Integration of health and social care
Coalition of Care and Support Providers in Scotland (CCPS)

Key points

- Integration is a means to an end, not an end in itself
- Successful integration will be as much about culture and behaviours as it is about ‘technical’ or legislative detail
- Integration of health and social care is an opportunity to create strong partnerships that go beyond a narrow focus on joint working between the NHS and local government
- Involving people in the design of their care and support, and enabling them to exercise appropriate control over how it is delivered, must be at the heart of integration in order to drive change and better outcomes
- Improving older people’s care and support is a clear priority, but proposals for integration must take account of the potential impact on everyone who uses care and health services
- Improved joint commissioning of care and support is crucial to better outcomes

CCPS welcomes the committee’s inquiry and is pleased to submit this short paper, focusing on the challenges to integration and how these might best be overcome. We have appended some further additional thoughts about the integration agenda for the committee’s consideration.

Challenges to integration, and proposals to overcome them

As the committee notes, integration of health and social care is a long-standing agenda.

The challenges to joint working and partnership have been well documented over the years, most comprehensively and recently in the Joint Improvement Team’s 2009 series of briefing notes (available on line at http://www.jitscotland.org.uk/supporting-partnership/briefing-notes-for-practitioners-and-managers/).

The JIT identifies the key areas where barriers to partnership working exist: structures; skills; people; roles; behaviours; environment; processes; and culture. Some of these can be addressed by legislation (structures, processes) whilst others (behaviours, culture) are ‘softer’ areas that will need to be approached by other means, including training and development, management and leadership. We would therefore be keen to ensure that proposals to promote health and social care integration do not focus disproportionately on ‘technical’ or legislative issues.

The Cabinet Secretary’s announcement in December 2012 addressed a
number of the barriers identified in the JIT paper, and we would comment on these as follows.

• **Integrated budgets:** whilst supportive of this element of the proposals in principle, we would like to see further clarification of what ‘integration’ will mean in practice. Earlier initiatives in this area have involved ‘pooled’ and ‘aligned’ budgets, rather than ‘integrated’ budgets, with the amount contributed by individual partners being largely a matter for agreement – with the implication (and on occasion, the result) that those same individual partners are able to withdraw their contribution. We believe that there is a strong argument in favour of an ‘integrated’ budget being composed of most if not all of the resources controlled by individual partners, in such a way that these cannot later be withdrawn.

One of the virtues of such a measure, from a third sector perspective, is that whilst some third sector providers are involved in the provision of acute or intensive services, most are placed further ‘upstream’, contributing directly to the prevention of escalation of need and consequently to a reduction in demand for more costly acute services later on. The value of third sector support in this respect is not always recognised under current arrangements, because the budget of the public body providing the funding for it is not always affected by its consequences (although the budgets of other public bodies may be). This is another facet of what the Cabinet Secretary refers to as ‘cost-shunting’. We can therefore see significant value in the proposal for fully integrated budgets, as we suggest, because of their potential to recognise and enhance the role that the third sector plays in keeping people safe, well and out of hospital or other institutional care.

• **Accountability:** health and social care have been subject to a “hands-on/hands-off” approach to accountability as a result of the different imperatives of the key public sector interests involved: the NHS is driven by central HEAT targets and is directly accountable to the Cabinet Secretary, whilst local authorities work to more local outcomes and accountability arrangements and looser central monitoring. Neither, in our view, have placed sufficient emphasis on the early intervention and ‘upstream’ activity that will reduce demand and impact on outcomes and budgets: a set of jointly agreed outcomes that include such an emphasis, and for which partnerships will be accountable within both NHS and local authority structures, is a positive step forward: the appointment of a single accountable officer for each partnership would also be very positive.

• **Nationally agreed outcomes:** we understand why ministers have opted to avoid the upheaval and disruption that would result from large-scale structural reorganisation, and to focus instead on better outcomes as the key driver for change. However, given that delivery arrangements are to remain a matter for local agreement, a very great deal will depend on the nature of these outcomes and how progress towards them is monitored. We have significant concerns, in this regard, about modelling the change process on the type of outcomes that make up Single Outcome Agreements: in our view, these are not always sufficiently clear or measurable, not enough independent scrutiny is brought to bear in assessing progress towards them, and there appears to
be little or no sanction for failure. If the goal is to bring about major change and improvement to care and support, then something much more robust may be required.

Further issues for consideration

• **Keeping the focus on change and improvement:** CCPS is keen to ensure that integration is seen as a means to an end, not an end in itself. The objective is transformational change resulting in improved outcomes for people with care and support needs: we have some concerns that this objective may become lost, as health and social care partners become immersed in the detail of agreeing new arrangements around structures, accountabilities, workforce, and so on.

• **The role of self-directed support:** integration is undoubtedly a key element in bringing about change in health and social care, but it is not the only one. In 2010 the government published a 10-year strategy for self directed support in Scotland, and intends to legislate in 2012. It is therefore a matter of concern that there was no mention in the Cabinet Secretary’s announcement of the role that SDS can play in helping people to identify and shape the care and support that is right for them. We would want to ensure that the SDS principles of choice and control are knitted into the integration agenda as the proposals are developed, as we believe that this will be major driver of change.

• **Integrating health and social care will require the involvement of a wide range of partners:** already, discussions taking place in the field about integration relate almost uniquely to closer working arrangements between the NHS and local government, whereas most social care and support is delivered by third and private sector organisations, families and unpaid carers. There is an opportunity here to create a much wider partnership with shared ambitions for better quality and better outcomes.

• **Wider implications for care and support in Scotland:** we understand why ministers have opted to begin the process of change for older people’s services specifically. However we are concerned about the impact on support for other groups, including adults with learning disability and mental health problems, children and families, since all the priorities and drivers for integration relate to matters – such as delayed discharge and shifting the balance of care – that may not be relevant to these groups. We would not want to see the introduction of two distinct systems emerging, one integrated, and one not; far less, a programme of change with major implications for other groups that is not led by priorities that are relevant to them.

• **Service quality and cost:** we agree that the quality of care and support needs to improve. We have consistently maintained, in our evidence to Scottish Parliament committee inquiries and elsewhere, that the severe downward pressure now being placed on costs in the third sector is likely to have significant consequences for the quality of care and support. We strongly support the recommendation in the Health and Sport Committee report of its inquiry into the regulation of care for older people, that the Scottish
Government should examine the merits of extending the powers of the Care Inspectorate in relation to commissioning and procurement, particularly now that joint commissioning is to become a central feature of the programme for integration and reform. Care that is poorly commissioned poses as much of a risk as care that is poorly delivered, as we believe the recent Audit Scotland report on social care commissioning highlights.

About CCPS

CCPS is the coalition of care and support providers in Scotland. Its membership comprises more than 70 of the most substantial third sector providers of care and support, supporting approximately 270,000 people and their families, employing over 45,000 staff, and managing a combined total annual income in 2009-2010 of over £1.2 billion, of which an average of 73% per member organisation relates to publicly funded service provision.

Care and support in the third sector

The third sector is at the forefront of quality care and support in Scotland. More than a third of all care and support services registered with the Care Inspectorate are provided by third sector organisations. In many areas of care and support for adults and older people – including care home provision, care at home and housing support – third sector services receive a higher proportion of ‘very good’ and ‘excellent’ quality gradings from the Care Inspectorate than their counterparts in either the public or the private sector.

The CCPS agenda for care and support

• More choice and control for people over the design and delivery of their own care and support, including, wherever possible and appropriate, the ability to direct how resources are spent

• A new agenda for all care and support agencies to foster independence and autonomy, increase wellbeing and promote resilience and self-help

• Greater priority for early intervention that prevents escalation of need and more costly service responses later on

• A better match between the requirements of the regulatory regime, and the agenda for greater choice and control, independence, outcomes and early intervention.

Our agenda for a stronger third sector

• Recognition and respect for the third sector as an engaged partner, not just a contracted supplier

• Funding incentives for high quality support that has a positive impact on individuals, families and communities

• Commissioning for outcomes, not for fixed service volumes based on hourly rates
• Creative alternatives to competitive re-tendering of existing care and support services

• Appropriate reward for a confident, competent and qualified third sector workforce.

CCPS - Coalition of Care and Support Providers in Scotland