

SCOTTISH GOVERNMENT CONSULTATION ON THE INTEGRATION OF ADULT HEALTH AND SOCIAL CARE.

Response on behalf of North Ayrshire Council

Introduction

North Ayrshire Council welcomes this opportunity to comment on Scottish Government's proposals for the integration of adult health and social care.

The Council recognises the strength of the case for change and is in agreement with the objectives set out in the consultation. We view these proposals as an opportunity to make major improvements in the quality of health and social care services and we are committed to working with Scottish Government and our local partners to develop and implement integration of adult health and social care in Ayrshire.

In the specific Ayrshire context, the Council has explored with NHS Ayrshire and Arran and East and South Ayrshire Councils, the issues around creating a single partnership in Ayrshire. As we have worked with partners to identify options for structural arrangements in Ayrshire, North Ayrshire Council has come to the conclusion that the most effective way of delivering change, improving services and outcomes for the people of Ayrshire would be a panAyrshire arrangement. We note however that the other Ayrshire Council's are not of the same view. We remain convinced that a panAyrshire arrangement would be the most economically efficient in terms of management and administrative overheads but would allow us to focus on the major issues which we believe require pan-Ayrshire solutions. Our biggest challenges are around health inequalities, where the gap is increasing and Ayrshire's position as having the highest proportion of emergency admissions in Scotland. In both areas we need Ayrshire-wide strategies if we are to deliver effective and sustainable change. While we are attempting to develop these strategies, the implementation is based on individual local authority areas. This is challenging in terms of consistency of approach, allocation of resources and tackling system wide issues.

The Council and its partners have made significant progress around reshaping care for elderly people. However, the improvements in response to those in hospital, dementia care and support, effective reablement services and improved housing options continue to be offset by increasing demand. Unless we are able to reduce emergency admissions across Ayrshire we will not be able to shift resources from reactive to anticipatory care. Effective solutions to emergency admissions will enable us to deal with rising nursing home admissions, a high proportion of which come directly from hospital. This issue has been difficult to tackle as three separate Ayrshire partnerships with the NHS and it is likely that any future arrangement which continues the three partnership position will not generate the scale of change which is necessary to improve the Ayrshire position on emergency admissions and free resource from the acute sector to improve community services.

In our response to the individual questions that follow we make reference to issues which require further development or clarification. Further work on these areas will strengthen the final arrangements for integration and make their success more likely. North Ayrshire Council is ready to work with Scottish Government and our local partners in this respect.

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 agree that the proposed initial focus on older people is appropriate given the demographic pressures that are being experienced and forecast across all of Health and Social Care. Although the proposals will not on their own tackle the scale of demographic change they should, if successfully implemented, help to mitigate the initial impact. This focus will also build on the progress made by local partnerships in transforming care for older people under the auspices of the older people's change fund.

The extension of this focus to all areas of adult health and social care should not be long delayed as effective management of health and social care needs for the adult population can positively impact on their needs in older adulthood. This is particularly the case for those affected by long term conditions or who have health and social care needs relating to disability, mental health or addiction issues. It would be helpful to agree national timescales for the development of these further outcome frameworks.

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 Council is supportive of the framework for integration. Further work and guidance at a national level is required on the role of the Chief Social Work Officer, which could sit within the Partnership or the Council. Dependent on which services local partnerships decide to include in the scope of the partnership further work will be required at a local level to ensure that those services which contribute to both adult and children's social care (e.g. addiction and mental health services,) are not fragmented.

As the consultation itself recognises further work requires to be done on the role of housing in relation to the proposed integrated structure, the Scottish Government's Strategy for Housing for Scotland's Older People 2012-2021 clearly recognises the role that housing, and the housing sector plays in shifting the balance of care. The strategy specifically highlights the need to strengthen the connections between housing, health and social care to improve outcomes. The challenge for integration is to ensure that whatever arrangements are put in place increase the likelihood that the objectives detailed in the national strategy are achieved.

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?

A single set of outcomes that applies to each Health and Social Care Partnership should provide one element of the framework that will help to achieve the extent of change that is required to shift the balance of care. For this to have maximum effect and to avoid creating a bureaucracy around performance management the outcomes should be relatively few in number and clearly focussed on the primary goals of the Health and Social Care Partnerships. In addition to avoid conflicts between the outcomes and shorter term targets, any shorter term targets should be clearly linked towards achievement of the longer term outcomes. As noted in our response to question 4, situating the Partnership outcomes in the local Single Outcome Agreement will ensure that there is no conflict between the Partnership outcomes and other Community Planning Partnership outcomes that would contribute towards improving adult health and social care.

Question 4

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

There is a wider issue to be considered here. That is, that the framework for the integration of adult health and social care should take account of the outcome of the review of community planning which is currently underway. Both proposed statutory partners in the integration of adult health and social care have statutory duties in respect of community planning. Changes made to community planning arising from the review must take account of the developing proposals for integration of adult health and social care and vice versa. To consider either issue in isolation from the other risks developing structures and processes that are not compatible with each other or that result in duplication of administrative effort which would divert resources from front line services.

We agree that adult health and social care outcomes should be included within local single outcome agreements (SOAs) since these represent a substantial part of community planning partners' activity on behalf of local people. Inclusion of these outcomes within the SOA will facilitate links to other services (e.g. Housing) that affect health and social care outcomes for adults are made. Equally, inclusion of adult health and social care outcomes within the SOA will help to ensure that these outcomes contribute to the wider community planning aspirations of the Community Planning Partnership.

Equally it should ensure that links are made with issues such as homelessness which are affected by health and social care.

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?

The arrangements for accountability as they are described in the consultation document focus on individuals who have the role of holding the Partnership/Committee to account, i.e. the Leader of the Council and the Chair of the NHS Board. This does not take account of the status of the Partnership as the Joint Committee of the local authority and the NHS Board. Existing legislation for local authorities does not permit delegation of functions to a single Elected Member. Empowering individuals within the partnership organisations will require amendment of at least the Local Government (Scotland) Act 1973. In the context of the local authority, it is the Council as a whole that should hold the partnership to account.

Similarly, the role given to the Chair of the NHS Board as is framed in the consultation document could be read as not taking account of the duty of the Board as a whole to hold the Partnership to account.

In order that clear understanding of the respective roles is achieved, it would be necessary to provide a detailed definition of “being accountable to” in relation to the Leader of the Council, the Chair of the NHS Board and the Cabinet Secretary.

Question 6

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

We agree that there should be scope to establish a Health & Social Care Partnership that covers more than one local authority. That is our preferred option for Ayrshire as the most effective way to deliver better outcomes for residents and to keep management overheads as low as possible by appointing a single Jointly Accountable Officer. The introduction to our response sets out in the major challenges which North Ayrshire Council believes can most effectively be addressed by a pan-Ayrshire arrangement. In practice, however, we recognise that the timescale for integration may not be long enough for this to be achieved but scope within the legislation to establish a Partnership covering more than one local authority would allow authorities, with their respective Health Boards to work towards this. We also recognise a number of potential difficulties, both practical and in terms of democratic accountability that require to be addressed to enable such a partnership to function effectively.

In, for example, a partnership covering three authorities each authority would have only one quarter of the voting rights if the proposed balance between NHS and local authority were to be maintained. Individual authorities might feel that their ability to influence the partnership was diluted in these circumstances. This would be particularly the case where the political composition of the local authorities was markedly different. Individual authorities might then consider that they were prevented from delivering the priorities on which they were elected.

Question 7

Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnerships?

We believe that the proposed Committee arrangements are appropriate to ensure governance of the Partnership. Consideration should be given to allowing for the appointment of substitutes from the statutory partners in the event that a designated member is unavailable. This would allow the balance between the NHS Board and the local authority to be maintained, thus retaining democratic accountability and preventing unnecessary delays to the business of the partnership.

It would be helpful for standard dispute resolution arrangements to be developed.

The involvement of third sector representation as a non-voting participant in partnership boards is seen as helpful towards achieving a consistent understanding among statutory and non-statutory providers of care. However, there is no one body that could be seen to represent the third sector and there is a risk that the legitimacy of the third sector representative could be called into question. Moreover, the outcome of procurement exercises could be the subject of challenge if some organisations were perceived to or actually had access to commercially sensitive discussions at the partnership board.

We believe that it would be advisable to include a housing representative as a professional adviser in order to ensure that the necessary strategic links are made.

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?

Early identification of poor performance will be crucial. Reporting against outcome frameworks and proportionate scrutiny by the Care Inspectorate and Health Improvement Scotland have a role to play in this. Arguably more important will be the ability of Partnerships to conduct robust and effective scrutiny of their own performance and to seek support where necessary. Networks for peer support from similar partnerships may also be useful, possibly based around the family groups that are being established for the SOLACE benchmarking process. In the longer term a review of the functions of the scrutiny bodies may be required to ensure that these bodies can appropriately assess the performance of the Partnership as a whole and do not place extra burdens on Partnerships by duplicating inspection exercises.

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?

We would support allowing NHS Boards and local authorities to include other CHP budgets in the scope of the partnership. Partnerships will have to give particular consideration as to where services that cover more than one care group are located in relation to the partnership. To avoid fragmentation there should be scope for such services to be located either within the partnership and to provide services to the NHS Board and Council as well as to the partnership or within either the Council or the Board and to provide services also to the partnership. The extent to which multiple services should be included within a single partnership will depend on local factors, including population density and geographical size. Legislation should be flexible enough to cope with a variety of local circumstances.

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?

Yes. However to gain maximum benefit from these models there are a number of supporting and “technical” issues that will need to be addressed in order that partnerships can focus on achieving outcomes and not on managing bureaucracy. Examples of such issues are:

- Aligning the budgetary cycles of the NHS and local authorities so that partnerships have clarity of the funding that is available to them as far as possible in advance of the start of each financial year. This will enable partnerships to make strategic decisions with regards to resource allocation.
- Longer term planning for capital investment that looks at the wider capital estate in the Partnership’s geographic area in order to make best use of public assets, regardless of ownership. This would allow the Partnership to take advantage of opportunities to co-locate services in a way that meets the needs of people who use those services rather than the convenience of the service deliverers. It would also support efforts to reshape the wider community infrastructure (including making land available for housing to meet older people’s needs and preferences).
- There needs to be investment in performance management, information, financial and Human Resource systems to ensure that Jointly Accountable Officers, managers of integrated services and Partnership Boards have access to consistent, high quality and timely information. This would be more difficult to achieve if each Partnership had to work with a number of legacy systems that had been designed to serve the requirements of a superseded structure. It is suggested that this is best developed on a national basis to achieve procurement efficiencies and to avoid duplication of effort. It is recognised that this is likely to be at best a medium term project and will require a level of funding from Scottish Government.
- Integration will challenge partnerships to create a workforce that is developed and empowered to deliver integrated models of care. The future workforce project that is being delivered by the Scottish Social Services

Council is an important first step in addressing the workforce development challenge but should be expanded to include Health staff who will be part of the integrated arrangements.

- Initially people working in the Partnership will be employees of the NHS Board and one or more local authorities. Each employer will have differences in terms and conditions, affecting pay, pensions, holiday entitlement and arrangements for managing performance and sickness absence. Over time this may become difficult to manage and consideration may need to be given to standardising terms and conditions of employment in order to avoid diverting management time from front line services.

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?

Ayrshire was a test site for the Integrated Resource Framework. In phase 1, which involved a cost-mapping exercise, there was considerable effort for little return. Not all costs could be attributed to geographical area and little has changed in terms of the allocation of resources or strategic financial decision making. While the phase two pilot projects had some success in developing new and, to an extent, integrated models of care these pilots sat within a framework of health and social care that was not integrated and subject to different management and budgetary arrangements. This placed limitations on the pilot projects.

Access to land held within the NHS is an issue in the context of reshaping housing supply in order to enable suitable housing for older people to be built to allow them to remain within their communities. Different approaches to the disposal of surplus land and approaches to determining “Best Value” have led to situations where the Council has been unsuccessful in acquiring land at affordable housing rates, with requirements within Health to achieve maximum price resulting in property being sold to the highest bidder on the open markets.

There is a need for resources to be looked at flexibly across capital and revenue.

There are also difficulties in ensuring that housing resources for adaptations which are central to achieving health and social care outcomes are available across all tenures. These different funding regimes for Council tenants, housing association tenants, private sector tenants and owner occupiers act as barriers to ensuring flexible use of resources.

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. The minimum categories of spend should be prescribed in some detail to ensure a consistency among the various partners and clarity for each partnership as to the resources that it has at its disposal. This applies equally to acute services and to secondary and social care services.

Further clarity is needed on the position of housing funding. Paragraph 2.6 states that “Where money comes from – health or social care or, indeed housing – will no longer be of consequence.” Funding for housing comes from many different sources dependent on the tenure involved: social rented (Council or Housing Association), private rented or owner occupied. The governance arrangements are also distinct with the Housing Revenue Account being ring-fenced.

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?

We agree that it is necessary for the Partnership to have the flexibility to manage all of its resources from all funding sources, to achieve its agreed outcomes, including as a priority, shifting the balance of care. This means that *within agreed parameters* Partnerships will require to have the authority to make decisions about use of funds.

The proposals as currently described vest a considerable amount of authority in a single individual, the Jointly Accountable Officer, and make no reference to the Partnership Board, the local authority or the NHS Board. The Partnership Board should have a role in scrutinising and approving decisions and recommendations of the Jointly Accountable Officer in respect of the use of financial and other resources. Each Board should agree appropriate levels of capital and revenue financial authority for the Jointly Accountable Officer. Beyond those levels the Jointly Accountable Officer should require approval by the Partnership Board.

We would envisage that major financial decisions would require approval by the local authority and/or the NHS Board. Both bodies will also hold the Partnership to account for its use of funds through scrutiny of the extent to which the Partnership has achieved its agreed outcomes which will include, as a priority, shifting the balance of care.

Further consideration of the role of the Section 95 Officer is required in the new model of integrated working. We will support the work of the Integrated Resources Advisory Group that has been established at a national level to progress this and other financial issues.

Successfully shifting the balance of care from the acute sector to the community will require the transfer of substantial financial resources and major changes to current practice. In order to ensure that the transfer takes place it is suggested that Partnership Boards agree with the statutory partners annual and longer term targets for the shift in resources, for which they would be held to account as part of the performance management arrangements.

Question 14

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

We agree that the Jointly Accountable Officer should be a direct report of the respective Chief Executives. Further clarification is required to cover the relationship between the Jointly Accountable Officer and the Chief Social Work Officer. In our view it is incompatible for the Jointly Accountable Officer and the Chief Social Work Officer to be the same person. There would be too great a potential for conflicts of interest to arise (in any direction). It would be appropriate for the guidance on the role of the Chief Social Work Officer to be updated to reflect the new partnership arrangements.

Question 15

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

The Scottish Government should place an obligation on partnerships to establish locality planning arrangements that are to meet the needs of each partnership area but should not prescribe what those should be. This will allow partnerships to respond flexibly to their particular social, economic and geographic circumstances.

We do envisage a role for national government in supporting workforce and leadership development issues that are likely to be common to all partnerships and to develop the GMS Contract to facilitate engagement of general practitioners in locality planning and in the wider work of the Health & Social Care partnerships.

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?

We believe that this duty is strong enough to ensure that the Health and Social Care Partnerships adequately consult local professionals. The success of such consultation will depend also on the active engagement of local professionals in the locality planning process.

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?

Where appropriate, contractual arrangements should be written to facilitate the engagement of clinicians and practitioners in locality planning.

Practitioners and social care professionals are likely to get involved with and drive planning at a locality level to the extent that they believe that their involvement will make a difference to service delivery. It is important that locality plans do not conflict with the wider strategic plans of the Partnership and that the strategic plans are developed taking account of the needs of localities in the Partnership area. Partnership boards will therefore have to ensure clear and consistent communication of their high level strategy and take account of the views of practitioners and clinicians in developing strategy.

Question 18

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

Locality planning should be based on natural local communities. While the role of GP practices is recognised as important for the success of locality planning, practices may not be coterminous with community boundaries. To organise locality planning based on clusters of GP practices could result in boundaries which are not those of the natural community. Fundamentally localities should be recognisable as communities to those who reside in them. This will help to ensure that planning is focused on the needs of communities and not on administrative convenience.

Question 19

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

Locality planning groups should have responsibility for defining the needs of the local area and for specifying services to meet these needs. These might be commissioned locally or on a wider area basis where the requirements are similar. Partnership Boards should have the power to delegate to locality planning groups the right to commission local services within a specified financial limit but this should be a decision for each Partnership board to make in the light of its own local circumstances and the maturity of locality planning in its area.

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?

Population size is of less relevance to locality planning than natural local communities. Imposing a fixed size could result in natural communities being split or merged so that they become administrative districts rather than areas that are recognised as a community by those who reside in them.