Integration of adult health and social care in Scotland

Response to the consultation on proposals

General

The Princess Royal Trust for Carers in Scotland (part of Carers Trust) welcomes the Scottish Government's consultation on the integration of health and social care. We are particularly pleased with the strong emphasis on prevention in the announcement and statements to date about integration and the commitment to legislating in favour of preventative action.

Ensuring that legislation includes recognition of and support for unpaid carers can help achieve these goals but the proposals fail to explain how carers, as equal partners in care, will be integrated into the plans. We are disappointed at the lack of mention of the Carers' and Young Carers' Strategies within the document and how the actions within these could be used to benefit the integration agenda. In general there is mention made of a number of other policy and strategic agendas but no clear read across of the links between them.

The document focuses a great deal on the processes behind integration rather than setting out the aspirations and the outcomes which are to be achieved had made it difficult to respond with clarity to some of the questions. Our fear is that this focus on process leads mainly to a reshaping of the bureaucracy which integration is meant to overcome rather than making a positive difference for Scotland's citizens.

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?

Whilst older people are likely to access a range of services across health and social care, and many illnesses and conditions that necessitate unpaid care from family or friends primarily affect older people, these proposals to change the way that health and social care is delivered would be best served by full integration of all areas of adult health and social care from the beginning.

Two parallel systems – one for older adults and one for adults in general – is not full integration, and would be creating a new barrier to streamlined services rather than reducing existing barriers. There is also not enough clarity around the definition

of older people – as the proposals themselves state, conditions associated with old age and frailty are often experienced much earlier than 65, and people with disabilities are of all ages. A focus on older people alone, even initially, would create an unnecessary artificial divide within adult services. The proposals also do not address the issue of transition from children's to adult services.

The Trust conducts an annual survey of carers' centres in its network to establish a demographic breakdown of carers and those they care for. In the 2011 survey, carers who cared for elderly people were the third most common group of carers. Many more people cared for family members of all ages with physical and learning disabilities, and it is these carers and their families who will also benefit from the integration of services.

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?

Part of the reason for integrating health and social care is to simplify the way that services are commissioned and delivered. It is vital that this simplification is apparent to the service user, including carers, without unnecessary and extensive changes to the basic services provided to carers and those they care for. More information must be provided on how local needs and priorities will be identified by partnerships and whether there will be clear guidance and requirement on involving local organisations in this planning.

We welcome the commitment to including carers' representatives on health and social care partnerships. However, in keeping with the principles in *Caring Together: The Carers Strategy for Scotland 2010 - 2015* that ensured representation of carers on community health and care partnerships (and other means of participation), the proposed framework would ideally include carers on partnership committees, not just carers' organisations and other carers' representatives. A clear commitment to resourcing and supporting this kind of participation will be necessary if it is to succeed.

Whilst a lack of centrally directed structural reorganisation will allow statutory partners to shape their service planning and delivery in a way that suits their service user demographic, local organisations and staff members, clear guidance must be provided for statutory bodies, other professionals and partners to ensure that the third and independent sector is an equal strategic partner in joint commissioning and locality planning.

We would also urge the Scottish Government to provide clearer indication of how Self-Directed Support will fit in with these proposals. Self-Directed Support is only applicable to social care; it is not clear how chargeable options of social care and support will mix with healthcare in an integrated budget environment. There is also

concern that no timescales are specified around developing outcomes and moving to integrated budgets. We would welcome further information on how soon national outcomes will need to be set by statutory partners, how frequently they would be subject to review and change, and the methods by which they will be transparent and accountable locally.

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?

As the proposals mention (3.8-3.10), the development of outcomes with a local focus and minimal central direction is similar to the approach that has been taken by local authorities and community planning partnerships in developing Single Outcome Agreements. Therefore it is likely that health boards will be the partners that have to adjust to a new planning method, and in the first instance leadership will be from local authorities because of this.

There are only six areas of Scotland where the health and local authority boundary is co-terminous. In most areas, one health board area encompasses a number of local authorities. There needs to be more information about how development of outcomes would work in these situations. Will areas where there are a cluster of local authorities within one or two health boards, such as greater Glasgow and Lanarkshire, have similar or identical high-level outcomes with locally variant indicators and measures, or will each Partnership develop its own outcomes independently?

It is also important to consider how the assets of health and social care are more than health boards and local authorities. Unpaid carers, third sector organisations, and other functions outside of statutory health and social care such as housing are also a key part of service delivery, and more information is needed on how these partners will be able to participate in forming outcomes.

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

It is vital that health and social care outcomes are included within Single Outcome Agreements, as one of the key benefits of integrating health and social care under nationally agreed outcomes is consistency of outcomes across Scotland, and similar experiences of support for carers no matter where in Scotland they live. Single Outcome Agreements are a good model of an outcomes-based approach to planning and delivery, and six of the National Performance Framework's national

outcomes and many of the national indicators relate directly to health and social care. The direction of health and social care has not changed significantly since the development of the National Performance Framework, so it will be useful for statutory partners to continue working within the same frameworks in order to measure long-term progress.

Community health partnerships are an existing example of how local authorities and health boards already integrate planning and service provision, so it is important that the good practice within existing structures is learned from – and lessons are learned from what has not worked so well. This will allow integration to be as efficient as possible and the planned structures can deliver real and consistent services for carers and those they care for. The review of community planning should take this into account.

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?

The proposals are adequate for accountability to central government, but it is not clear from the information given how local democratic accountability will be guaranteed and encouraged. Publicising local performance data is not always an accessible way to ensure accountability to carers and service users. We would like to see further proposals as to how carers, service users and the general public will be made aware of these new partnerships, how information will be made available to them and what routes are open for them to participate in local planning and decisions.

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

Whilst there are clear benefits to streamlining the number of strategic forums or committees in local areas, the proposals do not give enough information about how this will impact on locality planning. The planned reduction from 34 CHPs to a maximum of 32 health and social care partnerships, co-terminous with local authority areas, indicates that some areas of Scotland – those with multiple CHPs and CHCPs in one local authority area – may experience much more change than other areas. As mentioned in question four, it is important that current good practice in planning and structure is maintained, so if large or densely populated local authority areas would benefit from establishing more than one health and social care partnership, this option may be suitable.

We would also appreciate more information on how housing requirements, which underpin much of health and social care, would be planned for as part of the proposals. Lack of appropriate housing along with difficulties in accessing aids and adaptations are barriers to people being discharged from hospital or other

institutional settings. In other instances discharges take place with the carer being left to manage the situation or households moving across local authority boundaries where access to support is perceived as being more favourable.

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

As discussed in question three, true integration of services will involve many more organisations than the statutory partners. Whilst it is positive that health and social care partnerships will have enhanced budgetary and decision-making authority, we are strongly in favour of carers, their representatives, and third and independent sector representatives being voting members of the committee. Carers need to be equal partners in planning for the support of those they care for, and their participation in planning structures needs to be supported and resourced - this fits with the commitment in the Carers' Strategy for Scotland to including carers at all stages of services and support planning, and the proposals for integration that aim to ensure that resources are following the needs of service users, patients and carers. It is not clear from the proposals whether guidelines on the professional advisers will be extensive – as a minimum, we would advise that representatives from housing and children and young people's services have a place on the committee. The proposals currently state that the involvement of other services should be determined locally; this could risk the integration and provision of services not being consistent across Scotland.

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?

As discussed at question five above, one of the most important aspects of integration is ensuring that the services provided are fully accessible and deliver positive outcomes for all carers and service users. Whilst we welcome the commitment to effective working with external scrutiny bodies, it is not clear from the proposals what mechanisms will be in place for service users and the general public to complain about ineffective or inefficient services and how any concerns will be dealt with. There will need to be a robust public awareness-raising campaign and clear information about lines of accountability, to ensure that carers and service users are confident that the new structure is in place for their benefit.

The critical role of unpaid carers and the need to effectively support them is not clearly reflected in these proposals. Carers and their families understandably feel concerned about perceived and actual changes to the services they receive. It is important to point out that in developing real opportunities for consultation not all carers and service users will be able to attend formal engagement events or keep in touch with developments online as services plan integration. This highlights the need for continual reinforcement of key messages using a range of media (including social

networking) but also the need to continue working with and supporting carers centres as local community-based organisations which directly support carers and through this service users and their families. Consultation and communication with carers and families needs to be a continuing and underpinning element of integration plans at national and local level.

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?

As set out in the response to question seven above, it is important that the dedication to local planning and independence within health and social care partnerships does not lead to a discrepancy in the level of services provided across Scotland. If other CHP functions can be taken in to the health and social care partnership, guidance will need to ensure this is taken into account. It is not clear from the proposals how including other CHP functions in health and social care partnerships fits in with the proposal to initially focus on older people's services, and we would appreciate clarity on this.

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?

Based on the information made available in these proposals, we are broadly in favour of option 1 – delegating agreed functions to the health and social care partnership. This option would seem to be most in line with integrating services and having joint responsibility for these services, and ensuring that carers and service users are supported wherever they are in the system.

The option to delegate some functions and resources between partners has the potential to work well, as seen in the Highland partnership (cited in the consultation document), but the extent of integration may not be as apparent to carers and service users in this model, and it may lead to resources being viewed as still belonging to health or social care, rather than jointly.

It is important that whatever model of integrating budgets is chosen, the services delivered to people who use health and social care services is consistent, efficient and of the highest quality and shaped by carers and service users. Transparency in budget arrangements is a part of ensuring that people are aware of how statutory partners are planning budgets and service delivery; whichever model is chosen, it should be communicated clearly to all.

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?

The lead agency model in Highland is cited in the consultation document. Integration in Torbay is held up as an example of good practice and has been evaluated to show some positive results.

Torbay as an area represents a microcosm of the demographic challenges faced in the UK and Scotland. Many elderly people who have retired to the area do not have family support networks and are therefore more reliant on local services.
In *"Integrating Health and Social Care in Torbay – Improving care for Mrs Smith"*[1], an evaluation of the integration process and impact for service users in Torbay, the following learning points are cited:

- Pooling of budgets provided a wider range of care services including more intermediate and home based support.
- There were strong links between GPs and integrated teams.
- Outcomes included reduced use of hospitals, reduced rates of emergency admissions and admissions to residential care; also an increase in home care support.
- There was an increased uptake of direct payments.

Issues highlighted in the Torbay scenario include the importance of strong leadership and commitment to making integrated services work. This included strong political commitment to change which partly arose from the need to tackle under-performance and quality issues in local social care services. Involvement of staff affected at all levels and a strong focus on achieving better outcomes for service users seem also to have been key elements in the work to integrate services.

Provisions to enable more effective sharing of data between services were also deemed to be important to success. This included named coordinators who could access patient information and data sharing agreements / actions in GP practices.

Data sharing protocols and more integrated patient / client recording systems must be a critical element in planning to better integrate services in Scotland. It is also important in developing a joined up approach at local level, where it matters most to individuals and their families. One of the biggest frustrations continually faced by carers and their families is having to 'tell your story' to different professionals, sometimes on many different occasions and to people who may be co-located / work in the same team. This contributes to the disjointed experience and shunting between services which families can sometimes experience, leading to fatigue and disillusionment with 'the system'.

[1] Integrating Health and Social Care in Torbay – Improving Care for Mrs Smith. The King's Fund, March 2011

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?

As discussed in questions eight and five above, it must be clear about how carers, service users and their representatives can make their views known in how categories of spend are devised. As equal partners in care, carers should be at the heart of shaping provision at a local level. A clear point of access and contact for service users and carers is important – and that may not always be through statutory services. Local and community organisations will be able to provide further evidence on local need. Their input will be necessary to ensure that a clear and complete picture of the specific needs of a local area can feed in to budget planning.

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?

These proposals need to be clearer and more in-depth before we will be in a position to comment.

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

When driving significant change, senior leadership is valuable. However, in these proposals it is not clear as to who will report to the Jointly Accountable Officers to enable them to manage budgets and make decisions, and how much responsibility they will have to influence and direct the work plans of relevant teams within the statutory bodies.

It is also a concern that current focus is on seniority rather than appropriate leadership and planning skills. Senior experience within a health or social care environment may not be the best background to effect real change. Appointments made from either the health or social care sectors may also affect perception of priorities when it comes to joint planning and working.

There also needs to be clarity around how the cultural change required to deliver on the ambitions for integration will be embedded within organisations. This is unlikely to be within the scope of the role set out for the Jointly Accountable Officer.

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

It is recognised in the proposals that effective locality planning will only be successful if there is full participation and involvement of all those involved in the care of service users and patients. It needs to be made clear how involvement of carers, carers' representatives and the third and independent sector will be directly involved in planning.

Local determination may be a better way to ensure participation of local and community-based services. This is recognised in the proposals but it must be made clearer what guidance and support will be available, how participation at a local level will be supported and resourced, and how the views of carers will be taken into consideration.

Questions 16-17 are answered together:

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?

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

The proposals are not clear on how Self-Directed Support (SDS) outcomes will fit into planning and commissioning of services by health and social care partnerships. As previously mentioned in this response, it is vital that carers and service users are able to challenge and influence planning and decisions at all levels. Unpaid carers need equal regard as health and social care professionals. As equal partners in care, a practical step needed to support carers is a commitment to involving them in planning and monitoring of services, and ensuring that their involvement is adequately resourced.

The people who use local services are the experts on where local services need to improve and, as significant providers of health and social care, with in-depth specialist knowledge of the support needed by those they care for, carers' full and equal contribution is critical. There are over 657,000 adult carers in Scotland and replacing the care they provide would cost over £10.3bn annually, similar to the cost of delivering the NHS in Scotland. Ensuring carers' inclusion as equal partners in the planning and monitoring of integration is vital at local and HSCP level.

Questions 18-20 are answered together:

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

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

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?

Until more information about the shape of locality planning groups is known, it is not possible to comment on this. We have welcomed being able to participate in the locality planning focus groups and, as the discussions there are not yet finalised, this indicates how difficult it is to respond to proposals around locality planning until the shape of the proposals for integration become clearer.

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

The likely impact on carers needs to be looked at in greater depth. Although the intention of integration is to make accessing support services easier and simpler, it is not clear that this will be the case, especially as proposed governance structures seem quite complicated and multi-layered. It must be made clearer how service users can expect to feed in to processes and make their voices heard.

Do you have any further comments regarding the consultation proposals?

As mentioned in our submission to the inquiry on integration of health and social care in Spring 2012, there is still some concern at the complexity involved in disaggregating and restructuring services, and apparent complexity in the proposed new management / governance structures.

Our work with carers and carers' centres provides a strong understanding of the issues that affect unpaid carers and their families, including their experience of health and social care services in Scotland. Centres are already working closely with statutory and independent partners in a range of settings and in ways which bring to life the principles of integrated services and outcomes. The role of unpaid carers in achieving the vision and outcomes for more integrated services in Scotland cannot be overstated. We know that carers find the current system disjointed, and lack of communication between health and social care can place a great strain on carers as well as those they care for, and cause delays or difficulties in accessing personalised, appropriate and more integrated support.

The focus on integrating services must always remain on what individuals and unpaid carers experience from how services currently work, where improvements can be made and where good practice should be retained within the new structures. Direct involvement of carers and carers' representatives at all stages and levels of planning is necessary to achieve this.

The Princess Royal Trust for Carers in Scotland (part of Carers Trust)
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