Leicester
City Council

WARDS AFFECTED
ALL WARDS (CORPORATE ISSUE)

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:
CABINET **4 DECEMBER 2000**
SOCIAL SERVICES & PERSONAL HEALTH SCRUTINY COMMITTEE **2 JANUARY 2001**

THE HEALTH ACT 1999 AND THE NHS PLAN: PROPOSALS FOR THE INTEGRATION OF HEALTH AND SOCIAL CARE IN LEICESTER

Report of the Director of Social Services

1. PURPOSE OF REPORT

1.1 To seek approval for the proposed framework for implementing the Health Act 1999 and key aspects of the NHS Plan in the Leicestershire Health Community, and specifically in Leicester City. The report also sets out details of the governance arrangements for integrated services as they are developed.

2. SUMMARY

2.1 The Health Act 1999 introduced new arrangements for the commissioning and provision of health and social care with the development of Primary Care Trusts and new roles for NHS Trusts. The NHS Plan, published in July 2000, emphasised the importance of putting the needs of patients, service users and carers first, addressing health inequalities, and bringing health and social care together, including the concept of Care Trusts and new combined Mental Health and Social Care Trusts.

2.2 The attached paper has been prepared by the Director of Social Services for the City Council and agreed with the Health Community in Leicestershire, and Leicestershire and Rutland County Councils. It is intended to set the framework for an agreed joint approach across the whole Health Community. It will require detailed work and individual proposals will require separate consideration.

3. ISSUES FOR CONSIDERATION

3.1 The Government's clear aim is to bring health and social care closer together in the best interests of patients, users and carers. In most instances this is best done at City level by closer working with the Primary Care Group/Trust(s). For some services (equipment or mental health, for example), because of the size of overall service, or of the social care dimension, it is best aggregated at health community level, although with distinct City based staff covering the City.

3.2 Members' endorsement is sought for the direction of travel set out in the attached paper. The Cabinets of the two County Councils, Primary Care Groups, and the Health Authority and NHS Trusts will, similarly, be asked to endorse them. While not

committing any party to any fundamental reorganisation at this stage, it does give clarity to our efforts to improve the coordination of services of patients, service users and carers in the City. These issues will be fundamental to the Health Improvement Plan and the Community Plan.

3.3 Accountability will continue to lie with the organisation with statutory responsibility for the service in the City (either the NHS or the City Council). The oversight of implementation of these arrangements will be managed through the Health Partnership Board for the City.

3.4 The details of any pooled budget arrangements, for any transfer of staff or their management, and for common information systems will need further professional and legal advice. A joint workshop, with input from other areas where this has begun to happen, was convened last month to start preparation.

4. RECOMMENDATIONS

4.1 That the Cabinet:

i) endorse the principles and outline proposals as set out in the attached report;
ii) agree that the Health Partnership Executive should oversee the development of these ideas, with regular reports from the Cabinet Lead to Cabinet; and
iii) receive reports on specific proposals as they are developed where agreement is necessary.

4.2 That the Scrutiny Committee:

i) be invited to comment on specific proposals as they are developed; and
ii) monitor the work of the Health Partnership Executive on this and related matters as part of its brief.

5. FINANCIAL AND LEGAL IMPLICATIONS

5.1 These proposals are within the framework of the Health Act 1999. This allows for pooled budgets, lead commissioning and integrated services. Considerable further work will be needed on the financial, legal and personnel implications of projects as they are developed. However, there is the opportunity to learn from the experience of other local and health authorities.

5.2 These proposals can be developed from within existing resources, and through attracting development funds through the NHS Modernisation process or the anticipated Social Services Performance Fund.

5.3 The implementation of the Health Act flexibilities will require detailed legal consideration including advice on issues as diverse as the legal liability for negligence in service delivery, complaints, accountability, the employment status of existing City Council employees and the sharing of personal confidential information. (Guy Goodman, Assistant Head of Legal Services)

6. EQUAL OPPORTUNITIES IMPLICATIONS

6.1 The main reason for the Health Act flexibilities is to provide services in a better way with better outcomes and to start to combat the inverse law of care that services are least adequate in the areas of the greatest need.

7. SUSTAINABLE AND ENVIRONMENTAL IMPLICATIONS

7.1 None directly, although the location of services and service bases and links with public transport are key factors to be considered in shaping future provision. Co-location of staff should reduce the need to travel for meetings.

8. REPORT AUTHOR/OFFICER TO CONTACT

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APPENDIX

DRAFT (4)

THE HEALTH ACT 1999 AND THE NHS PLAN: PROPOSALS FOR THE INTEGRATION OF HEALTH AND SOCIAL CARE IN LEICESTERSHIRE'S HEALTH COMMUNITY

Introduction

1. The Health Act 1999 introduced new arrangements for the commissioning and provision of health and social care, with the development of Primary Care Trusts and new roles for NHS Trusts. The NHS Plan (published in July 2000) emphasised the importance of putting the needs of patients, service users and carers first, addressing health inequalities, and bringing health and social care together, including the concept of Care Trusts and new combined mental health and social care trusts.

2. This paper sets out proposals for implementing the Act and the NHS Plan in Leicester, Leicestershire and Rutland.

3. It is intended to set the framework for an agreed joint approach, following discussion with and confirmation by, Councils, the Health Authority, Primary Care Group/Trust Boards, and NHS Trusts Boards. This will be reflected in, and developed through, the Health Improvement Programme. In Leicester, this work has been built into the work programme for the Health Action Zone.

4. The implementation of these arrangements will be managed through the Modernisation Executive and the three Partnership Boards (where NHS non-executives and councillors are represented).

General Principles

5. These proposals are based on the following principles:
    - Being clear about where accountability and governance rests. Statutory agencies will continue to be accountable for strategy irrespective of the flexibilities adopted or the devolution of aspects of this responsibility;
    - Recognising the necessity to have audit trails for statutory responsibilities and the fulfilment of specific grant conditions by each agency contributing to a pooled budget, where this is the appropriate model;
    - Building on success and achieving early benefits for patients users and carers;
    - Setting a direction of travel and, where necessary, working towards it in agreed incremental steps;
    - Promoting co-location of staff and managers, joint teams, and integrated management arrangements where possible;
    - Promoting multi-professional teams that respect the skills and values of all staff;
    - Giving particular attention to organisational development and excellent HR practice during the change processes;
    - Minimum organisational disruption required to achieve the necessary changes.

Mental Health Services

6. The shape of future services for mental health has been set by the National Service Framework. The model recommended for Leicestershire is lead commissioning by the NHS with a pooled budget and integrated service provision across health and social care. It is assumed that the Health Authority or a lead PCT will host the pooled budget.

7. Work is underway through the Mental Health Partnership Board to develop a joint service plan. The Board, with representation from the Health Authority, PCTs, and local authorities, will act as the commissioning forum.

8. Work is underway to scope the shape of NHS services following the creation of Primary Care Trusts in April 2001.

9. Work to achieve an integrated provider trust by April 2002 will be undertaken through a jointly commissioned project.

10. Further work will be required on how social care provided by and through the social services departments and the independent sector will fit into the joint service plan. Similarly PCG/Ts are keen to ensure that the arrangements facilitate effective care management/partnership with primary care.

Learning Disabilities Services

11. The proposed model is lead commissioning by each of the three social services authorities for their area, with a common framework for the NHS role in service provision. This would be managed on a separate pooled budget basis through each of the three social service departments with their respective Primary Care Trusts, reporting to their Partnership Boards. A working assumption is that each local authority will host their pooled budget.

12. There is further work to be done on the configuration of services between the NHS and social care, where current and new services should be provided and managed in a mixed economy of care. The presumption will be unified management through social care with specialist clinical provision based in the proposed integrated mental health provider trust.

13. Agencies need to reach agreement about the short, medium and long term strategy for all aspects of the service. This will generate agreement about relative priorities and pressures and determine the investment profile and financial contribution from each of the partners. It will be important to ensure the lead commissioner manages the commissioning of complex care.

14. Critical areas for agreement in establishing pooled budgets are the completion of the current closure programme at Gorse Hill Hospital, and the funding of external placements for those with complex care and/or continuing care needs. This will continue to be done at Health Community level, with appropriate input from local authorities and PCTs. Work to achieve this will be undertaken through a jointly commissioned project.

15. The timetable for this change needs to bear in mind the consequences of the changes to housing benefit in April 2002 on independent living schemes, through the Supporting People initiative.

Community Care for Older People and Younger Disabled People

16. The proposed model is to work towards integration of services at the level of the three social services authorities up to and including the Care Trust model (if there is local consensus). As with learning disabilities services this would be managed on a separate pooled budget basis through each of the three individual social service departments with their respective Primary Care Trusts, reporting to their respective Partnership Boards. Close collaboration with the acute sector will be required on the delivery of planned and intermediate care, winter pressures, and the prevention of unnecessary admissions to residential and nursing home care. The working assumption is that any pooled budget could be hosted by the local authority or possibly by a host PCT, although the latter option may be a problem in the County.

17. The status and development of Primary Care Groups and Trusts will determine the pace of change. Early work can begin on co-location, common assessment, co-commissioning, new integrated service initiatives and integrating management arrangements. As an early step towards integration social care links with primary care teams should be explored.

18. This model could be extended to children's services but would require detailed consideration of the different statutory bases and the role of Education. A common City-wide approach to Sure Start and Sure Start Plus (teenage pregnancy) is already being developed.

Services for Children with Disabilities and Child and Adolescent Mental Health Services

19. The proposed model is joint commissioning with the NHS, Education and Social Services at the level of the three local authorities, in the context of an agreed framework across the Leicestershire health community. As with learning disabilities services this would be managed on a separate pooled budget basis through each of the three individual local authorities with their respective Primary Care Trusts, reporting to their Partnership Boards. A working assumption is that each local authority will host their pooled budget.

20. A number of initiatives are already under consideration in relation to:
    - Child Behaviour Intervention
    - Specialist residential services
    - Joint Solutions

21. Child and Adolescent Mental Health Services (CAMHS) will initially be considered as an integral part of the new mental health provider trust. However its relationship with other children's services is of considerable importance and this area will be kept under review as other strategies at national and local level develop.

22. In Leicester this will be accelerated through the Health Action Zone process.

23. As with learning disabilities, a precursor to this work is a formula for the resolution of current problems with the funding of external placements for those with complex care and/or continuing care needs.

Equipment

24. The proposed model involves pooled budgets and a joint commissioning consortium to consider service provision across health, social care and education.

25. Work is underway to develop a single specification and commissioning strategy.

26. Leicester City Council will seek sufficient flexibility in the model to promote its extension into disabled facilities grants and adaptation arrangements.

NHS Direct and Social Care Direct

27. There are distinct benefits to the Leicestershire Health Community of the development of NHS Direct within the County. We will work towards a Leicester base, including a walk in facility geared to the needs of the diverse population of Leicester and Leicestershire. Local authorities are keen to develop closer integration with social care services and 24 hour access.

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3/11/00