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Briefing paper on the Scottish Government Consultation on Integration of Adult Health and Social Care in Scotland

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SDF Scottish Drugs Forum

The Scottish Government has produced a consultation document on proposals for the **Integration of Adult Health and Social Care in Scotland**. Scottish Drugs Forum (SDF) has prepared this briefing paper to give a summary of the Government document and some comment on areas of particular interest for stakeholders in the drugs field.

SDF invites members and other stakeholders to respond and comment on these proposals and to contribute to SDF's final response.

The deadline for submitting responses to SDF is 6 September 2012.

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SDF Scottish Drugs Forum

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Integration of Adult Health and Social Care in Scotland

The Scottish Government produced a consultation document on proposals for the **Integration of Adult Health and Social Care in Scotland** in May. The consultation period ends on 11th September 2012.

BACKGROUND AND PREMISE FOR PROPOSALS

It is claimed that the proposals will address the traditional separation of health and social care – now referred to as the 'fault-line of 1948'.

The document describe "two key disconnects in our system of health and social care - that between primary care and secondary care and that between health and social care.
It is asserted that 'these disconnects make it difficult to address people's needs holistically, and to ensure that resources follow patients', service users' and carers' needs'; and that 'problems often arise in providing for the needs of people who access many services over prolonged periods, such as people with long term conditions, older people, and people with complex needs.'

SDF comment: *While there may be agreement that the disconnects described do exist, those between public, private and third sectors and between health and care and services including housing, welfare, employment services may be wider than that between health and social care; so too may the disparity in approach between the law enforcement/criminal justice and the health/care systems and these can impact on many people including problem drug users and people in recovery in similarly negative ways and prevent a holistic approach. Thus the proposals may be viewed as very limited in their scope and present a narrow vision of how services could be planned and delivered to offer holistic support to people with complex needs.*

The document claims that there has been "a good track record of partnership working over many years" but insists that such partnerships have not overcome a 'system of health and social care that still incorporates within it barriers in terms of structures, professional territories, governance arrangements and financial management that often have no helpful bearing on the needs of … service users, and in many cases work against general aspirations of efficiency and clinical/care quality.'

The document states that the Government 'need to reform the system to deliver care that is better joined up and as a consequence delivers better outcomes for patients, service users and carers … so that the balance of care shifts from institutional care to services provided in the community, and resources follow people's needs.'

The document quotes ***The Christie Commission Report: Commission on the future delivery of public services (June 2011)***.

SDF comment: *The proposed integration of health and care may not be, in itself, a guarantee of improving service response. The problems with the current system in adequately responding to complex needs of drug users despite the full or partial integration of services and of service planning and commissioning through Alcohol and Drug Partnerships evidences this. Interestingly, nowhere in the document are the experiences, good practice or lessons from the delivery of integrated drug and alcohol services or their joint planning and commissioning mentioned. This is concerning as there are lessons to be learned from these experiences. Also there are potentially lessons from the attempt to integrate health and Social Care in Glasgow in Community Health and Care Partnerships. The issues that arose in the attempt to integrate these structures will be crucial to the success of these proposals – an evaluation and review of the Glasgow experience may assist the implementation of these proposals.*

The link with the spirit of Christie in the terms of investment in prevention is perhaps weak. Instead the document focuses on the Commission's assertion that there is a need for radical change and that this may be resisted by institutions, an insight not unique to the Commission. Experience shows that this can be true. However, there may be concern that all opposition to these developments is simply dismissed in these terms.

WHICH SERVICES WILL BE AFFECTED?

The Government proposes that there should be legislation "to enable Health Boards and Local Authorities to integrate planning and service provision arrangements for all areas of adult health and social care."

However, they then prioritise the integration of services for older people. 'We recognise however… that assuring the ongoing provision of quality, sustainable services for older people is a priority. We propose that the initial focus, after legislation is enacted, will in terms of performance management be on improving outcomes for older people.'

SDF comment: *There is an apparent tension that is not resolved in the document as the Government then claims that 'the factors driving closer integration are particularly relevant to care and support for older people.' This last claim may be true but older people would not be the only group of people for whom integration would be 'particularly relevant'. Another obvious group to focus on would be problem drug users and people in recovery.*

The document points out that "Conditions associated with old age and frailty are often experienced much earlier than 65, particularly but not exclusively in areas with high levels of deprivation."

SDF comment: *This is true, as shown in SDF's research on the needs of older drug users. Health and Social Care services have been integrated wholly or partially for this group and with mixed results. Perhaps, it would be a missed opportunity if the lessons to be learned from this experience were not fully examined. They are not mentioned in the document.*

The Government promises to work with others to develop outcome measures for monitoring progress in terms of older people's services in the first instance, and also, over time, further measures to enable us to establish the impact of integrated services beyond older people's services.

The consequence of the focus on services for older people is that although all adult services will be able to integrate "the initial focus… will in terms of performance management be on improving outcomes for older people."

SDF comment: *It is hard to imagine that the significant investment in terms of management focus or resource spending on integration will be spent on any other than the area on which performance management indicators are developed i.e. services for older people.*

In terms of integration of wider services beyond health and care only housing is mentioned and only in terms of older people. The rationale for this focuses on easing hospital discharge. "It will be important that, in bringing primary and secondary health closer together, and health and social care closer together, partners ensure that housing services … are fully included in the integrated approach to service planning and provision, and that health and social care planning and local housing strategies are mutually supportive."

SDF comment: *Housing providers and services have a wider impact and potential role for many health and care service users including drug users and people in recovery. These have been delineated by the Advisory Group on Homelessness and Substance Misuse. The Government should be aware of their recommendations.* *www.drugsandalcohol.ie/12854/1/AGHSU_Recommendations_Paper.29.1.10..pdf*

The Government state that "the fundamental purpose of our proposals for integration is to improve people's wellbeing and cautions that "we will not succeed if, in bringing health and social care together, we overlook the need to build upon the progress that has been made in bringing third and independent sector partners to the table when planning delivery of services. The contribution of the third and independent sectors in enabling delivery of better outcomes is also a crucial factor in our wider public service reform plans."

SDF comment: *This acknowledgement may be welcomed but there is little detail on how this can be achieved. The experience of third sector organisations' involvement in drug service planning is inconsistent across different areas of Scotland but it may be fair to say that there are examples of good practice which could serve to inform some areas where there has been poor practice or where there has been no or little development in this area.*

WHAT IS PROPOSED?

The document does not give a list of proposals – the list below summarises and groups the proposals from various parts of the document -

Structures

- Community Health Partnerships (CHPs) to be replaced by Health and Social Care Partnerships (H&SCPs), which will be the joint and equal responsibility of Health Boards and Local Authorities
- H&SCPs will work in close partnership with the third and independent sectors and with carer representation.

Note - The proposals will not impose a single operational delivery arrangement on partnerships.

Planning and commissioning

- A 'strengthened' role for clinicians and care professionals in the commissioning and planning of services.
- The role of the third and independent sectors in the strategic commissioning of services for adults will be strengthened.
- H&SCPs 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.

Accountability

- H&SCPs will be accountable to Ministers, Local Authority Leaders and Health Board Chairs for the delivery of nationally agreed outcomes.

Performance Management

- National Outcomes will be developed and agreed
- National Outcomes will apply across adult health and social care
- National Outcome measures will focus, at first, on improving older people's care.
- A jointly appointed, senior Jointly Accountable Officer in each Partnership will ensure that partners' joint objectives, including the nationally agreed outcomes, are delivered within the integrated budget agreed by the Partnership.

Budgets and Funding

- Partnerships will be required to integrate budgets for joint strategic commissioning and delivery of services.
- Integrated budgets will include, as a minimum, expenditure on community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services.
- Under the control of the H&SCP all funding will 'lose its label' and no longer be health or care money. Alternative options for patient care – health visiting or social care for example will be purchased with the same money.
- Proportionally, fewer resources will be directed towards institutional care, and more resources towards community provision and capacity building.

WHAT WILL CHANGE IN THE PLANNING AND ACCOUNTABILITY OF SERVICES?

Currently there are two key components in the system for planning and accountability of the services affected by these proposals. These are:

- The 2007 Scottish Government / COSLA Concordat which introduced Single Outcome Agreements agreed between each Community Planning Partnership (CPP) and the Scottish Government. These are the mechanism by which CPPs agree local strategic priorities and demonstrate how those outcomes contribute to the National Outcomes that are part of the Scottish Government's National Performance Framework.
- For NHS Scotland, management plans and decisions for the delivery of nationally applied targets scrutinised and agreed with the Health and Social Care Directorates within the Scottish Government, with decisions for major service change ultimately sitting with Scottish Ministers.

Community Planning is currently being reviewed.

More detail on local governance and accountability is given in the section Governance, Structures and Accountability.

The document implies that current arrangements, for Adult Health and Care at least, will largely be replaced by the creation of H&SCPs and the National Outcomes.

WHAT WILL BE THE DIFFERENCE BETWEEN H&SCPs AND CHPs?

Health Boards and Local Authorities will jointly be required to set up a Health and Social Care Partnership. Each Partnership will cover one Local Authority area, and will replace current Community Health Partnership arrangements. The document explains that there is a "step change forwards from the Community Health Partnership model, in which Community Health Partnership Committees are sub- Committees of Health Boards, albeit with strong Local Authority representation."

The main differences between Community Health Partnerships arrangements and the new Health and Social Care Partnerships will be:

- Health and Social Care Partnerships will be the joint and equal responsibility of the NHS and local government. Community Health Partnerships are sub-Committees of Health Boards, albeit with strong requirements for Local Authority membership. The new Health and Social Care Partnership Committees will be Committees of Health Boards and Local Authorities.
- Financial authority for achieving outcomes, and the requirement to demonstrate value for money, will be delegated to Health and Social Care Partnerships by the Health Board and the Local Authority. Currently Community Health Partnerships have no delegated financial authority beyond managing Health Board community health budgets. Local Authorities are not required to delegate budgets to Community Health Partnerships.
- Decision making authority in relation to delivering outcomes will also rest with the new Health and Social Care Partnerships, without the need to refer decisions back "up the line" to Committees within the statutory partners.

Health Boards and Local Authorities will be jointly held to account for performance.

These proposals for the first time draw together performance management arrangements for teams working together across the NHS and local authorities.

There are currently 34 Community Health Partnerships. There will be one Health and Social Care Partnership per local authority area (32). Community Health Partnerships will be removed from the statute book. The document suggests that "partners may also find that other strategic forums or Committees are no longer required."

Where there is more detail provided, some of these proposals are dealt with in more detail below.

NATIONAL OUTCOMES

The document states that there will be "the introduction of a new set of nationally agreed outcome measures and standards for adult health and social care, with a particular focus initially on services for older people. From this starting point, "we will work with partners to develop outcome measures covering all of adult health and social care."

SDF comment: *This is the only mention of standards in the entire document and the term is not explained. Presumably there is no intention of introducing new care standards but confirmation of this may be useful. Clarification may be required.*

Health Boards and Local Authorities will be free to choose locally to agree joint outcomes for other areas of service. However, only the national outcomes for older people services will be subject to government scrutiny.

The specific outcomes themselves will not be written into legislation as they will be expected to change and develop over the years to come. Draft outcomes, focusing at this stage on older people's services only, are currently under development.

SDF comment: *It may be hard not to conclude that the focus on older people will mean that there is less focus on other service provision for others including problem drug users.*

The implications for the future of Alcohol and Drug Partnerships is not spelled out. If there is generalised integration of health and care how will the previously specialised integration of alcohol and drugs planning and commissioning operate? The delivery of national strategy may depend on a response to this challenge.

GOVERNANCE, STRUCTURES AND ACCOUNTABILITY

The **Cabinet Secretary for Health, Wellbeing and Cities Strategy**, **the Local Authority Leader** and the **Health Board Chair** will together hold the **Chair and Vice Chair** of the H&SCP, and the **Health Board Chief Executive** and **Local Authority Chief Executive**, to account for the delivery of the nationally agreed adult health and social care outcomes, the integrated budget and the development of community health and social care services.

A **Partnership Agreement** between the Health Board and the Local Authority will establish services to be delivered and outcomes to be achieved, within the context of the nationally agreed outcomes, and the financial input of each partner to an integrated budget to achieve those services. The Partnership Agreement will describe the mechanisms to effect integration of budgets locally.

A **Health and Social Care Partnership Governance Committee** will oversee the running of the H&SCP. The Health Board and Local Authority will nominate a Chair and a Vice Chair for the Health and Social Care Partnership Committee, which will rotate on an annual basis. The Committee will be made up of voting members and non voting members. Voting members will be an equal number of Health Board Non-Executive Directors and local elected members. (A minimum of three representatives from each statutory partner will have a mandate to act on behalf of their parent statutory bodies.) Non-voting members will represent the professional and service user perspectives and will include:

- The Jointly Accountable Officer (see below)
- Professional advisers
- Patient/service users' representation
- Third sector representation of the service user and carer experience of care.

SDF Comment: *There are several parts of the document which allude of the role of senior management and other figures including the Cabinet Secretary, Chief Executives of Health Boards and Local Authorities, Local Authority Leaders and Health Board Chairs however the document fails to show the relationship between these and how they will be held accountable or hold others accountable in practical terms. A diagram may help show the structure but the document gives little detail of powers or terms of reference. Mention of a 'community of governance' has to be substantiated with terms of reference. The role and structure of the H&SCP Committee's role, again, could be more detailed.*

Health Boards and Local Authorities will appoint a senior **Jointly Accountable Officer** for the H&SCP. The Jointly Accountable Officer will:

- report to the two Chief Executives, and through them to the Partnership Committee, which will be a Committee of the Health Board and the Local Authority
- be responsible for commissioning and managing services to deliver the nationally agreed outcomes using the integrated budget
- have a level of delegated authority from the Health Board and Local Authority that enables them to make decisions about use of the integrated budget without needing to reference to either partner organisation.

NON-ADULT SERVICES CURRENTLY PROVIDED THROUGH CHPs

Community Health Partnerships currently have responsibility for services that sit outwith the scope of these proposals; for example, they are also responsible for the delivery of children's community health services.

The Government anticipates that in some areas Local Authorities and Health Boards will include the budget for other services along with the budget for adult health and social care, and apply the H&SCP governance arrangements to the full range of current Community Health Partnership budgets and service delivery. However, others may choose not to integrate the budgets for other services along with adult health and social care, in which case the governance for other services might be provided by another Committee arrangement.

Whether or not other Community Health Partnership functions are managed within the H&SCP, the proposals for accountability to Ministers and Leaders apply *only* to adult health and social care services, and the nationally agreed outcomes relating to those. The delivery of 'other' national targets that fall within the integrated budget will be the responsibility of the Jointly Accountable Officer who will report direct to the NHS and Local Authority Chief Executives for these areas.

INTEGRATING BUDGETS AND STRUCTURES

The Health Board and Local Authority will be required to devolve budgets made up from primary and community health, adult social care and some acute hospital spend to the Health and Social Care Partnership. These will become integrated budgets, in which the resource will effectively lose its identity – those working with it to plan and deliver services will cease to view it in constituent "health" and "social care" parts.

Ministers will provide local H&SCPs with direction on the categories of spend to be included in integrated budgets as a minimum. Partnerships will be free to add other aspects of spend subject to agreement within the local Partnership Agreement.

Local partnerships will be free to choose which approach they take to integrating budgets. Under each option, a Partnership Agreement will establish the nature and scope of the Partnership. Staff could move between employers to support a shift in functions, if there were local agreement to such a change.

Health Boards and Local Authorities will be placed under a duty to put in place an integrated budget for adult health and social care, using one of the models described -

a) Delegation to the Health and Social Care Partnership, established as a body corporate

The Health Board and the Local Authority could delegate agreed functions to the Health and Social Care Partnership, which would be established as a body corporate of the Health Board and Local Authority.

The Health Board and Local Authority would agree the amount of resources to be committed by each to the integrated budget for delivery of services to support the functions delegated to the Partnership. The integrated budget would be managed on behalf of the Partnership by the Jointly Accountable Officer.

or

b) Delegation between partners

One partner can under current legislation delegate some of its functions, and a corresponding amount of its resources, to the other, which then hosts the services and integrated budget on behalf of the H&SCP. The financial governance system of the host partner applies to the integrated budget. A Partnership Agreement between the Health Board and the Local Authority establishes the functions and resources to be delegated between the partners.

In a delegated model, the delegating partner retains its legislative responsibility for the functions that have been delegated.

SDF comment: *Stakeholders may have a view on the pros and cons of these arrangements prescribed in the document and/or have evidence as to how similar arrangements have delivered for people affected by problem drug use.*

PROFESSIONALLY LED LOCALITY PLANNING AND COMMISSIONING OF SERVICES

In the document, it is claimed that "a criticism of some Community Health Partnerships has been the lack of perceived opportunity for professionals – including GPs, acute clinicians, social workers, nurses, Allied Health Professionals, pharmacists and others – to take an active role in, and provide leadership for, local planning of service provision." These proposals include a requirement for Health and Social Care Partnerships to put in place arrangements to address this.

There will be "a duty on Health Boards and Local Authorities to consult local professionals, across extended multi-disciplinary health and social care teams and the third and independent sectors, on how best to put in place local arrangements for planning service provision, at the level between Partnerships and individual GP practices. Having consulted, Partnerships will be required to put in place, and to subsequently support, review and maintain, such arrangements."

SDF comment: *It is possible that these proposals may, in their implementation, radically change the professional background and practice of personnel involved in planning and commissioning services. There may be concern that this narrows the focus of this work and that conflicts of interest will arise which may not be overcome by the usual established means.*

QUESTIONS ON WHICH THE SCOTTISH GOVERNMENT IS SEEKING A RESPONSE

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?

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?

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 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?

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

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?

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

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

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?

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?

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?

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?

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?

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?

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

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 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?

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?

The deadline for submitting responses to SDF is 6 September 2012.

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