

Policy Briefing

Health and Social Care: Uneasy Bedfellows?

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This LGiU Scotland briefing is specially commissioned for our new programme for local government across Scotland. LGiU Scotland is delivered in partnership with Centre for Scottish Public Policy and Boulder Group. Contact LGiU Scotland co-ordinator [Chris Naylor](#) for more information.

Summary

The partial relocation of the health and social care responsibilities of 14 Territorial Health Boards and 32 Councils into 31 Integration Authorities is less than six months away; scheduled for 1st April 2016.

The 'joining up' of health services and social care with the aspiration to create a seamless service, particularly for those whose condition does not require, or no longer requires, full time hospitalisation, seems an eminently sensible idea to many professionals and citizens.

It may, however, be one of those eminently sensible ideas that are laden with considerable difficulties, not merely in any transition period but in the longer term also.

This briefing looks at the social pressures driving social and health care integration in Scotland, and the additional organisational layers in the form of the Integration Authorities and their associated bodies.

A recent report from Audit Scotland on [Health and Social Care Integration](#) has provided a timely update on both progress and problems of integration. That report, along with experience elsewhere in the UK is discussed in this briefing which will be of interest to all those involved in public health, social care, community engagement, and partnership issues.

Briefing in full

What we usually refer to as 'the NHS' has had various contradictions at the heart of the organisation from the day of creation – or even before that 1948 vesting date. One of the central issues continues to be the boundaries and the overlaps between what we generally understand as 'health' and 'care'.

In simple terms, health has long been seen as being provided by the different NHS organisations in the four countries of the UK, and care by family; by charities; or by councils. The distinction between these is that the NHS admits people into both primary health care and hospitals without regard to their means, and without any general requirement to charge them. Care provided by voluntary sector organisations and councils was, and still is, charged for – though charged in different ways and to a different extent in Scotland, England/Wales and Northern Ireland.

Most often that boundary between health and care has been at its most stark at the point people enter the hospital system, and at the point they ideally should leave it. There are often occasions when people – often older and living alone – are admitted to hospital when they could be provided for in other ways. The same categories of people are then often kept in hospital when they could otherwise be able to leave if there were suitable arrangements to support them. There are both personal and individual health disadvantages that follow from this, and major costs are incurred.

Improved arrangements at either end of a hospital period would be better for the people concerned and much cheaper for society. The [Information Service Division](#) of NHS Scotland produces monthly reports on 'delayed discharge' from hospital which shows figures for 2014-2015 indicating approximately 650,000 bed days taken up on this basis. This is clearly costly and undesirable.

It is also apparent that these issues will become more significant as more of us live longer. The evidence is that as we do live to an increasing age – generally agreed to be a good thing – the complex array of conditions that we develop grows ever more numerous. By the time many of us reach an age greater than 85, the majority of us will have two, three or four disorders and about 25% of us will have more than seven disorders concurrently, posing complex challenges for our health and wellbeing.

Governments of all parties have struggled for a long time with how these boundary issues play out, whether that is in Westminster or here in Holyrood. There have been various and continuing attempts to address them and create a more seamless flow of activity and support for people. Governments throughout the UK are discussing this and trying to plan for it.

Scottish Legislation

The current legislative and organisational plan to tackle this in Scotland is contained in [the Public Bodies \(Joint Working \) \(Scotland \) 2014 Act](#). The explanatory notes to the Act explain the main purpose of integration is intended to:

“... Improve the wellbeing of recipients, as well as an expectation that planning and delivery will take account of key principles relating to integrated delivery; the requirement to balance the needs of individuals with the overall needs of the population; anticipation and prevention of need; and effective use of resources.”

The key operational date for the Act is April 1st 2016, when 31 Integration Authorities (not 32, for reasons explained below) are due to be operational in some form.

Essentially, the newly created integrated organisations will take responsibility for some of the functions of health boards and some of councils, particularly those where there are clear links into the community. So, for example, the response to an elderly person living alone who has had a fall and is judged in risk of falling again. They will not have involvement in specialist acute in-patient services.

The range of powers and responsibilities that may be delegated in different ways to these authorities is extensive, and the volume of potential spend is very high.

The range of hospital services included in the integration process ranges from mental health, through geriatric medicine, addiction and dependence to palliative care. Amongst the range of local council responsibilities that may be included are powers and duties that extend from the Acts that cover National Assistance; through to Housing; Mental Health; Children's Acts, and Disabled Persons.

At present it appears that the pattern of integrated services will vary from council area to council area, with some Integration Authorities planning to include a wide range of services including children's social work services and criminal justice social work.

The volume of expenditure to be under the control of the Integration Authorities is estimated by the Scottish Government and Audit Scotland to be in the order of £8 billion. That compares to current annual Health Budgets and Local Government Budgets of a little over £12 billion and a little under £11 billion, respectively, which gives some sense of the scale of the re-organisation being put into effect. However one of the concerns raised in the Audit Scotland report is that both health boards and

councils are still discussing the detail of the budget agreements that will be associated with the changes.

Some key issues of integration

In addition to concerns about the budgetary uncertainty, this Audit Scotland report also refers to some other matters that should be of some concern.

There are some complex governance matters that can take effect in different ways. In most areas, Councils and the various Health Boards are establishing Integration Joint Boards to which health boards and councils delegate budgets.

In Highland, there will be a different arrangement, which follows on from the earlier arrangement there of a 'lead body' with NHS Highland taking responsibility for adult health and care and the local authority for child community health and social care. In Stirling and Clackmannanshire, there will be a tri-partite arrangement between Forth Valley Health and the two councils, reflecting the established arrangements between the councils to collaboratively on certain services. These arrangements are explored further in the briefing.

There are additional complexities that will have an impact on communications; strategic decision making and quite possibly public perceptions of the new system. All Integration Authorities are required by law to divide their overall area into at least two 'localities', where various stakeholders such as GPs, carers and service users will be party to any consultation that will contribute to service and facilities planning in their locality.

The overall governance of these integration arrangements is also complex and varies widely between different geographic entities. The basic requirement is to appoint voting members in equal number from the council and the health board, with a minimum of three from each organisation and an equal number of nominated voting members. In some areas, four or even five voting members have been appointed. In addition to the voting members there are non-voting members drawn from voluntary organisations; carers; in some cases service users; and others from a range of groups with professional expertise and engagement. The numbers vary considerably, with some organisations having fewer than 20 members at the table, while other areas – such as Stirling /Clackmannanshire – will have somewhere in the order of 30 or more people involved.

There is also complexity in terms of staffing. Integration boards may at first directly employ few staff. They are required to have a chief officer – who is the accountable officer – and a financial officer, who may be the same person. The chief officer can choose whether they are employed by the health board or the council – with different terms and conditions – and is then seconded to the Integration Joint Board. In most cases, it appears that the appointees will be jointly line managed by both the chief executives of the health board and the council.

Even the above account does not fully describe the various complexities of the planned integration arrangements. Some of those will almost certainly emerge as we move to April 1st deadline and into the first year of the planned changes.

Comment

One of the intriguing aspects of the Scottish Government proposals is the relatively modest savings envisaged as part of the integration drive. There is clearly a sound argument for developing such forms of integrated service as a better way of addressing system weaknesses in health and care. It is also clear that such changes have often been argued as generating significant cost savings. The current

projections from the Scottish Government suggest cost savings of between £138-£157 million. These figures, at the middle of the range cited, amount to under 2% of total revenues.

We often talk as though greater integration between health and social care is a novel and pioneering exercise; perhaps we forget that in Northern Ireland there has been organisational integration through the Health and Social Services Boards created in 1973. There is little evidence to suggest that this system has achieved very different outputs and patient outcomes.. What evidence there is suggests, according to [The Kings Fund](#), mixed benefits from a system that has not been fully exploited, and a continued dominance of medical responses and therefore resource commitments.

There are more immediate and stark signals about the potential for problems in trying to achieve closer integration between different services. One such move in the English health and care system was a tender awarded to two hospital trusts to provide health and social care for older people in the Cambridgeshire area that commenced in April this year. It was [claimed](#) by the Clinical Commissioning Group that:

“We are clear that the innovative model of care for older people and people with long term conditions brings benefits for patients and the whole health and care system and we are all agreed that we wish to keep this model of integrated service delivery.”

The agreement provisions included specific plans to encourage reduced use of in – patient hospital stays and greater community based responses. The arrangement has now wound up after eight months [reportedly because it wasn't financially viable](#). It is unclear what will be put in its place.

The current proposed arrangements for 31 different integration areas in Scotland currently include arrangements for an Integration Board that brings together two councils – Stirling and Clackmannanshire – with Forth Valley Health Board in an unusual tri-partite arrangement. This is an outcome of the quite long standing initiatives to create shared services between the two adjoining councils that have included social work and educational services. Since some of these currently shared services are apparently [now being questioned](#) by one of the partner councils, it's not entirely clear whether current integration arrangements will survive long term and may have to be unravelled.

A major concern of the report by Audit Scotland is governance, both in respect of a clear purpose of the various integration authorities and also the complexity of governance.

It's worth recalling that the SNP government of 2007 introduced a trial to directly elect some of the membership of two health boards – Dumfries and Galloway and Fife. This plan, welcomed by most parties in Holyrood as an advance in democratic governance, was dropped last year having been poorly supported in the actual elections and it seems the government thought it made little difference to actions by the two health boards.

The current governance proposals appear to create a different combination of mixed status members, some with voting rights and some without and it will be intriguing to see how that develops. It will be interesting to see what public reactions there might be to strongly expressed views from non-voting members being rejected by voting members – as might easily happen.

There is also, of course, the over-riding pressure of budgetary squeeze affecting all of the choices that are made about how health and care budgets are distributed and allocated, now exacerbated by winter pressures. Current assessment and analysis, most recently from [The Nuffield Trust](#) looking at England, suggests that such choices will continue to be driven by the immediate pressures and traditional short term solutions employed every winter. They do make the point that matters are a little better in Scotland, mainly because there are slightly better ordered care arrangements here.

And last but not least is the assumption that creating integrated bodies, even with balanced joint membership, adds considerably to the totality of organisational actors all on the same pitch. 32 councils; 14 health boards; and 31 Integration authorities – all with distinct formal entity status and authority; all with accountabilities that are blurred and shared. That takes us from 46 players on the pitch to 77. In principle sound enough, in practice very challenging.

Original source: [LGiU Scotland](#)