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RESPONSE OF: The Royal College of Psychiatrists in Scotland

RESPONSE TO: Integration of Health and Social Care in Scotland

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The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

Chapter 1 – The Case for Change

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.

The College agrees that improving outcomes for older people should be the initial focus for integration. The disconnects within NHS services between acute hospital and community services, including Old Age Psychiatry, and between the NHS and local authority can have a substantial detrimental impact on the quality of care and treatment.

The purpose of integration is to improve outcomes for individuals where there is a lack of care co-ordination and poor quality care often resulting in these groups consuming a high proportion of resources, partly because of inefficient care processes. (Curry and Ham 2010; Goodwin and Smith 2011; Ham et al 2011b; Rosen et al 2011).

While the aim is to “Improve the experience of people using services when we all work together to ensure that we are integrating services as an effective means for achieving better outcomes,” in the recent evaluation of the Department of Health Pilots, patients did not in general share the sense of improvement. The most likely improvements following integrated care activities are in healthcare processes, they are less likely to be in patient experience and reduced costs. (Powel Davies et al 2011, Rand, Ernst and Young 2012). Successful measurement of integrated care as experienced by individuals is not well defined (National Voices 2011) and there is an evidence gap in relation to the effectiveness of integration on delivery of services in relation to service users and the wider health and social care economy (Cameron et al, 2012).

There are other groups where these disconnects can have an impact, such as those with Learning Disability, and these groups should not be disadvantaged by a focus on older people in the initial stages of integration.

Chapter 2 – Outline of Proposed Reforms

Question 2: Is the proposed framework for integration comprehensive? Is there anything missing that you would like to see added to it, or anything you would suggest should be removed?

Outcomes

At the current stage of development, there is no clear outcomes framework and this is an essential element of a comprehensive framework. A clear framework is essential for accountability, to avoid undue geographical variation, and to evaluate the integration process.

It must be made clear how the user perspective of integrated care will translate into the organising principle of those involved with planning and providing services, and how this will be measured. (Lloyd and Wait 2005; Shaw et al 2011). There are many methods of assessing individual’s views of care (Vrijhoef et al 2009) and to be effective an appropriate framework will need to be developed. This should include regular and detailed assessment of experiences of continuum of care across NHS and social care provision, which is not based on individual providers. There must be a way for the experience of end users to be tracked and data used to monitor and improve the system as a whole. Perceptions of patients are often that integration is a tool to increase efficiency rather than effectiveness

and service users must see a benefit to their care.

Assumptions that the majority of secondary care unplanned admissions for our very elderly citizens are avoidable are incorrect. Some may be but not the numbers or proportion which some planners have anticipated. Evaluation of ICPs show the cost of hospital care can be reduced but that it is less likely that there will be a reduction in hospital admissions. The prospects for reducing hospital admissions in a population with an increased number of frail older people who are acutely unwell with a complex mix of chronic, acute and mental health problems are very limited. Assessment and management will require adequate hospital beds in acute services and Old Age Psychiatry. The development of Old Age Psychiatry Liaison Services within acute hospital will be an important part of the improvement process, for instance, in improving the discharge process. Improvements are not likely in reducing numbers of admissions, but may be achieved in shortening lengths of stay and improving patient experience. There are unlikely to be significant savings in overall care costs and community health and social work teams need to be resourced sufficiently to allow intensive input by mainstream Older People's services, not only during the immediate post-discharge period but also to work on preventing deterioration and a potential further admission. Resourcing this area would close the loop between prevention of admission and successful early discharge. (Rand Europe and Ernst and Young, 2012)

These proposals are sufficient to facilitate "*Reshaping Care for Older People*" if political will remains strong and the Jointly Accountable Officer (JAO) is given an adequate starting budget plus satisfactory leeway for ongoing adjustments to this. The consultation indicates a willingness to be radical but will require sustained commitment to shifts in the balance between health and social, as well as primary, mental health and acute care.

Budgets

Integration of budgets is more problematic at a time of contracting finances. The relative protection of health budgets has been welcomed by the College, and there is a concern that joining with other declining revenue sources may lead to further pressure on what were health budgets. Increased efficiency and decreased waste may ameliorate this effect, but as noted above other attempts at integration have not reduced costs. Many of these budgets will have been inadequate prior to integration and there must be mechanisms to assess the budgetary starting point prior to integration in order to evaluate the effects.

The College is concerned about the lack of specific details in relation to Health and Social Care Partnerships. It is stated that HSCPs will ensure that "effective processes are in place for locality service planning led by clinicians and care professionals, with appropriate devolved decision making and budgetary responsibilities". The College agrees with this but would like more detail on what clinical representation on these groups and the support which clinicians will require to fulfil these roles.

HSCPs will have responsibilities for staff training and development and the membership of the HSCP should reflect this with University and other learning institution representation.

The consultation refers to the activity and budget for "some acute services" coming into Partnerships. There needs to be more detail on this crucial issue. Much of the improvements which could result from integration will come from improving pathways into and out of acute services.

A major omission from the Consultation is consideration of Criminal Justice budgets. There is much potential to improve pathways between criminal justice and other services in areas

such as services for mentally disordered offenders, offenders with learning disability, young offenders and Addictions. The Commission on Women Offenders drew attention to many of these interfaces. The inclusion of elements of Criminal Justice Services in CHSPs should be given serious consideration.

More needs to be said about Board wide services that input to different local authority areas and how the integrity and critical mass of these services will be maintained. We believe that good design can allow effective specialist services, organized on a regional basis, to deliver effective local services. The structure and culture of Partnerships must recognize and support this model.

The College is also concerned about the potential conflict of interest in allowing the participation of third and independent sectors in the strategic commissioning of services, which they will go on to benefit from. There is evidence that the competing demands of managing competition alongside collaboration can be a barrier to integration (Ahgren and Axelsson, 2011)

Chapter 3 – National Outcomes for Adult Health and Social Care

Questions 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 and for support to carers. 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?

Any legal framework will need to foster the attitudes and culture change which is essential for integration to work effectively.

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

The establishment of agreed outcomes is key to performance management, whether through joint, integrated or single organizations. Outcomes should be credible, practical and genuinely shared. There has been work undertaken in NHS Scotland, including within mental health and in partnership organizations such as Alcohol and Drug Partnerships which could inform this process.

Chapter 4 – Governance and 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?

If a system was being designed from scratch a clear single line of accountability would be the ideal. The College accepts however, that the reality is that national government through the NHS and local government will wish to retain these substantial areas of responsibility and that joint accountability is the realistic way forward.

In that context, the suggested arrangements sound sensible. Agreed national outcomes will be crucial for effective accountability. While local circumstances may affect how services are delivered, patient needs and evidence based best practice will not vary much across the country and a balance between local and central government accountability through NHS Boards is required.

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

There should be flexibility in arrangements to suit local circumstances. Effective mental health care is team based and requires specialist skills within NHS services. Teams need a critical mass in order to maintain specialist skills and this will often mean that specialist services will cover more than one local authority area. Health and Social Care integration should facilitate the functioning of these regional services.

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

Experience of the previous generation of integrated bodies, Community Health Partnerships, was that buy-in from clinicians was difficult to achieve. The role of the Professional Advisers is key here. The potential benefits of integration rely on the co-operation of a wide range of clinicians in acute care, mental health, primary care and other services. Professional Advisors will need to be supported by an effective representative structure in order to effectively deliver the benefits of integration.

We support the involvement of users and carers. There needs to be consideration of what structures are needed for users and carers representatives to effectively represent a wide range of care and treatment sectors.

We welcome the involvement of the third sector because of its key role as a service provider. Again consideration needs to be given to ensure representation of a diverse sector. All services, statutory and third sector are in direct contact with users and carers and should reflect their views. This is no more true of the third sector than the NHS.

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?

Yes. Nationally agreed outcomes will be important in measuring delivery. Effective patient complaint and staff whistleblower systems will be essential. Effective inspection systems should be in place, and we support the role of Healthcare Improvement Scotland in monitoring quality.

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?

The response to this question depends on the guidance on the expected budget inclusions. Clarity on the inclusion of acute service NHS budgets is required. We strongly encourage inclusion of significant parts of Criminal Justice budgets. If these are structured appropriately, there should be little need for local variation. On balance, we favour strong central government guidance on this with limited local flexibility.

Chapter 5 – 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?

We believe that the models are sufficient. Success will depend on the quality of the outcomes developed, the involvement, including budgetary involvement, of all the services

which contribute to care and treatment, and the quality of clinical involvement and leadership.

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?

There is considerable experience in Mental Health of attempts to make flexible use of resources. Some, such as Glasgow City founded, others, such as East Renfrewshire and Angus, have survived. As budgets have become tighter the difficulty of sharing has increased. One of our members described their experience as "Local authority colleagues tend to push for admissions without recognising the very negative impact this can have in certain situations. Health colleagues tend to push for increased hours of support without recognising that this impacts elsewhere in the system. Both are really saying this person needs something more or different from what they currently have."

The involvement of Primary Care and, in particular, General Practitioners is essential in managerial in clinical decision making.

Members of the Liaison Faculty of RCPSYiS are concerned about poor integration which arises in the general hospital. There are increasing examples of lengthy delays in progressing guardianship applications. Large numbers of elderly people with delirium and dementia present acutely to A&E. A proportion may then end up requiring guardianship, but usually, by the time they do, their care has appropriately been taken over by old age psychiatry. Where patients are younger (ie under 65), with stable cognitive impairment (most commonly due to alcohol related brain damage) they can languish for months on acute medical wards (the longest stay known to our members was over a year).

There are various reasons for these extended stays, but prominent among them is what appears to be a protracted procedure to enact guardianship. As cases of cognitive impairment in younger people are getting more common this is an increasing concern for users, carers and staff.

Mental health services for older people have historically suffered from the double stigma of "old age" and "mental illness". The greatest problems have not been with social care but with the failure to re-invest, within health services, resources released from closing long term facilities into community services for Older People. This has been exacerbated by acceptance of a "two tier" mental health service where working age adults have access to an appreciably greater level and range of resources compared to their older counterparts. Priority for older people's services initially in Health and Social Care integration should focus on ending this discrimination.

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 will depend on what the minimum categories are and how prescriptive they are around about the acute budget. Even very recent experience with difficulties consolidating successful Change Fund initiatives from acute hospital resource, both human and financial, confirms that advice on the scale of initial contribution from that sector will also be necessary. Most important of all will be robustness of information to underpin the financial consequences for Health and Social Care Partnerships (HSCPs) on the one hand, and acute services on the other, from altering patterns of activity against a changing demographic landscape. The need for further shifts in funding streams and distribution of personnel to be both fair and transparent,

as well as backed up by appropriate guarantees to general hospitals on reducing delayed discharge. An effective discharge pathway will need to be evident to patient, carers and acute hospital staff to secure the public support necessary to shift the balance of care to community health and social care services. Good care pathways need good real time information systems. There are few examples of this working well in mental health at present.

Chapter 6 – Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

The shift in resources will require strong leadership and practitioner support. The latter will be achieved by front line staff, including our members, seeing improvements in care.

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

Yes

Chapter 7 - Professionally led locality planning and commissioning of services.

Question 15: Should the Scottish Government direct how locality planning is taken forward.

Given the relative failure of CHPs it would seem desirable to offer strong central direction at this stage while the proposed changes are initially being trialled in hitherto disadvantaged patient / client groups. Clear national outcomes will be important for HSCPs. Thereafter, there may well be opportunities for local flexibility and variability as HSCPs “bed down” and mature.

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?

It needs to be clear that this is a fundamental part of the process and that views expressed will be considered. This should be much more specifically directed from the centre with clear responsibilities laid out for the involvement of local clinicians from both primary and secondary care, that is where the expertise in health delivery lies. Ideally, the duty needs to be strengthened with accountability perhaps in the form of a single outcome measure to ensure adequate engagement.

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

We received a number of suggestions from our members on this and these are given below.

Statutory powers to have a real influence and make a real positive difference to delivery. This is especially so in relation to professionalism and a recognition of the value of bringing their medical knowledge and expertise to bear and the conviction that those with budgetary responsibility will listen to and act on good evidenced based and experimental advice.

A culture change – an assurance to clinicians and social care professionals that time spend in these activities away from care delivery would make a difference.

Time needs to be spent on fostering engagement and improving the recognition of human value capital within organizations'. Time needs to be available within people's roles to allow this engagement.

Providing time and consolidating a belief that there is a genuine appetite from both the Scottish Government, Local Authorities and Health Boards to follow through on the difficult task of shifting resources in order to achieve the kind of service rebalancing which has been known to be necessary for more than a decade. A sense of confidence over being able to influence what actually happens will also be essential for the present proposals to work.

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

Locality planning should be organised around geographical boundaries that make sense in different geographical areas. In general GP practices, community health services and Mental Health services work within such boundaries. Areas where boundaries are not coterminous should be identified by HSCPs and this issue, which is vital for effective joint working, resolved.

Ensuring GPs are on board with the proposals is pivotal. Using GP practices for locality planning will require a need for GP practices to adapt rapidly to provide a platform for integrated care. There will need to be care taken that this does not lead to fragmented locality planning. Within locality planning there needs to be central and regional guidance to avoid excessive local variation, or "postcode prescribing."

For Older People's services there is a view that the local acute hospital is so central to effective and efficient care that the locality for planning could be based round the acute hospital catchment area, with supported discharge schemes to local care homes working within this locality.

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

This depends on the size of the localities and the services based there. On balance, we favour strong central guidance on this with limited local flexibility.

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

We have concerns that organizing round too small a locality will bring too much variance in services, fragment specialist teams leading to a reduction in quality and make linkage with services such as acute hospitals problematic.

The optimal size of catchment population will vary. The size of a locality for a Dementia team will be smaller than that for acquired brain injury or eating disorders. HSCPs must have a positive approach to working with specialist teams covering larger populations.

In general, we think that 15-20,000 is too small for effective, good quality locality services for most purposes and 50,000 minimum would be better to achieve a critical mass of expertise and experience, with larger populations for more specialized services.

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