

Consultation Response



Integration of Health and Social Care

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes No

This proposal may be convenient and seen as practical but it is not particularly helpful. We acknowledge that older people make up the majority of cases of delayed discharge and avoidable hospital admissions. However the emphasis placed on delayed discharge has created an imbalance in resources (time as well as money) placed on this. Under Joint Future, the same step was taken, to start with older people, but it did not move much on from there in the majority of partnerships.

We agree that the age barrier of 65 is artificial and would suggest that there should be concentration on the effects of a person's condition and circumstances rather than age. The age barrier takes no account of issues of the rate of ageing in some BME communities.

This also misses the opportunity to build on existing partnership work, for example in mental health and in substance misuse.

Should the Scottish Government choose to go down the route of initially improving outcomes for older people only, then there should be a timetable for extending this to other care groups.

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

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There are two huge gaps here, namely housing and the personalisation agenda.

Joint Future recognised the crucial role that housing services, particularly in the public and voluntary sector, have to play. The shift in the balance of care to people living in their own home depends on the person having suitable housing, no matter what housing sector they live in. Housing planning in line with health and social care policy is crucial for shifting the balance of care to be successful. We are very surprised that housing does not appear to have been invited to the table – it certainly receives barely a mention in the consultation document and consultation events on integration have had no housing representation, in our experience.

Housing services in the public and voluntary sector are responsible for funding and arranging housing adaptations. The public housing sector also awards grants for private sector adaptations. These elements are crucial to alleviating delayed discharge from hospital.

Local housing plans have to dovetail with the strategic planning of local health and social care needs – not just for older people – to successfully enable people to continue to live at home for as long as they wish.

MECOPP recommends that housing professionals are included immediately in the planning of integration and in the planning of health and social care services.

Secondly, personalisation of services is a major policy aiming to shift the way in which people's care and support needs are met. We are surprised at the omission of the importance of the shift to personalisation in the consultation paper. Personalisation and Self-Directed Support should be at the heart of the changes, with integration as a better way to increase the personalisation of care and support for individuals. This should be emphasised. There is an opportunity for increased use of funding originating from NHS previously used for NHS provided services to be shifted to SDS.

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

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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 No

We agree with this point. However, this needs an overhaul of the performance management framework for health and social care. At the time of the creation of community care outcomes several years ago, it was agreed that these outcomes should not be additional to existing measures but should replace them. This of course did not happen and the emphasis continued to focus on HEAT targets. We fully support an outcomes framework but the emphasis needs to be on these rather than HEAT targets.

We are encouraged to see the retention of the outcome "**Carers are supported:** People who provide unpaid care to others are supported and able to maintain their own health and wellbeing."

It will be essential that partnerships provide within their budgets sufficient funding to enable this outcome.

We are surprised that the Health and Care Integration Outcomes does not at the moment include anything about planning of services. We recognise that these outcomes are not yet finalised and we would expect to see included in the final version, the outcome included in the national carers strategy: "**Carers be involved in planning and shaping the services required for the service user and the support for themselves.**"

As well as addressing the national outcomes for adult health and social care, partnerships should also be focussing on how to develop and meet the equalities outcomes, as required as a duty under the Equality Act 2010. The Health and Social Care Partnership should be monitored on how it is meeting its obligations under the Specific Duties to publish equality outcomes and report progress.

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

Yes No

Adult health and social care outcomes are a very important part of the overall picture of the health and wellbeing of the whole community and should be part of the overall community planning and single outcome agreements structure.

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

This gives the right balance of accountability. However, there may be a conflict of interest in that the local authority leaders hold control over the amount of financial resources available from the Council's budget to the health and social care partnerships. It is therefore in their political interest to say that the partnerships have been properly resourced, even when this may not be the case if under-resourcing is the basic cause of not meeting the agreed outcomes. Has the Scottish Government considered funding the health and social care partnerships direct? This would get round the difficulty in relation to the removal of ring fencing from local authority budgets. If the partnership is funded directly rather than via the local authority and NHS Health Board, then the government can be assured that the budget is spent on the services intended.

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

Yes No

Some authorities are already sharing services. It makes sense to allow two

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or more local authorities (particularly smaller ones) and CHPs to come together as one health and social care partnership if this provides economies of scale whilst maintaining locally planned and delivered services.

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

Yes No

It is surprising to have heard the government's apparent commitment to the voluntary sector and then read that they will not allow the voluntary sector voting rights at the committee table. Why should this be? There is no good reason not to have voting rights.

Carers have a crucial role to play in the success of shifting the balance of care and provide a huge amount of resources, without which the number of people admitted to institutional care would rocket. The format of NHS board and local authority voting membership reflects the budget contribution made.

In the Scottish Government, in its Carers Strategy for Scotland, "Caring Together," states: "We recognise carers as equal partners in the delivery of care in Scotland and fully acknowledge carers' expertise, knowledge and the quality of care they give."

On the basis of the above, carers should also have at least one voting member on the partnership committee.

In view of the points made above, we consider the committee arrangements to be retrogressive rather than progressive and we would expect the government to change the arrangements accordingly.

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes No

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We agree with supporting the partnerships to improve to achieve the agreed outcomes, along with collaborative working with external scrutiny providers, to provide an integrated approach to continuous improvement to achieve outcomes. As previously stated above, national outcome measures should replace existing performance measures and not add to them. To provide public confidence, however, there should be a framework for partnerships to publicise their targets and reporting on their performance in relation to targets. This should not be limited to partnership committee meetings and returns to the Scottish Government but should be reported in well circulated publications.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes No

This should be open to local arrangements. For example, smaller partnerships may find it more cost and organisationally effective to include other services.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

Yes No

Yes, but just because budgets are integrated does not mean that the way in which people work is integrated. This should be a clear requirement. For example, shared assessments of need and carer assessments should be undertaken no matter where the need originates. Some hospital based staff

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have been extremely reluctant to undertake the required assessments for both patient/service user and carers, who need to be receiving a seamless service. Integrated budgets alone will not achieve this. There has to be a change in the way in which people work together.

Further comment on this is made under general comments near the end of this questionnaire.

Integration of budgets has largely been resisted up until now and this will be a step forward and will hopefully assist in real joint working.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes No

We have experience of being jointly funded in a joint contract with the local authority and NHS Board. This has worked well but there are tensions when each of the commissioning parties has different a financial agenda. (For example in achieving financial savings.)

Carers report people being discharged without appropriate support in place, at times with too much dependence on the carer without agreement from the carer. There has to be full engagement with unpaid carers in the discharge of people from hospital and in the planning and commissioning of services, both at individual and strategic levels. Carers must be offered an assessment of their needs ahead of discharge and commissioning of care, with agreed outcomes for both the service user and the carer.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes No

This is really a “depends” answer. It depends on what the minimum categories are. The minimum will have to be comprehensive enough to enable whole systems integration of service – which again raises serious

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questions about why housing is not involved in this.

It would make sense for housing adaptations budgets to be included, much of which currently lies largely in the public and voluntary housing sector domain.

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

The appointment of a Jointly Accountable Officer is a positive step. However, this will not in itself enable the shift in investment that is required to achieve the shift in the balance of care. There are examples of a jointly accountable officer in practice but sufficient shift in resources from NHS Board to local authority has not taken place. The Scottish Government will have to prescribe and monitor the shift in resources to ensure that it actually takes place in sufficient amount.

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

Yes No

No further comment.

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

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Guidance is suggested. Localities are different in nature and one solution does not fit all. However, the Scottish Government should direct that certain parties must be involved, such as the voluntary sector, carers and GPs.

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

There should also be a duty placed on GPs to be involved in planning service provision. In the past, many GP practices have been very reluctant to become involved in locality planning, despite the obvious advantages of GP involvement in local service planning. There has also been evidence of the reluctance of many GPs to undertake what can only be described as good practice unless they were paid extra to do so (the recording of the presence of a carer). It is therefore highly likely that the only way to ensure the participation of GPs is to write it into the GMS contract.

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 reluctance under the previous question applies equally to some clinicians and some social care professionals. There must be a mechanism to free up the time of clinicians, GPs and social care professionals from their important front line work to enable them to fully engage. Those clinicians and GPs who do manage to properly engage in locality planning make a positive difference.

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

An ongoing problem in many areas is the lack of co-terminus arrangements

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in different services. It makes sense for locality plans to be co-terminus with existing community planning boundaries or similar. The Scottish Government should encourage all services – not just health and social care – to be co-terminus to ease planning of all services. It is unhelpful where areas for adult social care services, local health services, housing services and children and family services differ. They should all share the same geographical boundaries.

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

A lot of this depends on the population and geographical size served by the health and social care partnership. What there does need to be is consistent strategic planning for delivery of services over all of the health and social care partnership area. It would be impractical to prescribe this for all localities in Scotland, as many localities will have different issues, needs and responsibilities. For example, one locality may have a community treatment centre that serves only that locality. Another may have a community treatment centre that serves several localities. It should be for each partnership to decide on appropriate levels of delegation and they should be encouraged to learn from the experience of each other partnerships. Again, one size does not fit all. However, the amount of delegation should be substantial enough to allow local decision making to make an impact on local services. Tokenistic delegation should not be acceptable.

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

Size of population will differ considerably between partnerships and likewise between localities. The different needs of urban and rural areas have to be recognised. Community planning areas may be a starting point but the importance of different services being co-terminus should be a guide. If existing services do not currently share boundaries, they should change so that they do. It should be for local partnerships in consultation with other

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services to agree local areas.

Do you have any further comments regarding the consultation proposals?

The integration of budgets and the appointment of a Jointly Accountable Officer will not in themselves resolve the issues of lack of joined up working, although they are a step forward.

The government will have to insist and oversee a substantial shift in resources from acute services in the NHS to the partnerships to enable a real shift in the balance of care.

People working for the partnership should be seen as being employed by the partnership and not the Council or NHS board – and there lies a problem. Until this is resolved, people will still see themselves as employees of one or other. It will take a substantial mind shift to achieve real working together across boundaries – this will involve shifting responsibilities and changing ways of working from senior management down to front line staff.

It is one thing to have a jointly accountable officer but if all of his/her staff are responsible to one employer or the other, the shift may be difficult to achieve.

Carers have been assured by the national carers strategy that they will always be equal partners in the planning of services. However, this is not much in evidence in this consultation document. The reliance of unpaid carers to prop up the health and social care service is very evident and yet receives little or no acknowledgement. With the huge amount of resources provided by carers, the importance of ensuring carers have the right training, support and breaks from caring are utmost yet this hardly merits a mention.

The shift in resources to community care must include sufficient resource to ensure the needs of carers are met to enable them to continue caring and to help minimise unplanned hospital admissions, delayed discharge and further call on expensive mental health services by carers themselves.

The emphasis yet again on preventing delayed discharge in this consultation document again highlights the lack of understanding of the importance of prevention services for service users, potential patients and for carers.

The eligibility criteria for many council social care services are for critical or substantial need only. Although we appreciate the importance of these services, such policies miss the point that preventative work that can save substantial amounts of financial resources whilst avoiding damage to people's health and wellbeing. Planning for all health and social care

partnerships must include prevention strategies to complement and minimise critical and substantial need for care services.

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

Regarding the point about language support services, surely this is an opportunity to pool existing resources, prevent duplication and instead provide language services that actually reach the minority ethnic populations. One of the main reasons for low take up of services is that many people in minority ethnic groups do not have English as a first language or do not have any English at all. This is exacerbated in services such as Self Directed Support where the vocabulary is difficult enough for a native English speaker, never mind someone who has little or no language. This makes accurate translation challenging.

However, accessibility is not just about language. Culture and trust also play an important part and the work of specialist organisations with minority ethnic is extremely important in enabling minority ethnic groups to access services, improve their health and to have a say in how services are delivered.

Delivery of the service by people who can communicate with the service user and carer is vital. An assessor or care worker cannot properly deliver a service if they are unable to communicate with the service user and/or carer. As well as cultural training required, we also need to recruit and train care workers who can communicate and who understand fully the cultural issues of the people for whom they are providing care.

Training that is undertaken for paid carers should also be available for unpaid carers. It is illogical to think that unpaid carers can do the same job as paid carers if they do not receive similar levels of training. The Health and Social Care Partnership should be funding this and making places available to carers on their training courses.

We have previously highlighted the reliance of health and social care services on unpaid carers. Partnerships must have a duty to ensure an acceptable caring/life balance for carers, which is essential to carers' wellbeing, which in turn helps to enable them to continue to care, relieving pressure on health and social care services.

Partnerships must get better in ensuring that carers are offered a carer's assessment, with agreed outcomes and ensure that the care receives the support required to achieve these outcomes. Staff must understand that unpaid carers have equal rights with service users to have their needs assessed. Everyone involved in the assessment of a patient or service user

has a duty to also assess the needs of the unpaid carer and assessors must be instructed that this is part of their job. Performance on this should be monitored and action taken to amend poor practice.

Health and social care partnerships must recognise that there comes a point when a carer is no longer able to care for someone. Staff must be trained appropriately to enable them to recognise this point and to put in place appropriate alternative caring arrangements.

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

Potential Costs

An additional cost will be the cost of providing adequate training of unpaid carers as recognised providers of care. The dependence on unpaid carers will increase with the increase of people staying at home in the community. This will require continued increase in the training and provision of short breaks and other support for unpaid carers.

Potential Benefits/Savings

Increased and improved training for carers will greatly contribute to the reduction in costs associated with the provision of acute beds and care home places. Carers will be better trained, avoiding accidents and unplanned admissions. Support and short breaks will contribute to carers having better mental health and wellbeing and avoiding more expensive mental health services for themselves and unplanned hospital admissions for themselves and for the care for person.

Business affected

The increase in social care provision will also mean the increase in the need for services specifically aimed at people in minority ethnic groups. Obligations under equalities legislation mean that mainstream service providers will increasingly find providing equal services to BME groups challenging and will likely need the input of BME specialist providers to assist them in compliance with equalities legislation.