**Borders NHS Board**

# PROPOSALS FOR FUTURE INTEGRATION IN SCOTTISH BORDERS

## 1. Aim

1.1 This paper aims to advise the CHCP of progress regarding both national and local integration in the Scottish Borders. As part of the proposals it is recommended that a shadow Pathfinder Health & Social Care Partnership Board be established and this paper outlines some initial proposals and timescales to take this forward.

1.2 The Scottish Government launched a public consultation on 8th May 2012 to inform recommendations for legislation to support the Integration of Social Care & Health Services in Scotland. This paper summarises the submitted responses to the consultation and the Scottish Governments response to these. The paper also outlines the proposed local interim arrangements to progress this agenda in the Scottish Borders.

## 2. Background

2.1 The Scottish Government launched a public consultation on 8th May 2012 to inform recommendations for legislation to support the integration of Adult Health & Social Care Services in Scotland. The stated aim of the legislation is to improve people's experiences of Health & Social Care Services and the outcomes these services achieve and to ensure that the substantial proportion of Scottish public services spending that supports these services is used to best effect.

2.2 The Scottish Borders CHCP submitted a joint response to the consultation and a summary of all responses have recently been published by the Scottish Government along with the Scottish Government's response to the consultation.

## 3. Summary of Consultation Responses and Scottish Government Response

3.1 315 responses were received from a wide range of sources (49 from individuals and 266 from groups or organisations). All Health Boards and Local Authorities responded either as an individual organisation or as a joint Health Board and Local Authority response.

3.2 The consultation responses highlighted that there were differing views regarding the scope of Health & Social Care Partnerships and whether it should focus on older people, adults or indeed include children and young people. The majority of respondents supported the delivery of joint outcomes and that these should be included with all local single outcome agreements.

3.3 The Government have responded that it is their intention to legislate to require Health Boards and Local Authorities to integrate health and social care services for all adults, and

to leave it to local agreement to decide whether to include other areas of service, such as housing or children's services, within the scope of the integrated arrangement. It is also their intention to legislate for the principle that Health and Social Care Partnerships should be held to account for their delivery of nationally agreed outcomes.

3.4 Responses to the detailed proposals for the formation of a new committee indicated that the proposed committee arrangements in the consultation document were not appropriate and a wider list of representations were suggested. The majority of respondents felt more Councillors would need to be on the committee beyond the minimum of three proposed and the importance of allowing the Leader of the Council and the Health Board Chair to sit on the Health & Social Care Partnership Committees was emphasised by respondents. In addition several respondents, mainly Third and Independent Sector organisations, felt the proposals should be strengthened to embed these stakeholders in the wider service planning process.

3.5 The Government have advised it is their intention to legislate for committee arrangements that confer voting rights on statutory members of the Health and Social Care Partnership Committee, and to strengthen these arrangements by legislating to require additional membership of the committee covering professional, carer, user and public interests.

3.6 The government identify two models for integration:

a) delegation of responsibility to a 'body corporate' model
b) 'delegation between partners' model

The former is likely to be the most common and involves integrating health and social care under a common partnership structure. The latter is a lead commissioning model exemplified by the Highland partnership.

Mixed responses to the consultation were received around the role of a Joint Accountable Officer, querying whether these posts were necessary or indeed appropriate.

3.7 The Government have advised that joint accountability at senior level is required for the 'body corporate' model, in simple terms, to achieve two objectives:

(a) To provide a point of joint accountability upwards, from the Health and Social Care Partnership, to the Partnership Committee, via which there is accountability to the full Council and Health Board; and
(b) To provide a single, senior point of joint and integrated management down through the delivery mechanisms in each partner organisation.

However, they appear to be suggesting some local flexibility about these arrangements.

3.8 In the 'delegation between partners' model, accountability flows from the chief executive of the service providing agency to the chief executive of the service commissioning agency and does not therefore require a jointly accountable officer.

3.9 In terms of joint resourcing the Government have advised it is their intention to legislate to make it necessary for all local partnerships to reach agreement on integrated arrangements to be implemented locally, subject to the specifications described in

legislation. It is the Governments intention to make provision for arrangements to be put in place where there is local failure to agree.

3.10 The government has given “firm reassurance” regarding the continuing importance of the role of the chief social work officer and to professional leadership in general.

3.11 The next step for this area of policy development nationally is the introduction of legislation by the Scottish Government to the Scottish Parliament before the summer of 2013.

**4. Proposed Local Interim Arrangements**

4.1 To progress the Integration agenda in the Borders, a paper proposing to build on the effective joint work locally has been produced by Senior Officers to aid further discussion locally. (see Appendix 1 attached)

4.2 This paper proposes the Integration of Adult Health & Social Care Services be founded on the key principles:

(a) Positive/effective and improved outcomes for service users
(b) Early intervention
(c) Personalised care and personal choice
(d) Shared vision and targets/objectives
(e) Local democratic accountability
(f) Integration requires balanced governance arrangements with transparent communication
(g) Integration should reflect community planning themes
(h) There should be one partnership board for Scottish Borders with five localities as now
(i) Integration should build in an organic way on the work undertaken in the Cheviot process which has been commended by the Christie Commission and has attracted the interest of the Scottish parliament via place based, locality managed services
(j) Integration should commence with adult primary community and social care
(k) Integration should minimise structural change and maximise flexibility
(l) The early agreement to agree a Joint Programme Director to progress actions.
(m) That the scope and principles of the joint financial arrangements are agreed but detailed technical proposals for integrating finance await national guidance

4.3 To progress these proposals it is recommended that the CHCP Strategic Board continues with its existing functions until such time as the new legislation is in place and a Pathfinder Health & Social Care Board be established in the interim until legislation is enacted. To assist with the progress of the new arrangements and ensure momentum with this agenda, it is proposed that the Partnership agree to appoint a Joint Programme Director reporting to both the Chief Executive of the NHS and the Chief Executive of the Council.

4.4 The Pathfinder Health and Social Care Board, it is proposed, will cover Adult Health & Social Care in the Borders. The CHCP will continue to meet as and when decisions are required in compliance with existing legislation.

The make-up of the Pathfinder Board will reflect the membership of the CHCP to ensure continuity. The proposed membership is therefore:

a) Leader of the Council
b) Depute Leader – Finance
c) Executive Member for Social Work
d) Executive Member for Education
e) Executive Member for Health Services

Five members of NHS Borders Board to include a Lead Clinician.

Two representatives of the Third Sector.

Other key officers or stakeholders to be invited to attend as required.

4.5 Proposed responsibilities of the Pathfinder Health and Social Care Board:-

(a) To assess and scope the detailed arrangements required for Integration in the Borders which will be developed and determined in line with draft legislation.
(b) Ensure appropriate stakeholder engagement in joint strategic policy and planning in relation to Integration.
(c) To recommend to the partner bodies actions relating to the implementation of agreed commissioning strategies.

4.6 Further work will be required to consider the formal governance requirements to ensure the new body is balanced and legal when the new legislation is finalised.

**5. Summary**

This paper advises the CHCP Board of the summary of the national consultation responses and of work to progress integration in the Scottish Borders including proposals to progress this agenda locally.

**6. Recommendation**

6.1 The Board is asked to:-

(a) Endorse the principles for the Integration of Adult Health & Social Care Services detailed in paragraph 5.2 of this report.
(b) Agree to further consultation on future proposals for Integration in the Borders by the partnership.
(c) Support in principle the establishment of a Pathfinder Health & Social Care Board by June 2013 and establishment of a Joint Programme Director to lead the implementation.
(d) Agree to support recommendations to NHS Borders Board & Council.

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| **Policy/Strategy Implications** | As detailed in the paper. |

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|---|---|
| **Consultation** | The Clerks to the Council and NHS Board have been consulted on the revised proposals and comments included.<br><br>There has been some initial consultation with communities as part of the development of existing local arrangements to date. However it is recognised that further consultation will be required as we progress this agenda. |
| **Consultation with Professional Committees** | Further consultation will take place following approval of this paper. |
| **Risk Assessment** | A number of risks have been highlighted in terms of progressing joint working including accountability arrangements, financial management arrangements and the different cultures that exist across organisations. To address these there will need to be robust financial governance arrangements and effective communication as this agenda moves forward. |
| **Compliance with Board Policy requirements on Equality and Diversity** | In line with Equality & Diversity requirements, a full EIA will be undertaken on any new structural changes as they emerge. |
| **Resource/Staffing Implications** | Further work will need to be progressed to agree procedures to manage joint resources for the new Health & Care Partnership and work will be progressed as part of the shadow Board arrangements. Joint Funding will need to be identified to establish a Programme Director post to progress this agenda. |

**Approved by**

| **Name** | **Designation** | **Name** | **Designation** |
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**APPENDIX 1**

**JOINT REPORT BY CHIEF EXECUTIVE SBC AND CHIEF EXECUTIVE NHS BORDERS**

## 1 PURPOSE

**1.1 This report sets out the Scottish Borders proposal for the Integration of Health and Social Care and describes how the Council, NHS Borders and partners can build on work to date by adopting a Community Partnership Approach. This adopts a locality approach to integration promoting joint services and integrated teams in local areas involving communities in providing local activities and solutions for their own community.**

1.2 Following a meeting of key senior officers a broad approach has been agreed for consideration by the CHCP Board.

1.3 Introduction

The Community Partnership Approach to integration is based on promoting improved outcomes for people, links to the Council's Single Outcome Agreement and enables locality models to flourish to provide support to all age ranges. It acknowledges the new initiatives such as self-directed support, asset based approaches and co-production and promotes social solutions that build on community self help, prevention and enablement. It is a model that is clearly focused on outcomes for the community and the individual encouraging independence, self-help, empowerment and health promotion. It is acknowledged that for some people specialist services will be needed to provide specialist clinical care and support for those with complex needs such as people with complex mental health needs or learning disabilities which will continue to be provided across the Borders.

## 2 BACKGROUND

2.1 On 8 May 2012 the Cabinet Secretary for Health, Wellbeing and Cities Strategy launched the Scottish Government's consultation on the Integration of Adult Health and Social Care. The consultation set out proposals to inform and change the way the NHS and Local Authorities work together in partnership with the third and independent sectors. Proposals include changes to how adult health and social care services are planned and delivered, aiming towards a seamless experience from the perspective of the patient, service user or carer.

2.2 The CHCP response to this consultation welcomed the principles of integration of health and social care services and the establishment of new Health and Social Care Partnerships, particularly the overarching focus on achieving the

best possible outcomes for all care groups. It also made specific points on a number of the consultation questions including:

- Consistent approach to inclusion of nationally agreed outcomes in local Single Outcome Agreements and Community Planning Process.
- The need to achieve clear governance arrangements with both Ministers and Local Authority Leaders.
- Need for clear accountability to Care Inspectorate and Healthcare Improvement Scotland.
- Local determination of budgets which are integrated or appropriate for integration.
- Need for sufficient seniority and appropriate accountability for the Jointly Accountable Officer.
- Local determination of locality planning arrangements and commissioning strategies.
- Agreement with consultation requirements with relevant clinicians and professionals – but also extension of this to fully engage service users and carers.

## 3 KEY PRINCIPLES

3.1 Scottish Borders Partnership is fully committed to the principles of positive business transformation in order to meet the pressures of reduced budgets, changing demography and increased/different types of demand for services. Such changes will need to be a core part of Community Planning arrangements for the Scottish Borders with joint financial governance arrangements and locally agreed targets reflected in the SOA. In turn, the transformation of adult health and social care business needs to be based on the following key principles:

a) Positive/effective and improved outcomes for service users
b) Early intervention
c) Personalised care and personal choice
d) Shared vision and targets/objectives
e) Local democratic accountability balanced with accountability to the Scottish Government

3.2 Any major decisions relating to organisational change need to be based on achieving effective outcomes for service users, which accords with the Christie Commission recommendations. Accordingly, the development of an integration model for the Scottish Borders must place outcomes at the heart of all early development discussions.

3.3 The Christie Commission stated that service reform should ‘encourage preventative approaches and tackle inequality’. Within the recently established Community Planning Themes, early intervention is a key strand, where much of the efforts of adult health and social care are focused. Any changes to the governance of these services must not lose sight of the key early intervention theme as new joint priorities are established.

3.4 Locally and nationally, significant investment of time and resources has established a system of care and support designed with the full involvement

and tailored to meet the unique needs of service users. Services need to retain the principle of personalisation throughout and after the integration process.

3.5 The agreed vision of the current CHCP has 'Creating Healthy Communities' as its overarching principle, and includes:

- Promoting health and wellbeing and addressing inequalities
- Building solutions with local communities
- Providing care as close as possible to home
- Making best use of resources

The CHCP also has the following principles within its vision:

- Maintain people as close to home as possible
- reflect the diversity of services contained within CHCP
- Pragmatic approach – build on what we have
- Community involvement/ engagement key to vision

It is recognised that there is more work needed to ensure that the vision details more specific outcomes and clearer performance targets against which initiatives and developments could be assessed.

3.6 The governance arrangements for a new integrated model are critical and must link closely with established mechanisms for ensuring that public services are delivered in an open and transparent way which enable communities and individuals to engage with decision making processes. The new arrangements need to be directly aligned to the decision making processes of both SBC and NHS Borders and link into Community Planning process. This approach will ensure delivery of the broader health and well-being agendas.

## 4 CONTEXT

4.1 The combination of demographics and the current financial pressures has led to care and support for all adults becoming a political policy priority. Despite the improvement in health in later years Scotland is set to see a material increase in the number of older people who need care.

4.2 Shifting the Balance of care and Reshaping Care for Older People is a priority both nationally and locally. One third of the total annual spend on older people's services is on unplanned admissions to hospital and more money is spent annually on unplanned admissions for older people than is spent on social care for the same group of people.

4.3 A key driver for change is improved outcomes for people who use services with the objective to:

- Reduce duplication in care and support to people in the community
- Ensure timely response
- Avoid unnecessary admission to hospital
- Prevent unnecessary delays in hospital

4.4 Evidence shows that there is an inconsistency in the quality of care and support for people who use services and their carers across Scotland,

predominantly in older people's services. The main issues highlighted through the Reshaping Care for Older People engagement programme were:

- unnecessary delays in hospital and
- the services required to support them at home are not always available quickly enough.

4.5 There is consequently a need to shift the balance of care to ensure services are provided in the community. The resources need to follow the person's needs to ensure the needs are met by the 'right person, in the right place and at the right time'. This can be achieved by Health and Social Care working together in unison with the third sector, independent sector and housing organisations.

## 5 EVIDENCE-BASED APPROACHES – BUILDING UPON WHAT WORKS

5.1 Integration is not a new concept for Health and Social care and many models have been tried and tested over many years. The ADSW report provides a useful characterisation of the terms:

'Partnership working as the process and integration as the potential outcome' (ADSW, 2011).

5.2 Whilst it is important to have a clear definition it is also essential to consider the evidence which supports a partnership approach and enables or facilitates integration. It is also necessary to remember the first law of integration:

*'You can integrate some of the services for all of the people, all of the services for some of the people, but you can't integrate all of the services for all of the people' (Walter Leutz, 1999).*

There needs therefore to be an agreed understanding across the partnership of what services require to be integrated and what does not.

5.3 Evidence supports the 'need to keep the service user at the centre and how their outcomes will be improved by any change' and it is important that any model of partnership agreed reflects evidence of what works (Petch, ADSW, 2011) .

5.4 Evidence demonstrates that there needs to be a shared understanding of the vision and strong leadership across the partnership to deliver these outcomes and suggests that integration will not deliver where it is dominated by one partner's agenda/model and is risk averse. It should be noted that outcomes are different to targets or outputs.

5.5 Professor John Bolton has highlighted some 'creative tensions' between health and social care which can prevent integration from delivering, e.g.:

- Sister in ward wants to clear the bed but Social Worker argues not ready for discharge; or
- Consultant thinks residential care the solution but Social Worker listens to patient who wants to remain at home

- Social worker thinks admission is needed but doctor can prescribe medication to support a person at home

This healthy dialogue needs to remain in any system to deliver best outcomes for service users.

5.6 A synthesis of the supporting evidence of international integrated care teams produced a number of similar themes which supported their success, such as case management, single point of access, geriatric assessment, and multi-disciplinary teams.

5.7 The evaluation of a Swedish local authority with a population of 60,000 which introduced a comprehensive integrated model to create one organisation with pooled budgets and a joint political governing board did not demonstrate improved outcomes for service users. The organisation integrated on a macro level and did not focus its results at a micro level, which is improvement for service users. Many of the changes were impeded through professional protectionism and occupational cultures. Attention and time was not given to resources to develop a co-ordinated approach at a micro level. What was identified was the importance of a 'receptive context' and 'a readiness to change' at all levels.

5.8 The evidence provides support for the 'form follows function' statement. The Torbay model which has now been in place for over 7 years clearly demonstrates this. In Torbay they were able to demonstrate success by starting small, using a bottom up approach. They focused their integration model at a micro level considering how they could improve outcomes for a fictitious service user who they named Mrs Smith. By modelling an integrated team around Mrs Smith they were able to 'sense check' their progress and motives. They appointed health and social care operators to provide a single point of access and triage referral effectively. They integrated a multidisciplinary team targeted at service users with the highest level of need such as older people and people with long term conditions. They cite effective leadership as being paramount and constant communication enabling them to progress effectively. Pooled budgets and allocation of service users to care managers by their registered GP practice rather than their address improved outcomes immediately. All the time their key message was 'keep the service user at the centre'.

5.9 Whilst integration has achieved positive results, there are a number of examples around the UK where integration has been less successful. In England and Wales, where the integration of adult health and social care is more established, there are valuable lessons that should be observed in the formation of a local model. These examples are generally where there has been a disproportionate focus achieving the objectives of the traditional roles of either the Local Authority or the Health Service rather than considering an holistic approach. Indeed, the areas where success has been achieved are those where the mutual benefits are fully recognised and investment has been targeted towards positive outcomes, prevention, and providing better healthcare/treatment.

## 6. Evidence within Scottish Borders

6.1 Scottish Borders Council seeks to build upon successful models of integration from the local area and beyond, whilst also being mindful of models that have been less effective.

6.2 The Scottish Borders has a positive record of partnership working and integration on a small scale. The Learning Disability team has been integrated for over 7 years and more recently there has been significant progress in integration services in mental health. With a Joint Director of Public Health we now have a Joint Health Improvement Team. Further joint posts are being created and a Joint AHP (Allied Health Professional) Lead has been appointed.

6.3 It has been evidenced locally that a partnership approach to discharge management will improve outcomes for people. In the Scottish Borders this has been demonstrated in the last 18 months where there has been a positive shift to a partnership approach leading to a decrease in the number of people with unnecessary delay. The focus of the meetings centre around the person and the mantra 'right person, right place, right time'. The success of the discharge management has supported by the merging of the Discharge Team with the Rapid Response team to create the Short Term Assessment and Reablement Team (START). A multi-disciplinary team which manages intermediate care, rehabilitation reablement along with discharge. All these areas have shown a positive result for integration.

6.4 Jointly Scottish Borders has been working with NHS Borders Primary and Community Services (PACS) to develop an integrated Health and Social Care Team at locality level. This project commenced two years ago with support from both Chief Executives for what is now known as the Cheviot Project. This project has followed a phased approach. The first phase was to undertake an analysis of all the finances which support older people within the community between health and social care through the Integrate Resource Framework (IRF). Secondly consideration was given to co-location of the Social Work Social Care and Health team in Kelso to Kelso Hospital. Further work has involved co-locating day services into Kelso Hospital, which was an initiative through Transforming Older Peoples Services (TOPS). The third phase is currently in progress which is to establish the integrated team and a number of options have been devised which will be appraised against a fictitious Mrs Scott.

6.5 In addition we have a very strong and effective Dementia Strategy Partnership Group (DSPG) which has demonstrated effective change and improved outcomes for service users Scottish Borders Council and NHS Borders have an agreed joint Dementia Strategy which is managed through the DSPG. Through service re-design there will be specialist teams which will eventually move to become integrated. The model allows for a phased approach to integration.

6.6 Shifting the balance of care from institutions to the community is a core aspiration that underpins the Change Fund Projects and reflects the Council's TOPS agenda to redesign services with greater emphasis on housing based solutions rather than 24 hour institutional care. Housing is core to enabling

older people or people with high level needs regardless of age to remain within their community and own home and the partnership is working with Registered Social Landlords (RSLs) to provide Housing with Care and Extra Care Housing. A full partnership approach to housing with care in the Borders has been demonstrated with Station Court, which is a facility for people with high level physical needs. The model is supported by health, social care and housing. The opening of this facility enabled a residential nursing home to close. Evaluation with tenants who moved evidenced improved outcomes.

6.7 Integral to the success of shifting the balance of care and enabling people to remain at home is the promotion of rehabilitation and reablement and Intermediate Care facilities have been developed to progress more . The development of these facilities has resulted in noticeable improvements in the ability of local partners to avoid the occurrence of delayed discharge from a hospital setting.

## 7 A SCOTTISH BORDERS APPROACH TO INTEGRATION

7.1 It is clear that CHCP has made significant progress in partnership working. However we are confident that we are able to make further progress with integration through a model of partnership which is focused on working with all Community Planning Partners and embedding the outcomes into the Single Outcome Agreement.

7.2 The evidence supports the need to remain focused at a micro level, that its ensuring integration benefits the person through improving their outcomes. Evidence also supports model of delivering integration at a local level. Delivering services to people closer to home and in their community is a key driver for both SBC and NHS Borders. Locality models of integration have a greater chance of success than centralised models, as evidenced by Torbay.

7.3 The Scottish Borders is well placed to deliver a locality model with its five distinct localities which are co-terminus with health, education and integrated children's services. Each locality is unique with its own demographic and facilities. Each locality is mostly self-sufficient when it comes to community services. For instance each locality has a high school (one or more). Four out of the five have a community hospital. Through the TOPS strategy there are now enhanced beds in each of the locality homes with Intermediate Care facilities. Each locality has an adult Social Care & Health Team and an Integrated Children's Services Team.

7.4 Rural areas can also benefit from delivering services at a locality level since it reduces the cost of transport and time through travel and assists with people accessing the services they need at the right time. People within the community will only need to travel to a central base for more specialist services. The Borders is a rural area with a wide geographic spread therefore it is difficult to provide specialist services to minority groups within the locality such as specialist dementia care. In order to address this we have designed a specialist team which will be split east and west therefore enabling outreach and in reach to ensure people can remain within their community without being disadvantaged.

7.5 Community Partnership Approach to integration based on single outcome agreements allows locality models to flourish. It acknowledges the new initiatives such as self- directed support, asset based approaches and co-production. It promotes the social model to support building on community capacity, prevention and enablement. It is a model that is clearly focused on outcomes for the community and the individual encouraging independence, self-help, empowerment. This approach allows for integration in the wider context. Integrated teams can be formed at a locality level focused around people with the highest need whilst strong partnership working can be enhanced with other community planning partners.

7.6 This model for integration allows for full partnership working in the widest sense providing 'a coherent relationship between integrated bodies- the point of connection is a clear focus on the needs of users' (Integrated Care Network). It should therefore be:

- Integration based on outcomes not just targets
- Integration based on cultures not structures
- Integration based on place not organisation
- Integration based on delegation not necessarily transfer of functions
- Integration based on clinical and professional engagement

In a study of what works Ham (2009) states that:

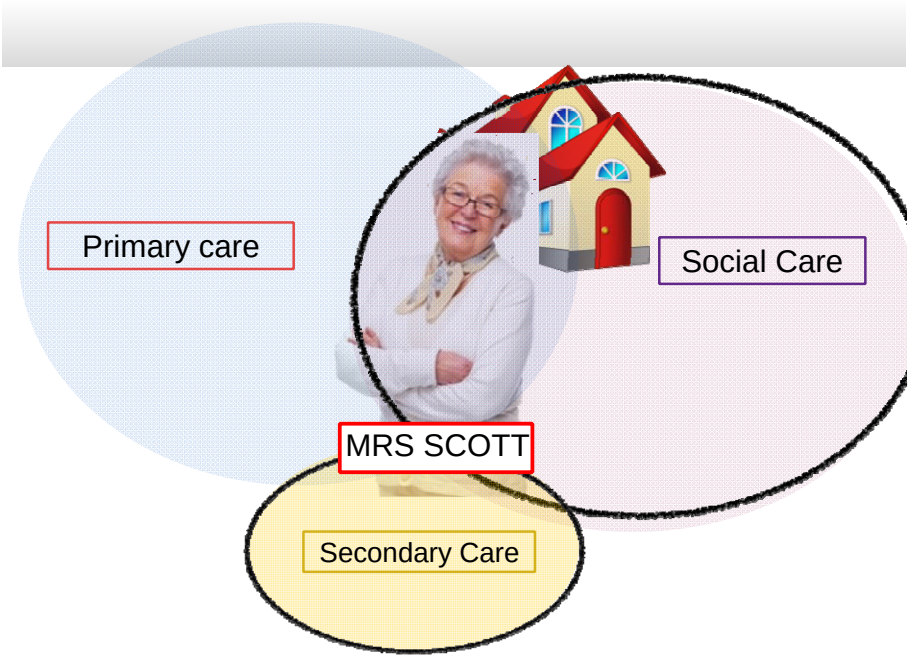
*"A clear message from this work is that the journey towards integration needs to start from a focus on service users and from different agencies agreeing a shared vision for the future, rather than from structures and organisational structures"*

It is proposed that these principles inform the Partnership on integration.

7.7 The Scottish Borders benefits from coterminous boundaries for the Local Authority and NHS Borders. This helps in terms of existing arrangements that can be built upon; and, enables future models of working to be developed without the complication of fragmented partnership agreements and governance arrangements within particular localities. In other words, a Borders-wide approach to integration can be embraced.

7.8 People in communities are not homogenous they come with different needs, wants and aspirations. Communities provide to meet the outcomes of the people who live within it and these outcomes will change through time and life. Most people will live within a community without accessing social services with occasional need for primary care. However there are people within the community that are more 'vulnerable' and they will need to access health and social work, in its wider context, at times of need. A Community Planning Approach which focuses on the holistic needs of the person in the community should be there to support the person when it is needed, right time, right place, right person, to support them to meet their outcomes.

This diagram attempts to show the links between services, service users, patients and the community.




## 8 THE INTEGRATION PROCESS

8.1 To ensure the success of integration in the Scottish Borders, there are a number of factors that will need to be considered and a systematic process of implementation that has been agreed by all key stakeholders including:

- Clear timescales
- A clear workplan – with responsibilities for all steps and actions agreed.
- A clear financial plan – with budget commitments.
- Financial resources for the programme of change, including dedicated programme management and staff.
- A binding partnership agreement.

8.2 Key principles of effective integration are:

- A clear vision based on making a positive difference for service users. It is this that needs to be the focus at all times
- Strong leadership at a senior and locality level
- Strong communication and engagement with all stakeholders
- Co-location and single point of access
- Shared IT/budget management processes

8.3 The partnership is keen to move forward with the integration of adult services as a priority, although agreement would need to be reached on the phasing-in of this and any other aspects of integration. In order to move forward with this agenda it will be necessary to agree with the width and scope of integration. Evidence from the research of Walter Leutz suggests integrated teams should be targeted at those with the highest level of need. This data can be collected

within each locality which will ensure each locality has its own locality plan dependent on the needs of the population. This would need to include scheduling the integration in phases that are appropriate for service users and within a logical sequence of the overall programme of change.

8.4 The Scottish Government consultation asked whether Older People's Services could be a priority area for integration and locally it is recognised that it would not be appropriate to plan services purely on age as this would reduce the opportunities to provide services that can be accessed by a range of ages in a community – an economies of scale that is essential for a rural area. If integration is aimed at the needs of the population then this negates the need to focus on age. It is therefore preferable to plan for all adult services as part of the same integration process/phase dependent on needs.

8.5 In future there may be scope to consider further integration of Children's Services and Criminal Justice but early consideration of the linkages at locality level is required. Consideration of the role of the acute sector in NHS also needs to be further considered.

8.6 Joint agreement will need to be reached on the nature of changes required to achieve a local model of integration, i.e. major structural change or changes to governance are not necessary for closer working or increased sharing of resources. Therefore, even if the final model of specific services is ambitious, the transition towards that is not dependent on immediate/short term structural or governance change. However, evidence is clear that major structural change is not required to achieve a successful model of integration.

## 9 CONSULTATION

9.1 This document builds on the CHCP response to Scottish Government's consultation paper on Integration of Adult Health and Social Care. Further consultation with clinical staff and managers will be needed as part of a broader discussion regarding integration at all levels taking into account the outcome of the National Consultation.

## 10 FINANCIAL IMPLICATIONS

10.1 Work is required on the detailed joint financial arrangements to make integration a success. Currently regular reporting on significant spend totalling 62,794M of joint agreed resources under the governance of the CHCP for adult services. This includes:

Learning Disability Services- 17,717M
Mental Health - 15,596 M
Joint Health Improvement team – 182K
Older People – Social Care – 23,424M
Borders Equipment Service- 720K
Change Fund – 2,548M

This will increase when the Joint Commissioning Strategy for Older People is completed and additional resources.

10.2 It is recognised that true integration will depend on meaningful financial agreements to manage a joint resource and move money across boundaries to meet outcomes. It will be important that agreement is reached on the budgets to be governed by the Health and Social Care Partnership and the mechanisms to manage these budgets across SBC and NHS Borders. Central to these arrangements will be the ability to shift resources to reflect more care in the community and early intervention. Further consideration is also needed on the amount and range of acute sector resources to be included in the joint pot which may be further clarified in the Government's response to the consultation process.

10.3 It is recognised that there may also be benefits of joint working with the NHS to consider best use of broader resources including premises and there may be scope to consider sharing back office functions (eg. Human Resources/ Finance Support).

10.4 There are significant financial implications of the integration agenda. Whilst it anticipated by Scottish Government that efficiencies will be achieved through increased sharing of resources and reduced duplication of effort/role, the focus on improved outcomes must remain paramount.

10.5 There will be a need for short-term resources for the programme of change. Initially, it is proposed that the use of existing resources from SBC's Business Improvement Service and those for NHS would be necessary for scoping out the programme of change; there will also be the need for a joint programme team to be established for the implementation of change.

## 11 RISK COMMENTARY

11.1 The national agenda for the integration of Health & Social Care carries significant risks, not least in the impact this could have on critical services.

11.2 This document sets out a number of areas that are crucial in the mitigation of risks associated with significant changes to governance arrangements and structures.

## 12 EQUALITIES

12.1 Whilst there is no specific equality impact from this document, the development of the integration model for the Scottish Borders will need to include careful consideration of the impact organisational change may have on all equalities groups. The primary focus on outcomes for service users is crucial to ensure that equalities groups are not excluded in any way from essential services, and associated consultation must ensure that all relevant views are captured.

## 13 SUMMARY

13.1 This paper is a starter paper to identify and define the Scottish Government proposals for the integration of Adult Health and Social Care services which are being embraced by both SBC and NHS Borders. It is important that we identify

the core principles upon which both organisations can agree and build upon the effective practice already in place.

## 14 PROPOSALS

14.1 The integration of Adult Health and Social Care services be founded on key principles

(a) Positive/effective and improved outcomes for service users
(b) Early intervention
(c) Personalised care and personal choice
(d) Shared vision and targets/objectives
(e) Local democratic accountability
(f) Integration requires balanced governance arrangements with transparent communication
(g) Integration should reflect community planning themes
(h) There should be one partnership board for Scottish Borders with five localities as now
(i) Integration should build in an organic way on the work undertaken in the Cheviot process which has been commended by the Christie Commission and has attracted the interest of the Scottish parliament via place based, locality managed services
(j) Integration should commence with adult primary community and social care
(k) Integration should minimise structural change and maximise flexibility
(l) The early agreement to agree a Joint Programme Director to progress actions.
(m) That the scope and principles of the joint financial arrangements are agreed but detailed technical proposals for integrating finance await national guidance

A timescale will need to be agreed to move the agenda to progress integration on an incremental basis.