



HEALTH AND SPORT COMMITTEE

AGENDA

9th Meeting, 2012 (Session 4)

Tuesday 6 March 2012

The Committee will meet at 10.00 am in Committee Room 6.

1. **Inquiry into integration of health and social care:** The Committee will take evidence from—

Anne Hawkins, Director, Glasgow City CHP, NHS Greater Glasgow and Clyde;

Julie Murray, Director, East Renfrewshire CHCP;

Jim Forrest, Deputy Chief Executive & Director, West Lothian CHCP;

and then from—

Elaine Mead, Chief Executive, and Jan Baird, Transitions Director, NHS Highland;

Bill Nicoll, General Manager, Perth & Kinross CHP, NHS Tayside;

Dr David Farquharson, Medical Director, NHS Lothian;

Dr Allan Gunning, Executive Director, Policy Planning and Performance, NHS Ayrshire and Arran;

Roddy Ferguson, Director, Fortuno Consulting Limited.

2. **Alcohol (Minimum Pricing) (Scotland) Bill (in private):** The Committee will consider a revised draft Stage 1 report.

HS/S4/12/9/A

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The papers for this meeting are as follows—

Agenda Item 1

SPICe briefing	HS/S4/12/9/1
PRIVATE PAPER	HS/S4/12/9/2 (P)
Submission from Glasgow City CHP	HS/S4/12/9/3
Submission from East Renfrewshire CHCP	HS/S4/12/9/4
Submission from West Lothian CHCP	HS/S4/12/9/5
Submission from NHS Highland	HS/S4/12/9/6
Submission from NHS Tayside	HS/S4/12/9/7
Submission from NHS Lothian	HS/S4/12/9/8
Submission from NHS Ayrshire and Arran	HS/S4/12/9/9
Submission from Fortuno Consulting Limited	HS/S4/12/9/10
Submission from Age Scotland	HS/S4/12/9/11
Submission from the British Medical Association Scotland	HS/S4/12/9/12
Submission from the Princess Royal Trust for Carers	HS/S4/12/9/13
Submission from the Scottish Association of Social Work	HS/S4/12/9/14
Submission from UNISON	HS/S4/12/9/15

Agenda Item 2

PRIVATE PAPER	HS/S4/12/9/16 (P)
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Agenda Item 1 6 March 2012		HS/S4/12/9/1
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HEALTH & SPORT COMMITTEE

INTEGRATION OF HEALTH AND SOCIAL CARE

INTRODUCTION

On 21 February 2012 the Committee decided to hold a small number of evidence sessions on the integration of health and social care. This was to provide the opportunity to discuss the Scottish Government's plans with a number of key stakeholders, in anticipation of the Government's forthcoming consultation on the topic, and future legislation.

This briefing provides Members with some background information they may find useful in preparation for the evidence sessions.

BACKGROUND

How best to support health and social services to work more closely is not a particularly new debate. Woods¹ (2001) notes that as far back the 1970s UK policy makers devised joint finance - a dedicated sum of money to be invested jointly by health and social services – as a way of facilitating better joint working. In the Scottish context Woods (2001) also describes how a number of labels have cropped-up to describe the policy of integration, for example: “joined up services”, “clinical or care pathways” and “care networks”. He explained: “Their common denominator is the purposeful working together of independent elements in the belief that the resulting whole is greater than the sum of the individual parts”.

However, the wider point raised by Woods and others is that “integration” can refer to different concepts and processes, each of which require health and social services to interact in particular ways. Petch² (p 5-6) argues:

“There is a range of terms used in the discussion of partnership working and potential models of integration between health and social care. It is essential that such discussion clarifies the meaning being attached to specific terms and that this meaning is clear to all the parties involved.”

¹ Woods, KJ, Prof. (2001) *The development of integrated health care models in Scotland*. International Journal of Integrated Care, Vol 1, April – June 2001. Available at: <http://www.ijic.org/index.php/ijic/article/viewArticle/URN%3ANBN%3ANL%3AUI%3A10-1-100271/57>

² See Petch, A. (2011) *An evidence base for the delivery of adult services*. Glasgow: Institute for Research and Innovation in Social Services. Available at: http://www.adsw.org.uk/doccache/doc_get_495.pdf

Reviewing available evidence from a variety of studies, including ones which analysed the results of integrated working in England, including the integrated teams in Torbay (p 33-40), Petch found that there is strong evidence that structural integration in itself does not deliver anticipated levels of service improvement:

“Differences in culture and in values and differentials in power tend to distort any blueprint and to undermine any projected model. Moreover major financial and time resources can be absorbed by attempts to implement such structural change without demonstrating effective outcomes.” (p 6).

Instead, it is the detail of local implementation that matters, with the evidence suggesting a number of dimensions key to effective service delivery across health and social care:

- the importance of culture
- the role of leadership
- the place of local history and context
- time
- policy coherence
- the need to start with a focus on those who access support
- a clear vision
- the role of integrated health and social care teams (Petch, p 7)

RECENT DEVELOPMENTS IN SCOTLAND

Some of the key developments in the run up to devolution and since are shown below:

Local Health Care Cooperatives (LHCCs) – created through “Designed to Care” (Scottish Office, 1997), and coming into being in 1999, these were part of Primary Care Trusts (PCTs) and organised round groups of GP practices in distinct geographical areas. They were not provided for through legislation. They were intended to bring health and social care providers together to deliver services.

‘Modernising Community Care: Action Plan’ – published by the Scottish Office in 1999 it aimed to secure better and faster results for people by focusing on them and their needs. It also sought more effective and efficient joint working based on partnerships between health, local authorities and other stakeholders.

The Joint Futures Group - established following a post-devolution summit of senior NHS and local authority personnel, which found that the vision of joint-working espoused in “Modernising Community Care” had not been fully realised. It published “Community Care: A Joint Future” (2000), which recommended securing better outcomes for older people through improved joint working, including developing arrangements for managing and financing joint services, and the introduction of a “single shared assessment”.

Community Care and Health (Scotland) Act 2002 – Part 2 provides Scottish Ministers with the power to introduce regulations that enabled further flexibility for joint working between NHS Boards and local authorities, by permitting them to make payments to one another, delegate functions and pool budgets. Such arrangements came into effect in January 2003. The Act also provides Ministers with intervention powers to direct NHS Boards and local authorities to enter into joint working arrangements where poor joint working prevails.

National Health Service Reform (Scotland) Act 2004 – As well as abolishing PCTs and acute trusts, bringing all the responsibilities under one unified NHS Board, it also required Boards to establish one or more Community Health Partnerships (CHPs) as subcommittees of the Board. CHPs were called for in the White Paper „Partnership for Care“ (Scottish Executive, 2003). They replaced LHCCs and were to bridge the gap between primary and secondary healthcare, and between health and social care.

However, despite such initiatives, there have been persistent concerns that joint working between partners has not been as effective as it could be, or that it has at least been patchy across the country.

Recent impetus to reconsider integration policy has come as a result of various pieces of work that have considered the impact of demographic change, the forecast increased demand for health and social care over the coming decades, and declining levels of public expenditure. This has led to calls for an increase in prevention, more personalised care and support in community settings, and less emphasis on acute services. Such work has included „[Reshaping Care for Older People](#)“³ and the „[Commission on the Future Delivery of Public Services](#)“⁴ (the Christie Commission), both of which envisaged greater integration of health and social care services as part of the solution to tackling such issues.

The Integrated Resource Framework

Recent work in Scotland has taken place through the [Integrated Resource Framework](#) (IRF) programme. This has been developed since 2008, set against the broad policy objective of the Scottish Government’s [Shifting the Balance of Care](#) (SBC) initiative.

The aim of the IRF is to enable local partnerships to understand more clearly their patterns of spend and activity across health and social care. This then helps local managers, clinicians and other care professionals to examine current service delivery and plan for improvements in quality, effectiveness and efficiency. Ultimately, it is hoped that partnerships will then be better equipped to realign their resources to support shifts in clinical/care activity

³ Scottish Government, COSLA and NHS Scotland. (2011) *Reshaping Care for Older People*. Edinburgh: Scottish Government. Available at: <http://www.scotland.gov.uk/Resource/Doc/924/0114884.pdf>

⁴ Commission on the Future Delivery of Public Services (2011) *Report on the Future Delivery of Public Services*. Edinburgh: Scottish Government. Available at: <http://www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf>

within and across health and social care systems. The IRF development process has two main phases:

- I. Map patient and locality level cost and activity information for health and adult social care and to provide a detailed understanding of existing resource profiles for partnership populations. This has been completed, and it was envisaged would be used in developing plans for the Change Fund for Older People.
- II. To develop mechanisms or protocols that describe agreed methods to allow resources to flow between partners, following the patient to the care setting that delivers best outcomes. There are four test sites across the country piloting different mechanisms, including the “lead agency” model, which is under development in Highland. The final evaluation is due to be published in March 2012. The other areas are Tayside, Ayrshire and Lothian. The test sites began their work in August 2009, and an [interim evaluation report](#) was published in June 2011.

Lead agency model

As noted in the section above this is the model being pursued in the Highland IRF Test site, and is the one that has received the most public discussion and debate. The lead agency model is that used in a number of partnerships in England, where it is known as lead commissioning. The Scottish Government⁵ (p 1) describes it as:

“...an arrangement via which statutory bodies as currently configured contract for the commissioning of services for a defined population. Contracting in this way allows Partnerships to pool their respective resources for the population of interest, into a single integrated budget for the commissioning of services. In many cases staff also transfer from one body to another to allow integrated service provision for the target population, which may be based on age (such as older people), or care groups.”

The Community Care and Health (Scotland) Act 2002 provides for similar arrangements to take place between NHS Boards and local authorities in Scotland. In terms of the Highland test site, its plans revolve round local authorities delegating adult social care to NHS Highland, and NHS Highland delegating children’s community services to the local authority. The new arrangements are to be in place by April 2012.

Integration and Community Health Partnerships

As noted above, it is argued that delivering public services in the future requires not just better joint working integration between NHS Boards and local authorities but also within NHS Boards themselves, most notably between acute and primary care. Key vehicles for achieving such aims are Community Health Partnerships (CHPs).

⁵ Scottish Government. (2011) *Lead Commissioning – A brief introduction*. Edinburgh: Scottish Government. Available at: <http://www.shiftingthebalance.scot.nhs.uk/downloads/1305042200-Lead%20commissioning%20introduction.pdf>

CHPs were established through the NHS Reform (Scotland) Act 2004. Under the Act, each NHS board must create at least one in their area, with the task of bridging the gap between primary and secondary healthcare, and also between health and social care. Audit Scotland⁶ (p 5) notes that CHPs were expected to coordinate the planning and provision of a wide range of primary and community health services in their area. This includes GP services; general dental services; all community-related health services; mental health services; and community-based integrated teams, such as rapid response and hospital at home services. NHS boards were also given flexibility to devolve any other function or service to the CHP. Audit Scotland found that two main types of CHP were developed – the health-led Community Health Partnerships and Community Health and Care Partnerships which sought to integrate social care into the partnerships.

Audit Scotland published a [report](#) on CHPs in June 2011. The principle aim of the review was to examine whether they were achieving what they were set up to deliver, including their contribution to moving care from hospital settings to the community. It is a wide ranging report containing a number of key findings, including:

- Despite their responsibilities, CHPs did not come with the necessary authority to implement the significant changes required.
- CHPs were set up in addition to existing health and social care partnership arrangements in many areas. This has contributed to duplication and a lack of clarity of the role of the CHP and other partnerships in place in a local area.
- Partnership working for health and social care is challenging and requires strong, shared leadership by both NHS boards and councils. Differences in organisational cultures, planning and performance and financial management are barriers that need to be overcome.
- Whilst noting the work of the Scottish Government in developing the IRF (see above), a more systematic, joined-up approach to planning and resourcing is required to ensure that health and social care resources are used efficiently. There are very few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available.
- Enhancing preventative services and moving resources across the whole system require effective joint working. NHS boards, councils and CHPs have a key role to play in this but it is not possible to identify individual organisation's contributions.

Amongst its recommendations Audit Scotland (p 7) considered that the Scottish Government should work with the NHS and local authorities to undertake a review of the various partnership arrangements that currently exist and assess these for efficiency and cost effectiveness. In addition, it called for streamlined indicators between local authorities and NHS Boards to

⁶ Audit Scotland. (2011) *Community Health Partnerships*. Edinburgh: Audit Scotland. Available at: http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf

enable better measurement of CHP performance, and also updated and consolidated guidance on joint resourcing. There were also recommendations for NHS Boards and local authorities, which included:

- putting in place transparent governance and accountability arrangements for CHPs
- collect, monitor and report data on costs, staff and activity levels to help inform decisions on how resources can be used effectively
- involve GPs in planning services for the local population and in decisions about how resources are used and work with them to address variation in GP prescribing and referral rates

SCOTTISH GOVERNMENT POSITION

A key part of the health and community care debate during the last Scottish Parliament election campaign was how to better deliver health and social care services, with most of the main parties being committed to some change or at least to consult on it.

On 12 December 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy [announced](#)⁷ the Government's plan to integrate adult health and social care. The key elements of the proposed new system are:

- Community Health Partnerships (CHPs) will be replaced by Health and Social Care Partnerships, which will be the joint responsibility of the NHS and local authority, and will work in partnership with the third and independent sectors
- Partnerships will be accountable to Ministers, leaders of local authorities and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people's care and are set to include measures such as reducing delayed discharges, reducing unplanned admissions to hospital and increasing the number of older people who live in their own home rather than a care home or hospital
- NHS Boards and local authorities will be required to produce integrated budgets for older people's services to bring an end to the 'cost-shunting' that currently exists
- The role of clinicians and social care professionals in the planning of services for older people will be strengthened
- A smaller proportion of resources - money and staff - will be directed towards institutional care and more resources will be invested in community provision. This will mean creating new or different job opportunities in the community. This is in line with the commitment to support people to stay at home or in another homely setting, as independent as possible, for as long as possible. The Scottish Government sees the Change Fund for Older People's Services as a vehicle for delivering such improvements

⁷ Scottish Government. (2011) *Integration of health and social care*. News release 12 December 2011. Edinburgh: Scottish Government:
<http://www.scotland.gov.uk/News/Releases/2011/12/12111418>

Aspects of these reforms would require legislation, and the Scottish Government⁸ is committed to holding a consultation on its proposals. Through its overall approach, the Scottish Government wishes to see:

- consistency of approach across Scotland and application in every council and health board area
- statutory underpinning
- integrated budgets to deliver some acute, community and social services
- someone clearly accountable for delivering agreed outcomes
- professionally led by clinicians and social workers
- simplifying rather than complicating existing bodies and structures
- be achieved with minimal disruption to staff and services, wherever possible

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SPICe Research
1 March 2012

Note: Committee briefing papers are provided by SPICe for the use of Scottish Parliament committees and clerking staff. They provide focused information or respond to specific questions or areas of interest to committees and are not intended to offer comprehensive coverage of a subject area.

⁸ Personal communication 27 February 2012