

Integration of Adult Health and Social Care in Scotland Consultation

Inverclyde Community Health and Care Partnership Joint staff Partnership Forum welcomes the opportunity to present some comments on the Scottish Governments Consultation on Integration of Adult Health and Social Care in Scotland.

Context

This response has been prepared on behalf of the Inverclyde Community Health and Care Partnership Staff Partnership Forum which represents the views of managers, professional groups and trade unions. The Forum was established at the inception of the CHCP 2010. The Inverclyde CHCP Joint Staff Partnership Forum is an important component of the governance arrangements of Inverclyde Community Health and Care Partnership.

The forum is founded on the principle that staff and Trade Unions will be involved at an early stage in decisions affecting them, including in relation to service change and development. Investment in and recognition of staff is key to supporting the development of integrated working within the CHCP.

Inverclyde CHCP was established in 2010, and as such has recent experience of the setting up of integrated services, and is well aware of some of the advantages and pitfalls in doing so. Many of the proposals within the consultation document have already been implemented in part, and the CHCP has been restructured and integrated with Joint Appointments down to Service Manager level.

This response reflects local experience and has been informed by West Dunbartonshire Consultation Response as there are common themes in the response which concurs with our experience. We do not wish to replicate those issues in this response but highlight key points which support a common and collective view to inform the integration agenda going forward

COSLA Response specifically the role of elected members, democratic accountability, engagement and involvement mechanisms, genuine shared decision making and citizenship in shaping responsive public services based on need. Linked to a genuine shared outcomes agenda through the Single Outcomes Agreement.

ADSW Adult Protection Subgroup this response articulates common themes and current issues on the role of Health and Social Care to support and protect people.

UNISON Scotland Response has a focus on a number of issues articulated in the above responses- including workforce issues and the practice realities of addressing these. There needs to be some consistency across Scotland in service delivery whilst retaining flexibility to respond to local need, workforce issues could be better planned through development of a Common National Framework.

'Workforce issues are covered in a very limited annex to the consultation paper. Experience in Highland and elsewhere indicates that there are a range of issues that should be addressed in a common national framework'

As a Joint staff Partnership Forum we consider that the most difficult aspect of the integration process is that of bringing together two large and different groups of staff. This requires considerable work and planning on the areas mentioned in Annex C, namely

Organisational development

Training and education of frontline staff

Staff governance and partnership working

Professional Accountability

Employment policies and procedures

Recruitment protocols and joint appointments.

These should not be underestimated as essential ingredients of successful integration of the two services.

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?

We would support the inclusion of all adult health and social care services, and would not wish care groups other than older people to be disadvantaged by initial focus on older people, where there have already been considerable developments implemented by the Change Fund.

In our view we would also wish all social care services, including Childrens services and Criminal Justice services to be included and consider there are major disadvantages and risks in disintegrating integrated services for children. The NHS has always considered that it provided a service from the cradle to the grave, and we do not see any advantage in separating childrens services from adult services.

Social Work services have a specialised role in providing "protection" to vulnerable children and adults, and to the community in terms of management of offenders. Unifying health and social services to vulnerable children and their families must improve the delivery of their services. Given that the population, especially in deprived communities, experience the impact of multiple health and social care issues in the later stages of life, it would seem logical to cover all age groups, and also health improvement and inequality issues by the same organisation.

" All services should be included, including adult, children and families and criminal justice services. From practice perspective there are numerous examples of investigations and reports into cases where lack of cooperation and an integrated approach to protection issues contributed to failures to protect vulnerable people. Locally we are working hard on developing better and improved practice to protect and support vulnerable children and adults. Separation out of services involved in this makes this all the more challenging and risky. This also pertains to situations where there are multiple health and social care needs for individuals and families out with protection" Quote Inverclyde SPF.

We recognise that progress has been made over a number of years through existing legislation. Whilst implementation will depend on progress on a number of work streams and service areas at a local level. A budgetary mechanism to move resources from acute to

community is welcome.

The aspiration is to move to whole systems and collaborative working to remove the structural barriers and silo way of working which can limit access to services, support and choice.

A focus on acute services alone conflicts with the ethos of developing seamless pathways, responsive services which can detract from the need for community capacity building and genuine shared resourcing in order that people have access to support and services appropriately. The principles of prevention, pathways for people to access services from 'the cradle to the grave' needs to be strengthened in order for a holistic collaborative approach to be adopted, facilitating the ability to work across boundaries. The Health and Wellbeing agenda and Social Work practice, reinforces the need for a shift in structural arrangements and bureaucracy which limit holistic methods of working. There are well documented examples of good collaborative arrangements and more challenging arrangements, referred to in for example the ADSW Adult Protection Subgroup Response.

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 feel that the proposed framework is not comprehensive enough, although not all aspects of the integration require legislation.

The phrase "integrated budgets will include....expenditure on the use of some acute hospital services" needs to be better explained. As identified, there is some disconnect between primary and secondary care in the NHS; the consultation document does not clarify if the proposed expenditure is for particular services that might facilitate earlier discharge (such as seven day a week physiotherapy), or control of some in-patient services. In Inverclyde we have experience of in-patient mental health services being managed by the CHCP. This model would appear to have advantages locally in reduced admission rates, but relies on a well developed structure of community support. Not all local authority areas have acute services within their boundaries, and this lack of co-terminosity for patient population may not suit other areas.

It is noted that the document recognises that achieving effective integration whilst maintaining focus on quality and consistency of services and supports to people in need will not be easy. We are clear that the most difficult part of integration is that of bringing together two different staff groups, with different terms and conditions, and differing ways of working. As outlined in the introduction there needs to be a greater focus on workforce issues and planning specifically on the points below

Staff transfer: There is an urgent need for a legislative framework for staff transfer that reflects current best practice and ensures a degree of consistency.

Pensions: The NHS and LGPS pension schemes have many different elements and while service is protected on a year for year basis other elements need to be addressed consistently.

Secondment: This may be a more flexible option in some circumstances. There are some complex legal issues and a secondment framework would again ensure some consistency

and guidance. Enabling terms and conditions to be retained and minimising costs in structural and organisational change, at a time when current conditions requires a collaborative effort focused on prioritising and maintaining a safe level of service delivery. This leads onto the need to continue to develop evidence of what works as any major change needs to be managed to achieve maximum benefit .

Research

Whilst there have been positive benefits to the experience of integration at a local level some of this has been achieved due to progress of work streams over a number of years. As described in point above there needs to be consistency in models of integration adopted across the country with a costs and benefits analysis. Research on integration of health and social care is still developing aligned with the fact public services need to manage any new policy direction in the context of reducing resources, loss of expertise and single person dependency.

Staff employed by different employers: Joint Future introduced working arrangements where staff from different employers work together. There have been problems with different procedures such as discipline, grievance and development review. Professional boundaries, ethics and codes of conduct can also be an issue. There is also an issue where staff carrying out comparable or interchangeable jobs are employed under different terms and conditions and different pay scales. (This has been apparent locally for service managers and administrative staff, but support workers and occupational therapists are also a case in point).

Industrial relations: NHS staff feel strongly that their model of Partnership working is to be valued and would wish to retain this.

Procurement: There is little consistency in approaches to public service reform that involve procurement. The Two-Tier workforce provisions including the PPP Protocol and s52 have been under review . Existing provisions are not well understood and certainly not consistently applied.

Equality duties: Organisational change and service redesign requires cross referencing with our duties to be properly compliant requires detailed analysis involving research utilising the expertise from ECHR and SHRC including adoption of a framework to facilitate genuine analysis to meet need. This will depend on progress within localities on the quality of this work and requires to be developed within a national framework.

Governance: Different governance arrangements can be complex and confusing. This applies to the governance of workforce issues and related industrial relations approaches, as well as professional, clinical, and financial governance systems.

There is a major concern that the models as described are a roadmap to privatisation. There is strong evidence across Greater Glasgow and Clyde that previous and current services which are delivered by the third or independent sector have led to a “race to the bottom” in respect of pay and conditions. This is of particular concern in these times of austerity.

Care integration has had and will continue to have a major impact on a large number of

workers in health, local government and community sectors. It also raises wider issues of public service reform including workforce issues and structural change.

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?

There is some concern as to how prescriptive the proposed National Outcomes will be, as well as concern that these are not added to the various performance frameworks already in existence (creating an industry to feed, defend and evaluate targets). There needs to be freedom to continue to choose local joint outcomes in other areas of service. There needs to be an appropriate balance between national and local accountability.

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, the outcomes need to be included in the Single Outcome Agreement but need to cover all care groups, including Children and Families, and Criminal Justice services.

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?

We feel that the Health and social Care Partnerships Jointly Accountable Officer needs to be jointly accountable to the Health Board and the Local Council.

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

We believe that co-terminosity of the Health and Social Care Partnership with the local authority area is more viable.

Any alternative could be counter productive to the aim of targeting resources on frontline services and could divert resources to support restructuring and organisational change which can be costly and complicate an already ambitious governance arrangement, and complicate existing structures. Alignment of management and planning arrangements across organisations could facilitate more effective services and economies of scale but this would need careful cost and benefit analysis to ensure resources and funding is targeted to frontline service delivery and minimises the risk of creating complicated challenging issues of organisational change which can negatively impact on frontline staff and local peoples access to services.

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

We would support the principle of voting members of the Committee being those with a clearly recognised mandate and formally recognised accountability for the decisions they make, either by being locally elected members of the Council or formally appointed Non-Executive Directors of the Health Board. We feel there may be some difficulties locally, however, in Greater Glasgow and Clyde Health Board being able to populate 6 Health and Social Care Partnerships with more than 3 Non-Executive Directors each with local knowledge. Our current CHCP committee has 5 elected members of the Council as voting members, so 3 would be a substantial reduction in local accountability. Whilst we would welcome the presence of Professional Advisors and Patient/service users' representation, we would regret the loss of representation from Public Partnership Fora and the Joint Staff Partnership Forum, from the Committee.

We recognise that the committee arrangements described provide a reporting structure, but will not alone ensure governance.

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?

We welcome proposals to simplify performance management regimes aligned with agreed priorities and outcomes to support frontline service delivery but needs aligned to proposals on ensuring democratic accountability and shared decision making.

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?

We feel this should be for local determination. Guidance and Direction will be required to free up resources within the scope of Health and Social Care Partnerships with more thought given to some challenges to budget setting when for example new treatments are agreed and impact on local budgets. Decisions on provision of specialist versus more generic services for example. There are complexities around budgets that need further discussion and debate to ensure fair and equitable service delivery can be achieved.

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?

We feel there are a number of issues related to an integrated budget. Integrated arrangements aimed to promote a single system in principle are supported but implementation requires to build on best practice models which minimise disruption of service delivery and access to services.

There is a particular issue where the H&SCP has a ring-fenced budget, but is obliged to provide resources to fund budgets that are out of their control e.g. GP's pharmacy budgets, or Health Board system-wide reform. It is recognised as well that a relatively small change in

forms of treatment can have large financial implications.

Whilst health care has always been provided free at the point of need, some local authority services incur charges. The final documentation around integration needs to recognise this potential dilemma and provide guidance to partnerships as to how to implement this and how to communicate the differences in the services to service users.

Again, there needs to be clarity about the expenditure on Acute Hospital services.

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?

Inverclyde CHCP has overall achieved a positive experience of integration based on collaborative work over a number of years however as outlined above, there are issues which require to be addressed within the proposed legislation based on experience and clarified.

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?

This needs to be viewed in the context of locally agreed objectives, democratic accountability, governance and performance management for the provision of sufficient resources within a pooled budget with sufficient flexibility to create and innovate. GP prescribing and self directed support being 2 examples which will impact on sustainable management of resources.

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?

Shifting the balance of care needs to be agreed at strategic level within the NHS and Local Authority. Investment shifting from Acute services will require national and local political support.

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

There is a need to have a Lead Officer with seniority to make decisions with greater set of accountability and reporting arrangements. But the key point is ensuring sufficient arrangements are in place at middle and frontline tiers of management and frontline services to be responsive to people presenting to health and Social Care services with diverse and complex needs.

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

Locality planning can only work at locality level, as proposed in the consultation, but within existing arrangements for us there remains significant tension between locality requirements and both Council and NHS Board wide expectations of what and how we deliver. The Health Board in particular seeks consistency across it's area and locally in mental health is only now really accommodating the principle of localities determining how to deliver on objectives. Focus therefore of integration must be on strategic objectives and outcomes to be delivered, not structures to deliver, and priorities based on locality needs. Current structures incorporate the input to developments in service design from a number of relevant bodies, as well as the Senior Management Team and staff-side under the current NHS partnership arrangements.

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?

Robust staff governance is required, including partnership working at all levels.

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?

Local planning requires to ensure key professionals and frontline staff are engaged and can influence and inform change. This will enhance the role of practitioner and professional forums and staff engagement forums in CHCP development.

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

Local planning should not be organised around clusters of GP practices. They should be organised around natural communities which local residents can identify.

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

Locality planning groups should engage and advise the decision-making process using local intelligence, however, they are not accountable for the decisions made by H&SCP.

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?

As above, localities should be organised around natural communities of residents and interest, not merely on population size.
