

**Draft Response to The Scottish Government's Consultation Proposals on the Integration of Adult Health and Social Care in Scotland.****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?**

NHS Forth Valley understands the drivers behind an initial focus on improving outcomes for older people, however, by focusing on older people, other boundaries are inevitably created e.g. with people in transition across the life stages. There are many examples where funding flows and budgetary boundaries impact on the planning and care delivery for individuals, an example of this would be a Third Sector Mental Health organisation which is only funded to deliver services to adults up to 65 while people over this age may easily benefit from this service. This creates an artificial boundary.

Services for Older People cross acute hospitals, primary care and community based specialist services (e.g. rehabilitation/old age psychiatry) and it will be more difficult to disaggregate budgets. In addition, Re-Shaping Care requires mainstream universal services to prioritise upstream support for Older People (e.g. sport and leisure activities) and this adds further complexity.

Health and Social Care do not operate in isolation and often work within a wider Partnership that involves Third Sector Partners and Community Planning Partnerships. The implications need to be fully considered. Many Third Sector Organisations work across more than one life stage or care group and are not compartmentalised. By Integrating within a care group e.g. for Older People we need to be aware of potential loss of wider integration opportunity for some services and indeed communities. We are beginning to explore the opportunities to work with whole communities on an asset based approach and the Health & Social Care Integration needs to support this and not create artificial boundaries.

We would urge that these proposals include children's services at the earliest juncture. There could be a risk of developing arrangements that may hamper or not be aligned if these arrangements are left to a subsequent phase of integration. We acknowledge, however, that the children and families agenda is more complex in that it includes Education Services having a key contribution, not just health & Social Care.

NHS Forth Valley would therefore emphasise the importance of local flexibility in determining the scope of the partnerships that would allow them to take forward a broader agenda if there was local ambition to do so. If, as the consultation suggests, this were to be the initial area of focus, local areas would quickly need to open up discussions on how this agenda could be broadened particularly as a result of the rising instance of complex cases from patients under the age of 65.

**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?**

The outcome of consistency across Scotland is commendable, however, the consultation

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then goes on to state that single operational delivery arrangements on partnerships will not be imposed. This suggests that there will be local approaches developed which in turn may then create inconsistencies in the way services are delivered across Scotland. It is important that people's expectations are managed and consistency across Scotland may therefore be aspirational.

The proposed framework is helpful, however, it would appear to be somewhat prescriptive. NHS Forth Valley would prefer to see a focus on enabling powers which can be used locally to achieve the desired outcomes.

Further clarity is sought in a number of areas including the role and budgetary shifts expected from the acute sector and how it is anticipated the role of clinicians, and independent contractors will be strengthened. The contractual arrangements negotiated with these professional groups will be very important in this regard. The consultation does not acknowledge the key role of national agencies such as NHS 24 and the Scottish Ambulance Service and how they will be engaged given their impact on the delivery of health & social care services.

There is also insufficient reference to the implications on IT and HR within the Framework.

We welcome the positive ambitions in relation to carers who play such a fundamentally important role and should be acknowledged for the work they do. It would be helpful if the role of the third sector could be strengthened as they play a crucial role in the delivery of services, particularly for older people.

**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?**

It is vital that the relationship between Community Planning and Health & Social Care Partnerships is clear and unambiguous. Achieving better outcomes for older people is not restricted to health and social care but would need to include housing, policing and many other services so working across all of these agencies is fundamental.

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Developing robust joint performance management arrangements is key. Proposals on shared outcomes for older people in relation to the current HEAT targets within the NHS require further clarity. Governance & performance arrangements must be developed that will support the delivery of joint outcomes which should not be overshadowed by bureaucracy.

Merging the accountability and governance arrangements is welcomed and could be a powerful enabler for success in this context. The logic of being jointly and equally accountable to Scottish Ministers, Local Authority Leaders and Health Board Chairs is understood, however, it is unclear how the H&SCP would deal with circumstances where the priorities of each of these three parties differ. The level of delegated authority given to the Jointly Accountable Officer is crucial here as is their ability to negotiate and reach a compromise where necessary between all parties. The 'holding to account' must have robust and meaningful sanctions.

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

Note the comments above in relation to Community Planning. If SOAs are to be the vehicle for measuring public sector performance locally then they should be included but we would advocate a clearly defined SOA. The comment about relating accountabilities (see Q 3) is also relevant here. Health and Social Care Partnerships would appear to be accountable both through the Partnership Board arrangements up to the Cabinet Secretary and to Community Planning Partners. There is a subsidiary issue here that needs to be clarified, ie. Where higher authority is located. However, a local and genuine connection to the population and its needs must not be lost.

We would also positively suggest that a 'Strategic Commissioning Plan' must include the 3<sup>rd</sup> sector and carers to ensure connection, support and appropriate resourcing, therefore delivery.

**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?**

There must be a clear accountability framework. This must be balanced between 'ring-fenced' national 'must-dos' for example, waiting times versus local flexibility within agreed parameters.

The concept of joint accountability as described is accepted, however, local democratisation needs to be balanced against the need, in some cases, for regional and even national solutions to delivery of some health services.

With this in mind, rather than accountability being to individuals as identified in the consultation, consideration should be given to accountability being to the full NHS Board and Full Council.

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

Yes NHS Forth Valley would strongly support scope under the legislation to allow for local decisions to suit local circumstances. In Forth Valley Stirling and Clackmannanshire Councils have already established shared social services and a CHP Partnership Board has been established with membership from these two agencies and NHS Forth Valley.

The benefit of this flexibility is that it will be easier to deliver consistent national outcomes to the population of Forth Valley and such an arrangement is more likely to deliver on efficiency and productivity across the public services than three separate Health and Social Care Partnerships.

There may be value in retaining more local area structures in terms of public partnership involvement and the valuable work that will still need to continue to address the broader agenda outwith the initial scope of HSCP's

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

NHS Forth Valley already has two Partnership Boards in place, one for Falkirk Council area and one covering Stirling and Clackmannanshire Council areas. These Committees are chaired alternately by the NHS Forth Valley Board Chairman and the appropriate Council Leader. NHS Forth Valley would wish to advocate local flexibility in determining what arrangements should be beyond any statutory minimum prescribed by the Government taking account of the local democracy and accountability points referred to earlier.

As currently proposed, there would need to be sufficient delegated authority given to the H&SCP by both the Health Board and Local Authorities to enable the Partnership to fulfil its remit. Given the potential scope of the H&SCP this will require further clarity & debate.

**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?**

National outcomes for Health & Social Care Partnerships are welcomed. These need to be underpinned by clear performance measures that demonstrate that the national outcomes are being met consistently. It is not clear how these will link to the existing HEAT targets for health and whether these will become competing priorities. Local Health Boards will presumably still be held to account for achieving HEAT targets whilst at the same time requiring to achieve the National joint outcomes for the H&SCP.

Local Authorities are elected and have local performance management systems in place. The NHS, as well as local performance management systems require to report performance on a national basis. Conflicts may also arise between achieving NHS Board wide level efficiencies versus H&SCP level priorities.

Information sharing and records access between agencies will need to be resolved to allow professionals to provide the best quality of care to patients / service users.

The comments regarding scrutiny partners are welcomed. It will be important that the various scrutiny bodies adopt an integrated approach to reduce duplication and ensure the same standards are applied across common service quality objectives.

**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. It is likely that at the outset each area will have different priorities and will be at different stages of integration. This will allow for greater flexibility for those areas that are more advanced with this agenda. NHS Forth Valley would advocate that Boards and Local Authorities should agree what should be included in the joint budget locally, based on what services will be managed within the H&SCP. NHS Forth Valley would want to take a pragmatic approach allowing flexibility to build on current local arrangements and create a budget model that works locally for both the NHS and Local Authorities.

**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?**

The proposed models would require community involvement and be supported by a locality approach to delivery. Greater emphasis should also be placed on the involvement of service users, carers and the third sector.

Further information would be helpful as to the evidence base behind what needs to happen to improve outcomes. The consultation appears to place structural reform at the core of achieving the required improvements.

**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?**

NHS Forth Valley has several example locally, more details on request :-

**Strategic Commissioning Projects**

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

**Joint Provision**

- Integrated Mental Health & Learning Disability Services
- Rural North West Forth Valley Partnership
- Sensory Centre
- Marchglen

**Integrated Approaches**

- Reablement/Rehabilitation/Day Provision
- Anticipatory Care Planning
- Management of Long Term Conditions
- Anticipatory Care/Health Inequalities Work

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- Locality arrangements for Childrens' Services, Falkirk

### **Wider Integrated Partnerships**

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

### **Sharing Accommodation**

- Forth valley Joint Asset Strategy
- NHS Staff co-location in Stirling Council offices
- Social Work staff co-location in Clackmannanshire Community Healthcare Centre

The importance of building relationships at a local level is crucial to the success of joint / partnership working and the extent to which resources can be used flexibly. Building successful teams takes time and an incremental approach to shifting cultural and practice changes should not be underestimated. As an example, NHS Forth Valley has the only fully integrated team in Scotland operating an integrated budget: the Clackmannanshire Community Mental Health Team. Despite its small size it has taken a long period of time to develop into a high performing team.

On a more general note, difficulties can arise when staff terms and conditions need to be taken into account due to the different arrangements between agencies. NHS Forth Valley have found different solutions depending on service / organisational needs. It is also critical to agree what outcomes are required and how to measure success when entering into joint arrangements so that all parties can benefit.

The need to consider how each agency fulfils its professional governance arrangements within a Health & Social Care Partnership will be important but we do have experience of how to do this with our Integrated Mental Health, Learning Disability Teams and Addiction Teams. In addition (and potentially more difficult) is the need to consider collective care governance arrangements so that there is assurance that the joint responsibility for

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delivering high quality care is understood. Agreement on individual agency and joint standards and outcomes need to be clearly articulated, and assurance systems put in place to deliver these.

**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?**

Enabling legislation is already in place yet delegating functions and resources between agencies is not widespread. It would be interesting to understand the reasons why this has not happened and what will be different within these new proposals. Understanding the spend profile (IRF) is also critical.

Providing guidance on the minimum categories of spend will be helpful but in reality it will require cultural change and winning of hearts and minds to make a difference in the long term.

Local flexibility to determine whatever budgetary arrangements can best support the H&SCP to achieve the required outcomes would be welcomed. As mentioned previously, reference to acute sector resources requires greater clarity.

The consultation is not clear on the potential impact on other services that still require to be managed outwith the H&SCPs. For example what will be the consequences for acute services once budgets for some services are transferred into a H&SCP?

**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?**

NHS Boards have historically struggled to shift resources from secondary to primary care. There is insufficient clarity within the proposals to suggest how this will become more achievable in partnerships and particularly that this responsibility appears to lie with an individual jointly accountable officer. This would imply a high level of delegated power being given to one individual and is unlikely to be compatible with existing schemes of delegation. There could be issues between Boards and Local Authorities as they will have to balance conflicting accountabilities and delegated authority levels to enable the Jointly Accountable Officer to fulfil what is expected of their role.

As mentioned previously, there is insufficient clarity regarding the acute sector budget contribution and this will have a material impact on the budget to be managed by the Jointly Accountable Officer. It is not clear how a shift in resources from acute services in

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Forth Valley will be achieved without undermining the provision of remaining services as previously discussed.

To ensure clarity, the shift in the balance of care and supporting investment planned will only be possible in the context of full support from the NHS Board and the Councils concerned.

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

Given the level of delegated authority envisaged for this role, it is clear that a very senior post is required. As each Partnership is likely to be different in budget and size it would seem appropriate that the level of seniority be determined locally.

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

This response should be read in conjunction with earlier comments in relation to community planning and the work on empowering and building capacity within communities envisaged by the proposed Community Empowerment and Renewal Bill.

Localities are currently likely to be defined differently between Local Authorities and Health Boards. Local determination will ensure that organising resources are done in the most efficient and effective way, for example, inequality may be better addressed in a smaller area whilst the broader Health & Social Care could be addressed in a larger area. It is also important that locality areas reflect the local population geography, cultural alignment and practical issues such as school clusters, GP Practice locations and micro localities eg Primary Healthcare Teams.

**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, this is helpful. The use of consult rather than engage is challenged, however, as experience suggests that it is more beneficial to engage with the various bodies concerned. Engagement will create better joint ownership and participation in locality planning and therefore greater opportunity to succeed in delivering on the integration agenda.

It will be important to ensure equal consideration is given to the views of different groups to ensure that equal weight, wherever possible is given and that a 'hierarchy' does not develop whereby one group is allowed to develop greater weight than others.

There also needs to be emphasis here on the views of engaging users and carers.

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**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?**

Professionals will need to see that their involvement is actually making a difference to service delivery. Initially they may need support to understand the complexity of the wider system, the current resource allocations and the traditional health & social care terminologies that exist. It will be important that we can build on existing good practice eg Keep Well.

It will be important to quickly agree a joint vision of what older peoples care, in the first instance, will look like and what the priorities are.

The consultation acknowledges that workload issues will need to be addressed to ensure professionals have time to participate in locality planning is maximised to best effect.

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

Locality Planning, as described earlier should be developed based on local flexibility and not prescribed. GP Practices are important but some in Forth Valley cross Health Board boundaries and do not form natural communities. It is proposed that more work needs to be done to determine what are meaningful communities and how we make best use of services to support those areas.

Consideration should be given as to whether core services could be delivered by each practice whereas other services could be delivered on an aligned basis, eg named social workers.

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

This is difficult to quantify at this time and should be allowed to develop over time. There should be devolved responsibility to an appropriate level and as a matter of principle as few decision makers in the chain as possible. The principles of locality planning are sound but, at least in the first instance accountability and decision making should rest with the Partnerships.

This also needs to be linked to Community Planning “Committees” and the importance of “place” as defined by the Christie Report. Locality Planning Groups should be health promoting as well as delivering care.

**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?**

There should not be a prescribed size based around population – see response to questions 15 & 18.

**Do you have any further comments regarding the consultation proposals?**

The consultation does not detail how much these proposals will cost versus the benefits (long and short term) that will be derived. In the current financial climate it will be essential that the Government can provide assurance to the public that these revised arrangements will not only provide better outcomes but will demonstrate best use of public money.

It will be important to create a vision of what we are trying to achieve; we should be emphasising the asset based approach and supporting individuals and their families in a different way from the traditional provision of services. They should be supported to keep as healthy as possible for as long as possible so the health improvement support needs to be part of any intervention.

When we have any proposals we should undertake an EQIA screening exercise with a number of people to look at any proposals from different points of view- this will help mitigate against any potential inequalities at an early stage.

Health Improvement, public health and health inequalities are key areas of focus within existing CHPs. These areas do not appear to have been given a focus within these proposals.

Little is said in the consultation about staff engagement and communication which will be key to success. A process needs to be developed that will ensure the wider workforce is engaged including staff side and trade unions representation.

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