CONSULTATION ON NEW HEAT TARGETS FOR 2012/13

Joint response from:
COSLA / Improvement Service / SOLACE / Association of Directors of Social Work
August 2011

1. We welcome the opportunity to comment on the development of the 2012/13 HEAT targets and the contribution they make to the wider outcomes we are all pursuing; this is especially important in view of the role of the NHS as a key community planning partner and the links between HEAT targets and the activities of other partners. We are fully supportive of the ambition to ensure HEAT targets are aligned to an outcomes approach to performance management, including the development of quality outcomes and indicators outlined within the Healthcare Quality Strategy. As noted in the COSLA response to the Healthcare Quality Strategy consultation, we, like the NHS, are ambitious about what the development of more integrated and outcome-focused NHS performance management arrangements can provide; we believe this will offer unprecedented opportunities to work together to focus on delivering better outcomes through Single Outcome Agreements (SOAs) and contributing to achieving national outcomes.

2. In considering outcome-based approaches to performance management, there are four related points we should consider:

    - How does this support better health outcomes for our communities?
    - How does this support the prevention of poor health outcomes?
    - How does this support partnership working for better health outcomes?
    - How does this support prioritisation of activity for better health outcomes?

    These four points have informed our response to this consultation.

NHS Healthcare Quality Strategy

3. The NHS Healthcare Quality Strategy represents an important milestone in the development of outcomes-based approaches to health and social care; it has meant that the NHS is now working towards a number of the overarching national outcomes through both this strategy and its joint ownership of SOAs.

4. The contribution of the Healthcare Quality Strategy toward the national outcomes, and in particular toward NO6 “We live longer, healthier lives”, is clear. However, the relationship between the quality ambitions, outcomes, and indicators would benefit from being more clearly set out. It will be important to ensure that quality outcomes are focused on the impact we want to make on the health of our communities over the longer-term, and that the quality indicators are able to capture this, allow us to establish baselines, set meaningful targets and measure progress.

5. In this respect, we would emphasise that it is indicators at the level of the quality outcome indicators, rather than HEAT targets, that are likely to form part of SOAs, and we look forward to working with NHS colleagues towards this end as part of our ongoing joint commitment to community planning.

6. We have a number of specific comments in relation to the quality outcome indicators, however as they are still in development, and as their development is overseen by the Quality Alliance Board on which COSLA is represented, we will be pleased to offer these separately.

Alignment with existing frameworks

7. It is clear that delivering effective healthcare and related services requires pathways across a number of agencies, and we are keen to ensure that the development of HEAT targets builds on this. Indeed, many of the quality outcomes which HEAT targets contribute to require a partnership response as they cannot be delivered by the NHS on its own. Similarly, many of the HEAT targets relate to areas of partnership activity. Therefore, HEAT targets need to be well-aligned to other relevant outcome frameworks and the relationships between them well-defined and clearly articulated. This alignment will be even more important as we move to develop new models of care across the NHS and social care sectors.

8. To this end, we welcome ongoing discussions with the Scottish Government on developing health and social care outcomes as part of our continuing efforts to better integrate health and social care services. We believe that there is a clear need for clarification and rationalisation of NHS performance reporting, particularly where it affects local government activity, and that these discussions will help to progress this. In particular, the relationships between any 'new' health and social care outcomes, HEAT targets, quality outcome indicators, the CCOF, re-shaping care indicators and SOAs need to be clearly articulated, and consideration given to dropping measures and rationalising frameworks where appropriate.

9. A substantive first step in this direction would be the mapping of all the NHS policy frameworks and performance measures which have a bearing upon local government activity and the delivery of SOAs. This mapping should also identify the intended relationships of these frameworks and measures, both to each other and to the NPF, SOAs, Quality Strategy, and HEAT targets. This process will identify indicators and targets which play a supporting role in underpinning outcomes, however where indicators are of tangential significance to outcomes, we would suggest they be dropped altogether.

10. We share the ambition to streamline the range of targets across the public sector, whilst also ensuring measures support comparison across partnership areas, and we are actively pusuring this issue with the local government community. It will be important to ensure that the development of HEAT targets are considered within this wider context as part of a whole-systems approach to delivering outcomes across community planning partnerships.

11. For example, in some areas, the quality outcome indicators, HEAT targets and community care outcome indicators seek to measure the same, or similar, things in slightly different ways. More importantly, it is not clear whether this overlap is intended by design (and the rationale for this), or how similar indicators appearing at these different levels are intended to link to SOAs. This can present challenges for partners in terms of the reporting burden, but also in terms of ensuring partners' strategic planning and performance management arrangements fit together in the most efficient and effective way. Where indicators seek to measure similar things in slightly different ways, this also presents a barrier to benchmarking performance across partnership areas as part of a strategic approach to delivering best value.

Fit with partnership activity

12. We view HEAT targets as an important part of the partnership process, which can contribute to achieving the wider outcomes we are jointly pursuing. Almost all the current and proposed HEAT targets focus on processes and outputs and as such would sit 'below the waterline' of SOAs, in line with joint SG/COSLA guidance. As there has been pressure from some health boards for the inclusion of the HEAT targets in SOAs we would welcome a clear statement from Scottish Government on this in the Local Delivery Plan guidance for 2012-13. However, it is worth noting that these processes and outputs support the delivery of outcomes, and are therefore likely to be the subject of local work on outcome planning. This will be especially true of HEAT targets which are closely related to the work of councils and other partners, for

example in relation to reshaping care for older people, child healthy weight, smoking cessation and suicide reduction.

13. In such circumstances, we need to ensure that HEAT targets and associated NHS activity are progressed in a way that can deliver efficiencies across the whole system. This means that the dedicated targets of each partner need to function to support wider partnership objectives. This will include ensuring that targets dovetail with the activities of partners working with individuals and communities as part of a wider care and support pathway. To this end, we would like to see a greater recognition of the complementary roles of community planning partners' services, and local government social work services in particular. We acknowledge that there are high-level discussions underway between the Scottish Government, local government, and NHS colleagues, regarding the development of joint outcomes for health and social care integration that will help take this agenda forward.

Developing integrated resources

14. Delivering efficiencies across the whole system also requires a change in the way that resources are allocated. We welcome the inclusion of HEAT targets on care interfaces and reshaping care for older people, and agree that shifting the balance of care from acute to community-based services will help reduce unnecessary admissions and length of stays in hospital. These changes are in line with our shared ambitions for more personalised services, and will also help to reduce the high costs the NHS faces in providing acute care. As we shift the balance of care into primary and social care, it will be important that resources are allocated accordingly. This will be crucial to ensuring these services are able to meet the increased demand this shift, along with projected demographic change, will bring.

COMMENTS ON SPECIFIC TARGETS

15. Both the new HEAT targets and those for delivery in 2012/13 onwards, reflect NHS priorities and many also relate to partnership activity. We do not wish to make comment on every target and have focused on those with the clearest links to, or impact on, local government services.

16. We have not commented on the HEAT targets due for delivery in 2011/12, as these largely relate to targets that will continue to be monitored by other means or to topics that are covered in our comments on new and 2012/13 targets below.

17. We recognise that there would be considerable resource involved in responding to every consultation submission individually; however, we believe that this would be beneficial in the case of local government, particularly in view of the key role it plays in the delivery system for health and social care outcomes. We would hope that the submission of a joint response will help facilitate this process. Where we have offered specific comment, it would be very helpful if you could provide your own comments in response. This will help support a continuing dialogue on developing systems that serve to achieve the shared outcomes we are pursuing.

New HEAT targets proposed for development

Early access to antenatal care

18. The evidence supporting the long term economic benefits of additional investment in the early years is compelling, and we strongly support the introduction of this target. It will be important that the target and any associated measures are sensitive to the context of the wider system of support and how it contributes to higher level outcomes relating to support for vulnerable women and children. This support pathway may involve voluntary sector partners as well as statutory services such as social work, and joint working across these teams provides the

opportunity to address a wider range of issues than those mentioned in the proposed target; for example, the specific challenges around domestic violence in relation to early years. Consideration should be given to adding this to the range of issues the target covers, to reflect the opportunity to address this difficult issue at the point when a mother registers for early access to antenatal care.

19. Going forwards, it would be useful to consider a detailed cost/benefit analysis. This could help inform future policy-making and HEAT targets regarding modifiable risks such as alcohol use. We would also support the asset based approach proposed and, if demonstrable success can be achieved, would like to see this extended to other areas in the future.

Cancer early detection

20. We would strongly support this target and welcome the focus on an ambitious new programme. A key element of tackling delays in presentation will be to raise public awareness. To help take this forward, we would like to see a public information campaign form part of the new programme.

Primary / secondary care interface

21. The primary / secondary care interface is critical to any shift in the balance of care from hospital based care to community or home based care, and the focus on the systematic application of existing best practice guidance on information transfer is welcomed. It is hoped that this will include ensuring guidance clearly draws out the role of GPs and that service user feedback is built in to the process. As with any target focussed on a process, the relationship between the process (in this case, implementation of guidance) and the overall outcome it is intended to support needs to be clearly set out and tested to ensure successful delivery.

22. There is a wide range of other services involved in supporting people receiving primary or secondary care, and the interface with social care services is equally crucial if we are to achieve this target's ambition of improving the safety and effectiveness of care throughout the system. For example, a particular challenge for a number of local authorities is the reliance of health boards on paper based transfer of information for Single Shared Assessments. We recommend that consideration be given to extending the scope of this target to reflect the interface with social care services. This could draw upon existing measurement frameworks, such as the Community Care Outcomes Framework and the Change Fund indicators, or develop a small set of other measures if these are clearly required.

Supporting reshaping care for older people and better integration

23. As noted in our more general comments above, we welcome a HEAT target in this area and would emphasis again that this shift in the balance of care needs to be accompanied by a corresponding shift in resources. For progress on this target to be sustainable, it will need to lead to a reduction in hospital beds and a corresponding increase in investment in community based services.

24. Reshaping care for older people and health and social care integration are high on partnership agendas and we have a range of outcome frameworks and measures in place which reflect this, including the Community Care Outcomes Framework and benchmarking project, the Change Fund indicators, statutory performance indicators, and further local measures through SOAs. Local authority staff are already required to collect and collate information in this area. It will be important that any HEAT target makes use of indicators already in place, developing new measures only where this is absolutely necessary.

25. As in the case for the early years, any targets relating to the reshaping care agenda need to reflect their place in a far wider system, for example more emphasis needs to be placed on

prevention and promoting both physical and mental wellbeing, and on the value of providing low level support. In order to make lasting and sustainable changes to our models of care, we also need to ensure that we change practice. It may be that we need to consider some process measures relating to changes in practice at this stage and set targets relating to this accordingly. In particular, a focus on the role of GPs and district nurses and their capability for a flexible response, including more availability out with the normal Monday-Friday 9am-5pm hours, will be critical in this area.

Cash efficiency savings

26. As noted in the consultation document, efficiency savings are about raising productivity, enhancing value for money and improving public service delivery; in short, making the best possible use of available resources. This is a complex area and any HEAT target needs to fit with the strategic outcome focus across all relevant services and partners, so that total available resources are applied in the most effective way, to produce the best value for communities. Often savings achieved by one part of the system can result in increased costs for another, and vice-versa. To secure genuine efficiencies across the whole system requires consideration of the public purse as a whole. Focusing on efficiency savings for the NHS alone, without these important linkages, will not guarantee that savings will be locally reinvested in the most effective way.

27. We would therefore suggest that consideration be given to a target that captures savings and re-investment across the system. A percentage target for shifting resources from crisis management and reactive services, toward early intervention and preventative services, would support the most effective form of investment, i.e. in the prevention of ill-health, and would also make a significant contribution to reshaping care for older people. This will initially entail capturing shifts in resources between the acute, primary care, community care and public health sectors; however, over time, this could be extended to the voluntary and community sectors as part of developing more asset-based approaches to health care and health improvement.

28. We also note that experience in England now suggests that significant cash efficiency savings can be secured through the renegotiation of NHS PFI/PPP contracts and would be interested to learn how this opportunity is viewed by the Scottish Government.

Existing HEAT targets for delivery in 2012/13 onwards

Child fluoride varnishing (inequalities)

29. While we recognise the importance of child fluoride varnishing, this is a very detailed activity target and needs to be set within the context of other initiatives for improving dental hygiene. For example, is fluoride varnishing more important than teeth cleaning at nursery, or is an additional activity to improve performance?

Child healthy weight (inequalities)

30. We recognise the importance of focusing on child healthy weight and acknowledge the potential this has for preventing obesity and other associated health conditions in adults. The proposed target focuses on one of the inputs that can impact upon child healthy weight - completion rates for interventions. However, completion of an intervention does not always evidence that it has had the intended impact. Success rates for child healthy weight interventions may therefore be a more useful measure, and would also ensure a better link to the national indicators for children's healthy weight.

Suicide reduction

31. A reduction in the suicide rate by 2013 is an outcome which requires co-ordinated activity by a wide range of partners. However, the supporting text suggests that the indicator relates only to training of frontline staff, and by 2010. With the emphasis on frontline staff it will be important to ensure that GPs also receive training.

Financial balance

32. Managing resources effectively is a core part of delivering high-quality public services across the whole system. It will be important for community planning partners to approach their responsibilities in this area with recourse to this wider context. A whole-system approach to the investment of public funds will be required if we are to deliver outcomes, whilst making the best use of available resources. If we are to avoid unintended financial impacts on other parts of the system, and realise our ambitions for shifting the balance of care, targets need to relate to funding flows across the public sector rather than presenting financial balance as an internal issue.

CAMHS / Psychological therapy waiting times

33. Faster access to services is to be welcomed, particularly as part of a commitment to earlier intervention. However, the waiting times for this target are far lengthier those for other care groups, for example in relation to cancer detection or drug and alcohol services. Moreover, a 6 month waiting time can represent a far more significant period in a child's life, than in those of other care groups, and is likely to be detrimental to children who are dependant on a CAMHS intervention as part of their overall care plan. We recognise that there exists a significant gap between CAMHS / psychological therapy intervention rates and those being delivered by many other health and social care services, and that it will take time to impact on this; however, we would hope this area could be given greater priority. We would also recommend that the target should go beyond referral to treatment and should address interventions' actual delivery and subsequent effectiveness. This would help deliver on our joint commitment to Getting It Right for Every Child, and ensure that services fit together to deliver the right support, at the right time.

Reduce A & E attendances

34. As with many other HEAT targets, reductions in A&E attendances will require action by a range of services across the public sector. This is particularly evident when considering the whole population. A whole population approach may deliver the greatest gain, and also ensure the target is more clearly located within the wider partnership context. A particular concern for community planning partners is the weekly concentration of A&E attendances and the number of alcohol-related attendances, with their associated health and social issues and resulting costs to other services. However, as it is currently phrased, the HEAT target appears to relate only to older people and so clarification on this point would be helpful. If the intent is to focus only on older people, a clearer acknowledgement of the role of crisis care, emergency response, and telecare services would also be useful, as would the role of at-home examination and treatment.

<u>Areas for further consideration</u>

35. One area that does not feature in the existing targets, or proposals for developing new targets, is adult support and protection (ASP). To date, referrals into local government care and support services from the NHS have been low. However, frontline NHS staff are often particularly well-placed to identify and raise concerns about vulnerable adults that come within the terms of the ASP Act. Including a focus on vulnerable adults within the HEAT performance framework could help support earlier identification, in line with our joint ambitions

around prevention and early intervention. There is a range of indicators that could be considered, including proxy measures such as the percentage of frontline staff in acute and primary care settings who have completed adult protection training.

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