INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND
DUNDEE CITY COUNCIL RESPONSE

QUESTION 1 - THE CASE FOR CHANGE

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?

COMMENTS

We agree that the achievement of improved outcomes should be the purpose and driver of change and the basis upon which performance is judged. We also agree that there is a compelling case for change. Local experience tells us that achieving improvement not only involves reorganising the complex interdependencies that are around the system, but also involves analysing how and why it has been resistant to improvement. Cultural influences feature strongly in the process of change. This is ambitious and challenging and cannot be a short term objective - it will require sustained effort over time.

Whilst locally we have demonstrated improvement in outcome measures like delayed discharge and in rebalancing care, we have not managed to make an impact on inequalities. The gap between the life circumstances of our most and least deprived citizens has grown in the last ten years and we have 29% percent of people living in the 15% most deprived communities. The Council is giving priority to inequalities and has recently published a Fairness Strategy. One obvious implication of the deprivation of our population is that, not only do we have an ageing population, but we also have the characteristics of ageing featuring in a much younger population with the resultant impact on demand for health and social care services.

Whilst we understand and appreciate the demographic imperatives that come from an ageing population we think inequalities are our most significant overall challenge. We would want, therefore,

to be able to keep our partnership approach flexible and open to approaches that would allow us to give health improvement priority. This would mean in practice, that we would want to be able to segment our population and 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 evidenced approaches. To do this effectively we expect to draw on and recognise a broad concept of partnership.

These factors aside, analysis of how our local system impacts on the needs of older people resonates with the Government's in that: we have unexplained variation in our services which is experienced as inconsistency by service users and carers; we have not sufficiently rebalanced care in favour of care at home; we have too many unplanned admissions; there are people delayed in hospital beyond their fit date for discharge; and some services are not delivered quickly enough. We know that much of this involves the health and social care interface and that there is capacity for improvement. We also know, however, that at all levels of service delivery, hospital, care home, or home, we are observing increased dependency and that consequently there is increased demand.

Local experience of the Integrated Resource Framework (IRF) has demonstrated that those with the highest dependency consume a significantly disproportionate level of resource. It is recognised, therefore, that we have much to gain from ensuring we have the most effective approach to service response in terms of improving individual and collective outcomes. This will not be sufficient, however, to deal with future demand. This will require a scale and pace of change beyond that which we have achieved to date.

Whilst we support the notion of the application to adults of the proposition that lies behind the integration proposal in general terms, we have a couple of observations that we would wish to make. Firstly, other adults are not a homogeneous group. Secondly, the interface issues are different, so for example, links with education training and employment are much more significant for people with mental illness and learning disability and the acute services interface much less, people with drug and

alcohol problem interface much more with children's services and criminal justice services. In addition, there are cross cutting aspects of service delivery like adult protection that apply to all categories of need.

The identified disconnects, between primary and secondary care and between health and social care apply most directly to older people. The proposed changes self evidently do much less to deal with the first identified disconnect than the second. We believe this disconnect is critical to the shift in the balance of care. We return to the pre-eminence of this issue in response to later questions.

In summary, and in response to question 1, we would want to retain the flexibility to adopt the approach that best meets the needs of our population and best sustains the achievements we have already made in partnership working. We agree, however, that it would be reasonable to focus initially on outcomes for older people.

QUESTION 2 - OUTLINE OF PROPOSED REFORMS

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?

COMMENTS

We believe the objectives of the reform should be;

- improved outcomes for our citizens, particularly those who are relatively disadvantaged with a concept of partnership that extends explicitly beyond health and social care and into the wider community;

- flexible deployment of resources by all partners in the achievement of these outcomes;

- improved experience of service delivery by the citizen;

- to support early intervention and prevention;

- explicit recognition of the positive contribution people and communities have to make; and

- to maintain strong local democratic accountability.

Locally we have a mature community planning partnership with good community participation combined with a developing Fairness Strategy that is designed to focus priority on narrowing the gap between our most and least advantaged citizens. We have similarly mature partnership working arrangements in adult services and we have a Total Place initiative in place for children's services.

Drawing on these experiences confirms to us that a clear policy direction; strong public and professional engagement; a common strategic direction with clear strategic leadership; an explicit focus on improved outcomes; the development and cultivation of positive working relationships and a supporting partnership machinery with an integrated commissioning and management framework have been constant factors where we have achieved most success.

The focus from the proposed framework on strengthening partnership working within a single commissioning direction is welcome and would do well to be matched nationally. We do not believe, however, that this framework in itself will necessarily bring the improvement sought. In particular, the identified disconnect, between primary and secondary care is occurring at present within a single organisation. The proposed structural arrangements could sharpen rather than smooth this boundary and consequently inhibit the process of the shift in the balance of care.

In conclusion, we support the objectives for the framework and the enhancement of the mechanisms available to support integrated working. We do not think they are an automatic prescription for success. We believe we will develop our partnership most effectively if we retain the flexibility to

determine locally how, to what extent, and over what time period we apply the proposed mechanisms. More specifically, our local objectives of improving health and wellbeing and reducing inequalities would be enhanced if Public Health was included explicitly within the framework and if the mechanisms offered by Community Planning Partnerships were recognised as a key feature of the framework. Finally, we think the possibility should be open but not required to include Criminal Justice Services within the framework.

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 and for support to carers. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

QUESTION 4

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

COMMENTS

Q3 - We believe a successfully integrated system needs to be, and should be, grounded on a common set of outcomes and should be accountable for achievement against these outcomes. The public policy significance of the integration agenda argues for strong accountability. We agree that placing a legislative duty on statutory partners would contribute to this. It would not, however, deal adequately with the interdependencies and broader interrelationships that are a necessary component of the change. The health and social care outcomes should be applied through all aspects of partnership and should and be incorporated directly into the Local Single Outcome Agreement. This would in turn form the logical basis for the proposed Local Partnership Agreement. As well as in this context, consideration should be given to this as part of the National Review of Community Planning.

Q4 - In line with the answer to three above we agree the nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements.

GOVERNANCE AND 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?

QUESTION 6

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

QUESTION 7

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

COMMENTS

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 proposals do not however, position the roles of Chief Executives of Local Authorities, or Local Authority Leaders comfortably for us in this respect. Local Authority Leaders do not hold committees of the Council to account. The full Council holds committees to account. The Chief Executive is not accountable to the Council Leader but to the whole council. This hierarchy should be respected in the revised agreements. The democratically accountable bodies should be held to account through their roles and duties with the Chief Executives and Council Leaders providing leadership and direction. The Local Authority 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 indicators in line with views outlined above. The public accountability should come through the mechanisms of the Single Outcome Agreement and Community Planning Partnerships.

The arrangements for the Partnership Committee will operate most satisfactory if they have the full and explicit support of the parent bodies. We recognise that to achieve a qualitative change in joint commissioning the Partnership Committee will need the proper delegated authority to undertake its responsibilities. We do not think the proposed committee arrangements are supportive to this. This is because the ambition and consequent scale and social reach of the responsibility of the proposed committee is very significant. It therefore demands proportionate membership in terms of the authority and membership numbers and balance between elected and non elected representatives. Specifically, we do not think the members of non elected representatives should be prescribed, we do not think that Council leader or Boards should be excluded from membership and whilst we think principles of equity should be applied, the availability of non executive board members should not determine the size of the committee. The duties and delegated powers of the committee should, however, be defined better. Accountability for the resource should be with the committee and not to the Jointly Accountable Officer. Officers should be subject to an agreed scheme of delegated powers as defined by the Partnership Committee and its parent bodies. This approach would be most consistent with our understanding of proper standards of public and democratic accountability.

On the matter of the Health and Social Care Partnership covering more than one Local Authority, we believe democratic accountability and local need would be best served if the partnership did not cover more than one Local Authority.

GOVERNANCE AND ACCOUNTABILITY

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?*

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?*

COMMENTS

Q8 - The focus of performance on integrated outcomes and national standards is sound and consistent with the overall proposals. We think, however, that further consideration should be given to how separately constituted scrutiny bodies will operate in the integration environment.

Q9 - We have indicated above that partnerships should have the flexibility but should not be required to include other functions that support local arrangement like, for example, Public Health and Criminal Justice.

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?*

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?*

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?*

COMMENTS

Of the two models of support our preferred route would be Model 2 - it would be a natural development of our current partnership arrangements. We think the potential advantages of pooling

over aligning may be overstated, but we are committed to the provision of seamless service delivery, and to reducing duplication and unexplained variation in our service delivery.

Locally, we have aligned our community adult budget and reported on budgeting performances against this aligned budget through a joint management team. Commissioning frameworks are developed through joint strategic planning groups which have brought partnership involvement. We have drawn on this background and experience to develop successfully our stakeholder monitoring and performance arrangement for our Older People Change Plan. We have extended these arrangements into a single management arrangement for learning disability. We have pooled our budgets and/or resources in certain discrete circumstances.

We have found it helpful to have aligned budgets across all adults and older people expenditure. This has enabled joint scrutiny of performance and enhanced flexibility for service development, so for example we have been able to use health resource to fund intermediate care development and local authority resource to increase care at home and enablement against an agreed objective of reducing reliance on care homes and long stay hospital care for older people. In the case of learning disability, this approach has allowed us to jointly analyse our cost pressures and agree a common management approach to the management and development of resources. The learning disability experience has also been instructive in developing our understanding of the limitations of such an approach. The application of differential human resource policies and terms and conditions of employment are challenging in both time and effort. Budget cycles, reporting arrangements, and financial regulations are all different so understanding of a dual system is required and is similarly challenging in time and effort since any budget that is aggregated has to remain capable of disaggregation.

As we interpret the situation at present altering this would require changes to primary legislation. The proposals as described at present to not specifically address how, or if, it intended to develop legislative and/or technical solutions to resolve these matters.

The attribution of acute resource has been a particular challenge for us in terms of budgetary alignment. Our proposals to advance plan a shift in the balance of care in our change plan for older people has 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, leading health board commissioners to conclude that the strategic objective should be to stop further growth in acute beds but not to reduce bed numbers significantly below their current level. The financial planning implication of this has been that we have had to push proposed shifts in resource from acute to community to the later stages of our financial planning cycle. In addition, attribution of resource has not been entirely transparent.

The debate and discussion about this combined with our experience of the IRF process have also revealed that we have very different approaches to unit costing and confirmed that there are significant issues about the application fixed costs that arise for the acute sector. We would conclude that detailed guidance and advice will be required about how acute resources can be disaggregated and attributed across the system flexibly or otherwise. In addition, our experience of managing programmes of change also tells us that buildings have a very potent political resonance with the public. Following through on the flexible deployment of resource will require strong and consistent political leadership both locally and nationally.

We have found that actual pooling of budget has been most useful in situations where we have different funding sources paying for exactly the same thing like for example occupational therapy equipment and some buildings.

In conclusion we recognise that both lateral and horizontal integration of resources could help us deploy our resources to better effect in the interests of our population. We do not think we should be required to do this for groups beyond older people but we think the flexibility to do so should be available.

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?*

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

COMMENTS

The role of the Jointly Accountable Officer (JAO) should be of leadership and management. The powers of the officer are argued above should be those delegated from the Partnership Committee which should provide democratic scrutiny. This approach provides necessary check and balance between the role of an officer, the Committee and elected representatives on 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 JAO would be given the power to flexibly deploy resources and would in turn have the authority of the Partnership Committee and its parent bodies in this respect. We believe such an approach would strengthen accountability.

Account should also be taken of the role and responsibilities of the local authority Chief Social Work Officer. Very little consideration is given to this role within the consultation framework.

We think consideration should be given to how failure would be dealt with and how it should be resolved. We would expect this to be a matter that would feature in the Partnership Agreement and lie with the Cabinet Secretary and Council Leader for ultimate resolution.

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

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?*

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?*

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?*

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

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

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?*

COMMENTS

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, and administrative boundaries, e.g. GP patient boundaries interact is best understood locally. In addition, we already have quite a complicated community engagement landscape. We would want to be free to co-ordinate our community engagement to make best use of machinery that is already in place. In addition and as indicated above we are 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 for procurement purposes by the Scottish Government would be helpful or effective in improving local outcomes.

We think we should use community planning mechanisms and involvement strategies to ensure both professional and public participation in our macro planning or commissioning and also in our service redesign. We note that micro commissioning as it is being developed through the self directed support

legislation is inconsistent care services social move to with the integration policy. We think this should be revisited.

We do not think, proposals as outlined provide a sufficient range of incentives the guarantee the active participation of GP's or other frontline staff. Our IRF experience supports this assertion. In this respect, we think consideration needs to be given to aligning the GP contract to reward activities that support the broad direction of change for older people and other adult groups. This should include the importance of time for participation in local commissioning processes, Social Workers and Social Care staff should also see direct benefit from their involvement and all need standardised information with support through training and learning to interpret and use data that tells them about activity and cost.

We do not think it is practicable to locate locality planning around GP practices for service delivery purposes because, with few exceptions in Dundee their population bases are dispersed and would be difficult to match administratively, their patient populations do not form a basis for community engagement, their independent contractor status means they do not operate representatively limiting their capacity to drive planning at a local level and locality based planning should be based on a much broader construct of partnership than the organisation of GP practices.

We think the segmentation of the population and devolution of authority for the organisation and delivery of services should take account of the lessons learned from tests like Total Place and evidence gathered through initiatives like IRF. We recommend, therefore, that there should be flexibility to allow the devolution of responsibility to locality partnership groups but no prescription around range of responsibility or the size of the population.