Inverclyde council

AGENDA ITEM NO. 14

Report To:	**Policy & Resources Committee**	**Date: 18th September 2012**
Report By:	**John Mundell** **Chief Executive**	**Report No:** **CHCP/46/2012/BM**
Contact Officer:	**Brian Moore** **CHCP Director**	**Contact No: 01475 712722**
Subject:	**SCOTTISH GOVERNMENT CONSULTATION ON INTEGRATED ADULT HEALTH & CARE PARTNERSHIPS**	

1.0 PURPOSE

1.1 The Policy and Resources Committee is asked to consider the proposed response to the Scottish Government Consultation on Integrated Adult Health and Social Care Partnerships, and comment as required, with a view to agreeing a final submission.

2.0 SUMMARY

2.1 The Scottish Government is currently consulting on proposals to develop new Health and Social Care Partnerships to replace existing CHP and CHCP arrangements. The aim of the consultation is to provide an opportunity to offer views on the new legislation that will be introduced in order to enable the changes, and as such should not be regarded as a consultation on the decision that has already been made to develop health and care partnerships across Scotland.

2.2 The Consultation document is published at (http://www.scotland.gov.uk/Publications/2012/05/6469/) and contributions are invited, to be submitted by 11 September 2012. Inverclyde Council's final response will be considered by the Policy & Resources Committee at its meeting on 18th September 2012.

2.3 Inverclyde Council is well placed to comment on the Consultation given that we established a Community Health and Care Partnership (CHCP) in October 2010 in partnership with NHS Greater Glasgow & Clyde, to bring together all community health and social care services.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Policy & Resources Committee approve the draft response to the Consultation, and approve its submission to the Scottish Government.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The Scottish Government is consulting on proposals to develop new Health and Social Care Partnerships to replace existing CHP and CHCP arrangements. The aim of the consultation is to provide an opportunity to offer views on the new legislation that will be introduced in order to enable the changes, and as such should not be regarded as a consultation on the decision that has already been made to develop health and care partnerships across Scotland.

4.2 The Consultation document is published at (http://www.scotland.gov.uk/Publications/2012/05/6469/) and contributions are invited, to be submitted by 11 September 2012.

4.3 Inverclyde Council is well placed to comment on the Consultation given that we established a Community Health and Care Partnership (CHCP) in October 2010 in partnership with NHS Greater Glasgow & Clyde, to bring together all community health and social care services. Those arrangements are now well established, which places us ahead of the required minimum position that is set out in the Consultation. The success to date of our CHCP arrangements has formed the basis for our response. In line with the Inverclyde CHCP stated aims, we are keen to ensure that the proposed new partnership retains a strong focus on securing better outcomes for the people of Inverclyde, moving away from the traditional focus of looking at service outputs as a measure of effectiveness, and considering how our actions and approach contribute to improving lives.

4.4 The maturation of Inverclyde CHCP has been aided by consideration of the findings of the *Delivering Better Outcomes And Use Of Joint Resources – National Evaluation of Community Health Partnerships* and Audit's Scotland's *Review of Community Health Partnerships* reports. These reports, and the debates they stimulated, highlighted key issues that we have worked hard to address positively, notably:

- Clarity of vision and strategy.
- Clear decision-making and accountability structures and processes.
- Agreeing what success looks like and indicators for measuring progress.
- Implementing a system for managing and reporting on performance.
- Achieving efficiencies through sharing resources.
- Understanding and respecting differences in organisations' cultures and practice.
- Personal commitment from the partnership leaders and staff

4.5 Our integration arrangements were locally developed, and currently meet local requirements. Although at an early stage of development these arrangements are proving successful. In the context of the consultation proposals we recognise the importance of local determination, underpinned by a number of key points.

- The case for change is applicable across all care groups, so whilst a minimum position is proposed, local partnerships should have discretion to decide whether or not to go beyond that minimum position, and what services would be appropriate for each partnership area.
- The responsibilities of the Chief Social Work Officer span all of Social Work, and those of the Clinical Director span all Community Health Services, so there is a potential logic for partnerships to decide to include all services that come under the auspices of these two key roles. This should be at the discretion of partnerships, but where partnerships decide on this course, they should be fully supported to do so.
- How integration is structured and delivered within and across these services should be determined at a local level.

5.0 OVERVIEW OF PROPOSALS

5.1 The proposals set out a vision of a successfully integrated system of adult health and social care for Scotland that exhibits the following characteristics:

- Consistency of outcomes, so that people have a similar experience of services, and carers have a similar experience of support, whichever Health Board or Local Authority area they live within, while allowing for appropriate local approaches to delivery.
- A statutory underpinning to assure public confidence.
- An integrated budget to deliver community health and social care services and also appropriate aspects of acute health activity.
- Clear accountability for delivering agreed national outcomes.
- Professional leadership by clinicians and social workers.
- An ambition to simplify rather than complicate existing bodies and structures.

5.2 The proposals are based on four key principles:

- Nationally agreed outcomes that apply across adult health and social care.
- Statutory partners jointly accountable to Ministers, Local Authority Leaders and the public for delivery of those outcomes.
- Integrated budgets across adult health and social care.
- The role of clinicians and care professionals strengthened, along with engagement of the third and independent sectors, in the commissioning and planning of services.

5.3 The key features of the proposals are:

- CHPs and CHCPs will be replaced by Health and Social Care Partnerships, which will be the joint and equal responsibility of Health Boards and Local Authorities, and which will work in close partnership with the third and independent sectors and with carer representation.
- The new Partnerships will be accountable, via the Chief Executives of the Health Board and Local Authority, to Ministers, Local Authority Leaders and Health Board Chairs for the delivery of nationally agreed outcomes.
- Partnerships will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes.
- A senior Jointly Accountable Officer in each Partnership will ensure that joint objectives, including the nationally agreed outcomes, are delivered within the integrated budget.
- The role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened.
- Proportionally fewer resources – money and staff – will be directed in future towards institutional care, and more resources will be directed towards community provision and capacity building.

5.4 The consultation states that these proposals for reform are not based on centrally directed structural reorganisation, and will not impose a single operational delivery arrangement on partnerships. Within this broad framework for integration, local leaders will be free to decide upon delivery mechanisms and organisational structures that best suit local needs and priorities.

6.0 IMPLICATIONS

6.1 Legal: Depending on the final legislation, there may be a need to revise the CHCP Scheme of Establishment to reflect possible changes in governance arrangements.

6.2 Finance: No new finance implications at this stage, although the Consultation proposes pooled budgets rather than Inverclyde's existing arrangement of aligned budgets.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel: No personnel implications.

6.4 Equalities: The Scottish Government has undertaken a partial Equalities Impact Assessment and no negative issues are identified.

7.0 CONSULTATION

7.1 The current draft response has been developed in consultation through an All Members' Briefing held on 6th August 2012. We have also consulted with Legal Services, who have contributed to the draft response. Presentations were made to the Public Partnership Forum Advisory group and the Staff Partnership Forum on 17th August, to generate further discussion and reflective comment.

8.0 LIST OF BACKGROUND PAPERS

8.1 Scottish Government Consultation on Integrated Adult Health & Care Partnerships.

Consultation Questionnaire

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 ☐ No ☐

While an initial focus on improving outcomes for older people might appear to promote evolutionary or transitional change, there is a risk that this could lead to a skewed approach. The successful transition to Health and Social Care Partnerships will rely on clear structures and accountabilities to guide the transformation of service delivery across all adult care groups.

There is already considerable focus on Reshaping Care for Older People which includes dedicated performance reporting and robust governance, and that workstream is already in line with the overall proposals.

For some partnerships however, an initial outcomes focus for older people might be appropriate. We recognise that the pace of integration needs to be determined locally, building on existing partnership working arrangements.

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?

Yes ☐ No ☒

The option to include Criminal Justice and Children and Families services would support a stronger focus on vulnerable children and their families, many of whom are already engaged with social care as well as health services, so in most if not all areas there are existing close working relationships that are in line with the ethos of the Consultation, and would therefore provide a strong foundation for the implementation of the new Partnerships. In Inverclyde, our experience of transition to a CHCP was strongly supported by these established relationships, and it would have been much more complicated to try to separate out these elements to achieve our CHCP incrementally. It is important to note that our local experience has been that joint working with other Council functions,

particularly Education and Community Safety services, has been further strengthened through our inclusive CHCP arrangements through the streamlining of two key interfaces (health and social work). We recognise however that decisions about which services should be included in the new partnerships should be a matter for local determination, based on existing strengths, pressures and recognised areas for improvement.

We would propose that responsibilities of housing partners should be made more explicit. It is our view that to assert that "*It will be important that ..., partners ensure that housing services ... are fully included in the integrated approach to service planning and provision, and that health and social care planning and local housing strategies are mutually supportive*" (1.17) is insufficiently robust. In common with some other Scottish Local Authorities, Inverclyde Council does not hold any stock of social rented housing. Our local RSLs, while keen to work in partnership and regularly encouraged to engage in local planning, are governed by some national targets and priorities that are not aligned to our transformational ambitions. As key partners, we suggest that housing colleagues are given robust guidance and clear support from the Scottish Government in order for them to be able to fully engage with the potential of integration and the shift to more community-based and less institutional provision, particularly around the ambitions of a healthier, fairer and stronger society.

We would welcome further discussion to clarify the Government's vision of "*An integrated budget to deliver ... appropriate aspects of acute health activity*" (2.1). We believe that this should be focused on elements of service rather than top-line budget figures, but the elements of service to be included need to make sense in the wider context of the key purpose and functions of integrated Partnerships.

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?

Yes ☒ No ☐

The overall approach should provide a sufficiently strong mechanism to achieve the extent of change that is required, provided that existing performance reporting and accountability regimes are revised so that new

nationally agreed outcomes and accountability arrangements replace existing regimes. Indicators should be clearly outcomes-focused and reflective of those issues that are predominantly and reasonably within the sphere of control of the new Partnerships to deliver upon. The detail of how these outcomes are to be delivered should be a matter of local determination within each partnership.

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 ☒ No ☐

We recognise that some of the population-based outcomes will require a CPP approach. A key strength of CPPs is their ability to capture the sum of partners' contributions. It is therefore important that the interface between the new partnerships and the existing CPPs is made explicit, and that those outcomes which require a community planning approach are written into Single Outcome Agreements. Some outcomes – particularly systems-based ones - will be the sole or main responsibility of the new partnerships, and should therefore be included within the partnership plans, but providing there is clarity about roles and responsibilities, and clarity about what the HSCPs and CPPs are held to account for, we do not anticipate conflict or confusion between these two strands of business.

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?

Yes ☐ No ☐

With regard to the position of Leader of the Council, a local authority cannot delegate its functions to an individual councillor. Its functions can only be delegated in terms of the Local Government (Scotland) Act 1973 to inter alia, a committee, a sub-committee, an officer of the Council or any other local authority in Scotland. The suggestion that the Leader of any particular Council be accountable in the manner envisaged would need further clarification.

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

Yes ☐ No ☐

In our view that would be very complicated. In Inverclyde our CHCP has benefited from clear political support and leadership, and is a central CPP partner. If the new partnerships were to span more than one local authority area, there is a potential that they would have to try to negotiate and balance the (at times) competing priorities of two political administrations and two CPPs. We do not believe that this would foster the right supportive arrangements that would enable Partnerships to flourish.

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

Yes ☐ No ☒

We support the principle that voting members of the Committee are only those with a clear mandate and formally recognised accountability for the decisions that they make, either by being locally Elected Members or formally appointed Non-Executive Directors of the Health Board. However would point out that Health Boards tend to be larger than Councils and yet have a relatively small number of Non-Executive Directors, meaning it will be harder for Health Boards to appoint to a number of Partnership Committees in their area. The number of voting members could therefore be dictated by the number of representatives that the Health Board was able to field, rather than what would be regarded as a balanced and appropriate approach locally. Given the potentially very large budgets that the Committee would be deciding upon, we would suggest that the minimum total of six voting members would be an insufficient number to satisfy Council Administration that all perspectives had been fully explored prior to decisions being made. There is an opportunity to recognise the enhanced leadership role of those councillors who are appointed to the Health Boards as Non-Executive Directors, thereby reducing the pressure on Health Boards to populate multiple Partnership Committees, but the minimum number of six might remain a significant issue, particularly on areas where there is a coalition Administration.

We support the identification of the Chief Social Work Officer and Clinical Director as non-voting members, as that emphasises and endorses the key professional leadership role of both those posts.

We welcome the explicit expectation that the Third Sector should be appropriately engaged with strategic commissioning processes, but with the clarity that the statutory responsibility for the delivery (either direct or indirect) of health and social care services lies with NHS Health Boards and Local Authorities, and consequently that the decision-making and

governance needs to reflect that. Inevitably the principles of ensuring that voting members are only those with a clear mandate and formal accountability for decisions means that there will have to be some changes to current voting regulations. We would regret the loss of the voting members from our Public Partnership Forum and Professional Executive Group, however we believe that we have sufficiently robust systems to ensure that those perspectives remain strong and influential in our planning and decision making processes.

We welcome the explicit expectation that communities should be appropriately engaged with the strategic commissioning processes of the new Partnerships, but require clarity on which individuals or groups the term "community" refers to, or if this is at the discretion of the Partnerships.

The opportunity should be taken to articulate community engagement as a process and clarify its relationship to the role of Elected Members, given that they are mandated to represent the residents within their constituencies.

The current legislation which governs, on the one hand local authorities and on the other health boards, is largely incompatible in certain important aspects which affect the governance of partnerships between local authorities and health boards. The opportunity should be taken to amend the legislation to facilitate the type of partnerships envisaged.

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?

Yes ☒ No ☐

The performance management arrangements, as described, appear to be sufficiently robust. Please see additional comments at Question 3.

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?

Yes ☐ No ☐

As noted above, Councils should be free to determine the service composition of the Partnership.

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 ☒ No ☐

There is no doubt that full integration will bring about significant opportunity to ensure the best outcomes are achieved for resources available.

Ensuring an appropriate governance framework will be key to the success of integrated budgets resourcing.

The initial resourcing level along with appropriate mechanisms for ensuring delivery of future savings and efficiencies, linked to clearly defined outcomes for both Council and Health Board, will allow appropriate levels of scrutiny and of challenge. Given the economic, financial and demographic medium term outlook financial sustainability is a fundamental.

We would expect that a medium term business plan would form part of the framework requirements to all adequate forward planning of financial and workforce resources.

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 ☒ No ☐

As a fully integrated CHCP Inverclyde has benefited from flexible use of resources, albeit through the constraints of two separate accounting regimes, two procurement regimes and associated VAT implications.

Notably efficiencies have been achieved through an integrated management structure.

Pooled budgets would certainly enhance integrated working and increase flexibility in the use of resources, however it is recognised that detailed work will be required in a number of areas, particularly the current challenges around prescribing costs, the self directed support agenda, along with shifting the balance of care and the associated resource impact between acute and community services. Careful consideration also needs to be

given to how partnerships can potentially harmonise the management of staff against the current context of different terms and conditions and employment policies.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes ☒ No ☐

Minimum categories of spend would provide a national framework position, however as indicated above there is wider benefit from maximising integration.

Consideration would need to be given, along with governance frameworks, for statutory provision, potential ring-fencing of resources within care groups.

The focus should be on outcomes, rather than categories of spend.

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?

Yes ☐ No ☒

Statutory obligations of Health Board and of Council must be met – this may impact on the ring fencing of certain resources. There will be a need to put checks and balances in place to ensure that Council statutory officers can still discharge their duties, in particular, discharging the S95 role. There would need to be a requirement for the new body to have a senior finance officer supporting and advising the Jointly Accountable Officer and liaising with senior finance officers from the two parent organisations.

The Jointly Accountable Officer would need to ensure sufficient initial resourcing and control from the new partnership outset.

There remains potential conflict between the new partnership and NHS Board and Council in a number of areas:

- Workforce – identity and terms & conditions
- Local planning versus national strategy
- Capital investment – possible loss of opportunities if pooled budgets reduce or restrict the range of finance options currently available to

either Councils or the NHS.

- Treatment and ownership of assets
- Treatment of acute resources, currently not clear

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

Yes ☒ No ☐

We fully support the proposed single Jointly Accountable Officer as being responsible for the full range of the Partnerships resources and services, reporting directly to the Council and NHS Health Board Chief Executives. However it is also crucial that the JAO is fully accountable to the Partnership Committee, underscoring the importance of democratic oversight and decision-making.

From our experience, having a JAO is essential if the Partnerships are to function as required. In Inverclyde the Senior Management Team is jointly appointed, reporting directly to the Jointly Accountable Officer which sets up a clear structure for an integrated approach to the planning and delivery or commissioning of community health and social care services across all sectors of our population.

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?

Yes ☐ No ☒

It is important that this be a matter of local determination given the variation of local needs, and the differences between localities that influence locality planning (such as rurality; pockets of socio-economic deprivation, or variations in the quality and quantity of available social rented housing). It is also important to recognise the importance of the planning process itself, in terms of supporting local ownership and a clearer understanding amongst professionals of the strategic landscape, as well as generating impetus behind the drive to ensure that plans are successfully implemented. Locality planning needs to be focused on the local outcomes that are to be achieved, and whilst these will be shaped by overarching national outcomes, the more detailed interpretation of what this means for services on the ground will by necessity be subject to local variation.

Locality planning will have to take account of the level of support that the

local Third Sector will need in order to adapt to outcomes-focused service delivery models, so will have to be locally adaptable and flexible.

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 ☒ No ☐

We welcome this duty and regard the engagement of local professionals, including GPs, as fundamentally important to ensuring that we are developing realistic approaches that can be delivered at operational level. We would also welcome consideration of how the Scottish Government could encourage and support all GPs and other external NHS contractors to constructively participate in these arrangements so that the responsibility for the effectiveness of these arrangements are mutually shared by all.

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?

Directly employed clinicians and social care professionals are already involved with and drive planning at a local level in Inverclyde, enabled by our existing CHCP arrangements. We regard strategic and service planning as part of the "day job". It is important to note that, because our CHCP includes all community health and social care services, our arrangements support the explicit inclusion of issues that cut across both adult and children's services.

Whilst we can schedule participation into the workplans of directly employed staff, it is more difficult for Independent Contractors to effectively and consistently engage due to the need for backfill and its associated costs.

One very practical way of enabling clinicians to engage would be to fund locum cover, however this would need to be against a very clear articulation of expectations, deliverables and accountability. This would also require consideration of how to ensure representativeness across the Independent Contractors (including practical support to allow the Independent Contractors time together to analyse and agree their shared priorities, to support representativeness), and how to ensure shared responsibility between the Partnerships and the Independent Contractors against the implementation of the agreed plans.

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

Yes ☐ No ☒

We would propose that locality planning needs to be organised around natural communities rather than clusters of GPs. In Inverclyde, GP lists do not always reflect the communities in their immediate locale. For example, families can be dispersed across or even outwith Inverclyde, but with members of those families all being registered with the same Practice. The immediate locale of Practices is a structural artefact based on the location of health centres rather than the patient base and local communities.

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

Overall responsibility needs to sit with those with a clear mandate and formally recognised accountability for the decisions that they make, in other words with the Partnership Committees. In our view, the Partnership Committees should devolve management of the integrated budget to the Jointly Accountable Officers within the parameters of established Financial Standing Orders of both parent organisations. The proposals identify the inclusion of the Clinical Director and Chief Social Work Officer as non-voting members, which emphasises and endorses the key professional leadership role of both those posts. On that basis it would be more constructive to frame the purpose of locality planning groups as being one of engagement and dialogue to ensure local intelligence underpins the planning and development of services.

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?

Yes ☐ No ☒

Localities within different Partnership areas should be locally determined on the basis of recognised natural communities of residents rather than an arbitrary population number.

Do you have any further comments regarding the consultation proposals?

There needs to be greater clarity around the status of Health and Social Care Partnerships as to whether or not they are envisaged, as a separate entity. This has relevance on two important dimensions.

1. Accountability: How would the accountability of the Health and Social Care Committee members relate to the wider accountability of the full Council or full Health Board?
2. If the Partnerships are separate entities, how would financial governance fit with regard to the mechanics of operation (Financial Standing Orders etc) and the constitutional and legal aspects of financial accountability?

A further point we would like to make is that in Inverclyde, as an established "all inclusive" CHCP we are still bedding in although we are beginning to realise some genuine benefits from integration. It is not clear whether the proposals allow for an option for existing CHCP's to continue with their current partnership arrangements with a future review date for new partnerships, so that we can then identify what aspects of the new partnerships offer something better, and then move to incorporate them.

We make this point because there are some local concerns that more change so soon after establishing our CHCP could in fact de-stabilise arrangements that are currently working very well.

Do you have any comments regarding the partial EQIA? *(see Annex D)*

Do you have any comments regarding the partial BRIA? *(see Annex E)*