The Highland Council/ NHS Highland

12th May 2011

Agenda Item	
Report No	

Planning for Integration- Development of a Lead Agency Model in Highland for Care Services

Joint Report by Chief Executive, The Highland Council & Chief Executive, NHS Highland

Summary: The Highland Council and NHS Highland Board are progressing a proposal to implement a Lead Agency Model for Adult and Children's Services across Highland. A programme of work is being followed to evidence the proposed change, demonstrate the relevance of the Lead Agency Model, engage users, staff and the wider public and prepare proposals for the governance, management and local accountability of Adult and Children's Services. A decision is sought with regards to progression and implementation based on the work to date.

Members and NHS Directors are asked to:

- Agree that the case for change is evidenced.
- Confirm that the Lead agency model is the preferred model
- Agree that work continues on defining the scope of the services to be integrated and this will be presented to the joint Highland Council /Health Board meeting in June
- Agree that a model of Governance will be presented to the joint Highland Council/Health Board meeting in June
- Agree that at present, recognising there is further work to be done, that there are no identified impediments to developing this model in terms of legal , financial or HR issues and that work on the details will be progressed
- Confirm that the outcome agreements and commissioning documentation will be the subject of further reports to the Board and Council
- Continue to support the Programme of implementation
- Acknowledge that there may be changes ahead that we are currently unaware of but may influence progress and implementation

1. Background

1.1 The Highland Council and NHS Highland Board considered proposals for a new partnership model to deliver health and social care in a report to a special joint meeting on December 16th 2010.

1.2 The report outlined the shared values and principles underpinning a joint approach to service delivery for Adult Community Care and Children's Services, summarised the reasons why the leadership of the Highland Partnership believe a new model for service planning and delivery is needed, considered a variety of possible models, highlighted the preferred model, and proposed further work to continue the momentum towards significantly improved arrangements to deliver better outcomes, increase effectiveness and achieve further efficiencies.

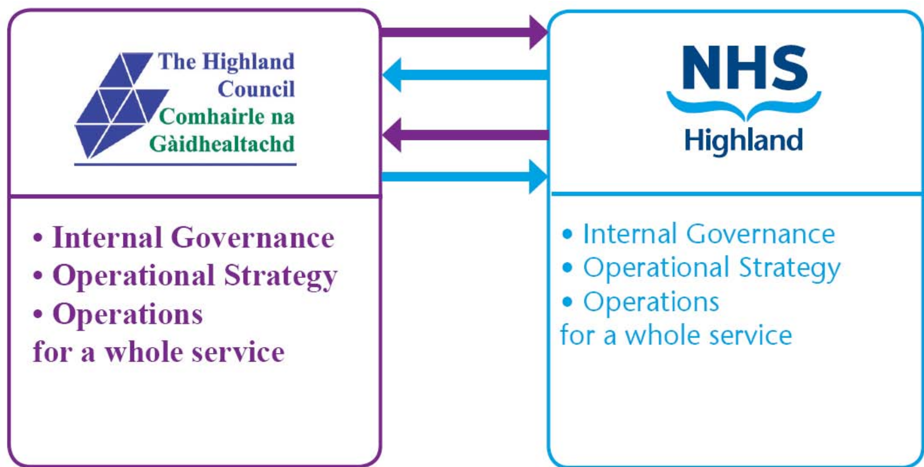
1.3 These shared values and principles were expressed as a statement of intent by the Highland Partnership:

The Highland Partnership is committed to achieving the best possible outcomes for our population and service users. We believe that services should be person centred and enabling, should anticipate and prevent need as well as react to it, should be evidence based and acknowledge risk. We will improve the quality and reduce the cost of services through the creation of new, simpler, organisational arrangements that are designed to maximise outcomes and through the streamlining of service delivery to ensure it is faster, more efficient and more effective.

1.4 The proposed model involves **single lead agency** arrangements, and would leave both organisations jointly accountable for determining outcomes and the resources to be committed. The lead agency would assume responsibility for all aspects of business delivery strategy, internal governance and operational delivery or commissioning of services and would be fully accountable for the delivery of agreed outcomes.

1.5 Whilst the bulk of Social Work Community Care Services have a clear joint application, several aspects of health primary care services are specialist, with little overlap with Council Services (e.g. Dentistry). On the basis then that GP and primary health care services are the common universal service providers for adults who need Community Care Services, it is suggested that the most appropriate lead agency for operational commissioning and service delivery for Adult Community Care Services is NHS Highland.

1.6 Whilst the NHS is the universal service provider for children under 3, Education become the universal service provider for the rest of childhood. Schools are a hub around which Children's Services can and do orientate. It is suggested then that the most appropriate lead agency for operational commissioning and service delivery for children is The Highland Council. This is reflected in the diagram below.



1.7 This model would recognise that whilst core responsibilities and accountabilities cannot be discarded, they can be discharged in a very different way than currently. Work continues to specify the joint strategic commissioning approach which will be presented in the report to the joint meeting of the Highland Council and NHS Highland Board on June 23rd.

2. The Case for Change

2.1 From the outset, the Leadership Group across the Highland Partnership has been committed to evidencing the case for change both in Adult and Children's Services. This has led to exploration of local, national and international reports which highlight the benefits of integrated working. We must demonstrate improvements in outcomes for the people of Highland and some base line information is being progressed to support this evaluation at a later stage. We know where we get it wrong – delaying people's stay in hospital, delaying access to services because of our cumbersome decision making, not sharing information and a lack of professional trust.

2.2 Much work has been completed on the benefits of integration and the Scottish Government produced its own summary in 2010 referencing the Arbuthnott Clyde Valley Review, development of Care Trusts in North East Lincolnshire and Torbay, as well as reflecting progress made through Joint Future.

2.3 The Scottish Government document summarises the reasons for integration as follows :
The basic rationale for taking an integrated approach to planning and service delivery is that service users should be able to access effective, efficient and well co-ordinated care services from a range of providers. By overcoming fragmentation and minimising organisational barriers between providers of care, it should be possible to improve outcomes for service users, and the experience of using services, as well as reducing duplication.

2.4 A further argument for integration lies in the inter-dependence of service providers' respective and shared objectives.
This inter-dependency can result in the costs generated by decisions and actions undertaken by one Partner adversely impacting on another Partner. The consequence of these costs, if not jointly planned for and agreed, is sub-optimal resource use. One of the key benefits of having an integrated approach is that these costs are internalised to the whole system, encouraging a principle of resource "stewardship" across the Partnership and promoting more effective resource allocation and use (ref1).

2.5 The Turning Points report of 2010 entitled *Benefits realisation: assessing the evidence for the cost benefits and cost effectiveness of integrated health and social care,* found that meeting people's needs with a preventative and integrated approach to health and social care can create efficiencies and savings.

2.6 Local reviews from various scrutiny bodies have also raised questions about the impact of integration and some of these examples will be highlighted in the relevant service sections below. It is worth highlighting the 2010 review by NHS Quality Improvement Scotland into *Clinical Governance & Risk Management.* Here the challenges were identified as the evaluation of joint service planning, service design and integration.

2.7 The Highland Partnership is not alone in considering new and innovative approaches to improving integrated working and outcomes for its population. This has been reflected in the manifestos of many of the political parties leading to the recent Scottish Government election, and also in the March 2011 (Arbuthnott) Report of the National Care Service Expert Panel, which confirmed "a clear need to reassess how we design, commission and deliver care and support services" and "three primary drivers for change":

- an obligation to provide appropriate care and support for the growing numbers of people who require it;
- real term increases in costs, as a consequence of demographic trends;
- a public purse that is under considerable pressure.

The Highland Partnership has also been part of the Integrated Resource Framework pilots and recognise that the other partnerships are developing proposals for integration.

2.8 Children's Services Highland has a well established record for developing integrated Children's Services since the establishment of the Joint Committee for Children and Young People in 2001.

2.8.1 The development and implementation of Getting It Right for Every Child has taken integrated working to a new level but there is a sense and a range of evidence that more could be achieved by stepping up the pace of change through the Lead Agency Model. Much has been learnt about the change process in developing integrated Children's Services and it is recognised that this learning will need to inform and underpin the next phase of change through the Planning for Integration process.

2.8.2 Highland Children's Forum has undertaken a series of consultations with Highland Joint Committee for Children and Young People's partners in recent years. The views of children, young people and their parents are essentially supportive of the changes undertaken to date and the general direction of travel. Many examples of excellent practice have been captured in the consultation exercises; however feedback indicates there remains scope for improvement.

2.8.3 The more recently published consultation exercise, *Getting it Right for Every Child Consultation with Children and Families Report (April 2010)*(ref 2)concluded that while there is a detectable move towards child centred practice and some excellent examples of it in practice, there are still pockets of resistance where service centred practice continues. A recent audit of children with exceptional health needs in Highland (ref 3) found that 40% of the children with some of the most extensive needs still do not have a lead professional. This adds weight to the view that more is required at a speedier rate of change than has been achieved to date.

2.8.4 Learning from change in Highland to date. A report on Integrated Children's services in the Highlands (ref4) identified four factors: rurality, pockets of deprivation, demographic trends (falling birth rates and increasingly older population) and local diversity that present significant challenges for Highland in planning and delivering integrated Children's Services. In an extensive review across NHS Highland they identified a series of key challenges for effecting strategic and operational change despite the strategic direction and strong leadership that is a feature of the Joint Committee structure in Highland.

2.8.5 Strategic challenges that were recognised include:

- Developing governance and management structures which are responsive to diverse needs and different local contexts, priorities and concerns and are sufficiently robust to overcome any problems that might arise where administrative arrangements for different services are not coterminous.
- Developing effective mechanisms for disseminating policies, plans and key decisions about the delivery of Children's Services to frontline staff and local communities across Highland.
- Planning programmes, and equity in access, of training and capacity building across the region, including the more remote areas.
- Reducing overlap and duplication of support to children and families in some areas of Highland while addressing absence of provision in others.

2.8.6 Operational challenges are identified as -

- Developing a new professional culture of integrated working without undermining professional/practitioner identity and culture, ethos and values.
- Persuading professionals to undertake the necessary shifts in their day to day work to support the different approach required to deliver an integrated agenda
- Ensuring the same approach to assessment and intervention.
- Finding effective ways of ensuring practice change.
- Finding ways of filling gaps that become apparent between the operational boundaries of the different partners.

2.8.7 Many of these strategic and operational challenges persist despite **GIRFEC** implementation and we believe could be better addressed through the Lead Agency Model. A comprehensive evaluation of the Highland pathfinder experience (ref 5) identified a series of ongoing challenges and areas for further development. Some of these are summarised below as further evidence of the case for Planning for Integration:

- pathways are still not in place for ADHD and other children with a range of needs
- staff have not changed their practices
- interventions are not as well matched to need as they could be

2.8.8 The expectation of the Lead Agency Model is that it will better facilitate the maturing of the GIRFEC process through a more shared understanding of needs, evidence, the pathways of care that children and young people undertake across different agencies and a better understanding of the outcomes, a better understanding of professional roles and the associated values of different professionals. This will enable us to move from a joint approach to Integrated Services.

2.8.9 An evaluation of **Children's Trusts** in England **(ref6)** described and compared the experience of integrating Children's Services in all 35 Children's Trust Pathfinders, covering 20% of children in England. The evaluation found that:

- Most professional interviewees supported greater inter-agency and inter-professional working because they believed children would benefit. Fears and complaints were reported less often in 2006 than they had been in 2004.
- Whilst no Children's Trust provided rigorous evidence of improvements in children's outcomes that were directly attributable to Children's Trusts in 2006, informants from most children's trusts reported improvements to specific services, and many provided examples of initiatives that they believed had improved outcomes.
- Better co-ordination between agencies and outreach to communities had increased access to services and thus improved outcomes for families.
- Pooling of resources led to new services being provided.
- Working with local communities had improved children's social environments and brought parents and professionals closer together.
- As well as improving the scope, accessibility and effectiveness of Children's Services, some initiatives had reportedly improved efficiency by reducing inappropriate referrals, eliminating managerial posts, reducing hiring of staff from private employment agencies and sharing accommodation and training.

2.8.10 The study identified that less was achieved in Children's Trusts where health services and practice were not as fully engaged in the Children's Trust process as Education and Social Work. The study suggests that where the NHS was fully engaged in a commissioning process more was achieved in process and practice for children and families. Although the study acknowledged that the impact of Children's Trusts on children's outcomes could not yet be clearly quantified, 'several key informants provided plausible accounts of how their Children's Trusts had increased efficiency or improved outcomes for particular groups of children'.

2.8.11 The development of the lead commissioner model in **East Lincolnshire** has identified the following advantages:

- Children remain a priority within the local authority as the lead agency.
- There is a better understanding of roles, services and structures and related development of teams breaks down misunderstanding and builds stronger relationships.
- There are less barriers to joint planning.
- There are more creative and innovative responses to meeting needs.
- There is a greater focus on children/families and children as siloed thinking and responses shift.
- Better access to joint training.
- More streamlined/smarter working.
- Transparent budgets and related decision making.

2.8.12 Engagement with children and families has begun alongside consideration of a number of valuable reports produced by **Highland Children's Forum**. When asked about the current proposals a small group of parents have given their perspective –

'*People worry about what it could mean'*

'I think it is a good move: it (journeys of care) should be clearer'

In conclusion the following key messages were received from families –

- Elements of current service design and delivery do not deliver the best service to children/young people and their families
- Delays in access to aids and adaptations incur additional hidden costs to services
- Opportunities exist to improve outcomes for children and families

2.8.13 In conclusion, there is a view that the experience and associated learning and evaluation captured by changes in Children's Services to date across the Highland partnership supports the assumptions that a Lead Agency Model will deliver the changes in service and positive outcomes. The service model and functions within Children's Services will best be delivered in an integrated model and need careful consideration to ensure the good progress made in integration to date is not lost and effective services can be sustained. Some staff groups remain concerned about the perceived benefits of this model for users and services and these concerns will continue to be logged and addressed.

2.9 Adult Services The Scottish Government have cited in their report of 2010 success in the integration of adult services experienced in England, bearing in mind the contextual differences in terms of demography, legislation and organisational structures.

2.9.1 In **Torbay,** a Care Trust was developed for commissioning and provision of all adult health and social care services. Within 2 years the Trust was assessed as improving performance notably – significant improvement in waiting time for assessment, reduction in waiting time for a package of care, district nurses commissioning packages of care.

2.9.2 In **North East Lincolnshire** the following have been integrated:

- Corporate governance;
- Commissioning for health and adult social care through delegation to localities (average 40,000 population) centred on groups of GP practices, linking practice-based commissioning with the personalised approaches developed through direct payments and individualised budgets;
- Provision of health and adult social care, again delegated to localities structured around groups of GP practices;
- Public health and housing in one team, able to influence the wider determinants of health and well-being with an explicit remit to target health inequalities;
- Commissioning of children's health and social care services;
- Provision of children's health and social care services;
- Support services and back office functions.

Key lessons for successful partnership noted by the Trust are identified so far as:

- Clear and simple vision about what Partners are trying to achieve;
- Delegation of resource which is then able to be used as if it has lost it's identity
- Strong patient and population focus
- Strong Leadership

2.9.3 A report by the influential **King's Fund** (2010) (ref 7) showed that moves to achieve closer integration of care in the English NHS should continue, but that organisational integration alone is unlikely to deliver better outcomes and effort must also focus on clinical and service integration.

2.9.4 At the *2010 Scottish Older Peoples Assembly* the community care workshop came out with resounding support for integration stating - "Scottish Government and Local Authorities to banish the artificial divide between health and social care, and involve charities, social enterprises and community groups more closely in service provision."

2.9.5 Highland Users Group (HUG) *Priorities in Mental Health in Highland: what we want our policy makers to do for us* published in June 2010 highlighted the importance of continuity of service and the need to avoid situations whereby service users had to tell the same story to a range of different professionals.

2.9.6 The Scottish Government's Strategy on Dementia published in 2010 highlighted that people want the health and social care systems to work better together (ref. 47-49) and that an integrated change programme should be piloted (ref. 80-83).

2.9.7 Locally the Highland Partnership has listened to users and carers across the whole area during the recent consultation on the Community Care Plan. Some of the themes that emerged were;

- service providers require to use clear communication so that people know who to speak to, what services were available and how to access them;
- Preventative care and earlier help can delay or avoid the need for crisis intervention later on (e.g. suitable home adaptations fitted quickly and prompt access to physiotherapy);

2.9.8 In conclusion, staff, users and carers can see the added value an integrated approach would bring but we must continue to work with all stakeholders as we define the models to ensure the revised services work better for all who use them, all who care for those users and all who deliver the services. The impact will be assessed by those measures which we know indicate failings such as delayed hospital discharge, extended length of hospital stay and emergency admissions to hospital.

3. Engagement

3.1 The Highland Partnership in presenting this proposal to the joint Council and Board meeting in December committed to wide engagement of all stakeholders. It was stated that a change of this order would require a formal consultation process.

3.2 Within the NHS, legislation and guidance relating to the staff governance principles would direct that staff and their trade unions should be formally engaged and involved in any changes that affect them. The same philosophy applies within the Council. Other stakeholders and community interest groups must be formally consulted in the creation of people-centred services.

3.3 A formal communications plan has been drafted and includes consultation work across Highland focussing on engagement with local and national media, working with NHS Highland and The Highland Council communications teams; engagement with professional organisations; engagement with service users and carers; engagement with and demonstrating evidence of support from local and national champions for change.

For The Highland Council members, the communications strategy can be accessed on the Council internal intranet.

For NHS Highland Board, the communications strategy can be accessed on the NHS internal Intranet.

3.4 As part of this to date, there have been a number of events and workshops, presentations to strategic groups and ongoing engagement through the development, for example, of the Staff Partnership Forum. Information gathered from these events has informed the issues log which will be managed through the Programme Board. Members of the Programme Board have committed to attending Ward Forums across Highland to ensure that the proposed changes are explained and local views are collected.

3.5 Children's Services – Interactive workshops have involved over 150 front line staff and managers from health, education and social work considering the scope and opportunities that will come from a Lead Agency approach. Events were held across Highland spanning January until April.

3.5.1 The principle outcomes that participants are seeking are as follows:

- Services will be child centred/focused
- There will be clarity over roles and responsibilities
- Expertise will be recognised and valued across services
- Services will be effective and efficient
- There will be better communication across services
- There will be confidence in the revised service

3.5.2 Through an exercise involving participants that explored values and principle it was considered that key staff groups wanted to see clear and effective services, professionals valued and supported, reduced bureaucracy, improved access to resources, common language and improved access to specialist skills and knowledge.

3.5.3 E mail correspondence with staff since these events, suggests that now with a greater understanding of the drivers for change and with the assurance that they will be participants in the change process, they will seek to engage positively in the development of a Lead Agency Model.

3.5.4 At the latest seminar it was clear that many attendees had been at previous workshops or had been engaged in further discussions about Planning for Integration and this was reflected in a noticeable positive shift in perspective. Key messages from this event were:

- Staff now appreciate the potential for positive change presented by the Planning for Integration proposals and are keen to be involved and engaged in influencing and delivering the change process.
- real opportunity exists to develop a new identity/brand to support a new culture of integrated children's services
- there should be an open dialogue about management, professional and leadership roles and accountabilities
- participants are keen to see the final model to fully understand what is required of them. However their expectations are realistic and indicate that they are ready to work incrementally to develop the model, and are ready to begin the journey.
- common recognition of the need/advantages of single information/shared emails/directories and that this may be a critical dependency
- training and development across the service is seen as key with a range of opportunities to add value and enhance existing opportunities to training and staff development
- design of a new system should be around associated school groups
- families and children need to be aware of the change process and engaged in the development of the emergent model
- need to be mindful and be able to capture the unintended consequences of change whereby, by addressing one set of issues, another set of issues develop
- clear need to develop a leadership programme to support and facilitate the development and embedding/maturing of the emergent model
- this is seen as an opportunity to re-allocate resource (staff/finance/service) across geography and services to better address differing need in different places
- professional identity, respect and understanding of roles will be important in the development of the model

3.5.5 These outcomes indicate that ongoing engagement in the development of an emergent model with all staff groups will pay dividends in ensuring a strong and sustainable service model that will improve outcomes for all children, young people and their families.

3.6 Adult Services – Workshops have been scheduled for staff delivering services across all community care groups. Interest in attendance has been encouraging and the agendas will span information updates to interactive group work focussing on the models and care delivery.

3.6.1 Stakeholder events are planned across Highland following the process adopted in gathering views about Community Care as we developed our Joint Community Care Plan. Briefings have also been delivered to a wide range of Social Work and Health Managers as well as administration, contract and training staff who although not delivering direct services provide a valuable support function.

3.6.2 The views of Adult Community Care service users and their carers have been sought. To date, meetings have taken place with older people, carers of older people, people with mental health problems and people with learning disabilities. Discussions took place with people from Easter Ross, from North and West Sutherland, and with members of the Senior Citizens' Network in Inverness and the inner Moray Firth area. Staff from Alzheimer's Scotland provided verbal comments. Written comments reflecting the experiences of people with Learning Disabilities were received from Health & Happiness, and, reflecting the views of people with Mental Health problems, from Highland Users Group. All have been very willing to give of their time to share their experiences and their views on the proposal, and their contributions are very much appreciated.

3.6.3 A full write-up of contributions to date, with vignettes of people's current experience of services, is available on the Highland Life website and included as Appendix 1 to this paper. In summary, with very few exceptions, most of the service users and carers who have contributed to date have been in support of the proposal. All who have expressed support have done so in the belief that integration and a Lead Agency Model would offer an opportunity to improve services and to tackle some of the problems they have experienced. It is clear that people do not see integration/lead agency status as an end in itself, but rather as a means to service improvement.

3.6.4 Whilst no-one expressed clear disagreement with the proposal, there were a few people who were sceptical about it. Some felt that the exercise was primarily driven by the need to make savings, and those who thought this expressed the view that whilst they felt integration to be a good idea in itself, services would inevitably deteriorate as a result of cuts. Others felt that the disjoint they experienced between primary and secondary health care did not bode well for the success of a plan to integrate social care services too. Yet others queried whether or not the time and energy needed to move staff and resources would detract from the need to improve services. These people worried about services deteriorating whilst the integration took place.

3.6.5 Those who expressed these views were clear that they were not against the proposal per se, merely that they had doubts that it would deliver the changes they felt were needed, within a foreseeable timescale.

3.6.6 The perspective from HUG was a 'don't know' whether or not the proposed change would benefit service users. This was partly for the reasons expressed above, but also because of concerns about the perceived different value bases of the agencies and professionals, for example as reflected in the differences between social and medical models of health, disability and care. People were concerned

about how integration might impact on this, and worried that it may possibly be to the detriment of services for people with mental health problems.

3.6.7 People identified a range of service improvements they hoped would result from service integration within a Lead Agency. These inevitably reflected their own experiences.
These improvements included:

- More timely support following hospital discharge
- More emphasis on prevention and early intervention
- Not having to constantly struggle and fight, or engage an advocate, to receive services
- An end to service users and carers feeling constantly passed from pillar to post
- A shared holistic/whole person view
- A shared outcomes focused approach with less emphasis on process and targets
- Appropriate information sharing
- More streamlined assessment and paperwork in general
- Better use of specialist skills
- Fewer people in and out of a person's life
- An end to professional 'territorial' disputes
- More co-operation between services, including the voluntary sector
- Improved health and wellbeing
- A truly person centred approach
- More respect and understanding of the roles and contributions of different professionals
- More respect and understanding of the important roles played by family and informal carers, and by the voluntary sector
- A shared and appropriate attitude to risk
- Better services for younger people with dementia
- Real partnership working, with the service user an equal participant in discussion and decision making
- More genuine influence for service users and carers at a policy and service planning level
- A 'can do' attitude amongst front line staff who are empowered to make the necessary happen
- More confidence amongst staff in supporting people who wish to try Self Directed Support
- More thorough and timely response to complaints
- A better use of public money

3.6.8 Appendix 1 provides summaries of some of the experiences people shared during discussion. Two examples are provided here as illustrations:

- The carer of an older person told of how the cared for person had their needs assessed whilst in hospital, and was discharged on the basis of a significant home care package having being agreed as necessary. The person was discharged four days after the proposed package was apparently agreed and told it would be in place from day one. It was six full weeks before any care at home was actually provided, and only then because the carer raised the matter with a very senior agency staff member who was personally known to her.

- A person with a long-standing mental health problem related how she was discharged home from very intensive in-patient mental health support with no care package in place other than an out-patient appointment with a psychiatrist six weeks later. This woman lives alone, and felt it very distressing

and disorienting to go straight from 24 hour care to zero support. She felt that this had slowed her recovery time considerably.

3.6.9 Further engagement is planned over the coming weeks, and those involved to date have been eager for longer term involvement in shaping future service change. Stakeholder Forums have been arranged, to which independent sector providers, and people who use their services, have been invited. Ward Forum meetings will provide the opportunity to engage with the wider public on the proposal.

4. Proposed Models

4.1 Lead Agency Definition: The Lead Agency arrangements illustrated above are a comprehensive form of pooled budgets in which the total resources for the care of a defined population are integrated in one organisation to either commission and/or provide the care for that population.

4.2 The Lead Agency arrangement achieves the same degree of integration of resources as pooling of resources but it has the attraction of using existing transactional relationships between Partners. This makes the financial governance and performance management of the integrated resource more straightforward than is the case with examples of limited pooling or where a separate organisation is charged with overseeing the pool. The legislative context is detailed in appendix 2

4.3 The Lead Agency service models for Children and Adults are being scoped with involvement from the Programme Board and the Staff Partnership Forum. These scoped models, identifying which services are proposed to be within the Lead Agency Model, will be presented to the full Council and Health Board at their joint meeting in June 2011. Work will continue to define the scope of the services which would benefit users and carers if more integrated and this is based on the information gathered form staff, users and carers and outlined in Section 2.

4.4 In order to scope the models; those involved have focussed on the services around the child and family, and around the adult and their carer(s), keeping a person centred approach as a matter of principle. The emphasis has then been on the functions or tasks involved that would be more effective if developed in an integrated way. This has led to a list of functions which would therefore be in the model to be delivered by the Lead Agency, as set out below.

4.5 The following services would constitute an Integrated Children's Service delivered by the Highland Council on behalf of the Partnership and accountable to the Health Board and Highland Council–
Health Visiting,
Community Learning Disability for children
School Nursing Services
Community services delivered by Allied Health Professionals
Early Years Services
Specialist Additional Support for Learning Education Services
GIRFEC within Primary and Secondary schools
Educational Psychology.
Primary Mental Health
LAC Services
Children and Families Social Work Services
Institutional provision

4.6 There are a number of other areas of children's provision yet to be agreed and which are being considered in the wider context of workforce planning, sustainability and effectiveness. These include –

Paediatrics
Specialist nursing
Youth Work
Specialist Child and Adolescent Mental Health Service
Health Promoting Schools and Drugs Education

4.7 The following services would constitute an Integrated Adult's Service delivered by the NHS Highland on behalf of the Partnership and accountable to the Health Board and Highland Council –
Community Nursing and Allied Health Professionals services for adults
Primary Care Independent Practitioner services
Adult Social Work
Telecare
Long Term Condition Management
Community Mental Health Service
Community Learning Disability Service
Substance misuse services
Care management
Institutional care including secondary care

4.8 There are a number of other areas of adult's provision yet to be agreed and which are being considered in the wider context of workforce planning, sustainability and effectiveness. These include –
Adult Learning and Basic Education
Community Capacity Building
Educational support through transitions

4.9 It is proposed that the final and complete list of functions is presented to the Joint meeting in June

5. Governance

5.1 Considerable work is progressing across the organisations to ensure accountabilities which remain with each organisation are clear and robust. The Programme Board have focussed considerable effort on reviewing current governance arrangements to ensure appropriate accountability at every level.

5.2 In terms of Strategic Governance, it is clear that both Elected and Health Board members need to be develop and agree the Commissions for the delivery of children's services and services to adults. There will therefore be a requirement for a commissioning strategy supported by a number of working groups involving providers, users, carers and voluntary groups etc. looking at aspects of service development. These groups will be required to report to a joint high level commissioning group which will consider and determine the outcomes to be achieved and the performance standards and measures for services and make recommendation to the Council and the Health Board.

5.3 A model is evolving which will allow this accountability to be recognised. This will build on the progress made through Joint Committees but recognise the need to ensure integrated governance

5.4 The lead agency will require to regularly report to the partner agency on the delivery of the commission, and there will need to be a process of escalation to Chief Executives and then to the Commissioning Group for any issues that involve escalation

5.5 It is widely acknowledged that these are complex and complicated structures which require further discussion and the proposed Governance model will be

presented to the full Council and Health Board at their joint meeting in June 2011

6. Local Accountability

6.1 Members of the Health Board and Council have emphasised the need to ensure that the model for integrated services includes the means for exercising local community engagement and democratic accountability.

6.2 It is clear that elected members have a responsibility and role to act on behalf of constituent and community interests, with regard to both Children's and Adult Services. In addition Health Boards are required to engage with patients, the public and communities in relation to the delivery of services for which it has responsibility. Accordingly, it is proposed to establish the means to exercise these responsibilities through Local Partnerships that bring together the various local stakeholders and front line staff representatives with managers in Children's and Adult Services.

6.3 The Local Partnerships should reflect community interests, but also enable meaningful engagement across relevant geographical constituencies. It is proposed that the Community Care Districts, which largely reflect established and traditional localities within Highland, form the natural boundaries for this, which are broadly:

- Badenoch & Strathspey, Ardesier and Nairn
- Caithness
- Easter Ross
- Inverness
- Lochaber
- Mid & West Ross
- Skye & Lochalsh
- Sutherland

6.4 These Local Partnerships would consider proposals for service development and the performance of services in their areas and advise service managers for Children's and Adults Services about the local implementation of policy and strategy. They would allow direct interaction between members, managers of Children's and Adults Services, front line staff and other stakeholders. They should ensure community and stakeholder awareness of issues across Health, Education and Care Services.

6.5 The Local Partnerships should also enable issues to be identified that should be raised, considered or addressed at the strategic governance level. It would therefore make sense for there to be a relationship between the involvement of members in the Local Partnerships, and representation on the strategic governance groups.

6.6 The Partnerships should be formal meetings, but without complicated and excessively bureaucratic processes. They should be community-friendly, and enable and foster the development of trusting and constructive relationships between members, service managers and local stakeholders.

6.7 It is proposed that consultation on these arrangements for Local Partnerships takes place at the Ward Forums and Community Care Stakeholder events that are planned in May and June, and that the outcomes of this are reported to the joint meeting in June.

7. Implications

7.1 At this stage of decision making it is important to be clear that while service planning discussions are at a relatively early stage, there are no issues which have emerged which are currently viewed as presenting insurmountable financial or legal barriers to integration. The following details the high level issues surrounding transfer

of responsibilities for services.

7.2 Finance Discussions have been held by the Finance teams of both partner organisations to consider the finance issues involved in the integration process. Broadly speaking these coincide around three main groups of issues:

- Funding/Governance Issues
- Staff/HR Issues, and
- Property Issues

7.2.1 Once the scope of the actual services to transfer has been agreed, there will need to be agreement on the budget costs of these services to transfer, together with a robust mechanism capable of dealing with any existing and future budgetary pressures affecting these services. This future governance arrangement will also have to deal with how the integrated service achieves any savings targets required by either or both partner organisation in future budget years.

7.3 Human Resources Discussions continue within the Staff Partnership Forum and its HR subgroup. It is acknowledged that the employment model chosen must meet the following criteria –

- Is consistent with the overall objectives of planning for integration
- Provides clarity etc with regard to pay and conditions
- Ensures best value

7.3.1 The Programme Board has approved a way forward based on these principles. Work is being carried out on the potential transfer of staff to the lead agencies and the consequent implications for terms and conditions of service, including pension arrangements.

7.3.2 At its initial meeting on 24 March 2011, the HR sub-group discussed the possible employment models which would support Planning for Integration, and agreed that:

- ❖ TUPE is worth exploring in depth, while retaining the option of secondment if unable to reach agreement on the detail of TUPE.
- ❖ The option of a Staff Transfer Order is also worth examining in depth with the Scottish Government. Noted this could potentially allow TUPE to apply to situations where the legal position is unclear.
- ❖ Pensions is a particular concern and detailed legal advice should be sought by NHSH/THC in relation to how this could be dealt with under TUPE. Trade unions will seek own legal advice as required.

7.3.3 In reaching this conclusion, the HR sub-group was conscious that Planning for Integration is seen as a long-term, permanent solution, and that implementing such a wide-reaching initiative on the basis of secondments and attachments would present logistical and contractual difficulties as time goes by. In principle, therefore, TUPE appears the logical way forward.

7.3.4 The trade unions have indicated that they reserve the right to seek to harmonise pay and conditions post-transfer in both Lead Agencies. The trade unions believe that harmonised pay and conditions will assist in the creation of fully integrated working within both Lead Agencies.

7.4 Property The Programme Board has agreed that an initial property framework is required which will enable the scoping of options regarding Council and NHS Board properties going forward. There will be a number of considerations and it will be important to learn from experience elsewhere as well as some of the models already adopted in Highland - joint delivery of residential respite for children for example. This

will be a major workstream and have to link closely to work being progressed in Finance and Legal Services.

7.4.1 Given the progress made in planning for integration for Adult and Children Services and the aspiration to complete this integration by April 2012, the Chief Executives of the Highland Council and NHS Highland have agreed to ensure involvement of key partnership individuals in any service critical decisions prior to finalisation. This action is to acknowledge that there may be decisions which will impact on the future configuration of services by the partner organisation which may ultimately assume responsibility for delivery. Existing capital commitments will continue.

7.5 Legal The 2002 regulations referred to in Appendix 1, provide a list of functions which can be transferred and, for the purpose of a transfer from Health to Local Authority only, a list of functions which cannot be so transferred. The scope of the transfer envisaged will require to be informed by these regulations. Accordingly further work is required to identify that the workstreams to be transferred fall within the scope of the regulations.

7.6 Information and Communication Technology An initial meeting has been held between the NHS Highland Head of eHealth and the Highland Council Head of eGovernment to start to consider integration issues.
Due to the many and divergent aspects of the forthcoming project which will require scoping and planning it has been agreed that there is the requirement to set up an ICT Sub-Group of the Project Team. There will be technical, information governance, networking, patient/client records, patient/client identification, ICT project management to be considered along with other items and sub-items.

7.7 Strategic Commissioning Key to the effectiveness of this model will be the strategic commissioning documentation, outlining the outcomes to be achieved, the resource envelope for delivery of the outcomes and the performance management arrangements. It is envisaged that this will lay out a 3-5 year programme of improvements to be delivered within agreed resource and which will require an annual review

8 Implementation

8.1 In taking forward Planning for Integration it is imperative that the key outcomes are clear and progress can be evidenced to contribute to improving these outcomes. The outcomes for this programme are those previously articulated in For Highland's Children and the joint Community Care Plan. Both of these documents outline what we are trying to achieve for our population in Highland and have been agreed by users of the service, carers and the wider public. The details can be accessed through http://www.forhighlandschildren.org/ and http://www.fhcommunities.org/

8.2 Implementation plan – in order to improve outcomes in the manner set out by the Chief Executives in their statement of intent in December 2010, this programme must deliver a key number of workstreams namely –

1. Project management
2. Lead Agency Model
3. Service specifications
4. Commissioning documentation
5. Change management Programme
6. Evaluation

These deliverables will involve a considerable commitment from a number of staff, Leaders across the organisation and the Programme Board and Project Team.
Further detail on these deliverables is available in appendix 3

8.3 An initial GANTT chart is attached at **appendix 4,** illustrating how these timelines will progress with some of the high level actions also included. Each strand of work will be supported by a number of actions, clear lines of responsibilities and timescales to ensure the programme moves at an acceptable pace and delivers as expected.
This will ensure that any detail required at any time can be provided to the Programme Board. RAG reporting to the Board will indicate any slippage in timescales or risks and should be by exception.

9. Proposed next steps

9.1 Following presentation of this report to the joint Council and NHS Board a further report will be prepared for a joint meeting on June 23rd. This report will detail the services being proposed to be transferred to a Lead Agency and the Governance arrangements to ensure each agency is able to discharge its new responsibilities whilst retaining accountability. Elected and Board members in retaining this accountability will have to be assured of a process and structure that enable scrutiny, performance management and support in line with the expectations set out in the Commissioning agreement.

9.2 A high level implementation plan is prepared in readiness for the decisions to be taken in June and this highlights the steps to be taken between now and April 2012.

9.3 Over the next two months leading up to the joint meeting in June a number of events have been scheduled to continue the engagement with people across Highland. Stakeholder events are scheduled to be held in Inverness and Fort William building on engagement processes adopted in developing the Community Care Plan. Further briefings for Elected members and Health Board members are scheduled. Workshops for staff will be ongoing, building on the work completed to date to engage staff groups across the organisations that are likely to be affected by the proposals. An extensive number of Ward Forums have been scheduled at which members of the Programme Board will be in attendance to update on the proposals and capture local views. Currently scheduled from the beginning of May through to December these span the Highland geography with a commitment to reach all areas.

9.4 As illustrated in the GANTT Chart a considerable amount of work is scheduled to follow on from the June meeting. This is major redesign and will require a review of all management structures to enable the new models to evolve into effective and efficient services.

10. Programme management and reporting back

10.1 This programme has followed a management process with a Programme Board co-chaired by the CEO of the Highland Council and CEO of NHS Highland. Following the appointment of a Transitions Director and external advisor, an implementation plan was drafted along with a risk register and progress reporting.

10.2 The governance for this programme of work has been through the Joint Leadership and Performance Group with summary progress reports at each meeting, There have also been update briefings to the Highland Council and NHS Highland Board. It is envisaged that this level of scrutiny and performance monitoring will be appropriate for the life of the Programme.

11. Equality Implications The Implementation plan and actions will be assessed for their impact on equalities.

12. Climate Change Implications There are no Climate Change Implications

13. Risk Implications In line with agreed programme management methodology. A risk register has been developed for this programme of work. Developed in conjunction with the Programme Board and Staff Partnership Forum, this register is a standing item on the Programme Board agenda to ensure appropriate review and management.

For The Highland Council members, the risk register can be accessed on the Council internal Intranet.

For NHS Highland Board, the risk register can be accessed by clicking on the NHS internal Intranet.

Recommendations

Council Members and NHS Directors are asked to:

- Agree that the case for change is evidenced
- Confirm that the Lead agency model is the preferred model
- Agree that work continues on defining the scope of the services to be integrated and this will be presented to the joint Highland Council /Health Board meeting in June
- Agree that a model of Governance will be presented to the joint Highland Council/Health Board meeting in June
- Agree that at present, recognising there is further work to be done, that there are no identified impediments to developing this model in terms of legal , financial or HR issues and that work on the details will be progressed
- Confirm that the outcome agreements and commissioning documentation will be the subject of further reports to the Board and Council
- Continue to support the Programme of implementation
- Acknowledge that there may be changes ahead that we are currently unaware of but may influence progress and implementation

Signatures:

Designation: Chief Executive Highland Council Chief Executive NHS Highland

Date: 12th May 2011

Authors: Chief Executive Highland Council & Chief Executive NHS Highland

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7 Clinical and Service Integration The route to improved Outcomes The King's Fund 2010

Appendix 1

Planning for Integration
Engagement with people who use adult community care services and those who care for people who use these services
Summary of discussions as at end April 2011

1. Introduction

The Project Board were eager to hear the views of people who use adult community care services and those who care for people who use these services, people from the independent sector who provide adult community care services, and the general public.

To date, meetings have taken place with older people, carers of older people, people with mental health problems and people with learning disabilities. Discussions took place with of people from Easter Ross, from North and West Sutherland, and with members of the Senior Citizens' network in Inverness and the inner Moray Firth area. In addition, staff from Alzheimer's Scotland provided verbal contributions, and written comments reflecting the experiences of people with Learning Disabilities were received from Health & Happiness, and, reflecting the views of people with Mental Health problems, from Highland Users Group. All have been very willing to give of their time to share their experiences and their views on the proposal, and their contributions are very much appreciated.

Stakeholder Forums have been arranged, to which independent sector providers, and people who use their services, have been invited. Ward Forum meetings will provide the opportunity to engage with the wider public on the proposal.

This paper summarises the views of the service users and carers who have contributed to this discussion to date. The written submissions from Health & Happiness and from Highland Users Group are appended.

2. Overall views on the proposal

With a very few exceptions, most of the service users and their carers who have contributed to date have been in support of the proposal. All who have expressed support have done so in the belief that integration and a lead agency model would offer an opportunity to improve services and to tackle some of the problems they have experienced. It is clear that people do not see integration/lead agency status as an end in itself, but rather as a means to service improvement.

Whilst no-one expressed clear disagreement with the proposal, there were a few people who were sceptical about it. Some felt that the exercise was primarily driven by the need to make savings, and those who thought this expressed the view that whilst they felt integration to be a good idea in itself, services would inevitably deteriorate as a result of cuts. Others felt that the disjoint they experienced between primary and secondary health care did not bode well for the success of a plan to integrate social care services too. Yet others queried whether or not the time and energy needed to move staff and resources would detract from the need to improve services. These people worried about services deteriorating whilst the integration took place.

Those who expressed these views were clear that they were not against the proposal per se, merely that they had doubts that it would deliver the changes they felt were needed, within a foreseeable timescale.

The perspective from HUG was a 'don't know' whether or not the proposed change would benefit service users. This was partly for the reasons expressed above, but also because of concerns about the perceived different value bases of the agencies and professionals, for example as reflected in the differences between social and medical models of health, disability and care. People were concerned about how integration might impact on this, and worried that it may possibly be to the detriment of services for people with mental health problems.

3. The main benefits people hoped would accrue from integration

People identified a range of service improvements they hoped would result from service integration within a lead agency. These inevitably reflected their own experiences.

These improvements included:

- More timely support following hospital discharge
- More emphasis on prevention and early intervention
- Not having to constantly struggle and fight, or engage an advocate, to receive services
- An end to service users and carers feeling constantly passed from pillar to post
- A shared holistic/whole person view
- A shared outcomes focused approach with less emphasis on process and targets
- Appropriate information sharing
- More streamlined assessment and paperwork in general
- Better use of specialist skills
- Fewer people in and out of a person's life
- An end to professional 'territorial' disputes
- More co-operation between services, including the voluntary sector
- Improved health and wellbeing
- A truly person centred approach
- More respect and understanding of the roles and contributions of different professionals
- More respect and understanding of the important roles played by family and informal carers, and by the voluntary sector
- A shared and appropriate attitude to risk
- Better services for younger people with dementia
- Real partnership working, with the service user an equal participant in discussion and decision making
- More genuine influence for service users and carers at a policy and service planning level
- A 'can do' attitude amongst front line staff who are empowered to make the necessary happen
- More confidence amongst staff in supporting people who wish to try Self Directed Support
- More thorough and timely response to complaints
- A better use of public money

4. Some very common experiences

People very generously shared their stories, some very personal and distressing, in the hope that this would contribute to service improvements. The bullet points above summarise the main improvements people hoped for, and many examples of where services or current approaches were lacking were shared. It is not possible to reflect here all the experiences shared during engagement to date. However, four particular problem areas were highlighted again and again and these are outlined in more detail below. These were:

- Problems with arranging care at home following hospital discharge

The carer of an older person told of how the cared for person had their needs assessed whilst in hospital, and was discharged on the basis of a significant home care package being agreed as necessary. The person was discharged four days after the proposed package was apparently agreed and told it would be in place from day one. It was six full weeks before any care at home was actually provided, and only then because the carer raised the matter with very senior agency staff member who was personally known to her.

A person with a long-standing mental health problem related how she was discharged home from very intensive in-patient mental health support with no care package in place other than an out-patient appointment with a psychiatrist six weeks later. This woman lives alone and felt it very distressing and disorienting to go straight from 24 hour care to zero support. She felt that this had slowed her recovery time considerably.

Several people told of being discharged home from hospital with a promise that a home care assessment would take place very shortly thereafter, and that weeks later they were still awaiting assessment. Intensive support from family and friends was necessary in these circumstances and several people told of very complex arrangements being put in place to ensure adequate support. People worried about the impact this had on their families, worried about others in their community in similar circumstances but with no family or able friends nearby, and felt that their chances of sustainable recovery from whatever had required their hospital stay had diminished as a consequence of inadequate and timely formal service provision being made available.

- A feeling that one had to constantly 'fight' for the smallest degree of support and that having an advocate or someone else to fight for you was crucial to having your needs met.

Several people related how having an independent advocate, or expressing the intention to approach independent advocacy services for help, was the 'magic key' to unlocking service provision. People related how they had struggled for weeks trying to arrange an assessment of their needs or the provision of services assessed as required, and how agencies appeared to suddenly become responsive when independent advocacy intervened.

Others related how the 'intensive' intervention of family or friends had been required before services were provided. One person related how a family member had to visit from several hundred miles away, leaving their own young family and work commitments behind for a week, to spend hours making phone calls and negotiating suitable care to sustain the cared for person at home.

People felt that their needs often escalated simply as a result of what they felt to be a constant struggle for services, and that this seriously impacted on their health.

One person said 'when you get hold of an OT never let her go, otherwise you'll wait years to get hold of one again'.

- A feeling that services were only available in a crisis situation and that a preventative, early intervention approach would be better all round

Several people spoke of how they felt that the stated emphasis on prevention and on early intervention was not reflected in practice, and that services were available only at crisis point. People felt that this must inevitably cost the public purse more in the long run, and that their own health deteriorated considerably as a result of services not being available to nip a problem in the bud or to prevent something escalating to crisis point.

An example was given of a person ultimately requiring a lengthy hospital stay followed by a place in care home following a deterioration in their circumstances over a period of time. Support had been sought during that period but had not been provided and the person relating

this story was of the firm view that a little support at the right time would have prevented hospital admission and the care home placement and that the individual could have been sustained at home at far less cost to all concerned.

- A feeling that services, health services in particular, saw their role as 'fixing' a particular problem and that rarely was any attention given to the whole person, to their wider health care needs or to their home circumstances.

One person related the experiences of a friend who lived alone and had been discharged home following an orthopaedic procedure that left her temporarily with the use of only one arm. The hospital staff had not enquired about her circumstances or how she would manage at home, but she had felt comforted because she had been told that a District Nurse would call on her. Several days following discharge the nurse did visit, but was concerned solely with the care of her temporarily disabled arm, and was not able to offer or arrange support for pre-existing intimate personal care needs. The woman was very distressed at having to rely on friends to help her with these needs.

The lack of a 'whole person' approach was felt to exist in the community too with several examples being given. People told of how several agency staff had been in and out of their houses over a long period of time with none asking about whether the individuals were receiving the benefits support to which they were entitled. When they stumbled across the information that they were eligible for certain benefits it made a considerable difference to their circumstances and their ability to eat well and do other things to keep themselves as well as possible. One person with a mental health problem related how being unable to find anyone willing to assist her complete a 52 page set of benefits forms had impacted further on her mental health.

5. Conclusions

The above is very much a summary of the most common views and experiences shared by people to date. Other real-life examples are reflected in the written submissions below from Health & Happiness and from HUG.

It is recognised that to date it has been possible to engage with only a small proportion of those who are eager to contribute and to share their views. However, the fact that discussions to date have very much echoed what we have been told in day to day engagement over recent years, and in particular in the discussions that underpinned the development of the community care plan, suggests that there is broad agreement on the service improvements that are needed.

It is clear that the majority of people who have been engaged to date are of the view that the proposed integration under a lead agency offers a welcome opportunity to significantly improve services.

Health and Happiness
Experiences and Reflections of Joint Working – Health and Social Work
General Issues

- Different perspectives on risk – health professionals and social work professionals have different regulatory bodies and registration requirements, which leads to different understanding of assessing risk when working with vulnerable adults. For example, we have had instances of agreeing a plan to help someone to learn how to be more independent. A health professional has stated we would be reported and they could lose their registration if it was permitted whereas the social worker and family were happy to allow it. Outcome – family were scared off of trying a new approach and a paid supporter was used for what should have been an informal community opportunity. This is a difference of approach that is fundamental and is a difference between medical model and social model.

- Outcome focus – there are differences in how health and social work see a final outcome. When this is coordinated, the person receives a better service, but this is entirely dependent on how open the professionals are to working in an outcome focused way as opposed to just following sets of procedures and signing off targets. Example – a middle-aged man with learning disability who was diagnosed with cancer and lived in North CHP area, but needed treatment at Raigmore. Initial arrangements were to have him travelling daily as opposed to being resident. The LD nurse voiced concern over this man's ability to cope with the journey and effects of treatment, and that he would need help to find his way about at Raigmore and support. In terms of a purely treatment outcome, the original arrangement seemed adequate but considering broader outcomes, a case was successfully made to enable him to be resident while having treatment so that he did not have to endure the daily journeys.

- Culture – a learning disability nurse, for example, is not viewed as a 'proper nurse' by colleagues – so any issue that we need to address (with a lot of help and support from the LD teams) is often not taken seriously. This is not isolated but symptomatic of the culture within institutions, where rivalry and status get in the way of the patient/person. Each 'boxed' profession has its own status, regulations, culture and they don't always have mutual respect.

- Many people we work with are still not clear about the different roles of an LD nurse and a social worker.

- Sharing information – huge obstacles in sharing information between professionals, who all protect their territory sometimes to the detriment of the person and family. Confidentiality is important but when it overrides commonsense and joint working, it is the person and the outcome for them that suffers. Examples are trying to work with a team of professionals on a care plan but not all aspects being shared – and then being told we are working contrary to an agreed care plan but we cannot be told what has been agreed!! In this situation, the family were very unhappy about the decisions being taken by the psychologist, who seemed to override the feedback from the social worker and nurse – but knew the person the least.

- When joint working works, it is the best way to achieve a positive outcome for people. Our positive experiences are around each person in a team being designated specific tasks, but all focused on achieving the same outcome for the person and family. In order for this to work well, professional egos must take a back seat and the focus must genuinely be on the person. The rewards are that no duplication of paperwork is being done, it is an agreed overall approach, each specialism is used effectively and designated a role that fits exactly where their expertise lies and there is mutual respect

for the role each professional plays – including the opinion and role of the family. Example – person with autism who would have been inappropriately placed in a traditional day service. Multidisciplinary approach assessed this young man as an individual and was prepared to 'think out of the box' to help him set up his own business instead. For this to happen, ourselves, health and social work all had to open doors and unlock gates to help make it happen but because everyone was working to the same agenda (namely, the young man's outcome of wanting to do something on his own), it went smoothly.

- When joint working goes badly, each professional is busy protecting their own territory instead of sharing and co-operating, communication is poor, the person is left out of the process and has no ownership of what is happening to them and ego's take over. There is no follow –up and no designation of tasks, so nothing happens between meetings. Example – young person who wanted to go to college but would have to be residential to do it. Family and social worker opposed to this but health professional in favour. A multidisciplinary meeting of about 13 people, with the young person bemused and isolated and within the meeting, put in the position of having to say whether they agreed with family and social work or health. This is not the time or place to put people in this position, especially with such complex issues. We always have to remember that we can walk away from these situations but the people we help cannot – and we have to think of what is the best outcome for them and what they really want. A compromise outwith the meeting was discussed where the young person was able to talk safely on a one-to-one basis about not wanting to upset anybody. They wanted to go to college but did not want to upset their parents – so support was provided to build-in some local activities with a view to showing the family that the young person was able to move towards residential college, away from home, and this was an achievable overall outcome.

- General feeling from people we have talked to about the joint approach and adult services coming under NHS is very positive. People are hoping for better communication, better coordination and simpler processes as opposed to duplication of forms, paperwork and assessments.

- Accountability and General Practitioners – a very serious concern is about the power that GP's have and any additional powers to come. If you have a good GP, this is not an issue. However, if you do not have a good service, vulnerable people are left with few options about how to make things better. Even with trying to encourage training about how to communicate better and acknowledge health inequalities, a GP can choose not to listen or take part. The attitude of some GP's to colleague professionals can be very poor with an attitude of superiority – almost feeling like they are untouchable! There seems to be nothing with any clout for the patient perspective (or commissioning?) that can call a potentially poor service to account. This is our NHS (the people) but it does feel like being under a 'feudal lord' with regard to some attitudes in the GP sector. This is a pity, because our feedback is generally showing improvement and excellent service – but I fear it is the already converted practitioners responsible for this. My own practice has developed excellent protocols for working with someone with severe autism, for example, that everyone has to follow – this means the young man concerned can see any GP and not be dependent on the same one (which would seriously restrict their service). However, this was due to an individual commitment on the part of the GP to make it happen.

Highland Users Group (HUG) March 2011.

EXPERT GROUP ON FUTURE OPTIONS FOR SOCIAL CARE

FOCUS GROUP OF 12 PEOPLE FROM ACROSS THE HIGHLANDS

Hug is a group of people with experience of mental illness in the Highlands. It speaks out on behalf of its membership on the issues that affect them. The following is the result of a brief focus group meeting of the HUG ROUND TABLE – the hug advisory committee. It involved 12 people from throughout the Highland area. All members have recent experience of mental health services.

1. WHAT HELPS PEOPLE TO LIVE INDEPENDENTLY IN THEIR OWN HOME OR RETURN HOME FOLLOWING HOSPITAL TREATMENT OR CARE.

Practical help i.e.:

- Medication,
- housework,
- budgeting,
- help with forms,

Not being alone at home
Feeling safe
Having support from family/friends/professionals

Having information regarding treatment and what is planned for us.
Having welfare rights advice and support to access it.

Help to make sure we have food and keep warm
Having enough money to live on

Having the right housing
Being socially included in society

Having access to advocacy
Being able to speak out for ourselves

Having 'diversional' therapy – social contact – meaningful things to do.

Having choice in the treatment we get

Being able to say how things are going for us even if this is not so good and this might imply criticism of our helpers

Having a planned discharge and knowing what this will involve and what help we will get with it.

Having a 'WRAP' plan
Having an advance statement

Having flexibility between different areas – i.e. we may not always be treated in our home area.

Having access to self directed support for those of us that want it.

Help with emotions and feelings and thinking.

Having peer support - from people who have been through it themselves. I.e. HUG
Having understanding friends

2. WHAT ARE THE DIFFICULTIES?

"I was unaware of what my discharge plan was. I worried about it because I didn't understand it."

"At first I didn't know what to tell friends, I wouldn't even let people know my address, I was suspicious of people and unwilling to seek support"

- Some people get lots of support and others get nothing: the distinction between the different needs and levels of support we have is not clear.

- Some people are discharged from 24 hour care in hospital to almost immediately having to cope at home with no support – except the occasional visit to see the psychiatrist.

- Qualifying for help from the c.m.h.t. and hospital can be hard if you don't meet the referral criteria. There do not seem to be other forms of support available for those in crisis and unable to access these mental health services.

- There seem to be increasing cuts in services – we are aware of support packages being cut with many people – this follows an assessment of need but we believe the assessment of need is being increasingly shaped to fit the current climate of resources.

- We sometimes don't get referral to specific services such as addiction services

- Sometimes services don't deal with the range of issues; an addiction specialist may talk about substance misuse but say that they are not qualified to deal with psychiatric difficulties such as anxiety.

- There is no statutory entitlement for our carers to have time off work to help care for us when we are unable to cope alone.

- Because we have fluctuating conditions our carers are also not entitled to financial support when they have to take time off of work – they don't get paid leave from work and they are not entitled to carers allowance.

- Our carers don't get enough support – the support in mind project for carers of people with mental health problems in the Highlands is losing its funding.

- Professionals can make assumptions about our physical health if we have a mental illness – we think the assumption that some of our physical health problems are psychosomatic is part of the reason that people with mental health problems have such poor physical health.

3 IF YOU OR A CLOSE FRIEND RECEIVED a) SOCIAL CARE AND OR b) NHS CARE OR TREATMENT IN THE LAST FIVE YEARS, WHAT HAS BEEN YOUR IMPRESSION OF THE SERVICE PROVIDED?

A AND B:

We can feel a lack of compassion

- Services are more and more matched to statutory requirements.

- If people are on CPA (care program approach) or sectioned they are guaranteed a service and help whilst if people don't come under this category they may get less help. It seems that there is almost a developing two tier service.

- It can be very difficult to know when and where to go for help

- Our notes don't always follow us if we change areas and we may need referred to services from scratch again.

Some of us feel we have good care:

" my nurses were good, they talked to me, they took time, they were empathetic and caring"

4 DO YOU THINK THE SERVICES ARE WELL CO ORDINATED?

- ten people said 'no'
- two said 'yes'

5 DO YOU FEEL PEOPLE HAVE ENOUGH INFLUENCE IN SHAPING THE SERVICES THEY RECEIVE? IF NOT HOW MIGHT THIS BE IMPROVED?

Even with the existence of HUG (which we are very happy to have) we think collectively we have limited influence over services – we are still in the early days of having a say on mental health services by people with mental health problems.

On an individual level we have the following comments:

- We have very little say or control over the fact that many people with mental health problems get little or no service.

- One of the key health issues facing us are changes to the welfare system. We feel we have no voice at all in the issues that this will cause us to face.

- We are going to face cuts and efficiency savings in mental health services. While we may be listened to we don't believe we can influence or prevent this.

- People with a mental illness are often not listened to. Their concerns about the service they should be or are receiving can be put down as a symptom of mental illness especially if those concerns are negative. Their ability to engage with professionals can also seen as a sign or impairment rather than a legitimate concern about the relationship they have with professionals.

- We also believe many professionals (especially grass roots workers) have limited say over the development of services.

6. A NATIONAL CARE SERVICE AIMS TO IMPROVE SOCIAL CARE AND HEALTH CARE BY INTEGRATING THESE SERVICES UNDER THE SAME ORGANISATION. DO YOU THINK THIS IS A GOOD IDEA?

We don't know.

If it results in the whole person and their wider life being dealt with in a better co-ordinated way this could be good – it could create a more holistic service.

However we worry that it is going to be a way to make savings without improvements in service and that integrating professionals with different backgrounds and cultures could be a problem.

THE VIEWS OF THE HUG FRIDAY FORUM ON THE INTEGRATION OF ADULT MENTAL HEALTH SERVICES INTO ONE BODY CONTROLLED BY NHS HIGHLAND.

The HUG Friday forum is a forum for discussion and consultation that meets on occasional Fridays.

This particular discussion followed a request from NHS HIGHLAND and involved 8 members – mainly from Inverness.

- Social work services are overloaded already; social workers seem to be increasingly taking on just the mental health officer role required by legislation. (two people in this discussion have already been taken off of the caseload of social workers against their will.) We need services that transfer to reflect what is needed from the council not what is presently delivered.

- Mental health officers are legally obliged to be employed by Highland Council. How will this be dealt with?

- The current managers in health and social work are already overloaded. How can a person administer teams that cover all of Caithness and Sutherland and some of Easter Ross on their own? Further reductions in management of mental health services may be dangerous to the sustainable work of the teams. However some of us think there are too many managers and that they are a needless expense on the services we need.

- The values of social work are different to health – Social work generally seems more holistic, less aimed at cure and medication, more long term, more aware of the importance of housing and employment on mental health. How do these differing value bases and approaches fit together in one team? – How does a manager with a different value base manage another person from a different discipline?

- There used to be a vibrant debate between agencies within the mental health teams. This autonomy and independence of debate may be lost.

- How do social work services that need to be paid for be dealt with if services come under NHS Highland? Will this lead to services that will now be under a health banner being charged for? Or will the current social work charges be scrapped?

- Will ringfenced services from the council be lost in the transfer?

- Will being based in health make services less vulnerable to cuts in the future?

- Support workers are having to use public transport to see clients. (this claim is denied by managers) but has been confirmed by workers in mental health teams and at the hospital. In this context we worry that all change is aimed at savings not the maintenance or development of a quality service.

- The interface between social work and health – it is hard to assign people to a social work service because these services are already overloaded. Will this be factored in to the transfer of services?

- Interface between social work and health – people tend to be assigned on a case by case basis at team meetings we don't know if there is a problem with the way in which people are currently assessed as needing social work or health support. Some of us think that there can be a good relationship between different agencies within the team already but we are not sure if this is the case.

- It is increasingly difficult to get a support worker especially for new clients

- We don't know whether this change is good or bad.

Appendix 2 Legislative context

Community Care and Health (Scotland) Act 2002

Sections 13-17 refer to joint working arrangements between local authority and NHS bodies including:

- transfer of funds between each;
- transfer of staff; and
- Ministerial powers to require delegation between local authority and NHS bodies.

More details on joint working are included in the Community Care and Health (Joint Working etc) (Scotland) Regulations 2002. The functions for which partnerships can delegate responsibility are included in schedules 2 and 3 of the regulations and the exemptions are outlined in regulation 5(2) and (3). Any arrangement to delegate functions/pool budgets must be outlined in a written agreement (regulation 9 and the details to be included in the written agreement are included in regulation 11). The composition and management of a pooled fund, including audit arrangements, are included in regulation 10. There is also a requirement to consult on by arrangement (regulation 6). Guidance on the Joint Working regulations was issued in December 2002.

Local Government In Scotland Act 2003

This Act introduces three key considerations:

- The duty to promote Best Value;
- The duty to initiate, facilitate and maintain Community Planning; and
- The power to advance wellbeing

Section 52 also details guidance

http://www.unison-scotland.org.uk/briefings/s52%20guidance.pdf

National Health Service Reform (Scotland) Act 2004

This legislation provides a setting in which the actions enabled by the Community Care and Health (Scotland) Act 2002 can take place.

Section 4A provides for the establishment of Community Health Partnerships (CHPs). CHPs are not independent statutory bodies, but are committees or sub-committees of an NHS Board. They operate within the Board's policy, planning and performance management systems. Some CHPs have established Community Health and Social Care Partnerships that directly manage a range of community based health and social care services, and are responsible for services already delivered jointly under the Joint Future agenda e.g. community services for learning disabilities, mental health and addiction.

Section 3 12 of the Act specifies that it shall be the duty of every Health Board to put and keep in place arrangements for the purposes of (a) improving the management of the officers employed by it; (b) monitoring such management; and (c) workforce planning."

Appendix 3 Implementation Deliverables

1. Project management – this workstream entails applying a robust methodology which will evidence objectives, dependencies and milestones and assure the Programme Board of progress, delays and risks. Developed in the initial phase, this methodology will be more firmly applied after the joint Council and Board meeting in May.

2. Lead Agency model – This workstream involves the gathering of information about this model, determining the application across Highland and developing the Highland model to enable testing, learning and full implementation. Key dependencies have been identified as HR, Finance, IT, Property, Legal.

3. Service Specifications – these will form the basis of the commission against which organisations will be measured and will detail how outcomes will be improved through a needs assessment, exploration of evidence and guidance, identification of duplication and/or gaps and clear performance management.

4. Commissioning documentation – learning from other areas has emphasised the need to develop robust documentation outlining the delegations, performance framework etc which is legally agreed across the agencies and Scottish Government. Much of this work will be informed by the models being developed in Finance and HR.

5. Change management programme – this is by far the most extensive workstream which will involve staff at all levels across the agencies and will rely on local champions and change agents for a successful outcome. Pivotal to this will also be the communities and users and carers who can add such value and support for change and will remind us of why we are taking this route.

6. Evaluation – every programme of work should have robust evaluation to demonstrate the improvements and capture the lessons learnt for the benefit of others. Work needs to begin at the outset to capture the existing baseline against which to measure improvements. The Public Health department in the NHS and Quality Assurance in the Council are engaged in defining the model that will best demonstrate change and quantify the data that will be required. Traditional reporting through a balanced scorecard is currently applied in Community Care for assessing progress against agreed Performance Indicators and will be reconsidered along with the methodology of wellbeing indicators applied in Children's services. This makes the link back to the outcomes in the Integrated Children's Services Plan.

Appendix 4

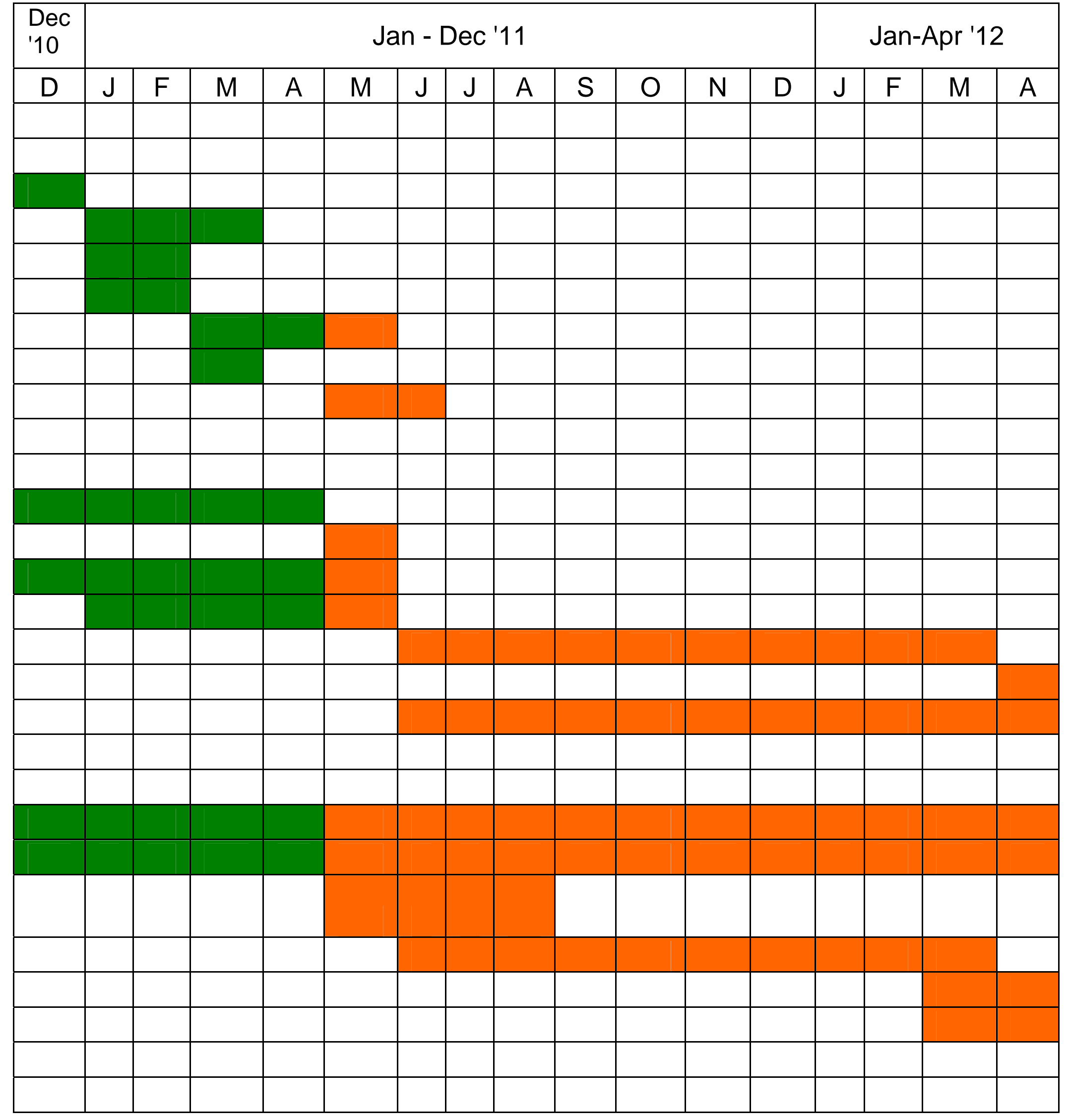
Implementation GANTT Chart

DELIVERABLES

PROJECT MANAGEMENT
determine project structure
agree documentation
identify all stakeholders
identify project team & board
agree role remit and membership of project
determine external reporting
specify risks
establish project plan & timeline

LEAD AGENCY MODEL
explore and analyse options
agree preferred option for Highland
determine implications
develop timeline for implications - HR, Finance, IT etc
test model
implementation
write up model development

SERVICE SPECIFICATION
Needs assessment
Evidence and guidance
Review current plans and established integrated provision
Gaps/service improvements
Agree 3yr service plan
Agree monitoring framework



COMMISSIONING DOCUMENTATION

explore options and examples from elsewhere
establish Highland requirements - HR, Finance, Legal
establish legal advice - internal and external
work up legal docs incl. Perf. Framework, delegation etc

CHANGE MANAGEMENT PROGRAMME

establish need for change
engage staff and leaders
engage users and wider public
explore issues, values and areas of good practice
identify change agents champions
establish mechanism for change
develop change programme
implement change programme
capture lessons learned
document process and lessons learned

EVALUATION

establish baseline
consider and agree desired outcomes
consider data capture
engage users and carers and user groups
establish methodology
establish recording mechanism e.g. KPI, BC, Dashboard
test KPIs etc
write evaluation report