Borders NHS Board

HEALTH AND SOCIAL CARE INTEGRATION

Aim

The aim of this report is to update Borders NHS Board on progress with the Integration arrangements for Health & Social Care and to make recommendations to the Board regarding the preferred model, outcomes and initial scope of the Integration Body. A report making the same recommendations is being presented to Scottish Borders Council for approval on 31st October.

Background

Currently the legislation for Integration is progressing through the Scottish Parliament with a proposed date for implementation of April 2015. This is the timescale we are working to locally for the new arrangements to be implemented in full although the aim is to make significant progress prior to this date and establish shadow arrangements where appropriate.

In March 2013 Scottish Borders Council and NHS Borders agreed to the establishment of a Pathfinder Board and the appointment of a Programme Director to lead the revised arrangements for the Integration of Health and Social Care in line with legislative requirements.

A number of key principles were approved at that time to guide the new arrangements including:

- Improving outcomes for service users and carers
- One Partnership Board to be established with 5 localities as currently provided
- Integration to build on work undertaken in the Cheviot area
- Integration to commence with adult primary and social care
- Integration to minimise structural change and maximise flexibility

Since this time there has been considerable local progress with the appointment of a Programme Director and agreement on a programme structure which is currently being implemented.

Further consideration of the model to be adopted locally, outcomes and initial scope of the Integration Board has been considered and supported by the Pathfinder Board and this report seeks to make recommendations to both NHS Borders Board and the Scottish Borders Council on these initial proposals.

Summary

This paper summarises progress to date on Health and Social Care Integration locally and the Board and are requested to agree the proposed model and initial scope of the partnership.

Proposed Model for the Integration Board

Two models are promoted in the legislation.

a) **The body corporate model** – under this model Local Authorities and Health Boards will delegate functions and budgets to an Integration Board which will be led by a Chief Officer. The body corporate when established will be a joint Board approved by Scottish Ministers which will be a separate legal entity and will have clear delegated powers and financial authority for managing a joint budget and be held accountable for the delivery of agreed outcomes. Both the NHS Board and Council will need to approve integration plan which will set up the body corporate and arrangements for reporting to the parent bodies will need to be established.

b) **The lead agency model** – under this model functions will be delegated from one body to another. This model has been implemented in Highland. The bill outlines 3 potential options, delegation from a Local Authority to a Health Board, delegation from a Health Board to a Local Authority or delegation of functions to both the Health Board and a Local Authority. As per the detail of the partnership the Local Authority or NHS would be accountable for the delivery of the agreed outcomes. This model would require the establishment of a joint monitoring committee to oversee delivery.

Each of these models have advantages and disadvantages but with each model there is a requirement for both the NHS Board and Council to jointly agree the model, delegated powers, financial arrangements and outcomes in an integration plan that will then need to be agreed and signed off by Scottish Ministers.

Advantages of the body corporate approach include:

- Service and structural changes can take place on an incremental basis therefore no large scale restructuring and transfer of staff required
- Enables partnerships to build on current joint arrangements
- New organisational culture can be established

Disadvantages include:

- Need to manage different terms and conditions of staff in the partnership although it is possible for the body corporate to employ staff
- As a separate legal entity the body corporate will require to comply with legislation. This will include production of final accounts, internal and external audit review.

Advantages of the lead agency model advantages include:

- Services will be managed under one organisations arrangements
- Harmonisation of staff terms and conditions working in joint teams.
- Structural change may enhance integrated working

Disadvantages include;

- Significant structural staff reorganisation and staff transfer
- Potential increases in costs
- Host agency may be perceived by some staff as " a take over"

Locally there has been a strong commitment to minimise structural change and focus on delivering agreed outcomes for patients, service users and carers. It is recognised that there has been significant progress in the Borders with the integration of existing services such as Learning Disability and Mental Health without the requirement for large scale staff transfer and there is therefore support to progress this approach. In addition there are concerns that the lead agency model may result in significant structural change and uncertainty for staff which is not required locally to deliver agreed outcomes.

Considering the points above at the Pathfinder Board on 23rd September 2013 all key partners supported the adoption of the Body Corporate model in the Borders and it was recognised that there was no appetite by partners for the adoption of the lead agency model at this time.

Outcomes and Improved Performance

There is agreement that a clear focus on agreed outcomes is needed to drive the integration arrangements and ensure there is added value and improved performance.
It is recognised that improved outcomes for recipients of services and their carers are key for the integration programme and these need to guide the vision and work of the Integration Board. The provision of quality services are key to this supported by a motivated and effective well trained workforce.

National outcomes for integration have been developed by the Scottish Government and at a recent local workshop progress was made to build on these and identify success measures for the programme as well as initial draft outcomes and performance targets for the partnership and these are detailed in Appendix 1.

Success measures proposed for the Programme include;

a) Improved outcomes for patients, service users and carers
b) Clear information and accessible timely services provided
c) Quality person centred services delivered in a person's own home or community
d) Open transparent and understandable governance arrangements
e) Effective use of resources, staff and premises and delivery of agreed efficiencies across the partnership.
f) Flexible, skilled workforce.
g) Meets agreed performance targets

These clearly reflect the principles embedded in the 20/20 vision for Health and Social Care and the Self Directed support agenda in Social Care.

A Programme Structure has now been agreed. Project Boards are being established to cover key themes of workforce, information technology/performance, commissioning and locality planning, financial arrangements and governance and accountability. These will be led by Senior Officers in the partnership and key to this work will be Performance Management reporting.

There will be further discussions and consultation with key stakeholders regarding outcomes and the production of base line information. This information will be discussed further at the Pathfinder Board and outcomes further refined with clear local targets proposed. A joint performance management process will be put in place across the partnership to report and monitor performance in the new arrangements.

Scope of the Integration Board

The scope of the integration arrangements is defined by the agreement of all parties within the partnership. There is an acceptance locally to focus on adult social care and health integration in the first instance and there has been initial work completed to ensure that the scope of the services to be included clearly will deliver the agreed outcomes. An illustration of this is to be found in Appendix 2. However, it is recognised that the scope will further develop as the new arrangements are progressed or as a result of direction from the Scottish Government.

The range of services that are being proposed for initial inclusion are those already jointly managed and reported through the CHCP, the exception to this being the Children and Young People's Planning Partnership. This includes:

a) Learning Disability services
b) Mental Health
c) Drug and Alcohol Services
d) Change Fund/ Delayed Discharge
e) Joint Health Improvement Team
f) Older People services including Residential and Care Home services

It is proposed that the scope of the available resource for the revised arrangements is broadened to include a wider range of services which through joint working will enable more effective outcomes for patients, service users and their carers. It is recognised that some service areas provide a service to the whole Borders population including children and these have been included where there is no perceived benefit to disaggregate these service areas.

Proposed additional services include:

a) Physical Disability Services - including care at home and day support
b) Community Hospitals and nursing services – this covers all services provided in the four community hospitals and district nursing, health visiting, and school nurse services provided to local communities
c) GP Prescribing and General medical services – this includes all prescriptions dispensed in Borders for all residents as well as all medical services provided by local GPs
d) AHP services - this covers physiotherapy, occupational therapy, podiatry, dietetics and speech and language therapy which provide both hospital and community based services to the whole Borders population

The scope of the partnership detailed above is considered to be an initial approach. As the partnership arrangements develop there will be further discussions at the Pathfinder Board to determine the final scope and a flexible approach will need to be adopted as it is

recognised that the scope may increase or decrease. Any changes will be brought to NHS Borders Board for approval.

Financial Implications

As a broad indication of the services currently being reported to the CHCP, excluding the Children and Young People's partnership totals £39.864m from SBC and £20.441m from NHS Borders totalling £60.305m.

The proposed additional indicative budgets total an additional £52.613m from NHS Borders and £0.753 from SBC totalling £53.366m.

The revised resource pot proposed for the Integration arrangements totals £113.671m for initial inclusion in the partnership.

Prior to the establishment of the partnership systems and processes will need to be agreed to finalise the amount and to sign off and actual transfer into the integrated budget.

Communication and Engagement

A communication and engagement strategy has been agreed by the Pathfinder Board. Key to this is the involvement of recipients of services, carers, staff and the broader public. The Joint Staff Forum which comprises of staff representatives from NHS Borders and Union representatives from the Council, HR and management is currently being reviewed and an invitation for a representative on the project groups has been offered to ensure staff engagement in the design.

There have also been early discussions with the Public/ Patient Forum and third sector regarding the most effective ways they will be able to input into the development of the new arrangements.

Recommendation

The Board is asked to

a) **note** progress with the Integration Programme
b) **agree** to adopt the body corporate model at this time
c) **approve** the success criteria for the Programme
d) **note** the progress on outcomes for the partnership detailed in Appendix 1 and endorse the direction of travel
e) **agree** the initial scope for the Integration Programme detailed in Appendix 2

Policy/Strategy Implications	The government are progressing legislation through Parliament which requires adult health and social care integration to be progressed at local level.
Consultation	A communication strategy has been agreed and the importance of communication, consultation and engagement with patients, service users and carers and the public is fully recognised as we move forward with the new arrangements.
Consultation with Professional	There has been work underway to refresh

Committees	the Joint Staff Forum to ensure that staff representation is embedded in the programme arrangements.
Risk Assessment	A full risk assessment and risk monitoring process for the programme is being developed as part of the programme arrangements.
Compliance with Board Policy requirements on Equality and Diversity	The full local arrangements for integration will need to be fully assessed to ensure that they meet the requirements on Equality and Diversity.
Resource/Staffing Implications	Work is now progressing to develop the joint resourcing arrangements required to manage the budget for the Integration Board when established.

Approved by

Name	**Designation**	**Name**	**Designation**
Calum Campbell	Chief Executive NHS Borders	Tracey Logan	Chief Executive Scottish Borders Council

Author(s)

Name	**Designation**	**Name**	**Designation**
Elaine Torrance	Programme Director for Health and Social Care Integration		

Draft Integration Outcomes

(Based on Pathfinder Board Workshop on 19th September)

1. High Level Success Criteria for the programme

- Improved outcomes for service users and carers
- Easily accessible services with clear available information
- Quality services delivered in a person's own home or community in a timely way
- Open, transparent and understandable governance arrangements
- Effective use of resources and delivery of agreed efficiencies across the partnership
- Flexible skilled workforce
- Meets agreed performance targets

2. Integration Outcomes and Measures (by – and – from June 2015)

Outcomes	Measures	Current Baseline	Current Target
• Effective governance and reporting arrangements in place • Agreed effective joint financial arrangements in place • Functional integration of IT solutions • Joint workforce plan and integration of HR policies and procedures where appropriate eg absence management processes, joint training plan • Establishment of robust performance and clinical/ care governance • Effective engagement of all key stakeholders • Effective commissioning arrangements based on the 5 localities	• Agreed integration plan and new arrangements in place – April 2015 • Agreed and deliverable Strategic (Commissioning) Plan (as per locally agreed and national timeframes)- June 2015		

3. Strategic Outcomes and Measures

a. Better Outcomes for the Population - People (patients/service users and carers)

Outcomes	Measures	Current Baseline	Current Target
• People are safe and dignity and human rights are respected • People are as well as they can be (independent living) • People have positive experiences –living where you want/ as you want / having things to do/ seeing people • Healthier living – people are as well as they can be • Carers feel valued and supported to continue in their caring role Related SOA/National Outcomes • We live longer, healthier lives (National Outcome 06) • Reduced Inequalities – We have tackled the significant inequalities in Scottish Society (National Outcome 07) • Our people are able to maintain their independence as they get older and are able to access appropriate support when they need to (National Outcome 15)	• % of people who say they are able to look after their health or say they are as well as they can be • % of people receiving care or support who say they can live as they want • % of people who are satisfied with care arrangements • % who said that care and support they received had a positive impact in improving or maintaining their quality of life. • % of carers who feel supported to continue in their caring role • % of people receiving care who said they feel safe • % of people who feel involved in their care	77% (SBC) 75.4% (SBC) 74% (SBC)	

b. Staff

Outcomes	Measures	Current Baseline	Current Target
• An engaged, skilled and effective workforce • We make the best use of staff resources • Reduction in management costs/overheads • Common culture is developed	• Positive staff satisfaction and engagement (appraisal, staff forum, feedback from staff surveys) • Workforce in joint services are clear on their role • Reduced absenteeism • Skills development • Progression	4% (NHS)	4% (NHS)

- c. Processes - Person Centred approach to policies and processes in place

Outcomes	Measures	Current Baseline	Current Target
• Improved Outcomes for service users and carers • Reduce delays/length of stay • Easily accessible services and information • Equality of access to services and information • Work with Communities to improve health and independence • Prevention and early intervention is supported • Productivity/Efficiency gains – service processes are reviewed, redesigned and streamlined around the needs of the client and carer resulting in better use of existing resources and tangible service improvements.	• Eliminate the number of bed days caused by delayed discharges - there should be no delays once assessed medically fit. (The aspiration is 0 days – it may take a little while to achieve)	0	0
	• Reduced accumulated bed days for delayed discharge (per year)	547 (Joint)	
	• There should be no discharges to a long stay care home place from hospital for anyone who was not admitted from a care home (There may be a number of exceptions – therefore 95% might be a better figure than 100%) This should be achievable within 1 year.		
	• Reduced occupied bed days for people with multiple/complex needs (definition needed)		
	• Reduction in emergency admissions to hospital for people over 75 (rate per rolling year)	398 (Joint)	
	• Increased % of people receiving care at home rather than in a care home or hospital as % of population receiving long term care (65+)	66% (Joint)	65%
	• Eliminate waiting times for delivery or equipment / adaptations – delivery should be as per the personal plan (need to agree a standard)		
	• % of people spending last 6 months of life at home or in the community – if preferred	90.81% (2011/12)	92% (SOA)
	• Increase in proportion of people with a telecare package (75+)	26.9%	28% (SOA)
	• Increased numbers of anticipatory care plans in place (aged 75+)	76 plans completed	100 (SOA)
	• Increase in number of carers assessments completed	123 (part data)(Jan – Aug 13)(SBC)	
	• Increased diagnosis of dementia (and early support)	912 (Heat)	

	• More effective management of continence • Reduction in falls (for people 65+ and attending A&E) • Increase in home based re-ablement services • Care packages in place within 48 hours for simple cases and 10 days for complex cases. • Increase in the number of people receiving Self Directed Support. (No. of adults with SDS per 1,000 pop) Measures identified in SOA • Rate of emergency admissions to hospital per 100,00 for (1) 65+ and (2) 75+ • Rate of alcohol-related hospital admissions • Rate of drug-related hospital admissions	67 4.06% (SBC)(Aug 13)	3.80%

Other process issues identified at the 19th September Workshop:

- There should be a review of out of area complex packages (already doing this in Learning Disabilities – need to extend this to other service areas – amounts to over £1m)
- Need to review readmissions that take place between 7 – 28 days
- Should have a single point of contact for out of hospital care arrangements (key worker)
- There needs to be an increase in the number of simple care packages that could be authorised by one person .

d. Technology, Performance Data and Information

Outcomes	Measures	Current Baseline	Current Target
• Staff have access to the systems, communications technologies and information that they need to deliver services effectively. • Clients have easy access to the information they need • Data is secure • Equality of access to information • Up to date performance data is readily available and used to support continuous service improvement by managers and staff.	• There are clear data sharing protocols in place that enable joined-up service delivery and maintain appropriate levels of security • Joint Performance score card is produced by the partnership • Short term solution for access to Framework in place for people working in joint services		

e. Make best use of resources – e.g. Property

Outcomes	Measures	Current Baseline	Current Target
• Integrated services will make best use of NHS and SBC properties resulting in an overall reduction in accommodation requirements with associated efficiency gains • Reduce duplication and make best use of resources and efficiencies are realised when service is redesigned	• A clear specification of property requirements, centrally and in each locality • A plan for meeting those property requirements and the identification of revenue savings/capital receipts • Achievement of planned savings • Reduction in management and staff - should there be a target?		

INITIAL SCOPE AND OUTCOMES FOR INTEGRATION BOARD **Appendix 2**

In Scope	**Outcomes for people and carers**	**Performance Targets**	**Estimated Budget**	**Specific Projects / Workplan**
Current Services in the CHCP			**NHS SBC** **£m £m**	(Examples)
a) Joint Learning Disability Service	People are safe Having things to do Keeping safe	Reduction in numbers of people in day services Increased % of people living in own home or community	3.636 13.753	Day Opportunities Review Joint Commissioning of complex care packages No of people with LD in employment
b) Joint Mental Health Service	People are safe People are as well as can be	Increased diagnosis of dementia and early support No of people with long term conditions supported at home Zero delayed discharges Number of joint assessments completed	12.946 2.113	Evaluation of supported living project Co-location of joint teams
c) Drug & Alcohol Services	Increasing independence Early intervention/prevention	Rate of alcohol related hospital admissions	1.637 0.213	Brief Alcohol interventions
d) Assessment & Care Management Teams	Single point of access Safer care People have positive experiences Carers feel valued	Co-location Management review Increase in numbers of people with SDS Care packages in place within 5 working days Reduction in management costs Number of carers assessments completed		SDS programme Cheviot project work AHP redesign Carers centre
e) Joint Health Improvement Team	Health improvement	We live longer healthier lives Improving health of older	Further work required	Say Well 75 plus Number of older

		population Number of older people involved in physical activity Having things to do Increasing number of older people involved in volunteering		people participating in Active Ageing classes
f) Older People Residential/Home Care Services	People are safe Increasing independence Being as well as can be Single point of access	Zero delayed discharges Dementia Targets Anticipatory care Reduction in length of stay Increase in re-ablement services Increased % of people aged 65 living in their own home	23.032	Rapid reaction team Assessment/ Intermediate care beds
g) Other – including Change Fund/Delayed Discharge	Reshaping care Outcomes	Reducing emergency admissions Zero delayed discharges Increase in alternatives to hospital / care home provision	2.222 0.753	Commissioning of housing with support places Building Community capacity work
h) Ability Equipment Store	Increased independence	Reduced waiting times for provision of equipment Zero Delayed Discharges Support to carers		Redesign of Ability Equipment service
New Services				
a) Physical Disability Services including Home Care/Residential Day Services)	Increasing independence People are safe People are as well as they can be % of people receiving care who feel safe	Delayed Discharge SDS targets Increased no of anticipatory care plans in place Reduction in readmission to hospital		Ability Centre redesign Re-ablement project and training
b) Community Hospitals	Supporting people in own home	Day Services Redesign/Co-location and integrated working Reduction of length of stay Nil delayed discharges Reduction in people going from hospital to care homes Reduction in admission to hospitals	4.620	Cheviot work Co-location Day service/ day hospital integration

c) GP prescribing	People are safe	Maintain people in own homes Reviews/effective prescribing and compliance Links with home care support Integrated working with pharmacy services	21.739	(Falls/Change Fund Projects)
d) AHP Services	Increasing independence – people being as well as can be	Intermediate Care/Single Assessment Reduction in falls Integrated working between hospital and community based services	5.450 (NHS) included in assessment teams (SBC)	AHP joint redesign/Intermediate Care
e) General Medical Services	Increasing independence – people being as well as can be Supporting people in own home	Key role of GPs in providing community based services and avoiding admissions to hospital and care home Key coordinator of integrated community services		Cheviot project Locality planning Delayed discharge
f) Community Nursing	Single point of contact and Single Assessment Improved information	Co-location/Single Assessment/Single contact point	5.450	Cheviot Work/SSA
Other Areas for future discussion				
a) Continence Services b) Dental, ophthalmic, pharmacy services				