

INTEGRATION OF ADULT HEALTH AND SOCIAL CARE

DRAFT Response

Shetland Community Health and Care Partnership

Annex G Consultation Questionnaire

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?

Yes, given the pressures and priorities associated with demographic change and the benefits in allowing Partnerships to develop in phases if this is determined to be beneficial locally.

However, there are probably significant advantages in including the totality of community health and social care within partnerships, in the long term, given the risks associated with fracturing currently integrated social care services and that primary care services currently provide health services from cradle to grave. We therefore believe that the process of integration could be phased where services are not already fully integrated; this would then start with older people through to adult and children's services at a pace which suits local circumstances. However setting the overall direction of travel will be crucial to establishing a structure in the partnership that will ultimately be able to deliver fully integrated services. Where partnerships have a wider range of integrated services already in place, or they believe it makes sense to do so, they should be encouraged / free to develop proposals wider than "Older peoples" services / outcomes.

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?

As indicated in the response to Question 1, we believe there are advantages in including all community health and social care services for a defined geographical area.

We also believe the role of the partnership as a health improvement organisation and what that means in terms of delivery and commissioning needs to be addressed. This is not referred to in the consultation document and has been a significant strength of CHPs. There are real opportunities for Health & Social

care partnerships to lead work with Council departments and community planning partners to improve health locally and to tackle inequalities.

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?

Yes, we are supportive of there being nationally agreed outcomes and agree that statutory partners should be jointly accountable for their delivery.

We are concerned however to ensure that in the development of these Outcomes that a full review takes place of the current Outcomes and Targets currently in place across Health, Social care and Community Care (i.e. HEAT, Community Care Outcomes Framework, SOA etc) so that the new Outcomes are fit for purpose. It will be important that the statutory organisations, and in particular the Chief Executives of Councils and NHS Boards are accountable for making these new arrangements work and supporting the single accountable officer and the partnership committee.

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, this is crucial to a strategic sign up to joint working across the public sector as well as operational delivery.

Many of the issues will need to be tackled across the whole partnership, not just adult health and social care. As highlighted in our response to Question 3, it is very important that all current targets and outcomes are reviewed to avoid duplicate reporting and any unintended consequences of targets that are not outcome focused.

Whatever outcomes are agreed this provides an opportunity to streamline the current range of Outcomes / Performance frameworks currently in place. .

Governance and joint accountability

Question 5. Will joint 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?

We are not persuaded that the arrangements described in the consultation document are sufficiently clear given the different roles of the Council Leader and Health Board Chair. We believe it is important that Partnerships are given the scope to develop and agree accountability mechanisms that are appropriate for their own circumstances. These should also recognise that the mechanism that is appropriate in a small co-terminus Board / Council area should, probably, work differently from a large Board area engaging with multiple councils.

In some of the existing integrated arrangements the single joint officer is already directly accountable to the Council and NHS Chief Executives, and to the CHP partnership committee. The Council CE is then held to account by the Council and the NHS CE by the Health Board Chair and the Cabinet Secretary. These arrangements generally work well and emphasise the crucial role of the Council and NHS Chief Executives in supporting the partnership to succeed.

It should be clear that Joint Accountability really is Joint and equal Accountability and one partner cannot be accountable to the other. This is best done through the Accountable Officers (Chief Execs) and their existing accountability mechanisms.

Again, it is important that partnerships have one set of performance measures and a single performance framework, and the responsibility of the partnership committee in being accountable for this locally needs to be clear within the proposals.

Question 6. Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

We would not be supportive of this in a Shetland context. However this should be determined locally.

Question 7. Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

It is recognised that the role of the Committee is important in agreeing local plans and priorities. Where integrated partnerships have been successful it is felt this is because both the Council and Health Board have felt real ownership of the Partnership and Committee. It is also important that roles and arrangements for the Committee are clearly described and agreed between the relevant parties.

It is therefore important that local partnerships have the flexibility and take responsibility for determining what will be most appropriate to their local circumstances

It should be recognised that there is a tension between a large committee with significant councillor and therefore Board non-executive involvement and a small committee that is effective and responsive in its decision making.

It also needs to be recognised that the nature of Board Executive and Non-Executive Board members and Councillors and Officers are different and to develop an effective committee will require compromise and discussion.

A key function of existing committees is professional engagement and it is therefore important that the new committee has a clear mechanism for ensuring Professional engagement and involvement in decision making.

It is important that the NHS Board and Council are seen as equal partners regardless of any anomalies in the size of the two organisations.

It is therefore concluded that while it is important to establish clarity at a local level that the current proposals are too prescriptive; it is important there is “buy in” from both partners and this requires us to identify local solutions that work and are effective / owned locally. The legislation / guidance should focus on the principles to be addressed by the partnerships and not the specific composition of the partnership committee.

*We would therefore recommend that if it is felt necessary to determine a **minimum representation** then we would support a **minimum of 3** from either agency but would not support a greater number being dictated in the legislation.*

Public Partnership Fora have been a major success of current Partnerships and their members will regret the loss of voting rights. It will be important that the new Partnerships are encouraged to ensure these perspectives remain strong and that services are planned and delivered in the spirit of co-production with the community.

This could be addressed by enshrining a principle in the legislation on Involvement without specifying how or what status PPF reps have on the committee and allowing local partnerships to develop this, including voting rights if agreed locally.

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?

Council scrutiny and health board performance arrangements need to be set in a single collective framework and proportionate to the range of services delivered through the partnership.

We are not sure whether the proposals to have a triumvirate of Cabinet Secretary, Council Leader and Health Board Chair is workable given the different role of Health Board Chair and Council Leader.

Ultimately accountability needs to be to both organisations and then for both organisations through their respective authority and to the community i.e. for health services to the Cabinet Secretary and through the Council for Social Care.

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. We should assume all functions are in, unless there is a clear reason and criteria for exclusion.

We believe we need the least disruption of structures; otherwise there may be more complexity and more transactions across the system preventing us from focussing on improved delivery. If NHS Boards and Councils create new and separate entities to manage services excluded from partnerships this will run counter to the spirit of the proposals to streamline and improve efficiency.

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?

It will be important to ensure that the statutory partners commit financial allocations that fully reflect at least existing expenditure. Financial arrangements need to be established which hold Partnerships to account but enable full delegation to the Committee and thereafter relevant delegated authority to the Single Accountable Officer (see comment in response to Ques. 13) so that redesign and service change can be delivered. Essential to improved service delivery will be the streamlining of complex financial arrangements. Decision making and budget management need to be simple and flexible. We do believe that it is appropriate that resources allocated to the Partnerships lose their NHS or Social Work identity in so far as the statutory agencies can integrate budgets to give flexibility to direct resources to local priorities. It does however, raise complex issues about the governance of the statutory responsibilities of the two parent bodies and there is a risk that the ability of either or both organisation to comply with audit regulations and guidance will be compromised. This needs more detailed work and consultation with Audit Scotland. There are some existing arrangements which work well that could be built on. A sound commissioning framework will help strategically in establishing a clear service framework and pathways of care across the whole system.

We are not clear of the meaning of ‘body corporate’ as set out in the consultation, as this suggests a separate body rather than a partnership, and it would be useful if this could be expanded on for clarity.

We would not support a proposal that appears to introduce a third accountable organisation with a separate legal basis / accountabilities and governance. We feel this will be costly in terms of time and effort in setting up a separate organisation and that accountability of the partnership exercised through contractual arrangements will be cumbersome and inflexible.

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?

Any examples?

There are different arrangements across CHPs currently that allow for service planning and service delivery to take account of all the resources available for an area of service. In Shetland, the financial governance framework is set out in the CHCP Agreement; budgets are aligned and set out by care group / service area. The funding is then used flexibly to meet the service priorities set out in the Agreement.

Funding for independent advocacy is effectively pooled in the Council's budgets and the Council then enters into a service level agreement with the provider on behalf of the parties within the CHCP.

The allocation of funding for substance misuse services is discussed and agreed by the local ADP and then disbursed accordingly with external procurement from a pooled budget administered by the Council on behalf of the CHCP.

In this way, the allocation and spend can still be seen and audited separately for the Council and the Board while being administered from a pooled or aligned budget stream through individual transactions between the two organisations which gives a full audit trail. It is difficult to see how this could be improved upon without losing the accountability of each organisation's funds with consequent issues for audit purposes including production and sign off of annual accounts.

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; it is suggested that Partnerships are challenged to identify how they will address / account for the use of acute resources within the partnership area. It is recognised that the services to be included in Partnerships already have real influence over expenditure in acute services and the links and interaction between partnerships and acute services need to be improved to facilitate better pathways of care; this is a significant opportunity to make a difference across the whole system and to support the shift in the balance of care.

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?

We fully support the proposed role of Jointly Accountable Officer responsible for the full range of the partnership's resources and services, reporting to the Council and NHS Board Chief Executives. Experience in integrated CHCPs suggests that this is an essential post to lead a fully integrated management team. Further work will need to be done on the relationship and delegated authority of the jointly accountable officer to the Partnership Committee. It is important however that the responsibilities of Council and NHS Chief Executives to the post / partnership extends beyond accountability to emphasise their role in supporting and facilitating the work of the Partnership.

We would strongly recommend that a different term is used for this role / post since the term "Accountable Officer" has a very specific meaning in relation to the management of Public Resources and the relationship to Parliament and this risks causing confusion over the relative Accountability Officer roles of the Chief Executives and the Integrated Jointly Accountable officer.

With regard to the issue of whether or not the authority vested in 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", it is clear that this role will be key, however, there are many factors that will require support from the wider partnership and the scope and range of services in the partnership will be significant in this regard. It is an unrealistic expectation that the creation of this role will of itself shift the balance of care/spend.

Question 14. Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes, the Jointly Accountable Officer must be a senior role and it is likely this will be accountable to the Chief Executives since at a lower level it would be an extremely difficult role to have. Clarity and simplicity of structures are essential. However, bearing in mind the variation in scale & nature of Health Boards and Councils across Scotland it may be helpful to be less prescriptive as to how this post sits in both organisations and allow a degree of local determination. It should be for Partnerships to agree subject to very clear criteria about the nature / importance and responsibility of the role

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?

It would be appropriate for the Scottish Government to outline what the principles / features of the locality planning landscape should be and the outcomes to be delivered.

How it works locally must be determined locally.

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 as long as it is clear this is about **all** professionals (including but not just GPs.)*

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?

Capacity, time and finance are sometimes barriers in the engagement of clinicians, specifically independent contractors. This is the crux of much criticism of CHPs as they stand, particularly in comparison with LHCC's and it needs to be addressed as a whole system (for example through national GP contracts) rather than seeing it as an issue for each partnership to resolve.

Clinicians will get involved if they have influence over change, we have to devolve and empower local clinicians in the new partnerships to engage in change and improvement across the whole system.

Question 18. Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

This should not be prescribed. Let the local partnerships agree the best configuration, but it will be essential to emphasise the central role of GPs in helping to deliver the intended outcomes.

Question 19. How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

This should not be prescribed. Let the local partnership agree what should be devolved.

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 not be prescribed. Local partnerships should be free to decide how their locality model should work. In Shetland the Community Partnership already has locality arrangements in place and work is in hand to strengthen these and use the localities increasingly in health promotion projects. In a Shetland (Island) context our localities are likely to be significant smaller than 15,000 people if they are to be meaningful to the local population / environment / service distribution.

Ref CF/
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