



Integration of Adult Health and Social Care in Scotland

**UNISON Scotland's Submission to the Scottish Government on their
Consultation on the Integration of Adult Health & Social Care in
Scotland**

September 2012

Introduction

UNISON is Scotland's largest trade union representing over 160,000 members working in the public sector. We represent over 60,000 health staff as well as social workers, social care staff, who are part of adult health and social care workforce, many of whom will be affected by the Scottish Government's proposals.

UNISON Scotland welcomes the opportunity to respond to the Scottish Government on their consultation.

General Comments

UNISON Scotland members have been involved in various proposals for the integration of health and care services since the late 1990s when Local Health Care Co-operatives were first launched, followed by the Joint Future initiative through to the NHS Reform (Scotland) Act (2004) which established Community Health Partnerships (CHPs).

Despite all the policy and legislative developments joint working has not worked well in all parts of the country, although there are many examples of excellent service improvement across Scotland. However, the new emphasis on demographic change is now driving further initiatives to meet the increased demand and costs that an ageing population may need. In its recent response to the call for written evidence to the Scottish Parliament's Health and Sport Committee on Demographic Change and the Ageing Population, UNISON advised caution over the projections, as there is some evidence that while the population is getting older, it is also getting healthier. Inward immigration is also rebalancing the age ratio of Scotland and the rest of the UK.

Recent developments have included Reshaping Care for Older People (2011) which provided Change Fund monies to introduce innovative plans for increased preventative and personalised services with support in community settings rather than acute hospitals and which included housing and leisure services. In addition, the Christie Commission (2011) recommended greater integration of health and social care in its review of the delivery of future public services, although it did not support top down structural changes, but expressed a preference for local initiatives.

The Integrated Resource Framework (IRF) aimed to enable local partnerships to better understand patterns of spend and activity. They mapped data and support in test sites in Highland, Tayside, Ayrshire and Lothian.

Lastly, the lead agency model was used as the model for the Highland IRF test site. It involved the local authority transferring adult social care to NHS Highland, and NHS Highland transferring children's community services to the local authority. This involved wholesale change of employment for

affected staff and associated budgets. The new arrangements were implemented in April 2012, but major issues still remain to be resolved in terms of actually providing fully integrated services.

The financial pressure on social work and NHS budgets is already intense following cuts in recent years. Many local authorities have or are planning to privatise care services or expand personalisation in an effort to cut costs. The impact on the Community sector has been particularly severe, with job losses and cuts in pay and conditions right across the care sector

The Scottish Government has also introduced the Social Care (Self-directed support) Bill that, while sound in principle, could also lead to a further race to the bottom in social care.

Evidence from a range of studies indicates that structural integration in itself does not deliver anticipated levels of service improvement. For example, Petch (2011) stated that:

“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).

These studies show that local implementation is the key to effective service delivery across health and social care and that depends on culture, leadership, local history, context, time and vision. This is reflected in a critical Audit Scotland report on CHPs in June 2011. Despite IRF, Audit Scotland found few examples of good joint planning and recommended a review of the various partnership arrangements.

UNISON Scotland does not therefore support the options set out in the consultation paper, particularly options that involve the transfer of services from local democratic control to the NHS. Democratic accountability is a key principle for UNISON Scotland. A balancing consideration for UNISON Scotland is that social care in local authorities is being cut and outsourced at a pace that is likely to seriously undermine the delivery of services over the coming years. Some benefits for staff (and services) have been achieved in Highland, for example an agreement to pay the Living Wage to relevant former local authority staff, and the extension of the NHS no compulsory redundancy policy to all staff transferred to NHS Highland. The likely effectiveness of any proposals in protecting services from privatisation will therefore be a factor in our consideration.

All the evidence shows that top down reorganisation does not achieve integration and these plans are much more prescriptive than they claim to be. A more constructive approach would be to focus on joint outcomes, with local partners agreeing operational arrangements relevant to their local circumstances.

Questions

The case for change

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?

UNISON Scotland agrees that there needs to be a focus on older people's services in the first instance, but we are not clear what the strategic aims are. We are concerned that central direction through outcomes will be too prescriptive, undermining local solutions to local circumstances.

We believe that the proposals are too prescriptive and do not allow for sufficient determination at local level where the focus should be on the joint outcomes which need to be achieved.

We do not believe, however, that we should lose focus on the importance of other issues, such as health improvement, across other age groups, as these are important to ensure that people reaching old age are as healthy as possible.

Outline of proposed reforms

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?

We do not believe that the proposed framework is comprehensive as it is not only health and social care that determines the wellbeing of older people. Housing, suitably adapted where necessary and leisure services are all part of an integrated service that needs to be delivered for older people.

One of the greatest challenges for implementation of the proposals will be the difficulties in bringing together two large groups of staff who have their own cultures, terms and conditions as well as a range of other workplace issues that appear to have been given very little consideration in the proposals to date.

In addition, whilst the proposals are very prescriptive with the organisational arrangements, they say little about how the local implementation would be achieved. As evidenced in the Christie Commission, we do not believe that top-down structural change delivers the desired improvements and local determination of joint outcomes must be provided.

National outcomes for adult health and social care

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. 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?

As stated above, the arrangements must be put in place for local implementation of the proposed national outcomes.

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

Yes we believe that the Single Outcome Agreements should be the method for delivery at the highest and lowest levels of the structure. These are agreed locally not determined solely by ministers.

Governance and joint accountability

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?

No, local democratic accountability is a key feature of local authorities as they are accountable to the electorate. We do not believe that the proposals as they currently stand gives adequate recognition to the role of councils.

Local democracy is the opposite of centralism. Instead of government decisions being taken at one central point, they are dispersed to councils that have been elected by local people. Services provided closer to their point of use better reflect local need and can be more effective than if provided by central government. Local citizens know best how to spend local money raised by local taxation.

In recent years we have seen a gradual drift in services away from democratically elected councils to the centre in Scotland. We believe these proposals are a further centralising measure with some 15% of council budgets being shifted to a Jointly Accountable Officer, subject to NHS style performance management from the centre. This gives insufficient weight to the role of elected Councillors, responsible to their electorate not a central government minister.

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

This should be a matter for local determination. Although this should not be seen as an opportunity to create larger administrative units. By European standards Scotland already has very large local authorities.

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

The governance and democratic accountability arrangements in the new Health and Social Care Partnerships look too weak for the major implications their decisions could have for health boards and councils. Decisions on acute services could impact on the viability of acute hospitals and typically 15% of council budgets will be transferred with consequences for remaining services. Such decisions require much stronger democratic scrutiny. We are also unclear about how the Jointly Accountable Officer will balance conflicting accountabilities. Whilst the proposed committee arrangements are similar to those currently used in informal partnership in some authorities to implement some joint outcomes, they are not sufficient to govern a decision-making body to ensure that democratic accountability can be sustained. The proposals would remove all social care from the province of the council committee structure which governs services and budgets for delivery of those services.

In addition, it would undermine the roles of the Chief Financial Officer and Chief Social Work Officer, both of which are statutory appointments and this situation must be addressed.

There are different approaches to health and safety and asset management between health and local authorities – these will need to be reconciled. As we highlight at the end, workforce issues are largely ignored in the consultation paper. There are major staffing issues that should be addressed through a staff governance framework that offers a system of industrial democracy ensuring the opportunity for staff and their trade unions to be fully involved, from an early stage, in the formulation and implementation of change within the service.

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?

The role of the inspection agencies must be outlined more fully in the proposals if the public are to have confidence in any new structures. Performance management arrangements from the centre are reasonable in an NDPB structure. However, different arrangements apply to local authority services that are accountable to the local electorate.

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?

We believe that this should be a matter for local determination. However, clearly there will need to be differences between the make up of the proposed Health & Community Care Partnerships - a one-size fits all approach will not accommodate the needs of the various areas of Scotland.

Also as outlined above in Q2, housing and leisure services are an integral part of providing comprehensive services to older people.

In addition, we do not believe that the proposals ensure that the essential links which exist between any care services transferring and other Council services are not put at risk. For example, Mental Health and Criminal Justice, Children's disability services and Adult services in relation to transition, social care and housing adaptations, community support for learning disability with Leisure services, etc. There are similar concerns about the viability of some acute hospitals when wards are closed.

It is unclear whether the new arrangements will inherit or share local authorities' responsibility for the "promotion of social welfare". We are not sure why councils would invest in creating stronger supports in communities if they had no responsibility for providing care.

We are not clear whether the new organisations would continue to employ Community Development staff in order to support the delivery of the "community development approach"

We would also wish to know where public health responsibilities would sit in the new structures.

We are concerned that these proposals would have a serious impact on the viability of local government. It looks like a further attempt to centralise control of council services following on from the reintroduction of ring fencing and the centralisation of police and fire. The involvement of the third and private sectors together with housing stock transfer, the creation of trusts and arms length organisations, all lead to the fragmentation of service delivery which is not dissimilar to the 19th century mess that local government was created to resolve. Therefore these proposals need to be viewed in the context of defining the future of local government in Scotland.

Integrated budgets and resourcing

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?

There is limited information in the consultation paper on how much the proposals will cost, including set up costs, staff transfer etc. In the current financial climate there would need to be a robust cost benefit analysis.

It is unclear how joint budgets would operate and the financial accountability of pooled or integrated budgets. This has not been achieved to date.

The situation with VAT would need to be clarified to ensure that any status changes would not result in a loss of funds for services in Scotland, as they have been in the centralisation of police and fire.

It is also unclear how the impact on other services would be managed. For example, as acute hospital costs are included, how would the health board fund the consequences of potential long stay and general ward closures in hospitals?

The figures for delayed discharges are not reflected in the experience of front line staff in hospitals and social work. There needs to be a more rigorous study of this issue to ensure that there is consistent practice and statistical recording.

It is also important to recognise that whilst health services are provided free at the point of use, there are increasingly many local authority services for which charges are made. Clarification would need to be given to ensure transparency about which services were to be charged for and which provided free. The consultation paper is not explicit enough in explaining that this proposal will shift costs onto individuals.

It is also unclear how the personalisation policy would be addressed within the new organisations. In many areas this is being used as cover for budget cuts and privatisation and under these proposals that could be extended to NHS care.

The paper refers to partnership with the third and independent (private) sectors. This strongly implies the privatisation of services and more challenges under procurement regulations. This does not fit with the current Scottish Government policy in relation to NHS privatisation and would be of great concern if it were to be extended to the NHS.

We would also seek clarification on what changes are envisaged to the Scottish Government’s Guide to Strategic Commissioning in Social Work Services and Guide to Procurement of Care and Support Services.

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?

Our members advise us of many excellent initiatives that are being carried out under the auspices of the Change Fund as well as current

partnership working models across Scotland.

However, there is a concern that money could be 'flexibly' deployed from health into services provided by commercial providers, including the commercial end of the voluntary sector. This would be privatising the NHS through the back door.

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?

We believe this is a matter for local determination. Not for ministers to intervene.

Jointly Accountable Officer

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?

We believe that current decision-making structures must be taken into account, including democratic accountability and the appointment of Jointly Accountable Officers does not fit within this scenario. Staffing structures should be agreed locally.

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

See answer to Q 13 above.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

UNISON believes this should be left to local determination. Clearly there are a range of locality planning relationships in place across Scotland which in general operate satisfactorily. We support the development of these arrangements as described by the Christie Commission report.

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?

The consultation states that there is to be a central role for professionals. However, it is unclear how legitimate different professional approaches are to be reconciled. In lead NHS approaches there is a risk that a medical model will dominate and vice versa in local authority led models.

The staff management arrangements in circumstances when the budget, but not the staff transfer is unclear. We need clarification about whether nurses could be managed by Social Workers and/or vice versa. In addition we would wish to know what role GPs and Consultants would play and whether they would have access to the care budgets.

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?

See Q 16 above

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

We do not believe that GP practices are an appropriate area for locality planning which should be determined by local circumstances in the local area. Locality planning should be done in real communities of place, not artificial population groupings or GP areas designed for other purposes.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

We again believe this is a matter for local determination, and further consideration of the relationships between localities and the Partnerships

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?

Again, we believe this should be a matter for local determination, based on currently recognised geographical and population needs as set out in Q18 above

Do you have any further comments regarding the consultation proposals?

Workforce Strategy

As mentioned in our comments on Question2, there are a range of workforce issues that appear to have been given very little consideration in these proposals to date. These issues are not unique to care integration and need to be addressed as part of the wider public service reform agenda - if the Scottish Government is serious about workforce development as one of its pillars of service reform. The issues that need to be addressed include:

Staff transfer: There is an urgent need for a legislative framework for staff transfer. Statutory reorganisations are not treated in a consistent manner in legislation. Local reorganisations operate without consistent guidance leaving management and unions to reinvent best practice in a complex legal context. A legislative framework should include a standard staff transfer order that covers the essential TUPE+ issues.

In the model proposed for HSCPs the employment relationships are unclear and this could lead to complex legal issues including defining the employer.

Pensions: While the public sector transfer club operates for individuals, large scale staff transfer requires regulations for block transfers. The NHS and LGPS pension schemes in Scotland have many different elements and while service is protected on a year for year basis other factors may be important to individual staff. Again a consistent approach is required.

Secondment: Not all reorganisations require the permanent transfer of staff. A short term transfer may be a more flexible option. This approach has also been used in circumstances involving a non public sector provider. There are also some complex legal issues with secondments following the Celtec judgement. A secondment framework for temporary or short term transfers would again ensure some consistency and guidance.

Staff employed by different employers: Joint Future introduced working arrangements where staff from different employers work together. In addition a worker can be managed by someone from a separate employer on different terms and conditions. There have been problems with different procedures such as discipline, grievance, training and development review. Professional boundaries, ethics and codes of conduct can also be an issue. Recent legal decisions (Weeks) have highlighted employer responsibilities in these circumstances. Some agreed national protocols to cover these issues would be helpful.

Procurement: There is little consistency in approaches to public service reform that involve procurement. The Two-Tier workforce provisions including the PPP Protocol and s52 have been under review for years with no real progress. Existing provisions are not well understood and certainly not consistently applied. A common procurement framework agreement would assist everyone involved in organisational change.

Equality duties: Organisational change almost always requires an equality impact assessment. Our experience is that this process is often

not understood and inadequately implemented.

Governance: Different governance arrangements can be complex and confusing. This also applies to the governance of workforce issues. Christie therefore recommended the development of “an appropriate set of common powers and duties”. We believe there should be a single statutory staff governance framework.

One public service: Christie also identified a destination for reform of local partnership working that all public service organisations see themselves as part of a common framework for public services in an area. The report suggested that this could lead to collective public identity and branding (e.g. Public Services South Lanarkshire). The current arrangements do not address issues like staff moving voluntarily between employers. We believe the time has come to develop the one public service concept from a workforce perspective.

Conclusion

This response to the consultation outlines our initial concerns and the issues that need to be addressed under the outline proposals for care integration in the context of UNISON’s approach to public service reform. Our long experience of organisation change means that our members will inevitably be sceptical about the merits of major structural change. The looser arrangement being proposed may offer a better way forward, but significant questions remain over how this will operate in practice.

We accept that care services face major challenges and it is important that service users are able to easily access services. In practice this has been achieved in parts of Scotland without another major upheaval that could have unforeseen consequences for councils, the voluntary sector and the NHS. There are also many cultural, professional and managerial issues that are not simply resolved by structural change.

We have deliberately put a focus on workforce issues that are given only cursory consideration in the consultation paper. These issues are not limited to health and care integration and we believe the time has come to consider a consistent staff governance framework for public services across Scotland.

A statutory staff governance framework would set out what each employer must achieve in order to continuously improve in relation to the fair and effective management of staff. It would ensure that all staff have a positive employment experience in which they are fully engaged with both their job, their team, and their organisation. Such an outcome has a positive impact on organisational performance, and therefore on quality of service provision, but it is also an important component of providing all employees with dignity at work. The key characteristics of a staff governance framework are that staff are well informed, appropriately trained, involved in decisions which affect them, are treated fairly and consistently and have a safe working environment.

Do you have any comments regarding the partial EQIA? (see Annex D)

The proposals are insufficiently clear to comment at this stage.

Do you have any comments regarding the partial BRIA? (see Annex E)

As above

Mike Kirby, Scottish Secretary

UNISON Scotland
UNISON House
14, West Campbell Street,
Glasgow G2 6RX

For further information please contact:

Dave Watson
d.watson@unison.co.uk

Diane Anderson
diane.anderson@unison.co.uk