Improving Outcomes through Transformational Health and Social Care Integration – The Scottish Experience

Anne Hendry, Alison Taylor, Stewart Mercer and Peter Knight

Abstract

The Scottish Parliament recently passed legislation on integrating healthcare and social care to improve the quality and outcomes of care and support for people with multiple and complex needs across Scotland. This ambitious legislation provides a national framework to accelerate progress in person-centred and integrated care and support for the growing number of people who have multiple physical and mental health conditions and complex needs. Additional investment and improvement capacity is helping to commission support and services that are designed and delivered with people in local communities and in partnership with housing, community, voluntary and independent sectors.

Introduction

The Scottish Parliament recently passed ambitious legislation on integrating healthcare and social care to improve the experience and quality of care for the growing number of people in Scotland who have multiple conditions, complex care and support needs or challenging life circumstances. This paper describes the health and care context in Scotland and the drivers for healthcare and social care integration underpinned by analysis of data on the changing population and needs for healthcare and social care. It outlines the anticipated outcomes from integrated care and highlights progress in Reshaping Care for Older People through support and services that are designed and delivered with people in local communities and in partnership with housing, community, voluntary and independent sectors.

Drivers for Change

The population of Scotland is projected to rise by 7% from 5.4 million in 2014 to 5.7 million in 2039 (National Records Scotland 2015). The population aged 75 years and over – the highest users of health and care services – is projected to increase by 85% over that period. The prevalence of long-term conditions increases with age, from 25% of adults aged 16–24 to 77% of those aged 75 and over (Scottish Health Survey 2015). Overall, 46% of adults had one or more long-term conditions (31% limiting and 15% non-limiting), and 19% of children had a long-term condition. In the 2013 Scottish Household Survey, 34% of households reported at least one adult or child with a long-standing illness, health problem or disability (Scottish Government 2014a, 2014b). This figure rises to 45% in households with an income of £20,000 or less.

Recent epidemiological research in Scotland, which included 32 physical conditions and eight mental health conditions, found that 24% of the primary-care population have two or more long-term conditions (multimorbidity). The onset of multimorbidity occurs 10–15 years earlier in deprived areas compared with affluent areas, and socioeconomic deprivation was particularly associated with multimorbidity that included

mental health disorders (Barnett et al. 2012). A combination of physical and mental health problems increases clinical complexity and is generally associated with negative outcomes for individuals and families (Naylor et al. 2012).

Based on the evidence of this changing demography, it was clear that separate, and often fragmented, healthcare and social care systems could no longer meet the needs and expectations of the growing number of people in Scotland who have multiple, complex, long-term conditions and who require well-coordinated, person-centred and integrated care that offers empathy, continuity of care and collaborative relationships with professionals (Mercer et al. 2012a).

Table 1, adapted from ''Delivering for Health'' (Scottish Executive 2005), illustrates the paradigm shift required to create a system that will be attuned to multimorbidity and complexity. The core element is well-coordinated and integrated healthcare and social care.

TABLE 1.

A paradigm shift to create a future system

Current system	Future system
Geared to acute/single condition	Designed around people with multiple conditions
Hospital-centred	Embedded in local communities and their assets
Doctor-dependent	Multiprofessional and team-based care
Episodic care	Continuous care and support when needed
Disjointed care	Well-coordinated and integrated health and care
Reactive care	Preventive and anticipatory care
Patient as passive recipient	Informed and empowered patients and clients
Self-care infrequent	Self-management/Self-directed support enabled
Carers undervalued	Carers are supported as full partners
Low tech	Technology enables greater choice and control

The Scottish Health and Care Landscape

Since 1999, the Scottish Parliament and the Scottish Government (known as the Scottish Executive until 2007) have had full legislative control of healthcare and social care, resourced through the block grant to Scotland from the UK Treasury. Fourteen NHS Health Boards are responsible for planning and delivering hospital, primary-care and community services for their local populations, working closely with 32 local authorities (local government organizations) that directly provide or commission social care and housing services from the independent and third sectors. These local authorities also lead the Community Planning Partnerships (CPPs), which involve the local NHS Board, police, fire, transport, voluntary, community and private sector organizations. Ham et al. (2013) describe in detail how these arrangements differ from the rest of the UK.

Collaboration between healthcare and social care partners in Scotland has been actively promoted since the report of the Joint Future Group (Scottish Executive 2000). Although the Community Care and Health (Scotland) Act 2002 conferred powers to create pooled budgets between healthcare and social care, this legislation resulted in few examples of effective joint planning and shared resources (Audit Scotland 2011). Integrated care has featured in most healthcare policy documents for over a decade (Scottish Executive 2005, Scottish Government 2010a, 2010b) and is one of the 12 priorities in the route map to the 2020 vision for the future of healthcare in the face of changing demographics and increasing demand for services. Service integration at a local level, a greater shift towards prevention, addressing health inequalities and improving outcomes for individuals are key priorities within the Christie Commission Report on the Future Delivery of Public Services (Scottish Government 2011). So how did we take these priorities forward?

The Path to Legislation

The degree of cross-party support for the policy direction on integration is illustrated by the fact that all major political parties included a commitment to integrate healthcare and social care in their manifestos for the 2011 Scottish Parliament Election (Taylor 2015). During 2012, the Scottish Government consulted on proposals for the integration of adult healthcare and social care (Scottish Government 2012). The vision was to ensure better health and well-being outcomes for people at home and in local communities through care and support designed around the patient/service user and commissioned through effective cross-sectoral planning for the needs of the local population (Scottish Government 2013a, 2013b). There was agreement that services need to be planned and budgeted for across the whole pathway of care, drawing on the assets of local, voluntary and community resources that help to improve health and well-being and with a stronger leadership role for professionals.

The Public Bodies (Joint Working) Scotland Bill was introduced to the Scottish Parliament in May 2013 to provide a firm legislative framework for the integration of adult healthcare and social care services in Scotland. The Act received Royal Assent on 1 April 2014 and requires the local integration of adult healthcare and social care services with the option to include children's healthcare and social care services, criminal justice social work and housing support services in local integrated arrangements.

This unique and internationally groundbreaking legislation (Scottish Government 2014a, 2014b, 2014c) is grounded in a set of principles that explain what people using services and their carers can expect from integrated services and from the individuals and organizations delivering care and support.

- Services must be integrated from the point of view of service users and planned and led locally in a way that engages the community (in particular service users, carers and those involved in the provision of healthcare or social care) and enables participation by service users in the community in which they live.
- Services must take account of the characteristics, circumstances and needs of different service users and people from different areas in the local community.
- Services will be provided in a way that respects the rights and dignity of service users; improves quality of care and protects and improves the safety of service users; best anticipates needs and prevents them from arising; and makes best use of available facilities, people and other resources.

Health Boards and Local Authorities were required to establish one of two models of integrated partnership arrangements by April 2016: delegation of functions and resources between Health Boards and Local Authorities (Lead Agency) or delegation of functions and resources to a Body Corporate (Integrated Joint Board). Only one partnership (NHS Highland and Highland Council) adopted a Lead Agency model. The remaining partnerships have established Integrated Joint Boards, each with a Chief Officer providing a single point of management for the integrated services and related budget.

By 1 April 2016, each Integration Authority will oversee an integrated budget to support delivery of the integrated functions that have been agreed upon. The new arrangements will manage more than £8 billion of healthcare and social care resources, including all adult social care, adult primary and community healthcare and those aspects of adult hospital care that are most amenable to redesign through enhanced primary and community care. This approach generally includes specialist hospital services for older people and emergency medical care that may be improved through whole-system pathways for prevention and coordination of chronic care and support, palliative care, ambulatory care and intermediate care at points of transition.

Local communities are acknowledged to be the engine room of integrated care and the space to best engage and empower those who deliver and receive healthcare and social care support. Therefore, each Integration Authority will establish locality planning arrangements as a forum for strong local professional leadership and engagement of local, voluntary and independent sectors in service planning. A strategic plan and integrated budget, developed with involvement of providers, non-statutory partners, patients, carers and service-user representatives, will commission the required range of integrated services and community support to improve local population health.

Services must take account of the characteristics, circumstances and needs of different service users …

Building on Strong Foundations

This legislation builds on a strong platform of improvement and innovation in care for older people and adults with long-term conditions in Scotland. In 2008, the Long-Term Conditions Alliance Scotland (LTCAS), an umbrella organization of voluntary sector organizations (now known as the Health and Social Care Alliance) developed "Gaun Yersel," the strategy for Self Management in Scotland (LTCAS 2008). This strategy and the chronic care model (Wagner 1998) formed the basis of Improving the Health and Wellbeing of People with Long-Term Conditions in Scotland: A National Action Plan (Scottish Government 2009). A national improvement collaborative from 2008–2011 supported adoption of high-impact changes across three work streams: self-management, condition management and complex care for people with long-term conditions (NHS Scotland 2012). Between 2006/2007 and 2010/2011, the rate of inpatient bed days for coronary heart disease, diabetes, asthma and chronic obstructive pulmonary disease reduced by 14%.

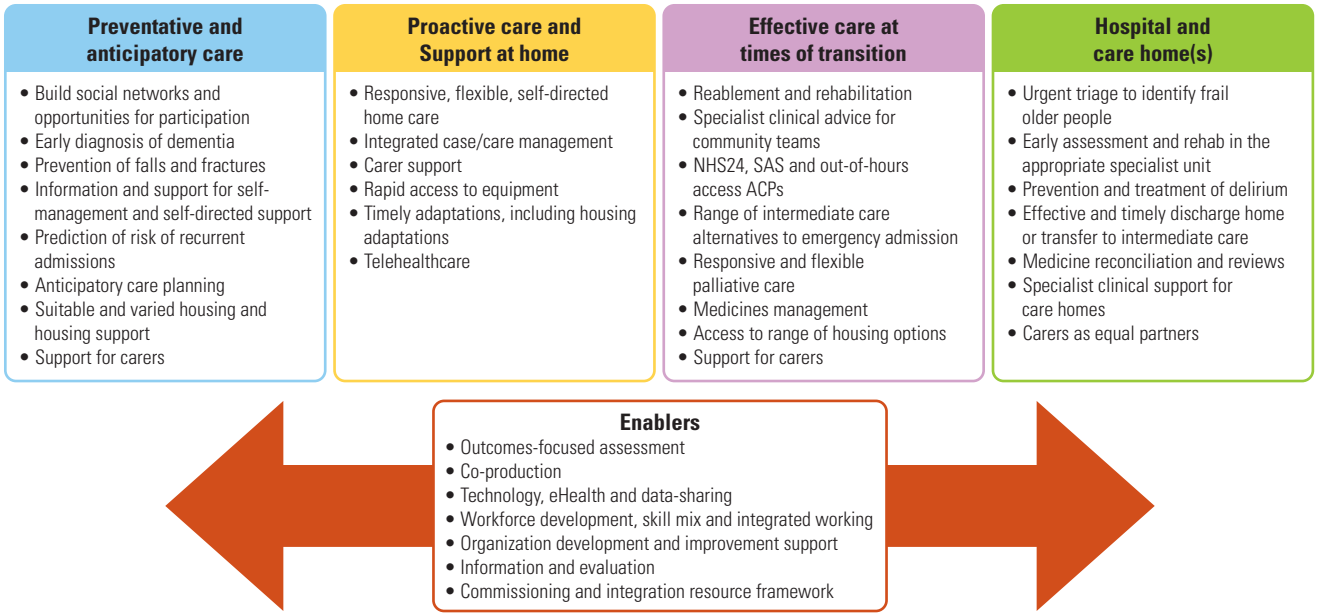
The system learning from the Long-Term Conditions program informed the Reshaping Care for Older People (RCOP) program (Scottish Government 2010a, 2010b). For four years from April 2011, a £300-million Change Fund (around 1% of the healthcare and social care budget for older people) was introduced but dedicated for the specific purpose of local transformation. Local health, social care, housing, third sector and independent sector partners worked together to use this funding to enhance the well-being and independence of older people and their carers; prevent, reduce or delay dependency; improve experience and personal outcomes; and increase the resilience of the system.

The Joint Improvement Team supported the local partnerships to implement a set of interventions across the four pillars of the RCOP pathway (Figure 1) and to learn together as a cross-sector improvement network (Joint Improvement Team 2013). This network adapted breakthrough collaborative methodology to test new approaches, spread good practice, tackle variation and track progress on a core set of improvement measures. The specific aims, ethos, interventions and improvement indicators are all highly transferable to Canada and to other healthcare systems. More information can be accessed at <www.jitscotland.org> and at <www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration>.

The Reshaping Care and Change Fund Building on Progress Report (Joint Improvement Team 2015) contains over 100 case study examples and key lessons from the partnerships.

Box 1 illustrates progress made against the core RCOP indicators.

FIGURE 1.
Reshaping Care Pathway



BOX 1.
Progress from Reshaping Care and the Change Fund by April 2015

- 39% of the Change Fund provided support for carers including assessments, short breaks, information, advice, training, income maximization and advocacy.
- Around 16% of the Change Fund was invested in the voluntary sector.
- 85% of older people receiving support at home now benefit from telecare.
- 17% reduction in rate of conveyance by Ambulance to the Emergency Department for older people who have fallen and are not injured.
- The hospital bed day rate for people aged 75+ following an emergency admission reduced by 10.3% from 2009/2010 to 2014/2015. In absolute terms this equates with a reduction of around 2% in the number of beds used, despite the increasing number of older people.
- In 2014, there were at least 5500 fewer older people in care homes than projected based on the 2009 rate and demographic trends. Older people spent around 2.5 million more days at home in 2014/2015 than would have been expected based on previous balance of care and population ageing analyses.

Improving Health and Well-being Outcomes for Adults with Complex Needs

While Barnett et al. (2015) found that multimorbidity increases with age, more people under the age of 65 years have multimorbidity in Scotland than those aged over 65 years. Health has not improved quickly enough among the most vulnerable groups in society and entrenched inequalities remain (Audit Scotland 2012). The Ministerial Task Force on Health Inequality (Scottish Government 2008) set the national approach to tackling this issue through the development of social capital, a specific focus on the 15–44 age group and the development of a Place Standard to improve living environments.

The Public Bodies (Joint Working) Scotland Act requires integration of healthcare and social care for all adult care groups. Integration Authorities are tasked with contributing to reducing health inequalities as one of nine health and well-being outcomes that are the framework for measuring progress in integrated healthcare and social care in Scotland:

- People are able to look after and improve their own health and well-being and live in good health for longer.
- People, including those with disabilities, long-term conditions or frail physicality, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use healthcare and social care services have positive experiences of those services and have their dignity respected.
- Healthcare and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Healthcare and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and well-being, including to reduce any negative impact of their caring role on their own health and well-being.

- People who use healthcare and social care services are safe from harm.
- People who work in healthcare and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of healthcare and social care services.

Extending Prevention and Early Intervention

Building on the learning from the older people Change Fund that concluded in March 2015, the Scottish Government introduced an Integrated Care Fund (£300 million, in total, over three years from April 2015) to help Integration Authorities extend prevention and early intervention approaches to all adult care groups and strengthen their focus on tackling inequalities. Partnerships are expected to plan to reduce future demand and to address issues around the inverse care law, where people who most need care are least likely to receive it (Mercer et al. 2012b).

Guidance or advice on the use of the Integrated Care Fund (Scottish Government 2014a, 2014b, 2014c) encourages investment in preventative supports and interventions for adults with multimorbidity through a stronger focus on personal outcomes, supporting health literacy and adopting a co-production approach; using technology to enable greater choice and control; and adopting an assets-based societal model to improve population health and well-being. It acknowledges the crucial role of the voluntary sector in supporting the assets of individuals and communities so that people can have greater control over their own lives and develop capacity and confidence in self-management.

The guidance encourages the extension of successful chronic care approaches to all adult care groups as described in the Many Conditions One Life, a national action plan for multimorbidity (Joint Improvement Team 2014). The Health and Social Care ALLIANCE involvement network of people who live with multiple conditions supported the Joint Improvement Team to develop this action plan to outline how the Integrated Care Fund can be used to support adults with multiple conditions to live well and to experience well-coordinated, person-centred and integrated care. Individuals and their carers describe the impact on their lives from the practical actions that local partnerships can take:

- anticipatory and collaborative conversations between the person and the professional in every consultation, with a focus on the outcomes that matter to the individual, their carers and families;
- new ways for health and care professionals to work together and with volunteers and local community resources that help people to stay well, in multiprofessional teams configured around clusters of general practices; and
- improved coordination and continuity of care and support planned around the needs of the individual throughout their whole pathway between home and hospital, including access to specialist support at home and closer to home.

It acknowledges the crucial role of the voluntary sector in supporting the assets of individuals and communities …

Lessons for Other Systems

The ambitious top-down legislation has been supported by a compelling narrative and extensive engagement on improving outcomes for individuals. Audit Scotland, the independent public spending watchdog, found widespread support for the principles of integration (Audit Scotland 2015). Success factors include a consistent policy direction, strong local and national leadership and the opportunity to build local readiness for change.

> "The Change Fund has been a positive catalyst for change, allowed new service models to be nurtured and developed and to begin to change our approach to supporting people in line with the national and local vision." (Joint Improvement Team 2015)

Practical support is an important enabler for transformation. Support provided includes guidance on the new planning, commissioning, governance and management arrangements; access to data for strategic planning and investment decisions; and phased targeted investment. In addition to the two phases of innovation funding (Change Fund followed by the Integrated Care Fund), a further £250-million investment in social care announced in the Scottish Government's draft budget for 2016/2017, and in telehealth and telecare, primary care and mental health services will build capacity in community services to reform complex and high-cost service models that are, in many cases, not delivering the outcomes that people need, especially in less affluent areas (Scottish Government 2015a, 2015b).

The conditions in Scotland are set for a unique and large-scale transformation in healthcare and social care. This is not a quick fix. The April 2016 milestone marks the start of a highly ambitious and intensive period of reform. Perhaps the most urgent challenge for the new Integration Authorities will be transforming their workforce in line with the future paradigm described in Table 1. This must happen at pace and scale and at a time when many organizations face significant recruitment challenges. Growing recognition by all professions that the current paradigm is neither desirable nor sustainable offers a strong platform for the required transformation. HQ

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