

	<p>SCOTTISH GOVERNMENT CONSULTATION</p> <p>ON THE INTEGRATION OF ADULT HEALTH</p> <p>AND SOCIAL CARE</p> <p>SUBMISSION FROM CCPS</p>
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CCPS is the Coalition of Care and support Providers in Scotland. Its membership comprises more than 70 of the most substantial providers of care and support in Scotland’s voluntary sector, supporting approximately 300,000 people and their families, employing around 45,000 staff and managing a combined total income of over £1.3bn, of which an average of 79% per member organisation relates to service provision that is commissioned, purchased or otherwise funded by the public purse.

CCPS members provide services right across the spectrum of care and support, including services for older people; children and families; adults with physical and learning disabilities; and people facing a range of challenges in their lives, including mental health problems, addictions and involvement in the criminal justice system.

CCPS welcomes the opportunity to contribute to the Scottish Government’s consultation on integration of adult health and social care. We support the policy aim of integration but believe it should be a means to an end, not an end in itself. We have set out below some general points, along with a number of specific issues relating to the proposals contained in the consultation document:

General comments

- Successful integration will be as much about culture and behaviours as it is about ‘technical’ or legislative detail
- Integration of health and social care is an opportunity to create strong partnerships that go beyond a narrow focus on joint working between the NHS and local government



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- Involving people in the design of their care and support, and enabling them to exercise appropriate control over how it is delivered, must be at the heart of integration in order to drive change and better outcomes
- The physical environment where people live and the control they are able to exert over that environment and how long they remain there (e.g. staying in their own home) can have a fundamental impact on the outcomes of health and social care services
- Improving older people’s care and support is a clear priority, but proposals for integration must take account of the specific needs of, and the potential impact on, everyone who uses care and health services
- Improved joint commissioning of care and support is crucial to better outcomes

Specific responses to consultation questions

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?

Comments

There are indeed compelling reasons to focus on older people, not least the reality of demographic change and the potential for improving outcomes by tackling knotty problems like delayed discharge. However, there may be consequences for other groups if this reform is too narrowly focused on older people. For example, there is a concern that two different systems will evolve, resulting in priority to one group (i.e. older people) over other groups (adults with long term conditions and disabilities), when promoting self-management and independent living should be an equal priority for both groups.



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In addition, one of the principal aims of these reforms is to reduce the inconsistency in quality of care across Scotland. Strong guidance from the Scottish Government will be necessary in order to ensure consistency about how and when these reforms are to extend beyond older people's services.

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?

Comments

We have three areas of concern in response to this question: first, the issue of focusing on structure and process; second, the role of the third sector; and third, consideration of cultural and systemic differences.

Para 2.10 of the consultation recognises that these proposals are 'necessary but not sufficient by themselves to transform health and social care'. Change should be, and is already taking place across the country in many and various ways. These proposals, we are told, are not about structural change. However, despite the Government's stated intention to avoid structural change, the proposals appear overly focused on statutory organisations (NHS and local authorities) and structural changes (new partnerships, integrated budgets, accountable officers, etc.). The danger is that they will become the focus, thereby diverting the energy and resources for this agenda into directions that may not ultimately produce the outcomes we need.

It is generally recognised that the NHS and local authorities have historically found it difficult to share budgets and shift resources from one to the other. These proposals

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begin to address this challenge but without in our view sufficiently robust mechanisms to overcome them. We have expanded on this in relation to specific proposals below.

Second, there are some encouraging statements in the consultation about involving the third sector and the wider community. This seems an obvious point, given that third sector organisations provide a third of all registered social care and support services in Scotland. And more importantly, much of this work is preventative in nature. Our member organisations focus on keeping people well, keeping them out of hospital or returning home more quickly, and maintaining or re-establishing their independence, resilience and overall wellbeing. However, the aspirational statements are not supported by robust mechanisms for ensuring that involvement will happen effectively. The proposals need to clearly recognise the valuable contribution of the third sector to the provision of public services and ensure the practical means to make that happen. The requirement for a four-way 'sign-off' to Change Fund plans is a useful precedent for a more equal partnership.

Third, we all recognise that legislation has its limits and will not by itself address the challenge of cultural change. There are some cultural and systemic differences between the NHS and social service delivery that we think may pose problems for this agenda and which have not been explicitly considered in the consultation:

- The different approach to charging for services – this is common practice in local authority social care, whereas NHS services are free at the point of delivery
- The different approach to externalisation of services; again, common practice in social care but not in the NHS. Indeed, the mixed economy in social care has resulted, particularly in relation to third sector providers, in provision of services of higher quality and lower cost and therefore better use of the public pound.



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- There are also structural challenges to integration inherent in the way the NHS is set up. For example, where services currently sit within acute care but are not actually acute. There are some examples of this in geriatric care.
- Concerns about the different ethos/values and potential imbalance of power between social care and health (in favour of the latter). For example, in the area of social care, a lengthy battle has been fought to shift from a medical model towards a social model of disability. Providing care in the community and focusing on independent living has been an integral part of this. There are concerns about the extent to which 'integration' poses a risk to the progress made by certain groups, especially those with learning disabilities, to gain more control of their care and support and a fear of the pendulum swinging back towards the medical model with the move towards greater NHS involvement in social care (e.g. with the increased role of GPs).
- Finally, there is the question of the relationship between these integration proposals and the self-directed support strategy. The self-directed support bill proposes a new system whereby individuals can choose to manage some or all of their social care budget; yet the current consultation proposes that there will no longer be, in effect, a social care budget, but an 'integrated' social care *and* health budget. It remains unclear therefore how implementation of SDS will proceed in practice, when duties relating to choice and control for individuals are placed on one of the partners, but not the other, in the context of 'integrated' budgets and services.

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,



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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?

Comments

We strongly support the focus on outcomes. However, we think more work needs to be done to establish whether these are the right outcomes. There is concern that some may not properly reflect the aspirations of individual service users. For example, the outcome for independent living omits the word 'choice'. This is a fundamental principle underpinning the self-directed support agenda. The promise of greater control rings hollow if it is not accompanied by a reasonable degree of choice.

Further, these outcomes are very broad, which makes it more difficult to hold people or agencies accountable for them. We question how effective they will be as drivers of the shift towards prevention and care in the community. Will they be sufficiently robust to provide the measure of how much existing systems, institutions and cultures are making the difficult changes necessary to address increasing demand and improve quality of care? And how do we link the outcomes to the decisions that will be made about resource allocation?

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

Comments



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CCPS recently provided [evidence](#) to the Scottish Parliament Local Government and Regeneration Committee for its inquiry into public service reform and local government. We queried the extent to which single outcome agreements, in relation to social care and support, have improved the outcomes for individual service users.

We note that the Scottish Government and COSLA are currently reviewing community planning partnerships and single outcome agreements in order to identify what improvements are necessary to address the challenges of public service reform. Subject to the outcome of this review, we would have concerns about using single outcome agreements for driving the integration agenda unless significant changes are made to local planning processes.

Our concerns revolve around the lack of involvement of the third sector in the planning process, the tenuous links between agreed outcomes and resource decisions made by local authorities, and the fact that outcomes are still not being incorporated into commissioning and planning processes, which remain stubbornly input/output oriented in most cases. In order to assess and encourage improvement, there need to be significant improvements in the system of scrutiny and accountability, and sanctions where outcomes are not achieved.

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?

Comments

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No. We think the consultation provides insufficient detail to fully understand the mechanisms for scrutiny and accountability.

Accountability to the public via publication of local performance data is inadequate. The nature of this information tends to be inaccessible to the average person and publication of data offers no realistic opportunity for challenge or sanction where the data demonstrates that outcomes are not being met.

Returning to our earlier comments regarding the broad nature of the national outcomes, any system of accountability is substantially weakened if it is not clear what the partners are accountable for. For example, there are no clear parameters for the shift from acute care to community based prevention. Without this, there is nothing to hold public authorities accountable for. There is no clear picture of what success will look like, and no sanctions for failure.

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

Comments

n/a.....

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

Comments

We question why there is a different voting status among the partners. The consultation provides insufficient rationale for making a distinction between third sector and statutory sector partners. This lack of parity is at odds with various statements in the consultation supporting an enhanced role for the sector, and with the statements of the Cabinet



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Secretary for Health in her evidence to the Health and Sport Committee on 20th March 2012. She confirmed not only that there would be a legal right for the third sector to be on the Partnerships but that 'it was the intention that the voluntary sector is there not just to speak for its resource but to influence the spend of the totality of the resource in a much stronger way than perhaps it does just now.' However, it is difficult to see how this can realistically be achieved without any voting rights.

There are several examples, including community planning partnerships and the Change Funds, which provide a precedent for frameworks based on a more equal partnership. Historically, statutory partners have tended to protect their own interests and resources, which has slowed the progress towards integration and improved outcomes. If we are going to make progress, these proposals need to find an effective way of increasing the influence of the wider community on the decisions about resources. However, if voting rights remain with the same players (i.e. statutory bodies) it is difficult to see what will change. We suggest that a wider debate is needed to find the right balance and that the Government consider broadening the scope of existing projects designed to enhance the role of the third sector in local engagement, and the links between local and national organisations.

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?

Comments

The performance management arrangements include improvement and performance support for Partnerships and nationally agreed targets, as well as the involvement of the Care Inspectorate and Healthcare Improvement Scotland (HIS). We support the introduction of national targets and believe the involvement of the Care Inspectorate

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and HIS is essential. Both the Health and Sport Committee in its integration inquiry, and the Public Audit Committee in its investigation into social care commissioning following the Audit Scotland report have endorsed an enhanced enforcement role for the Care Inspectorate, including a role in inspecting joint commissioning strategies.

The effectiveness of this role is dependent on whether we know if targets and outcomes are achieved. There will need to be a robust and transparent methodology for monitoring and reporting progress.

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?

Comments

Widening the scope of the functions and corresponding budget included in the Partnerships may bring benefits. However, leaving this up to individual Partnerships to decide may have an impact on one of the Government’s key objectives of providing “consistency of outcomes across Scotland”. We suggest that there would need to be clear guidance from the Scottish Government in order to manage the impact of differences that might arise.

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?



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Comments

We support the idea that the resources from the NHS and local authority partners will lose their identity in an integrated budget. This should make it easier to take decisions about resources that enhance the outcomes for individuals rather than catering to a particular organisational interest and structure.

However, it is unclear exactly what 'integrated budget' means in practice, and most importantly, how much of the acute care budget will be included. It is unclear from the consultation what is going to motivate statutory partners to significantly change the historical reluctance to shift resources towards different approaches. The Government may need to be more prescriptive in terms of setting out the categories of spend that must be included in the integrated budget. However, there is the further difficult question of what resources are put into each category and from where they flow.

Returning to our earlier point about the potential of the third sector to contribute to this shift, much of the work of the third sector focuses on promoting independent living, resilience and self-management. We want to do more of this but cannot if there is no significant shift in spending toward greater prevention.

And in relation to housing support in particular, to what extent will local authority funding of housing support fall within the integrated budget? Integration could lead to increased separation in the commissioning of housing support for homeless people (possibly staying with housing departments) and older people (possibly going across to the integrated budgets) If funding for low level housing support aimed at preventing crises were moved into the integrated budget there would be a risk of it being diverted to more acute need. This would have a negative impact on health and social care outcomes.

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These concerns link to our earlier points about accountability and performance management. The implementation of 'integrated budgets' needs to be accompanied by effective monitoring of where the spend is going and how the spend is contributing to the achievement of targets and outcomes. Without this, there is every possibility that budgets will not shift, or even that budgets will shift in the wrong direction. And again, without voting rights, the third sector and other non-statutory partners are unlikely to be able to influence those resource decisions or hold partners accountable for them.

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?

Comments

n/a

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?

Comments

see comments to Q 10 above

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?

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Comments

No. As we understand it, the Jointly Accountable Officer will only be able to work with those services that the Partnership has decided to integrate and with the resources that are committed to them. As noted above, the Scottish Government may need to provide strong guidance on the categories to be included in order to encourage the desired shift. And furthermore, if the Jointly Accountable Officer is only accountable to local authorities and the NHS and not to the Partnership itself (which includes third sector and other community partners), then how does the Partnership hold him or her to account for decisions about resources? This lack of accountability to the Partnership is compounded by the fact that non-statutory partners under these proposals will have no voting rights and therefore cannot influence the original decisions.

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

Comments

n/a

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?

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



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then implement, review and maintain such arrangements. Is this duty strong enough?

Comments for Q 15 and 16

No. We understood one of the aims of these reforms was to strengthen the role of the third sector in planning service provision. At para 2.6 of the consultation it states ‘the role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened.’ This idea is expanded on in chapter 7, para 7.5 where the Government says that locality planning will only be effective with ‘the direct involvement of local elected members, **representatives of the third and independent sectors, and carers and patient’s representatives**’.

However, the proposal is to place: a ‘duty on health boards and local authorities to consult the third and independent sectors on how best to put in place local arrangements for planning service provisions’ (para 7.9). This is not the same as ‘direct involvement’ and will not necessarily achieve the desired aim of bringing the wider community into the decision making process. This duty needs to be strengthened to a duty to ‘involve’, not just consult, and must be accompanied by specific directions from the Scottish Government as to how this will happen in practice, to ensure effective involvement of the third sector, carers and patients’ representatives.

As previously noted, the Change Fund model could be considered as a useful potential framework for how to organise the engagement of diverse partners. And in respect of the range of partners, the role of housing and housing support workers should be specifically included among the professionals that play a part in planning and delivering local services.



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We wanted to briefly comment on para 7.11, which considers how to encourage better GP engagement with locality planning, and specifically the workload issues. There are also pressing demands on voluntary sector provider organisations and their workforce. The Government needs to consider how third sector organisations and carers can be supported in order to ensure their effective engagement with locality planning.

On a more general note, it is unclear from the consultation how 'locality planning' will fit with the joint strategic commissioning initiatives that are underway. Both provide an opportunity to change the culture of commissioning, which currently does not take full advantage of the expertise of third sector care and support providers. For many third sector organisations, their role has been limited to that of contracted service provider, rather than partner, and there are few, if any relationships between local authorities and third sector organisations that extend to strategic service planning. The recent [Audit Scotland report](#) on social care commissioning highlights a very poor track record, based on hourly rates with very little evidence of any outcomes based commissioning.

As mentioned above, in addition to involving the third sector in joint strategic commissioning, there is also a role for the Care Inspectorate and HIS in scrutinising the outcomes of commissioning, and particularly the extent to which commissioning adheres to the Scottish Government's social care procurement guidance.

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?

n/a

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

n/a



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

n/a

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?

n/a

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