NHS Western Isles

Integration of Adult Health and Social Care in Scotland
Consultation on Proposal ~ Comments from NHS Western Isles

Statement

NHS Western Isles welcomes and will embrace the drive to improve the experience of patients, clients and carers by the closer integration of the delivery of health and social care services. We support and endorse the vision and the case for change set out in the consultation paper. Whilst we can demonstrate from our experience the benefits for patients/ clients of integrated services, it is clear that in the current arrangements patients/clients do not reliably receive the health and social care they need in the right place and at the right time.

The focus of the integration should clearly be the patient / client / carer that is the recipient of the service. As we jointly develop new, more integrated joint and improved ways of working it is important that front line staff both in health and social care are completely alongside and signed up to that closer and integrated working. There is much evidence to suggest that, should the focus shift its attention to structural changes and realignment without the buy-in and commitment of frontline staff, then the drive for joint and closer working will achieve very little. This focus on the point of care and the patient/client we believe is fundamental and critical to the success of the changes. Therefore, that in itself drives a focus on the front line teams who deliver the services and who in some respects work in parallel lines rather than in integrated services. Harnessing the commitment and innovation that exists within existing teams holds the key to successful and better outcomes. Opportunities facilitated through more integrated working for a structured career ladder are welcome.

Demographic trends within the Western Isles' population pose significant and unique challenges, both in terms of an increasing number of older people and the reduction in working age population. There is no sign of either trend changing.

Service delivery can only be achieved through the effective deployment of all staff caring for patients, clients and carers. The workforce is unlikely to reduce in terms of those numbers required however a flexible integrated workforce with new and changed jobs will be a critical success factor.

Whatever form of integration evolves we must focus on actioning the following:

- Keeping people out of hospital with appropriate and effective rapid response health and/ or social care services deployed to maintain independence and avoid admission;
- Getting people ready for discharge out of hospital – facilitate discharge without delay;
- Clear accountability for decision making and deployment of services;
- No cost shunting or cost avoidance through delayed decision making;
- Effective clinical engagement; and
- Focus on effective outcomes.

Chapter 1: The case for change

NHS Western Isles

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?

No. A broad focus on outcomes for older people across what would be a very wide range of specialities/ services may not be the optimum approach.

The focus should be on the services that are delivered in the community and which are community / home based. This should drive forward and increase the momentum of single systems that are working to shift the balance of care into the communities and into homes where that is safe, effective and appropriate. An examination currently of most hospitals will probably show that at any time somewhere between 60 and 70% of all inpatients in hospital will be over the age of 65. Therefore focusing on a particular group of people will serve to complicate matters. The focus should be on the community and home based services where organisations are currently and predominantly providing the services. Focusing on community and home based services will also optimise the opportunity to engage actively with the third sector. The modernisation, redesign and integration of services to involve the third sector will deliver in some cases fundamentally different services agenda. Again, the focus on the home and the community will afford the maximum opportunity for joined up and integrated working.

Reducing the demand for acute hospital care is a key policy objective and ensuring new partnerships have a focus on the use of acute care is important in achieving that objective. Whilst there is potential to shift resources from acute to community services, that will not address all of the pressures on the provision of care for older people.

A common agreed set of evidence based outcomes across all partner agencies will provide a clear focus for planning, decision making and service delivery. The absolute local and national commitment to, and accountability for, achieving the outcomes will be critical to success.

We support the inclusion of all adult social care services even if there is an initial focus on older people. We need to ensure that this focus does not create disadvantage for other care groups.

There are major issues about disintegrating currently integrated social care services if the new partnerships do not cover all social care. Comprehensive integrated partnerships will be better placed to focus on prevention and early intervention working with the whole family and whole community.

Chapter 2: 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?

We welcome the development of the nationally agreed outcomes. These will clearly allow us to drive and demonstrate tangible progress in the integration of services. Taking account of the experience of those who receive the services will be an important factor in the process of continuous improvement and learning. It is not clear how patient, client and carer experience across integrated services will be collected and reported. The document also suggests there will not be a single operational delivery arrangement placed on partnerships and indeed the emphasis throughout is for them to decide on how best to improve services. Any change to improve and expand the integrated provision of services must be in response to evidence of local need. The national outcomes aligned with the health and social care needs assessment will drive strategy formulation (what) for NHS Boards and Local Authorities with the Health & Social Care Partnership charged with delivery (how) of the agreed strategy. There is an inherent risk in this in that we will and could develop a multiplicity of service models across Scotland, which could raise questions about equity and access.

A balance between the ability to respond to local need and equality of access and experience needs to be struck.

In smaller health and social care systems the development of community health partnerships was not necessarily helpful, as it almost introduced a third organisation between health and social care. It is important that we do avoid mistakes of the past i.e. not being clear about the responsibility for and distinction between planning and delivery. It is equally important that both the local authority and the health board are focused on improving the care received by patients and clients in the community and in their homes. Time should not be taken up with the development of, in effect, a third organisation that will require management, capacity, capability, resources and systems to support it, where this is unnecessary to achieve the very important goals which are clearly set out. The requirement to establish health and social care partnerships as proposed may in fact make that unnecessary bureaucracy unavoidable.

If the Health and Social Care Partnership is to be a requirement for all systems it must have the emphasis placed on delivery rather than strategic decision making and planning which should be set jointly by Health Board and Local Authority.

It would be clearer if the local systems were charged, managed and held to account for delivery of the national outcomes without a prescriptive approach to the structure which in small systems may be an unnecessary organisational layer and detract from getting on with real improvement.

The local system should be focused on as much of the resources as possible, being directed at improved delivery and outcomes.

The impact across Health and Social Care systems has the potential to improve the experience of those receiving the service and at the same time represent significant service change. The document does not make reference to the process and requirements for the changes in terms of public involvement in, and consultation on,

significant service change.

Chapter 3: National Outcome for adult health and social care

Organisations are committed to improving people's experiences and welcome the development of nationally agreed outcomes. It is stated in the consultation that health boards and local authorities will jointly be clear about local priorities for integrated working and will be held to account for delivery. It is not clear how the accountability is going to be exercised given that currently local authorities and health boards are held to account in different ways and at different times.

Question 3: The 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?

The requirement in law for statutory partners to deliver and to be held jointly and equally accountable is in itself welcome. Chapter 3 thereafter is vague about how this will be achieved beyond the present state which represents substantially different ways of working, decision making systems and public accountability. The system for public accountability must be clear and unambiguous.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included in all single outcome agreements?

Yes. This is also linked to the point regarding accountability. It may not be appropriate to only single out the Single Outcome Agreement: the nationally agreed outcomes for adult health and social care should be explicit and visible in whatever document, or in whatever process, accountability is to be jointly exercised through. It is currently unclear how effective the accountability arrangements are for the single outcome agreements. Therefore based on the information given, it is not clear if this is the best place for the outcomes to be situated specifically for accountability purposes, other than, for the purposes of information and guiding the actions and decision making of community partnership members. Ultimate accountability must rest with the local authority and the health board. The new Health and Social Care Partnerships must essentially be service delivery focused and be key partners in the Community Planning process, sharing the same obligations as the other Community Planning Partners but with governance through the Joint Committee.

Chapter 4: Governance and accountability

We agree entirely with the devolved integrated budgets, however the continual reference throughout the document to the 'pound losing its identity' is not a realistic statement to make. The point has already been raised in several forums about the accountability mechanisms for each organisation and the question has been asked several times how the accountability will

be exercised should the health and social care partnership commit resources that result in an overspend in the overall health and / or local authority budget. The question has remained unanswered. The focus here should not be on making unrealistic statements, but should be on the very clear statement of what is expected, i.e. that the integrated and joint working will use the totality of the resource available to maximum effect i.e. improved outcomes and experience of service delivery. It will be necessary within that exercise to be able to identify the appropriate resource that will be deployed to tackle a particular challenge or problem. It will mean that the totality of the resource is jointly managed and that the partners are held jointly accountable for its impact in terms of the outcome. Financial systems need to be established which clearly hold the Partnerships to account but which will enable full devolution and delegation to deliver key agreed NHS Board and Council objectives including re-design and service change where necessary

The partnership agreement will be welcomed. It states in the consultation document that a governance committee will oversee the running of the health and social care partnership. Is this an absolutely necessary additional committee, particularly in small systems with the risk here of creating unnecessary bureaucratic additional structures. Additional committees in small boards should be introduced by absolute necessity only.

Currently executive groups bring a strong and influential perspective to decision making.

This section seems to fundamentally change the position of NHS Board members who are currently, whether executive or non executive, of equal status. It is acknowledged that this is not the case in local authority structures. The section that describes how members, and which members, can vote in the event that a vote is required, is written to the exclusion of the executive directors of NHS Boards. There is no evidence or rationale advanced for this proposal, it seems simply to be a shift towards the current operational status of local authorities. It is unclear whether executive board members are excluded from the Health & Social Care Partnership Committee to reserve their expertise and accountability for NHS Board level. We would regret the loss of current voting members from executive groups.

The section also seems to draw the NHS Board Chair closer to the role of the effectiveness of NHS delivery rather than the current status of the Board, which is to be reassured regarding governance and accountability systems. This section also has a fundamental impact on the role of the Health Board Chief Executive as Accountable Officer. The document makes no reference as to whether the role of the Chief Executive as Accountable Officer is to be changed.

The section also makes a suggestion that the health and social care committee can commit resources with no need to refer a decision back, which in itself is acceptable if the committee is working within the agreed strategy and financial resource. This links to the point already made about the “golden thread” of accountability which is by no means clear. The section also states that organisations will be jointly held to account, but there is not any detail in to where and by who and when.

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

This question goes right to the heart of how local democratic accountability is exercised and is visible. The structure and system within health is visible, transparent and clear and the Board is held to account in public for its delivery and actions. The concept of joint accountability is very welcome; however it is not explicit or suggested how systems will converge to make that system of joint open accountability to both ministers and the public deliverable in reality.

In terms of joint accountability, during the first period there should be agreement between the Local Authority and Health Board regarding the "what" (objective & target) passing over to the Health and Social Care Committee to undertake the "how" (delivery). The accountable system will take time to develop and mature.

Much more clarity is required regarding how financial accountability will operate.

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

Cannot see how practically a committee responsible for delivery of strategy that covered more than one local authority would work.

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

In theory they could be, however with the lack of detail provided it is difficult to say. In small systems there is a real risk that an additional structure is developed which requires to be supported in terms of management, information, support functions, decision making and governance. This is unnecessary in a small Island Health Board where individual staff have multiple roles and which is coterminous with a single local authority.

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?

It is not clear in the document how joint accountability will be exercised at a national or local level. There is a lack of detail on the system to be used to publicly demonstrate performance assessment i.e. where, when, who, what.

Question 9: Should Health Board 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. Across Scotland the current make up of community health partnership functions is variable. Local systems need to now set out very clearly, in relation to the outcomes they expect to achieve, the components of the respective systems that are critical to success and thereafter realign systems accordingly. To take a view that what is currently in a CHP is therefore automatically included in the health and social care committee is not a rational, or effective, approach.

The fundamental changes to the members of health boards and in particular the changes to the health Chief Executive as Accountable Officer need to be carefully considered and made fully explicit. The document, as it stands, fundamentally proposes changes to the equal membership and equal voting rights which currently exist on NHS Boards and, as stated earlier, there is absolutely no evidence or rationale to support such a move. In fact the performance of the NHS across Scotland almost invariably would suggest that the current arrangements work effectively.

Chapter 5: Integrated budgets and resourcing

It is essential to integrate budgets and present a joint resource to best meet the needs of patients and clients. Clearly a senior manager/director should be responsible for the delivery and outcomes and the best use of the resources available.

The introduction of the health and social care partnership with resources delegated as a "body corporate" would in many systems and in particular small systems create an additional and unnecessary new structure with all the management support and functions it would require to work effectively. Delegation between partners seems to be a more practical and achievable first step in this movement towards integrated services. The former is likely to require a substantial amount of time being spent on structure, functions, systems and accountability; whereas the latter would essentially deliver minimum structural turbulence but maximum impact for patients and clients, which at the end of the day should be our main focus.

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

The patients and clients will of course support any system changes that deliver quicker person centred, effective and efficient care. It is, however, not realistic to suggest that resources can "lose" their identity. This is not a sensible statement in the current climate of accountability and financial constraint. The goal and priority should be to produce the joint resource and have that managed efficiently and effectively. We will need to be clear where resources are required, where gaps exist, and to have an agreed structured strategic plan for future services. This, of course, will not be possible if resources lose their identity. The concept that is being put here is one that we whole-heartedly support, i.e. that patients should not in any way have their care and or treatment held up by arguments or debate over resourcing. This of course can be overcome if the system is set up properly with the totality of the resource available, the priorities clear, and the national outcomes driving performance.

A separate new "body corporate" in a small system would represent on additional drain on scarce resources even if only looked at from the perspective of the administration and resources required to support such a body. The concept of delegating function and the existing budget seems to represent a viable, less cumbersome, more practical method of making early progress.

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

In the Western Isles, for well over a decade now, the Occupational Therapy service has been a jointly managed and delivered service with joint resources deployed. This service also contains the community equipment provision and community equipment bank. This service has recently moved to co-location of occupational therapists and social workers. This has been a highly effective service managed by a single manager across both services with the available budget to deploy to optimum effect. It has been a substantial success and a model which we intend to take forward and use as an example of good practice to drive other systems towards more effective integration.

A second example is the modernisation of Mental Health Services across the Western Isles. Joint working across health, local authority and the third sector has delivered a preferred option that will deliver a model that is recovery focused, responsive to the needs of patients, delivers sustainable high quality services and increases community capacity by reducing in-patient facilities.

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?

The national outcome indicators should drive local discussion and agreement regarding the categories / elements of the system and service that should be included within the integrated budget. Local systems should be held to account over their delivery plans which must be clearly aspirational and stretching but achievable. Staff on the ground in local systems are more than likely to know what actions will deliver quick and effective benefits to patients, clients and carers. Direction could achieve a standardised approach which has merit or it could stifle local innovation and commitment, particularly from front line staff. Ensuring that the opening financial allocations fully reflect current spending on health and social care is critical. In our view, this will require consistent guidance.

Chapter 6: 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?

The document proposes joint accountability for Health and Local Authority and national outcomes to drive decision making and service delivery.

Is the appointment of a Jointly Accountable Officer (JAO) absolutely critical to success? Our view would be that it is not. If a separate "body corporate" was to be established, requiring the appointment of a JAO would be a logical step. In a model of delegating functions we would suggest a JAO is not necessary, as both organisations already have accountable officers in place. This could run contrary to the good progress made locally in the Western Isles. Both Chief Executives can have clearly established joint accountabilities with or without the JAO.

The document is clear that the Jointly Accountable Officer manages the integration budget and oversees the delivery of the outcomes.

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

No. It is unclear whether or not this post is being placed at director level with the associated additional cost. Not clear whether there will be a national job description, national grade, etc.

Chapter 7: 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?

No, the real danger / risk here is of the application of a "one size fits all" approach. The system for engagement locally should be for local discussion, debate and agreement. Important in this agreement will be the engagement and buy-in of clinical / professional staff to a system that they can practically participate in. Dictating the system in Island areas could lead to moving away from a current system that works, to a cumbersome system difficult to administer, support and resource financially.

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. All clinical staff within primary and community care settings have a role to play in this work, in terms of where care is provided and resources deployed.

Within the NHS arrangements there are requirements to inform, engage and consult with staff widely. Not least through the systems to support the Staff Governance Standard, the Professional Advisory Committees and a plethora of other forums where staff are involved and engaged. It is not clear enough about why and what additional systems are needed. This assumes, without evidence, that all existing systems and advisory arrangements are not working satisfactorily.

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

Consider an extended hybrid Professional Advisory Committee(s). Evidence locally within the Western Isles would suggest current systems for informing, engaging and consulting staff work effectively.

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

No. In remote Island communities a locality planning group system already exists reflecting appropriate community involvement for members of the public. Review and strengthening would be part of the agenda moving forward.

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

None. No information is given linking Locality Planning Groups to responsibility accountability. This is not a potential or workable proposal for an Island health and social care system. Much more clarity re: accountability would be required. The current system to inform, engage and consult works effectively.

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000, and some other range? If so, what size would you suggest?

We suggest this should be left to local agreement. In the Western Isles, there are currently four active Locality Planning Groups serving a population of 26,500, mainly located within three Island groups.

Other

Third Sector and other Partner Agencies

Other organisations will be critical to the success of the new Partnerships. NHS Western Isles welcomes the emphasis on their involvement and closer working but with the clarity that the statutory responsibility for the delivery of health and social care lies with the NHS and Local Authority.