Integration of Adult Health and Social Care in Scotland - Consultation on Proposals

South Ayrshire Public Partnership Forum (PPF) - Response for South Ayrshire Community Health Partnership (CHP)

1. Background

Following the announcement of the national consultation on the proposals for Integration of Adult Health and Social Care in Scotland, the PPF Core group were informed. The group believed this consultation needed far wider involvement than just the PPF Core group. The CHP Facilitator offered to support two events in South Ayrshire which the Core group agreed to host in order to gather public and community views. Abbreviations used are tabled at end of report

2. Process undertaken

	Activity	Date	Actions arising
1.	Consultation on proposals	08/05/2012 (to 11/09/2012)	Submission date extended
2.	Full PPF network informed of consultation and Scottish Health Council Regional events	23/05/2012	
3.	PPF Core group meeting (Agenda item & PPO Update)	06/06/2012	Presentation given; agreement to host and virtually plan two South Ayrshire events
4.	Virtual event planning group formed (includes supporting staff from VASA, SAC and NHS)	15/06/2012	Event planning template started
5.	Full PPF network informed on local events	29/06/2012	
6.	Girvan event Prestwick	06/08/2012 07/08/2012	Feedback collated into one event report for use by PPF, VASA and Carers representatives on CHP Forum as well as SAC and CHP support staff
7.	First draft joint event report shared with request for comments. (Final draft by 17/08/2012)	09/08/2012	Receiving report: CHP Forum representatives – PPF, VASA and South Ayrshire Carers Centre as well as SAC and CHP support staff
8.	VOiCE report opened by NHS Public Partnership Officer and SAC Community Engagement Officer	14/08/2012	Reviewer status: CHP Facilitator SAC Head of Housing and Community Care PFPI Manager
9.	CHP Ayrshire wide event	21/08/2012	Report supported CHP Forum representatives
10.	PPF Core group meeting	29/08/2012	Receive and discuss feedback
11.	Final report sent to event attendees	11/09/2012	Report also shared with those unable to attend but

			wanted to participate in consultation. Also advised on Scottish Government's website for own direct response
12.	Submission to Scottish Government	11/09/2012	Sent with events report

3. Attendees

From the events' registers, the following voluntary /community groups were identified:

1. Alzheimer Scotland
2. Ayr Stroke Club
3. Ayrshire Independent Living Network
4. Ballantrae Rural Initiative Care in the Community
5. Care & Repair South Ayrshire
6. Foodbank South Ayrshire
7. Girvan Community council
8. Girvan Elderly Forum/South Ayrshire Forum on Disability
9. Hospital Patients Council
10. New Life Centre, Prestwick
11. Quarriers
12. Recovery Across Mental Health
13. South Ayrshire Carers Centre
14. South Ayrshire Dementia Support Association
15. South Ayrshire Seniors Forum
16. Troon Tenants and Residents Association/Troon Community council
17. Voluntary Action South Ayrshire

Other attendees included: elected members, Patients Advice and Support Service plus supporting staff from South Ayrshire Council (SAC) and NHS Ayrshire & Arran. There were also Individual members of the PPF and carers from the Carers Centre.

Girvan total = 21 (8 not registered)**; Prestwick total = 34** (12 not registered) SAC and NHS supporting staff are not counted in totals

4. Summary of discussion and points emerging from local events

Section 1 - The case for change
There was a general agreement to focussing on improving outcomes for older people and then extend focus to all areas of adult care. Age needed defining and dementia considered. There were concerns about a period of inequalities in adult care whilst older people integration occurred and concerns relating to the size of the partnerships.

Section 2 - Outline of proposed reforms
There were a number of areas missing from the proposed framework which included:

- housing
- related (older people) adult support services such as adaptations
- falls prevention
- transport
- public health promotion and education
- public involvement/community engagement
- inclusion of private providers
- community led social enterprises and
- third sector groups/organisations.

How the health and social care partnership develops, for example leadership, staff training - would need to be considered as well as internal systems, such as complaints and communications.

Section 3 - National outcomes for adult health and social care
National outcomes for adult health and social care were not seen as a strong enough mechanism to provide the shift in direction. This was mainly due to concern about accountability. All groups said if nationally agreed outcomes were provided they should be included in the SOAs.

Section 4 - Governance and joint accountability
Accountability and governance was of concern due to transparency of where responsibility would lie and national and local politics could be in conflict. There were mixed views on partnerships covering more than one LA. There were benefits, for example, sharing resources however there was a fear of centralisation and increasing the number of Chief Executives to report to. There was a strong concern about the lack of public involvement and third sector in the committee arrangements. A lack of public involvement would not make the performance management arrangements robust enough to provide public confidence. Functions that support vulnerable groups/services may suffer if associated budgets were not included. There were uncertain/mixed views on how this could be achieved with a suggestion that associated support services should be included.

Section 5 - Integrated budgets and resourcing
It was difficult to provide comments on the models without knowing more about the Highland model. There were concerns the Highland model would have transition problems. Whatever model a Health and Social Care Partnership chose, it should consider it in relation to its own peoples needs. A variety of experiences were given including: hospital discharges, administration of medicines, communications, self directed support, means testing.

Ministerial direction on minimum categories of spend to achieve their objectives gave concern about localism. However some felt it was needed but asked what happens if it is not sufficient and how much time is needed to determine if funding is sufficient.

Section 6 - Jointly Accountable Officer
The financial authority and level of seniority of the JAO's post was difficult to answer. A deputy was suggested because of concerns about the JAO's own political leanings. It would also be depend on the supporting financial structure.

Section 7 - Professionally led locality planning and commissioning of services
There was general agreement for local determination on how locality planning is taken forward with a suggestion for some ministerial guidance. The duty to consult was generally thought not to be strong enough. It should also include a duty to show feedback form all is considered. Suggestions for getting health and social care involved and drive planning at a local level included the provision of opportunities for all professionals to become involved. Inclusion in contracts, joint training and shadowing were also suggested.

Locality planning should happen within local geographic areas and not necessarily around GP practice clusters with responsibility and decision making kept local. Organising localities around a given size of population could be problematic for rural areas. A suggestion was made to consult with front line staff and also to consider travel times (for professionals to reach patients) as a range.

5. Full workshop notes

Section 1 - 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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Already good relationships between health and social care and therefore further integration was helpful and practical	Define age – 65 + - Reshaping care agenda Logical to start with older people – ageing population	Focus on older people -roll out after lessons learned and used appropriately Ties in with Reshaping Care	Good idea – it would be practical and helpful. Resources, people could be shared through one access point	Generally this is supported albeit with clarity needed re 'grey' areas like dementia Starting on area of older

Concern about the affordability of integration Concern over the equality of care if the process starts with older people and other vulnerable adults (disabilities) left behind Concern over the whole case for change due to the unknown	Falls prevention should they be sent back home Integrated service provision should service the needs of local people better Integrated health and social care package for older people Should be a holistic approach to care Issues of joint training, front line care staff	where focus is on improving life for older people Reshaping care – needs update – services should continue providing projects and demonstrate they are reducing hospital admissions Implying improvement – services need to be addressed	Patient is not concerned where support comes from (either through NHS or the LA) so long as they get it Concern about over bureaucracy and overloading the system	people was building on strong foundations of existing joint work.

Section 2 - 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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Areas missing: Housing (sheltered and the wider) Support services – a fear some of these may be missed if not identified at the outset Public health: health promotion and education – where would this now lie? Currently fits in community health; consultation paper	Will there be more money to provide more services? (Less money in the acute sector) Timing of release of money from acute sector? Preventative integrated measures. Change fund. Lack of information on timescales and funding – crucial to have more information and detail	Preventative measures should be included Concern with keeping people in own home unless services are there to support - may cause isolation Need for falls prevention – early interventions redress cost in long term Need for more carers and care services – training	**Areas missing:** Good organisational development should include staff training Supply of housing Adaptations not only to housing but also ensure adaptations specific for patients needs are also included A quality complaints	Housing should be added New arrangements need to address the issue of people being 'stuck' in the system It was noted that integration is more dependent on good leadership, relationships, communication, behaviours, culture, etc than structures New structures need to embed Standards for

focuses on elderly and unwell only When including missing areas – need to be aware of complex financial issues due to monies coming from a variety of sources Concern about centralisation and localisation not based on needs Wheelchair accessible transport	Overlap between Change fund ending – gap in funding What it means for service users – too woolly - needs to be more specific for service users to understand Ensure quality of provision of care in the community Issues of respite Issue of assessment of needs for service users Rural issues – housing, leisure, mental health, education Issue of scrutiny – by whom? Service users? Transport for older people	needs Low wages - incentives for people to want to work in care More community led social enterprise and third sector requirements Infrastructure required in the community – community involvement Third sector can feed in to community plan (South Ayrshire - Mirrored Thematic Groups) Need to get better at publicising what is going on in the community Community empowerment	procedure Should recognise public involvement as well as voluntary groups/organisations, patient groups and carers	Community Engagement within way of working There were concerns regarding private providers and lack of accountability and suggestion that they should be subject to Freedom of Information legislation

Section 3 - 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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
concern the mechanisms described will not be strong enough as accountability is not local	Joined up accountability Equality – health more dominant partner – need equal consideration to social care	What structures/roles will local councillors have - three from council and three from NHS – rotating Chair	There were doubts about using National outcomes Strength of mechanism - the Joint Accountable Officer must have the quality	Yes – this was generally supported and remove the 'blame culture' between organisations

Common outcomes across adult services Should be outcomes for each area of care with sets of outcomes joining up Local identities could be lost	Enablement outcomes need to b clear Who is agreeing outcomes? Various indicators required Tendering for work – impact on quality measures in place	Makes sense to have joint outcomes Structures of partnerships – important to keep people informed How will it work for front line social care and health staff? Single shared assessment – workers may not be aware of all legislation Accountability and scrutiny	skills with strong leadership National outcomes can help but will require local input National agreed outcomes could provide guidance for Single Outcome Agreements	Suggestion of learning lessons from Glasgow set up Integration is often the result of 'personalities' that make it work

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Yes - consistency across Scotland was good but as guidance for the content for local SOAs which should reflect local issues	SOA – nationally agreed outcomes need to be in SOA Strategic objectives need to be embedded in SOA – wider services	Yes – partnership need the right people and services involved – voluntary and public sector Nationally agreed outcomes should be in SOA	National outcomes can help but will require local input National agreed outcomes could provide guidance for SOAs	Yes

Section 4 - 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				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
A strong group "no" Democratic accountability at	SOA – transparency, joint accountability	Shared powers and accountability Social care accountability	Concern about working to two Chief Executives and the size of the Health and	Generally supported Concern re clarity of who to

a local level could be “in deficit” – “no one to carry the can”	Scrutiny and accountability – needs to happen at local level	split – accountable to Health Board, ministers and head of council Social services need to be **<u>equal</u>** to health service considerations – ensure **<u>equal</u>** partners Needs to be more public involvement as this is not clear in the document Local elected members are accountable to voters – need more Learn more from other areas where integration has taken place Partnership needs to be accountable to local members/public Scrutiny measures needed	Social Care Partnership Concern about politics - a similarity to Westminster’s coalition government	go to to ask accountability questions (eg re resource allocation) and general transparency

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Group did think there could be some benefits to having only one Health and Social Care Partnership. With only one Health and social care partnership in	No - local people look to local councillors. If pan Ayrshire - rural dimension and access to services Concern about centralisation of services	Should be provision for each local authority to decide Would prefer local partnership Mixed views – some	The legislation does need scope to cover more than one locality – e.g. cities. Should allow local areas to decide based on local needs	Mixed views on this It was supported that this should be in legislation but mixed views re whether a larger structure would lack local accountability

Ayrshire – accountability would be more complex as reporting would be to three LA Chief Executives plus a Health Board Chief Executive. If it was to be one Health and Social Care Partnership for each LA area in a NHS Board area – the Joint Accountable Officer should work in partnership with any other LA's in a NHS Board's area		organisations work pan Ayrshire with different policies and procedures – accountability would be difficult to manage	Advantages to covering more than one local authority means services can be shared across boundaries	

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Public involvement and views of public not supported	Does not serve needs of local people living in rural areas; makes rural areas more rural – isolation Planning structures based on population?	Accountability to the public – community engagement with voluntary sector and patients Structure for PPF and voluntary sector to be involved in partnership Ensure people are listened to	No – committee arrangements not appropriate Volunteer members of the public should be included as voting members	Mixed views on this It was felt that Public voice might be more influential if they were not voting members of Committee and could remain more critically independent It was felt the Third sector representative should be a full voting member

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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Concern that local actions and decision making will be removed or diminished Public involvement needed		Public involvement required – the PPF has a place on the CHP Not robust enough – democratic accountability How budgets are spent - Elderly forum involvement – need stronger voice	Robustness will depend on including a member of the public	Yes - but we have to wait to see if it 'does what it says on the tin'

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				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
	Planning of services at local level Cross party consensus on integration manifesto	Children's services, additions services, mental health issues – individuals may have multiple issues Provision should be there – however initially need to focus on integration of adult health and social care budgets Preserve links and build upon good practice	Concern that children, young people and those with disabilities are left behind if not included Get adult health and social working before including other CHP functions then start including other areas provided existing functions do not suffer	There should be national consistency regarding what is included Probably, this needs to be services where the outcome is dependent upon what they provide, for example, housing, some leisure, health promotion

Section 5 - 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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Difficult to answer - as to which one could be best for Ayrshire without knowing more about how the Highland model works	Would not want medical model of health making decisions on social care – should be joint equal	Problem at transition – when you go from child to adult services Need to know if Highland model works effectively – or other areas Would vary depending on urban/rural population Would need to have clear approach relating to transition Scope to consider other models **<u>Monitoring</u>** – accountability – evaluation Learn from other areas - Northern Ireland for integration of health and social care	Concern using the Highland model as there was a fear it could not support the transition form children / young people to adults Whatever model is chosen, there should be flexibility to include for example - mental and learning disabilities	Thought to be a leading question! This was hard to answer – we need to se evidence of Highland model to assess whether it works or not It was felt that different models might work in different areas Another comment was ' it's better than what we've got'

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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Means testing for residential	Health and social care	Who is providing care?	A patient can leave hospital	Experience in group of use

care? Local Authority could lose money if people remain in the community	outcomes Girvan Opportunities links with community learning disability team Very difficult to get in touch with appropriate person urgently Some services already working well in partnership – learn form this Scrutiny of accountability Who to contact – need for clarity at local level – customer services – quality Feedback to service users Concern that the social needs are not recognised in favour of health needs Unmet social needs are factors in deterioration of psychological and emotional well being	Who is administering medication – issues of insurance Integration should mean services work more effectively together for the individual. Holistic. Issues at planning – people doing what they say they are doing	once package is in place but physiotherapy in hospital stopped immediately. The doctor said you can go home. Patient only got home because family kept pressing issue with social work. No-one would help the patient who was on the discharge list. As a carer of someone with dementia, resources across the health and social care system I would like to see are: A clear streamlined complaints procedure for all organisations (private and public) that are caring for older people. Complaints procedure to include the Scottish Public Services Ombudsman with the capacity to do independent review of professional social work judgements, as well as NHS clinical judgements, using a panel of independent experts A thorough community care assessment undertaken within set timescales Home carers (for older people) in rural and	of Self Directed Support Need flexible use of resources

			suburban areas need better support in accessing transport Inclusion of carers of those with dementia to be highlighted/included when making clinic and other social care appointments for dementia and for other issues Reduce problems around "bed-blocking" and similar situations in dementia care, because of adult incapacity issues Improving access to Occupational therapy resources including approved private-sector contractors	

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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Concern about what minimum categories could be Should be local decisions	No job losses on front line staff Bureaucracy No – needs to be agreed at local level to enable all outcomes identified to be met	Yes – probably What time is allowed before it can be determined that funding is sufficient	Concern that this will not be sufficient - safeguards to be inbuilt to ensure outcomes are achieved	Minimum categories should be included based on proper consultation

Section 6 - 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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
What will the financial structure look like that will support the JAO. Where will it exist – in the LA or with the NHS Board or in the "Body Corporate" Concern about generating *quango*s Differences in financial rules between the LA and NHS Board – for example the inclusion / or not of VAT Success could be dependent on money following services automatically	Need local decision makers	Insufficient information	As the JAO sits between two Chief Executives there could be political pressures on him Concern about JAO's own political leanings A need for a second person and/or deputy	Insufficient information

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Insufficient information		Insufficient information	Insufficient information	Insufficient information

Section 7 - 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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Locality planning is already in community planning Local determination	Need locality planning person centred approach Local determination	Insufficient information	There needs to be some Scottish Government direction	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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Duty is not strong enough due to lack of public involvement within appropriate timescales	GPs don't engage in relation to some services	Decided locally	Consultation with GPs and other professionals has to be a duty – but feedback from consultation has to also be considered Potential to review the GP contract Who will monitor new Partnership to ensure consultation is happening – Audit Scotland or the Scottish Health Council – to ensure feedback is listened to and acted on.	'Aye'

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?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
GPs – it requires building in – for example through GP contracts. GPs to be given opportunity to be involved. Financial incentives was discussed but group thought if they want to be involved it was opportunities that were important	Nurses, people who know issues – local people, public involvement, community council, family, carers, community sector Concern that the social needs are not recognised in favour of health needs.	Good working relationships already in place and should not be compromised Joint training; joint workshops Shadowing	All stakeholders should be included in planning services Need to be included in contracts	Get them together to get their views

Question 18: Should locality planning be organised around clusters of GP Practices? If not, how do you think this could be better organised?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Preference for locality planning to be within one local authority area – however it was recognised GP involvement could be lost	No. Local geographical partnerships for example – Girvan and South Carrick partnership	Leave to local discretion – do not prescribe	Local planning should be around the towns and surrounding villages which will include GPs	Not necessarily

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?				
Girvan		**Prestwick**		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
Will depend on membership/type of locality planning groups	Locality of planning - for example not going to Ayr for appointments from Girvan area		Unable to answer – "the devils in the detail"	Thought this should not be too prescriptive Probably as local as is possible

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?				
Girvan		Prestwick		
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
	Organised around a local geographic community - for example Maybole and North Carrick partnership of Carrick wide.		Concerns about rural areas Could range be based on travel times for health and social care professional reaching patients This also links in with responses given in question 18	This was logical but it was felt that front line staff (for example District Nurses) should be consulted about the best planning size to use It is hard to put an exact figure because of rural issues It needs to be viable but we don't want it too prescribed

6. Event reflection

In the initial stages of this consultation, PPF Core group members were unaware there was to be a shift in the submission date to the Scottish Government. An event planning group was formed as soon as it was decided events could be undertaken. In planning these events, previous event feedback reports were taken into consideration. Planning timescales were tight and a number of factors needed to be taken into consideration such as the availability of venues, speakers and the planners.

Attendees at both events had the opportunity to complete evaluation forms. Both venues were found to be accessible and fit for purpose; however the Space Place was affected on by the good weather. Light, heat and outdoor noise (lawnmower noise) were conditions out with the control of the event planners.

The information pack, the Chair's opening speech and the presentation were found to be helpful by the majority of attendees. Discussion groups generally went very well however it is recognised there is also a feeling amongst some attendees they could have been improved. Timing was always going to be a problem in covering all the Government's full questions. The reason for choosing the full set of questions rather than the Easy read version was to support those who would be answering the same questions at further events/meetings as part of the feedback process to the CHP Forum. This was to ensure consistency of feedback.

The reason for all discussion groups in one area was to enable areas of debate could be considered by all. On the whole most attendees were positive of this approach. Planners knew this would be a difficult task and had hoped to make it as easy to understand and work through as possible. Promotion of hard to read information and terminology by ensuring it is available at future events.

At the Core group meeting, there was a feeling there was not enough detail in the information provided in either the full or the easy read version of the consultation papers. Clear decision making was therefore a problem in answering all the questions meaningfully.

We would like to thank all attendees for their participation, hard work and feedback on both days. The information gathered and this report have been valuable in supporting further PPF member involvement and in creating a South PPF submission.

7. Abbreviations used:

CHP	Community Health Partnership
GP	General Practitioner
JAO	Joint Accountable Officer
LA	Local Authority
PFPI	Patient Focus and Public Involvement
PPF	Public Partnership Forum
PPO	Public Partnership Officer
SAC	South Ayrshire Council
SOA	Single Outcome Agreement
VOiCE	Visioning Outcomes in Community Engagement
VASA	Voluntary Action South Ayrshire
VAT	Value Added Tax

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To whom it may concern

Integration of Adult Health and Social Care in Scotland – South Ayrshire Public Partnership Forum response

Please find enclosed a response to the national consultation from South Ayrshire Public Partnership Forum (PPF). The PPF held two local events to gather PPF members' views. Non PPF member groups/organisations and wider members of the public were also invited. The report on the two events is also enclosed in support of the submission.

We hope this is satisfactory.

Kind regards

Gill Rogers
Public Participation Officer (PPO)

On behalf of Linda Sharp, Core group Chair, South Ayrshire PPF

Enc/
Annex F Respondent Information Form
Annex G Consultation Questionnaire
SA PPF Local events report

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 ☒ No ☐

Comments Good idea – majority of comments from the discussion groups thought this to be practical and helpful.

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?

Yes ☐ No ☒

Comments We feel housing, support services, partners such as SPT, accountability structure, community engagement/public involvement are missing. There should also be a stronger emphasis on voluntary sector and carer involvement.

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 ☐ No ☐

Comments Unsure – because need to know which mechanisms are going to be used to support the structure / framework. Who will be agreeing the national outcomes in the first place?

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 ☒ No ☐

Comments National outcomes will help but these will need local input.

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?

Yes ☐ No ☐

Comments There are concerns about shared powers and accountability. Scrutiny and accountability needs to happen at local level. Social services need to be equal to health service considerations – ensure equal partners.

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

Yes ☐ No ☐

Comments There should be scope for one H& SCP however there are local concerns in this area for one H&SCP. There are mixed views as there are advantages to services sharing resources – however rural dimensions and access to services could be comprised.

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

Yes ☐ No ☒

Comments There is a concern about lack of public voice. Also a concern that there is no voluntary sector member on the committee.

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 ☐ No ☒

Comments Public Partnership Forums were legislated for previously but there is no mention of them in this paper. The consultation paper appeared to be limited in its information and there is a strong concern about lack of public involvement - in particular (older) adult people involvement – and then sustaining this involvement.

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 ☐ No ☐

Comments There is a concern about vulnerable people - children, young people, those with disabilities including mental health – being left behind whilst budgets are decided.

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 ☐ No ☐

Comments Different models may work in different areas – maybe need to look further afield – Northern Ireland. We would need to know how the Highland model evaluates. There was concern about the transition period from child to adult and also need to consider mental health and learning / physical disabilities. Whichever model is decided monitoring and evaluating will be important to assess delivery in use of money.

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 ☒ No ☐

Comments There are many experiences of good and bad use of resources. It is arguably the case of people who shout most for resources or people who have knowledge of systems who receive resources. What is required is a fairer system with more thorough community care / health assessments undertaken within known timescales. Please see attached full discussion report for further experiences.

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 ☐ No ☐

Comments Budgets need to be agreed at a local level and that the minimum categories should be based on proper consultation between key stakeholders.

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?

Yes ☐ No ☐

Comments There was insufficient information in paper to be able to discuss this effectively. However there is a feeling that any Jointly Accountable Officer may require a deputy / team to provide a balanced view.

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

Yes ☐ No ☒

Comments Insufficient information in the consultation paper.

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?

Yes ☐ No ☐

CommentsThere needs to be a level of government guidance with local determination on how locality planning is taken forward.

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 ☒ No ☐

Comments There is a concern about GPs not fully embracing partnership working. So therefore the duty to consult should not solely be on the Health and Social Care Partnerships and other professionals but also on GPs. The duty could also include a duty to feedback on what has been considered during consultation. Is there a potential to review the GP contract to ensure this happens?

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?

Comments Get them together to get their views could be achieved by including “steps /changes” in staff contracts.

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

Yes ☐ No ☒

Comments Local planning should be around the towns and villages which will include GPs

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

Comments This will depend on what the Health and Social Care Partnership will look like and work.

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?

Yes ☐ No ☐

Comments It needs to be doable but not prescribed.

Do you have any further comments regarding the consultation proposals?

Comments Future national consultation where good meaningful and effective public involvement could follow National Standards for Community Engagement. Timescales were problematic; accessible documentation for people to consider was needed and it would have helped if questions asked were consistent throughout the consultation period.
There was not enough detail in the consultation papers in either the full or the easy read version. Clear decision making was therefore a problem in answering all the questions meaningfully.

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

Comments

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

Comments