

Integration of Health and Social Care in Scotland

Scottish Government consultation on proposals

City of Edinburgh Council and NHS Lothian

Joint Response

- 1.
2. This response is submitted on behalf of the City of Edinburgh Council and NHS Lothian.
3. A number of joint discussions have taken place between May and September. The deadline for submission to the Scottish Government is 11 September 2012. It is proposed that the response be:
 - submitted as a draft to the Joint Board of Governance for comment on 27 August;
 - submitted for approval to Policy and Strategy Committee on 4 September;
 - subject to ratification by the NHS Lothian Board on 26 September.

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

The initial focus on outcomes for older people provides a practical baseline, which leaves sufficient scope for local determination. Given that the arguments in favour of integration are sound, serious consideration will be given in Edinburgh to extending the scope to all service user groups, particularly as many of our services provide simultaneously for older people and adults.

This will have the benefit of ensuring that management arrangements are not complicated by the creation of new barriers between groups.

As the consultation document states, conditions associated with old age often present much earlier than 65, and people with disabilities and mental health issues have needs irrespective of their age. A focus on older people alone creates 'an artificial divide within adult services'. It would be helpful to consider specifically the management and treatment of long term conditions for adults, such as diabetes, heart failure, dementia and COPD.

There is a commitment to explore the development of an integrated children's service for Edinburgh.

A number of services that are currently provided by East, Mid and West Lothian CHPs on behalf of the City of Edinburgh Council are being reviewed.

The consultation document is explicit about the need to integrate some acute services. This is welcome. NHS Lothian is keen in principle to integrate acute services within the Health and Social Care Partnership in order to improve pathway management, resource utilisation and most importantly, patient experience.

In re-designing and reconfiguring health and social care services, it will be essential to ensure that the integration of primary and secondary care services is enhanced, such that positive outcomes for people are maximised and that those services not included in the partnership are clear about their relationship to it.

The integration process will also need to take account of other local authority strategies, which have a significant effect on older people. For example, community engagement, fuel poverty, leisure and housing.

Appendix A outlines the services that may be considered for inclusion between NHS Lothian and City of Edinburgh Council. This is not an exhaustive list and continued discussions across the Council and NHS may identify additional services which, if integrated could improve pathways of care and outcomes for people.

Outline of proposed reforms

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

The proposed framework is reasonably comprehensive. It is helpful to see acknowledgement of the good examples of integrated working, which already exist, and the stated intention that proposals will not dictate local delivery mechanisms or organisational structures so that these can be developed to suit local needs.

The joint responsibility arrangement is helpful in ensuring equity between organisations in the integration process. It avoids the distractions of structural change and allows a focus on matters which deliver best outcomes for people.

It would be helpful if the Scottish Government would consider a more holistic approach to an individual's needs and include guidance on the connections with other critical support services, which are not referenced in the national proposals. This will include areas such as community engagement, fuel poverty, leisure and housing services.

As the consultation document states, additional 'improvement work' will still be necessary at a local level to complement the proposed 'systems changes' outlined in the framework.

Additional guidance would be helpful on how shared capital assets should be managed as part of the integration agenda and into the future or whether this would be left to local determination.

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

It is important for effective operation and delivery of services that we have a joint set of performance measures and outcomes, jointly agreed and owned, which continue to improve on current national indicators. Joint reporting is an important component of this shared responsibility.

The approach will be sufficiently strong to effect the changes required, subject to joint agreement being achieved.

An outcomes-led approach with jointly agreed and reported outcomes between Health Boards and local authorities will ensure the partners are focused on the

same priorities. This will make them easier to deliver. However, the necessary cultural shift within both organisations will be significant and should not be underestimated.

The required changes to reporting arrangements and developing mechanisms to support joint accountability will need to be managed as part of the change programme.

The Edinburgh Health and Social Care Partnership intends to:

- focus on a small number of outcomes, which are critical to effective service delivery for service users and to engage with service user representatives to ensure their relevance;
- strip out any organisation-specific indicators, which do not contribute to the agreed outcomes, in order to make the reporting arrangements more manageable and focused;
- review whether there any existing perverse incentives or conflicts in performance targets, which may be within the existing separate performance management arrangements to ensure overall care is at the forefront of the newly integrated approach;
- ensure that governance structures and decision making processes are clear in order to avoid slowing down integration and service delivery; and
- develop structures which ensure that other partners in a holistic approach can be included in the planning process.

We intend to ensure strong and effective linkages to the Community Planning agenda, as this develops, to ensure the proposals support the broader goals of Single Outcome Agreements, such as tackling health inequalities.

It would be helpful for any future legislation to support these approaches.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Depending on the scale and nature of the national outcomes, inclusion in the SOA may be helpful. However, this should be left to local determination.

Partner agencies should have the ability to determine locally the content of the SOA, in line with their joint priorities. It has been agreed in Edinburgh that the partners will determine a small number of key priority outcomes, based around key issues for the locality. The SOA may not simply be a reflection of the local position on national outcomes for any specific service/agency. It might therefore be unhelpful to include all national Health and Social Care outcomes in the SOA. This is particularly the case when considering that the SOA is a focus of joint work across a multiplicity of agencies.

Governance and joint accountability

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Further work will be required to mandate the roles required.

This is one of the most complex areas of the proposals. For the arrangements to be truly effective in terms of ensuring accountability of the key players, there will need to be discussions on current local government legislative powers.

Under current local government legislation, only a council committee, sub-committee or a delegated officer can be authorised to commit resources/ take decisions on behalf of the council. In view of this collective responsibility, the council leader cannot currently undertake this role.

Further work will need to be undertaken at a national level to connect the governance role of the Leader and the Health Board Chair back to the full Council and Health Board.

It would also be helpful to reflect on the ability of the arrangements to truly hold the chair and vice chair of the new Health and Social Care Partnership to account under current local government legislation, when the collective responsibility applies.

It is proposed that the Chief Executives of NHS Lothian and the City of Edinburgh Council be accountable for performance to the Council Leader, Health Board Chair and Cabinet Secretary. However, constitutionally, the Council Chief Executive is formally accountable to the full Council, not to the Council Leader. This therefore needs to be addressed properly in the proposals.

The Edinburgh Health and Social Care Partnership will specify clearly the leadership and accountability roles and responsibilities held by the Partnership itself and those delegated to the Jointly Accountable Officer, particularly with respect to budgets, investment and the obligations associated with these. Guidance from Scottish Government on this would be welcome.

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

It may be sensible to allow for partnerships to cover more than one local authority area, but this must be subject to local determination.

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

Yes in principle, but they require alignment with current local government legislation.

The proposals to have voting members of the Health and Social Care Partnership Committee made up of an equal number of Health Board Non-Executive Directors and local elected members are sensible and balanced in principle. A minimum of three representatives from each statutory partner may be insufficient to reflect the political mandate of the local population. However, it is important to ensure that local authority representation on the Partnership reflects the democratic make up of the council.

There are a number of issues, which need to be addressed to facilitate this proposal.

Currently, any committee of the City of Edinburgh Council is required, in law, to have two thirds membership of elected members. Further work will be required to marry this legal requirement with the proposal for the Partnership Committee to be both a committee of the Council and of the Health Board, and have an equal split between elected members and non-executive Health Board members.

In NHS Lothian there is an issue of insufficient Health Board Non-Executive Director resource to service partnerships across the NHS Lothian region. NHS Lothian is currently considering how it can support the governance arrangements for the Health and Social Care Partnership.

There are concerns regarding the number and role of non-voting members on the partnership committee, and a balance needs to be struck between the need for these roles and the size of the partnership committee. However, the importance of professional, patient and third sector advisers is strongly supported.

Patients, service users, the third sector, neighbourhood partnerships and carer organisations have all made a significant contribution to the development of CHPs. Consideration will need to be given to the best way to enhance and improve these contributions in the partnership arrangements, learning from both good practice and lessons of the past.

It would be helpful if the Medical/Clinical Director role could be chosen from a variety of the clinical leads/professions and have a clearly specified role on the committee to represent the range of clinical perspectives (not simply that of their own profession). Alternatively the partnership may consider the establishment of a clinical advisory support structure with the chair of this structure responsible for representing a range of clinical views. The key point is that relevant clinical/functional perspectives are clearly represented when these need to influence decision making.

The NHS has a strong history of partnership working with Trade Unions. This will need to be reflected in the final governance arrangements for the Health and Social Care Partnership.

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?

More detail required.

The introduction of a new set of nationally agreed outcome measures, which are jointly agreed and which apply across all adult health and social care will improve the alignment and balance of performance measures for older people/ adult services. The coverage must expand beyond measures such as delayed discharge to be truly meaningful. This has potential to improve the robustness of performance management arrangements in a way that is meaningful for those in receipt of services.

However, joint performance management will take time to bed in across the two organisations because of practical issues related to data, systems, etc., and these issues should not be underestimated.

NHS Lothian and the City of Edinburgh Council each has its own distinct performance management arrangements and systems to manage failing services and these provide sufficient public confidence. It is less clear how performance will be managed at the level of the new Health and Social Care Partnership. Clarity is needed on the nature of support arrangements for managing 'failure'.

The shift to personalisation must also be recognised as an influencing factor on outcomes for people. The monitoring and measurement of this will be an important part of overall outcomes monitoring.

It would be helpful for the collaborative working across external scrutiny partners to provide for a consistent approach to measuring performance, establishing evaluation criteria and supporting quality development in adult health and social care. It is essential that this is aligned to the Local Government Strategic Group, which identifies and agrees the key risks in each council and develops an appropriate programme of scrutiny activity.

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?

Local determination on this matter is very welcome, particularly for the Edinburgh CHP where it is hoped a broad view of integration will be taken.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

The models proposed do offer a real mechanism to improve the effective use of the resources available. However, demographic forecasts are such that the efficiencies achieved through these changes are unlikely to be sufficient to offset the need for increased resources in future.

Key issues to be addressed will include:

- finding the most appropriate model to allow the integrated resource to be used efficiently across both organisations;
- establishing long-term financial planning arrangements and practical funding mechanisms, which deliver the best outcomes for people within the reality of the budgetary constraints; and
- agreeing the mechanisms for managing inflation, the ordering and authorising processes, procurement, etc.

There are a number of ways in which the NHS and local government differ. These include charging, VAT and capital rules. It would be helpful if detailed guidance were made available to progress these issues.

A national work programme has been established to consider the implications of these proposals on staffing. While it is believed that changes to terms and conditions are an unnecessary distraction and will not form part of changes in Edinburgh, it is important for these matters to be fully scoped, and any issues addressed at an early stage at a national level.

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?

In Edinburgh, there are examples of flexible use of resources across both

organisations, including:

- Intermediate Care;
- Geriatric Orthopaedic services; and
- Stroke Pathways.

Edinburgh has some experience of resource transfer between organisations and with the development of joint approaches through the Change Fund.

It would be particularly helpful to learn of examples from other bodies where flexible use of resources has led to demonstrable improvements in patient care and/or efficiencies, which can be redirected to front line services.

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?

Edinburgh is one of the few CHPs in Scotland with a jointly appointed Director of Health and Social Care with responsibility for services in both the NHS and the local authority.

A joint management team meets regularly to work towards joint outcomes.

A number of joint services have been established with both NHS and Council staff, for example Intermediate Care.

Edinburgh is keen to retain its position as a leader of integration across health and social care, and therefore the Council and NHS Lothian will seek to integrate beyond the scope outlined in the consultation document.

Local determination is important. Therefore minimum, rather than maximum, categories of spend are welcomed.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

The financial authority to manage budgets would be established either through a service level agreement/partnership agreement between organisations or through accountability to the chief executive of the host organisation.

With the requisite commitment from both partners and clarity within the agreement, these mechanisms would deliver sufficient financial authority to the Jointly Accountable Officer to facilitate shifts in investment and deploy resources across the partnership to ensure efficient pathways of care.

Strategic financial decisions, for example over major investment, will remain the responsibility of the Health and Social Care Partnership.

The proposals can be interpreted as going beyond what would normally be allowed within a local authority context, where only a delegated officer of the council or committees can allocate resources or make decisions on behalf of the Council. However, the scale of these changes is necessary if current barriers to quality of care are to be removed and the reshaping care agenda is to be progressed to deal with future service demand.

It would be helpful to specify clearly the governance and leadership responsibilities for budgets, as noted in the response to Question 5 and 7.

We note that the National Group on Commissioning is considering the issue of Jointly Accountable Officer in relation to joint procurement. The views of this group will be important in ensuring adequate authority.

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

Generally, the proposals will allow sufficient autonomy to facilitate integration and management of resources, without moving to centrally directed structural change.

The collective responsibility in the council's decision-making role, highlighted in the response to question 7 above, must be addressed to facilitate these proposals.

Professionally led locality planning and commissioning of services

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

Local determination is a key factor in local planning. Central direction may not be sufficiently flexible to cater for the range of local circumstances across the whole of Scotland. However, it would be helpful to develop an overall national framework to reduce the risk of 'postcode' variations in services.

Community Planning arrangements in Scotland are currently under review. Any locality planning arrangement proposed through the Integration Bill should take full cognisance of the outcomes of this review.

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?

The duty to consult local professionals is very strong. During the process of developing the new arrangements, it will be essential to ensure effective engagement of a range of professionals, including acute clinicians, social care professionals and all primary care practitioners.

Public Partnership Forums, patients, service users, Neighbourhood Partnerships, the third sector and carers organisations have all made a significant contribution to the work of Community Health Partnerships. In addition, Health and Social Care Services in Edinburgh have a range of consultation mechanisms, which also make an important contribution.

Consideration will need to be given to how these contributions can be maintained and enhanced within the Health and Social Care Partnerships. Both the City of Edinburgh Council and NHS Lothian would welcome the opportunity to rethink these mechanisms in the light of integration.

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?

A key incentive, which will encourage clinicians and social care professionals to become involved in local planning, is linked to the positive influence they will have in the new Health and Social Care Partnerships, and in the creation of new and more effective pathways of care, which increase the benefits to their patients/ service users.

It will be important to consider new ways to encourage professional groups to participate fully in locality planning forums and groups.

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

Clusters of GPs are one option to facilitate locality planning. The rationale for local planning should be left to local determination so that local circumstances influence the design.

It may be helpful for Scottish Government to develop a range of options for local areas to choose from and apply as most appropriate to their circumstances. Alternative configurations could be linked to actual geographical communities or to other administrative boundaries, such as wards, neighbourhood delivery areas or school catchments.

Whatever the arrangements, the reference to the direct involvement of elected members is to be welcomed.

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

A key aim of the proposals is to facilitate integration across organisational boundaries to deliver improvements across a whole system of care for older people and adults.

It is critical that the responsibilities and decision making within locality planning arrangements fit firmly within this whole system concept and facilitate local delivery of whole system improvements for care.

The benefits of locality planning should not outweigh the possibilities for economies of scale and strategic oversight, which are achievable at a partnership level, nor should they lead to 'postcode variations' in outcomes for people.

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?

This matter should be left to local determination, in line with local circumstances and should not be based on national, arbitrary statistical populations.

Do you have any further comments regarding the consultation proposals?

The principles of the proposals are strongly supported in Edinburgh by all partner agencies. Central direction is welcome on matters of principle and in delivering the enabling legislation.

Local determination should be a key factor in deciding delivery mechanisms and organisational structures for the improvement of outcomes for individuals.

There are a number of links to other initiatives, which will need to be understood and managed carefully. These include:

- Self Directed Support/personalisation;
- Change Fund;

- Commissioning strategies;
- Integrated Resource Framework – where experience could be used to inform integration;
- Sustainable Procurement Bill – and the need to ensure a common approach to implementation of its provisions by councils and NHS Boards; and
- Management of health inequalities.

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

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

Services to be considered for Integration in the Health and Social Care Partnership

Adult Services

The overlap and interdependencies of health care and social care are complex. The proposals for integration offer a positive opportunity to consider the whole care system for adult service users and to resource care in a way which is responsive to need rather than being restricted by organisational budget and management boundaries.

With this in mind the services being considered for inclusion are:

- Learning Disability Services;
- Mental Health Services
- Addiction Services;
- Older People's Services; and
- Elements of Acute Services

Hosted Services

There are currently a number of 'hosted' arrangements where services are hosted by a CHP, but are provided across the whole of NHS Lothian. Discussions have begun to reconsider the existing arrangements for hosted services.

NHS Lothian and the City of Edinburgh Council will consider the integration of hosted services, except where the disadvantages outweigh the benefits, for example where they are:

- highly specialist
- small in scale and patient numbers
- currently configured and operating in a way which would be too complex and not in the interests of patients/clients to change

Council Services

There are a small number of services not currently within the remit of the health and social care where the merits of further integration need to be considered.

There may also be some small and specialist services currently within health and social care which may need to be integrated with other Council services.

Children's Services

There is a commitment to explore the development of an integrated children's service for Edinburgh.