Discussion Document on NHS Lanarkshire's Response to the Integration of Adult Health and Social Care in Scotland Consultation Document May 2012

Version 6

General Context

NHS Lanarkshire and its partners are committed to putting in place a system of Health and Social Care that is robust, effective and efficient and which reliably and sustainably ensures the highest possible quality of support and care for the communities we serve. In working towards this goal we fully acknowledge the need for services to be designed around the service user and their carers in a way which is as seamless and integrated as possible.

Together with our community planning partners we also recognise the importance of being jointly accountable for improving service delivery. It is therefore considered to be imperative that there is an appropriate balance between national expectations and targets and the local priorities that emerge from service user and carer involvement in determining the range of services to be provided to best meet the needs of local communities. The performance management arrangements that are employed must also reflect both national and local democracy, especially where there are differences in terms of service priorities.

As we begin this process it is helpful to recognise that we are building on existing strong foundations and within the NHS Board area there is already a range of integrated services that are recognised as delivering consistently high levels of performance.

As we seek to redesign services using evidence based practice we consider it also to be very important that we make the necessary changes with due regard to the wealth of research evidence on integration itself.

At a recent independently facilitated event involving NHS Lanarkshire, North and South Lanarkshire Councils we considered this evidence with particular regard to those factors which characterise both successful and unsuccessful approaches to service integration. We noted that successful partnerships tend to be characterised by strong embedded partnership working, a shared vision, co-terminosity and committed leadership. Whilst unsuccessful approaches are often characterised by top down imposition, are driven by financial pressures, are overly focused on performance regimes and have high levels of organisational and financial complexity. Within this, the factors which are considered to most help integration are where there is a focus on local circumstances and cultures. Equally, the factors that are said to most hinder integration are where there is too much focus on structures and national perspectives.

For these reasons, NHS Lanarkshire would wish to support the recognition within the Consultation Document that “local leaders will be free to decide upon delivery mechanisms and organisational structures that best suit local needs and priorities”. It is helpful that the document and supporting annexes recognise the need for effective organisational development work to strengthen leadership and provide training and support to frontline staff. We are of the view that these factors are at least, if not more important, than agreeing which model and structures best suit these local circumstances.

It is also recognised that there are some differences in the employee relations models used within the NHS and Councils and it is extremely important that this is addressed in advance of service integration to ensure staff and staff side can continue to play a prominent role in managing effective service redesign across the Health and Social Care Partnerships. The NHS in Scotland has a robust statutory Staff Governance Framework and we consider that this approach needs to be adopted within any new integrated structures which are formed.

Whilst we recognise that an integrated budget should make it easier to target resources more effectively there needs to be detailed consideration of the various legal, tax and financial accounting issues before any new models are introduced. This is essential if we are to secure the most advantageous position for the partnerships and avoid budgets being depleted through changing the regime.

There is also widespread agreement that robust governance systems need to be in place not least where there are clinical and professional accountabilities. It is welcomed that further work will be carried out to ensure that professional leaders, especially where there are statutory duties, have a prominent role to play in ensuring these systems are fit for purpose within any future partnership structures.

We would therefore welcome the opportunity to participate in the preparation of the plans to support the organisational development; training and development of frontline staff; partnership working agendas; professional accountability models and reviews of employment policies and procedures highlighted in annex 'C' of the consultation document.

Colleagues across the NHS and Local Authority recognise the importance of the four pillars around which we will build a sustainable future that are described in the Scottish Government response to the Christie Commission report, "Renewing Scotland's Public Sector". Amongst these pillars is the need for preventative spending to avoid negative outcomes arising. This is an approach which we fully endorse and we are a bit disappointed, that of the four pillars, this does not feature as prominently in the Consultation Document as Integration, Leadership and Stronger Performance Management. Making preventative spending integral to the integration process would reinforce the patient-centred element of the quality of adult health and social care. This would ensure that the key public health and health improvement issues such as improving the quality and quantity of life for Scotland's people, and tackling health inequalities have suitable prominence in the delivery agenda.

Our response has been prepared following extensive discussion with Community Planning Partners, the Public Partnership Forum members, Area Clinical Forum and our Area Partnership Forum. It should be noted that whilst there is a consensus across the partnership on the overall policy objectives of providing seamless, efficient and effective services that are designed around the service user and are as integrated as possible, that there are some areas where there are some differing views on how this can best be achieved.

There is a fundamental question raised within the community planning environment on why, given that the existing partnerships are seen to work well and there is already provision within the Community Care and Health Act for partners to delegate resources from NHS to Local Authority and vice versa, is such a transformation required? This gives rise to a further question around whether the proposed reforms will deliver better outcomes, in those partnerships which already have a good track record on joint working, than existing partnership structures.
This position will no doubt be reflected in the responses that are submitted through partner organisations.

One final consideration is that there is a general consensus that the issues under consultation are too complex and important to answer in yes or no terms. For this reason we have not ticked these boxes, preferring to share the NHS Board perspective through the more detailed answers given in the template provided.

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?

Given that many people, especially in our more deprived communities, experience the impact of multiple health and social care issues at an earlier stage in life it is logical to extend the integration to include all adults. There is a concern though, that with the proposed performance focus being on improving outcomes for older people, that this could potentially have a detrimental impact on performance for other community care groups. It will therefore still be very important to ensure that agreed objectives and performance measures are set and monitored for Health Improvement, Mental Health, Physical Disability, Substance Misuse, and Learning Disabilities within the Single Outcome Agreement.

Whilst there is reference within chapter 3 of the document that the nationally agreed outcomes for older people is the starting point and work will be ongoing to establish similar outcome measures for all adult care groups it would be helpful to see this with a timetabled programme for action. Equally, we consider that if we are to positively promote a shift in the balance of spending between prevention and intervention to reduce the level of negative outcomes from arising in the first place, then having clear performance measures around preventative spending and tackling health inequalities will be very important.

Question 2
Is the proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it or anything that you would suggest should be removed?

It is helpful that the document recognises that achieving effective integration whilst maintaining focus on the quality and consistency of services and supports to people currently in need will not be easy.

In discussing the proposals with staff across NHS Lanarkshire there is a clear recognition that the most difficult aspects of the integration process will be on bringing large groups of staff, with varying terms and conditions and established traditions and cultures, together. Whilst there is some reference to this in chapter 2, and more obviously in annex c, it is considered to be extremely important that the timescales and processes linked to the transition plans recognise these challenges. Future plans will need to describe the organisational development approaches that will be required to support those leading the changes to bring the various groups of staff together in the most harmonious and productive way. It will of course be critical for well-defined governance arrangements to assure standards of care especially as the new organisations will result in greater blurring of professional boundaries.

Whilst it is recognised that the proposals for reform set out in the consultation are not based on centrally directed structural change, it would be helpful if there is a commitment nationally to prepare Model Partnership Agreements and Schemes of Delegation to assist discussions on local delivery.

In terms of what we would like to see added to the framework, it would perhaps be helpful to see a stronger statement around the need for improved integration within the NHS between primary and secondary care. Whilst good progress is being made on this area, especially through the Reshaping Care for Older People Programmes, it would be helpful to see more obvious reference to this to strengthen the need for further changes in mindset within professional groups across the NHS.

Given the important role that GP's play in managing patient referrals, admissions and discharges to and from acute services there is some concerns that NHS Boards do not have sufficient influence over existing practice because of GP's independent contractor status. It would be helpful for this to be a key feature of any future reviews of the GP Contract.

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 and for supporting carers. 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?

It is clear that we cannot have two performance frameworks, one for the NHS and one for the Local Authority if we are to have successful service integration. Moving to a single set of nationally agreed outcomes will assist Local Authorities and NHS Boards in moving on from the integration process itself to focusing leadership attention on the outcomes and results being achieved

rather than on the structures that need to be established to support delivery. As has already been highlighted in the context section of this response, it is also considered to be very important that there is an appropriate balance between national and local democracy and accountability.

As has also been previously stated, it is important that community planning partners recognise the critical areas of service delivery across other community care groups and the work with children and families, including child protection, requires careful consideration. There are of course a number of cross cutting issues that impact on families, which are not age specific. These of course include physical disability, substance misuse, mental health, learning disability and homelessness. It is very important that performance monitoring across all areas of the Single Outcome Agreement are considered. It is suggested that the existing performance frameworks which are in operation within the Lanarkshire partnerships and which focus on inputs, outputs and outcomes for all of the community care groups are used to establish the baseline performance requirements until the proposed outcome focused measures are established.

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, the outcomes need to be included in the single outcome agreement. As stated earlier however, there must be a single jointly agreed delivery and performance management system that covers all community care groups and which is sensitive to the cross cutting issues that are experienced across all age groups and families.

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?

Yes, this is possible if there is agreement at both national and local level on the key performance measures that are to be delivered and that there is a standard approach to measuring performance against these outcomes.
It is also very important that the delivery plans and single outcome agreements have stretching but realistic objectives. These need to take account of growing demand and increasing expectations at a time of resource constraints. Failure to adopt this approach could result in tensions around e.g. whether increased spending on new drugs and treatments or speedier access to health care services is more of a priority than increased levels of home care support to maintain independent living as the numbers of older people in the population grows. These are also examples of the requirement for balance between local accountability and national targets and expectations.

There are also concerns within Local Authorities around the current accountability of Chief Executives being to the full Council when the proposals in the consultation propose that for the JAO this is through the Council Leader.

Question 6
Should there be scope to establish a health and social care partnership that covers more than one local authority?

This should be a matter for local determination, however, within Lanarkshire even the minimum level of integration, as described in the document, would make the two Lanarkshire Health and Care Partnerships very large, with revenue budgets in excess of £400 million each.

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

From an NHS perspective, these are considered to be appropriate provided there is clarity around the delegated authority to the Health and Social Care Partnership. This needs to include clear agreement on the rules of financial engagement especially on the levels of authority to vire across budget heads. This will be crucial to speed up decision making processes without reference back to committee level, whilst at the same time ensuring that an appropriate level of governance is applied to decisions taken through the Jointly Accountable Officer. As stated in response to question 5 there are concerns within Local Authorities that these proposals to do not recognise existing standing orders within Councils.
It is also recognised that there are some differences in the employee relations models used within the NHS and Councils and it is extremely important that this is addressed in advance of service integration to ensure staff and staff side can continue to play a prominent role in managing effective service redesign across the Health and Social Care Partnerships. The NHS in Scotland has a robust statutory Staff Governance Framework and we consider that this approach needs to be adopted within any new integrated structures which are formed.

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, for older people. However, the proposed programme of reform for other care groups needs to be established to ensure appropriate outcome measures are agreed for all service users. It is also important that the proposed performance management arrangements are seen within the much wider infrastructure of pre-existing inspection and regulation. This includes bodies such as The Care Inspectorate, The Mental Welfare Commission, The Scottish Social Services Council, QUEST and The Older Peoples Inspection

Programme currently managed though Health Improvement Scotland. Some consideration requires to be given to the level of cooperation required amongst the existing inspection and regulation bodies, which in themselves are not integrated, to ensure that uncertainty and confusion does not prevail.

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, this should be for local determination.

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?

From the NHS perspective, it is considered that the models described can successfully deliver on the policy objective. Both models create an integrated budget which should make it easier to target resources more effectively. It is important however that the various legal, tax and financial accounting issues are resolved before these are introduced to avoid the budget being depleted through the change in regime. A number of particular concerns are set out below. Little is known of the legal form a new Body Corporate might take and that uncertainty makes it a riskier option.

VAT – the council VAT recovery regime is more beneficial than the health regime, and any move which reduced the potential VAT reclaim on the part of the budget originating from social services could significantly reduce the amount to spend on care. Whilst it is believed possible to reach individual agreements with HMRC based on identifying the separate streams, as the desired outcome of the funds losing their source identify is achieved this may be threatened. Dependant on the agreed organisational form the new body corporate may find it loses the beneficial VAT status at the outset.

Charging - health is a universal service, free at the point of need whilst some Local Authority services incur charges. The final documentation around integration needs to recognise this potential dilemma and provide guidance to partnerships on how clarity can be given to service users about the difference between NHS and Social Care provision and that which is free at the point of use and that which may incur charges. Loss of income as services merge and become more generic would again reduce the amount available for care.

Pay regimes – whilst TUPE regulations could provide a solution for any staff transferring at the outset, the terms and conditions of new staff would have to be resolved quickly. Any equal pay claims or general levelling up of terms and conditions would increase the costs of providing services which would then require greater efficiencies. It is believed this was experienced in the early English models.

Property – the funding regimes for purchase and depreciation of assets differ this would then have an impact on any transferred budgets and need to be resolved so objectives could be met.

Negligence – Health self-insures by pooling with other Health Boards, the councils have commercial insurance. Certain risks would not be attractive to commercial insurers without an increase in premium.

Financial reporting and accounting regimes – it is unclear how a Body Corporate, which is understood as a new legal entity, could as the consultation suggests in section 5.13 "be subject to the respective financial governance arrangements of each partner". Certain forms of Body Corporate could introduce further regulatory requirements (e.g. company or charities law) which may add a layer of overhead to operating the budget.

It will also be important to have clarity around how parallel legislation, such as on Self Directed Support can continue to be delivered through the new partnerships.

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?

There are excellent examples already in operation across Lanarkshire. These include, Integrated Substance Misuse, Integrated Day Services and Integrated Home Loan. The Alcohol and Drug Partnership has also presided over the development of a single service strategy and delivery plan which is underpinned by an agreed commissioning strategy and single performance framework. It is suggested that this approach is a useful model to follow for Adult Health and Social Care Integration. One key principal which is recognised in the document is that structures and legislation alone will not deliver the improvements, rather, it is people involved in the new arrangements who will make the difference. A big learning point around this integration process has been the need for significant organisational development support in bringing staff together in to a jointly managed team. Given the magnitude of the integration agenda, as described in the consultation document, the level of leadership and organisational development energy cannot be underestimated.

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, but overall the approach taken must be a matter for local determination.

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?

Shifting the balance of care will be achieved through programmed service transformation that needs to be agreed at a strategic level within the NHS and Local Authority partnerships and not necessarily through the decisions made by individual officers. Any disinvestment from the acute sector as a result of successful initiatives to shift the balance of care will also require local and national political support.

There will be a requirement for clearly defined rules on delegated authority to support the Jointly Accountable Officer in making prompt decisions around individual cases that are compromising the partnerships ability to achieve the stated goals. Whilst the level of delegated authority should be a matter for local determination it may nevertheless be helpful to develop model partnership agreements and rules of financial engagement at a national level as a framework which can be customised to fit with local circumstances.
It is perhaps worth repeating here that with reference to rebalancing care, the Scottish Government accepted the Christie Commission recommendations that this was not only about the balance between residential and community provision but also about the balance between prevention and intervention. If this is to achieve a relevant level of prominence in the service planning and delivery process then performance measures will need to be set to track how the Local Authorities and NHS Boards are progressing this very important issue.
It should be recognised however that the system is not static. Even with successful measures to shift the balance of care and provide the potential for the release of resources from the acute sector, demographic change, bringing with it increased incidence of cancer and conditions associated with old age as well as the annual emergence of new expensive drugs and treatments, will exert a pressure in the opposite direction.

Question 14
Have we described an appropriate level of seniority for the jointly accountable officer?

Yes, given the size and complexity that most integrated Adult Health and Social Care Services will present then it is important that the Jointly Accountable Officer has the relevant level of experience, qualifications and seniority to deliver on this agenda.

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

This should be left to local determination. There are already strong locality planning arrangements in place based on the recognised townships that together make up Lanarkshire. These groups have a good understanding

of local needs and service priorities which in turn can contribute to the development of both service delivery plans and an overarching commissioning strategy. This approach also strengthens local involvement from service users, professional staff, the wider community planning partnership members and locally elected members.

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?

This duty is expressed strongly enough, however, it is very important that health and social care professionals are clear about their role in developing a sustainable mix of services and supports across the whole patient journey and that they do not become involved to promote the interest of a single profession or aspect of service.

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?

It is very important that clinicians and social care professionals become directly involved in locality planning arrangements that already exist across Lanarkshire. It is also important that consideration is given to the level of recompense that independent contractors will require to support their effective contribution to the locality planning process.

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

No, because to do this would disregard the lessons of community planning and the need to organise around natural communities with which local residents can identify. The existing locality planning arrangements are organised around recognised townships and it is into these which health and social care professionals, including GPs should input.

Question 19
How much responsibility and decision making should be devolved from Health and Social Care Partnerships to Locality Planning Groups?

This is a matter for local determination. Locality planning groups are a key element in an effective approach to delivering integrated support. The embedded nature of locality planning groups in Lanarkshire will also be very

important in ensuring an appropriate balance of care for adults and children and families within their defined areas.

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?

No, localities are not determined by population size, but by recognised townships. As has been highlighted in questions 15 through 19, the existing strength of locality planning groups which are built around these townships are seen as an essential component in the planning and delivery of an effective mix of services for all community care groups.

Do you have any further comments regarding the consultation proposals?

Yes, these are set out in the context section of this response.

Do you have any comments regarding the partial EQIA?

No.

Do you have any comments regarding the partial BRIA?

No.