FALKIRK COUNCIL'S RESPONSE TO

THE SCOTTISH GOVERNMENT'S CONSULTATION DOCUMENT ON THE INTEGRATION OF HEALTH AND SOCIAL CARE SERVICES

1 GENERAL POINTS

1.1 Falkirk Council fully supports the objective of achieving the best possible outcomes for older people. In conjunction with partners, we have developed a vision for older people in the Falkirk Council area and it is against this vision that we have evaluated the proposals which have been set out in this consultation.

1.2 Local Authorities, and in particular Social Work Services across Scotland have an excellent track record in shifting the balance of care from institutional care to community care. In the Falkirk area we are proud to have led the way in the re-provisioning of services to people with Learning Disabilities who previously spent their lives in institutional hospital care. The closure of RSNH was a major achievement demonstrating strong multi-agency working and the impact on the former patients has been immense. Likewise we have seen a significant reduction in other forms of acute hospital provision with the level of acute beds now being amongst the lowest in Scotland. In relation to the use of continuing care hospital provision for older people, we have seen a significant reduction in people receiving continuing NHS care from 187 in 2003 to 65 in 2011. None of this would be possible without a strong commitment to effective multi agency working and to achieving the best possible outcomes for the people who use our services. It is from this strong starting point that we face the challenges arising from demographic changes, financial pressures, social changes and changing public expectations.

1.3 There are no simple solutions to the problems and challenges we face and we would caution against the integration agenda being seen as a panacea for all ills. The consultation paper, in setting out the case for change, identifies two areas of "disconnect" that can impact on the effectiveness of community based support. The first is the disconnect between primary and secondary or acute care within the NHS. The second is the perceived disconnect between health and social care services. This consultation paper does nothing to address the first area of "disconnect" which arguably may become even more challenging if resources have the potential to transfer from acute hospital care to community based social care. If partnerships are to be expected to achieve an appropriate balance of care, it is important that they do so with the benefit of clear guidance on what constitutes appropriate levels of acute hospital provision. There are clearly concerns about the potential for acute care to be compromised by transfer of resources from acute care into primary or community care. This will be a particular issue in areas such as the Forth Valley which already has low levels of acute provision. While we are supportive of placing as much resource as possible "upstream" in community settings, where earlier and preventative intervention is possible, we do not want to see hospital provision compromised to the extent that people in our communities are unable to access essential services. The development of guidance in relation to these matters is essential if partnerships are to be able to make informed decisions about how resources are to be used.

4. Although we welcome the emphasis on an outcomes based approach to deliver integration, which is in accordance with Christie Commission report on integrating public services, we are disappointed that the proposals in the consultation paper do not recognise the centrality of Community Planning as the vehicle for agreeing, measuring and monitoring outcomes. Likewise we consider that, although the proposals are intended to "enable" locally implemented integration, the details of some of the proposals appear to be highly prescriptive and are expressed as requirements. In this regard, we have concerns about the level of prescription implied by this consultation, particularly in relation to the two models which are proposed for achieving integration and would suggest that this may not give sufficient flexibility to achieve local solutions which are relevant to local circumstances. We would have similar concerns about the level of prescription attached to the proposals regarding governance, the integrated budget and the jointly accountable officer. Our concerns are covered in more detail in the relevant consultation questions.

5. We are concerned that the consultation document does not address the potential implications for the protection services that Social Work provides, and in particular the risks associated with such services becoming fractured.

6. The potential structural changes implied in this document are immense and the risks associated with such prescriptive change cannot be underestimated. We would advocate that a more measured approach would be to enable a range of approaches to be tested out and evaluated across Scotland, as happened with Children's Services in relation to GIRFEC implementation. This would enable learning to be shared and an evidence base of "what works" to be developed. We would also suggest that sufficient time needs to be allowed to achieve the changes which are envisaged.

2 COMMENTS RELATING TO ANNEX C

1. A group to look at the workforce issues is welcomed but it would be helpful to see COSLA involved in this group as well as balanced Local Authority representation; there seems to be an imbalance in the numbers of bodies on this group who work with the NHS by comparison to local authorities.

2. There are a number of employee relations and workforce issues which are not fully explained in the document For example:

- Whatever model is agreed at a local level, it will involve a significant culture change for all existing employees involved in this regardless of the level at which they work. These points are very much played down within the paper but could result in significant barriers if not handled sensitively and if Trade Unions are not directly involved in the change process. What consideration has been given to the employee relations issues as opposed to the OD issues raised within the consultation paper, as these need to be considered;

  What consultation has been undertaken by the Scottish Government with national Trade Union colleagues given that they are a key stakeholder?;

- The report refers to staff moving between NHS and Council employers. This would disrupt their continuous service and in turn their conditions unless a change was made to the redundancy modification order, which allows Councils to count service from other employers (or equivalent for the NHS);

- Comments within the paper about employees being able to move between employers requires further consideration to ensure the public sector continues with an approach of openness and transparency in its recruitment practices;

- For joint future work, there was a requirement to put in place some form of protocol to ensure all stakeholders were fully signed up to the cultural and OD changes and the principles of how these would take place – it appears that something similar may be required and it may be helpful to obtain a national model for this which offers guidance but with sufficient flexibility to enable Partnerships to develop local protocols which meet local needs;

3 COMMENTS RELATING TO ANNEX D

3.1 Whilst it's helpful to have an initial equality impact assessment, it may also have been helpful for local authority and NHS employees to be part of this work as it moves on.

Detailed response to the consultation questions

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?

We fully support the proposal that there should be a focus on improving outcomes for older people, however we have concerns about the suggestion that improvements require the integration of all services for older people. There are major difficulties associated with separating out services for older people from services to other adults, as outlined in our response to Question 2. It is important that we are both ambitious but realistic in our aspirations and that we apply an evidence based approach to any proposed changes. In our view the case for integration of all adult services has not yet been made and there are concerns about the potential disconnect of adult services and children's services. Successive adult and child protection enquiries have highlighted the importance of retaining strong connections between children's services, criminal justice services and adult services, particularly those relating to substance misuse and mental health. For this reason we would urge a cautious and considered approach.

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?

The information regarding the acute sector is significantly under-developed. The document proposes that all of the older people's care budget from Councils, NHS Community Health budget and 'some' acute spent. is combined into a pooled budget. Clarification is needed on what aspects of acute spend would form part of an integrated budget.

We also have significant reservations about the concept of a single integrated budget covering all areas of health and social care spend in relation to older people being an absolute requirement. We would suggest that it would be more helpful for legislation to provide enabling powers to integrate budgets in whichever ways best serve the objective of delivering improved health and social care services. A number of service areas span all adult services. For example, our mobile emergency care service and home care service responds to the needs of all adults who require such support. If there was a requirement for all resources relating to older people to be combined in an integrated budget then clarification would be required on how any shared overheads would be treated.

The proposed framework is also highly prescriptive and proposes structural change, which research shows is at best ineffective at delivering better outcomes. We would suggest that the level of prescription is removed with there being a focus on ensuring enabling powers which can be used flexibly to achieve agreed outcomes.

There is a lack of clarity about what is meant by locality service planning by clinicians and care professionals. There is also a lack of acknowledgement of the challenges relating to the involvement of GPs as independent contractors and no acknowledgement of the critical role of NHS 24 in ensuring timely access to primary care when people require this.
The framework makes no reference to the significance of self directed support as a new policy and practice imperative.

The framework does not adequately cover the IT implications associated with integration, which have been significant barriers to date.

The proposed framework does not give sufficient consideration to the HR implications which, in our view, requires careful consideration if they are not to act as barriers to change.

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 support to 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?

In our view, performance management should be embedded within the community planning frameworks that already exists in Scotland. If we are to truly deliver better outcomes for older people then it is not just Health and Social Work that have a role: housing, policing and many other services will also be critical. Partnership working across all of these agencies is fundamental to our community planning arrangements.

Holding partnerships to account for the delivery of national outcomes changes the focus of community planning partnerships and single outcome agreements. Our focus currently and in the future must be on local solutions to local issues and thus while we will inevitable make a contribution to achieving national outcomes, our accountability must be local. We do recognise that given the national oversight of Health services there maybe tensions between national and local priorities but this is nothing new and in a mature partnership can be overcome. However that is dependant on the Government not unduly placing an emphasis on national outcomes over local priorities.

The proposals should be clearer about where the outcomes for older people will sit in relation to the HEAT targets for the NHS. These dominate the way services are provided in the NHS and rely on a process approach as opposed to an outcomes approach. It is important that the nationally agreed outcomes for older people have a similar profile and complement the other performance management arrangements in existence within the NHS as they do within Councils, otherwise they will not deliver what they are intended to.

We have significant concerns that information technology which enables sharing of information and recording of outcomes remains underdeveloped.

Question 4

Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

As mentioned above the emphasis on national outcomes within the SOA could change the content and focus of local partnerships. At the moment SOAs report on local outcomes with a link to how these relate to national outcomes. By shifting the emphasis so significantly on this issue, it would be unclear how this would sit within an SOA that covers other significant issues such as economy, safety etc.

We also understand that through the SOA review there will be a significant reduction of PIs to be reported. It would therefore not be clear how the progress and success of integrating health and social care would practically be reflected within an SOA.

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?

In broad terms, the governance arrangements proposed are unnecessarily complex and diffuse. There are too many roles prescribed for too many bodies or individuals. Roles are prescribed for the Partnership Committee, its Chair and Vice Chair, the JAA, the Chief Executives of both the Board and the Authority, the Council Leader, the Board Chair and the Cabinet Secretary.
It is recognised that as the Scottish Ministers will retain statutory responsibility to provide the health part of the partnership and likewise the Authority will remain responsible for delivering its responsibilities, there will require to be a line of accountability from the partnership to both the Ministers and the Authority. The proposed partnerships will be based on a Partnership Agreement between the Health Board and the Authority (pare 4.8). This would provide a useful starting point for considering the accountability arrangements. Both the bodies forming the Partnership would have the opportunity to agree the terms on which the Partnership is being formed. In terms of the democratic legitimacy of the decision making, a decision by the Authority to enter into the agreement would provide such legitimacy so far as the social care services are concerned. The proposed Partnership Committee will be a committee of both the Authority and the Board. That being so, there will already be a clear line of accountability between the Committee and its parent bodies.

It is possible to see that there could be a simpler version of the system of accountability proposed. Nationally agreed outcomes (presumably agreed by COSLA and the Scottish Ministers) would inform the Partnership Agreement between the Authority and the Health Board. This would be the high level outline of the work of the Partnership to be overseen by the Partnership Committee and directed by the JAA. The services anticipated to be provided by the Partnerships are important to the communities which Authorities serve. Members appointed to Partnership Committees will well understand the significance of delivering services successfully, as will the parent bodies. It is not clear that superstructure proposed to sit above this would add much to the process of accountability.

In relation to the question of the balance of local and national decision making, it is not easy to comment on the whether the right balance has been struck in the absence of further information on the level of detail proposed in the national agreed outcomes, the extent to which these are outcomes as opposed to the means of achieving them and the extent of compulsion which the proposals would allow Ministers.

It should also be noted that the governance arrangements as described ascribe a role to the Council Leader, to Committee Chairs and to the Council Chief Executive which do not easily articulate with the longstanding governance principle within local authorities that the officers of the Council are responsible to the Council as a whole.

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

Whilst we have no objections to there being scope to establish a partnership covering more than one local authority, we are clear that our preference would be for a local partnership to cover the boundaries of Falkirk Council. In our view this provides maximum local accountability for local services whilst still enabling us to undertake a wider Forth Valley approach to planning and delivery of services when it makes sense to do so.

Question 7
<u>Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?</u>

No, they need to be strengthened and the link to democratic accountability made more strong. At the present time our services are accountable to 32 Elected Members. The new proposals could see scrutiny resting with only 3 Elected Members and 3 non-elected Directors of the NHS Board. This represents a significant reduction in scrutiny and accountability.

We have some concerns abut the role of the Chair of the Partnership Group and the expectation that, in carrying out this role, they will set not be representing the interests of their own organisation or of their constituents.

We also have some concerns that issues of professional governance are not fully explored in the document. Lack of clarity about professional governance can become barriers to effective integrated working and can comprise effective delivery and management of risks.

Question 8
<u>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?</u>

It should be up to local partnerships to determine the performance and quality management systems they require to support improvement. There must be recognition that there will be different approaches to improvement, assessment, inspection and review in place for services that will be covered by the integration arrangements. It will take time for these to be brought together and integrated.

Support for change is welcomed but this would have to be practical and reflect local circumstances.

We understand the proposal is that if there is unsatisfactory service delivery or national targets are not achieved, the there would be the power to intervene and deliver services locally. This would be a significant change in the power Government would have to intervene in the delivery of local authority services.

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 a decision reached locally by the partnership.

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?

Our view is that the models outlined above are too prescriptive and lack an evidence base. Models need to be developed from a starting point of what needs to happen to improve outcomes, not from an assumption that structural change will result in improvements. The VAT treatment of the various models has yet to be clarified and this could be a very significant factor.

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 have undoubtedly been difficulties associated with the deployment of resources across the health and social care system, with the issue of resource transfer being a recurring area of potential conflict. One of the issues which is not referred to in the consultation document, but which a very significant factor for local authorities, is the issue of charging and the basis on which charges can or cannot be applied to integrated services. Much more detailed consideration at a national level is required in relation to this issue.

Question 12
If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide impetus and sufficient local discretion to achieve the objectives we have set out?

Direction will certainly provide clarity, however, it will also reduce flexibility and discretion. On balance we would prefer to have the flexibility to enter into whichever budgetary arrangements can best support us to achieve our objectives.

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?

No, we have serious concerns here, because we feel the contribution of the acute sector is unclear and that this is a major weakness of the consultation.

NHS Boards have had single accountable officers in the form of Chief Executives who have struggled to shift resources within the NHS. We would question why this should this be any easier in partnerships. In our view there needs to be an honest appraisal of the barriers to shifting investment in this way rather than brushing over them.

We have concerns about the comments regarding the jointly accountable officer having the authority to make decisions about resource prioritisation without needing to refer back to partner organisations. This implies a very high level of delegated power to a jointly accountable officer which would not be compatible with existing schemes of delegation in many local authorities.

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

It is clear from the high level of delegated authority implicit in this post that a very senior post is envisaged. See comments above in relation to the appropriateness of this level of delegation.

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

No, by definition locality planning should be local.

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 appears to be sufficiently strong. However, it is important that equal consideration is given to the views of different occupational groups and that a "hierarchy" is not allowed to develop which gives greater weight to the views of medical professionals.

We would suggest that there also needs to be an emphasis on consulting users and carers.

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?

As indicated above, the challenge will be in getting equality of involvement and influence.

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

No. GP practices do not represent natural communities. Locality planning should take place within communities that are meaningful to people and, wherever possible, should encompass the services which are used in that area.

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

The Health and Social Care Partnerships should remain the decision making and accountable body, and, as such, should not be expected to devolve responsibility in this way. There should, however, be scope for locality planning groups to make informed proposals for the partnership consider.

Question 20
Should localities be organised around a given size of local population –eg. of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

See Q18.