Corporate Policy and Stategy Committee

10am, Tuesday, 5 August 2014

Health and Social Care Integration: Options Analysis of Integration Models

Item number	7.11
Report number	
Executive/routine	
Wards	All

Executive summary

This report provides Corporate Policy and Strategy Committee with an options analysis of the available models for the creation of an Integration Authority within the Public Bodies (Joint Working) (Scotland) Act. The detailed options analysis report is provided in Appendix 1.

The report includes:

- The context and case for change;
- Purpose of the legislation;
- Benefits expected by Scottish Government;
- What an Integration Authority is;
- What happens under each of the Models;
- Observations and comments on each model;
- A joint view on the technical viability of each model for Edinburgh;
- Scrutiny of the two viable models against seven key strategic considerations;
- Next steps.

Links

Coalition pledges	P12 and P43
Council outcomes	CO10, CO11, CO12, CO13,Co14, Co15
Single Outcome Agreement	SO2

Report

Health and Social Care Integration - Options Analysis of Integration Models

Recommendations

1.1 To note the outputs of the technical options analysis in Appendix 1.

1.2 To agree that Models c) and d) were dropped from further work on the basis that they were not viable for Edinburgh.

1.3 To approve the recommendation that Model a) Integrated Joint Board provides the best fit in terms of the strategic considerations and Council's organisational values.

1.4 To agree the preparation of the Integration Scheme jointly with NHS Lothian for submission to Scottish Government Ministers on the basis of Model a).

Background

2.1 The report presents an options analysis of the models available for the creation of the Integration Authority for Edinburgh as required by the Public Bodies(Joint Working) (Scotland) Act 2014.

Main report

Public Bodies (Joint Working) (Scotland) Act.

3.1 The Public Bodies Act received Royal Assent at the start of April.

3.2 The Act requires the Council and NHS Lothian to establish an Integration Authority for the governance, planning and resourcing of adult social health and care services in Edinburgh. It allows for the inclusion of other optional services, such as Children's health and social care services.

3.3 The Council and NHS Lothian must agree the model and describe the approach they will adopt in the Integration Scheme which must be submitted to Scottish Government by 1 April 2015 for approval.

What is an Integration Authority?

3.4 The Integration Authority is the body to which the Health Board and/or the Council delegates functions and makes payments associated with those functions. It is the body which is then responsible for the governance and

carrying out of those functions and receives all associated powers and duties associated with that delegation.

3.5 The Integration Authority can be an Integrated Joint Board (IJB), the Council or the Health Board. It is the body which is responsible for planning health and social care services for the local population of Edinburgh, through the Strategic Plan. It is the body which then must instruct the delivery of these functions and make associated payments/allocate resources in line with the intentions in the Strategic Plan.

3.6 It is the accountable body for the carrying out of the functions and for delivering on the national health and wellbeing outcomes and must publish an annual Performance Report.

3.7 Where the Integration Authority is not an Integrated Joint Board, the authority must create a Joint Monitoring Committee to oversee and scrutinise the carrying out of the functions.

Technical Analysis

3.8 There are four models available to the Council and NHS Lothian. Each of these is outlined in detail in Appendix 1, along with a technical description of what happens under each arrangement and a number of observations relating to the impact of the models on the role and function of the Council and NHS Lothian.

3.9 A joint NHS Lothian and Council team undertook the technical analysis supported by internal and external legal advice.

3.10 A summary of the key elements of each model is provided in Annex 5 to the main report.

3.11 Annex 6 of the report contains a brief description of the viability of each model based on the view of the joint team.

3.12 The joint team's view is that both model a) an Integrated Joint Board and Model b) NHS Lothian and lead agency for adult health and social care services are viable options.

3.13 Neither Model c) or d) are considered to be viable due to:

a. the need in Model c) to disaggregate planning and resources for adult health services within NHS Lothian and the potential risk this creates for a degradation of service/facilities/functions across geographical boundaries; and

b. The fact that Model d) would only be viable if NHS Lothian delegated its optional children's health services. This would create two Integration Authorities; one very large Integration Authority with responsibility for adult health and care services and one small Integration Authority responsible for Children's health and social care services. The model does not realistically offer any additional benefits over model b).

Strategic Analysis

3.14 Given that the models are not simply an end in themselves but are intended to improve health and wellbeing outcomes for people and ensure improved functioning and resourcing of the whole health and social are system, a further analysis of the viable options was requested in terms of which model can best deliver on the national health and wellbeing outcomes. In addition, the Integrated planning principles are key to the activities of the Integration Authority so the key planks of these principles were also considered. It was also considered important to reflect on how the models related to the values of both organisations.

3.15 Section 12 of Appendix 1 provides details. Council and NHS officers considered both models carefully in terms of how each could achieve the national outcomes and integration planning principles and therefore which would be best. The reality in both cases, is that it comes down to the proposals of the Strategic Plan and to the flow of resources to meet outcomes. Both models will have the mechanisms in place to do this, such that both models could equally achieve the outcomes.

3.16 The questions for the Council then become:

a. Which model does the Council believe is the best approach to preparing and approving the Strategic Plan?

b. To what extent does the council wish to retain involvement in decision-making?

c. To what extent is local democracy and accountability important in the planning of adult health and social care functions in Edinburgh?

d. What appetite exists for ‘wholesale’ transfer of adult social care staff (and a proportion of corporate staff) to the NHS?

e. Which model offers the most effective and efficient decision-making and implementation option?

f. Which model offers the best approach to engaging with people in the planning and delivery of functions?

g. Which approach aligns most strongly with current Council organisations values?

Recommended Model

3.17 Appendix 1 provides comments and analysis for each of these questions. Annex 7 of the report provides a summary in table form.

3.18 In light of this analysis, it is recommended that Model a) Integrated Joint Board is approved as the Council’s preferred Model for the Integration Authority and that

preparation of the Integration Scheme with NHS Lothian proceeds promptly on this basis.

Timescale

3.19 The Integration Scheme must be submitted to Scottish Government by 1 April 2015. There is a great deal of work to be done within a few months in order to meet this deadline and a detailed work programme has been put together. If Ministers approve the Integration Scheme, Scottish Government will establish, in law, the new Integration Authority sometime during 2015.

3.20 Following submission of the Integration Scheme the focus of the work becomes the preparation of the Strategic Plan, the process and document by which the Integration Authority will plan services for Edinburgh, and make the changes to services it must to deliver on the national outcomes and to shift the balance of care.

3.21 Appendix 2 provides a critical path for the development and approval of the Integration Scheme and for the production of the Strategic Plan. The timeline for the Strategic Plan is indicative as it assumes a three month period for the approval of the Integration Scheme and creation of the Integration Authority by Scottish Government. This may vary.

Measures of success

4.1 The Scottish Government have issued draft National Outcomes for the delivery of integrated Health and Social Care within the regulations for the Act. The Strategic (Commissioning) Plan work stream is tasked with planning for the delivery of these outcomes for the services in scope.

4.2 The Programme Sub Group on Performance and Quality is tasked with establishing local outcomes for measuring the success of the new Health and Social Care Partnership in relation to the national outcomes. A joint baseline has been developed and work is continuing on a joint framework for the future

Financial impact

5.1 It is estimated that the new Health and Social Care Partnership will encompass a combined budget of around £4-500 million, subject to the final scope of functions included. This brings together existing budgets from the Health and Social Care Service in the Council as well as those from NHS Lothian's Community Health Partnership

5.2 Appendix 3 contains a summary of the current 2014-15 budgets for Council health and social care services and NHS Lothian Community Health Partnership

services. Further services may be included relating to housing services and to some 'acute' services. Funds for 'acute' services will be subject to specific 'set aside' arrangements as specified in the Public Bodies Act. Guidance is awaited on this from Scottish Government.

5.3 These budgets will be delegated to the Integration Joint Board for governance, planning and resourcing purposes. The Integration Scheme will set out the mechanism for this. The Strategic (Commissioning) Plan will identify how the resources are to be spent to deliver on the national outcomes.

Risk, policy, compliance and governance impact

6.1 A detailed risk log is maintained for the integration programme and reported through the status reporting process to the Shadow Health and Social Care Partnership and through the CPO Major Projects reporting procedure.

6.2 Enterprise level risks for integration are also identified on Corporate Management Team, Health and Social Care and NHS Lothian risk registers.

6.3 Shadow arrangements based on the Integrated Joint Board have been in place for over 18 months. Doubt about the preferred model will cause a delay in preparation of the integration scheme. Inability to reach an agreed position with NHS Lothian will lead to Ministerial intervention and the imposition of an Integrated Joint Board for Edinburgh.

Equalities impact

7.1 The integration of health and social care services aims to overcome some of the current 'disconnects' within and between existing health and social care services for adults, to improve pathways of care, and to improve outcomes.

7.2 Furthermore, the intention is to improve access to the most appropriate health treatments and care. This is in line with the human right to health.

7.3 Work is in progress to develop a combined EqHRIA procedure between NHS Lothian and Health and social Care Services. This will be used for all EqHR impact assessments as required across the joint service once the Integrated Joint Board is fully established.

Sustainability impact

8.1 The proposals in this report will help achieve a sustainable Edinburgh because:

- joint health and social care resources will be used more effectively to meet and manage the demand for health and care services
- they will promote personal wellbeing of older people and other adults in needs of health and social care services; and
- they will promote social inclusion of and care for a range of vulnerable individuals.

Consultation and engagement

9.1 Consultation and engagement form a key work stream in the programme. A number of events have taken place and mechanisms are being established to ensure the Shadow Health and Social Care Partnership is engaging at all levels. This includes the recruitment of service users and carers as members of the Shadow Health and Social Care Partnership with the express purpose of bring their own perspective to the discussions.

9.2 A comprehensive engagement programme is also underway to engage with a range of staff and practitioners across health and social care services, including the Professional Advisory Committee (whose Chair and Vice Chair are voting members of the Partnership). Finally, the Strategic Commissioning Plan process will adopt a co-production approach to developments to ensure timely and productive engagement with key stakeholders.

Next Steps

10.1 The City of Edinburgh Council and Lothian NHS Board established a key stakeholder reference group to consider which integration model was the best option for Edinburgh.

10.2 The Group's membership was made up of the Council Leader and Chief Executive, as well as five councillors from the Administration and the NHS staff side partnership lead. From the NHS it further included the Chairman and Chief Executive of the NHS Lothian, five non-executives and the Employee Director. The group was supported by officers from both the Council and the NHS Board.

10.3 The group has concluded that the Integration Joint Board is its preferred integration model.

10.4 In reaching the agreed model of integration, the Council Leader and Chief Executive, as well as the Chairman and Chief Executive of NHS Lothian are proposing that this infrastructure is retained and utilised for the development of the Integration Scheme and until the establishment of the Integration Joint Board, following which, it will be disbanded. The membership of the group will

be extended to include opposition politicians, the voluntary sector, service users and carers, and Council union representation.

10.5 The focus and remit of this group and the support function will be to:

- Develop the draft integration scheme for the agreement of the NHS Lothian Board and the Council;
- Agree the process and principles in relation to budget setting to achieve both a balanced budget as well as addressing any care deficits. The principles will include having a shared and equal responsibility for the operational management and use of the Integration Joint Board's resources and an agreed approach to the management of any overspend or underspend;
- Design innovative organisational arrangements to secure delivery of the Integration Joint Board's Strategic Plan;
- Develop a performance management system and agree performance management reporting arrangements;
- Agree the roles, responsibilities and composition of the Edinburgh Integration Joint Board.

10.6 The relationship with the Shadow Health and Social Care Partnership will also need to be carefully considered.

Background reading/external references

Finance and Resources Committee – 30 July 2014, Health and Social Care Integration Update. (TBC)

Corporate Policy and Strategy Committee- 13 May 2014, Health and Social Care Integration Update.

Finance and Resources Committee - 7 May 2014, Health and Social Care Integration Update.

Corporate Management Team – 19 March 2014, Health and Social Care Integration – General Update.

Corporate Management Team – 5 February 2014, Health and Social Care Integration – General Update.

Corporate Management Team - 8 January 2014, Health and Social Care Integration, Progress on the Public Bodies (Joint Working) (Scotland) Bill.

Corporate Management Team – 20 November, Health and Social Care Integration - Strategic Commissioning Plan.

Corporate Management Team – 4 September 2013 City of Edinburgh Council – Proposed Response to the Public Bodies (Joint Working) (Scotland) Bill.

Corporate Policy and Strategy Committee – 6 August 2013 – City of Edinburgh Council proposed Response to Public Bodies (Joint Working) (Scotland) Bill.

See reports above for earlier reporting.

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Links

Coalition pledges	Ensuring Edinburgh and its residents are well cared for.
Council outcomes	Health and Wellbeing are improved in Edinburgh and there is a high quality of care and protection for those who need it.
Single Outcome Agreement	Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Appendices	Appendix 1: Technical Options Analysis Report (includes Annexes 1-8)
	Appendix 2: Critical Path
	Appendix 3: Summary of Council Health and Social Care and Community Health Partnership Budgets 2014/15

Appendix 1
Integration of Health and Social Care
Public Bodies (Joint Working) (Scotland) Act.
Option Analysis of the Integration Authority Models

Annexes

Annex 1: Audit Scotland Review of Community Health Partnerships 2011– Extract

Annex 2: Draft National outcomes and indicators

Annex 3: Integration Planning Principles

Annex 4: Scope of Functions to be delegated (local authority and health board)

Annex 5: Summary of key elements of each Model

Annex 6: Joint Team view on viability of each Model

Annex 7: Strategic Considerations

Version Control

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Version control

Version	Changes	Status	Version date
V1	Initial draft	Draft	2 June
V2	Input from Finance	Draft	10 June
V3	Update following input from Legal Lizzie Connell and Ste4phen Phillips) and Governance (Steve Langmead and Gavin King)	Draft	w/c 16 June
V 4	Strategic Option Analysis	Draft	14 July
V5	Final wording changes for Committee	Final Draft for CP&S APM	16 July

Distribution and review history

Version	Distribution list	Purpose	Comment/action location	Distribution date
V1	Michelle Miller/Monica Boyle/Peter Gabbitas	Initial review	No comments	2/6/14
V3	Michelle Miller/Monica Boyle/Peter Gabbitas/Lizzie Connell, Moira Lyne, Gavin King, Karen Dallas, Steve Langmead	Review version for CP&S – minus strategic options analysis	No comments	8/7/14
Associated slide presentation	Michelle Miller/ Monica Boyle/Tim Montgomery	Update on presentation for NHS and Member Stakeholder Group	No comments	8/7/14
V4	Michelle Miller/Monica Boyle/ Peter Gabbitas/Hilary Coyne	Comments on strategic options analysis extract	Wording amendments	15/7/14
V5	Peter Gabbitas	Sign off for CP&S APM	Working amendments and clarification of NHS values	16/7/14

1 Introduction

1. This report provides an option appraisal of the models available for the creation of the Integration Authority between NHS Lothian and City of Edinburgh Council.
2. There are four models available within the Public Bodies Act and it should be noted from the outset that:
    a) most models require the delegation of functions and funds to another body for governance, planning and resourcing with the exception of when a delegating body is also the 'Lead Agency'.
    b) all the models are included in the legislation and as such they are all viable, legal models. Scottish Government have taken legal advice to ensure the models are sound for adoption by the public agencies in question.
3. As a result, this options appraisal is intended to support a policy decision and will provide information:
    - **on the context on the current position;**
    - **on outcomes and benefits expected from integration;**
    - **the technical governance approach of each model;**
    - **where governance, accountability and liability will lie;**
    - **scrutiny of which model can best meet the national health and wellbeing outcomes.**

4. **In summary, the recommendation rests on:**
    - **the extent to which the Council believes each model can provide the 'best' Strategic Plan;**
    - **the Council's preference for the level of engagement it wishes to retain in the governing and planning of adult health and social care services,;**
    - **the level of local democracy and accountability the Council wishes to see across adult health and social care functions;**
    - **the appetite for 'wholesale' staff transfer;**
    - **the extent to which each model can provide the best approach to engaging with people in the planning and delivery of the functions;**
    - **the extent to which the council considers each model can undertake efficient decision-making and implementation; and**
    - **alignment with the Council's current organisational values.**

2 Context and Case for Change

Background

5. The Integration legislation is set within a context of Christie Commission report (2011) and three very specific pressures on public services, particularly health and social care services:

    - Greater and unceasing demand for services for at least the next 20 years. The SG Finance Committee has estimated that expenditure on health and social care services will be expected to rise by between 18% and 29% by 2030;
    - Higher expectations from people who use our services in terms of availability and quantity, but with a continuing expectation that services will be either free of charge or heavily subsidised by the public purse; and
    - Diminishing resources to deliver historic models of operation, specifically, reducing local authority resources and a static position within the health sector.

6. The fundamental dilemma is therefore, how to meet the minimum 18% rise in demand with less money. It is clear that current models of governance, planning and operation are no longer sustainable and a fundamental transformation of how these services are delivered is required.

Community Health Partnerships (CHPs)

7. The 2004 NHS Reform (Scotland) Act required NHS Boards to set up CHPs with the purpose of bridging the gap between primary and secondary health care and also between health and social care in attempting to address the pressures above.
8. The statutory guidance at the time is not dissimilar to the objectives of the 2014 Public Bodies Act. CHPs were expected to coordinate the planning and provision of a wide range of primary and community health services for their area. Health Boards were given flexibility to devolve other functions to the CHP. The latter happened only rarely.
9. Audit Scotland reviewed CHPs in 2011 and found that while there had been progress in joint working in many areas, it was obvious that the level of partnership required to make the difference was not being achieved. Their key messages are in Annex 1.

10. In Edinburgh, a health only CHP was established with a Joint Director who is also responsible for social care in the Council. The CHP is a committee of the NHS Board, however does not relate to council governance structures. The CHP is regarded as a committee of representatives of the local area and includes two elected members.

11. A Joint Board of Governance was created in an advisory role only. The advisory nature was due to the constraints on local government that a committee of the Council must have two thirds majority of elected members.

12. With respect to shifting the balance of, and resources for, care in community-based settings, ‘’overall (nationally) there has been a slight increase in the percentage of total NHS resources being spent in the community between 2004/5 and 2009/10 (period studied by Audit Scotland). But there has been no change in the percentage of NHS resources transferred to councils for social care services during the same period’’) Audit Scotland 2011. Indeed Audit Scotland note that ‘there has been no large-scale shift in the balance of care despite this being a key priority since 2000’’.

13. Within NHSL and City of Edinburgh Council the resource transfer framework has been the mechanism used to transfer the balance of resources to adult social care and the figures for the past ten years are in Table 1 below. Table 2 identified current CHP and Council adult social care budgets.

Table 1: Resource transfer from NHS (acute sector) to adult social care 2006/7-2013/14

	Total £m	% increase	Total % increase
2006/07	19.290		
2007/08	19.580	1.50	
2008/09	19.780	1.02	
2009/10	19.897	0.59	
2010/11	20.282	1.93	
2011/12	20.368	0.42	
2012/13	20.414	0.23	
2013/14	20.822	2.00	7.94
Percent of total budgets*		4.16	

Notes:

* RTF as % of current CHP and REAS budgets

Table 2: Current Shadow Partnership Budget

	14/15 budgets	
	Total £m	
CHP	296.775	
CEC(asc)	203.342	(from Partnership finance presentation-March 2014)
	500.117	(approved budget)

Notes

CHP= Community Health Partnership (NHS)

CEC(asc) - Council adult social care budget

Source: Finance Division

28/05/2014

14. Audit Scotland made a number of recommendations (Annex 1). Most of the recommendations were for Scottish Government and have been met or overtaken by the Public Bodies Act legislation. The CHPs will be dissolved once the Integration Authority is established.

Change Fund

15. The Reshaping Care for Older People (RCOP) Change Fund has been a very useful support to NHS, local authority, third, housing and independent sectors to work more effectively together and to share ownership of local change plans and delivery. The governance arrangements and improvement support for Change Plans, which created an equal space at the table for all partners, have accelerated a change in attitudes, cultures and behaviours and have resulted in a greater focus on preventative and anticipatory care.

16. While it is acknowledged that the full ambitions of the RCOP ten year programme of reforms have not yet been fulfilled the recent Audit Scotland report,[1] noted that ''we have not yet been able to achieve a shift in resources away from institutional care''.

http://www.audit-scotland.gov.uk/docs/central/2014/nr_140206_reshaping_care.pdf

17. Further progress will be possible via the Public Bodies (Joint Working) (Scotland) Act 2014 to include key stakeholders within the decision making processes (Strategic planning process) to take advantage of their advice, experience and delivery. Strategic Commissioning will be critical to achieving this and Integrated Care Plans will need to be developed within the strategic commissioning process.

18. Scottish Government and COSLA are of the view that we need now to move to a more targeted but transformational redesign focused on the complex and high cost service models that are in many cases not delivering the outcomes that people need, especially in less affluent areas.

19. Central to these approaches must be the shift to support the assets of individuals and communities so that they have greater control over their own lives and capacity for self management, particularly of multiple conditions. The third sector has a particularly crucial role to play in supporting such an approach.

1

3 Integration Legislation

Purpose

20. The major aim of the Public Bodies Act is to create the conditions for service transformation which can help the public sector meet the challenges above and in particular to :

- achieving the national outcomes across Scotland (Annex 2);
- shifting the balance of care from the costly acute focus on health care, to more sustainable community based care.

21. It could be argued that this is one of the most major shifts in health and social care governance and planning in a generation. Partnership working through CHPs and Change Fund has not been able to deliver the required shift in the balance of care to the level required so more prescriptive legislation has been prepared. The legislation is predicated on:
    - considering the existing health and social care systems as a single 'whole system' rather than as two organisations working separately;
    - a scope of functions to be included to ensure whole system transformation is possible;
    - ensuring comprehensive and inclusive strategic planning arrangements to improve strategic leadership across the whole system to shift the balance of care and resources;
    - building on the best of both health board and local authority approaches to public service provision;
    - transforming organisational cultures to be person centred in both individual health and care circumstances and strategic planning processes;
    - engaging more strongly with local clinicians and professionals who are at the 'coal face' of demand;
    - Engaging with communities – third sector, independent sector and local people and their representatives, to ensure that health and social care services are governed, planned and delivered in a way that increases localisation, builds on and enhances community assets and increases responsiveness across local populations.

22. The Act specifically identifies and enshrines in law the Integration Planning Principles (Annex 3), and the health boards and councils have a duty to pay specific regard to these in the carrying out of their duties.

23. Specifically, a number of strategic enablers are required to ensure the right conditions are in place. The legislation creates these strategic enablers in the form of;

- an Integration Authority responsible for governing and planning the 'whole system and jointly resourced;
- a strategic planning process
- a requirement for local planning – with flexibility to local circumstances inbuilt
- mandatory integration planning principles
- accountability for national outcomes;
- a joint (forthcoming) performance framework for which both partners through the Integration Authority are accountable; and
- a fall-back position for Scottish Ministers to intervene should local resolution be impossible.

24. Enablers must deliver:

    a) integrated governance and accountability across health and social care
    b) Integrated planning and financing of health and social care services for the local population of Edinburgh

    They must do this in a way which meets the Integration planning principles.

4 Localities

25. A key strand of the legislation is the emphasis on planning for local populations, engaging with local service users and ensuring that health and social care professionals are fully engaged in the planning and delivery of services for people.

26. A major element of this will be ensuring that the Integration Authority can engage fully in, and build upon, community planning processes for engagement at a local level. This will require some improvements within health and social care and an ongoing commitment to the joining up of local health and social care planning with local service management and delivery.

27. In the longer term there is an expectation that localities will have an influence over resourcing of service provision within their areas. Whilst this may not be full community participatory budgeting, influence over major service spend is expected through the planning process.

5 Expected Benefits

28. The cost of the 'do nothing' option, as mentioned above is impossible to meet. At best it would require, by 2030 a minimum of an18% increase in both NHS and adult social care resourcing. Based on 2011/12 figures and operating current

service models this would equate to an extra c£378m on adult social care in 2030 and an extra c£1.62 billion in 2030 for health services nationally.

29. Current spend nationally on health services for adults in 2011/12 was almost £9 billion. For the same period spend on adult social care was £2.1billion.

30. The Finance memorandum notes that the main areas of savings would be delivered through the areas below.

- Reducing delayed discharge to release beds and funds
- Improving anticipatory care and so avoid admission to hospital in the first place to release beds and funds
- Improving consistency in health and social care delivery and costs to improve the allocation of resources across Scotland

31. The estimated national benefits combined from these are between £138million and £157 million per annum. This must be considered in the context of the funding 'gap' above if we 'do nothing'. The Scottish Government presume that any release of funds will need to be reinvested within partnerships to help meet demand.
32. It should be stressed that, as organisations currently exist, all of these financial benefits would accrue to the NHS and as such the release of any of these resources must currently be made by the NHS to invest in CHP and/or the Council's social care to help meet demand and shift the balance of care.
33. Currently each resource transfer must be worked through in detail and agreed jointly and it is within the control of NHS Lothian to amend and retain agreed amount for a variety of reasons.
34. Current resource transfer levels are £20.822m. The level has risen only in line with inflation over the ten year period from £19.290 in 2004/5. See Table 1 earlier
35. It is obvious that in comparison to a total NHS budget of over c£1.1 billion (2012/13) and total council adult social care budget of £203m (2013/14), the current rate of resource transfer is unlikely to address the demand the minimum 18% increase in demand.

6 Shadow Arrangements

36. Based on the history of joint working, NHSL and the Council took a decision in late 2012 to progress with a shadow arrangements based on the body corporate model. Furthermore, NHSL and other Lothian Councils appointed Joint Directors in preparation for the 'body corporate' model.

37. All shadow arrangements and work so far, over the last 18 months, for the Integration Scheme and preparatory work for the Strategic Commissioning plan has been based on meeting the requirement of this decision. Furthermore, all communications with staff have been on the basis of this decision.

7 Scope of Services

38. Critical to the delivery of the shift in the balance of care is the scope of services of the Integration Authority. The wider the scope across unplanned admissions/unscheduled care (acute hospital), community based health and care and support services for community based approaches, the more likely there is to be a shift in the balance of care in a sustainable way for individuals and for the system as a whole. Learning has been taken by Scottish Government from the narrow scope of CHPs and their inability to shift the balance of care in a way that was envisaged.

39. Inclusion of a wide range of services is challenging for existing organisations. This tension must be acknowledged and addressed to ensure the model adopted is fit for purpose and sufficiently robust to deliver on behalf of the constituent authorities.

40. ***However it must be remembered that the role of the Integration Authority is a governance, planning and resourcing role, essentially a 'commissioning' role. Operational management of services can remain with the constituent authorities.*** Furthermore, it must be remembered that Scottish Government are clear, that this approach is not about the administrative convenience of the existing bodies, but about planning well to meet the national outcomes for local populations.

41. In line with the decision above, an initial scope was agreed in Spring 2013 and additional services were transferred to the management control of the Joint

Director from 1 December 2013. Further discussion has continued during 2013 and early 2014 on scope of NHS services and the NHS Board agreed a scope on 17 April 2014 for the 'body corporate' model.

42. The Bill and Act have, all along, outlined that a portion of acute/hospital services will be required to be in scope and have also included housing aids and adaptations and housing support services.

43. Changes in the Bill have reflected significant concerns by the NHS about the inclusion of acute/hospital services within scope and the arrangements for 'payments' of funds in relation to delegated functions have been 'softened' to the 'setting aside' of funds where they relate to acute/hospital funds.

8 Clarity on Scope of Functions to be delegated

44. The draft regulations released on 12 May prescribe in detail the services to be in scope.

45. For local authorities it is mostly as expected. All adult social care services must be delegated along with housing aids and adaptations.

46. The unexpected element related to the inclusion of housing support services and work is in hand to determine the implications of this. COSLA are preparing a response to this and ongoing discussions between Scottish Government and Directors of Housing in local authorities has clarified that the term is in relation to housing support for social care client groups. As such, it looks as if it will excluded housing support specifically in relation to homelessness and so avoid potential difficulties in relation to complex models of service delivery.

47. Children's social care services and criminal justice services are optional functions and may be delegated.

48. For the NHS, the draft regulations were as expected for primary and community based health services. They also detailed very specific services in relation to the acute/hospital functions. These are indeed challenging and are the services for which monies would need to be 'set aside' for the Integration Authority to utilise. See Annex 4 for details.

49. For NHSL, this effectively means they need to work out an apportionment of funds from their whole acute sector to be set aside for the unplanned / unscheduled care services and then apportion this across four local authorities in many instances. This is an administratively challenging task and will also impact on financial accounting matters going forward.

9 What is an Integration Authority?

50. The Integration Authority is the body to which the Health Board and/or the Council delegates functions and makes payments associated with those functions. It is the body which is then responsible for the carrying out of those functions and receives all associated powers and duties associated with that delegation.
51. The Integration Authority can be either an Integrated Joint Board (IJB), the Council or the Health Board. It is the body which is responsible for planning health and social care services for the local population of Edinburgh, through the Strategic Plan. It is the body which then must instruct the delivery of these functions and make associated payments/allocate resources in line with the intentions in the Strategic Plan.
52. It is the accountable body for the carrying out of the functions and for delivering on the national health and wellbeing outcomes and must publish an annual Performance Report.
53. Where the Integration Authority is not an Integrated Joint Board, the authority must create a Joint Monitoring Committee to oversee and scrutinise the carrying out of the functions.

10 Models Available

54. The local authority and health board must agree the model for the Integration Authority for their area and draft an Integration Scheme which specifies the details of this model.

55. In summary the models are

    a. The 'body corporate' model - The health board and local authority choose to deliver integrated services through delegation to ***an Integration Joint Board*** established as a body corporate. This will require the appointment of a Chief Officer as the jointly accountable officer.

b. The delegated authority model or ‘lead agency’ model, which has three permutations and will be accountable through the ‘lead’ agency Chief Executive.

   i. the health board and local authority choose to deliver services through delegation to the health board in a delegation between partners arrangement and establish a ***Joint Monitoring Committee***;

   ii. the health board and local authority choose to deliver integrated services through delegation to the local authority in a delegation between partners arrangement and establish a **Joint Monitoring Committee**; or

   iii. the health board and local authority choose to deliver integrated services through delegation to the health board and the local authority in a delegation between partners arrangement and establish a **Joint Monitoring Committee.**

56. A technical options analysis of each model is provided below. This is a technical analysis in terms of how the models work for each of the key elements of the act, (governance and delegation, what actually happens, strategic plan and performance report).

57. Whatever the preferred model chosen the detail needs to be set out in the Integration Scheme – this is the formal agreement between NHS health board and the council in terms of how matters will work.

58. Specifically is must include details about:

- Governance and financial arrangements
- Strategic planning arrangements
- Local operational delivery arrangements
- Legal liabilities in each model
- Management of risk in each model

11 Technical Options Analysis

59. The technical options analysis was undertaken by a joint team of Council and NHS Lothian officers in June 2014 and drew on internal and external legal advice.

60. A number of items of clarification were sought from Scottish Government and, as a result of the process, Scottish Government have noted the need for Regulations to clarify a number of points with respect to Model d) in particular. The options analysis is written on the basis of the clarification received, rather than on the wider interpretation which is currently possible.

61. A summary of the key elements of each model is provided in Annex 5 and a view on the joint teams' view on the viability of each model is provided in Annex 6.

62. Detail of what happens in each model is provided in detail below along with a number of comments and observations about each.

Models for Integration Authority

Interpreted as would be applicable to Edinburgh and NHSL

(the references a), b) c) and d) refer to the legislation Section 1 (4).

Model A

Governance Model a) Body Corporate: The Integrated Joint Board is the Integration Authority.

What happens…

63. The Council and the NHS delegate the functions that MUST be delegated to an Integrated Joint Board (IJB), another legal body which is set up by Scottish Government. This body is established via the Integration Scheme. They can delegate functions that MAY be delegated such as children's services.

64. Once the IJB is established the Council and the NHS must delegated the associated resources, via payments, for these functions to the IJB. Where functions are related to hospital/acute setting the NHS must 'set aside' the associated funds for use by the IJB. The process for doing this and for the financial monitoring must be set out in the Integration Scheme.

65. The IJB is to carry out the functions delegated and has all the powers and duties that go along with the functions.

66. The IJB is wholly responsible for strategic planning and must prepare a Strategic (Commissioning) Plan (SCP) – see below. It then MUST instruct the council and the NHS to deliver these functions in line with this (SCP). It cannot instruct any other bodies to perform these functions, however this direction can be given to instruct the bodies to deliver the function jointly.

67. Current delivery responsibilities can be moved between NHSL and the Council and staff transfer and secondment is possible.

68. The IJB must set out how the funds available to it are to be used to meet these instructions by the constituent authorities who will perform the function operationally (the specified amount). The IJB may regulate the manner in which the function can be carried out. Where the funds for delivery are 'set aside' (for acute/hospital functions), the IJB may required the constituent authority to 'pay to it unused amounts'. If the health board requires to use more than the specified amount it may require the IJB to reimburse it for the additional amount used.

69. The IJB appoints a Chief Officer – who can be seconded from a constituent authority

70. The IJB is made up of :

- Voting members - the same number of representatives from the local authority (elected members) and health board (min 2 non-exec directors and 1 other health board member). A minimum of three and up to 10% of the full council number.
- Non-voting members (advisory) –must include minimum of
- A nominated health professional
- Chief Social Work Officer
- A staff-side rep
- A third sector rep
- A carer rep
- A service user rep
- The Chief Officer

71. Chair and Vice Chair must be one from each of local authority and health board and must rotate every three years. Chair has casting vote should it be needed.

72. The IJB is a separate legal entity responsible for governance, resourcing and planning of the functions delegated to it.

Strategic Plan

73. The IJB is responsible for preparing and approving the Strategic (Commissioning) Plan (SCP) which sets out the details of how the delegated functions are to be carried out, how they will meet the national outcomes, how funds are to be used/spent over a three year period in order to deliver on the national outcomes

and to shift the balance of care. The SCP must divide the local authority area into at least two localities and set out separately the arrangements for each locality.

74. The first SCP must be prepared before the integration start day- i.e. the day on which functions are delegated.

75. The IJB must establish a Strategic Planning Group (SPG) and it must include

- at least one person nominated by the Health Board;
- at least one person nominated by the Council; and
- other members as prescribed by Scottish Ministers, including locality representatives.

76. The IJB will be required to:

- Embed patients/clients and their carers in the decision-making process
- Treat third and independent sectors as key partners
- Involve GPs, other clinicians and social care professionals in all stages of planning work

77. The IJB must seek views from the SPG and take account of these views on the approach and each of two drafts, prior to the final version. It must also send a copy of the second draft to the health board and local authority, seeking their views. It must take account of their views in finalising the SCP.

78. The IJB must publish its SCP along with a statement of the action it took as a result of the views expressed on the second draft SCP.

79. If it appears to a constituent authority that the SCP is preventing or is likely to prevent it from carrying out any of its functions appropriately or from meeting integration planning principles/national outcomes the constituent authorities acting jointly, may direct the IJB to prepare a replacement SCP. The IJB must comply.

Performance Report

80. The IJB is accountable for delivery of the outcomes and must prepare a performance report for the reporting year (annual) to set out how it has planned and carried out the delegated functions. It must contain

- Progress to deliver national outcomes
- Performance against key indicators/measures
- How strategic planning and locality planning arrangements have contributed to delivering services
- Info on any review of the SCP

- Any major decisions taken out with the SCP
- An overview of the IJB financial performance
- The extent to which IJB has moved resources from institutional based to community based care and support, specifically the proportion of budget spent on each type of care and support
- A comparison with at least the preceding 5 years

81. The IJB must publish the report and provide a copy to the Health Board and Council.

82. Comments and Observations relating to the Council

- The IJB is a partnership body with decision-making powers. Councillors will have a vote on all decisions in a timely fashion
- The IJB jointly prepares the SCP and councillors will have stake in its development
- If the Council still does not consider the SCP is 'safe' to implement it can request, jointly with the NHS that a replacement be made
- The IJB jointly prepares the locality element of the SCP and councillors will have stake in this
- The IJB jointly prepares the Performance Report and councillors will have a stake in this.
- It is likely that the IJB will need to appoint a distinct Section 95 Officer to be operationally accountable for funds.
- The IJB does not employ anyone or own any assets
- The Council delegates its functions and resources to this third party for governance and planning purposes
- The Council must decide each year how much it will pay to the IJB and as the IJB receives funding from only the Council and NHS, the Council and NHS continue to carry the financial risk
- The Council must take instructions from the IJB on how to deliver adult social care functions (albeit from a body with 50% voting share) including how much to spend (by default this could be different from past spend)
- In practical terms the liabilities and risks associated with the Council's statutory obligations will remain with the Council

83. Comments and Observations relating to NHS Lothian

- The IJB is a partnership body with decision-making powers. NHS Board members will have a vote on all decisions in a timely fashion(as often as the IJB meets)
- The IJB jointly prepares the SCP and NHS Board will have stake in its development
- If the NHS still does not consider the SCP is 'safe' to implement it can request, jointly with the Council that a replacement be made
- The IJB jointly prepares the locality element of the SCP and NHS Board will have stake in this
- The IJB jointly prepares the Performance report and NHS Board will have a stake in this.
- The NHS delegates its functions and resources to a third party for governance and planning purposes
- The NHS must decide each year how much it will pay to the IJB for community and primary care functions and as the IJB receives funding from only the Council and NHS, the Council and NHS continue to carry the financial risk
- The NHS must work out how much it will set aside for Edinburgh for its acute/hospital based functions
- The IJB does not employ anyone or own any assets
- The NHS must take instructions from the IJB on how to deliver its community based functions (albeit from a body with 50% voting share) (by default this could be different from past spend)
- The NHS must take instruction from the IJB on how it is to deliver the portion of acute/hospital functions (albeit from a body with 50% voting share) (by default this could be different from past spend)
- In practical terms the liabilities and risks associated with the NHS statutory obligations will remain with NHS Lothian

84. The Joint Team considers Option a) as a viable model for Edinburgh.

Model B

Governance Model b) Council delegates to NHS – NHS Board is the Integration Authority or 'Lead Agency'.

What happens…

85. The Council delegates the functions that MUST be delegated to the NHS Board. It can also delegate functions that MAY be delegated.

86. The Council must delegate the associated resources, via payments, for these functions to the Health Board. The Health Board does not need to delegate its own functions as it is the integration authority (lead agency). The process for making annual payments by the Council to the NHS and for the financial monitoring must be set out in the Integration Scheme.

87. The health board, as the integration authority, MAY give direction to the local authority which prepared the integration scheme to carry out the functions delegated. The health board has all the powers and duties that go along with the functions delegated. In effect, the council hands over the powers, duties and funds for the functions and MAY be instructed to carry out the functions) (– equally it may not). The Health Board can instruct ANYONE to deliver the services.

88. Where the Council is instructed to carry out the function on behalf of the integration authority, the Health Board must specify to the local authority the funds /payments to carry out the function and how such an amount can be used.

89. Alternatively the council can transfer its staff to the health board such that the direction above is not required. (a range of additional elements of the Act apply)

90. There is no requirement for a Chief Officer.

91. An Integration Joint Monitoring Committee (IJMC) is established by the Integration Authority. Its purpose is:

    - for the monitoring the carrying out of the integration functions for the area of the local authority; and
    - to hold the body or bodies to whom functions are delegated to account for the delivery of integrated services.

92. It will provide assurances to the Council of the progress that is being made to achieve the national health and wellbeing outcomes. It can write reports and make recommendations to the lead agency, where it sees fit. It is key to providing scrutiny and accountability of the integrated arrangements.

    - Min of three councillors from the Council
    - Min of three NHS board members
    - A registered health professional from health board

- Chief Social Work Officer
- Health Board Director of Finance
- A staff-side rep from Health Board
- A third sector rep
- A carer rep
- A service user rep
- Other members as the IJMC sees fit.

93. Chair must be agreed jointly by the NHS and Council and can jointly change the chair person with one months notice in writing.
94. Additional members are permitted as the integration monitoring committee sees fit.
95. The IJMC is enabled to monitor these arrangements and can make reports/recommendations to the Integration Authority. The Health Board must have regard to these IJMC reports/recommendations and take any action it considers necessary. It must also provide a response to the IJMC. (There is nothing explicit in the Act which specifies that the integration authority must take account of the recommendations.)

Strategic Plan

96. NHS Lothian will prepare and approve the Strategic (Commissioning) Plan (SCP) which sets out the details of how the delegated functions are to be carried out, how they will meet the national outcomes, how funds are to be used/spent over a three year period in order to deliver on the national outcomes and to shift the balance of care. The SCP must divide the local authority area into at least two localities and set out separately the arrangements for each locality.
97. The first SCP must be prepared before the integration start day- i.e. the day on which functions are delegated by the Health Board.
98. The Health Board must establish a Strategic Planning Group (SPG) and it must include:
    - at least one person nominated by the Council; and
    - other members as prescribed by Scottish Ministers, including locality representatives.

99. The health board will be required to:
    - Embed patients/clients and their carers in the decision-making process

- Treat third and independent sectors as key partners
- Involve GPs, other clinicians and social care professionals in all stages of planning work

100. The Health Board prepares the SCP and must seek views from the SPG and take account of these views on the approach and each of two drafts, prior to the final version. It must also send a copy of the second draft to the Council, seeking its views. It must take account of their views in finalising the SCP.

101. The Health Board must publish its SCP along with a statement of the action it took as a result of the views expressed on the second draft SCP.

Performance Report

102. The Health Board must prepare a performance report for the reporting year (annual) to set out how it has planned and carried out the delegated functions. It must contain

- Progress to deliver national outcomes
- Performance against key indicators/measures
- How strategic planning and locality planning arrangements have contributed to delivering services
- Info on any review of the SCP
- Any major decisions taken out with the SCP
- An overview of the Int Auth (Health Board as lead agency) financial performance
- The extent to which Int Auth (Health Board as lead agency) has moved resources from institutional based to community based care and support, specifically the proportion of budget spent on each type of care and support
- A comparison with at least the preceding 5 years

103. The Health Board must publish the report and provide a copy to the Joint Monitoring committee and to the Council.

104. Comments and Observations relating to the Council

- Council can determine how much it wishes to spend on adult social care functions each year and delegates accordingly
- Council need only monitor performance annually and contribute to SCP once every three years

- The Council delegates its functions and resources to the NHS Board for governance and planning purposes - but will remain statutorily liable
- The Council must decide each year how much it will pay to the NHS Board and make a payment to the NHS. It may not be able to recoup any in year savings.
- The Council MAY be instructed by the NHS Board on delivery of adult social care functions and be given payments from the NHS (by default this could be different from past spend)
- The NHS need not give instruction to the Council to carry out the functions. (it is not clear whether this means another Local Authority could be instructed instead)
- Any future corporate decisions affecting the budget e.g. staff terms and condition changes would need to be negotiated with NHS in terms of the impact on budgets
- Council role in SCP becomes - handing over resources; being a nominated member of the SPG and a consultee in on the second draft
- There is no joint 'veto' on the lead agency SCP.
- Council role in Performance Report is that of a recipient of the annual report. The IJMC can make recommendations that the Health Board must consider, can take action it thinks necessary and respond. There is no legal requirement to action the recommendations as requested.
- There is no Council Finance officer required on the IJMC
- There is no Council staff side representative required on the IJMC
- If the Council become dissatisfied with performance then the only recourse is either a joint review of the integration Scheme, dispute resolution or Ministerial intervention
- This option allows for transfer of staff and if this were to be pursued would reduce the administrative burden on HR, payroll and other related functions in the medium –long term potentially allowing reductions in staffing in some corporate functions.
- Given that functions, powers, duties and payments must be delegated to the Integration Authority and that the Integration Authority need not instruct the Council to deliver the services operationally, it would be less risky for the Council to transfer/second its staff to NHS Lothian.
- Transfer of staff may bring a number of risk to the Council such as:
    - The potential loss of all adult social care skills and experience with which to monitor performance

    - Staff discontent and industrial action
- It is also likely that the Council would require NHS Lothian to indemnify it against all claims relating to its statutory obligations

105. Comments and Observations relating to NHS Lothian

- NHS Lothian becomes accountable for the delivery of the national health and wellbeing outcomes for Edinburgh
- NHS Lothian has governance and planning control over the 'whole system' of health and social care
- NHS Lothian need not delegate functions to another body
- NHS Lothian need not make payments for community and primary health care functions
- NHS Lothian need not 'set aside' amounts (funds) for acute/hospital functions
- NHS Lothian need not take instructions from a third party on how to deliver its functions
- NHS Lothian prepares the SCP
- NHS Lothian prepares the Performance Report
- NHS Lothian Board must develop knowledge and skills on governing and planning adult social care functions
- NHS Lothian would become liable for any financial shortfall within the agreed financial period, but the shortfall in subsequent periods will need to be jointly agreed
- NHS Lothian would need to indemnify the Council for any failure to meet statutory obligations
- This option allows for transfer/secondment of staff to NHS Lothian. Transfer of staff brings a number of risk to NHS Lothian e.g.
    - Potential costs of harmonising terms and conditions – specifically when the larger portion of staff may be on lesser pay levels (TBC)
    - Wider staff discontent and industrial action during transfer
    - An increased administrative burden for HR, payroll etc.

106. **Joint Team considers Option b) as a viable model.**

Model C

Governance Model c) NHS delegates to Council – Council is the Integration Authority or 'Lead Agency'.

What happens…

107. The NHS delegates the functions that MUST be delegated to the Council. It can choose to delegate its optional services.

108. The NHS must delegate the associated resources, via payments, for these functions to the Council. The Council does not need to delegate functions as it is the integration authority. The process for making annual payments by the health board (annual budget setting process) to the Council and for the financial monitoring must be set out in the Integration Scheme.

109. The Council, as the integration authority MAY give direction to the NHS which prepared the integration scheme to carry out the functions delegated and the Council has all the powers and duties that go along with the functions delegated. (The NHS hands over the powers and duties and MAY be instructed to carry out the functions) (– equally it may not). The Council can instruct ANYONE to deliver the services.

110. Where it is instructed to carry out the function on behalf of the Integration Authority the Council must specify to the NHS the funds /payments to carry out the function and how such an amount can be used.

111. Alternatively the health board can transfer its staff to the Council such that the direction above is not required.

112. There is no requirement for a chief officer.

113. An Integration Joint Monitoring Committee (IJMC) is established by the council and health board. Its purpose is:

- for the monitoring the carrying out of the integration functions for the area of the local authority; and
- to hold the body or bodies to whom functions are delegated to account for the delivery of integrated services.

114. It will provide assurances to the health board of the progress that is being made to achieve the national health and wellbeing outcomes. It can write reports and make recommendations to the lead agency, where it sees fit. It is key to providing scrutiny and accountability of the integrated arrangements.

- Min of three councillors from the Council
- Min of three NHS board members
- A registered health professional from health board
- Chief Social Work Officer

- Local Authority S95 Officer
- A staff-side rep from local authority
- A third sector rep
- A carer rep
- A service user rep
- Other members as the IJMC sees fit.

115. Chair must be agreed jointly by the NHS and Council and can jointly be changed with one months notice in writing.

116. Additional members are permitted as the integration monitoring committee sees fit.

117. The IJMC is enabled to monitor these arrangements (note make-up above), and can make reports/recommendations to the Integration Authority. The Health Board must have regard to these IJMC reports/recommendations and take any action it considers necessary. It must also provide a response to the IJMC. (There is nothing explicit in the Act which specifies that the integration authority must take account of the recommendations.)

Strategic Plan

118. The prepares and approves the Strategic (Commissioning) Plan (SCP) which sets out the details of how the delegated functions are to be carried out, how they will meet the national outcomes, how funds are to be used/spent over a three year period in order to deliver on the national outcomes and to shift the balance of care. The SCP must divide the local authority area into at least two localities and set out separately the arrangements for each locality.

119. The first SCP must be prepared before the integration start day- i.e. the day on which functions are delegated.

120. The Council must establish a Strategic Planning Group (SPG) and it must include:

- at least one person nominated by the Health Board; and
- other members as prescribed by Scottish Ministers, including locality representatives.

121. The Council will be required to:

- Embed patients/clients and their carers in the decision-making process
- Treat third and independent sectors as key partners

- Involve GPs, other clinicians and social care professionals in all stages of planning work

122. The Council prepares the SCP and must seek views from the SPG and take account of these views on the approach and each of two drafts, prior to the final version. It must also send a copy of the second draft to the Health Board, seeking its views. It must take account of their views in finalising the SCP.

123. The Council must publish its SCP along with a statement of the action it took as a result of the views expressed on the second draft SCP.

Performance Report

124. The Council must prepare a performance report for the reporting year (annual) to set out how it has planned and carried out the delegated functions. It must contain

- Progress to deliver national outcomes
- Performance against key indicators/measures
- How strategic planning and locality planning arrangements have contributed to delivering services
- Info on any review of the SCP
- Any major decisions taken out with the SCP
- An overview of the Int Auth (Council as lead agency) financial performance
- The extent to which Int Auth (Council as lead agency) has moved resources from institutional based to community based care and support, specifically the proportion of budget spent on each type of care and support
- A comparison with at least the preceding 5 years

125. The Council must publish the report and provide a copy to the Joint Monitoring committee and to the Health Board

126. Comments and Observations relating to the Council

- The Council becomes accountable for the delivery of the national health and wellbeing outcomes for Edinburgh
- The Council has governance and planning control over the 'whole system' of health and social care
- The Council need not delegate functions to another body
- The Council need not make payments for adult social care functions

- The Council need not take instructions from a third party on how to deliver its functions
- The Council prepares the SCP
- The Council prepares the Performance Report
- The NHS must take direction from the Council on the use of set aside funds. If the NHS requires more than the amount directed the NHS may require the Council to reimburse it for the additional amount.
- The Council must develop knowledge and skills on governing and planning community and primary care functions as well as on a number of acute/hospital based health care functions
- This option allows for transfer of staff to the Council. Transfer of staff brings a number of risk to the Council e.g.
    - Potential costs of harmonising terms and conditions – specifically when the larger portion of staff may be on lesser pay levels (TBC)
    - Wider staff discontent and industrial action during transfer
    - An increased administrative burden for HR, payroll etc
- The Council would become liable for any financial shortfall within the agreed financial period, but the shortfall in subsequent periods will need to be jointly agreed
- It is also likely that the Council would need to indemnify NHS Lothian against all claims relating to its statutory obligations

127. Comments and Observations relating to NHS Lothian

- NHS can determine how much it wishes to spend on community / primary functions each year and delegates accordingly;
- NHS need only monitor performance annually and contribute to SCP once every three years;
- This option allows for transfer/secondment of staff and if this were to be pursued could reduce the administrative burden on HR, payroll and other related functions in the medium –long term potentially allowing reductions in staffing in some corporate functions.
- The NHS delegates its functions and resources to the Council for governance and planning purposes- but will remain liable for its statutory obligations.

- The NHS must decide each year how much it will pay to the Council and make a payment to the Council. It may not be able to recoup any in year savings.
- NHS Lothian must determine the amounts to be set aside for 'acute/ hospital functions and ensure these are transparent for the Council
- The Council need not give instruction to the NHS to carry out the functions.
- NHS Lothian must take instructions from the Council, if given, on how to deliver health care functions and take payments made (by default this could be different from past spend)
- NHS Lothian must take direction from the Council, if given, on the use of set aside funds. If the NHS does not use all of the Council may require it to pay the unused amount back. If it requires more it may require the Council to reimburse it
- Given that functions, powers, duties and payments must be delegated to the Integration Authority and that the Integration Authority need not instruct NHS Lothian to deliver the services operationally, it is possible that NHS Lothian would wish to transfer/second its staff to the Council.
- It is also likely that NHS Lothian would require the Council to indemnify it against all claims relating to its statutory obligations.
- Any future corporate decisions affecting the budget e.g. staff terms and condition changes would need to be negotiated with Council in terms of the impact on budgets
- NHS Lothian role in SCP becomes - handing over resources; being a nominated member of the SPG and a consultee in on the second draft
- There is no joint 'veto' on the lead agency SCP.
- NHS Lothian role in Performance Report is that of a recipient of the annual report. The IJMC can make recommendations that the Council must consider, can take action it thinks necessary and respond. There is no legal requirement to action these recommendations as requested.
- There is no NHS Board Finance officer required on the IJMC
- There is no NHS staff side representative required on the IJMC
- If NHS Lothian become dissatisfied with performance then the only recourse is either a joint review of the integration Scheme, dispute resolution or Ministerial intervention
- The delegation of functions and resources which are currently planned for and delivered on a regional scale, to a more local Integration Authority is likely to be very challenging.

- Furthermore, planning at such a local level brings a potential risk to introduce a degradation of services across geographical boundaries. This option allows for transfer/secondment of staff to Council. Transfer of staff brings a number of risk to the NHS e.g.
    - The potential loss of all community /primary are skills and experience with which to monitor performance
    - Staff discontent and industrial action

128. The joint team do not believe Option c) is a viable option due to the potential degradation of services across geographical boundaries.

Model D

Governance Model d) Council delegates to NHS AND NHS delegates to Council. NHS is the Integration Authority for some functions and the Council is the Integration Authority for some functions.

What happens…

129. Advice from Scottish Government confirms that groups of services for adults or for children's services must be kept together which means that either the health board or the council must delegate all its adult services to the other. i.e. Model b) or c).

130. Children's services are optional services for delegation and as such a Model d) would only exist if the Council or NHS delegated the optional Children's services in the opposite direction, such as is the case in Highland.

131. Given that the delegation of adult health care services to the Council (model C) is not considered to be a viable option the only way Model d) could work in Edinburgh would be:

- The Council delegates its adult social care services to NHS Lothian (Model b) AND
- NHS Lothian delegates its optional children's services to the Council (Model c)

132. The result is that Edinburgh would have two Integration Authorities, both lead agency models, one for adult services and one for children's services.

133. An Integration Joint Monitoring Committee (IJMC) is established by the council and health board. Its purpose is:

- for the monitoring the carrying out of the integration functions for the area of the local authority; and
- to hold the body or bodies to whom functions are delegated to account for the delivery of integrated services.

134. It will provide assurances to the health board and council (as appropriate) of the progress that is being made to achieve the national health and wellbeing outcomes. It can write reports and make recommendations to the lead agency, where it sees fit. It is key to providing scrutiny and accountability of the integrated arrangements.

- Min of three councillors from the Council
- Min of three NHS board members
- A registered health professional from health board
- Chief Social Work Officer

- Health Board Director of Finance
- S 95 Officer
- A staff-side rep from Health Board
- A staff side rep from the Council
- A third sector rep
- A carer rep
- A service user rep
- Other members as the IJMC sees fit.

135. Chair must be agreed jointly by the NHS and Council and can jointly change the chair person with one months notice in writing.

136. Additional members are permitted as the integration monitoring committee sees fit.

137. The IJMC is enabled to monitor these arrangements (note make-up above), and can make reports/recommendations to the Integration Authority. The Health Board and Council must have regard to these IJMC reports/recommendations and take any action it considers necessary. They must also provide a response to the IJMC. (There is nothing explicit in the Act which specifies that the integration authority must take account of the recommendations.)

Strategic Plan

138. It is likely that two Strategic Plans would be required, one for adult services and one for children's services with each lead agency taking being responsible for preparing and approving the relevant plan. It is possible that the mechanism for developing the strategic plan could be streamlined, e.g. one Strategic Planning Group, but this will need to be agreed.

139. The Council and the Health Board must seek views from the SPG(s) and take account of these views on the approach and each of two drafts, prior to the final version. (The Act is not clear whether a copy of the SCP(s) must then be sent to each constituent authority). It must take account of the views in finalising the SCP.

140. The Council and the Health Board must publish its SCP(s) along with a statement of the action it took as a result of the views expressed on the second draft SCP.

Performance Report

141. Each Integration Authority must prepare a performance report for the functions delegated to them for the reporting year (annual) to set out how it has planned and carried out the relevant functions delegated to it. It is possible that the process for this could be streamlined.

142. Comments and Observations

- The comments would apply from Models b) and c) dependent on the direction of delegation of which functions to whom.
- If adult social care functions are delegated to NHS board and children's health services are delegated to the Council then the relevant comments apply as follows:
    - Adult social care delegated to NHS – Model B
    - Children's services delegated to Council – Model C
- The IJMC would be a more balanced and a more joint committee.
- It would still have an assurance role rather than a decision-making role.

143. The issue of scale of relevant services would need to be considered. Adult Social care = £189million. Children's health care services – c £5-10million.

144. **The joint team does not believe that Option d) offers any more advantages than Option b) in Edinburgh, therefore the team recommends that this option is not pursued.**

12 Strategic Options Analysis

145. As well as a technical analysis, consideration must also be given to how the models could best achieve the national health and wellbeing outcomes (Annex 2) and the requirements of the integration planning principles (Annex 3).

146. This section examines Model a) Integrated Joint Board and Model b) NHS as lead agency against the national outcomes and integration planning principles.

147. When considering national health and wellbeing outcomes the key benefits expected by Scottish Government across the whole system (outlined in the Policy and Financial Memoranda to the Public Bodies Bill) include:

- ***Avoiding unnecessary admissions to hospital***
- ***Reducing delayed discharge into the community***
- ***Shifting the balance of health care to community-based setting***
- ***Providing person-centred health and social care***
- ***Ensuring consistency of provision***
- ***Providing local responsiveness of provision***

148. To deliver on these, the Integration Authority must fund, plan for and instruct delivery of:

- New / improved health care solutions in the community;
- New improved social care solutions in the community;
- New/ improved home-based health and care solutions;
- A redirection of budgets across whole pathways;
- A rebalancing of budgets to community health and care;
- Supported self management for health and care;
- Local area responsiveness; and
- Safe and effective service re-design.

149. The key challenges within the planning principles mean that the Integration Authority must also :

- improve the wellbeing of service users (note it does not reference health or social care, but the overall wellbeing of people)
- include the participation of service users
- ensure services are planned and led locally in a way which is engaged with the community(including in particular service users, those who look after service users and those involved in the provision of health or social care)

150. The key mechanism to do all of this is via the Strategic Plan and associated processes of engagement and consultation. This mechanism exists within both Model a) and b) and the 'devil is in the detail' of this.

151. The 'devil' is in the need to:

- Be innovative in re-design of services and re-balance these towards the community;
- Ensure we take efficient and effective decisions for the whole system;
- Address the historic 'siloed' approaches to planning and service re-design of services.
- Listen and be responsive to individuals, practitioners and communities; and
- Redistribute resources from institutional settings to community-based settings.

152. Given that both the Council and NHS have different strengths in each of these areas and that we cannot have two Strategic Plans – one from a IJB and one from the NHS as lead agency - and then choose the 'best', it is not possible to objectively assess which model can best deliver on the outcomes.

153. It is only possible to pose some key questions and make a judgement based on our organisational history, values, background and beliefs as follows:

Key Questions

154. Question 1: Do the Council believe that there is a greater likelihood of meeting the challenges in paragraphs 148, 149, 150 and 152 through a Strategic Plan which is prepared, approved and funded by a joint body approach?

155. It is possible that Model a) will allow a greater level of debate and challenge which could encourage more innovative service redesign, redistribution and resources, tackle organisational inertia, ensure responsiveness to individuals, practitioners and communities in a way which would not be possible in the continuing practice of one existing organisation.

156. The NHS has had for a number of years the power to transfer resources to community-based functions. However, as was evidenced in early sections of this report, the progress on this across the whole of Scotland has been slow. While it is possible that a single organisation could be more likely to 'obey 'instructions from an existing board rather than from a new partnership board and could adapt more readily to those instructions, it is open to debate, given past history, whether the shift in the balance of resources would progress faster with an NHS Board alone in charge of both institutional and community based care.

157. If the answer is YES to the question in paragraph 154 then the choice is Model a) Integrated Joint Board. If the answer is NO and the view is that the NHS as a single agency could have more chance of meeting the challenges alone then the choice is Model b) NHS as lead agency.

158. Question 2: Does the Council want to continue to be involved in making decisions about the ongoing planning and functioning of health and social care functions in Edinburgh?

159. The Council has had a long standing role in planning for the social care needs of its population and delivering services to meet these needs. Delegation to the NHS (Model b) would relinquish the governance and planning role and would more than likely remove its delivery element (via staff transfer to minimise risk and liabilities). The Council role in relation to adult social care would become one which encompasses funding and scrutiny of delivery.

160. If the answer is YES to the question in paragraph 158 then the choice is Model a) Integrated Joint Board. If the answer is NO then NHS as a single agency would be the choice.

161. **Question 3: Does the Council believe that local democratic accountability is important to the process of governing, planning and funding of services for the population of Edinburgh?**

162. The advantages of this relate to the fact that council members of the Integration Joint Board will be directly elected by the population of Edinburgh and accountable to them. A disadvantage could be viewed as the perceived bureaucracy that the inclusion of elected members could create. However this is mitigated by the fact that the Integration Authority receives all powers and duties associated with the delegated functions and as such there is no need for duplicate reporting/approval. The NHS Lead Agency model brings with it national level democratic accountability through the Minister to Parliament and local democratic input through two Councillors on the NHS Board.

163. If the answer is YES to the question in paragraph 161, then the choice is Model a) Integrated Joint Board. If the answer is NO then Model b) NHS lead Agency remains on the table.

164. Question 4: Does the Council wish to hand over, in a single arrangement, all of its social care staff and potentially a proportion of its corporate staff to the NHS and in so doing does it believe this will deliver the challenges identified in paragraphs ?

165. It is possible that this arrangement would mean more effective and efficient implementation of decisions in the long run, however this is not guaranteed an d the short term consequences of this would need careful handling. Some transfer may still occur under Model a) but this would be on a case by case basis in line with the Strategic Plan (effectively a business case to justify any transfer)

166. If the answer to this is NO, to the question in paragraph 161 then the choice is Model a). If the answer is YES then Model b) remains on the table.

167. Questions 5: Does the Council believe that NHS as lead agency would be a faster, more efficient governance and implementation model than a joint arrangement?

168. The assumption would be that one existing board which encompasses funding, planning and implementation could be more responsive than an IJB with a chief officer who instructs one or both of the existing organisations to deliver. Given the clear role of the Chief Officer, if the Strategic Plan specifies requirements well enough and the process of giving direction is also clear, AND both organisations follow these instructions in the spirit with which they are intended then there should be no reason for a slower response to an IJB matter.

169. Furthermore, the NHS Board will have a range of national, regional and ‘planned’ health services to plan for and deliver, whereas an IJB can focus on its

attention on the ‘unplanned’ health and community-based functions which are currently causing the most concern to Scottish Government.

170. If the answer is YES to the question in paragraph 164 then the choice is Model b) NHS as lead agency. If the answer is NO then an Integrated Joint Board remains a viable option.

171. Question 6: Does the Council believe that engagement with individuals, practitioners, clinicians and communities can be best achieved through a joint approach or through a single lead agency approach?

172. Both the Council and the NHS have a range of different practices and practical experiences for engaging with individuals, professionals, clinicians, service users and wider communities. Currently, all these approaches are drawn on for planning and developing services. There is a risk that delegation in Model b) single agency may lead to a focus on NHS existing approaches only without a concerted requirement to continue to build on the best of both approaches, possibly through performance measures. Model a) could ensure consideration of the approaches used by both partners in a more balanced way drawing on the best of both worlds.

173. Question 7: Does one model fit more closely with the Council’s organisational values:

- Which model allows the Council to put the ‘customer first’?
    - By remaining involved in decision-making and planning through Model a), the Council can ensure that the customers of health and social care services remains at the centre of what is happening at all decision-making points. In Model b) the Council would ensure the customer is put first through the performance measures set for the NHS in relation to delegated functions and funds and could scrutinise this, after the fact, and make recommendations through the Integrated Joint Monitoring Committee.
- Which model is the most ‘honest and transparent’?
    - By remaining involved in decision-making and approval of the Strategic Plan through Model a) the Council can ensure ongoing challenge. Furthermore, local democratic accountability will remain a part of governance and planning of services into the future as a number of elected members will remain fully accountable for the delegated functions within the IJB. In Model b) the Council will ensure transparency through the arrangements established for the delegation of functions and liabilities and via the Integrated Joint Monitoring Committee.
- Which model allows us to best deliver on ‘working together’

- By remaining involved in decision-making and approval of the Strategic Plan through Model a) the council continues to work together in a partnership with the NHS. In model b) the Council will adopt a more contractual approach by delegating and paying for the functions to be delivered and will scrutinise delivery via the Integrated joint Monitoring Committee.

- Which model is the most 'forward thinking'?
  - It could be argued that Model b), full delegation of functions and funds and ultimately staff, is the most forward thinking. However given the points above, there is no guarantee that the NHS will be any more forward thinking than is currently the case and that a true partnership may stimulate more ideas and debate than may be possible in the single agency NHS Board.

174. The choice of Model a) or b) depends entirely on the balance of views across the points above.

175. A summary of the questions and comments above is outlined in Annex 7.

176. If the responses to the questions posed lie mostly in Column A – the preferred Model will be Model a) integrated Joint Board.

177. If the responses to the questions posed lie mostly in Colum B – the preferred response will be Model b) NHSL as lead agency.

13 Matters which are not relevant

178. Matters of administrative convenience for constituent bodies are, from a Scottish Government policy perspective, not relevant to the options analysis.

179. Furthermore, operational management can be determined locally irrespective of which model is chosen so should not be a specific consideration in the governance model.

14 Recommendations

180. It is assumed that:

- the Council will wishes to remain involved in decision-making and planning;
- the Council will consider local democracy as important in ongoing planning and delivery of health and social care;

- a joint approach to strategic planning would be better than a single agency approach from the perspective of range of experience available to draw on; and
- a joint approach to engagement with people would be preferred as it minimises the risk of losing the range of methods and experience currently available.

181. The Model a) Integrated Joint Board also aligns more closely with current Council values than does Model b).

182. The remaining factor of efficient and speedy decision-making and implementation will come down to the clarity specified within the Strategic Plan and the willingness and transparency with which constituent authorities respond to the instructions from the IJB via the Chief Officer.

183. Based on the assumptions above it is recommended that the Council's preferred model of governance for Edinburgh's Integration Authority is Model a) the Integrated Joint Board.

15 Conclusion

184. This report has provided:

- background to the options available under the Public Bodies Joint Working Scotland Act;
- a technical analysis of the options in terms of what each means and how it will work with the pros and cons for each;
- identification of two technically viable options for Edinburgh – Model a) Integrated Joint Board and Model b) NHS as lead agency;
- an acknowledgement that both models can deliver on the national outcomes and integration planning principles and each model must demonstrate how it will do that through its Strategic Plan but that it is currently impossible to determine which can best deliver on these;
- A number of key strategic criteria against which to assess the two technically viable options and associated commentary;
- A recommendation for the preferred option: Model a) Integrated Joint Board.

Annex 1

Audit Scotland Review of Community Health Partnerships 2011– Extract

Key Messages

- CHPs were set a challenging agenda, however responsibiliti3es did not come with the necessary authority to implement the significant changes requri3ed
- CHPs were in addition to existing health and social care arrangements and contributed to duplication and lack of clarity
- Partnership working in health and social care is complex and challenging, differences in cultures, planning and financial management are barriers that need to be overcome.
- There are very few examples of good joint planning underpinned by comprehensive understanding of the shared resources.
- Enhancing preventative services and moving resources across the whole system requires effective joint working. Limited progress has been made

Key Recommendations

Scottish Government should

- Update and consolidate guidance on joint planning and resourcing for health and social care. This should cover the use of funding, staff and assets to support NHS boards and councils develop strategies for joining up resources across the whole system…
- Streamline existing partnership arrangements…
- Put in place transparent governance and accountability arrangements for CHPs…
- Have a clear joint strategy for delivering health and social care services
- Clearly define objectives for measuring CHP performance…
- Collect monitor and report data on costs, staff and activity levels to help inform decisions on how resources can be used more effectively….
- Improve CHP financial management and reporting information to ensure that financial reports are regularly considered by the CHP, NHS board and appropriate council committees.
- Involve GPs in the planning of services for the local population.

Full report can be found at

http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf

Annex 2 - Integration: Outcomes, Indicators and Health & Care Survey Questions

The Health & Care experience Survey questionnaire : http://www.scotland.gov.uk/Resource/0043/00438630.pdf will be the key data source for several of the **proposed** indicators.
Data on health and social care indicators referenced in the table can be found here:
http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/Data/CareData

Outcome	Possible Indicator(s)	Source
1. **Healthier living** *Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.*	*% of people who say they are able to look after their health very well or quite well*	Health & Care Experience Survey Q52. Due June 14
2. Independent living *People, including those with disabilities, long term conditions or who become frail, are supported to live as independently as possible in the community.*	*% of people receiving any care or support who agree that they are supported to live as independently as possible*	Health & Care Experience Survey Q36 Due June 14
	% people receiving personal care at home rather than in a care home or hospital	ISD. Health and social care indicators - table 7
	Rate of emergency admissions to hospital for people aged 75+ or aged 65+	ISD Health and social care indicators - table 3 (select relevant age group)

Outcome	Possible Indicator(s)	Source
3. Positive experiences and outcomes *People have positive experiences of health and social care services and support they use, which encompass their needs and preferences and empower them to maintain or improve their quality of life.*	*% of people receiving any care or support who rate it as excellent or good*	Health & Care Experience Survey Q37 Due June 14
	% of people receiving care and support who say that people took account of what mattered to them	Health & Care Experience Survey Q36 Due June 14
	% who agree that their care and support services had an impact in improving or maintaining their quality of life	Health & Care Experience Survey Q36 Due June 14
	Delayed discharge bed days	Source: ISD http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/
4. Health and Social care services are centred on helping to maintain or improve the quality of life of service users	*TBC- included in regulations for consultation*	
5. Health and Social care services contribute to reducing health inequalities	*TBC- included in regulations for consultation*	

Outcome	Possible Indicator(s)	Source
6. Carers are supported *People who provide unpaid care to others are supported and able to maintain their own health and wellbeing including by having a life alongside caring.*	*% of carers who feel supported to continue in their caring role*	Health & Care Experience Survey Q45 Due June 14
	% of carers who agree that they have a good balance between caring and other things in their life	Health & Care Experience Survey Q45 Due June 14
	Mental wellbeing of carers	Indicator not developed but could potentially be developed from combined Scottish Surveys core questions
	Self-assessed health of carers	Indicator not developed but could potentially be developed from combined Scottish Surveys core questions or combined data from Health & Care Experience Survey Q44 and Q49
	% of carers who say caring has had a negative impact on their health and wellbeing	Health & Care Experience Survey Q45 Due June 14
7. People are safe *People using health, social care and support services are safe-guarded from harm and have their dignity and human rights respected.*	*% of people receiving care and support who agree that they felt safe*	Health & Care Experience Survey Q37 Due June 14
	% of people receiving care and support who agree that they were treated with respect	Health & Care Experience Survey Q37 Due June 14

Outcome	Indicator(s)	Health & Care Survey Question(s)
8. Engaged workforce *People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.*	*% of staff survey respondents who would recommend their organisation as a good place to work* *Or* *% of staff survey respondents who say they feel supported to do their job as well as possible*	Source: Staff surveys and ISD *TBC* *The actual question to be used is to be determined. Staff surveys for NHS and Local Authorities would be expected to include the agreed question and submit centrally. Work ongoing to develop this.*
9. Effective resource use *The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.*	*Balance of spend across institutional and community settings*	ISD/ SG IRF data (under development?)
	% of last 6 months of life spent outside acute hospital	Source ISD/ SG
	Delayed discharge bed days	Source: ISD http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/

Annex 3: Integration Planning Principles

Take from Public Bodies Act (Section 4 (1))

a) The main purpose of services which are provided in pursuance of the integration functions is to improve the wellbeing of service users,
b) That, in so far as consistent with the main purpose, those services should be provided in a way which , so far are possible
    i. Is integrated from the point of view of service users
    ii. Takes account of the particular needs of different service users
    iii. Takes account of the particular needs of service users in different parts of the area,…
    iv. Takes account of the particular characteristics and circumstances of different service users
    v. Respects the rights of service users
    vi. Takes account of the dignity of service users
    vii. Takes account of the participation by service users in the community in which service-users live
    viii. Protects and improves the safety of service users
    ix. Improves the quality of services
    x. Is planned and led locally in a way which is engaged with the community(including in particular service users, those who look after service users and those involved in the provision of health or social care
    xi. Better anticipates needs and prevents them arising
    xii. Makes the best use of available facilities, people and other resources.

Annex 4: Scope of Functions to be delegated

Scope of Local Authority Functions:

Social Work services for Adults and older people
Services and support for adults with physical disabilities, learning disabilities
Mental health services
Drug and Alcohol services
Adult protection and domestic abuse
Carers support services
Community cre assessment teams
Support services
Care at Home services
Adult placement services
Health Improvement services
Housing support services, aids and adaptations
Day services
Local area coordination
Respite provision
Occupational therapy services
Re-ablement services, equipment and telecare.

Scope of Health Board Services:

Unplanned inpatient services (in hospital)
Outpatients – accident and emergency (in hospital)
Care of older people (geriatric medicine) (in hospital)
District Nursing
Health visiting
Clinical Psychology (including those in hospitals)
Community Mental Health Teams
Community Learning Difficulties Team
Addictions Services (incl those in hospitals)
Women's health Services (including family planning) (incl those in hospitals)
Allied Health Professional services (incl those in hospitals)
GP Out of Hours services ((incl those in hospitals)
Public health dental Services (incl those in hospitals)
Continence Services
Home Dialysis
Health promotion
General medical Services (GMS) (General practice)
Pharmaceutical services (GP prescribing)

Annex 5: Summary of key elements of the Models

MODEL	A	B	C	D
New decision making body created	✔	x	x	x
Integration Authority	Integration Joint Board	NHS	CEC	NHS, CEC
Scrutiny Function JMC	Optional	✔	✔	✔
Staff Transfer/Secondment possible	✔	✔	✔	✔
Who MUST be instructed to carry out a function?	NHS or CEC or both together	No restrictions	No restrictions	No restrictions
In period financial risk	NHS & CEC	NHS	CEC	CEC, NHS
Approval of Strategic Plan	Integration Joint Board	NHS	CEC	CEC, NHS
Operational Risk (e.g. clinical)	NHS, CEC	NHS	CEC, NHS	NHS, CEC
Reputational Risk	Integration Joint Board, CEC, NHS	CEC, NHS	CEC, NHS	CEC, NHS
Professional Regulation/Registration	Remains with original organisation	Remains with original organisation	Remains with original organisation	Remains with original organisation

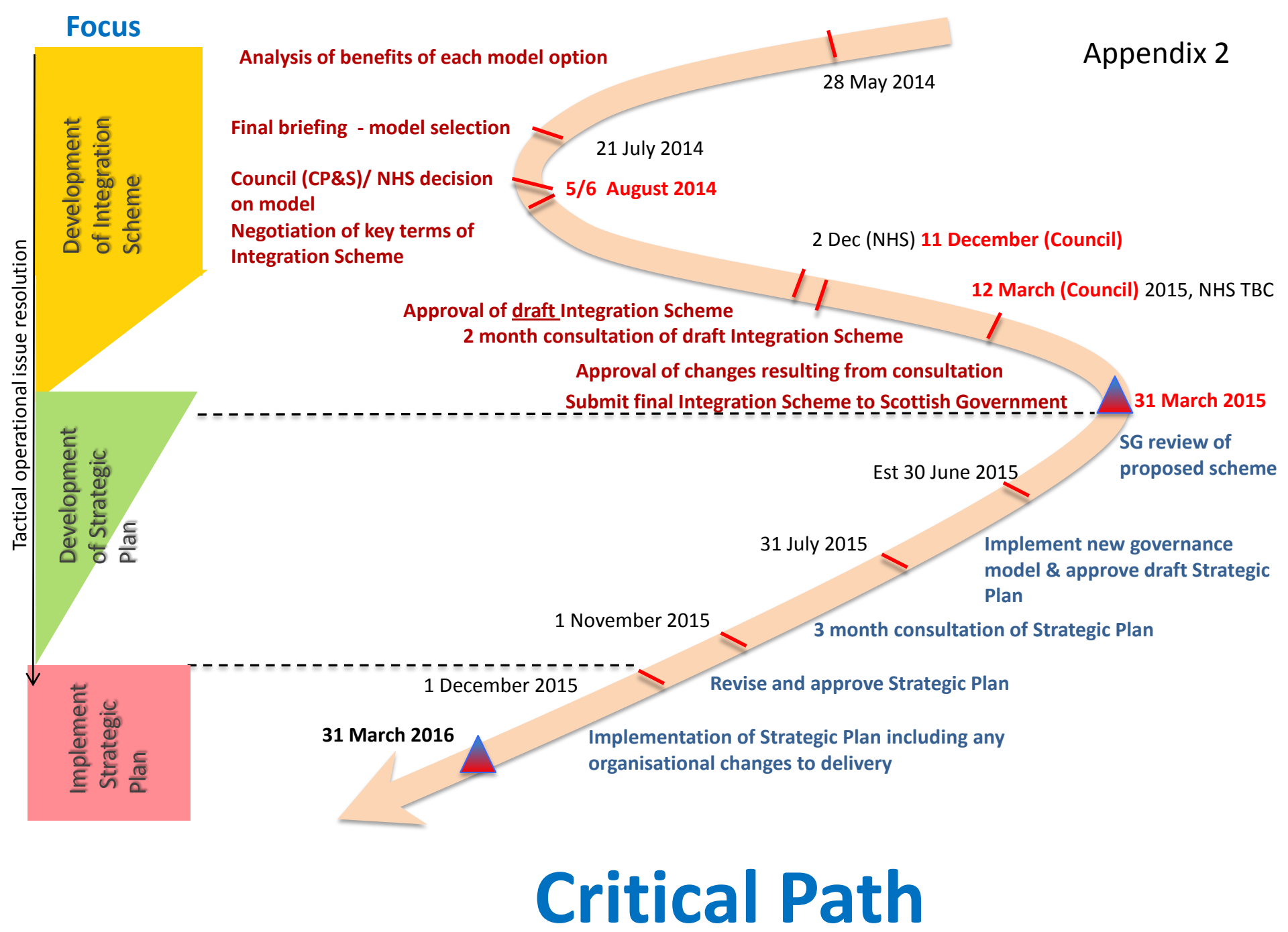
Annex 6: Joint Team View on Viability of each Model

Model	
A	This is the only option that both creates a single decision making body and therefore simplifies the process and allows both organisations to remain involved. In the team's opinion there would still need to be consideration of transfer/secondment of staff. **The team believes that this is a viable option.**
B	This creates a single decision making body and therefore simplifies the process but only the NHS has control of the planning process and associate allocation of resources. In the team's opinion option B is only viable if agreement can be reached on the transfer of staff and liabilities to NHS. **The team believes that this is a viable option.**
C	In effect NHS would remain liable for functions but would have no control over planning and delivery of services. As NHS serves more than Edinburgh it would be extremely difficult to disaggregate those services. It has the potential to introduce degradation of services across geographical boundaries. **The team do not believe this is a viable option in Edinburgh.**
D	Following on from our points on model C, in practice this can only be a large model B and a small model C. C still has a potential risk of degradation of services. **The team does not believe that this model offers any more advantages than B in Edinburgh; therefore the team recommends that this option is not pursued.**

Annex 7: Strategic Considerations

	Questions	Model A - IJB	Model B – NHS Lead Agency
1	Best Strategic Plan?	Jointly prepared and approved	NHS prepared and approved
2	Council wants involvement?	Decision-making	Fund and scrutinise (with no actual power)
3	Democratic accountability	Local and Parliamentary	Parliamentary.
4	Efficient speedy decision making and implementation?	View that this would be 'slower' - but not if there is a clear Strategic Plan and NHS/LA adhere to Chief Officer instructions	View that this would be 'faster'?? NHS deciding and adhering to its own instructions
5	Best engagement with communities?	Council and NHS expertise in community engagement	NHS led : risk of losing council connection without concerted effort through CPP process
6	Transfer of Staff?	Potentially on a case by case basis	Likely transfer of Adult Social Care Staff to NHS
7	Alignment with Council values?	Strongly aligned	Less strongly aligned

Appendix 2



Critical Path

Appendix 3: Notes

Appendixn 3a) CEC-H&SC Budget- Net £203m

All figures in the H&SC budget MUST be delegated as per the regulations apart from Criminal Justice. CJ services MAY be delegated as per the regulations.

The H&SC budget whilst including some aids and adaptations budgets (e.g. Telecare) does not include the budget for other Housing Support services that MUST be delegated as per the draft regulations (e.g. gardening). These budgets are held within other CEC departments and are to be determined.

Children's services MAY also be delegated as per the regulations and this budget is not included in the analysis.

Appendix 3b) Edinburgh-CHP Budget- £285m

The analysis provided by NHS Lothian contains budget for Children's services. Children's services MAY be delegated as per the regulations. The adult elements of the budgets MUST be delegated.

Further to this budget for regional and national services is also included. This MAY NOT be delegated as per the regulations.

The Notional budget for large hospital services relating to the Edinburgh Partnership is to be determined and is not included in the analysis.

The budget analysis contains the full budget for Hosted services provided by Edinburgh CHP on behalf of all Lothian CHPs. These services will be run by one partnership but used by all Lothian partnerships, for planning and commissioning purposes these budgets need to be disaggregated across Lothian and allocated proportionately to each Partnership.

Appendix 3a - Council Approved Budget - Health and Social Care Service - for 2014-15

	2014- 15 approved budget		
	Gross Budget £000's	Income Budget £000's	Net Budget £000's
S5100: OP INTERNAL CARE HOMES	23,413	-7,572	15,840
S5101: OP INTERNAL HOME CARE & REABLEMENT	24,457	-324	24,133
S5102: OP INTERNAL DAY CARE	1,850	-188	1,661
S5103: OP EXTERNAL PURCHASING	65,016	-9,055	55,960
S5104: OP OTHER SERVICES	7,023	-1,086	5,936
(change fund, capacity plan, emergency homecare, EMC step down, P&C OP)			
S5010: OLDER PEOPLE SERVICES	121,758	-18,226	103,532
S5110: DISABILITIES INTERNAL RESIDENTIAL	1,958	-126	1,831
S5111: DISABILITIES INTERNAL CARE & SUPPORT	7,868	-101	7,767
S5112: DISABILITIES INTERNAL DAY CARE	3,768	-88	3,679
S5113: DISABILITES EXTERNAL PURCHASING	56,491	-2,356	54,135
S5114: DISABILITIES COMMUNITY EQUIPMENT SERVICE	3,334	-1,930	1,404
S5115: DISABILITIES OTHER SERVICES	9,006	-144	8,862
(transition team, day services, OT teams, shared lives, LAC, P&C disabilities, FIT)			
S5011: DISABILITY SERVICES	82,424	-4,745	77,679
S5120: GENERIC SECTOR PRACTICE TEAMS INC SOCIAL CARE DIRECT	7,784	-287	7,496
S5121: SPECIALIST TEAMS	4,203	-372	3,831
MH north and south teams, adult protection team, Royal Infirmary and WGH teams			
S5122: EMERGENCY SOCIAL WORK SERVICES	957	-291	666
S5012: ASSESSMENT & CARE MANAGEMENT INC WELFARE RIGHTS	12,943	-950	11,993
S5013: BUSINESS SERVICES	5,283	-266	5,018
S5020: DIRECTORATE	687	-60	627
S5021: STRATEGIC FUNDING & DEPARTMENTAL COSTS	5,225	-22,327	-17,102
S5140: MENTAL HEALTH INTERNAL CARE & SUPPORT	772	-35	737
S5141: MENTAL HEALTH INTERNAL DAY CARE	42	0	42
S5142: MENTAL HEALTH EXTERNAL PURCHASING	9,368	-471	8,897
S5143: MENTAL HEALTH OTHER SERVICES	800	-65	735
(P&C MH, REH- CRT & ABI)			
S5030: MENTAL HEALTH	10,983	-572	10,411
S5150: CRIMINAL JUSTICE CEC-CONTRACTED 27	7,807	-9,705	-1,898
S5151: CRIMINAL JUSTICE CJ-NON SECTION 27 INC PRISON CONTRACT	992	-859	133
S5152: CRIMINAL JUSTICE L&B CJA SECTION 27	0	0	0
S5031: CRIMINAL JUSTICE	8,799	-10,564	-1,765
S5160: SUBSTANCE MISUSE	4,714	-3,334	1,379
S5161: AIDS/HIV	2,009	-232	1,778
S5162: VULNERABLE/HOMELESS SERVICES	1,162	-11	1,150
S5032: SUBSTANCE MISUSE, AIDS/HIV, VULNERABLE GROUPS	7,884	-3,577	4,307
S5033: QUALITY & STANDARDS	2,793	-176	2,617
S5034: STRATEGIC POLICY & PERFORMANCE & CONTRACTS MANAGEMENT	4,082	-40	4,042
S5180: SOCIAL STRATEGY HISG	1,758	-84	1,674
S5181: SOCIAL STRATEGY SOCIAL JUSTICE FUND	294	0	294
S5182: SOCIAL STRATEGY COMMISSIONING STRATEGY SOCIAL EXC PROJECT	18	-1	17
S5035: SOCIAL STRATEGY	2,070	-85	1,985
Grand Total	264,931	-61,589	203,342

Appendix 3b - Edinburgh Community Health Partnership Components	£m
Community Nursing (District Nursing & Health Visiting)	17.9
Community Mental Health Nursing	9.3
Older People Hospital Services	13.3
Community Physio and OT	3.2
Health Centres and Clinics	3.9
Other Community Services (Continence, Community Equipment etc)	5.4
CHP Core Services	**53.0**
Rehabilitation Services (including regional services)	17.3
Sexual Health Services	4.3
Mental Health and Rehab Physio/OT services	5.3
Equality and Diversity activities	0.8
Hosted CHP services	**27.7**
Resource Transfer to Council	**22.2**
Prescribing across Edinburgh Localities	**64.4**
General Medical Services by GPs across Edinburgh	**65.5**
Child & Adolescent Mental Health Services	6.8
Older Peoples Mental Health Services	7.8
Adult Mental Health Services	11.8
Forensic Mental Health Services	5.3
Other Services (including Management and Admin)	1.2
CHP Mental Health Services	**32.9**
Learning Disabilities Services	13.7
Substance Misuse Services	5.9
Hosted Mental Health Services	**19.6**
Total Recurring Budget 2014-15	**285.3**

(figures as at June 2014)