AGENDA ITEM 6a

South Ayrshire Alcohol and Drug Partnership
Integration of Health and Social Care Consultation Template

Section	Question	Yes / No	Comments
The case for change	**Question 1:** Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?	Not clear at this time	Unclear of what the benefits/ drivers would be to extend across services and if this model would be suitable for different services. Noted that no consideration is given to where/if ADPs would sit within the structure. ADPs have current structures in place which appear to be working well and have the flexibility to target resources in line with local need. Any changes would need to complement current arrangements and ensure that connections remain in place e.g. in relation to CAPSM.

			Not clear what kind of authority the ADP would have if incorporated into new structure. Would the ADP be accountable to the Jointly Accountable Officer? It would be important for a commitment to be given that alcohol and drug budgets would remain ring fenced for allocation by ADPs in line with local need and that substance misuse would remain a priority area and not subsumed into other services.

Outline of proposed reforms	**Question 2:** Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?	No	As above. Not comprehensive and lacking detail e.g. would hospital services (e.g. detoxification services, NHS alcohol and drug rehabilitation services, A&E Liaison services etc) be included in new structure. Also noted that Public Health services are not considered within document.

National outcomes for adult health and social care	**Question 3:** This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly	Yes	Supportive of joint high level outcomes. The reporting mechanisms need to be clear and consistent.

	and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?		ADPs have been able to incorporate HEAT targets into the Recovery Model which looks at the much wider support requirements than purely access to services. Consideration needs to be given on how the outcomes will be compatible with NHS HEAT targets.

	Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?	Yes	There is a need to ensure that outcomes are clear and consistent. Important for all partners to have a common understanding of what an 'outcome' is. Also important that clear and relevant indicators are developed which provide data to measure progress towards achieving outcomes.

Governance and joint accountability	**Question 5:** Will joint accountability to Ministers and Local Authority Leaders provide the right balance of	Not clear	Potential for the Jointly Accountable Officer to have multiple reporting mechanisms. Also the potential

	local democratic accountability and accountability to central government, for health and social care services?		for challenges between different local and national political aspirations. Need to ensure that the governance mechanisms are balanced and that one discipline is not able to dictate decisions.

	Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?	Yes	Multiple models available for consideration each of which has challenges for local authorities and health. Need to be clear on driver for change and implications for services. ADPs are working more effectively on a locality basis and benefits for change to a Pan-Ayrshire model would need to be evident.

	Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?	No	

	Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?	Partially	Further clarity required in relation to governance arrangements. Clarity needed on 'who' in the proposed structure ultimately has the decision making powers. Lacking in detail on how the proposed structure will link to CPPs.
	Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?	Yes	Planning and accountability should remain at a local level and resources directed in line with local need and when the time is right.
Integrated budgets and resourcing	**Question 10:** Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?	Yes	The premise is sound however challenges exist in relation to budgets and competing priorities. See comments above.
	Question 11: Do you have experience of the ease or difficulty of making flexible use	Yes	South Ayrshire ADP has experience of managing shared budgets based on evidence of

	of resources across the health and social care system that you would like to share?		local need.
	Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?	Possibly	See comments above.
Jointly Accountable Officer	**Question 13:** Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?	No	Will be very challenging to achieve a shift away from acute services especially if the Jointly Accountable Officer is not responsible for acute service budgets.
	Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer**?**	-	Not able to comment at this stage as this will depend on how the HSCP's are developed.
Professionally led locality planning and commissioning of services	**Question 15:** Should the Scottish Government direct	-	This should be left to local determination based on need.

	how locality planning is taken forward or leave this to local determination?		

	Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?	Yes	There should be a duty on all partners to engage. In relation to alcohol and drug misuse and adult services GPs are an essential component and involvement is essential. However role of GP's in new structure is not clear particularly in relation to the role of 'clinicians' and with budgetary decisions. Not clear what the implications will be if partners not bought in.

	Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?	-	Localised planning and ability to influence budget decisions.

	Question 18: Should locality	-	There is a need to ensure that

	planning be organised around clusters of GP practices? If not, how do you think this could be better organised?		locality planning is consistent amongst all services and structures. Locality planning models already exist which need to be considered.
	Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?	-	Unclear at this time. Governance arrangements need to be put in place first.
	Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?	-	This should be considered at a local level. Any proposed planning linked to population size needs to be considered with a clear rationale based on evidence.
	Do you have any further comments regarding the consultation proposals?		Consideration needs to be given to the support structures which will require to be in place. For example, IT systems and HR arrangements. Information sharing remains a significant challenge which needs to be addressed.

	Do you have any comments regarding the partial EQIA? (see Annex D)		

	Do you have any comments regarding the partial BRIA? (see Annex E)		

Integration of Health and Social Care Consultation

Notes from South Ayrshire Adult and Older People OLG Integration Session 12/6/12

Section	*Question*	*Comments Group 1*	*Comments Group 2*
The case for change	**Question 1:** Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?	● Danger of fracturing services by too narrow a focus on either age or care group. ● Start with older people and move incrementally? ● Include more services e.g. Housing (but not all) (if not all how much?)	● Doing it at one time is practical ● Age discrimination ● Separation of ages ● Life courses hard to do ● New OP? further behind ● Hard to differentiate

		● Include mental health services (but not all?) ● Key issue is to ensure we don't fracture existing pathways that have been created.	● Outcomes for other services need to catch up with OP? ● Lots of under 65s with Long term conditions ● Create demand ● Earlier intervention ● Efficiency issues in longer term ● Support Adult and OP
Outline of proposed reforms	**Question 2**: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?	● Paper refers to 2 'disconnects' 1. Primary and Acute 2. Health and Social Care Paper only makes reference to a potential solution for disconnect (2) and no further reference to disconnect (1). Where does co-production and S.D.S. fit in?	● Framework close to what we're doing ● Services – need to think broader ● Health Improvement missing "some acute hospital services"? ● What locality? Tension

		• Community Planning Partnerships have a limited emphasis in this consultation • More detail required in relation to the devolution of resources and services below the single accountable officer. This is particularly relevant to the use of independent contractors: - GPs, Pharmacy, Optometry. • Where do the independent contracts fit? e.g. GPs, Pharmacy, Optometry – who manages these in the new world? • Where do the council and commissioning staff sit? Majority of council services are contracted externally, is there a separate contracting and commissioning (and monitoring) team in the H & S C?? •	between pan Ayrshire expertise and function. • How will 3rd sector be engaged? • How will patients/service users be involved? • Highlight Ayrshire Forum model • Forum – use rather than start from scratch. 3 year bedding in.

National outcomes for adult health and social care	**Question 3**: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly	• Are these joint outcomes built into the S.O.A.? Yes. • The Community Planning Partnership does not sit well within the proposed governance	• Move to joint accountability • Direction of travel already – link to SOA

	and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?	structures, as it may add an unnecessary level of governance. ● National agreed joint outcomes are positive ● The proposed arrangements are sufficiently strong to achieve the changes required. Also – see *	● Agree with approach ● Need robust performance framework – outcomes model ● Need for conference? ● Some tensions with HEAT – lack of congruence ● Local target setting ● Easing off of other targets ● Move to talking points – methods
	Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?		● SOA / Outcomes could be useful ● Consistency ● Still flexibility locality
Governance and joint accountability	**Question 5**: Will joint	● Local democratic accountability is potentially	● Health Boards missing? (mistake)

	accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?	challenged / compromised by the increased role of the minister. This required further clarification.	• Elected members – massive learning curve • Tension of local and strategic accountability • Different languages – e.g. clinical effectiveness • Tension of local and national politics – generally ok
	Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?	• Should be <u>scope</u>	• More than one local authority • Yes – but in reality hard to achieve without reduction in local authorities in Scotland • Why not beyond Ayrshire? • Could each HSCP 'host' services – senior clinical leader • Is there a 'win – win' • With 3 SAO's around same

			table (Strategic Alliance Place?)

	Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?	• Lack of clarity • Potential lack of local accountability • Issues re professional advisors	• How would 3rd sector find its' representative • What about private sector attending committee? • Tension between local authorities and NHS • What happens when in conflict e.g. bed/service closures

	Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?	• Performance management arrangements are complex and not necessarily sufficiently open and transparent (nor understandable) E.g. how does a member of the public make a complaint? • To whom? • How? • Role of Inspectorate across services?	• National Action if we don't deliver 'hit squad' • Should there be integrated external scrutiny arrangements?

	Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership	● Yes, if Health and Social Care Partnerships are created around Adult and Older People's services, there is the risk of a vacuum created for Children's services.	● Yes – but risk of inconsistency (bench marking) ● Should the different models be evaluated?
Integrated budgets and resourcing	**Question 10**: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?	● This may be achieved within the Health and Social Care Partnership. However it does not fully address the disconnect between Acute and Primary Care. In addition the requirement to reduce inappropriate admissions, requires to be made more explicit	● Issue of staff potentially having to work across 3 partnerships ● Model doesn't tackle corporate support requirement ● Decisions as to what budget comprises of ● Risk to creating new barriers e.g. Hospital versus new Partnerships ● Challenge of NHS agreeing contribution to each local authority ● Manage expectations

			• Where does 'overspend' of Partnership come from? E.g. prescribing Can body corporate contract for services?
	Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?	Yes. Require emphasis on achieving outcomes in an open and transparent way.	• Positive example of Pan Ayrshire Change Fund posts • Jointly funded posts – i.e. Homeless Facilitator • Co-location – Biggart • Resource transfer, NHS to local authority. CMHT and LA to Ailsa • Shared account – cross charging e.g. rent • IT Systems – data sharing and protection – Caldecott? • Acute resources not being released to community • Difficulty of allocation of resources to 3 x LA versus 1 NHS

			● Terms and conditions – carry forward of budgets ● VAT – body corporate?
	Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?	● Ministerial direction will inhibit local decision making and choice.	● No – minimum not explicit enough because extent Acute included is key to success
Jointly Accountable Officer	**Question 13**: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?	● As described, their S.A.O. role will be mainly influential with the main power to shift resources resting with the Chief Executives.	Dependent on answer to Q 12 ● How will JAO be supported? 'HR, Finance, OD' – unclear, more description required of powers of 'body corporate'.

	Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?	• Sufficient seniority to manage their resources. Not sufficient to shift resources from other Sectors.	• Assumption at least Executive Director level – ultimately who manages them?
Professionally led locality planning and commissioning of services	**Question 15**: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?	• Leave to local determination	• Direction nationally to ensure left to local determination, e.g. GP engagement, but challenge of locality resource allocation • Impact of neighbourhood approach? NHS can't support 3 different approaches in 3 LAs.
	Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?	• Needs to be stronger than a duty. • Should be a duty on professionals to engage. • Responsibility on both Health and Social Care Partnership and professions to engage.	• No – current opportunity via Forum, but only works if Primary Care engaged in Partnership. Not sufficiently engaged at present. • Function of Clinical /Medical Director will be key to this • Links to existing professional committees – both NHS and LA

			e.g. Chief Social Worker

	Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?	● Link to contracts ● Health and Social Care Partnership have wide ranging commissioning powers.	● Support structure locally in place – local integrated team leaders in place (potential issues – clinical versus line management supervision ● Staff governance – people able to contribute – change of culture – empowering people ● Access to resources could be seen as incentive to engagement in partnership

	Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?	● Existing locality structures are in place. These need to be considered prior to any change.	● Yes – but, practical geographical issues, political ● Acute hospital has to be part of locality planning – with flexibility to local (rural/island) needs

	Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?	● Unresolved – require to ensure consistency and to reduce unnecessary bureaucratic levels.	● Key challenge to get HSCPs up and Running! ● Responsibility of Individual/ client care decisions ● At HSCP – service level decisions, parameters set by Partnership – outline 'givens'

	Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?	● As determined by each Community Health and Social Care Partnership.	● What evidence suggests, e.g. in SA potentially 4 exceptions – extreme rural islands ● 15 – 25,000 people? Capacity to serve – avoid bureaucracy ● Fall in with other locality structures – e.g. Children's services – this perhaps doesn't fit with GP Structure ● Other – Staff? – Why has the staffing implications not been considered / consulted on? ● Communication

	Do you have any further comments regarding the consultation proposals?		Staff – why have the staffing implications not been considered/ consulted upon? Communication
	Do you have any comments regarding the partial EQIA? *(see Annex D)*		
	Do you have any comments regarding the partial BRIA? *(see Annex E)*		

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NHS | MINISTER | NHS CHIEF EXEC	MINISTER LEADER OF COUNCIL CHAIR OF HEALTH BOARD?	COUNCIL | COUNCIL COMMITTEE | CHIEF EXEC

NHS CHIEF EXEC		COUNCIL CHIEF EXEC

Integration of Health and Social Care Consultation
Summary of discussion and emerging points from South Ayrshire Officer Locality Group for Children

Section	*Question*	*Y/N*	*Comments*
The case for change	**Question 1:** Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?		There does not seem to be a clear rationale in relation to the scope for integration to apply to children's services and its linked set of outcomes. Whilst the case for starting integration with adults (and older people, explicitly re outcomes) is clear, the downsides and risks associated with the non consideration of other services is not well considered.
Outline of proposed reforms	**Question 2**: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it,		No – as above, children's services and their eventual destination is not considered in any detail.

	or anything you would suggest should be removed?		

National outcomes for adult health and social care	**Question 3**: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?		There is some concern that the understanding of 'outcomes' may be varied and not shared. Some of the national outcomes are really descriptions of key priority areas to ensure the delivery of outcomes, at both individual service consumer level and in aggregated ways. Essentially, if we use outcomes based approaches, we need a very clear definition and approach to outcomes that is widely understood and shared. If the first suite of national outcomes is specifically focusing on older people, there is a concern that outcomes for children could become de-prioritised in relation to planning and, even resources.

			The Joint Accountable Officer's role could extend towards the delivery of all outcomes including children's services based ones. The consultation paper does not give sufficient consideration to the 4 (Christie) principles of public sector reform, not least early intervention.
	Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?		Yes – but this should be for <u>all</u> services
Governance and joint accountability	**Question 5**: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of		The proposal will still have the limitations of the JAO having to report via non-elected Health Board directors (appointees). According to the governance,

	local democratic accountability and accountability to central government, for health and social care services?		with equal numbers of NHS and elected members as voting members, if the chair of the committee is from the NHS (which should happen in alternative years) then the balance of decision making has non-elected members in majority which might be a challenge to democratic accountability.
	Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?		Yes
	Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?		No – the committee should be accountable to both Council and Health Board and not simply the leader of the Council and Chair of the Health Board.

	Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?		Yes – as long as there is clarity regarding governance (as above)

	Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership		Yes

Integrated budgets and resourcing	**Question 10**: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?		The NHS spend that is implicated needs to be made specific. The integrated budget has potential for a more efficient and effective use of resources but there is a potential, if children's services are not included, of marginalisation.

	Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?		Examples at very grass roots level have been identified (eg integrated Girvan work within pre-5 establishments) At a higher 'commissioning' level, the Integrated Resource Framework pilot work at an Ayrshire level on children with complex care packages, proved much more challenging in relation to the flexible deployment of resources.
	Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?		Yes
Jointly Accountable Officer			Partially

	Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?		
	Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?		This is not very clearly articulated in the paper and would need to describe the competencies of the JAO in a more comprehensive way.
Professionally led locality planning and commissioning of services	**Question 15**: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?		At a local level.
	Question 16: It is proposed that a duty should be placed		There should also be a duty on GPs to engage with the new organisation

	upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?		arrangements, perhaps this could be addressed at GMS contract level of through local enhancement of GMS.
	Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?		Meaningful engagement, the potential to influence the use of resources and shaping of services.
	Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?		There is a clear need to ensure that the planning constructs for adult and children's services are congruent with existing children's services locality planning arrangements. There are certainly some problems in relation to GP

			practices and their boundaries and reach that might not conform to proper geographic localities.

	Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?		Most resources, in relation to children's services, could be devolved down to locality planning with the resource allocations for different localities being explicitly linked to robust needs assessment. It is also important that the locality planning is not simply concerned with 'services' but with a range of more community based and developmental work particularly concerned with early intervention and prevention. These could be based on Community Development, Asset Based and Co-production methodologies.

	Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?		Needs to be locally determined but with some national guidance underpinning this. For example, when CHPs were being planned, there was a clear evidence base that determined their size (in terms of a critical mass of population, notwithstanding highlands and islands issues). Any proposed planning construct that links to population size should also have an explicitly linked rationale on size based on evidence and not simply, convenience.
	Do you have any further comments regarding the consultation proposals?		● There was concerned that the document does not have a sufficient level of coherence. ● There was also the fear of very disruptive structural change might undermine the significant existing integrated practice that most certainly takes place across children's services.

			● There is very little consideration of service user involvement and engagement other than it being an aspiration. ● There is very little focus of health improvement as a shared and crucial responsibility for the new partnerships. ● There is little consideration of how specialist services deployed at a community level may articulate and support the locality based approach. (this could be at HSCP, Health Board, regional and national levels) ● There is no consideration of education linkages. ● There are challenges in Ayrshire and Arran in relation to borders with other health board areas and service use (GG &C and D&G) ● There needs to be greater acknowledgement of the

			wider Community Planning Partnership and its relationship to the new HSCPs.

	Do you have any comments regarding the partial EQIA? *(see Annex D)*		

	Do you have any comments regarding the partial BRIA? *(see Annex E)*		