Annex F   Respondent Information Form

Integration of Adult Health and Social Care in Scotland

RESPONDENT INFORMATION FORM

<u>Please Note</u> this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

SAMH (Scottish Association for Mental Health.)

Title Mr ☐   Ms ☐   Mrs ☐   Miss ☐   Dr ☐   *Please tick as appropriate*

Surname

Forename

2. Postal Address

SAMH
Brunswick House
51 Wilson Street
Glasgow

Postcode G1 1UZ	**Phone** 0141 530 1000	**Email** policy@samh.org.uk

3. Please indicate which category best describes your role/group or interest in health and social care integration. (Tick one only)

NHS Health Board	☐
Other NHS organisation	☐
General Practitioner	☐
Local Authority	☐
Other statutory organisation	☐
Third sector care provider organisation	☒
Independent/private care provider organisation	☐
Representative organisation for professional group	☐
Representative organisation for staff group e.g. trade union	☐
Education/academic group	☐
Representative group for patients/care users	☐
Representative group for carers	☐
Patient/service user	☐
Carer	☐
Other, please state	☐

5. Permissions - I am responding as…

Individual	/	Group/Organisation
☐	*Please tick as appropriate*	☒

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate ☐ Yes ☐ No

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(c) The name and address of your organisation *will be* made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your *response* to be made available?

Please tick as appropriate ☒ Yes ☐ No

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☒ Yes ☐ No

**SAMH Response
Integration of Adult Health and Social Care in Scotland: Consultation on Proposals**

Consultation Questionnaire

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?

Yes ☒ No ☐

The consultation document states that the factors driving integration are particularly relevant to care and support for older people, citing unnecessary admissions of older people into institutional care and demographic change as making the case for change urgent. SAMH appreciates the rationale behind this approach and recognises the importance of addressing the needs of an aging population at the local level. However, we would stress that people of all ages experiencing mental ill-health also have requirements for care which are particularly relevant to these proposals. Whilst we support the intention to focus initially on improving outcomes for older people, it is essential that this does indeed later extend to encompass all areas of adult health and social care.

Many of our service users receive services from a high number of different agencies. This is neither sustainable nor sensible. It leads to uncertainty for the individual, who may have to manage appointments with many different agencies, even at times when their mental health is poor, and it cannot be a good use of resources. There will be less money available for all Scottish Government departments over the coming years. As such, we will need more efficient, better integrated services and departments across the board.

Too often, mental health is seen solely as an NHS issue. In fact, mental health is about self-esteem and resilience: it's at the core of Scotland's well-being. The social and economic costs of mental health problems in Scotland are £10.7 billion a year[1]: that's more than the entire NHS annual budget. Poor mental health and well-being lies at the heart of some of the most expensive problems that Scotland faces: not only in health but also in areas such as crime, unemployment and deprivation. SAMH therefore welcomes an approach which aims to enable integration beyond just health and social care, recognising that other areas of service also play a key role in the delivery of better outcomes for people with long term conditions and complex needs. Partners beyond health and social care, including those in the voluntary sector, must fully included in the integrated

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[1] What's it Worth Now? The Social and Economic Costs of Mental Health Problems in Scotland, SAMH, 2011

approach if the intended objectives are to be realised.

Improving outcomes - in the first instance - for older people will require that we can meet both their physical and mental health needs. SAMH is concerned that there is often an assumption that mental health problems are a 'normal' aspect of ageing, and approaches to older people's mental health have traditionally focused on dementia. Older people, like anyone else, can experience both 'common' and more 'severe and enduring' mental health problems: 10 -15% of the population aged over 65 years will experience depression.[2]

As such, SAMH expects that an initial focus on improving outcomes for older people will entail at least some degree of mental health service integration, in order to better meet the needs of older health and social care service users. This may be helpful in paving the way for broader integration of mental health services, whilst allowing time for lessons to be learned and best practices identified. This would also allow greater time for relationships to evolve between people and organisations, and for mutual trust to be established. There is, however, a lack of clarity about the overall timeline for delivery and clear timescales should be laid out in this regard. In particular, a date should be set for when the focus of integration will be extended to include other areas of adult health and social care.

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?

Yes ☒ No ☐

The starting point must be recognition that the primary focus is on the individual patient or service user, and this should be clearly reflected within in the objectives and principles of reform.

Traditionally, integration initiatives have often focused on the organisation, the service, the budget, or the professional discipline.[3] These represent the means to an end, not the end in itself. SAMH therefore welcomes the Scottish Government's commitment to a person-centred approach and intention to ensure that resources follow people's needs.

SAMH is pleased that the proposals for reform are not based on centrally directed structural reorganisation, and will not impose a single operational delivery arrangement on partnerships. There is evidence to suggest that the main factors promoting integrated working are locally determined – local leadership, vision, strategy and commitment. Conversely, nationally determined factors may hinder

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[2] Iliffe, S, 'Guidelines for managing late-life depression', Geriatric Medicine, April 2003
[3] Integrating health and social care: Where next? The kings Fund, March 2011

integrated working, such as performance regimes, funding pressures and financial complexity.[4]

Within the broad framework for integration, it is proposed that local leaders will be free to decide upon delivery mechanisms and organisational structures. Partnerships will also be able to choose to delegate functions and budgets to each other if there is local agreement to do so but they will not be required to do so. SAMH believes that this is fundamentally the right approach. However, it is unclear whether the proposed framework will be sufficient to avoid unacceptable variations between services across different localities. We suggest that Audit Scotland may wish to undertake an audit of several different localities after the implementation of health and social care integration, to establish whether such variations are occurring.

We have provided more detailed comments on specific aspects of the proposals in the sections below. However, some overarching issues include:

- How it will be assured that the focus is truly on the individual patient or service user.
- How meaningful involvement of the voluntary sector will be assured; from planning and commissioning through to delivery.
- How continuity of care will be maintained while changes are implemented.
- How poor performance or slow progress will be addressed promptly and inconsistencies prevented.
- The extent to which the financial pressures facing the NHS and local government may help or hinder integration.
- The urgent need to address potential conflicts between integration and personalisation/self-directed support.
- The need to 'sweep away' the remnants of previous attempts at integration before implementing new approaches.

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?

Yes ☒ No ☐

Developing shared outcomes for adult health and social care could potentially go far to promote integration at a local level. SAMH welcomes moves to introduce,

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[4] Integrating health and social care: Where next? The kings Fund, March 2011

for the first time, a mechanism for ensuring that Health Boards and Local Authorities are jointly and equally clear about their priorities for integrated working. This should also assist in ensuring that each can be jointly and effectively held to account for delivery.

However, the success of this approach will depend largely on the extent to which NHS and Local Authority functions are seen to be aligned to the nationally agreed outcomes for adult health and social care, and how many outcomes are actually held to be shared. It remains likely that, within health and social care, some outcomes and functions will continue to be seen as being specific to either Local Authorities or the NHS. This prevailing division may make it difficult to measure performance and join up working across the whole system of health and care.

We particularly welcome a Health and Care Integration Outcome in relation to positive experiences and outcomes for people receiving health, social care and support services. It is vital that partners implement robust and rigorous mechanisms for gathering data that both capture qualitative aspects of service user experience and also allow for some quantification. This may pose a challenge where such data is not already systematically gathered but will be fundamental in order to determine success.

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 ☒ No ☐

Given that Single Outcome Agreements provide the mechanism via which CPPs agree local strategic priorities and demonstrate how these contribute to the National Performance Framework, this would seem like a sensible approach. However, the limitations of SOAs also have to be acknowledged and addressed, especially if these are to be seen as a vehicle for transformational change. SAMH has concerns that there is not enough independent assessment of progress towards SOAs, and there appears to be little or no sanction for failure in this regard. Audit Scotland[5] have also identified that, as local partners agree their own performance indicators in relation to SOAs, benchmarking local performance is not always possible. They recommended that the Scottish Government should work with NHS boards and councils to streamline and improve performance information for SOA, HEAT and other performance targets to support benchmarking.

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?

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[5] Review of Community Health Partnerships, Audit Scotland, 2011

Yes ☒ No ☐

Whilst joint accountability to Ministers and Local Authority Leaders may help to provide the right balance, there are important lessons to be learned from the operation of the existing Community Health and Care Partnerships (CHCPs) and Community Health and Social Care Partnerships (CHaSCPs). These integrated CHPs are partnership bodies and therefore have dual accountability to both the NHS board and relevant council.

Audit Scotland have reported[6] that governance arrangements for integrated CHPs are generally more complex because they need to take account of different lines of accountability and the existing corporate governance arrangements of both partners. As a result, there is an increased risk that there is a lack of transparency in decision making and that decision-making is slow. Auditors found weaknesses in joint governance arrangements such as a lack of clarity on financial management processes including budgetary control, and evidence of decisions being taken outwith the authority of the integrated CHPs.

It is intended that reporting meetings to Ministers, Health Board Chairs and Local Authority Leaders, will be established and will use an agreed set of measures to support monitoring of progress towards outcomes. Performance reporting arrangements must be consistent between localities and at all levels within them, as must be the content of the performance reports to the various parties involved. It will also be vital that any discussions about or challenges to performance reports can be clearly evidenced to stakeholders and the public.

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

Yes ☐ No ☐

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

Yes ☒ No ☐

The proposed Committee arrangements do appear to be a significant improvement upon some of the arrangements seen within existing integrated CHPs. Strong leadership by NHS boards and councils is essential to improve how health and social care services are delivered, and make best use of available resources. It is therefore appropriate that the Health Board and Local Authority will nominate a Chair and a Vice Chair for the Health and Social Care Partnership

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[6] Review of Community Health Partnerships, Audit Scotland, 2011

Committee, and that this will rotate on annual basis. The fact that voting members of the Partnership Committee will be made up of an equal number of Health Board Non-Executive Directors and local elected members should also help to maintain fairness and balance.

The professional and service user perspective on the pathway of care is intended to be provided by non-voting members, who will support the Health and Social Care Partnership. However, it is not stated how many non-voting members are expected to sit on the committee, how these members will come to be selected or how it is intended that they will provide support. There is a danger that patient/service user and third sector representation on the Committees could become tokenistic, and that their representation could become inconsistent between localities. Therefore, SAMH wants to see a specified proportion of places (for parity reasons, this would ideally be three places) reserved for service users and a clear statement of their duties, an acceptable selection process and the support they will receive.

It will be absolutely vital that partners across all sectors and beyond just health and social care are fully and appropriately involved in planning and decision making within the new partnership arrangements. Whilst the consultation states that the NHS Chair and Local Authority Leader will ensure that appropriate stakeholders are engaged by the Health and Social Care Partnership in the planning and delivery of services, it is unclear how this will actually be achieved in practice.

Governance in health and social care is essentially about ensuring transparent and effective decision making; so that public money is properly accounted for and care delivered to the agreed standards. Successful partnership working can be best achieved where all partners adopt and adhere to key governance principles. Audit Scotland[7] has developed a set of good governance principles which we believe to be relevant to these proposals, this includes:

- Clear vision and strategy
- Personal commitment from the partnership leaders and staff for the joint strategy
- Partners agree what success looks like and indicators for measuring progress
- Clear decision-making and accountability structures and processes
- Roles and responsibilities are clear
- Right people with right skills
- Risks associated with partnership working are identified and managed
- Partners implement a system for managing and reporting on their performance

The creation of a Partnership Agreement, between the Health Board and the Local Authority, to establish the services to be delivered and outcomes to be achieved

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[7] Review of Community Health Partnerships, Audit Scotland, 2011

(within the context of the nationally agreed outcomes), should help to foster a clear vision and strategy. Joint commissioning strategies and delivery plans over the medium and long-term, with regular publication of local performance data, are also positive steps towards more efficient integrated partnerships. A further strength of the new proposals is that financial and decision making authority for achieving outcomes will be delegated to the Health and Social Care Partnerships.   We have provided a more detailed analysis of some of the financial elements of the proposals in the sections below.

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?

Yes ☐ No ☒

The intention is to put in place a sliding scale of improvement and performance to assure the delivery of national outcomes. Improvement support will be offered to ensure sharing of good practice, benchmarking, leadership and organisational development, and development of commissioning skills. This is a much welcome and much needed approach, with all of these areas being of fundamental importance.   However, to succeed, improvement support must be provided as opposed to simply offered to all the Health and Social Care Partnerships.

The consultation document states that where Health and Social Care Partnerships fail to deliver nationally agreed targets, performance support will be offered and, where critical, put in place. From this, it does not seem that performance management will be a matter of routine, and it certainly does not appear that it will be a priority. The fact that performance support will only be put in place where a situation is deemed 'critical' is particularly concerning. The public require to know that poor performance or slow progress will be identified and addressed in a timely manner, ideally long before a critical point is reached.

Whilst major strategic reviews and revision may only happen every few years, robust processes to ensure regular reporting on performance towards the nationally agreed targets must be established to enable any problems to be identified at an early stage. Careful consideration must be given as to when under-performance will be considered a problem requiring additional action or when performance may simply need to be observed. It is likely that the appropriate trigger will depend on the type of indicator or service being considered – for example, two reporting periods of declining performance or poor performance in relation to other Health and Social Care Partnerships.

The nationally agreed targets should also be fully integrated into other performance planning mechanisms, such as Single Outcome Agreements, service plans or individual performance and development plans. Indicators must not only reflect what's happening but also provide a basis for decision-making, identifying areas for improvement or where learning could be shared.

Health and Social Care Partnerships must also communicate their objectives clearly, in a way that all staff and service users can understand and therefore judge if they are being achieved.   We would stress, especially given that the primary intention behind these proposals is to improve the patient/service user experience, that it is the views and experiences of the people accessing health and social care services which should be used to determine the extent of success. Performance management should be used to help to keep focus on the service users and citizens at the heart of these proposals.

SAMH is pleased that the consultation recognises the importance of effective collaborative working with external scrutiny partners. Both the Care Inspectorate and Healthcare Improvement Scotland will play a key role in reviewing the quality of service and outcomes achieved.

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?

Yes ☐ No ☐

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?

Yes ☐ No ☒

Under these proposals, Health Boards and Local Authorities will be required to integrate resources for adult services. The new, integrated budget will then be managed by the Jointly Accountable Officer who will have authority to make decisions about resource prioritisation, without needing to refer back up the individual lines of accountability in the partner organisations. This is a significant change which we believe could help to prevent issues such as 'cost-shunting' between the NHS and Local Authorities. However, we are not entirely convinced that the models described can successfully deliver the intended objectives.

The consultation document outlines two options via which Health Boards and Local Authorities could integrate budgets, with local partnerships being free to choose which approach they take. The first option entails delegating agreed functions to the Health and Social Care Partnership, which would be established as a body corporate of the Health Board and Local Authority. The integrated budget would then be managed on behalf of the Partnership by the Jointly Accountable Officer.

The creation of a 'body corporate' suggests that the Health and Social Care Partnership will in fact be distinct from both health and social care; sitting between NHS and Local Authorities where their functions overlap whilst both continue to operate outwith this structure within their own remits. Again, this raises the question as to which functions will be seen as contributing to joint outcomes, and to what extent outcomes will be held as shared.   Furthermore, whilst the integrated budget would be managed by the Jointly Accountable Officer, this will be subject to the respective financial governance arrangements of each partner. This may create tensions or make it difficult to ensure that the Jointly Accountable Officer is able to make decisions impartially.

Some of the proposals contained in the consultation document (such as the creation of National outcomes for adult health and social care, Partnership Agreements and joint accountability) may help to secure the success of this approach.   However, at present, there are simply too many variables and uncertainties to accurately assess whether the cumulative effect of the proposals would be enough to make this model work. It is also difficult to offer comment without a clearer understanding of timescales and, ultimately, the intended end extent of integration between health and social care.

The second option is delegation between partners; whereby one partner can delegate some of its functions and resources to the other, which then hosts the services and integrated budget on behalf of the Health and Social Care Partnership. This is a similar approach to that already implemented in the Highland partnership. SAMH would, therefore, be keen to see an evaluation of this initiative in order to offer more informed comment. It is not clear at present whether this is an effective approach to integration and it would appear that fundamental divisions remain. These divisions may then come to be reflected in the experience of the patient/service user, for example whilst making the transition from childrens to adult services.

Of these two options, SAMH would prefer the first: delegating agreed functions to the Health and Social Care Partnership, which would be established as a body corporate of the Health Board and Local Authority. However, the successful implementation of this approach would require the full commitment of both the Health Board and Local Authority. The issues we have raised above would also need to carefully considered, monitored and addressed.

SAMH also has a serious concern regarding the intention that the integrated resource should lose its identity in the integrated budget – so that where money comes from, be it "health" or "social care", is no longer of consequence. Specifically, we do not know that proper consideration has been given as to how this may impact on the implementation of personalisation and self-directed support. Elsewhere in the UK, where health and social care services have been well integrated with pooled budgets, there have been resultant difficulties in providing direct payments to people experiencing mental health problems. This is largely due to difficulties disentangling pooled NHS or social care funds into separate personal

social care budgets and funding for NHS services.[8] While all services provided by the NHS are free at the point of access, some social care services are charged for on an individual basis. If health and social care services are to be seen as contributing to joint outcomes, it may be an appropriate time to reconsider and clarify what exactly constitutes 'health' and 'social' care and what services people should be expected to pay for.

SAMH is aware that - with the introduction of the Social Care (Self- Directed Support) Bill and the bringing together of health and social care - the RCN[9] have also raised concerns that self-directed support will be introduced to the NHS in advance of a national debate on if and how self-directed support is the best way to allocate health resources. We believe that health and social care integration is not necessarily incompatible with self-directed support but there is clearly an urgent need to consider how these two approaches can be progressed together, especially given that such significant changes are being progressed at the same time.

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?

Yes ☒ No ☐

In Glasgow:

SAMH has been delivering community based mental health services in Glasgow for almost 20 years. We recently undertook a review of these services in order to achieve better outcomes for service users by developing more integrated service models, and aligning our services with the CHCP infrastructure within Glasgow.

Our primary intention was to increase the number of people who moved on from accommodation registered as a Care Home into their own tenancy with gradual decreasing levels of support. We wanted to deliver more flexible housing support and social care models, so that services could be delivered in a much more integrated way with the focus being upon outcomes for people.

This has allowed service users to move more easily between different elements of service without the need for additional assessments or an increase in number of agencies involved. We also developed relationships and protocols with Care Managers, Supported Accommodation Allocations Groups and CMHTs operating within the CHCP structures to ensure that SAMH services are integral to local delivery and that the best use is being made of resources. This has helped address some long standing anomalies such as VOIDS, old and varied rates and low demand for a high number of places. We have been successfully working in partnership with GCC to ensure we can deliver services to people where, when and

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[8] Financial management of personal budgets, challenges and opportunities for councils (summary of national report), Audit Commission October 2010

[9] Debate on health and social care integration, Royal College of Nursing Scotland, 15 December 2011

how they need it most.

This demonstrates how shared outcomes and good communication between partners can enable the more efficient use of resources; delivering genuine benefits to people accessing community based services and supports.

In Moray:

SAMH services in Moray were redesigned to provide better accommodation and more individualised service packages. Working in partnership with Springfield Housing, a local building contractor and Grampian Housing the old Care Home model was replaced with a brand new Care at Home with Housing support service. The service users who had previously been in 24hour care homes were all reassessed and are now living in their own tenancies with care provided by SAMH on an outreach basis.

Other joint working in Moray includes rural groups which are staffed mainly by SAMH whilst the premises are provided by Health. This has enabled us to reach people living in more isolated areas. We also work closely with Hanover Housing who gave us tenancies for a more elderly client group whilst we provide the outreach services. The SAMH services in Moray have excellent working partnerships with Health, Local Authority and Housing providers.

This demonstrates how different partners can together draw upon their collective resources, expertise and knowledge of local issues. In doing so, we were able to respond to a wide range of local needs whilst also achieving shared strategic objectives.

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?

Yes ☐ No ☐

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?

Yes ☐ No ☐

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

Yes ☐ No ☐

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?

Yes ☐ No ☐

This question does not seem to lend itself well to a yes/no response. Provided that there is enough direction to ensure at least some consistency in approach, it would be sensible to allow local solutions to be developed within different localities. However, effective scrutiny, governance and accountability will all be crucial to ensure that locality planning arrangements are robust.

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?

Yes ☐ No ☒

SAMH welcomes the intention to create a duty to consult local professionals, across all sectors (including the third and voluntary sector), on how best to put in place local arrangements for planning service provision. However, we would like greater clarity regarding the nature of this engagement and how it will be evidenced.

The consultation document also states that it will be important to ensure the direct involvement of representatives of the third and independent sectors, and carers' and patients' representatives. However, it does not seem that there will be a duty to ensure that this happens. "Commissioning" is defined by the consultation document as meaning the activities involved in assessing and forecasting needs, agreeing outcomes, considering options, planning future services and working in partnership to put these in place. The voluntary sector has a great deal to contribute in relation to all these activities, but is too often excluded from discussions about service planning and delivery. We do not believe that the proposals as they currently stand go far enough to rectify this imbalance; a duty to consult with the voluntary sector and community and service user forums should also be placed upon the Health and Social Care Partnerships.

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?

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

Yes ☐ No ☐

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

It is not clear within the consultation document who is expected to be included within locality planning groups, what structure these will have, or the types of areas it is expected they might decisions in relation to. Care should be taken to ensure that there is not confusion or conflict between the roles and responsibilities of the Health and Social Care Partnership Committees and locality planning groups.

Locally, it is important that work on delivering integration is informed by the real life experiences of service users, and is rooted in what is happening and what could happen if service users are actively involved as partners.

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?

Yes ☐ No ☐

Do you have any further comments regarding the consultation proposals?

SAMH greatly welcomes moves to better integrate health and social care and place the patient/service user at the heart of the services they receive. Overall, the proposals in this consultation are ambitious and far reaching and we look forward to seeing how they are refined and developed to deliver better outcomes for people via integration. However, legislation can only go so far to drive integration and the importance of the behavioural aspects of organisational change cannot be overstated. The experience of health and social care integration in recent years suggests that closer attention should be paid to this aspect in future policy. [10]

A common theme in many evaluations of partnerships and integration initiatives has been the quality of relationships between people and organisations, and the time needed to build up mutual trust. The experience of care trusts in England suggests that where relationships were good to start with, integration improves them, but where they were poor to start with, integration causes them to deteriorate further.[11] Good relationships can be fostered by good communication, strong leadership, a shared vision and transparent decision making. This will likely take time to develop, and areas with a history of successful joint working will likely have an advantage. It should be considered how histories of joint working and/or relationship problems can be documented and how this information can be included in evaluation processes.

The needs of people experiencing mental ill-health will often extend beyond the reach of social care services. Many people who use social services will also rely on other public services in areas such as health, housing, employment, education and welfare. The problems that people experience are often interrelated and so SAMH would welcome an approach to integration that goes beyond just health and social care, so that we can better acknowledge and engage with the realities of peoples lives.

As stated in the consultation document, the availability of information and evidence will be critical to success in terms of service planning and accountability for delivery. It will be imperative that local authorities and their health partners develop a good understanding of the needs of their population. This will require a clearer analysis of the reasons behind variations in spending, costs and outcomes from one area to another.[12] It will also be particularly important to draw on the experiences of people who use local health and care services.

SAMH also welcomes recognition in the consultation document that a more integrated approach to sharing information across services and local systems will be required to enable and evidence improvement. The 2009 Audit Scotland

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[10] Integrating health and social care: Where next? The kings Fund, March 2011
[11] Integrating health and social care: Where next? The kings Fund, March 2011
[12] Integrating health and social care: Where next? The kings Fund, March 2011

review of mental health services pointed out that different information systems are used by NHS Boards and councils and this limits their ability to deliver joined-up, responsive services.[13]

We would also caution that too great a focus on integration could detract from the delivery of quality services at the front line. What matters most are the outcomes for the people using the service and we must ensure that this remains the focus for all concerned if these proposals are taken forward.

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

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

Comments

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[13] Overview of Mental Health Services, Audit Scotland (2010)