

HEALTH AND SOCIAL CARE INTEGRATION RESPONSE TO CONSULTATION

1. BACKGROUND AND PURPOSE

- 1.1 This paper sets out our response to the Scottish Government consultation on the integration of health and social care. NHS Greater Glasgow and Clyde currently has three fully integrated Partnerships with East Renfrewshire, Inverclyde and West Dunbartonshire Councils. These Partnerships manage all community health and social care services, including criminal justice and children and families social work. The Partnerships are led by a single Director, jointly appointed by the Councils and the NHS Board, and accountable to the respective Chief Executives. The Partnership Committees are chaired by local Councillors who are also Board members. In our view, these existing Partnerships have demonstrably improved services, reduced duplication for patients, reduced management costs and have benefitted from the direct engagement of Councillors in decisions about local health services.
- 1.2 We also have the experience of creating fully integrated Partnerships with Glasgow City Council which were subsequently dissolved due to issues about governance and accountability and our response, therefore, also reflects experience of what does not work. From our perspective, the most important factor in this situation was the failure to put in place a single joint officer directly responsible to both Chief Executives and a single Partnership Committee.

2. RESPONSE TO CONSULTATION

- 2.1 This section sets out our response to consultation under the following headings:

- Vision and Case for Change
- Coverage of the New Partnerships
- Committees
- Governance
- Joint Officer
- Resources
- Acute Services
- Improving Health and Addressing Inequalities
- Planning and Commissioning
- Third Sector and Other Partners
- Community Planning
- Locality Planning
- Workforce
- Organisational Change

2.2 Vision and Case for Change

We endorse the vision and the case for change articulated in the consultation paper.

The separation of health and social care creates major issues in quality of care, efficiency and effectiveness.

It is clear that in the present arrangements patients do not reliably receive the health and social care they need in the right place and at the right time.

Integrated health and social care is essential to deliver the shared aspiration to move to prevention and early intervention.

2.3 Coverage of the New Partnerships

We fully support the inclusion of all adult social care services even if there is an initial focus on older people, although we need to ensure that this focus does not create disadvantage for other care groups not covered by that

However, in our view all social care services, including criminal justice and children's services, should be included in the new Partnerships from the outset because:

- there are major issues about disintegrating currently integrated social care services if the new Partnerships do not cover all social care;
- social care for children focuses on vulnerable children and their families. These families are served by adult health and social care services and their children are served by specialist NHS community services and are also a core focus for NHS primary care and community services. Unifying delivery of these services in a single Partnership from the outset will improve quality, efficiency and effectiveness. We can evidence benefits from our existing integration. We do not believe that the joint working with other Council functions, particularly education, would be undermined by fully comprehensive Health and Social Care Partnerships;
- primary care contractors would potentially need to relate to three different structures if children's social care is not included: the Local Authority; the Health and Social Care Partnership; and whatever arrangement the NHS has to manage its children's services if they are not within Partnerships. This will undermine the model of locality working which is essential to clinical and professional engagement;
- criminal justice social work is an adult social care service and it is not clear why the delivery of these services would not be included. There are critical relationships with addictions and mental health and other services which will be within the Partnerships. Inclusion of the social work service delivery element would not need to undermine or change the strategic planning arrangements, indeed the new Partnerships, with a full range of service responsibilities, would be a comprehensive and critical new partner in Community Justice Authorities and related structures;
- comprehensive integrated Partnerships will be better placed to focus on prevention and early intervention working with the whole family and whole community and maintaining cohesion for social work services;
- creating a new organisation will be a major challenge - structures, systems, culture, etc. In our view establishing fully integrated organisations is preferable to enable these challenges to be comprehensively addressed.

On this issue of coverage, as on others, there is a clear choice about the level of prescription to be framed in the legislation and the related guidance. Less prescription is argued to enable different local approaches to be developed. However, experience would suggest that those who do not accept the benefits of integrated Partnerships will engage in limited change. This creates a number of issues; most importantly if the benefits of integration are as we have experienced them, then those benefits will not be uniformly achieved and, as integration is key to delivering improved outcomes, those outcomes will not be uniformly delivered.

In essence, our experience has been that integrated Partnerships will not be established and function effectively without clear direction on a small number of essential issues but leaving the detail to be established locally.

2.4 Committees

We support the importance of parity, most importantly in voting, and recognise the concerns from Local Authorities about the number of Councillors. Our current Committees have at least five Councillors enabling them to reflect the political balance of the Council. Linked to this is the issue of scrutiny arrangements which a number of Councils now have in place. These could still form part of Council relationships to Partnership Committees. Sub Committees, links to community planning and locality structures may also offer the opportunity for wider Councillor involvement.

We would regret the loss of current voting members from Public Partnership Fora and Professional Executive Groups but this reflects different governance and accountability arrangements from current CHCPs and CHPs. It will be important the new Partnerships ensure that those perspectives remain strong and influential in their ways of working and decision-making. This might be reflected in attendance and contribution rights.

Public Partnership Fora have been a major success of the current Partnerships and it is vital they carry forward to be a core and credible element of the new arrangements. Real engagement of the full range of professionals is also critical.

2.5 Governance

We are aware the consultation process has raised a number of issues which require further detailed consideration including the roles of Council Leaders and Finance Directors and accountabilities within Councils. There are a number of complex governance issues which need to be worked through when the headline basis of the Partnerships is defined.

We believe the accountability of the Partnership Committee should be to the full Council and the full NHS Board.

One section of the consultation paper introduces the concept of the Partnerships being distinct “bodies corporate”. This does not seem consistent with the proposition they will be governed by a joint Committee of the Council and the NHS Board rather than as a separate entity. We would not support the creation of separate legal entities.

There are issues around mental health officers which require further consideration but which we believe can be resolved.

Professional advice to the joint accountable officer and the Partnership Committee is important. We have well established arrangements within our existing Partnerships which include the Chief Social Work Officer.

2.6 Joint Officer

We fully support the proposed senior Joint Officer post, responsible for the full range of the Partnership’s resources and services, reporting to the Council and NHS Board Chief Executives. This post has to be established with the core function of ensuring delivery of the Partnership’s objectives and this accountability reflects that. From our experience such a post is absolutely essential if the Partnerships are to function.

The delegated authority from the Committee to the Joint Officer needs to be appropriately set out. The employment and related arrangements for this post need careful consideration.

2.7 Resources

Ensuring that the opening financial allocations fully reflect current spending on health and social care is critical. In our view this will require a consistent national guidance.

It is clear that resources allocated by the parent bodies will need to be ring-fenced so that money can be moved as redesign is delivered, but this does have implications for the wider financial governance of both bodies.

If resources allocated to the Partnerships lose their NHS or social care identity rather than being aligned this raises complex issues about financial governance and the different means testing, self direction and charging regimes which apply to health and social care.

Our assumption is that capital planning, funding and approval will remain within the processes of the parent bodies although the Partnerships will plan the capital requirements for their responsibilities.

There are risks associated with the reference to consistency when adult social services are not currently provided on a consistent basis.

The resources which fund primary care contracts will be a critical part of Partnership budgets but the use of the majority of those resources is defined by national contracts, set at a UK level. Creating greater flexibility to enable Partnerships' primary care resources to be used differently to deliver service changes is an important area for further discussion.

There are a number of technical financial issues which require detailed work.

2.8 Acute Services

Reducing the demand for and reshaping acute care is a critical policy objective and ensuring the new Partnerships have a focus on the use of acute care is essential to achieve that objective.

This will not be achieved by a simplistic budgetary mechanism, which might run the risk of undermining the cohesion of the system of acute care. There needs to be a framework of incentives and disincentives for Partnerships to change services to ensure only patients who require acute care are treated in hospitals but which does not generate excessive bureaucracy.

We also need to be clear that while there is potential to shift resources from acute to community services that will not address all of the pressures on the provision of care to older people. Delivering that shift will also depend on wider decisions made about priorities for the use of acute services resources. For example, if further improvements to access to acute care and new treatments and technologies are prioritised for funding, then resources may not be available to shift to community services.

In order to change acute care Partnerships will need to be able to change local health and social care services. A major issue for further consideration is how those services can be changed where they are delivered through UK wide contracts.

2.9 Improving Health and Addressing Inequalities

At present our Partnerships have the lead responsibility and resources for health improvement and tackling inequalities at Local Authority level. In our view these should remain core in the new Partnerships.

However, there does need to be a debate about to what extent these roles and resources are matched for the partner Councils. There is the opportunity to establish a stronger and more formal joint public health and health improvement focus in these new Partnerships.

There are also complex issues about the responsibilities of the NHS and Councils for equalities, particularly the setting of outcomes under the new legislation and how we ensure that the Partnerships can effectively identify and discharge their responsibilities.

In addition to these wider responsibilities the Partnerships will be responsible for the whole service delivery to a number of groups who experience significant inequality, including disabled people. Enabling dignity and self determination need to be key values for Partnerships.

2.10 Planning and Commissioning

We see the new Partnerships as having the critical leadership to plan for the populations for which they are responsible and to secure the services they require, either through direct delivery or commissioning. There needs to be a clear planning system for the Partnerships which operates within the strategic planning frameworks of Councils and NHS Boards.

We recognise that there are areas where provision by the third or independent sector may offer benefits over direct provision.

The complexities of the NHS independent contractor arrangements for planning and commissioning require further detailed consideration.

2.11 Third Sector and Other Partners

The third sector and a range of other organisations will be vital to the work of the new Partnerships and we welcome the emphasis on their involvement but with the clarity that the statutory responsibility for the delivery of health and social care services lies with the NHS and Local Authorities and that the decision-making and governance should be required to demonstrate close working with all stakeholders.

The third sector will be particularly important in ensuring that the Partnerships have a balance of perspectives on medical and social models of care and achieve a focus on supporting self care.

2.12 Community Planning

The new Health and Social Care Partnerships must essentially be service delivery organisations and will be one of the key partners in the community planning process, sharing the same obligations as the other Community Planning Partnerships but with governance through the Joint Committee. Community planning does not provide an alternative management, governance and accountability structure to the proposed integrated Partnerships.

If the public health role is developed as we have outlined this would be a distinct leadership role for the Partnerships within community planning.

2.13 Locality Planning

We support the development of locality planning as a means of ensuring that decisions are made at local level about services and there is engagement with local professionals and cohesion between contracted primary care and community NHS and social care services.

All contractors will have a role to play in this work but with GPs particularly critical because of the decisions they make about wider NHS resources, where care is provided and their key clinical role in local health and social care teams.

2.14 Workforce

There are a series of issues which need further consideration. The NHS and local government have different industrial relations models. We believe the staff Partnership approach has delivered significant benefits to the NHS and should be a core element of the new Partnerships.

Partnerships will need to have consistent human resources and related policies.

Communication and engagement with staff will remain critical during the transition and development process.

2.15 Organisational Change

Moving to these new Partnerships would present a whole range of organisational change challenges and detailed planning would be required to address these to ensure that transitions occur without disruption and the gains we believe the Partnerships can deliver are realised. Our experience has been that moving to integration through a rapid but managed, orderly transition process with a clear timetable is the least disruptive approach.

3. CONSULTATION QUESTIONS

3.1 This section sets out our responses to the questions set in the consultation paper.

3.2 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?

Yes, with the provisos we have expressed, including as a minimum that there is a clear and short timetable to move to the integration of all health and social care within the new Partnerships and that full Partnerships can be established from the outset where there is agreement to do so.

3.3 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 Partnerships should include all health and social care services and responsibility at local level for health improvement and tackling inequalities.

3.4 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?

National outcomes are a key and necessary mechanism but not alone sufficient to drive the required changes. Setting national outcomes without the substantive changes proposed in the consultation, to establish integrated health and social care Partnerships with a Committee and Joint Officer, would not enable the outcomes to be delivered.

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

Yes.

3.5 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 issues of accountability require further consideration; accountability to the NHS Board needs to be clear.

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

Yes.

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

We support the headline arrangements but further detailed work is required.

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?

The detailed arrangements need to be set out but the principles proposed clearly strengthen accountability and therefore confidence.

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 national prescription on the key inclusions and flexibility thereafter.

3.6 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?

Yes.

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?

Yes, a single senior officer holding health and social care budgets can make better 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?

That will depend on whether the direction of minimum is sufficient.

3.7 Jointly Accountable Officer

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

The proposals are necessary but not sufficient as this shift requires change to primary care and acute services.

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

Yes, the single post with the reporting line to Chief Executives is essential.

3.8 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?

Principles and objectives should be set out and detail determined locally.

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?

Yes.

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?

There are a series of practical steps including availability of professional, planning and managerial time to work together 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?

Should be a combination of geography and practice clusters.

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

There should be real devolution of decision-making about local services but the detail needs to be determined locally.

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?

Needs to be determined locally. If this was applied in large Partnerships there would be high multiples of localities, for example, 24 in Glasgow City.