local circumstances.

If it is thought necessary to proceed on the basis of the proposals in the consultation document then it would be helpful if the arrangements were clarified and potentially strengthened in relation to three aspects. The first is in relation to the Voting Members as set out in paragraph 4.17 of the consultation document. It would be helpful to have a national discussion for example about Partnerships covering more than one Local Authority and the approach to ensure parity between Health Board Non Executives and Council Elected Members. The local democracy point made earlier is also important in relation to this question and a concern that potentially three Council members on behalf of the Council would be accountable and scrutinise a budget that may potentially be bigger than the overall budget for the Local Authority. This same point also relates in the same way to the Health Board accountability. Local Authority colleagues advocate therefore that primary accountability for the Partnership should rest with the full Council and full Health Board.

The second issue relates to the Accountable Officer status of the Chief executives of the Local Authority and their relative accountabilities to Council and DG and CEO of NHS Scotland and Cabinet Secretary. It would be helpful to explore how these accountabilities fit with the proposals in the consultation document.

**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?**

The answers to the questions above re Committee membership and the relationship of Health and Social Care Partnerships to Community Planning Partnerships need to be taken account of in relation to the response to this question. National Outcome measures for Health and Social Care Partnerships are welcomed but need to be underpinned by performance measures that demonstrate delivery and improvement. The document does not make clear how these will relate to the existing HEAT targets and whether the national outcome measures will become a competing priority. The comments regarding scrutiny partners are welcomed. It will be important that the various scrutiny bodies adopt an integrated approach to reduce duplication and to ensure that the same standards are applied across common service quality measures.

**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 this should be a decision made on a local basis given different priorities and stages of integration.

**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?**

We would recommend a greater emphasis on the involvement of service users, carers and potentially the third sector in service planning and commissioning than is currently evident in the consultation document.

We would caution against any over emphasis on the role of structural reform – and prescriptive models without an evidence base – in securing improved outcomes. It is important that any structure which emerges is clear and understandable to the public, professionals and other agencies. We draw attention to the point we made in the Overview and Context, where we thought it might be helpful before moving to definitive models if the pathfinder approach adopted in relation to GIRFEC was considered for the broader agenda of Health and Social Care Integration.

There are lessons to be learned from the experience of other merging organisations and the “hidden” tax or other financial downsides e.g. change of VAT registration.

**Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system?**

There are a number of examples which recognise the benefits of making flexible use of resources across the health and social care system. Some of these examples are set out below:

***Strategic Commissioning Projects***

- Advocacy Services
- Learning Disability Commissioning Project
- Tillicoultry Project
- Stirling Care Village

***Joint Provision***

- Integrated Mental Health and Learning Disability Services
- Sensory Centre
- Marchglen



### *Integrated Approaches*

- Reablement/Rehabilitation/Day Provision
- Anticipatory Care Planning
- Management of Long Term Conditions
- Anticipatory Care/Health Inequalities Work
- Locality arrangements for Children's Services, Falkirk

### *Wider Integrated Partnerships*

- Substance Misuse Redesign/Addiction Recovery Service
- Clackmannanshire Healthier Lives
- Forth Valley wide approach to GIRFEC

### *Sharing Accommodation*

- Forth Valley Joint Asset Strategy
- NHS Staff co-location in Stirling council Offices
- Social Work Staff co-locating in Clackmannanshire Community Healthcare Centre

Three further observations. The first is that these joint projects have benefited from an incremental approach taking time to build teams that can work together to achieve change. It is clear that it will take time for outcomes to be realised. While the potential benefits of enabling the flexible use of resources are fully recognised, the time required to secure the cultural and practice changes that will underpin improved outcomes should not be underestimated.

The second is that there is a legacy of potentially difficult experience of deploying resources across the health and social care system which should also be learned from: resource transfer.

The third issue is not mentioned in the consultation document which is the issue of charging and what can or cannot be charged for in relation to integrated services. This needs more detailed discussion and consideration at a national level.

**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?**

This clarity would be helpful. However, we draw attention to the points made earlier about local flexibility and integrating budgets to target local improvement and outcomes rather than laying down a requirement under a prescribed model. We also draw attention to the issue about acute hospital resources made in the introductory comments and would welcome further discussion and clarity.

**Question 13: Do you think 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 shift the balance of care?**

The contribution of the acute sector to the pooled budgets is not clear in the consultation document. This will have a potential material impact on the budget to be managed by the Jointly Accountable Officer. There is a requirement for a long term strategy and culture change to shift investment and public perception to prevention and health promotion from particularly acute service delivery. It is not clear how a shift of resources from Acute Services will be achieved in Forth Valley without undermining the provision of current services as discussed in the opening section.

The comments made earlier about accountability and responsibility of Partnership Boards, the relative size of the Partnership budget vs the budgets of the individual statutory bodies, the balance of local democratic accountability, the Accountable Officer Status of the CEOs should also be read in conjunction with this question.

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

The answer to question 13 is linked to this. The size and proportion of the pooled resource will vary across Partnership areas. We would recommend that the seniority of the post should be determined locally taking into account budget size and reporting arrangements.

**Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?**

No by definition locality planning should be local. This response should be read in conjunction with our comments on the link to Community Planning which is also focussed on localities and e.g. to the work on empowering and building capacity within communities envisaged by the proposed Community Empowerment and Renewal Bill.

**Question 16: It is proposed that a duty should be placed on 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?**

This is helpful but a concern expressed about the parity of professions in this regard. However, there needs to be a greater emphasis also on the duty of Partnerships to consult and involve service users, carers and the wider public in planning and commissioning activities at a local level.

**Question 17: What practical steps/changes would help to enable clinicians and social care professional to get involved with and drive planning at local level?**

Joint Strategic Commissioning and the proposed National Learning Framework for Joint Strategic Commissioning will help support this. It will be important to ensure that there are adequate skills and capacity at a local level to support this and to enable the contribution of wider partner agencies as well as service users and carers in planning and commissioning activities.

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

We would be against making this a prescribed recommendation. GP practices are obviously important but they do not necessarily represent natural communities e.g. some in Forth Valley cross Health Board boundaries. We will need to do further work in Forth Valley to be clear about what are meaningful communities for the population and how to encompass services which are used in these areas. We would therefore recommend local flexibility to respond to local circumstances.

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

It is hard to make a comment here in the context of the responses to the previous questions. It is not an immediate priority and would need to develop if at all over time. There are concerns about diluting the accountability of the Health and Social Care Partnership as the accountable body while recognising the requirement to engage and involve the locality planning groups.

**Question 20: Should localities be organised round a given size of local population?**

The size of localities should be determined locally. This is linked to the response to question 15.