Integration of Health and Social Care
Royal College of Speech and Language Therapists

Speech and Language Therapy services will inevitably be affected by IHSC because SLTs -

- Work for an estimated 0.25 million plus people from birth to death in Scotland on essential life capacities of communication and eating, drinking and swallowing.
- Speech, language and communication needs (SLCN) are THE most common difficulties faced by children and young people (6% of all children and 50% of children from deprived communities).
- Have a key role in services for all major clinical priority groups – stroke, cancer, dementia, frail elderly, learning disability, mental health
- Work at all stages of the care pathway – from primary to secondary to tertiary care; from universal to specialist level services; from preventative to rehabilitation and reablement to end of life care.
- SLTs already work routinely across public health, social care, education and justice services as well as with private and third sector care providers.

Integration of Health and Social Care (IHSC) is a positive development for SLT service users if appropriate, accountable professional clinical leadership and governance structures and procedures are in place, supported and utilised to ensure safe, effective and person centred services for service users.

Learning so far – SLT experience in NHS Highland:
Based on her extensive engagement with the “Lead Agency” model pursued there, SLT Professional Head of Service in NHS Highland, Iris Clarke is;

a) Confident that the clinical governance and leadership proposals developed by NHS Highland thus far are good.
b) The process so far has presented good opportunities to communicate the value of SLT at all levels of service (universal, targeted and specialist) to both health and local authority colleagues.

Lessons learned from the exercise are;
a) Positive progress is crucially dependent on inclusive, mutually respectful and informed collaboration and communication between all those professions and other stakeholders involved in service changes.
b) Even with this – change is progressive and takes time.
c) Ensuring quality clinical governance at a uni-professional level in new agencies can prove challenging particularly where people work across care or age groups.
d) Efficient and effective change management of this size requires clear, widely owned and understood project planning from the start.

Ms Clarke’s detailed comments on the “Lead Agency” model in relation to clinical governance, operational outcomes and benefits of integration are given in the appendix to this brief.
Based on SLT learning in Highland RCSLT would want the Bill to;

1. Regulate for access to all the health and social care services users require – as described in national clinical standards.

2. Ensure adequate professional clinical governance structures and procedures are in place and utilised whatever the local IHSC structure which are at least equal to now in respect of access to advice from uniprofessional expertise.

3. Ensure all health and social care services users interests and needs are adequately and equally represented by establishing statutory AHP Directors with equal influencing power to Nurse and Medical Directors at national and local levels in the new structures.

4. Ensure services design is transparent, accountable and informed by evidence based risk assessment and management.

RCSLT ask the committee to consider during passage of the IHSC Bill.;

a) Hearing oral evidence from SLTs and SLT service users

b) Visiting AHP Health and Social Care Services

RCSLT would be delighted to support the committee in any way it can during it’s deliberations.

Royal College of Speech and Language Therapists
Appendix: SLT learning in Highland

In December 2010 the Joint Report by Chief Executive of Highland Council and the Chief Executive of NHS Highland made recommendations for integration. In that document they wrote...

**A: On Clinical Governance:**
- There must be sound Leadership, Governance and Accountability
- ...the lead agency would be responsible for establishing its own scrutiny and performance management arrangements for this.
- The implication of these proposals is that relevant staff will be ‘transferred’ to the lead authority and that authority will be responsible for their direct line management and deployment. ... the issues concerning the professional and clinical accountability of staff need to be fully considered.
- A risk register and risk management plan will be developed as part of the implementation plan and will be included as an integral part of all future progress reports.
- Those who deliver services, service users and their carers need to acknowledge that risks cannot be eliminated and that approaches to maximise a user’s potential may require the acceptance of a higher level of risk

The SLT experience:
In Highland a programme of work has been carried out involving all the key practitioners to develop individual Service Descriptors and more detailed Best Practice Statements for each of the NMAHP professions affected by the Integration Programme. This has been coordinated by an officer of the Programme Board for consistency and has resulted in transparent specification of processes and minimum requirements for safe service delivery. It has also allowed for quality service development opportunities to be explored in the context of the Lead Agency model.

The AHP Lead in NHS Highland with a portfolio for children’s services, with the support of the National AHP Lead for Children and Young People’s (C&YP) services has set up a C&YP AHP Forum for Highland, to take the process of monitoring and planning AHP services forward.

**A Professional NMAHP Leadership Framework within the Lead Agency Model**
was developed and submitted to the Programme Board in December 2011.

The NMAHP Leadership Framework
“...sets out the principles to be applied with regard to the role of the Executive Nurse Director within the lead agency model in Highland, and details the Nursing, Midwifery and Allied Health Professions (NMAHP) Leadership Framework and structure, developed to assure the reciprocal responsibilities in delivering safe, effective and personalised care within a Lead agency model...

…….. The principles, framework and structure require to be embedded in the governance and management structures that are developed for both integrated services in Highland (NHSH and the Highland Council).”

Using this document as a foundation, the more detailed specification of AHP and Uni-Professional Leadership is now in development. It is clear that this requires careful planning to accommodate the changes within the Lead Agency
Model (ie the restructuring of NHS Highland CHPs), the existing operational boundaries of Highland Council and the framework of the Argyll and Bute CHP which will continue to deliver cradle to grave services meantime.

As yet the uni-disciplinary leadership framework has not been agreed with the Council.

This is posing a challenge and there have been anxieties about the process expressed by a number of individuals, however the “Issues log” is carefully monitored and has been invaluable in identifying areas of potential risk to the service and users of the service. In view of the complexity of the task, interim leadership and management arrangements have been established which seek to ensure safety, stability of services and clinical governance remains throughout the interim phase whilst services are being re-aligned and reconfigured. It has been agreed that only those with 100% clinical commitment to C&YP’s services will transfer on 1st April 2012. The remaining “Cradle to Grave” practitioners will transfer on 1st April 2013 following service reconfiguration.

B: On operational outcomes:

- They must be Efficient and Cost Effective
- (The lead agency) would directly control all relevant staff and other assets. It would determine how to organise and manage delivery without referral back to the other partner.

The SLT experience:
In NHS Highland there remains a significant proportion of services currently delivered on a “cradle to grave” basis. This model has evolved in response to the needs of the remote and rural communities in Highland, where the critical mass is insufficient to sustain specialist practitioners. Having practitioners with generalist skills has provided the necessary flexibility and economy of travel time.

Disaggregating these services will require very careful risk assessment and in view of this, the NHSH SLT Action Plan has stipulated an options appraisal to be carried out as a priority within the next year in order to identify the model of delivery that will provide a safe and sustainable service of the highest quality within the spirit of Integration. The Professional Head of Service and the AHP Leads for the Children’s Service and for the Adult service will work on this exercise in collaboration with key staff and service users. There is also an AHP Workforce Planning exercise currently underway which will help inform this process.

C: On benefits of the integrated service design
- Integration would result “in fewer professionals to communicate with”

The SLT experience:
SLTs in NHS Highland currently operate within integrated teams in a diverse number of settings. In preparing the service specification there has been an opportunity to highlight these areas of good practice to promote the value and contribution of SLT in integrated teams and to serve as models for areas of practice where there is poor understanding of the SLT role, poor communication between agencies, blurred boundaries of responsibility and resulting duplication of effort and inefficiency.

It is essential that outcome measures are developed that capture the effectiveness of the Lead Agency model in terms of risks and benefits to the
service and service users and again, this will be addressed in the options appraisal and other aspects of the SLT Action Plan to be carried out over the next year.