

Integration of Adult Health and Social Care in Scotland

Consultation on Proposals May 2012

NHS Fife AHP Clinical Area Forum Response

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?

The proposal to focus on older people initially is presumably driven by demographics and demand. We do not think, however, that it is practical to separate older people from other adults even if only for the initial stages of the partnership development. Many workforces are designed to support all adults i.e. the same group of therapists support adults of all ages therefore to separate the workforce would mean economies of scale are lost. Also artificial barriers between adults and older people services would increase. If S.A.Y. means anything, then Adults with Learning Disability should also be included.

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?

The framework is very broad indeed and as the “devil is in the detail” the broad brush approach makes it difficult to comment but the proposed arrangement may shift barriers to integrated care from one place to another e.g. if health/social care staff are working better together in care of the elderly one barrier has gone, however if only the elderly are supported through these new practices then we have a transition between adults and elderly. In short, we think the authors should consider the inevitable down side of the proposal so we can anticipate and manage any issue.

We also see under the newly appointed senior Jointly Accountable Officer, the possibility of many sub units in each Partnership and the distinct possibility of adding to the layers of managers/bureaucracy. In our view this would not represent best value for money.

Question 3

This proposal will establish in law a requirement for statutory partners – Health Board and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care and for support to carers. 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?

While beginning with outcome is sensible, previous outcomes have never been sufficiently sensitive and have often become a tick box exercise. We should be trying for quantitative and qualitative outcomes. We are also concerned about what would nationally agreed outcomes look like will they be high level outcomes like HEAT targets or SOA's or will they be more person focussed?

We are also concerned about how in practice the legal requirement will affect services. Onerous legal process is likely to push up costs to the detriment of patient care.

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 see response to Q3.

Question 5

Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability to central government, for health and social care services?

This depends on quality of those involved rather than the structure, however, it would appear that there is a disconnect with the Local Authority leaders accountable to Local Councillors but the accountability of the HB is less well defined locally.

Question 6

Should there be scope to establish a Health and Social Care Partnership that covers more than one Locality?

AHPCAF are unsure if the HSCP covering more than one locality will or will not be effective however we are concerned that the HSCP should be local enough to be accountable while not replicating layers and layers of bureaucracy that will inevitably mushroom from this type of change.

Question 7

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

As you may expect the AHPCAF are concerned that what is being proposed represents from the health perspective a very medical model of advice and engagement. We would be more supportive of an arrangement for HB representation that was more reflective of local service priorities.

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, what's described in the consultation document seems appropriate but once again the devil will be in identifying the reasons for poor performance which may not be in the power of the HSCP to resolve.

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?

In the longer term we think it would be a mistake / confusing to allow variation between Authorities. In any structure there are pluses and minuses so to have the same structures across Scotland allows joint learning and is easier for patients if they move from one area to another.

Going forward should this model be shown to be effective at delivering health and social care decisions should be taken at the COSLA/ Government level to agree if other services should be included.

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?

Pooled resources encourage collaboration so we hope the outcome would be effective.

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?

SLT staff working with Adults with Learning Disability have noted the difficulties between Health and Social Care Staff when it comes to settling people in domestic homes outwith a hospital - who pays for what?

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?

We think it would be more likely to achieve the objectives if the spend categories were agreed collaboratively between Ministers and COSLA.

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?

Yes, if the individual is good and he/she is given real authority as well as responsibility. There needs to be very clear guidance about the JAO and we are not sure this is clear enough in this draft

Question 14

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

Yes, as long as he/she is next in line to the Chief Executives and has management authority over all the relevant budget holders regardless of which organisation becomes the 'host' for the JAO.

We think that there could be more clarity around this as described in paragraph 6.9

Question 15

Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

To allow integration across Scotland, we think there should be at least a range of limited options.

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?

AHPCAF are concerned that there seems to be a disconnection between the question above and the text within the consultation. The consultation suggests a duty to 'consult' however earlier in the document it states that professionals will: *'take an active role in, and provide leadership for'*. We would welcome more clarity on what's proposed and would support the statement about professional groups taking an active and leadership role.

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?

- Pathway planning
- Joint training
- Shared accommodation

Question 18

Should locality planning be organised around cluster of GP practices? IF not, how do you think this could be better organised?

This would have the advantage of encouraging GP involvement although this could encourage too many layers of committees/decision making groups.

Question 19

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

There are advantages and disadvantages in both top/down and bottom/up approaches. Whatever is decided, delegation or otherwise needs to be clear so issues do not go round in circles with no one willing or able to make decisions or everyone having to agree the smallest decision.

We would however support a National approach to decision making devolvement which may usefully inform the subsequent organisation of the localities.

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 second part of 18.

AHPCAF are also of the view that localities should be agreed by the HSCP to take into account other factors such as geography, social deprivation, populations etc