Integration of Health and Social Care

Glasgow City Community Health Partnership

1. Introduction

1.1 The Committee have asked for a short written submission on the challenges faced in integrating health and social services with specific reference to what it is believed the Scottish Governments proposals need to address in overcoming barriers to integration. This submission summarises the main barriers/challenges and makes suggestions about the way forward.

2. Background

2.1 The Audit Scotland Report “Community Health Partnerships” published in June 2011 provides a useful summary of the history of CHPs and CHCPs. The arrangements for CHPs, the responsibilities they have, the services they manage, membership of their committees etc all differ significantly across Scotland. It is worth remembering that the original CHP guidance supported this approach with a view that there was to be no fixed model.

2.2 Each NHS Board with their Local Authority Partner/s was to establish a CHP or CHCP and what emerged was dependent on a number of factors including, the strength of previous local joint community care planning arrangements, senior management and executive relationships, political involvement and commitment and the willingness of partners to share or devolve power.

2.3 Within Glasgow City 5 CHCPs were established in April 2006 with the City divided into 5 geographical patches. Each CHCP had a Director who had a joint reporting line to the Health Board Chief Executive and to the Councils Director of Social Work. These CHCPs were established at the time of significant organisational change in Greater Glasgow and Clyde. April 2006 saw the dissolution of Argyll and Clyde Health Board and NHS Greater Glasgow became NHS Greater Glasgow and Clyde. There was a major managerial reorganisation during 2005/06, an Acute Operating Division 4 CHPs (Renfrewshire, East Dumbarton, West Dumbarton and Inverclyde) and 6 CHCPs (5 Glasgow and East Renfrewshire) were established. All of these new operating units had new management teams and in the Glasgow City CHCPs these were a combination of managers from health and social work backgrounds.

2.4 The Glasgow City CHPs were dissolved in November 2010. The reasons for their dissolution are complex and multi-faceted and would require an in depth study to analyse them and objectively assess the reasons that they no longer exist.

2.5 The points which follow build on the experience of both the CHCPs and the current Glasgow City CHP which was established in November 2010.
3. **Challenges to Future Integration of Health and Social Care**

3.1 **Organisational Development**

The creation of any new organisation with a new management team (as will be the case in integrated health and social care partnerships) will require a robust organisational development programme tackling the culture and identity of the new organisation and building teams at all levels. This very comprehensive programme will require to be resourced appropriately.

3.2 **Leadership**

The Health and Social Care Partnerships (HSCPs) should have a single accountable Director reporting directly to the Chief Executives of the Health Board and the Council. The experience from the Glasgow City CHCPs would support this approach.

3.3 **Devolution of Budgets**

It is proposed that the NHS Board and the Local Authority will devolve an integrated budget to the HSCP. There needs to be clarity about the services that this will relate to. Is it to be all current CHP NHS Services? CHPs currently manage ‘hosted’ services on behalf of the Board. Currently in Glasgow the CHP manages a range of services for the entire Board areas including sexual health, prison healthcare, forensic and children and adult mental health services. Hosting arrangements are quite common across Scotland and justified for many services where it would not be cost-effective or clinically sensible to disaggregate them. The Scottish Government proposals will need to consider the implications of continuing hosting arrangements and the governance consequences for Health Boards in doing so.

It is difficult to understand why the proposal to include all NHS services in CHPs is not matched by including all social works services, i.e. children’s and criminal justice as well as adult services. The rationale for fragmenting social care into two distinct organisations is not clear and this has significant organisational, governance and cost issues with a requirement for parallel structures in Councils.

Allocations by NHS and Councils to Partnership need to be set by a consistent and synchronised budget process and once allocated to the partnership should not be subject to in year changes unless there is a partnership agreement to make such changes.

3.4 **Joint Performance Management**

There needs to be a very tightly defined set of outcomes for the HSCPs, with a robust performance management process. Experience demonstrates that reporting to a Committee alone does not provide a sufficiently robust approach to performance management. There will also require to be a joint Health/Local Authority Chief Executive lead performance review process if
HSCPs are to be fully held to account for their performance against a set of defined outcomes/targets.

3.5 Governance Arrangements

Governance arrangements need to be very precise. All Committee members will require clearly defined roles. There needs to be clarity about the reporting relationships for Committees. COSLA have proposed accountability to the Council Leader and Cabinet Secretary. This implies partnerships are not between local authorities and local health boards but between local authorities and Scottish Government, but the whole governance structure of the NHS is based around the roles of Boards as is accountability to the local population. In addition this model would see the Cabinet Secretary becoming involved in disputes and conflicts in 32 partnerships. A more measured appropriate approach would be accountability to the Board Chair and Council Leader. The governance arrangements need an effective process to resolve deadlocks.

3.6 GP Engagement

General Practitioners in particular but also some other clinicians have felt disempowered by CHPs and CHCPs. In Greater Glasgow and Clyde we have established GP Locality Groups to ensure better engagement with Primary Care Contractors and GP Clinical Directors are part of CHP Management Teams and Committees. The Scottish Government proposals for HSCPs will need to fully embrace the role of General Practitioners recognising the key role they play in access to and the provision of healthcare.

3.7 Workforce Issues

The difference in workforce pay and conditions between Health and Local Authorities has been an issue for the integrated CHCPs. This has primarily manifested itself at a senior level but as we move into the new HSCPs then the differences at all levels will become more apparent and equal pay issues may emerge. The Scottish Government should consider minimising the likelihood of equal pay or TUPE issues by enabling employment to continue with either Health or Local Authority at least in the set up period for the new organisations. This would then allay staff/trade union anxieties about one aspect of the change.

There are substantial issues to remaining with separate terms and conditions but equally substantial issues about moving to a single employer, although such a move would provide a more appropriate long term solution. There are immediate issues about the different industrial relations models in the NHS and local authorities, with partnership in the NHS based around a national staff governance standard and more traditional negotiating arrangements in local authorities. NHS staff have lifetime protection and security of employment. These issues would need resolution prior to the new organisations being formed.
4. Conclusion

The move to HSCPs will be a significant organisational change for many of the CHPs across Scotland. For the few CHCPs which exist there will be some change albeit with a lower level of impact. The day to day impact of organisational change should not be ignored. We know from the many reorganisations which have taken place in Health that a successful reorganisation requires a substantial time and resource commitment from a wide range of managers.

The Scottish Government will require to carefully consider what they want HSCPs to be. Do they want to take the route taken with the creation of CHPs in 2003 given minimal direction and permit a range of models to be created or do they want to be much more prescriptive and mirror the much more directive approach taken in some previous reorganisations e.g. when Trusts were established?

Glasgow City CHP