WEST DUNBARTONSHIRE COUNCIL

Report by the Chief Executive

Council: 28 October 2009

Subject: NHS Integration Proposals

1. Purpose

1.1 The report seeks the Council's approval, in principle, to commit to a new level of partnership and integration with the NHS. The goal would be the development of a local integrated partnership model for the strategic planning and delivery of local authority and community health services within a new combined Council/NHS structure: with particular emphasis on the integration of community based health and social work services through a single management team.

1.2 The key feature of the partnership would be a joint appointment, by the Council and the NHS Glasgow and Clyde Health Board, to the post of Executive Director for Social Work and Health. In taking such a step the Council would realise the ambition, signalled by the original creation of the post, to integrate frontline services across health and care.

1.3 There have been extensive informal discussions with the NHS Greater Glasgow and Clyde Health Board. At a meeting earlier this year between the Chair of the Board and the Council Leader it was agreed that further work to examine models would be prepared for the Council's consideration. This report sets out proposals to take forward integration.

2. Background

2.1 The significant drivers for change can be identified:

- The historical commitment, in our area, from both the Council and the NHS to pursue the incremental integration of our local health and care services; and the success of this incremental approach.
- The shared responsibility both services have for many care groups and the need to simplify access to joint services.
- The new relationship between the Scottish Government and local government signalled by the Concordat and the Single Outcome Agreement [SOA] for all local authorities. A key factor in the delivery of national and local outcomes is effective partnership working.
- The Council and the NHS, particularly through the CHP, have shared objectives and matched resources to expand and deliver services and to manage and support them on an ongoing basis.
- The financial context facing all the public services linked to the Community Planning Partnership presents a challenging context to sustain and develop services that can respond meaningfully to the

needs of West Dunbartonshire's people. In such a context it is essential that key partners consider the management and support costs of running services across all their agencies.

- The Clyde Valley Review, led by Sir John Arbuthnott, has promoted consideration of different models to deliver and support frontline services.

2.2 The Scottish Government has sponsored wholesale exploration and study of new ways of working through shared services and combined approaches to roles and functions such as procurement and workforce planning. It is logical to pursue other structural solutions and service delivery models. Part of the Concordat was an undertaking by the Scottish Government to avoid unnecessary structural reform or boundary change for local government. The economic factors facing the public sector however suggest that all options have to be considered by all partners.

3. The Milestones towards Integration with the NHS

Over the past ten years there have been significant developments in pursuing the integration of social work and NHS services and better joint working across all partner agencies.

- By 2001, in response to national Joint Future policy developments, the Council had a Strategic Partnership Agreement involving the NHS and Scottish Homes [later known as Communities Scotland]. This generated the formal Health Improvement and Social Justice Partnership which paved the way for joint services for Adult Health and Community Care.
- Another Strategic Agreement was signed off to promote joint planning for children's services to tackle inequality and disadvantage. This agreement involved a wider range of agencies and partners, including Strathclyde Police. The agreement provided the basis for the successful development of the 'Integrated Children's Services Plan'.
- By 2004 the Council and the NHS Boards of Greater Glasgow and Argyll and Clyde had committed over £30m of adult community care and health services into joint management arrangements with single managers and co-location of services [Addiction and Learning Disability services were the early pilots].
- In 2005 Community Health Partnerships were created in response to national policy and the Council was invited by our two NHS Boards to consider becoming one of the first Community Health and Care Partnerships similar to the model being developed for Glasgow City Council and East Renfrewshire Council.
- Ultimately the Council rejected the proposal. This decision was based on several factors. There were concerns about the complexity of a partnership which had two separate and very different NHS Boards. The large deficits in the NHS Argyll and Clyde Board made elected members anxious about financial risk and control of the Council's budgets. There were tensions in the Council about the NHS Boards' stated views in their strategic reviews of acute/hospital services

affecting our area; threatening services at the Vale of Leven Hospital. Finally the manner of the negotiations which were presented within very tight timescales did not help achieve agreements. The Council has, however, always remained committed to a pragmatic and evolutionary approach towards integrated services and better joint working.

- Over the past three years the joint work towards integration has made good progress. The dissolution of NHS Argyll and Clyde brought more clarity to joint working. In November 2007 both the Council and NHS Greater Glasgow and Clyde formalised the commitment to better integration by agreeing 3 joint Heads of Service Posts across all Adult Community Care and Health services. Both partners agreed to consider further structural changes on the basis of the outcomes of progress achieved.
- The resolution of the future of the Vale of Leven Hospital will also diminish uncertainties and offer options for future shared services.
- External scrutiny by Audit Scotland, HMIe and SWIA, has identified the strengths of partnership working across the Council and the NHS; but SWIA noted that the governance arrangements for integrated working need to be finalised and made clear.

4. The Case for the Next Phase of Integration

The arguments to support the development of a partnership model based on a joint Executive Director's post for social work and health are compelling:

4.1 Public Service Transformation

The development will fit well with the national public sector reform agenda and will provide an innovative model of shared leadership and accountability. A formal partnership with the CHP can continue the work to reduce bureaucracy and duplication across services; and ensure that improved access to services and better outcomes for service users and carers are achieved. When teams work together across professional and agency boundaries service users and carers can expect better communication and understanding of their needs.

Service re-design can get the right mix of skills and professional workers in joint teams. With shared responsibility for so many care groups it makes sense to take a combined approach to involving service users and carers in shaping service responses. With added NHS capacity there can be better flexibility for out of hours access and management support of the staff involved; particularly for older people and people affected by mental health issues.

A formal partnership engaging the Council and the NHS would enable both organisations to be in a stronger position to direct future planning for wider integration and a coming together of the public services and partners working across West Dunbartonshire; a single public sector provider in shared premises.

4.2 A Strategic Approach to Tackling Poverty and Health Inequality

The strategic leadership of the two main public services within West Dunbartonshire will be strengthened and more focused on the shared challenges set by the SOA, the Community Plan, the Council's Corporate ambitions and the objectives of the CHP Development Plan.

The Council will realise its potential as a 'Public Health Organisation'. With an NHS CHP presence on the CMT and stronger political accountability for the NHS the Council will be better placed to tackle health improvement and health inequality. Direct engagement with all Council services including Education, Leisure, Economic Development and Housing will enhance the combined efforts of both partners to provide preventive measures and to resource and deliver national outcomes and local Community Planning goals. Our Social and Economic and Disability profiles for West Dunbartonshire document the scale of the challenge we face in addressing the changes needed in the life circumstances and lifestyle choices of our people.

4.3 Shared Costs and Duplication

Management costs will be shared and opportunities to review departmental, corporate and support costs will be presented to the partnership.

The joint appointment of an Executive Director will offer immediate savings to both partners. The Council and the CHP, however, already have a range of joint management and support posts on a shared cost basis.

In addition both organisations each have managers and specialist staff with lead responsibilities for similar functions and services.

At a departmental/service level these include:

- children's services
- adult community care for older people
- strategy and planning roles
- health improvement
- community engagement and public involvement
- finance
- HR and OD
- Administrative support

Corporately each partner funds and has access to Finance, Audit, HROD, Legal Services and ICT.

Significant resources are also dedicated by each partner to Estates/Properties and Asset Management.

It is recognised that there are currently corporate structural reviews being undertaken in a number of the above areas within the Council, however further integration may provide new opportunities to review the provision of the corporate services identified above in partnership with the NHS.

Strategic risks in the key areas of asset management, shared premises and financial planning for both partners could be shared. For example, the development of services for older people at the Vale of Leven Hospital site, shared HQ/support services and optimising site options to bring forward the new Dumbarton Academy are examples of potential early gains.

The Council's capital programme is very stretched. The Council has rightly declared its commitment to the new Dumbarton Academy and the Schools Estate as its first priority. This will add to the pressures on these budgets.

Across social work there are services and teams co-located in new or refurbished properties. These highly regarded developments in services for Addiction, Mental Health, Learning Disability and for Older People would not have been possible without significant capital investment and shared revenue costs from NHS Greater Glasgow and Clyde. Half of the 'Best Practice' examples selected by SWIA were in these areas of service delivery.

4.4 Reputational Risk and Performance

Given the concerns expressed by Audit Scotland and the Accounts Commission about the Council's performance the proposed partnership will offer the Council access to increased capacity to improve strategic leadership, governance, corporate reputation and performance levels.

For the Greater Glasgow and Clyde NHS Board the alliance will allow greater impact and influence to secure the health gains and efficiencies needed in an area of high deprivation. It will also promote the Board's capacity to earn the trust of local people and our communities. Social Work and Education Services, in particular, have a good track record of community involvement and engagement with service users, carers and other providers. New forms of accountability will also address criticism of the 'democratic deficit' within the NHS.

4.5 New Developments

If the Council and the NHS commit to further integration a number of new developments will be realised.

- 'Re-enablement' Strategy - Services for Older People and Disabled People.
  The transfer of resources and the re-design of acute hospital services in Glasgow will present the CHP and the Council with the chance to invest in community based services. This will include a much strengthened joint OT and specialist team that can focus on rehabilitation and skills for independence for people with long term conditions and disability. There are high levels of disability amongst our adult and older people in the area. The movement of specialist staff and resources from the hospitals will represent an investment equivalent to £500,000 for the new services.

- Specialist Delayed Discharge Services
  This model will bring together an authority wide service of NHS and Social Work staff to target delayed discharges and improve assessment. Performance since 2008 has been improving steadily but a jointly managed team will sustain and improve our contribution to this national priority. Hospital admissions often trigger loss of independence for older people and we want to establish preventive services which work with people to restore self-confidence and functional capacity. This model of anticipatory care can help avoid people having to leave their own homes.

- Support for Residential and Nursing Homes for Older People
  Increased resources to community based clinical services will allow us to support all care homes to manage complex health issues, including palliative care, to make sure unnecessary hospital admissions are limited

- Linking all Residential/Nursing and Hospital Services for Older People with Mental Health issues

  It is proposed that all such services will be under single and joint management arrangements to ensure that resources are matched to individual need.

- Assessment and Care Management Review

  It is proposed that all the existing Social Work teams for older people and the remaining community care adult services across the authority will be brought under joint management arrangements. A key focus will be improving the care management and review practice of all cases placed outwith our own local authority care homes

5. Key Assumptions for the new Partnership Model

5.1 Social Work and Education

External inspection and scrutiny processes have confirmed that the major services of the Council for Social Work and Education (including Culture, CLD, Early Years and Psychological Services) are performing well.

It is important that these services, within emerging resource constraints, continue to sustain and improve their performance. The new model will work best if each of these Council directorates is left intact. Given the statutory accountability of social work for children's services and child protection the lead Head of Service must be a Council employee.

5.2 A Generic Social Work Service

Judging by the evidence of the Council's SWIA Inspection report the Council's generic and holistic social work service has delivered good outcomes for people. It is valued by the community and has been a good corporate resource for the Council and the NHS. The centrality and focus of a generic social work service is important. The Chief Social Work Officer is of the opinion that the most effective performance of statutory social work is best managed from a coherent generic social work service that includes Children's, Criminal Justice and Adult Community Care Services. The sustainability of such a 'stand-alone' model however is a challenge in terms of the Council's economic circumstances.

The best way to sustain this focus and leadership for social work in West Dunbartonshire, and in an affordable organisational context, is within a formal partnership with health.

The other critical issue is the role of the Chief Social Work Officer.

Across Scotland the organisational structures and contexts for social work services are varied. Following the completion of 32 inspections of local authority social work services SWIA have not declared so far publicly any preferences for particular models. Their emphasis has been on outcomes, strategic and professional leadership and capacity for improvement. Neither resources nor organisational contexts have been demonstrated to have a direct causal link with performance.

SWIA guard against making simplistic statements about performance. They do not adopt a 'league table' approach towards performance, however it is possible to differentiate between poorly performing and better performing services. There are 13 local authorities that have a version of the 'stand-alone' model. Their performance is scattered across the range of achievement levels: 6 are in the best performing third but 3 are in the lowest areas of achievement. West Dunbartonshire Council is unique in having joint Heads of Service across all Adult Community Care and Health services. Other Councils in the top band, particularly Angus and Renfrewshire, like us, have levels of integration within services operating as co-located teams. Almost all the best performing councils for social work have these kinds of local developments at team level which bring staff and resources together to benefit service users and increase co-ordination of services.

Genuine Community Health and Care partnerships exist in 4 local authorities, 2 of them can be ranked in the top three performing social work services in Scotland. In these examples the director does not hold the role of CSWO. The other 2 local authorities across Scotland with these community care and health partnerships are in the poorest third of performance.

Other local authorities have different models of mixed Directorates with social work as part of housing, education or community services; sometimes with adult services separated from children's services.

It should be noted that performance in HMIe Child Protection is similarly varied in relation to organisational structures.

The critical question is whether the benefits of easy access to services [the one door approach] and the effective co-ordination of services can be achieved without structural change; or if the movement towards a more formal integrated structure can deliver better services more effectively.

5.3 Joined Up Services

The report of the 21st Century Social Work Review highlighted the importance of partnerships between social work and other public, private and voluntary agencies.

"Social Work services alone cannot solve society's problems. We need to harness all our resources and expertise to design services around the needs of people, delivering the right outcomes for the people who use them. That means finding new ways of working that position social work services alongside the work of their partners in the public, voluntary and private sectors. Together we will shift the balance towards a much greater focus on preventing problems and intervening early to resolve them."

The reforms of service to achieve the required improvements include:

- Shared information, assessment and care planning
- Co-location of services with clear access points
- Better information for the public, service users and carers
- Agreed protocols for referral and acceptance of cases
- Multi-disciplinary teams
- Joint management and accountability

Every day in the lives of people facing problems they have problems trying to get the right help to respond to their needs. Our health, welfare and care services are complex. Staff from all agencies encounter the same complexity. Even in areas where we have joint teams with shared information and assessments, care plans and defined care pathways there can be disagreements about where responsibility lies. However , the experience of services where there are joint management arrangements suggests that co-location and team building do enable service users to make better use of joined up help. Equally we have other services without joint teams who work hard to cross agency boundaries and co-ordinate care and care planning.

On balance it seems reasonable to contend that an integrated structure can deliver good conditions to promote 'joined up' services.

5.4 The Role of Chief Social Work Officer (CSWO)

Last year the Council approved a report welcoming the new Scottish Government Guidance on the role of the CSWO and agreed to follow the Principles established. Under the heading 'responsibility for values and standards' the CSWO must promote the values and standards of professional practice and ensure that only registered social workers undertake key functions reserved for them in legislation. The CSWO must be a qualified social worker and registered with Scottish Social Services Council. The CSWO should give professional advice to the Council as a 'proper officer' similar to the 'monitoring' officer. Ideally the CSWO should have direct access to the Chief Executive and be part of the CMT. In any partnership arrangements these accountabilities have to be taken into account. It is not a requirement that the CSWO's role has to be undertaken by a Executive Director but the Council must ensure that the arrangements allow the CSWO to carry out the role effectively.

5.5 Legal Context

The partnership model described could be delivered by using the powers available to the Council and the NHS Board under the Community Care and Health Act [2002].

Under Part 2 of the Act both local authorities and the NHS have the ability to delegate functions to each other, whilst retaining responsibility and liability for their respective statutory duties.

The key test is that such arrangements will lead to improvements in the way functions are exercised and Scottish Ministers agree the arrangements.

As indicated earlier, SWIA in their inspection of social work services in West Dunbartonshire earlier this year, commented that the existing governance arrangements between the Council and the CHP need more formality.

The Council's existing Standing Orders and the existing Scheme of Establishment for the West Dunbartonshire CHP would need revision or replacement to implement these proposed changes and would require approval by Scottish Ministers.

It is important that the proposed model is not perceived to be a 'take-over' or an absorption of one body by another. The locus of West Dunbartonshire provides an opportunity for the NHS to locate CHP services within a new local arrangement.

It is also vital to state at the outset that this would not be a vehicle for either statutory body to impose its 'will' on the other. The governance arrangements as set out below would be crucial in making that statement a reality.

5.6 Governance and Accountability

These aspects of the model need careful thought and will need to be addressed in discussions with the Health Board. As a new partnership a joint political process including NHS Non-Executive Board members and the Council's elected members would need to be created to allow the proper exercise of governance and accountability.

It is suggested that the role of Executive Director for Social Work and Health should hold the dual accountability on a day to day basis across the NHS and the Council and this Chief Officer should act as the CMT member in both organisations.

A revised Scheme of Establishment and the Council's standing orders should be used to create a new joint Committee which has a balance of control across social work and health services to replace the existing CHP Committee and the Council's Social Work and Health Improvement Committee.

In the areas of NHS GG&C where integrated partnerships already exist, the Governance Committee is chaired by a local Authority elected member and the vice-chair is a non executive director of the NHS Board. This appears to represent a viable and workable model that could be replicated in West Dunbartonshire.

At the same time the redundant Social Work and Health Improvement Committee should be ended.

Children's services are also affected in that they represent a significant part of the responsibilities of both the Council and the NHS. Previously the Council's Committee for Education had a standing invitation to include a senior representative from the NHS to attend. In the past a Consultant or Director has taken on this role. This level of representation would not offer the governance required for such major services if it were to include all child health issues and services.

Further consideration would be required to establish whether the Council's Education and Lifelong Learning Committee would have the capacity to assume responsibility for all children's services issues or whether it would be preferable to establish a separate committee to deal with non-educational children's services.

The remit and membership of a new joint committee for social work and health would need to reflect the joint interests of both parent bodies and the principle that cooperation, agreement and consensus is the mode of operation to deliver and implement change and agreed priorities.

6. Personnel Issues

6.1 The first phase of the new partnership model is achievable through the early retirement of the Council's Executive Director of Social Work and Health (and who is the Council's Chief Social Work Officer).

6.2 An agreed basis for recruitment for the post will have to be put in place. The partners have experience of this kind of process already having appointed 3 joint heads of service.

6.3 As has been the practice in past joint future appointments successful applicants will have the right to determine their host as employers depending on their current positions. Usually postholders opt to remain within the NHS or local authority, whichever body is their present employer.

6.4 Over the past two years the CHP and the Council have used a 'Joint Staff Forum' [JSF] to engage Trades Unions/Professional Bodies and staff in considering the implementation of integrated working. The JSF has been effective in opening up issues and considering solutions. A paper on 'Joint Accountabilites' has been approved by the SMTs of each agency and this has been helpful in resolving issues about HR joint management processes.

7. Financial Implications

7.1 When considering the financial implications of these partnership proposals it is important to understand the scales of spend and staffing involved. The CHP has a budget about £67m and over 600 staff. A significant proportion of the CHP spend, about £40m, is devoted to prescription costs and GP contracts and Family Health Services. Across Social Work there are 1,500 staff and the gross spend is over £72m (net budget of over £60m). It should be noted that the Council is in receipt of around £8m in income from the NHS in relation to Resource Transfer funding. It is understood that in the future this would be managed as part of the CHP budget and governance arrangements would be required to support the transfer of funds.

7.2 The current financial savings to the Council from joint management arrangements is £145,000. This saving is already taken into account in the current budget for Social Work. If the joint Executive Director's post were included this would generate further savings to the Council of around £60k.

7.3 The potential for future further efficiency savings through management changes and support costs (per 4.3) should be identified within a reasonable timescale and agreed within each co-ordinated budget cycle of the partners. There may also be opportunities to review some corporate support functions with further integration.

8. Risk Analysis

8.1 Sustainability

The key risks attach to not addressing shared concerns about future sustainability of services, increasing costs and declining public sector funding.

8.2 Rehabilitation

Without access to increased capacity and competence the Council faces a hard struggle to overturn public views of performance and the verdicts of Audit Scotland and the Accounts Commission.

8.3 Credibility

For both organisations there are credibility issues. On the NHS's part there may be concerns about the reputation of the Council as a key partner. The Council, however, may also have reservations about Greater Glasgow and Clyde NHS Board's track record in persuading local people, local politicians and the Scottish Government that they have the capacity to engage local communities and listen to their concerns. This is a significant strength of some of the Council's key services.

8.4 Workforce Morale and Disruption

Probably the most difficult judgement to make is the risk presented by such a major shift to the workings of the services in social work and the Council. The recent SWIA inspection recommended that governance arrangements underpinning our joint working with the NHS should be formalised as soon as possible. They also reported that some staff expressed concerns about the delay in concluding decisions about further integration.

It is important to note that SWIA, on our own staff surveys, and the latest Corporate staff survey have demonstrated clear improvements in staff morale over the past three years. The services in themselves are effective and valued and staff have firm views of their purpose and see management as supportive.

From internal discussions it is evident that the workforce and the management within social work and health have divided views about the prospect of formal structural integration with health. It is important to understand this ambivalence and establish how reservations and such ambivalence might be managed if we were to move towards greater integration.

There are two aspects to the problem.

Firstly, the question of values. Through the CSWO's role and the functions of registered social workers there are clear expectations set for social work staff. In particular there is a system of accountability for key tasks such as risk management and protection. There are also areas where social work staff are expected to pursue justice and fairness for people. These roles and tasks appear, at times, to sit uneasily within NHS systems.

The experience of social work staff engaged in adult community care joint themes has been largely positive. In some settings, however, the CSWO has had to intervene to ensure accountabilities are respected.

For staff in other settings without direct experience of joint management or co-located teams there are concerns that the value base and operational roles of social work would not be respected.

The second issue is more difficult. It is the perception of culture and organisational style. The recent struggles across Glasgow City Council and the NHS Board have not been helpful to the cause of integration. From first hand experience across our own services we have been involved in issues with NHS GG&C where NHS senior staff are perceived as managerial and directive; and not affording proper respect to partnership working. This is a major cause of concern to staff.

This has not been our experience in local working at CHP level, but staff and elected members have voiced doubts about our local services in partnership working being dependent on the personalities of current postholders. In other words there are concerns these relationships do not reflect the culture of the NHS and local authority partnerships elsewhere.

Any proposed partnership will need to ensure these misgivings are examined fully.

8.5 Conflict Resolution

Obviously the best way to manage disagreements is not to have them. Historically our relationship with the NHS has had difficulties.

One of the most significant issues facing partnerships across the NHS and local government is their ability to pre-empt and resolve conflicts. This has been a feature of other CHP and CHCP arrangements. In particular Resource Transfer issues and control of budgets have been highlighted as presenting difficulties. It would be important to address these issues at an early point in any negotiations over the model. Historically there has been a strong level of collaboration locally and positive working relationships which would bring a solid foundation to underpin a new set of arrangements as set out in this proposal.

Recent discussions between CoSLA, NHS and the Scottish Government may help provide some standard way of dealing with disagreements.

9. Conclusions and Officers' Recommendations

9.1 The model is recommended because it offers both the Council and the NHS the opportunity to maximise the impact of their resources and reduce costs. The proposed partnership recognises the duplication of functions and resources and offers, in a planned way, a route towards the sustainability of key services. The major concern of both the Council and the NHS is the

prolonged and damaging nature of health inequalities and the need to generate opportunity for people to improve their life chances. The chance of achieving these goals will be greater if more effective partnership working is achievable. Even at its most basic level, the opportunity for reductions in management costs and overheads as alternatives to savings in frontline services cannot be ignored. Once the new arrangements are in place it then more easily facilitates opportunities for further efficiencies in other aspects of the Council's and NHS Board's activities.

9.2 It is the Chief Executive's and CSWO's view that a stand-alone model of a generic social work service provides the clearest approach to the management of social work services. The sustainability of this model is more difficult. More significantly, the impact of social work services corporately within wider partnerships has to be considered.

9.3 It should be recognised that the process of concluding partnership agreements towards integration will take time. Apart from the separate agreements of the Council and the NHS Board a revised Scheme of Establishment for the CHP has to be approved by Scottish Ministers. Over the next three month period detailed discussions and consultations will be held with elected members, staff, trades unions, the CHP and Community Planning Partners. If the Council agrees a commitment towards further integration the outcomes of consultation can be used to inform the development of the final integration proposals.

9.4 It is recommended that the Council agrees to ask the Chief Executive to meet with the Chief Executive of NHS Greater Glasgow and Clyde Board to consider proposals for integration; and to invite the Chair of the Board to meet with senior elected members to consider these proposals, providing regular reports on progress to Council.

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Date: 15 October 2009

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Appendices: None

Background Papers: Report to Council on 28 November 2007 - Integration of Adult Community Care and Health Services

Wards Affected: All