Integration of health and social care

Age Scotland

Q1. What have been the challenges in better integrating health and social services in the past and are there exemplars of good practice?

Age Scotland is pleased to respond to the Committee’s inquiry into health and social care integration. Given the attempts to develop an integrated system over recent years, we have detailed below the major challenges and issues which have in the past derailed attempts at integration both in Scotland and the rest of the UK. Age Scotland fully support to drive to developing an integrated system. We believe it can help improve service for older people and has the potential to reduce costs in the long run for the public purse. However, we also recognise there are a number of challenges to overcome in seeking to implement this agenda.

Ageing population

The ageing population is a principal driver behind integrating health and social care. Managing the unplanned and often prolonged health and social care requirements of an increasingly older constituency is one of the main obstacles towards meeting this goal. Focusing limited resources on crisis management and immediate health and care needs means local authorities and health boards have fewer resources available (whether financial or staff resources) to direct towards building an integrated, outcome focused system. The number of people aged 75 and over is expected to increase by 84% between 2008 and 2033. Therefore, the challenge for public bodies is to address this issue before the associated costs of an ageing population – such as dementia, sensory impairment, restricted mobility and the construction of care homes – lead to integration only being deliverable if we are willing to accept unmet need as a trade-off.

NESTA (National Endowment for Science, Technology and the Arts) estimate that as a consequence of an ageing society and ill health, over the next 15 years Scotland’s public services will need an additional £27bn to cope with the increased demands in health, social care and justice alone due1. While the Scottish Government estimates that were we to continue delivering care services as we currently do, we would require an additional £3.4bn by 2031. This, in turn, would require:

- A new 600 bed hospital every 3 years for 20 years
- A new 50 bed care home every 2 weeks for 20 years.

The growth in demand due to demographic shifts needs to be considered within the context of the financial projections over the coming years. The draft budget for 2012-13 projected that, given the likely scale of spending cuts over the next 10-15 years; it could take until 2025-26 for the Scottish Budget to return to 2009-10 levels in real terms – an adjustment period of 16 years. This implies a cumulative real terms loss of approximately £39 billion from the base
year of 2009-10. Given decreasing budgets and increasing demand, all public bodies must, therefore, focus their resources on services which deliver effective outcomes for both service users and the public purse – for example, reducing unexpected admissions and tackling delayed discharge.

Integration should help deliver improved outcomes for older people and lead to reduced costs in these areas in the long-term. However, the evidence base for this is not yet fully established and many report that integration as a process could lead to increased costs in the short term. This risks discouraging some from pursuing the preventative support agenda, particularly in light of the fact that there is no single preferred model for integration.

**Model of Delivery**

Audit Scotland reviewed the performance of Community Health Partnerships (CHPs) and concluded that, despite Government support for them as vehicles for integration, they principally helped contribute to a landscape of duplication and confusion. For example, while CHPs were set up in addition to the existing health and social care partnership, they have not been given the necessary authority to implement significant change. CHPs have often run in competition with existing structures but with few powers or resources to deliver meaningful outcomes. The failure to substantially devolve power to CHPs has meant they lack status and authority, which has encouraged GPs to disengage from CHPs and work, instead, through health boards.

The challenge is that, despite the failure of CHPs to deliver the results hoped, no other model of integration exists to which the Government, Parliament or practitioners can look to as a guaranteed template on how to deliver an integrated, outcome-focused system. Indeed, both the Scottish Government and a review conducted by Sir John Arbuthnott for the Scottish Labour Party each favoured a continuation of the principle behind CHPs, whilst correcting some of their inherent problems, which are addressed in this paper below.

The appropriate mechanism for delivering health and social care in Scotland, in spite of the relatively small population of just over 5 million, must be around meeting local circumstances and will necessarily depend on the part of the country in which service users live. In areas where there are small populations and we find local authorities and NHS Boards are coterminous, the existing CHP model often fails to deliver any additional value towards achieving integration. A single public body consolidating health, care, police, fire and other services in island communities may be the preferred model for these parts of the country, while other parts of the country such as the Highlands are free to adopt their own approach. This fragmentation of models, while sensitive to the needs of communities, does, however, raise concerns about the ability of Government to ensure equitable standards and outcomes will be achieved across Scotland as a whole.
Outcomes-Focused

At present, supported care is provided for 90,000 older people in Scotland, the total cost of which is estimated to be £4.5bn out of an entire Scottish budget of around £30bn. Despite the significant levels of funding directed towards the delivery of an integrated system and improved outcomes, unexpected admission to hospital still cost around £1.4bn, almost a third of the overall cost of delivering care for older people. An integrated health and social system is only a legitimate goal for Government if this integration produces better result for patients (and can reduce unnecessary expenditure).

A major problem with the current system for commissioning care is that it often results in poor quality care. This can be best evidenced in relation to home care for people with dementia which is generic rather than specialist, poses a risk for the individual and is more likely to exacerbate admission to hospital or care home.

An earlier report on health and social care planning found:

“There are serious doubts about the analytical power of commissioners… It will require sophisticated economic, epidemiological, activity and cost modelling to determine what services will be needed over which periods of time and in which settings. Without this, services will change only incrementally – if at all and any imagined benefits for patients or costs will not be realised.”

The challenge for Government is to provide accurate information on how much is being spent and on which services for local populations. Potentially, the Integrated Resource Framework (IRF) developed by the Scottish Government will allow local care partnership to map their respective spends in order that it can be better utilised for the benefit of patients and communities. The ultimate goal is to ensure the result of these changes will lead towards outcome-based commissioning practices becoming the norm across the Scotland.

Integrating two cultures

Given there are two principal bodies responsible for health and social care as a collective public policy issue – with respect to health boards and local councils – any approach to integration must establish reporting arrangements which marry the needs of two different organisations cultures and targets. The problem in attempting to find a compromised position is the likelihood that priorities are not always aligned.

Audit Scotland has reported that NHS Boards, councils and CHPs have often failed to set out a joint vision, priorities, outcomes or resources for health and social care and, furthermore, that performance monitoring has not been linked to local strategies. The lack of leadership in both councils and health boards has allowed previously distinct organisational and structural issues to become
perceived as legitimate reason for not delivering on outcomes. The failure to formalise partnership working as a means of overcoming these, has inevitably led to inertia in the journey towards integration.

In addition to this, as perhaps may be expected, there is limited effective sharing of information across health and social care partners. The difficulties around data protection and IT systems which are incompatible for sharing information electronically have hampered previous attempts to exchange information and improve services. The Single Shared Assessment process should reduce the need for health and social care professionals to separately collect identical data sets from patients. However, different departments have IT systems which remain incompatible with sharing their data, which has led to a lack of engagement and from health and social care personnel.

**Governance, accountability and coordination**

In 2010, Sir John Arbuthnott examined the failed approach taken in Glasgow to create five localised CHPs. These had been established with a view to delivering integrated health and social care, and as partnership bodies they have dual accountability to both the NHS board and relevant council. Arbuthnott’s report highlighted a number of issues which led to the breakdown of the partnership, as well as a range of challenges which will need to be addressed in the development of any future models of integration. For example:

- Although the respective health board and local authority approved the approach, there was insufficient detail and reciprocity about the specific services and budgets which were to be devolved by each partner to the integrated CHPs. For example, while the Health Board devolved responsibility for all primary and community care services and budget to the CHPs, the council did not do likewise for all social care services. Auditors found this approach lead to decisions being taken outwith the authority of the integrated CHPs, thereby undermining its status and effectiveness.

- The public bodies did not implement a partnership agreement, joint financial framework or joint scheme of delegation. In absence of such agreements, there is a risk that any dispute could lead to relationships deteriorating, eventually precipitating a breakdown in dialogue to a point where the model fails, as happened in Glasgow. This has important implications for replicating this model throughout the rest of Scotland.

Furthermore, service users can easily be moved from one public body to another without the consequence of no-one taking responsibility for any identified failures in service delivery. The lack of a central organisation, let alone an individual within existing parameters, who can be held accountable for failures in service delivery is one of the principal barriers to a successful social care policy. A clear line of accountably can help drive an organisation’s or department’s work to ensure outcomes are delivered. The current multifaceted approach does not deliver this.
Too much focus on the acute sector

Shifting the balance of care from the acute sector into the community has been the clear policy direction of successive administrations in the Scottish Parliament, accompanied by a myriad of policies since 2000. However, the £1.4bn currently spent annually on unexpected admissions amongst older people, suggests that partnerships across the country are struggling to realise this aspiration in practice.

One reason for the focus on the acute sector is the reluctance amongst politicians and the public to make the case for community care at the expenses of specialist or large general hospitals in their location. Such a trade-off would, however, be necessary to adequately resource preventative support services, and maintaining the current focus of investment is unsustainable. The reality is that the closure of beds, wards and hospitals would ultimately free up resources to reinvest in community care help keep people out of hospital and care homes.

Despite increased resources going into the NHS, the focus on delivering resources in the acute sector is leading to mixed progress in the meeting of key outcomes. While there has been good progress in tackling delayed discharge, the outcomes around emergency admission to care homes have been less positive, with significant rise in the number older people admitted in 2009/10.

Good Practice

Despite the clear challenges facing the Government in delivering an integrated system there are a number of examples of good practice which have been developed across the country.

Clackmannanshire CHP: NHS Forth Valley and Clackmannanshire CHP have established a pooled budget for an integrated mental health service. While the council manages the budget on a day-to-day basis, both the NHS and Council have a service specification agreement in place to manage this arrangement. Since 2003, the number if people involved in the scheme has increased from 500 to 2,000, however, the type of service has shifted focusing on earlier intervention and prevention. Over the duration of the scheme, there has been a 35% reduction on people receiving psychiatric services.

Highland NHS and Highland Council: The Lead Agency model as proposed in Highland is one where two organisations agree that one agency or organisation will manage the delivery of agreed services on behalf of both. Although this will shift responsibility for delivery of certain agreed services, accountabilities will remain with both organisations. In relation to Planning for Integration, NHS Highland and Highland Council (The Highland Partnership) have agreed that they will work together to commission a full range of community-based children’s and adults’ services. As of 1st April 2012, Highland Council will manage the delivery of Children’s Services on behalf of...
both organisations, while NHS Highland will manage the delivery of Adult Services on behalf of both authorities. Following the establishment of this programme, the daily average number of occupied beds in Torbay fell from 750 in 1998/99 to 502 in 2009/10. Similarly, emergency bed day use in the population aged 65 and in 2009/10 was the lowest in the region (1,920 per 1,000 of the population compared with an average of 2,698 per 1,000. Furthermore, delayed transfers of care from hospital have been reduced to a negligible number, something which has been sustained over a number of years.\viii

Q2. What would the detail of the Scottish Government’s proposals need to address to overcome the barriers to integration?

The Government’s proposals on health and social care integration legislation will not include the creation of a new body that merges NHS and local authority social care services\ix. Instead, the main characteristics of new system will be:

- Reform of the current CHPs, making them the joint responsibility of the NHS and councils, as well as accountable to the government and local authority leaders
- 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.
- Direct a smaller proportion of resources – in terms of money and staff - towards institutional care, with more resources being invested in community provision.

With respect to the specific elements detailed in the announcement, Age Scotland is supportive of the overall direction of travel set out by the Government. The issue of outcome-focused integration is something that must be addressed jointly by health boards and local authorities, and the process must deliver more resources for the community sector to deliver better outcomes for older people.

However the Government must be aware of raising unrealistic expectation that integration will, in itself, deliver improved outcomes immediately. The reality is that coordinated actions across partner bodies will take some time to bed in and deliver improvements to the patient experience. There are a number of common issues found in failing partnership working that will have to be addressed by the Government in creating any new integration approach

- Clarity about outcome and timeline for delivery;
- A realistic approach to outcomes;
- The major driver for change (outcomes for patients);

Age Scotland is keen to see how the Government plans will address the issues raised in Question 1 under ‘model of delivery’. Some additional questions to be answered around this include:
- What steps will be taken to ensure there is effective engagement with the new Health and Social Care Partnerships from all relevant bodies?
- Will the Partnership be given appropriate powers and a budget to deliver on agreed outcomes?
- How will it contribute to the integration process rather than confusing the landscape?
- How will the proposals allow for any local determination on what integration should look like across different Partnerships?

In addition to this, given that any integrated system will, by definition, bring two different organisations and cultures together to deliver a shared objective, there is a fundamental requirement that good governance is in place to ensure transparency around decision-making and that there exists a framework of accountability. Age Scotland believe the Government proposals on integration must contain a number of key features:

- Strong leadership and commitment from health and council management to develop a joint strategy
- Strategy that focuses on outcomes and not institutional processes which are defined and shared by all partners
- Clear decision making process and accountability built into the structures
- Reporting systems compatible with partner organisations
- On-going monitoring of costs and effectiveness of initiatives.

Priority on prevention

With the development of the Change Fund, the Scottish Government has already stated that prevention is a priority with respect to health and social care and, indeed, public services in general. Given the costs associated with an ageing population, a preventative approach to health and social care services is the most pragmatic and appropriate basis for spending decisions. The development of an integrated care system must complement and build on the work in this area. However, one principal concern about the Change Fund in its first year was that some of the monies were mis-apportioned and were not used to exclusively fund preventative programmes, but instead were focused on institutional care:

- Evidence from the first six months of this year’s programme show that only 18% of the current spend had gone towards preventative and anticipatory care. 19% went toward hospital and institutional care, 24% went towards support and care at home (some of which could be preventative) and 33% for care at time of transition (e.g. re-ablement, NHS 24, alternative to emergency admissions) and 6% on enablers like workforce development and IT.
- Third Force News carried news of anecdotal reports about a council using change fund money of £1m to buy in social care services from their own in house provider to cover their own budget shortfall and £3m for two years and £2m in year three to purchase care home place.
The development of any new single commissioning body has the potential to dwarf the existing third sector and marginalise its contribution to health and social care. This would reflect how the input of third sector has been largely marginalised through with local Change Fund partnerships and lead to the above spending patterns. This could undermine the necessary focus on innovative preventative approaches in which the third sector has a proven track record of delivery. For example, South Ayrshire Carers Centre received £80,000 to seek out and link up older carers in rural areas—ensure they were accessing the right support and were not isolated. Additionally, Alzheimer Scotland has a successful post-diagnostic support for people with dementia. This latter project worked with people with dementia for up to a year to ensure they were better informed and equipped with skills to manage the challenges of living with dementia. Furthermore, it provided support in the way best suited to the individual, thereby maximising the benefit from the allocated budget and minimising the need for crisis intervention. Specialist early intervention with dementia can not only delay admission to a care home for up to two years but the cost of two weeks care home fees will pay for a year’s support for an individual following diagnosis.

There exists the potential for any new integrated system to have its social care value and priorities dominated by the health system. Given the high media profile of the acute sector, it is conceivable that resources could be siphoned away from preventative care work to tackle medical work which commands attention from the broadcast media. This has been the experience in Northern Ireland under their integrated health and care model, and has helped curtail a shift in resources from the acute to the community sector.

The examples detailed above demands that any model in Scotland must give a higher profile to social care to ensure it is not subsumed by health services and has a robust evidence base to inform its commissioning decisions around preventative spending. Indeed, Age Scotland expect to see an outcome focused system prioritise investment in prevention, with services commissioned on the basis of results rather than on a fixed service volume, based on hourly rates or historical allocations. This includes adapting the commissioning of care and support services to take account of greater personalisation in the form of individual budgets and direct payments in light of the Scottish Government’s Self Directed Support Bill being launched in March 2012.

**Commissioning**

Examining the evidence of different models across the UK, it is clear that some means of merging health and social care budgets and/or having a single body responsible for commissioning all older peoples’ services, is the preferred way to develop an integrated health and social care system. Different masters, separate budgets, parallel structures and cultures have created a turf war between health and social care. What older people desire and require, however, is to experience health and social care as a single service that gives them the care they want when they want it. To ensure that
any new system truly puts the service user - the older person - first, there must be a significant shift in the resources available to support older people in the community. Age Scotland is, therefore, pleased that the Government’s announcement addresses these two issues. The key test of the Government’s integration plans will be delivering a step-change in the level of community-based services that older people need. Resource transfer has been a tension between health boards and local authorities previously, with CHPs given only limited budget to deliver on their outcomes. Therefore, any new model will have to overcome historical barriers about devolving budgets. However, this process may be made easier if organisations are compelled to do so through statute and we look forward to seeing further detail of the Government’s plans around this in due course.

This change in commissioning will require any new body to have a much deeper understanding of service costs and what they deliver in order to make informed decisions about commissioning. This will involve not only drawing on the experience of the Integrated Resource Framework, as detailed above, but also utilising the expertise of the third sector, which has the capacity to play a crucial role in reforming health and care systems if it is given the opportunity to contribute.

Standards

Another major driver behind integration is the belief amongst service users that standards and services are different across the country. When Age Scotland consulted with our members on the issue of integration, the main message is that older people want to know why we cannot provide the same service regardless of the part of the country in which they live. We understand that the means of delivering can be different from one authority to another; however, there must consistency in outcomes, quality and efficiency in every local authority and health board area. The Government must commit to a challenging yet realistic outcome for all service users and develop these with local partners, health boards, GPs and local authorities as well as co-producing indicators for a monitoring and reporting regime. Integration must not, however, be an end in itself. The main priority must be an outcome-based approach to health and social care, which the charity agrees is best achieved through integration.

Age Scotland believe that any outcome based framework must cover (i) preventing admission, (ii) speeding up discharge, (iii) improving anticipatory care and (iv) focus on prevention, rehabilitation and re-ablement. Critically though, it is not possible to disentangle outcomes from accountability. Enshrining the integration process in legislation will help develop a line of accountability to the Health Minster. At a local level, however, older people must have a single point of contact where they can access if they need to raise concerns about the quality of the service. One simple, local test of accountability to review the effectiveness of service improvement could be around identifying whether people know where to turn to when thing go wrong. This is why the appointment of a single accountable officer for each partnership is also a very positive development. The standard method of
passing responsibility between two different organisations, with neither acting in the service user's best interest, must be eradicated.

**One Size fits all**

The previous question addressed the issue about having local flexibility in developing an integrated system and that no one system delivers the best results per se. The main driver of successful integration is not the specific system but the detail attached to local implementation. For example, in Torbay, the integrated model developed over a lengthy period, building slowly in order to maintain a focus on outcomes.

While Age Scotland does not believe any one model can meet demands for integration and that the degree and rate of integration should reflect local circumstances, there are a number of common features that the Government should seek to ensure are in place with any new system. These include: a single point entry; GP engagement; outcome based commissioning and a multi-disciplinary team.

Furthermore, it is essential to ensure there is a common understanding about what the model is designed to do. When dealing with commissioning, the priority should be to focus less on the organisational structures and more on the relationship between managers and professionals who make the key decisions. This requires strong leadership and a collectively agreed vision within the new integrated body that can deliver successful partnership working across two different organisations and cultures. Beyond the leadership, there are a number of technical elements that need to be addressed to eliminate local barriers. These include an agreed mechanism for collating and sharing data, appropriate governance and dispute resolution procedure and agreeing commissioning strategies and outcomes through partnership working.

**Age Scotland**

---

1. Radical Scotland, NESTA, October 2010
3. Audit Scotland Review of CHP, June 2011
5. Single Public Authorities for the Islands, CSPP, June 2011
6. Commissioning Toolkit for long term conditions (Asthma UK; BHF; Diabetes UK)
7. Audit Scotland Review of CHP, June 2011
12. An evidence base for the delivery of adult services, ADSW, August 2011