Draft Consultation Response Integration of Adult Health & Social Care

The Scottish Directors of Public Health (SDsPH) welcome the opportunity to respond to the consultation on the proposals to integrate Adult Health and Social Care in Scotland.

In this brief paper, we set out some general comments about the consultation paper. We then comment on some specific issues, acute healthcare, public health and governance and public engagement. This is then followed by some suggested answers to the consultation questions. For ease of evaluation, there may be some repetition between our overview and our response to the individual questions.

These proposals aim to carry forward the priorities identified in the Christie Report. The Scottish Government response to the Christie Commission report, "Renewing Scotland's Public Sector" recognised four key aspects – preventative spending, integration, leadership, and stronger performance management. It is disappointing that the need for preventative spending to avoid negative outcomes arising does not feature more prominently. Making preventative spending a pre-requisite of the integration process would reinforce the patient-centred element of the quality of adult health and social care, and ensure that key public health and health improvement issues such as improving the health of Scotland's people, tackling health inequalities and protecting their future health are prioritised in the integration agenda.

Significant achievements have been made in shifting the balance of care from long stay institutional care to care in the community by partnerships between Councils, Health Boards and the Third Sector. Nevertheless much still has to be achieved given the demographic changes that are taking place and the downward pressure on public sector resources.

We therefore support the policy direction of the consultation with the emphasis on Health and Social Care Services firmly integrated around the needs of individuals, their carers other family members and the wider community.

In general, we welcome the explicit statement that changes are aimed to be Patient Centred but that this should be a given. We would be concerned, however, if the needs of current service users overshadowed areas of unmet need. Our comments are intended to highlight key areas where the proposal can be strengthened.

A partnership-based development of robust and appropriately resourced plans and delivery arrangements for agreed outcomes needs to be in place, and appropriately overseen.

The consultation sets out the broad context of the proposed legislation. We are aware that considerable work is ongoing to develop the detail and we look forward to continuing to engage positively in the further development of these proposals,

regulation and guidance. The acknowledgement that legislation will be only one small part of the collective effort that will deliver on our goals is important; again we would expect a full Integrated Impact Assessment to be undertaken. This would encompass positive and negative impacts on equalities groups with protected status and people with low socioeconomic status. From a public health perspective the inclusion of the Business Regulatory Impact Assessment is particularly valuable given the role of health as a tool for development and the effect of the economy on health and well-being. In addition there are six main areas that are under developed, and which require to be addressed to ensure the success of the integration agenda.

Acute Health Care

Firstly, the extent to which the Acute Sector in Health is expected to contribute to the shift in the balance of care/integrated budgets and the levers which will facilitate this to happen.

Public Health

It is disappointing that there is no explicit mention of Public Health from either the point of community well-being or that of the professional discipline of specialist Public Health. While advice and support to health and social care partnerships are only one aspect of the public health role across health and local authorities, it is an important part of our efforts to reduce the health and social inequalities that blight Scottish society. These inequalities produce significant levels of preventable ill-health and disability 10-15 years earlier among people who live in our most deprived areas compared to our most affluent ones.

The comments about disconnects in Paras 1.2. 1.3 is valid. In terms of Para 1.4. It is not just that the services are not available quickly enough but whether they are in place and have sufficient capacity. Paras 1.6 1.7 are a fair statement of problems currently faced in the provision of "secure and care services" for older people. There is no mention of the importance of developing work to improve and protect the health, well-being and independence of current and future older people. Is this not part of the remit of these new bodies as they are termed "Health and Social ***Care*** Partnerships”?

It is welcome that Para 1.17 highlights the health impact of drivers such as housing. These comments implicitly point up the wider statutory role of the local authority in promoting health and well-being. It would be helpful, and indeed is necessary, to be explicit about the crucial and universal public health role of local authorities in addressing the social determinants of health. The emphasis on third sector partners beyond the NHS and Local Authority is welcome, and important (Para 1.16).

We would like to think that lying buried beneath what is expressed in Paras 2.3 and 2.4 is an understanding of the importance of public sector reform. This has to be a

paradigm shift in the way public sector interventions and services function and are delivered. However, any transfer of work to the specialist public health function will require appropriate resourcing.

Primary Care

There needs to be a framework for ensuring that General Practitioners and other professionals in health and local government such as housing engage in the development of strategic planning and commissioning. This is essential, for integrated service delivery they need to be jointly held accountable for performance. There are good examples of joint and integrated services that already work in this way but these are often specific in scope, at the locality or neighbourhood level and person dependent.

Community Planning

There is a lack of clarity as to how the Health and Social Care Partnership will relate to community planning processes. Some authorities are already developing frameworks that see health and social care partnerships as one of several mechanisms for delivering the services required to achieve the outcomes envisaged in the single outcome agreement. This would fit with implementation of the Colin Mair report and some of the evidence emerging from other countries.

Governance

Para 2.3b states that “Statutory partners will be jointly accountable to Ministers, Local Authority Leaders and the public”. The remainder of the paper does not make clear how the joint accountability will be exercised in order to produce coherent and unified governance. Will one agency have primacy of governance? There is the potential for a clash in oversight between the two authorities. The independent role of the Director of Public Health is resolved through the relationship with the Chief Medical Officer and the accountability of Scottish Government Directorates is addressed through the Management Board and Cabinet. Is a similar structure envisaged or will this occur at Community Planning Partnership level?

The accountability as described Para 2.6 does not seem to be entirely congruent with Para2.3b. It seems to say something different and is potentially confusing. Is the “Governance Committee” in Para 4.8 the same as the “Partnership Committee” in Para 4.6? The lack of clarity continues in Para 4.11 which states “The NHS Chair and Local Authority Leader will form a “community of governance”. What exactly does this mean? The role of the Leader is to lead the Council’s administration; it is not a statutory role. There is no explanation of Para 4.17, why, despite NHS executive directors, including Chief Executives, being members of the NHS Board they will not be members of the Health and Social Care Partnership Board – this devalues the ability and contribution of current NHS Executive Directors. In terms

of committee membership in Para 4.18, it should include Senior Specialist Public Health Representation, such as the Director of Public Health because of their independence, statutory role as advocate for the health of the population and the added value their professional training and expertise can bring to, for example, the commissioning process (needs and evidence base for interventions, population (including demographic) and health economic perspectives) – see Para 7.1. The development of a more integrated approach to health and local authority functions would seem to be an excellent opportunity to provide integrated governance of health protection through the Director of Public Health, to address professional governance for Environmental health officers and scientists and to formalise the resourcing and governance of infection prevention and control for directly provided and contracted local authority services, and independent care homes.

Information governance is given only a fleeting mention and yet this area is crucial to success and so could prove to be the rate-limiting step in progressing the proposals in the consultation document.

Notwithstanding Annex C, In terms of staff governance there are risks to professional roles through decisions being taken by those who do not necessarily have experience or understanding required. There is a huge staff side concern at a time when people are already de-motivated and under stress. A healthy Scottish Public sector will incorporate the evidence on organisational justice as it seeks to take this opportunity to implement “Closing the Gap” in a generation. It would be helpful to require all public services, and their contractors to pay a living wage. Failure to do so simply transfers costs from the private to the public sector as health and local authority services deal with the consequences at individual and population level.

Public Engagement

Scant attention is given to communicating such changes to members of the public and patients and making it seem relevant in such straitened times. This does not sit well with the emphasis on capacity building and community leadership. We have assumed this is implicit as the integration programme provides a real opportunity for capacity building using the MESH framework.

Universal, publicly provided and delivered prevention, treatment and care, free at the point of use

The consultation document says very little about the specific protected status of health in terms of competition and World Trade Organisation rules. Scottish Government has, however, set out very clearly its opposition to privatisation, its philosophy of achieving best value through collaboration and continuous improvement and the use of non competitive direct engagement. All of these statements are helpful and reflect the evidence regarding delivery of efficient,

effective and equitable health and welfare services. It should be noted that reform of dental services is incomplete as regards cost sharing in primary care.

We will now address the specific questions within the Consultation:

Annex G Consultation Questionnaire

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 X No ☐

It is sensible for the legislation to focus initially on care for older people as a practical starting point; this is the highest priority for service redesign across Scotland. However, this should not stop partnerships from incorporating other services where this is consistent with existing practice and experience; older people's services overlap with those of other groups. We need assurance that these will be picked up too; we need to avoid losing focus on other client groups (e.g. people with multiple morbidity, people with physical disabilities or mental health problems). Outcomes to measure the success of this integration are necessary to ensure any decision on the future roll-out of the model to other population groups is evidence based.

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 X

The importance of prevention is mentioned briefly early in the document but should be given more prominence. The scope of Prevention and Health Improvement within 'Health and Social Care' should be broadened to avoid focussing on 'downstream' problems. There is a lack of clarity about workforce development – this area may appear muddled because of a lack of clear agreed outcomes.

Other issues that are insufficiently developed are:

1. Leadership and managing cultural differences

2. Shared information – technical issues, governance

3. Public involvement and engagement

4. Role of acute sector – crucial contribution to the development of seamless services, shifting the balance of care and contribution to integrated budget

5. Mental Health - not referenced and an essential part of the care of people with chronic illness.

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 X No ☐

The proposals will be strengthened by positioning them clearly and explicitly within the framework of Community Planning and Single Outcome Agreements.

A key component of the commitment to delivering outcomes is a joint approach to performance assessment and improvement. Existing lines of accountability do not run concurrently. Within the NHS there is heavily prescribed target setting and performance monitoring with centralised reporting and a duty to engage and involve communities in the design and delivery of services. Local government has locally agreed targets and performance monitoring systems with community facing reporting but the requirement for active engagement in service design and delivery is more limited. Formal scrutiny bodies in particular need to think carefully about how to integrate to ensure that the regulatory burden is appropriate and that a common approach is adopted. It will be important that partnerships are not pulled in two different directions and there should be a single set of performance reporting, with evidence that replaces rather than adds to existing arrangements. It would also be helpful if investment were linked to evidence and anticipated outcomes.

The strength of the mechanism will depend on clarity of lines of governance and accountability. Para 2.3b states that “Statutory partners will be jointly accountable to Ministers, Local Authority Leaders and the public”. The remainder of the paper does not make clear how the joint accountability will deliver coherent and unified governance. Will one agency have primacy of governance? There is the potential for a clash in oversight between the two authorities. Surely the accountability is through Ministers to Parliament and the public – not just the electorate as this excludes important sections of the population who rely on health and social care? The previous lack of accountability for the health, education and social welfare of looked after and accommodated children and young people is one reason why accountability to local voters alone provides insufficient scrutiny.

The accountability as described Para 2.6 does not seem to be entirely congruent with Para2.3b. It seems to say something different and is potentially confusing. Is the “Governance Committee” in Para 4.8 the same as the “Partnership Committee” in Para 4.6? The confusion continues in Para 4.11 which states “The NHS Chair and Local Authority Leader will form a “community of governance”. What exactly does this mean?

National outcomes need to replace existing national measures and complement other national targets. We welcome the focus on user outcomes but population outcomes are essential as is evidence of good quality access, engagement and service provision based on ability to benefit. Clarity is needed as to whether we can develop locally-agreed outcomes alongside national ones. We have noted the challenges in data collection in our answer to Q2.

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 X No □

Yes, national outcomes should be in the SOA. Any local outcomes should be derived from these. Conceptually, this is the current situation but they should be linked more explicitly to the WHO Europe health strategy Health 2020, and support a health in all policies 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?

Yes ☐ No X

The principle of joint accountability is important and welcomed. However, there will be real challenges in implementing this (which are acknowledged in the bill).

The role of the Council Leader is to lead the administration of the Council. It is not a statutory role and that individual requires the agreement of Council in order to progress policy and strategic issues. The relationship between the Leader and the appropriate Scottish Government Minister is very different to that of the Health Board Chair and the relevant Scottish Government minister. At present it is the Council which is responsible and accountable rather than one individual. The role of the Health Board and its Chair is different. The NHS Board is a board of governance reporting directly to the Scottish Government Minister. Integration of governance (and any appropriate performance management) at Scottish Government level "a community of governance" at central government level, is a prerequisite to successful oversight at local level. Some thought must be given to dispute resolution processes. Further consideration is required on this issue before a satisfactory solution can be agreed.

There are other practical issues such as the possibility that circumstances may lead Chief Executives to prioritise their individual organisational priorities over the Health and Social Care Partnership.

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

Yes X No ☐

We would agree that such an option may be appropriate depending the local context and practicality of the arrangement e.g. there is already successful joint planning between neighbouring local authorities influencing their engagement with their local health board. We would recommend the legislation is permissive and enables local determination of a model that best suits each partnership. Barriers to implementation will need to be overcome and local benefits evidenced.

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

Yes ☐ No X

Further detailed work should be completed on the Governance and Accountability arrangements to ensure that the level of democratic oversight and involvement is appropriately recognised. Coordination of partnership governance systems and Board and Council governance systems is essential.

It is important that the role and function of the partnership committee is well defined. The committee's responsibility for the overall determination of priorities and use of resources, including decisions to disinvest in one part of the system in order to invest in another, needs to be set out more clearly. The proposals currently imply these responsibilities lie solely with the Jointly Accountable Officer rather than the Committee. There might be benefit in stressing that attempts at consensus decision making should be striven for and use of voting arrangements a last resort

The Chief Executives of the Council and the Health Board should be able to attend the Health and Social Care Partnership Committee, on a non-voting basis if they are to be held accountable for the delivery of outcomes overseen by that Committee.

More work is required in relation to the budget setting arrangements and the management of any subsequent efficiency or over spend. While the move to a more strategic approach to investment in health is welcomed, the methodology for how the partnership moves to 3-5 year strategic budget planning cycle needs to be developed further.

Representations from non-exec directors and elected members are insufficient for robust governance. There is a risk – particularly when changing local government administration- that decisions are made without complete understanding of the implications. There is no explanation of Para 4.17, particularly why, despite NHS executive directors, including Chief Executives, being members of the NHS Board, will not be members of the Health and Social Care Partnership Board – this devalues the ability and contribution of current NHS Executive Directors. Why should Local Authority Chief Officers not be given the same opportunity to input?

This implies that health and social care partnerships will be second tier vehicles for service delivery and not legally autonomous bodies with responsibility for policy making.

The successful functioning of the Health and Social Care Partnership Committee depends on depends on appropriate partnership behaviours from all members in that environment. This is particularly important given the different roles of Non-Execs and Elected members in their own organisation. While there are opportunities to co-opt members to reflect local requirements, the non-voting membership of Partnership is vague and the status of non executives that are public representatives is not clear.

In terms of committee membership in Para 4.18, it should include Senior Specialist Public Health Representation, such as the Director of Public Health because of the added value such expertise can bring to, for example, the commissioning process (needs and evidence base for interventions, population (including demographic) and health economic perspectives) – see Para 7. The roles of professional advisors are unclear, including for example, the non executive director role of the Chair of the Area Clinical Forum. Minimal reference is made to secondary care consultants, or general practitioners, without whom there would be no universal health service, and no reference to other clinical professions.

We are not suggesting that non-executives and elected members cannot be equipped with the knowledge required to undertake their roles, rather that the benefit of the expertise of professionals specialising in these areas should be organised to maximise support for decision makers.

There must be staff side representation on these committees so that there is scrutiny of organisational justice, commitment to life long learning for staff and adequate attention to terms and conditions. These factors are central to the delivery of effective services. This is separate from the requirement for staff side engagement in organisational change associated with integration. There are particular challenges for small NHS Boards, e.g. in voluntary sector representation. In Borders, for example, there are only two organisations who can act as representatives and who are not also delivering individual projects. A strategic approach to the development of the third sector is essential – each local authority area should be able to develop and support leaders who can bring

together radical activists and mainstream service providers.

There is minimal mention of user involvement; this has to be more than tokenistic. Third Sector Representation is necessary but cannot replace the range of user and public representation required in strategy development, teaching, training, and research and service evaluation. Representation in all of these areas will be essential if health and social care partnerships are to deliver real improvements in health, wellbeing and service provision.

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 X No ☐

The framework described is satisfactory however more work is required on the detail.

A system of incentives and disincentives needs to be developed within the Quality and Outcomes Framework in order for the Partnerships to have greater influence over the 'commissioning' behaviour of GPs.

It is essential that existing performance reporting and accountability regimes are revised so that new nationally agreed outcomes and arrangements replace existing regimes rather than add to them.

It is not clear what performance support means but, assuming it is evidence based, targeted, outcomes focused and with clear deliverables then the proposed model should help address concerns, particularly where individual organisational pressures impact on delivery at partnership level.

Inspection bodies and processes need to be coordinated, focused on their core purpose and the evidence base from which their authority is drawn.

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 X No ☐

This should be determined at a local level but the requirement to protect publicly funded and delivered prevention, treatment and care that is free at the point of use is essential. Unless there is significant additional investment, some functions such as public health and health promotion will require to be provided across larger populations in most areas as there will be insufficient mass to provide resilient services, assure professional governance and deliver essential undergraduate and postgraduate education, training and research and development.

If partnerships are completely free to choose, smooth implementation of integration that varies across the country will be extremely challenging particularly in relation to budgets, accountability and workforce. Also, how confident would members of the public be if the arrangements were locally decided without external scrutiny? There is a risk of perpetuating the CHCP – in a different guise - in some areas at the same time as running with the new Partnerships. Detailed before and after evaluation is essential so that the opportunity to learn from the initial implementation is not lost.

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 X No ☐

The legislation should concentrate on the outcomes agenda rather than highlight two organisational options. Partnerships should be empowered to develop organisational arrangements, which encompass the key principles of these models. They should resolve local operational and service management issues to improve outcomes for clients or patients. The danger of highlighting specific organisational options is that partners will focus their activity around one of the two rather than concentrating on outcomes which should form the basis of the future organisational arrangements.

The description of the model suggests that it can be effective assuming a level of

knowledge or support to the Joint Accountable Officer to best inform decisions. It is not clear what 'appropriate areas of acute' spend might be and it will be extremely complicated to extricate these monies as the spread of activity in acute health sectors will be across all areas and specialties.

Financial integration will enable flexibility of resource usage and, if services remain free at the point of use, 'no wrong door' policies may reduce barriers but…

1. The traditional model of health and social care funding pools risk and resources over time and across the population. Individuals should have a greater say over the design and delivery of services that affect them but it is vital that the interests of current users do not ride roughshod over the needs of future service users or those who could benefit but who find services difficult to use until an emergency arises.

2. Shifting resources will result in disinvestment in services. Unless this is undertaken in line with the evidence, is designed to improve outcomes, tackle inequalities and retain services in the public sector, it will still be seen as taking money from one organisation to give to another

3. It does not tackle the challenges of disinvesting in failure to invest in prevention and early intervention while maintaining services for vulnerable individuals and populations –financial integration and the post of Jointly Accountable Officer will not of themselves resolve these issues

4. The socioeconomic patterning of unscheduled care requires a focus on early intervention, planned acute care and investment to address the social determinants of health. Simply shifting the location of services will not improve value for money or outcomes.

5. There is a real opportunity to reduce hierarchy and increase professional autonomy and responsibility to deliver improvements in standards, services and outcomes.

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 X No ☐

(a) There are numerous examples across Scotland of creative and flexible use of resources including:

Social Care & Health - East Renfrewshire

East Renfrewshire Council and NHS Greater Glasgow and Clyde took the decision to create a fully integrated Community Health and Care Partnership in 2005. The CHCP has a single Director accountable to both the Chief Executive of the Council and to the Chief Executive of MHS Greater Glasgow and Clyde. The Director is on the Council's Corporate Management Team and the Senior Management Team of the NHS Board.

Aberdeenshire

Joint equipment service, joint teams for mental health and learning disabilities. Joint management arrangements for Children's Services.

Edinburgh
Joint Director for Health and Social Care in Edinburgh but partnership working also between public health and local authority corporate services (health inequalities and statistics), environmental health and planning.

West Lothian

Fully integrated community health and social care partnership.

Argyll & Bute

The established practice in Argyll & Bute over the past 10 years is one of re-designing in partnership, pooling resource release and delayed discharge revenue and investing in services in the context of a joint performance framework for older people. This has seen the development of a constructive working relationship between the council and the CHP and is evidenced by the creation of a number of community services across health and social care and significantly improved performance in the area of delayed discharge.

(b) Barriers include:

The move towards outcomes, integrated budgets and practitioners being empowered to make operational and strategic decisions is welcome. The organisational, management and professional issues that could work against smooth implementation are key to developing a successful integration model. These include:

- Local authority history of outsourcing and competitive tendering rather than strategic partnerships

- The partners have different management and accountability regimes with the NHS accommodating a degree of clinical autonomy. The potential tensions with strategic commissioning require active engagement.

- Support for service redesign that will ensure that all directly employed and contracted staff take home a living wage, bring together professionals from different backgrounds while respecting their terms and conditions and enhancing the teaching, training and research roles of local authority staff.

- The experience of developing a joint commissioning strategy for older people via the Integrated Resource Framework has been challenging in that the both sectors have differing quality of data or analysis of activity and spend on older people. NHS financial data are poor in Scotland compared with comparator countries such as those in the Nordic region.

- Multiple and complex information management systems within both sectors have militated against ease of data sharing between the partners. This has been a frustrating feature of national and local initiatives to improve the integration of data systems and continuing concerns over the principles of data sharing. A mature approach engaging all of the relevant stakeholder groups requiring all areas to implement and invest in Data Sharing Partnerships to assure governance will assist in the short term whilst the technical aspects of system based data sharing are resolved at a strategic/ national level. Lothian, for example, has established governance that allows partners access to de-identified linked data. The Integrated Resource Framework is only one example of this approach.

- Significantly different approaches to the engagement of employees and

employee representatives on strategic change and service review programmes. It will be necessary to ensure that all employee/Trade Union/Professionals have the opportunity to develop the skills and competencies necessary to engage meaningfully in strategic discussion at local and national level.

To date, aligning budgets has proved less challenging and more effective than attempting to merge budgets, although some joint teams have been created.

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 X No ☐

The integration of acute sector budgets into the Health and Social Care Partnership is one of the most complex elements of the integration agenda. This real opportunity to shift the balance of care to communities requires an ambitious approach. It is important that all relevant aspects of the budget are considered and relevant patient pathways and all the resources used in these pathways are identified. This includes costs incurred by health services because of lack of social care provision on a 24/7 basis and will require some direction regarding deprivation weighted spend across health and social care.

The scope for including acute services is unclear. A significant proportion of care in general practice is acute, in and out of hours, as is the minor ailment service in community pharmacy. There is a real opportunity to provide integrated emergency and urgent health and social care outside traditional settings. We recognise that different models may be appropriate in different Health Board areas depending on the configuration of services and the number of Partnerships in the Health Board area. Whether the Partnerships directly manage this resource or have a 'commissioning' budget it will be important that the source and contribution of NHS acute sector spend is completely transparent at both Health Board and Partnership level, that there is consistency of approach across Scotland in identifying these budgets and that services are not transferred from the public to the for profit sector.

There is a risk of creating multiple governance systems to oversee provision of different parts of the same pathway of care, while fragmenting NHS services for patients with multiple morbidity, who should be the main beneficiaries of

integration. If a minimum amount is to be integrated what is the governance of the out of scope spend, particularly in areas where the population is growing, resource allocation is some distance from NRAC share and the needs of vulnerable populations have been underestimated? How will patients who require input from multiple specialists hold integrated services to account?

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 X

The respective roles of the Partnership Committee and the Jointly Accountable Officer in relation to financial accountability and authority require further consideration to ensure proper governance and democratic accountability. A single reporting line will be helpful but does not in itself guarantee a successful shift in the balance of care; potentially, it could be dependent on the skills of the postholder and the support from the Chief Executives. Financial authority is only one aspect of the ability to lead change and make it happen. An ability to engage with elected and appointed expert board members, professionals, support staff and trades unions will be key to the post. The postholder will also require the ability to command the confidence and understand the different approaches required to work with elected members, clinicians, particularly medical and nursing staff and expert local authority staff for whom the balance between advice and decision making has been different to that of clinicians.

A shift in investment is going to be extremely challenging. Investment in addressing the social determinants of health and prevention is lower than in comparator countries and investing in the public as well as the public sector is key to addressing the health, welfare and societal challenges Scotland faces. Legislation will support this but the opportunity should be taken to restate the responsibility of local authorities for the well being of their populations and the NHS responsibility to protect and improve the health of their populations. Changes must avoid vested interests in the decision making processes, support local service providers rather than remote corporate bodies and take the opportunity to secure the protected status of health.

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

Yes ☐ No X

The size and scale of the proposed partnerships will vary across Scotland from medium sized organisations to very large ones. Decisions about seniority, scope, and salary level would be best left to local partnerships to agree; to prevent potential tensions with other director posts in the organisations, the Jointly Accountable Officer should be a post with senior levels of accountability across several directorates. Unlike the English NHS, Scotland has not prescribed a hierarchy at Executive level, but it would seem to be reasonable for these posts to be Executive/Cabinet level posts, directly accountable to the Chief Executive.

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 X

This should be left to local determination, taking account of local circumstances and geography. However, there should be some direction regarding standards of access and engagement as well as specification of outcomes for local areas as there is a real risk that the aspirations for equity of access, engagement, service provision and outcome across Scotland will not be met otherwise; powerful local voices could sway decisions made. One helpful outcome might be the extent to which Gypsy Travellers will self identify.

Cross Partnership solutions will have to be developed to take account of patterns of service delivery particularly in relation to General Practitioner catchment areas or recognised communities/ administrative areas. There are techniques that address these issues but these seem little known outside technical and expert circles. Localities need to demonstrate that they improve service planning and delivery to individuals and communities– above GP and below Board level. There are risks of inequity of service provision between different client groups in different localities, of fragmenting services, making them unviable in small Health Boards and of marginalising client groups within localities

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 x

Strong GP engagement along with that of other professionals in the Health & Social Care Teams will be essential for locality arrangements to succeed.

The proposals would be strengthened by a duty of partnership in development, design and delivery being placed on the Partnership to ensure service user or their representatives are involved in the process. Consultation is too little too late and does not reflect the evidence on how to improve services and tackle inequalities let alone comply with current national standards on engagement. GPs are important but other professional groups have equally important roles.

Bringing together wider professional groups to advise on service planning and delivery would be the best model.

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?

The most practical step is to ensure that there is clear evidence of the impact that local planning has on the design, delivery and commissioning of local services.

It will be important to invest in organisational development and leadership development to ensure that clinicians, social care professionals and third sector partners can fully engage and contribute.

GPs in particular are critical to this agenda and there will be national work required to ensure that GPs and other independent contractors are given opportunities for leadership development. There also needs to be thought given to the additional resources required to enable independent contractors to fully engage in locality and partnership wide planning and redesign. .

Unless there is additional investment in GP posts in areas of deprivation, it is likely that GP representation will only be secured by payment for backfill under the new arrangements. This highlights the imperative to review the GP contract so that there are resources to release clinical staff, development programmes to provide service planning skills wider than just primary care clinicians. There need to be accountability structures for those participating in planning.

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 X

This is one option. The complexity of local service delivery, demography and geography all reinforce the need to develop locally derived solutions to this issue. It may be more reasonable to develop local planning based on existing locality models in an area, widening the reach and remit of the teams so that a comprehensive approach to the delivery of primary care results: health, social care, housing, practical support and community planning . GP Practices will be a key part of the locality planning arrangements but are not the only consideration. Locality planning may identify the need for additional GP practices or for investment in other professional teams so that a critical mass is available to serve localities. See response to Question 15.

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

Each partnership should be challenged with developing a scheme of delegation to Local Planning Groups which recognises the importance of developing very local solutions to local issues within a Partnership wide strategic planning and commissioning framework. Councils have gained valuable experience in locality planning through the statutory requirement to develop schemes of decentralisation while 95% of healthcare is already delivered at neighbourhood level through primary care. See response to Questions 15 and 18.

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 X

Please refer to the answers to Questions 15 and 18. There is confusion between community leadership and community planning. One size or range will not fit with the demography and geography of Scotland. Populations of 15-25,000 will be too large to allow rural communities to meet their own needs – here a market town might be the right size, even if the population is 4000. It is important that the process of governance is not bureaucratic as local responsiveness risks having an overload of planning and management meetings. Whatever size is set there should be an upper and lower margin for urban/rural areas as appropriate, based on evidence of what works well in Scotland and in comparator countries. The

framework, evidence and required outcomes should be set out but the detail is better left to local determination.

Do you have any further comments regarding the consultation proposals?

The consultation process is taking place at a particular point in time when much of the detail to underpin the principles and deliver the outcomes is still being worked on collaboratively. Premature decisions should not be reached before this work is complete.

Further consideration should be given to how the Charging Policy for social care services will be impacted by an integrated framework and the impact of current policies on creating and sustaining inequalities should be reviewed. The impact of self directed support on an integrated health and social care system/ budget needs careful consideration. It is vital that healthcare remains free at the point of use and that integration does not affect health or financial security of vulnerable many of whom already have incomes below the poverty line and significantly below the minimum income for healthy living.

There are real opportunities to develop integrated approaches to improving health and reducing inequalities. In some integrated partnerships there are joint Health Improvement Teams who work to support other Council Departments and Community Planning Partners on this agenda. There are also further opportunities to align members of the Public Health teams with the local Partnerships and this should be included in the proposals.

Key to this change process is leadership and the development of a shared culture which will then drive forward the integration agenda.

The Scottish Directors of Public Health are committed to working with colleagues in the Scottish Government, Health and the Third Sectors to achieve integrated services that achieve measurable improvement in outcomes for individuals and communities.

Do you have any comments regarding the partial EQIA? *(see Annex D)*

Yes – a full integrated impact assessment is required. It is not clear that all of the relevant international evidence of potential benefits and harms was made available to the panel that, nevertheless, identified many of the areas that, if unaddressed, would lead to significant difficulty in implementing integration in a manner compatible with NHS principles and with equality and human rights legislation.

Do you have any comments regarding the partial BRIA? *(see Annex E)*

See page 1

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