

Response to the Scottish Government's Consultation on the Integration of Health and Social Care

Part One: Introductory Comments by East Lothian Council

1. The Council welcomes the opportunity to comment on the Scottish Government's proposals to legislate for the integration of health and social care services. We support the overall drive to improve outcomes by integrating health and social care services which we believe can build upon the improvements we have already made through joint working with our partners, and integration should bring further benefits for service users, carers and communities.

2. Our response to the consultation paper is set within the context of other major change underway across the public sector and the need to ensure that the establishment of Health and Social Care Partnerships is fully connected within this framework.

3. The principles of the Christie Commission on public sector reform should underpin our approach to integration. This means that we should focus on outcomes, local delivery, leadership and front line staffing capacity.

4. The Community Empowerment and Renewal Bill seeks to strengthen community participation, unlock enterprising community development and renew our communities. Health and Social Care Partnerships will be more successful by ensuring their approach puts the contribution of local communities at the heart of their activity and works with individuals, community groups, voluntary organisations and independent providers to deliver local solutions.

5. We believe that community planning partnerships should play a key role in driving integration locally. Local authorities have well established models of community planning in place and the integration agenda should fit within these arrangements albeit strengthened by more local partnering and community involvement. This is in line with the outcome of the recent review of community planning which placed a new statutory duty on individual partners to work together to improve outcomes for local communities through participation in community planning partnerships and the provision of resources to deliver Single Outcome Agreements.

6. The ongoing review of Community Planning and Single Outcome Agreements has focused on revising and strengthening the current approach and produced a 'Statement of Ambition' in March 2012. To implement the Statement of Ambition three core proposals have been agreed:

I. **Strengthening duties on individual partners** – new statutory duty on all relevant partners to work together to improve outcomes for local communities through participating in CPPS and the provision of resources to deliver the SOA

II. **Placing formal requirements on Community Planning Partnerships** by augmenting the existing statutory framework to ensure that collaboration in the delivery of local priority outcomes via CPP and SOA is not optional.

III. **Establishing a joint group at a national level** to provide strategic leadership and guidance to CPPs.

7. These proposals will equally apply to the new partnerships strengthening the links between activity and outcomes and a need to be able to demonstrate best value in the delivery of integrated services. Where a partnership-based or integrated approach is required the CPP will be expected to ensure that the development of robust and appropriately resourced plans and delivery arrangements for agreed outcomes are in place, and to exercise appropriate oversight over these.

8. We would suggest that it should be made explicit in the proposals that the integration of health and social care should be more formally aligned with these strengthened community planning partnerships. This will provide a good fit with the report of the Christie Commission in its aspirations to develop integrated services, focused on local communities that are aimed at improving outcomes for local people. It will also provide a good platform on which to build the locality planning arrangements described in the consultation paper.

9. The Council plays a key role in shifting the balance from institutional care to community care, and we are making good progress on this working with our public, voluntary and independent sectors partners. Equally, we are focused on managing increasing demand for services brought about by population growth, against a backdrop of reduced funding. These dual pressures mean services need to change and our transformation programme is already reshaping care for older people in East Lothian.

10. This is a challenging process at a time of financial constraint and while the introduction of the Change Fund has helped to provide a small amount of bridging finance, the more fundamental need to shift core resources, including acute NHS resources, mentioned in the paper is to be welcomed. We are concerned however about the meaning of the phrase "some acute" resources used in the paper. Local partnerships will require much more clarity on exactly what is meant by this phrase to enable them to plan the scope of their partnerships and inform their strategic decisions.

11. We are concerned that aspects of the consultation paper are overly prescriptive. This is particularly true in relation to governance arrangements, and integrated budgets. These should be determined at a local level.

12. The role of any Jointly Accountable Officer should be clarified and defined in relation to the role of the Chief Social Work Officer. The Chief Social Work Officer is a statutory role within local authorities to ensure the provision of effective, professional advice to local authority elected members and officers, in the authority's provision of social work services.

13. The Council has worked closely with its partners in East and Midlothian Community Health Partnership and Midlothian Council in preparing our responses to the consultation exercise. Through the course of these discussions it is now considered that our preferred model is for the establishment of single Health and Social Care Partnerships in both East Lothian and Midlothian with strong connections to the Community Planning Partnerships and Single Outcome Agreements.

14. As partners, we believe this offers the best solution to the delivery of local services and improved outcomes. Equally however, we recognise the value in further partnership approaches where it can be shown this will continue to improve service delivery in local communities, building upon services that currently exist in East and Midlothian. Existing arrangements are set out in Appendix 1.

APPENDIX 1

Part Two: Joint Response from the East Lothian Partnership

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?*

Focus is crucial to ensure tangible progress, and demographic pressures provide a strong case for focusing on older people. However this should be viewed as the first stage of a programme of change across adult care. Whilst the proposed focus on outcomes for older people is understandable given the investment and costs associated with this grouping, and the opportunities recognised already through Change Fund have allowed early exemplar work to be embedded, we believe it would be disruptive to people who use services, and to services and organisations, if a false age defined focus was applied. We also believe that this requires, as much as practicable, a whole system approach and not an incremental approach.

The significant change programme required to drive and implement integration needs to be recognised at all levels. The benefits should be evidenced across all adult care groups, and we believe that only in this way can we enable a more flexible and efficient approach to the deployment of staff and services in delivering the improved outcomes required and expected of us. We will establish a Shadow Integration Board to drive the detailed planning required to deliver a Health and Social Care Partnership by 2014.

There is, in addition, a view in some quarters that any improvements in commissioning care arising through the integration of adult health and social care services, should also be extended to children's services. Transition between children's and adult services is an integral part of the continuum of care and the arguments in favour of integration are similar. However overall, whilst this argument is well rehearsed and understood, we believe that within the current limited capacity to manage the change programme across all sectors locally, we should learn the lessons from adult health and social care integration and harness this to effectively plan for the integration of children's services in the medium to longer term.

Within NHS Lothian there are currently a number of "hosted" services provided on a pan Lothian basis but hosted by one CHP. Examples include learning disability, substance misuse, Lothian unscheduled care service, prison healthcare and health promotion. Existing arrangements are currently under review and will need to be considered within

the wider scope of the integration agenda. However, as a point of principle and where practicable, the East Lothian partnership would look to provide local integrated services in line with our current structures and care systems as much as possible.

Finally, the development of more effective services for older people in particular without additional government funding is highly dependent on the participation and appetite for service redesign in the acute sector. This needs to be very clearly stated to ensure successful management of change.

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 proposals are reasonably comprehensive and reflect the necessary change in focus to outcomes as well as the development of strategic commissioning as an approach to the planning and delivery of services. This term – strategic commissioning – is, however, subject to significant differences in interpretation across the Public, Third and Independent sectors and it will be vital that organisations working together on this agenda agree their understanding and clarify language and expectations at the outset.

The focus on health and social care is understandable but runs the risk of implying a lesser importance of the wider community planning approach. Housing, financial inclusion and transport and the contribution of the full range of NHS acute services are critical to the wellbeing of our population and new structures should enhance rather than diminish their contribution.

The value of involving patients, carers and the public in the development and planning of services has not been included in the proposals and this is a major omission given the legislative and policy requirements placed on both the NHS and council. NHS services, whether integrated or not, cannot work without the partnership of the people who use the services. Given the current Scottish Government consultations on the proposals for the Community Empowerment and Renewal Bill as well as Self Directed Support and new duties under Community Planning, it is a further omission

Good long-term strategic commissioning strategies allow providers to plan services better to build more preventative services into their business plans. From the consultation document we note that each H&SCP will be expected to produce joint commissioning strategies and delivery plans over the medium and long-term. It is also noted that partnerships will be required to produce integrated strategic commissioning plans for use of the integrated budget over the medium and long-term. Whilst working in this way is new for many, particularly in the NHS, the early learning from Change Fund work will facilitate this although anxieties around financial pressures across sectors are early indicators of where robust and effective planning (and associated transparency) will be required for partnerships. This should be an early focus for development.

We particularly welcome the references to engagement of the Third and Independent sectors in the consultation document. However this sector will require ongoing support within and across partnerships to ensure they can fully contribute and be involved in a meaningful way for all.

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 helpful to unify the accountability and reporting mechanisms for the new health and social care partnerships via community planning partnerships, and important to align reporting between local authorities and the NHS to fulfil statutory duties for public performance reporting.

It will be essential to ensure that partnership reporting is routed through community planning partnerships and Single Outcome Agreements. This is to maximise opportunities for other agencies and services involved in the community planning partnership but not in the health and social care partnership to contribute to better outcomes for users of health and social care services

We view the approach set out in the consultation paper as welcome, timely and a necessary enabler in supporting the principles of integration. However it will be successful only if there are jointly agreed, jointly owned and jointly reported outcomes routed through community planning partnerships which lead to tangible improvements rather than partners working to these and their own individual agenda(s). Previous experience of developing joint local improvement targets whilst also working to, for example, HEAT targets diluted the full commitment of all partners. The development of joint outcomes will also need to be reflected in national inspection regimes.

Full recognition at all levels of the significant investment which will be required in staff engagement and development and effective management systems across all sectors (as well as across sectors locally, regionally and nationally) to ensure a consistency of approach and understanding will be required.

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

This is a welcome approach to supporting and developing an integrated partnership, which builds naturally upon the thinking, values and aims of Single Outcome Agreements. This approach will ensure that account is taken of local pressures and demographic factors. There will be, however, a need to achieve consistency with the level of detail agreed for SOAs as a whole. It may be necessary to revisit the concept of indicators being below the “waterline” to avoid SOAs becoming too unwieldy

The importance of building in a robust governance structure and removing duplication of reporting to enable scrutiny at the appropriate levels will be an early priority for partnerships, and should be built into the comprehensive detail of Partnership Agreements

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?*

The principle of joint accountability is important. The role of the Council Leader however is to lead the administration of the Council. It is not a statutory role and that individual requires the agreement of Council in order to progress policy and strategic issues. At present it is the Council which is responsible and accountable rather than one individual. Further consideration is required on this issue before a satisfactory solution can be agreed

The Partnership agrees that local accountability is key if integration is to be successful and effective – and in doing so ensures meaningful involvement of front line staff (including independent contractors and secondary care), managers, service users, carers, third and independent sector and the local population.

However, further work is necessary to understand the complexities and detail of the roles and functions required to deliver this.

Early discussion, with sufficient strategic support to “tease out” *whole systems* accountability to partnerships, particularly in those Health Board areas spanning multiple Health and Social Care Partnerships, will be required and could be viewed as a significant gap in arrangements. The need, therefore, to ensure engagement of all relevant partners

in developing the exact detail of the Partnership Agreement, will be a crucial element of the governance and accountability structure.

Nonetheless, it is recognised that the current accountability arrangements for CHPs, and the expectations of others of CHPs, has often presented challenges and clear guidance on enhanced local, democratic processes is welcomed.

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

We support the proposal that will enable partnerships to operate across more than one local authority boundary. Whilst the benefits of co-terminosity are well rehearsed and understood, there is concern that small and sometimes specialist health services' viability may be at risk in small separate partnerships. This could have detrimental effects on outcomes. In addition the economies of scale possible across more than one Local Authority in partnership with health may not be achievable.

Equally, the value in developing shared partnership approaches where it can be demonstrated that this will lead to improved, productive and efficient service delivery in local communities should be recognised and the decision subject to local determination. We have positive experience of shared partnership approaches through our work in Public Protection, Calls Response Service, Drugs and Alcohol and across numerous other services. Any such decisions, if taken, will require some flexibility to establish governance mechanisms that satisfy the needs of more than one local authority at the same time.

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

The balance of democratic scrutiny and accountability within the proposals needs to be strengthened. Having a minimum of three elected members and three non executives making decisions on potentially very significant budgets is not adequate. This process should involve a larger group of members and non executive directors to mirror the scale and importance of health and social care partnerships and the scale of resources involved.

Terms of reference for committees setting out their powers, budget setting processes and disputes resolution procedures are required.

Further clarity is required on the relationship between these processes and councils' and NHS budget setting and accountability processes, and the Community Planning Partnership's role in scrutiny and governance

Involvement of communities, voluntary and independent sectors in the formal governance processes should be determined as appropriate by partnerships. Any lessons learnt from the Directly Elected Health Boards pilots that are appropriate to community engagement should be considered.

The proposed membership of the Health and Social Care Partnership committee only partly addresses perceived problems with current CHP guidance which resulted in heavily populated, but unproductive committees within a complex governance structure. This does not reflect on, nor diminish in any way the significant contribution of patients, service users, third sector and carers' organisation to the work of CHPs; serious consideration on the best way to continue, if not enhance, this contribution will be a cornerstone of emerging partnerships.

Similarly, the NHS has a requirement for strong and effective working with Trade Unions, and Partnership Fora have formal representation within CHP structures. We believe this should be reflected in H&SCP governance arrangements. We recognise that there are, however, different structural approaches to staff engagement across sectors and we will actively work towards a shared solution to this, recognising the importance and value of the partnership role.

The East Lothian partnership also believes there is a need to include appropriate representation of secondary care, with appropriate devolved responsibility, given their key role across the health and social care continuum and the influence of the acute sector on budgets.

Finally, there is a risk with the proposed structure that services currently in CHPs but not within scope in partnerships are marginalised in some fashion and the importance of these services and integration with them is lost.

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?*

Further clarification is required in terms of how the performance management systems and requirements of each organisation will play into such arrangements, both jointly and severally. Equally, this is dependent upon what is fully within the control of the local Partnerships. The status of independent contractors would imply limited local control by Partnerships and the Acute Sector often covers more than one H&SC Partnership area. This could challenge the ability in the Partnership's capacity to take effective action in relation to acute/hospital services

Close working with and support from agencies such as Audit Scotland, the Care Inspectorate and Healthcare Improvement Scotland will be necessary and valuable.

As outlined in the consultation, and most crucially of all, performance management must focus on outcomes and not structures or delivery.

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?*

Partnerships already vary significantly in terms of demography, need and influencing factors, and in terms of maturity and vision / ambition and capacity. Local planning, scoping, commissioning and decision making should be carried out in the context of these

parameters and permissive legislation put in place to enable such local ambitions within the agreed outcomes framework. These should be determined at the local level.

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 question implies an over reliance on the benefits of structural change. The models may help but will not on their own deliver without accompanying cultural change towards outcomes, support and care at home and coproduction. Importantly, the reference to resource identity and the recommendation to eliminate the need to track this is welcome and does acknowledge that an outcome based approach will lead to significant change in the way that we deliver care. In making this change in resource identity, the role of the Jointly Accountable Officer and the supporting structures put in place for accountability, governance and planning will be crucial.

However, further evidence is required to allow our understanding of which model allows the most effective and productive use of an integrated resource locally.

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 our wide ranging consultation exercise we heard many examples of highly successful teams working across sectors in an integrated fashion for the benefit of our populations. These include Child and Adult Protection, Integrated Mental Health Team, Response and Rehabilitation Teams, Drug and Alcohol Teams and through the overall delivery of our Older Peoples Strategy. There was a strong recognition in teams of the myriad positive benefits of integrated working and of minimising duplication across sectors and an enthusiasm at service delivery level to embrace this proposal.

Commitment from strategic, middle management and from clinical/frontline staff is a prerequisite for success but the lack of a shared IT system reduces the effectiveness of joint working. Employment terms and conditions is a potential obstacle whereby staff employed in different organisations are perceived to be carrying out very similar roles but with varying T&Cs. There was little success in addressing this issue through the Joint Future agenda and it will be important not to repeat the largely unsuccessful but very time consuming efforts to harmonise terms and conditions across large organisations

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?*

It is fully recognised that there must be a sufficient critical mass in an integrated budget and its constituent parts to enable flexibility and efficiency and to support local planning and response for the partnership population; this should include elements of acute sector spend. The early work we have done via the Integrated Resource Framework will give us a helpful starting point, but it will be important for the credibility of partnerships to reach an early agreement on how much of the acute pot is to be included within the scope of the partnership and how much flexibility can realistically be attached to the financial resource this represents. For example, given that the majority of acute resources consumed by East Lothian residents are located in Edinburgh, what is the latitude available to our local partnership to make decisions about how this resource is used?

Conversely, if the Ministerial direction is too limited the desired outcomes may not be achieved for that local population. A “one-size-fits-all” approach to integration as a concept should be avoided. The type and degree of integration should reflect programme goals and local circumstances. Approaches to integration require some flexibility, adapting to stakeholder views including those of front-line staff, users, carers and managers and this should be reflected in guidance. However, the emphasis should be on what we need in order to deliver our outcomes safely and effectively – and what functions are needed to deliver these outcomes and not dedicated categories or services as such.

Equally importantly, evidence suggests that there should not be significant expectations, at least in the short term that the integration agenda will reduce costs. Within this, the need for transparency across the statutory sectors in identifying and agreeing allocated funding will be a crucial enabler to the success of the new partnerships. We recognise that this identification of agreed allocations could be challenging for NHS Boards with multiple partnerships within their boundaries, and therefore unambiguous guidance and supporting information in order to help make informed financial decisions would be welcomed.

Local determination of budgets should be the norm, therefore minimum, not maximum, categories of spend should be determined.

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?*

We believe that proposals for financial authority of the JAO require further clarification and unambiguous direction. It is important that the arrangements for the authority of the Jointly Accountable Officer ensure that local democratic accountability is retained, if not strengthened.

Under proposals, the JAO will remain separately accountable, through the partnership, to the Chief Executives of the Local Authority and the NHS Board, (which, in turn, have separate governance and accountability arrangements and may have different priorities for service delivery). Delegation of minimal powers of authority from statutory organisations to the JAO should be permitted by legislation, recognising the need for effective governance of the JAO.

In determining the role of the JAO, it will be important to acknowledge the role of the Chief Social Work Officer in managing the risks associated with the creation of H&SCPs and for the ongoing delivery of social work services within H&SCPs.

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

The seniority of the Jointly Accountable Officer should not be nationally prescribed. It will by necessity vary according to the size and scope of the Partnership.

However, we recognise that such posts should be at a very senior level, with sufficient autonomy and able to operate at director level within a significant public sector body. They should evidence appropriate demonstrable experience within the public sector in order to engender the confidence required to lead this significant policy change.

Integrated budgets should include appropriate funding for the post and for supporting infrastructure.

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?*

We recognise that integrated care must be delivered quickly and at large scale. This requires work across whole council area populations and at community level, as well as with a range of stakeholders. To achieve integrated care, and the expected outcomes, those involved with planning and providing services must include the user's and carer's perspective as an organising principle of service delivery (*Lloyd and Wait 2005; Shaw et al 2011*). This has been reinforced in national policy through Changing Lives, Self Directed Support and most recently Co-production.

It should be left up to partnerships to determine how locality planning is taken forward to ensure a good fit can be established with local community planning. Too much government direction may restrict innovation and the development of effective community involvement. There should, therefore, be flexibility to take forward different approaches in different areas with an ongoing requirement to continuously evaluate the impact. Within this, the East Lothian partnership recognises the ongoing review of community planning across Scotland, and the outcomes of this review should inform any proposals.

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?*

No single 'best practice' model of integrated care exists. What matters most is service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations. It follows, therefore, that these professionals should be pivotal in planning and reviewing service arrangements.

The East Lothian partnership recognises that we should invest in approaches that capture the voices and experiences of patients, service users and carers in relation to integrated care planning and whether services are being delivered that meet their needs. The proposal should therefore set out how service users, carers and local communities are to be involved in line with national standards for community engagement.

In harnessing all this knowledge and input for local planning, strong clinical and professional leadership will be required to deliver the level of organisational intelligence needed. The duty placed on Health and Social Care Partnerships to involve and consult on service provision should therefore be clear, unambiguous, measurable and evaluated.

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?*

All health and social care professionals involved will need to be supported to ensure that the local approach is central to how they do their jobs, not something they do on top of their jobs. It will be important for local partnerships to define the role of locality planning so that all participants understand what is expected of them and support them to maximise their contributions.

Integrated care is unlikely to happen at scale unless those implementing it are given support. Whilst for professionals, users and carers, financial support to ensure involvement is important, other organisational supports also need to be considered. These could include:

- building leadership skills
- building commissioning skills and public health skills for prioritising investments
- supporting networks within partnerships to share learning and ideas

While much of this might be sought and delivered locally within partnerships, there is a need for the Scottish Government to equally invest resources and support the development of skills and competencies for integrated care, to promote learning and share ideas to support the adoption and successful application of integrated care.

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 fundamentally be organised around natural communities such as Council Wards. Economies of scale may prove a challenge to local commissioning on this basis but we have local experience to draw upon including “neighbourhood planning” designed to support community planning.

Each partnership will look quite different in terms of urban / rural make up, or GP population sizes; nor do GP practice lists always fit neatly with local authority boundaries, so for many areas GP clustering would be challenging. In line with the response to Question 15, there should be flexibility to take forward different approaches to planning in different areas with a requirement to continuously evaluate the impact.

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

At the population level suggested (15,000 – 20,000) it is difficult to see what direct strategic role locality planning groups could play other than to feed their local knowledge of needs and resources up to the Council-wide strategic level. Perhaps the focus for locality planning should therefore be on improving day to day operational activity across statutory, voluntary, independent and community sectors to find ways to improve local service delivery.

Whilst we agree with the principle of devolving decision making as close to the point of delivery as possible, this cannot always be defined as there are a number of factors such as geography, level of need and deprivation and demography that will influence this. The level of responsibility should therefore be determined locally once it has been agreed what the role and geographic focus is to be. Local decision making would be restricted to any devolution of resources that had been made by the partnership to the locality planning level, and accountability would need to remain at the Health and Social Care Partnership level.

There is a danger of raising unrealistically the amount of responsibility which locality planning groups could undertake and sustain without additional infrastructure to support their activities. The key shift is to ensure that locality groups have a real say in the design, implementation and review of new services/service redesign at a local level.

There is, however, also a need to fully recognise the value of existing structures such as Public Partnership Forums, and their history of delivering for local communities, and not simply “re-invent” new ways of working.

It is only at partnership level that the critical mass to achieve integration will be delivered.

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?*

There are too many parameters to consider in a country of the size and diversity of Scotland. *No one size fits all* is a good mantra when dealing with the complex landscape that faces us; this should be a matter for local determination

Do you have any further comments regarding the consultation proposals?

The broad principles of health and social care integration are welcomed by the East Lothian partnership and we are eager to start planning our joint work programme to deliver improved outcomes for our population

The consultation is being carried out at a time of great change for the public sector, and it is important the legislation reflects this. Strong links with the report of the Christie Commission, the review of community planning, welfare reform and the Community Empowerment and Renewal Bill are required. However, the consultation document underplays the importance of strengthening an effective community planning system, focusing as it does on the health and social care dimension alone. There is also a danger that the focus on the creation of Health and Social Care Partnerships becomes the dominating issue in the next few years rather than the continuing implementation of an outcomes approach alongside the transformation required to deliver Self Directed Support.

It is regrettable, however, that the consultation of necessity concentrates on the proposed new organisational arrangements. Structures may help but will certainly not deliver the step change required in the drive towards truly community based care and the shift in resources required to deliver this. Research and experience tells us that leadership and culture are critical.

East Lothian

- Local Issues
- Assessment and Care Management– CSWO
- GP Practices
- Local Nurses – Lead Nurse
- Local Allied Health Professionals
- Community Capacity – Vol Orgs
- Preventative /Health Improvement Work
- Locality Planning

Accountable Officer

Embedded in Community Planning process

East Lothian Health & Social Care Partnership

PARTNERSHIP OPPORTUNITIES

- Local In-Patient Services
- Emergency Response Services
- Commissioned Social Care Services
- Telecare
- Joint Store
- MELDAP
- Adult Protection
- Violence Against Women

NHS Lothian

- Acute beds
- Clinical Leadership
- Clinical Governance

Accountable Officer

Embedded in Community Planning process

Midlothian

- Local Issues
- Assessment and Care Management– CSWO
- GP Practices
- Local Nurses – Lead Nurse
- Local Allied Health Professionals
- Community Capacity – Vol Orgs
- Preventative /Health Improvement Work

Midlothian Health & Social Care Partnership