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NHS Tayside

INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND CONSULTATION ON PROPOSALS

NHS TAYSIDE AND DUNDEE CITY COUNCIL CONSULTATION JOINT RESPONSE

Introduction

NHS Tayside and Dundee City Council support the principles underlying the Scottish Government proposals and the move to setting clear outcomes that all Health and Social Care Partnerships are asked to meet.

Our local Partnership has a strong track record of working together engaging positively with the Community to provide timely and appropriate services and we see the core principles as a means of providing the opportunity to move to the next stage of developing these achievements and believe that there are a number of areas we would want to draw attention to.

Local experience tells us that achieving improvement involves reorganising the complex interdependencies that are around the system and how and why they have been resistant to improvement. Whilst locally we have demonstrated improvement in outcome measures like delayed discharge and in rebalancing care, we have identified that we have not managed to make an impact on inequalities. The statutory and third sector organisations in Dundee recognise that future development opportunities must focus on prevention/early intervention if the gap between the life circumstances of our most deprived and least deprived users has grown in the last ten years. One obvious implication of deprivation is that like everywhere else, we have an ageing population, but we also have the characteristics of ageing featuring in a much younger population with the resultant impact on the demand for health and social care services. Whilst we understand and appreciate the demographic imperatives that come from an ageing population we think health inequalities are our most significant overall challenge locally. We would want to keep our partnership approach flexible and open to means and approaches that would allow us to give health improvement priority. This means that we would want to be in the position to be able to segment our population to give priority to those in the greatest need, identify evidenced approaches that are likely to deliver the most significant improvement for individuals and prioritise resources beyond health and social care on these approaches. We want to be able to draw on and recognise a broad concept of partnership.

Public sector services are now experiencing an increase in demand as a consequence of demographic change which has been predicted to affect service demand. We are aware in Tayside that were we required to continue to operate

within the existing model of care, we would be have to build a new, additional 500 bed hospital the size of Ninewells by 2030. Changing the model of care is therefore imperative if we are to deal with this increasing demand without building a new facility. We believe this needs to be done in partnership including the 3rd Sector and the public. The attribution of acute resource has been a particular challenge for us in terms of budgeting alignment. Our efforts to advance plan a shift in the balance of care in our change plan for older people have drawn this into sharp focus. This is in part due to the fact that our local evidence and experience does not demonstrate a reduction in demand for acute care in the short medium or long term.

Our view is that successful Health and Social Care Partnership working will allow more people to retain their independence at home. However, we will see the acuity of patients in acute and community hospitals increase and it is important that it is understood that as well as the demand for acute hospital beds increasing there is also the need to meet increasing demand. There will also be increasing demand in community hospitals, nursing homes, care homes and in individual's homes. New arrangements should be based on an understanding of flow through acute, primary care, social care and peoples' homes. There should be significant focus on the need to provide clear and focused patient pathways and ensure timely flow through these pathways to enhance the patient experience and outcomes of care. We conclude from this that the strategic objective should be to minimise further growth in acute beds but not reduce significantly below the current provision.

Non-statutory Partners

It is our belief that partnerships need to take the opportunity to increase the level of third sector involvement in shaping and designing new pathways of care and services. The third sector has a long history of innovation and is driven by the voices of people who use local services and support. Including the third sector as a key strategic partner will be vital to the design and delivery of appropriate, cost-effective services that are responsive to patient need and which enhance the patient experience.

Carers continue to play a significant role as key partners and it is now widely acknowledged that carers devote very significant parts of their lives to the support of relatives and friends. Helping to support, sustain and grow this capacity is essential if we are to achieve better outcomes.

It is also necessary to support individuals, families and communities to take responsibility for their own health and well-being. An asset-based approach focusing on positive outcomes and prevention of ill-health will be required to achieve this now and in the future.

Information Technology

The future of Health and Social Care integration will be very reliant on information technology to share information between partners, and in the absence of the National eCare Program being unable to deliver and sustain products to do this, it will be important to ensure that this work is not lost in this challenging agenda.

We welcome the Sixth eHealth Strategic aim and the small amount of recurring funds that come with it to try and start to support this agenda, but would ask that further work is undertaken to enable easier information sharing, build joint eHealth

infrastructure between Health and Council colleagues and ensure a single identifier is used to allow us to move forward in the future.

Workforce

Developing a motivated and capable workforce is necessary to underpin high quality services and to promote the principles of personalisation and an asset based approach. One of the key challenges for the new Health and Social Care Partnerships will be the need to address cultural differences between statutory and non-statutory partners. In order to address this it will be essential to work constructively with staff and staff organisations.

Reducing variations in services and service quality

It is already recognised that there is significant variation in experience and quality of services. Organisations need to demonstrate their ability to tackle and reduce variation and improve quality. This should be the criteria on which we judge them and on which basis we would seek to give them more areas of responsibility.

Population data and analysis

It is recognised that demographic change will have a significant and challenging demand on services as described above. Knowledge of this demographic change and the predicted impact of this on services will be key to ensuring appropriate services can be designed and delivered. For example, it is estimated that there is 5,999 older people in Tayside with dementia with it predicted to rise to 6,582 by 2020. The increasing numbers of older people in the population who have higher incidence of adverse conditions, higher levels of severity for those conditions and poorer rates of recovery present particular challenges for the delivery of services. Increased levels of need, and particularly unmet need, within communities with higher levels of deprivation also need services to be targeted effectively which clearly benefits from in-depth demographic intelligence.

Consumption Fund

Councils and NHS Boards will need to ensure that joint decisions are taken around the management of mutually committed resources such that investment and disinvestment in health and community care services are effectively planned and co-ordinated. Identification and effective use of these consumption funds will be essential to effective partnership working.

The Purpose of Commissioning

We have a strong view that locality planning should be left to local determination. We think that understanding of how local communities of interest, for example people with learning disability, geographical communities i.e. regulations and administrative boundaries, e.g. GP patient boundaries interact is best understood locally. We would want to be free to co-ordinate our community engagement to best effect, making best use of machinery that is already in place. Locally we are also exploring a Total Place approach for children's services and are considering how we could segment our population focus for adults differently to increase the scale and pace of change. We

do not think therefore that the definition of sub-localities for service delivery or procurement purposes by the Scottish Government would be helpful or effective in improving local outcomes

We think, and to some extend have had this confirmed, through our IRF experiences that the proposals as outlined do not provide a sufficient range of incentives that guarantee the active participation of GP's. In this respect, we think consideration needs to be given to aligning the GP contract to regard activities that support the broad direction of change for older people and other adult groups.

The purpose of Commissioning is to ensure that all services are working together to shift the balance of care and enable more people to be supported to live independently in their own home. It is not a budgetary process although understanding the consumption of resources and the cause and impact of variation from optimal pathways of care is vital. The Commissioning plan needs to be able to articulate how a General Practitioner is able to access a range of service options without the need to engage in a large level of bureaucracy. This means either being able to commission services direct from the consulting room or though a single point of contact. The Commissioning Plan should clearly articulate the shift from the current model of service to a more optimally based pathway of care.

Scotland is proud of its decision to abolish the internal market. This has slashed transition costs and has promoted joint working across traditional boundaries. It is imperative that this new model of commissioning does not result in the introduction of additional costs of bureaucracy and a shift to more elaborate management arrangements.

Governance and the Jointly Accountable Officer

Our position on governance and joint accountability is informed by our wish to have an open and transparent governance framework that recognises the strength of public accountability that comes with democratically appointed elected representatives and also respects the necessity for clear lines of accountability for non elected representatives. We also recognise that a balance has to be struck between local and national accountabilities

The democratically accountable bodies should be held to account through their roles and duties with the Chief Executives and leaders providing leadership and direction. The Council Chief Executive should be accountable to the Council and the Health Board Chief Executive to the Health Board and Cabinet Secretary. They should however, be held jointly accountable for achieving the nationally agreed outcomes and indications in line with views outlined above.

Operating within the arrangement of a Partnership Committee, the role of the Jointly Accountable Officer should be predominantly of leadership and management. The powers of the officer should be those delegated from the committee which should provide demographic scrutiny. This approach provides necessary check and balance between the role of an officer and the committee. The management accountability should be to the Chief Executives of the Health Board and Council and we would expect that within such a system the Joint Accountable Officer would be given the power to flexibly deploy resources and would in turn have the authority of the committee and its parent bodies in this respect. We believe such an approach would strengthen accountability.

We think as with other aspects of the proposals that local partnerships should be able to interpret the role flexibly into their own situation

Conclusion

The areas highlighted above need to be addressed to ensure effective integration of health and social care. However, it is vital that we do not simply focus on what needs to be done at the expense of how the transformation is achieved. At the earliest stages it is important to consider how we will make the required changes, how we can best work together between organisations, with individuals and communities and identify how this can be done on a large enough scale. These aspects are equally important and we believe partnerships need to be challenged to demonstrate that they can deliver on the integration agenda.

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